LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Public Health Amendment Bill 2021 (No 2))

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 1 FEBRUARY 2022

Secretary to the committee:
Dr D Monk (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

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Amended 20 May 2013

The committee met at 2.32 pm.

RATTENBURY, MR SHANE, Attorney-General, Minister for Consumer Affairs, Minister for Water, Energy and Emissions Reduction and Minister for Gaming
NG, MR DANIEL, Acting Executive Group Manager, Legislation, Policy and Programs, Justice and Community Safety Directorate

THE CHAIR: Good afternoon guys, gals and non-binary pals; welcome to the second public hearing of the Legislative Assembly's Standing Committee on Health and Community Wellbeing inquiry into the Public Health Amendment Bill 2021 (No 2).

The committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture, and the contribution they make to life in this city and this region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander peoples who may be joining today's livestream.

Today's witnesses will include the Chief Minister, Andrew Barr, the Attorney General, Shane Rattenbury, and the Minister for Health, Rachel Stephen-Smith.

Please be aware that today's proceedings are being recorded. They will be transcribed and published by Hansard. The proceedings are also being broadcast and webstreamed live.

For those appearing before the committee today, if you take a question on notice, could you please state clearly that you will take that question on notice. This will help the committee secretariat to follow up with you after today's hearing, to ensure that those questions are noted.

Appearing first today is Mr Shane Rattenbury MLA, in his capacity as the Attorney-General of the ACT. Welcome, Minister. Minister, please be aware that today's proceedings are covered by parliamentary privilege, which not only provides protection to witnesses but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter, and all participants today are reminded of this.

Can you please confirm that you have read and understood the privilege statement that the secretary has sent to you?

Mr Rattenbury: Yes, I have; thank you.

THE CHAIR: In lieu of an opening statement, we will head straight to questions. As the chair, I will kick us off. Minister, we have received quite a number of submissions to this inquiry from individuals. From reading a lot of those submissions, the perception of the human rights implications of this bill was invoked by a number of those who have made submissions. I understand that, as the Attorney-General, you have some responsibility within the government to ensure human rights compliance or compatibility of government legislation. Would you mind talking the committee through what your role in the process of the development of this legislation has been?

Mr Rattenbury: Certainly. From a formal point of view, I am required to sign the human rights compatibility statement before the bill is tabled in the Assembly. I signed that compatibility statement. Based on advice from the Justice and Community Safety Directorate, the bill is compatible with human rights.

In terms of the development of the bill, the Justice and Community Safety human rights and scrutiny team and the Human Rights Commission were both involved in extensive discussions with ACT Health, in terms of developing the bill. I guess that is what we call a dialogue model—the idea that we should work on human rights issues as we develop the bill so that they are embedded into the bill.

As some of your submitters and, I am sure, the committee have noticed, the objects clause of the bill is explicit in stating an expectation of consideration of human rights in the use of this bill. In going through the bill—and I am happy to go to specific areas that the committee might be interested in—as an overall observation, there are extensive safeguards through the bill in terms of requirements for publication of information; the necessity of advice from both the Chief Health Officer and the Human Rights Commission; and, in some places, disallowable instruments, which provide oversight from the Assembly.

THE CHAIR: It might seem like a redundant question, but could you explain in lay terms what a disallowable instrument would mean in the context of this bill, and how that interacts with some of those human rights protections?

Mr Rattenbury: There are a couple of key instruments. The bill allows for both notifiable instruments and disallowable instruments. A notifiable instrument is signed by the executive and published, and it simply becomes enacted. A disallowable instrument can be overturned by the Legislative Assembly voting to overturn it. There are particular parts of the bill that are disallowable to provide that additional level of scrutiny where the parliament can have oversight.

It is fair to reflect that the ACT government looked at the Victorian bill as well, which seeks to create a similar framework, and felt that this provided a better level of scrutiny than we saw in the Victorian legislation.

This bill seeks to create a temporary framework for COVID-specific public health measures for an 18-month period. Built into that are a number of specific safeguards. The first is that measures in this are COVID-specific. They do not create more generic powers for the government. Secondly, the bill has a specific time period. It has a sunset clause in it. It is valid only for 18 months, unless the Assembly chooses to extend it further. That will be something that we will need to consider, but at the moment that 18 months takes us through to the end of winter 2023. Our view is that that will be a sufficient time to understand the ongoing nature of COVID in our community.

THE CHAIR: Minister, you mentioned that there were some specific elements of the bill in terms of its human rights compatibility that you are happy to go into. For the person watching at home or submitters who have raised human rights concerns, what are some of the highlights that you identified that you would point people to, to say, "These are some of the very specific measures embedded in the bill that do in fact

protect human rights"? Where would we point people to?

Mr Rattenbury: In some regards, I have already touched on the first couple. With respect to the scope of the bill, in limiting it to being both COVID-specific and putting a time line on it, it is not giving government unfettered power. It has created a specific framework.

The disallowable instruments are important. I am not sure how we table documents for an online hearing, but I have a specific list that I have prepared for the committee that outlines the safeguards included in the bill. I will table that through whatever mechanism we now use. I will probably email it later. Things like the vaccination declarations are specifically disallowable, being mindful of the fact that that is an area of particular interest and concern to the community. There is also the ability for the external review of particular decisions. The Chief Health Officer, for example, has the power to require somebody to undertake isolation.

We have created a specific, independent, external review of those decisions, so that if somebody feels that they disagree with it, or that the decision is in some way unfair or biased in their mind, there is an ability to go to an external reviewer outside the health system or those health decision-making roles. Those would be a couple of examples.

MR PETTERSSON: The ACT Law Society have voiced concerns about section 118U, which indicates that a Chief Health Officer direction can be made to apply to a particular person. Is this deliberate? If so, what considerations were had in drafting it in such a way?

Mr Rattenbury: I will invite Mr Ng to make some further comments on this, but this is a deliberate policy decision. This is a medical response to a person potentially being a risk to others in the community, and that is why that is in there. Mr Ng might have some further comments.

Mr Ng: Thanks for the question, Mr Pettersson. Yes, as the attorney indicated, it was an intentional decision to allow for individuals to be subject to directions. Obviously, there are a range of powers and tools that our public health officials require to manage the impact of COVID-19 in our community. Some of those issues and impacts are dealt with at a macro level, with community-wide directions and the ability to influence particular sectors of activity. Some of them are quite particular to individuals and their circumstances.

In relation to the Chief Health Officer's powers of direction under the bill, they relate to medical examination testing, and segregation or isolation. The committee would appreciate that, in those particular circumstances, under that suite of powers, there are occasions when they are better targeted towards individuals than directed to the community at large.

THE CHAIR: Minister, the parts of this bill that would obligate some people to get a vaccine seem to be what have captured the attention of the majority of our submitters. I think that the real value of this process is being able to provide more detail and, hopefully, even some assurance to some who might have some anxieties about some of those provisions. Are you able to explain, to the best of your understanding, what

confidence you have that the bill, in its current form, protects people from not having a vaccine if they do not want one? A lot of our submitters have argued that this bill, from their interpretation, would force them to get a vaccine. That is not my understanding, but could you elaborate a bit further on that point?

Mr Rattenbury: Yes, I can be very clear about that. This bill has been designed because vaccination orders are important in high-risk workplaces, to make sure that vulnerable clients and other workers are not subject to unnecessary risks. It is very much about that need to protect some of the most vulnerable in our community. These orders will be made where it is necessary to keep people safe.

In making a vaccination order, the government is required to seek the advice of the Chief Health Officer. First of all, we have to get that medically based advice. We must also consult with the Human Rights Commission. That is where the human rights considerations will begin. So you have those two arms of advice that the government must seek under the legislation.

The advice of the Human Rights Commission will be particularly important in making sure that human rights are fully considered on that case-by-case basis, because any direction under these sections will be for a specific workforce or a specific workplace, for example.

As I touched on earlier, understanding the sensitivity of the community around these issues, and the fact that it can be a contentious discussion, the orders are disallowable instruments. This is one of the main parts of the bill that is disallowable. They are subject to that high level of scrutiny and can ultimately be disallowed by the Assembly; a majority of members of the Assembly could actually reject such a mandate if there was a view that it was inappropriate in some way.

The bottom line, and in terms of your question, is that it is really important to understand that no-one is being forced to have a vaccine against their will. No-one will be taken to a medical facility and have the needle put in their arm. However, there may be areas in which people cannot work if they choose not to have a vaccination. Again, it brings us back to that question of high-risk settings and high-risk members of our community who are particularly vulnerable to this disease.

Of course, under our Human Rights Act, there is a right to work. This provision could be considered to limit that right to work. But we also have an understanding in the Human Rights Act, where a specific section talks about reasonable limitations. The government considers this to be a reasonable limitation, as it is necessary for public health and safety.

THE CHAIR: Can I ask a quick follow-up, Minister, before we go to Mr Milligan for his substantive? Are you aware of instances in the government currently where there are staff or individuals and, even though they are working in high-risk settings, their right to work has been guaranteed, and they have been moved into other roles or other areas of the workforce where they may not be working directly with people in a high-risk setting?

Mr Rattenbury: I am sure that the Minister for Health could provide some more

detailed examples of this. Certainly, in the government's approach so far to vaccine mandates, we have been very clear, and there has been extensive discussion with unions and other workplace representatives, that where somebody does not wish to be vaccinated, and they are in that frontline, high-risk role, the first response will be to seek redeployment, so that they may work in a different part. Health would be a great example where there are lots of jobs that are not necessarily public or patient facing, and people can still work in the health department. I am sure that the health minister could provide you with more specific examples.

MR MILLIGAN: Mr Rattenbury, there are a lot of submissions that have concern over human rights within this bill. The Human Rights Commissioner attended; they answered quite a few questions for us. From your perspective, when it comes to proof of vaccination and showing your vaccination status to enter a building for work-related matters or anything else like that, what form of proof is required? At what point does your latest vaccination date need to be stated on your proof of vaccination? As I understand it, the date that is listed is your last vaccination or booster; is that correct?

Mr Rattenbury: I believe so. It is probably best to check that with the health minister, but I am pretty sure that that is the case.

MR MILLIGAN: As I understand it, people have a right to request that information from an individual, but it is up to the individual whether or not they want to show their vaccination status to enter a business or to show it as proof of vaccination for employment. They are not forced to do so; it is simply their choice.

Mr Rattenbury: Yes.

MR PETTERSSON: Failure to comply with any direction made under the bill is an offence. This includes a failure to prevent or restrict another person who is not vaccinated from accessing a particular place. It is unclear how a person to whom such a direction has been given can comply with the obligation—for example, whether they have the power to physically prevent someone from entering a venue. Could you elaborate on that for the committee?

Mr Rattenbury: I will ask Mr Ng to go into the detail on that one.

Mr Ng: Mr Pettersson, could you ask that question again?

MR PETTERSSON: I will give you the whole question again. Failure to comply with any direction made under the bill is an offence. This also includes a failure to prevent or restrict another person who is not vaccinated from accessing a particular place. However, from my reading, it is unclear how a person to whom such a direction has been given can comply with the obligation. For example, do they have the power to physically prevent someone from entering a venue if they are not vaccinated?

Mr Ng: I think there would be particular circumstances where occupiers of land would have certain rights about the use of and entry to their property. My colleagues in Health might be better placed to answer that, particularly given that they are responsible, in part, for the enforcement of public health orders, including the

proposed regime as well. I might defer to my Health colleagues on that question. They will appear before you in the near future.

MR PETTERSSON: They are next up, so that is fine.

MR MILLIGAN: I want your position on the restrictions, to be able to restrict someone from movement into and out of the ACT, and internally. How is this consistent with human rights and freedom of movement?

Mr Rattenbury: This goes to the notion of reasonable limitations—section 28 of the Human Rights Act. The bill seeks to balance the necessity of protecting public health with the rights that are contained in the Human Rights Act. That is why there are requirements. First of all, the Chief Health Officer will make that assessment of the necessary restrictions based on her best understanding of what is necessary to protect the health of the community; then there is input from the Human Rights Commission through the process. It is a balancing act, Mr Milligan, as we have experienced over the last 18 months or so. We have to find that reasonable limitation on rights.

MR MILLIGAN: Obviously, there are measurements, requirements and parameters on which you make these decisions—guidelines, or however you want to phrase it. How are you ensuring that you get that balance right, in restricting someone's freedom of movement while also ensuring the public health and safety of the community? Is there any example or a guide that you will be following, in order to measure this?

Mr Rattenbury: Perhaps one of the things I can say about this new bill is that, in creating an ongoing, deliberate framework—of course, we have been operating under emergency powers until now—there is a requirement for the publication of reasons. I think that transparency is very important in demonstrating that weighing up, that you were talking about, of the considerations that have been taken into account. That is certainly one way for both the Chief Health Officer and the government to be held to account and the public to be able to form their own view on the reasonableness and the balancing of those rights and limitations.

MR MILLIGAN: I totally understand that; yes, you have to publish the reasons behind putting in these restrictions. Could the public refer back to when these restrictions were in place, on travel between states and territories? Could they use that as an example of what COVID has to be like at the time for these restrictions to come back?

Mr Rattenbury: If you were to ask the Chief Health Officer that question, based on some of the advice we have had from her over time, there are not those single thresholds. The assessment of the public health risk looks at a range of things, including how much movement is going on in the community; what sort of restrictions are in place; the number of people that currently have the disease; and how many people are vaccinated. There is a whole series of factors which the Chief Health Officer seeks to take into account as she thinks through the risk profile. They are the things that get weighed up when trying to find the right set of public health safety measures to put in place. There is not a linear formula, in that sense. I am sure that the CHO would be happy to talk to you a bit more about that. That is the advice

that the government has been consistently given over the last 18 months.

Mr Ng: If I could add to the attorney's answer on that question, on the issue of the manner in which there is the relevant right to balance, we have talked a bit about the limitation on the freedom of movement. One of the fundamental aspects of the bill is that it does support and promote one of the other rights in the Human Rights Act, which is the right to life, which also enlivens that government responsibility to make reasonable safeguards to protect life within the jurisdiction.

The Human Rights Act anticipates the potential tension between some of those. It also has the mechanism to resolve that tension. One of the means by which we can ensure and support consideration of the balancing of human rights within a framework is the inclusion of these oversight and procedural safeguards. The attorney has mentioned a few of them specifically.

In relation to the ministerial directions about entry into the ACT, there is the requirement to consult with the Human Rights Commissioner in relation to the consistency of the directions with human rights. There is also a need for the articulation of the statement of why the minister considers that the particular directions that she is making are consistent with human rights.

On top of that, there are also the review functions that can be afforded against undue or inappropriate use of those powers. In there, we have internal review decisions about whether people should be exempt from those types of directions. There is also the external review that the attorney mentioned before.

MR MILLIGAN: However, there is no consultation with the general public before making these decisions; it sits with the Human Rights Commission, the Chief Health Officer and the ministers.

Mr Rattenbury: In terms of specific decisions, that is true, Mr Milligan. As you have seen through the last 18 months or so, some of these decisions have been taken very quickly, out of necessity, to protect public health. What would normally be a government consultation period of four to six weeks obviously would not be effective in that context. That is the counter factor there that we had to take into consideration.

THE CHAIR: Given the time, on behalf of the committee, I would like to thank you, Minister, and officials for answering our questions and providing your evidence today. The secretary will provide your office with a copy of the proof transcript of today's hearing, when it is available, to check for accuracy. If you have taken some questions on notice, or in the case of that document you have prepared, Minister, please feel free to forward that to the committee secretary, to aid the committee in our deliberations.

Short suspension.

BARR, MR ANDREW, Chief Minister, Treasurer, Minister for Economic Development and Minister for Tourism

STEPHEN-SMITH, MS RACHEL, Minister for Health, Minister for Families and Community Services and Minister for Aboriginal and Torres Strait Islander Affairs

THE CHAIR: Welcome to the Standing Committee on Health and Community Wellbeing public hearing into the Public Health Amendment Bill 2021 (No 2). Please be aware that today's proceedings are covered by parliamentary privilege, which provides protection to witnesses, but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter, and all participants today are reminded of this. On the first occasion that you speak at today's hearing, could you please confirm that you have read and understood the privilege statement that the secretariat has provided.

Chief Minister, do you wish to start with an opening statement or are you happy to jump to questions?

Mr Barr: I will alert the committee that Dr Coleman is not with us. All other witnesses are here. We are happy to go to questions.

THE CHAIR: I will kick off with the first question. Chief Minister, I appreciate that there is a lot to this bill. Based on the submissions that the committee has received so far, the question of vaccine mandating seems to have captured the attention of most of our submitters. One point that has been put to me on a few occasions is that Canberrans were tuning in en masse to your daily press conferences, particularly during the lockdown. When the question of vaccine mandates, or vaccines in general, was raised, you rightly pointed out the challenge for the territory to receive an adequate supply from the commonwealth. The conversation was, "We don't have enough." It would appear that we now have, given the high rate of vaccine take-up in our community—98.6 per cent as of today. It has begged the question from some who have made a submission as to why those elements of the bill are necessary on this occasion. Could you talk us through that?

Mr Barr: Sure. Yes, the take-up of vaccination in the territory has been nation leading, and in many instances world leading. That has been largely a voluntary process, except for a small number of areas that were mandated, either by decisions of the national cabinet that the ACT enacted or some local decisions that were risk based and assessed by the Chief Health Officer and others on the basis of the risk of unvaccinated people working with vulnerable communities. That has largely been the basis for the limited number of vaccine mandates that have been applied in the ACT.

I described, at various points, some of the interventions and policy decisions of other jurisdictions as being unnecessary in the ACT context, given our very high level of voluntary vaccination participation. In most instances, that remains the case. However, there are examples, in particular workplace settings and particular community settings, where there must be a balancing of rights—rights for those who are vulnerable and at significant risk of severe disease, illness and potentially death, if they are exposed to unnecessary risk from an unvaccinated person.

The evidence across the various strains of the coronavirus has been that unvaccinated people are more likely to transmit the virus, and indeed to develop more severe disease. This has the potential in certain circumstances to place other people at significant risk. In balancing those various rights, the advice to government was that a mandate in certain limited areas was appropriate.

It is also a question of the timing of a mandate and the time frame in which individuals would have to achieve a vaccination status. Certainly, that was a factor that you alluded to in your question around supply. We felt that it would be unreasonable to demand vaccination, or have a vaccination mandate, when there were not sufficient vaccines to enable someone to comply with that mandate in the limited circumstances that we did apply it.

As you have identified, at this point, in relation to most vaccine availability, it is in a much better position than it was during the primary course of vaccination in calendar year 2021. But there are still examples of particular vaccine types not being available or for particular cohorts. There are different dosing intervals for particular vaccines that need to be taken into account in any decision that is made in relation to mandates.

Equally, the status of those at risk has changed over the duration of the pandemic. An example is that access to vaccines for under 18s has changed significantly over the last six months. These are all factors that need to be considered, together, of course, with decisions that are necessarily made at a national level, through the national cabinet, for implementation in each jurisdiction, often according to our own timetables and particular local issues, where national consistency is required because, for example, workforces might move across state and territory borders.

THE CHAIR: I want to pick up on one thing that you said about rights around work. Another point made in many of our submissions, and I fear purposely inflamed by some unscrupulous corners of the internet and social media, has allowed some people to feel like their jobs may be threatened or their right to work may be threatened. In his appearance just moments ago, the Attorney-General spoke about our government's right to work legislation. Could you talk a little more about what it would look like if an ACT government employee chose not to get a vaccine? What systems and processes do we have in place to still ensure their right to work, while obviously protecting the vulnerable that they might otherwise be working with?

Mr Barr: Obviously, it would depend on the context of the employment within the ACT public sector. I will take the question to be referring to instances where a mandate is in place and someone was not vaccinated. We have put in place redeployment arrangements. That will vary from directorate to directorate, depending on the nature of the work and the nature of the clients or otherwise that that particular public sector employee was engaging with. A school setting would be somewhat different from a health setting, or a hospital setting, for example, as opposed to some other areas of ACT government employment.

There is a standing policy in relation to redeployment. It is very clear, in terms of ACT public sector employment, that no-one is stood down or made redundant, as in to lose their pay. There are some people for whom the redeployment process may take longer than others, depending on the specialised skills or otherwise of individual

circumstances. But we have retained within the ACT public sector all staff. No-one has lost their job in the ACT public service. They may have been redeployed to another area where their vaccination status does not put others at risk.

THE CHAIR: I think this is really important for those who have been particularly agitated by that suggestion that, I think it is fair to say, others have made. Can I get some assurance from you and from the government that an ACT government employee who chooses not to get the vaccine will not lose their job? They may not do the same job, but they will not lose their job.

Mr Barr: That is correct, yes.

THE CHAIR: Tremendous. Thank you, Chief Minister.

MR PETTERSSON: The bill allows for three types of directions—a ministerial direction, a Chief Health Officer direction and a vaccination direction. Could you explain to the committee the delineation of decision-making for each of those separate directions and why those decision-makers are responsible for those responsibilities?

Ms Stephen-Smith: I acknowledge the privilege statement. Yes, you are right. There are three different types of direction and there are a couple of reasons for that. I will start with the Chief Health Officer directions. The Chief Health Officer can make directions in relation to a requirement for the provision of information, including information about the identity of a person or the production or keeping of documents; a requirement for the medical examination or testing of a person; or the segregation or isolation of a person.

If we think about the way that we are currently managing, and have been managing, the pandemic over the last couple of years, those are effectively test, trace, isolate and quarantine type directions that need a health judgement from the Chief Health Officer. They are not so much about balancing the impact on the economy, although, obviously, there are economic and social impacts from quarantine and isolation. It is really about saying: what is the appropriate response to somebody who has COVID-19 or has been exposed to COVID-19, in terms of protecting the community from further transmission of the virus in that circumstance?

The ministerial directions are more in the sense of what we have described in the management of COVID-19 as public health social measures, such as preventing or limiting entry to an area or into the ACT; regulating gatherings, whether that is public or private gatherings—the number of people who can go to a household or a density restriction in a hospitality venue, for example—and requiring the use of personal protective equipment. The requirement to wear masks indoors is a good example of that.

There is regulating the carrying-on of activities, businesses or undertakings—again, those density requirements, and other requirements, that might be put on businesses. Again, mirroring the Chief Health Officer's, there is the provision of information, including information about the identity of a person, and the production and keeping of documents. Things like use of the Check In CBR app would also come into that, from both a requirement for individuals to check in and a requirement for businesses

to have that Check In CBR app and require people to use it.

With respect to the reason why that has shifted, as you would be aware, Mr Pettersson, with the emergency declaration that we are currently sitting under, the public health emergency declaration, the Chief Health Officer makes all of our public health directions and has the authority under the Public Health Act to do that.

The reason we have chosen, in this legislation, to shift those public health social measures into the ministerial realm is that those are the things that require that bigger conversation about the social and economic impacts of that. There was consideration around the appropriateness of taking that out of the sole realm of the Chief Health Officer and putting that into the realm of the minister, to balance those broader considerations, with the advice of the Chief Health Officer and with the advice of the Human Rights Commission, while also taking into account those wider things, which the Chief Health Officer has consistently done.

Part of the feedback we have received from the community, and in response to other jurisdictions' legislation, was that these are appropriate decisions to be made by politicians who are elected, in the context of an ongoing response to the pandemic.

The third type of public health direction is the vaccination direction that we have been talking about. The determination was that this is something that should be done by the executive. That means two ministers need to sign it. That means, in practice, that it is really a cabinet decision—again, on the basis of advice from the Chief Health Officer and the Human Rights Commission—and being made as a disallowable instrument rather than a notifiable instrument. It provides that higher level of scrutiny by the Legislative Assembly.

Those vaccination directions would relate to a requirement to be vaccinated against COVID-19 to engage in particular work, to work at a particular workplace, to engage in a particular activity, and to access a particular place. That consideration was that this is a very significant human rights-related decision, so requirement for vaccination should be imposed. That deserves whole-of-cabinet consideration. In practice that is what has occurred, anyway. The Chief Health Officer briefs the cabinet and there is a conversation about these things for these types of directions in any case.

It is about taking it up to that level and then turning it into a disallowable instrument, so that the Assembly has that formal role in both considering the human rights implications through the scrutiny committee and the opportunity to debate that—potentially move a disallowance motion and debate that in the Assembly if there was a strong view by somebody in the Assembly that that was not justified.

MR PETTERSSON: Will vesting some of these powers in politicians lead to political considerations in some of our decisions in responding to a pandemic?

Ms Stephen-Smith: I will hand over to the Chief Minister in a moment. It is a really good question, Mr Pettersson, because there are both pros and cons in having that layer of consideration that is very much about the elected representatives making the decision. One of the really strong elements of our response to the pandemic throughout has been that we have listened to the health advice, we have followed the

health advice, and the decisions ultimately are made by the Chief Health Officer. That has served us really well. I think people also look for that level of accountability from their elected officials, and the government, the executive of the day, around those decisions that have a specific economic and social impact.

Mr Barr: It comes down, ultimately, to balancing a range of very significant considerations. The process that is outlined in the legislation effectively broadens the decision-making circle to encompass, via an executive decision, the whole cabinet; and the disallowable instrument element enables the entire elected parliament to have a view. Obviously, that would be most pertinent if the parliamentary view was different from the executive view. That has been the case in the history of the Assembly, over 30 years, on occasion—not always. That provides the avenue for that parliamentary debate to occur.

MR MILLIGAN: In the ACT Law Society's submission, they note that the use of powers must be necessary and proportionate to the health risk. You have spoken briefly about what measures you have in place to justify what health directions you do bring out in relation to the community. My question is also around what measures of current COVID cases at the time will be required to bring out any of these restrictions. Will it depend on how many people are in hospitalisation? How many people are in ICU or number of cases? Do you have an example of when you might use these powers to bring in these new directions and restrictions?

Mr Barr: That is a difficult question to answer in an absolute, black-and-white fashion, as in whether there would be any one particular number that would dictate one decision or the other. Clearly, there are a range of considerations that would be before the Chief Health Officer, the cabinet and, indeed, the Assembly, depending on the nature of the decision.

That would pertain to local, national and global information, as it pertained to COVID. We have seen how quickly the situation can change with new variants that have emerged very quickly that are different from previous ones, that have proved to be more infectious, and that have been more evasive to existing vaccines, for example. There are a variety of different circumstances.

Some of the issues that you touched on, Mr Milligan—around case numbers, hospitalisations, intensive care, impacts on the health system broadly, and community wellbeing in the health sphere—are the number one set of considerations, but there are other very important considerations that we are living through in a contemporary example. It is very clear, at least in the Australian context, that there is quite a close correlation between people's perceptions of safety and their levels of economic confidence. These things are necessarily intertwined, and they do form part of balanced decision-making.

I know that at various points there will clearly be contested views in relation to the level of public health social measures; the level of testing, tracing, isolating and quarantining; and the level of effectiveness of vaccination necessary in order to move to different stages of the public health response. One thing that is certain about the last two years is that there is a plethora of views on each and every one of those questions—views that are often based in lived experiences, views that are based in

academia, views that are based on preconceived understandings of past experience, even within this pandemic, let alone previous ones.

It is difficult to give, as I say, black-and-white answers to what triggers a certain situation, but there are some broad trends and datasets that are looked at. Effective reproduction rates of the virus are one such example. The overall capacity within a health system is another obvious and limiting factor, in terms of what level of transmission of a virus can safely be managed. That intersects with the level of vaccination. There are all of these moving parts. Of course, there is what is known or not known about the particular virus, or variant of a virus, that we are dealing with.

They are all, in many instances, quantifiable in time factors, but often some of these decisions need to be made in the absence of absolutely definitive information, for example, on the infectiousness or level of disease or severe illness that a particular virus variant might cause. We often have limited datasets from which to draw upon. If there is bias in the system, it is towards caution and taking a conservative and protective approach to community health.

I might wrap up my remarks there and invite the health minister to add anything, if she would like to do so.

Ms Stephen-Smith: The only thing that I would add, Mr Milligan, is in relation to the different types of directions, and therefore the different types of triggers or reasons that you might put a direction in place. For example, a requirement for someone who is diagnosed with COVID-19 to isolate for seven days might be in place continuously, whether or not we had cases in the ACT. As soon as we have a new case, we would want to know that that public health direction was in place and that person was required to isolate, and their close contacts or household contacts were required to quarantine.

You might move up and down in your public health social measures according to the risk that is presented by all of the factors that the Chief Minister went to—how many cases we have in the ACT and what that variant looks like. Also, it is about how many cases we have down the road in New South Wales, and whether that presents a risk to the ACT that has not yet resulted in a number of cases here but could do so very easily.

You might put in place a public health social measure to ameliorate that risk. If we get back to identifying hotspots around the country, for example—I think that is very unlikely, but we consistently said, "Never say never" throughout the pandemic—you might put in place that kind of travel restriction, which does not mean density requirements for the ACT but does put in place a type of public health social measure. It is highly variable, depending on which type of direction you are talking about.

MR MILLIGAN: In terms of economic impact, how much will that play into any decision you take, going forward? Is there any measure that you will use to determine, if we put in these requirements and these health measures, what the economic impact will be on the ACT? Will it be too severe, or will it have little impact? When talking about the health impact and the social impact, what about the economic impact?

Mr Barr: It is a very good question. Economic impact can be assessed in a number of different ways. Part of that assessment would be also over the potential duration, breadth of impact across the economy, and an assessment of the counterfactual. We have had a pretty good lived exercise of what the counterfactual is, through Omicron.

There are examples of the mix of economic and other public health settings that have been put in place at various stages that give you a sense of what the economic impact of different measures are and how broad that is. There is no doubt that society-wide prolonged lockdowns have the most significant economic impact. We have also seen that very high case numbers, even in the absence of any significant public health social measures, can have an economic impact.

We are not yet in a position to draw a definitive conclusion on the level of economic impact and its breadth across the economy. Even in the case of the very significant lockdowns, there were sectors of the economy where consumption shifted to, and they were doing better than they would have under other circumstances, because people's consumption choices were necessarily narrowed. As an example, supermarkets did particularly well when you could not go to a restaurant or go out anywhere to eat. People still need to consume food, so their consumption shifted to more purchases from supermarkets to cook things at home than restaurant meals or otherwise. That is one practical example. There are numerous others.

From the evidence that I can ascertain now that we could derive from the ACT situation, and from what has happened in other states and territories in Australia, is that the more significant the level of public health social measures—the more the government seeks to curtail activity in the community, in terms of physical movement—clearly, the sharper a particular downturn is. Equally, when that measure is released, the steeper the economic recovery is. Effectively, government is setting the time frame for which the economic restriction occurs and when the rebound occurs.

What we will see in the Omicron context is that because that was not necessarily a hard lockdown across the economy determined by government, but the collective sum of tens of thousands of individual decisions from consumers as to how they responded to their perception of risk associated with particular activities, it has meant that it has not been as steep a decline, but nor will it be as steep a recovery.

To put it in a very simple context, it is V-shaped versus a shallow U-shape, in terms of how you would describe the economic impact. A government-enforced lockdown tends to have a shorter time frame, a sharper impact and a sharper recovery. One that involves a situation like we are in now, where the public health measures are lighter, is likely to see a shallower dip but a more prolonged recovery arc, because it will be the sum total of the decisions of thousands and thousands of individual consumers as to when they feel comfortable to go back into particular settings or businesses.

MR MILLIGAN: Have you considered compensation for businesses or anyone that may be affected by any of the new health measures that may be introduced? We have spoken briefly about employment and anyone who may be affected by these types of restrictions, and we have spoken about the public service employment. We have the private sector to consider, too. What about business? Is there any consideration of

what impact this might have on business, and any form of compensation?

Mr Barr: Yes. "Compensation" is not the word I would use. Economic support has been provided across the Australian economy to the tune, according to APRA, of $420 billion of accumulated savings on household and business balance sheets. In the ACT context, there has been nearly half a billion dollars of direct assistance to 29,000 businesses, or thereabouts. It is a very significant level of economic assistance.

It is not formally titled "compensation". It is not designed to compensate for loss of profit, for example, but it is and has been in place, and remains in place, for particular sectors of the economy that are most directly impacted. A contemporary example is that decisions around not allowing dancing certainly impacts on the economic viability of four licensed nightclub facilities in the ACT; hence, they are being provided with additional economic support.

It does partially impact in terms of the seated requirement for certain licensed premises, in that it reduces the total number of patrons that they could serve. So whilst it is not a complete impact, it is a partial impact; so further economic support by way of fee waivers and access to additional small business hardship schemes and top-up grants have been provided over the course of not just the Delta wave but the Omicron wave as well.

Yes, this is a consideration, but "compensation" is not the language that I would use. Undoubtedly, in the context of situations where there is no public health direction, no active decision of government that is limiting trade, but simply decisions of hundreds of thousands of individual consumers, that is market forces. There is only so much that government can do in that regard. That is the nature of the business cycle. It may not necessarily even be pandemic related.

There are some things that undoubtedly will change that are consumer trends that were occurring, anyway, that may have been accelerated in the pandemic. An example of that is the balance between bricks and mortar and online retail. That was heading in a particular direction in terms of market share and it has now been accelerated. There are countless other examples of things in the economy or decisions of consumers that have changed. But that is not always necessarily to the detriment of particular businesses.

There have been examples where the public health directions have in fact reduced competition and enhanced opportunities. A practical example of that was the ban on international travel. It was a great thing for domestic tourism, in that it meant the billions of dollars that Australians were spending overseas were, for a period of time, being spent on domestic tourism. There are swings and roundabouts in all of this. There are examples where the pandemic has impacted positively and negatively on different sections of the economy.

THE CHAIR: I have a supplementary specifically on the question of the economic supports for businesses. A lot of political hay has been made locally around the role that the ACT government has played in providing those economic supports and whether that has been sufficient or not. Have you seen the recent comments from the New South Wales Liberal Treasurer, Matt Kean, with regard to the role that the

federal government plays in providing those economic supports?

I appreciate that this might sound like I am taking a bit of a political pot shot, but I think that the context is really important here. I would like to understand, for those in our business community who are concerned about those economic supports, what relationship you had with the federal government in developing our economic support package. How do you understand that that might relate to the economic supports that business have received in other states and territories? In particular, would you join in those calls from your New South Wales colleague for more support from the commonwealth?

Mr Barr: Thank you, Mr Davis. Firstly, it has been difficult to miss Treasurer Kean's interventions on these matters. He has obviously been vociferous in his prosecution of the New South Wales argument in relation to federal engagement on further economic assistance. I note that has been in contrast to his South Australian colleague from the same political party. This would be more a case of there being some differences in terms of economic impact in particular jurisdictions than necessarily a party political issue.

The process around commonwealth and state and territory collaboration on economic support has varied at various stages of the pandemic. It is impacted by the fiscal capacity and constitutional responsibilities of the different levels of government.

I will make a few broad remarks. There have been many examples across the last two years where the constitutional responsibilities of the commonwealth have been passed to the states and territories to practically enact, in terms of both economic and public health responses. There have been other examples where there have been very good levels of cooperation between the two levels of government and, in jurisdictions other than the ACT, between three levels of government, with a role for local government as well.

At this point there is still a role for the commonwealth to play. I believe it can be broader than how they have narrowed it in relation to essentially just providing pandemic disaster leave assistance, and they have even narrowed that further. I am not advocating for a return to the poorly targeted first round of the JobKeeper program that sprayed billions of dollars to firms that actually increased their profits. We are paying the price now, with the commonwealth saying that they no longer have the fiscal capacity or desire to provide any assistance, by the fact that the first round was so mistargeted.

The second round of JobKeeper refined the process and it got better. But there is an inescapable fact that there has been a $420 billion shift from public sector balance sheets to business and household savings. All of the debt that sits on the federal government budget and balance sheet, and on state and territory government budgets and balance sheets, has transferred over into the private sector, be that households or businesses. According to APRA, it is $420 billion. A rule of thumb, in terms of what that is for the ACT, is that somewhere between about 1.75 and two per cent of that is sitting in business and household balance sheets in the ACT. At some point that money is going to be spent. What we do not know is when and where.

In terms of making assessments on where there might be a need for future economic stimulus, it is a judgement call to look at the data on where all of that household and business savings is being deployed—where and when. Business investment lead indicators, and credit card spending indicators, from a household consumption level, are important guides in that regard, as well as the monthly data we get from the Australian Bureau of Statistics.

We got the retail trade figures for December this morning. They showed that the month of December was the largest-ever spend in the month of December in the history of retail trade in the ACT, and the fourth largest month in the history of the data collection. The three other largest months of retail trade, in the history of the Australian Capital Territory, occurred in calendar year 2021. They were the months that were the rebound out of COVID restrictions.

I go to the point I made in response to Mr Milligan over the time frame in which you make an assessment. If you look at quarterly, six-monthly or annual data, and look at three months, six months or 12 months, you do pick up a discernible trend. We are seeing that all of that household savings is translating into increased expenditure in the economy, but it does vary sector by sector. The timing can be different week on week or month on month. The important thing, in this current context, is to draw upon that data to make informed decisions, and that is what we intend to do.

THE CHAIR: I will move to my last question on the subject of business. It particularly relates to this bill. The committee has received a publicly available submission from the Australian Hotels Association, the ACT branch. I think it is fair to say that some might have raised an eyebrow about what stake the Australian Hotels Association might have in this particular bill.

Certainly, having appeared at our public hearings, I am challenged by our conversation today, in that you cite some fantastic figures about certain parts of our business economy that are doing tremendously well, and that is great. It would appear to me that that organisation represents a certain proportion of Canberra businesses that we must acknowledge are doing particularly poorly, on the basis that their business model is making money from the congregation and socialisation of people, which, between a combination of a literal pandemic and individuals' risk appetites, is having that huge economic effect.

They gave a lot of substantive evidence, but there was a theme around consultation—how much they were engaged in the process of either the development of the bill or, more importantly, how the bill might have implications for businesses, particularly in that sector. Can you talk me through what the government's consultation process was for that particular sector, which we acknowledge is uniquely challenged, as opposed to businesses across the economy more broadly?

Mr Barr: I acknowledge that in fact over the course of 2021, for example, that sector would have seen a couple of its best months ever and a couple of its worst months ever, all in one calendar year. It is a correct observation that those who make profit from the close interaction of people are going to make less profit during a pandemic. There is no doubt about that.

The question of engagement with that sector through peak organisations, and indeed geographic chambers, lobby groups or otherwise, has been extensive. Literally dozens of meetings, and probably over two years coming close to 100 meetings, would have been held by various areas of government in that engagement.

What becomes a very difficult thing to resolve is that it is understood that certain public health measures, density limits and otherwise do have an impact on the level of profit or otherwise that can be generated. But the public health decisions in and of themselves cannot be made on the basis of profit levels of particular businesses. That has been a tension that every jurisdiction has experienced. Some have fallen more on the profit side and others have fallen more on the public health side, within a reasonably narrow spectrum across eight different state and territory responses across this country over the last two years. Sometimes fairly minor differences have been blown out to suggest that there is a radical difference, when that has not necessarily been the case.

There is a threshold issue here. It is fully understood that the intersection of public health and profit does not always necessarily mean that both outcomes can be achieved. At various points we have had debate and discussion where the argument has been that the public health restrictions have been too restrictive, and it impacted on profit. Yet, in recent times, I have also heard the same individuals and groups mounting the counterargument that the lack of public health restrictions—the fact that case numbers are significantly high, and consumers are making their own decisions rather than having them enforced by government—is leading to similar loss of profit. It goes to highlight the complexity and the challenges associated with this.

I do have to be very clear, and I think this is crystal clear and the community understands this, and the stakeholders understand this as well: our decisions in the ACT have been based on public health grounds, not on putting the interests of particular businesses ahead of broader public health.

When you do adopt that decision-making process, which we have, there is then a legitimate debate about what is an appropriate level of economic assistance, to reflect the fact that the public health direction is impacting on a business's ability to make a profit. There is also a reality that government cannot compensate for all lost profit. The government is not in a position of underwriting every single loss that might occur in the economy. It simply cannot be the case. If you were to entertain that, even at an ideological or intellectual level, the corollary of that is that if there are super profits being made, then the government will scoop them up as well, thank you very much, in order to pay for the bad times.

THE CHAIR: I assume that is not a policy announcement, Chief Minister.

Mr Barr: The best practical example of this in another industry setting is the Higher Education Contribution Scheme—if we went down the path of HECS-style business loans that were provided in the down times but repaid in full with interest in the good times. There is an intellectual public policy debate to be had around how you might balance this. I think that would be an administratively complex solution to a particular challenge that we are facing at the moment. I acknowledge, as the Minister for Health acknowledges, and as everyone across the country who has been in these decision-

making roles acknowledges, that there are conflicting priorities in this regard.

The position of the AHA is understood. They are doing their job of representing their members' economic interests, and I would expect nothing less. But the role of the elected official is to look broader than just the needs of one industry sector and to look across the entire community, and indeed the entire economy and our society more broadly, and balance all of those competing interests.

To draw a long answer to a conclusion, that is what we have sought to do with this legislation. The issues that we are addressing, and attempting to address, in this legislation draw from all of those lived experiences, including literally hundreds of meetings over the last two years. Minister Stephen-Smith, do you wish to add anything?

Ms Stephen-Smith: On the question of consultation, in relation to both public health directions and the bill itself, obviously, when we introduced the bill, we referred it to committee quite specifically and deliberately. It was a choice between putting out an exposure draft which then may take longer to get through the Assembly—you have the consultation on the exposure draft, then you introduce it, then it gets referred to committee, and then it gets considered—or you can introduce it to the Assembly, refer it to committee and have that as part of the consultation process on the bill. That was a decision partly driven by the timing late last year and the recognition that it was going to take a long time to get to the next sittings of the Assembly et cetera. We were keen to ensure that we did have these public hearing processes and this inquiry process to ensure that the voices of all of those who were interested in having a say on the bill could be heard and considered. We very much welcome this inquiry.

On the question of consultation more broadly, the Chief Minister pointed to the dozens of meetings—I would say probably well over 100 meetings—over the last two years that various officials and ministers have had with a wide range of stakeholder organisations who were affected by public health social measures. Also, in the process of drafting directions, and once directions have been drafted and they are being implemented, there has been an ongoing discussion around, "Maybe we could just tweak it. From a public health perspective, this activity is not actually necessarily presenting a risk or a further movement of people across the economy. Could we maybe consider changing something this way, maybe consider changing something that way?"

If you look at the evolution of the public health directions during lockdown, you will see, very much, that while we went into short, sharp, very strict lockdown at the beginning, from 12 August, we then incrementally considered a range of industry sectors and social activities—as the Chief Minister said, balancing right across the economy and community, not focused on any one particular sector—to consider where we could take the foot off the brake a little bit and see what happened, recognising the social and economic impact that restrictions do have, as well as the public health intention of minimising movement across the community.

This has been an ongoing conversation, and we have learnt a lot through that. We also need to remember, when we are considering this bill, that it was introduced pre Omicron. This bill was introduced in an environment whereby we thought we were

going to be moving to a relatively low level of cases in the community, and trying to manage at a low level of cases.

This is about being able to continue to implement low-level public health social measures and TTIQ requirements in a context outside a public health emergency. The reality is that, with where we are now, we are genuinely in a public health emergency with Omicron. That is also something that the committee might want to think about, as it is considering all of the submissions that it has received and all of the evidence it has received—where this bill sits in relation to a public health emergency which is continuing and ongoing. It is always an option, if we start to see a massive increase in case numbers, that we may indeed need to shift from what we would be seeing under this bill, back to public health emergency settings, if we thought we needed to go to that point. We have seen in the Northern Hemisphere that that has sometimes been required—for example, going into winter.

I have moved a long way from the consultation question. There are a whole lot of issues that need to be considered around the complexity. I was going to the Australian Hotels Association's bigger question of: what is the need for this bill? If there is an emergency, there is an emergency. You have to take that comment and go back to the environment of where this bill was developed and drafted, where living with COVID was looking quite different from what it has looked like since Omicron came along.

MR PETTERSSON: If this bill does not pass, does the ACT face any issues in continuing to respond to COVID-19 under the current legislative framework?

Ms Stephen-Smith: Thank you, Mr Pettersson. That goes to the point I was just making around the fact that we can continue to remain in a declared public health emergency. As I said I would consider that this Omicron wave has been a public health emergency, and that would be quite appropriate. But if we get back to the point where we want to get to living with COVID in a more normalised environment, and we do not think, as a community, that an emergency declaration is justifiable, we will not be able to have in place the low-level TTIQ and public health social measures, and potentially very limited vaccination mandates, that we would require to do that, without this bill or something very similar to it.

There is no in-between in the Public Health Act at the moment. The measures that the Chief Health Officer has available to her to manage infectious diseases, outside a public health emergency, are not fit-for-purpose for this type of pandemic-epidemic response. We would then be in a position where we would have to maintain a public health emergency declaration because we really did not have a lot of other options available to us.

This bill is moving to a situation where we can maintain those measures and significantly increase scrutiny and oversight of those measures themselves, and a requirement for consultation with the Human Rights Commission, for example, that is not currently required under the public health emergency. Of course, the Chief Health Officer considers the human rights implications of every direction that she makes, and she has a statement in every direction saying that she has done that. There is a published consideration of human rights. But a lot of the additional measures that are contained in this bill are not contained or required under the public health emergency

declaration or Public Health Act. It would not be in place—they might be in practice, but they would not be legal requirements—without new legislation.

Mr Barr: Based on where we are now, the experience of the last two years, and what is being forecast that lies ahead of us, we will be dealing with COVID as a significant issue for many years to come. There will be peaks and troughs. There will be new variants and new waves. Depending on the jurisdiction, with respect to wave 3, 4 or 5, in the Australian context, there will be more.

This is not going away, so it is important that there is a more sophisticated and fit-for-purpose legislative framework to manage this in an ongoing way, rather than the very binary situation we have at the moment.

As a spectrum, if the public health emergency is dialling it up to nine or 10, and the alternative is zero, we do need something that sits in the middle. It is important that this legislation is given due consideration by the Assembly. Certainly, as a co-sponsor of the bill, I will be voting for it.

THE CHAIR: Thank you, Chief Minister, health minister, and officials. On behalf of the committee, thank you for giving evidence today. The secretary will provide you and your office with a copy of the proof transcript of today's hearing when it is available, to check for accuracy. If you have taken any questions on notice or need to provide any more information or context for the committee, could you please liaise with the committee's secretariat to provide answers to those questions.

Short suspension.

POULTER, MR ADAM, Deputy Chief Executive Officer, ACT Council of Social Service
KILLEN, DR GEMMA, Acting Head of Policy, ACT Council of Social Service

THE CHAIR: Good afternoon, and welcome to the public hearing of the Legislative Assembly Standing Committee on Health and Community Wellbeing inquiry into the Public Health Amendment Bill 2021 (No 2). This afternoon we will be hearing from representatives of the ACT Council of Social Service.

Can I please remind all attending today's hearing that the proceedings are covered by parliamentary privilege, which provides protection to witnesses but also obliges them to tell the truth. The provision of false or misleading evidence is a serious matter and all participants today are reminded of this. On the first occasion that you speak today can you please acknowledge that you have read and understood the privilege statement? On that note, friends, I will turn to you for an opening statement.

Mr Poulter: I can confirm that I have read the provisions and agree to abide by them. I will be speaking to you today with Gemma Killen, who is the Acting Head of Policy at ACTCOSS. I will give the opening statement but we will very likely rotate, answering questions that you may have after it.

Firstly, we appreciate the opportunity to appear today before the Standing Committee on Health and Community Wellbeing. ACTCOSS is supportive of the Public Health Amendment Bill 2021 (No 2). We know that the emergency powers in the Public Health Act are not well designed for a long-term pandemic like the COVID-19 outbreak.

ACTCOSS believes that public health measures should have a legislative foundation wherever possible to avoid overreach of government powers and to ensure appropriate oversight mechanisms. A legislative foundation offers increased accountability and transparency, as the Human Rights Commission have noted in their submission to the inquiry. We believe that the bill provides this kind of legislative foundation. For people with medical exemptions for vaccinations, the bill also offers an opportunity to provide clearer guidelines.

As COVID-19 becomes endemic, we need to ensure that our responses are sound, just and continue to protect the most vulnerable members of our communities. Around 40,000 Canberrans, nearly one in 10 of our population, live in low income households. They are among Australia's most disadvantaged, and must be protected and not placed in a worse position by public health mandates. Therefore our focus today will be on considering how the proposed bill may impact on ACT residents at risk of vulnerability and the community sector which supports them.

We will suggest several ways of mitigating potential perverse outcomes of the bill as follows. Firstly, we support the principles of mandating necessary measures such as vaccination in targeted areas as well as mechanisms to enable test, trace, isolate and quarantine orders. We must also safeguard the community sector and the most vulnerable and disadvantaged in our community through this process. Secondly, the ACT government must have clear communication channels in place to ensure

community service providers are given adequate time for planning and implementation of mandates and have clear mechanisms to raise questions and feedback where necessary.

Thirdly, for the broader ACT community, there need to be protections in place for vulnerable and disadvantaged people so that they are not disproportionately penalised for not adhering to mandates due to their circumstance. Some people may not be aware of mandates or be in a position to enact those mandates.

It is also vital that fines are only issued as a last resort, are proportionate to an individual's income and do not cause unnecessary hardship. Across our advocacy, ACTCOSS has been calling for the ACT government to introduce an income-based approach to ACT government fines, fees and other charges to ensure that penalties are not regressive and do not impose a disproportionate penalty on people living on low incomes, thereby posing a risk of deepening, and/or widening social and economic disadvantage.

We also recommend that police should take an educative rather than a punitive response to those not adhering to mandates. We note text in division 6C.7 of the bill which reads:

> … a police officer may—

emphasis added—

> warn them that they do not have to answer the question or do anything but anything they say or do may be used in evidence.

We believe the word "may" should be replaced by "must" or equivalent.

This is our opening address to the committee, and we look forward to any further questions you may have, which will be rotated between us.

THE CHAIR: As chair, I will start off with our first question. One of the things that have struck me in reading the quite overwhelming number of submissions the committee has received to this inquiry has been the amount of those individual submitters who have invoked what they perceive to be a threat on their rights: their right to work or work in the job that they want to work in; their right to go to places that they want to go to at the date and time they want to go to them. But we also heard some really interesting evidence from the Minister for Disability about, in particular, members of our community with a disability, our immunocompromised and some of the effort the government has made to try and protect their rights as well.

I wonder: as the big organisation that represents so many of these organisations in Canberra that work with some of our most vulnerable, how do you reconcile that balance between the rights of individuals of able body and financial means to do as they wish within our community but then also the protection of, in particular, some of those health rights for the more vulnerable that your organisation seeks to represent?

Mr Poulter: Thank you for this very interesting and pertinent question. We did note

that there are a large number of individual submissions indeed which speak to this issue. Firstly, you mentioned a balance between public and individual rights. As we see it, the intent of the bill is to strike such a balance appropriately. In fact, as I mentioned in my address, it is to move on from a situation in which emergency powers in the Public Health Act are put on a solid legislative foundation and are open to increased scrutiny, in fact, from the parliament, as the Human Rights Commission, for example, have already testified far more eloquently.

I think when looking at some of these issues, including vaccination mandates and test, trace, isolate orders, really it throws into light that trade-off, in that those measures that are in place are public health measures with the intention of protecting the majority of the community and perhaps, especially within that community, those who are vulnerable. You mentioned the immunocompromised who are particularly vulnerable.

With regard to disability, there have been some notable efforts to try and help people living with disability, including those who are stuck at home in the pandemic, to access, for example, vaccination via in-reach programs. And there has been some significant and positive collaboration with the community sector to try and enable those people to realise their rights.

I think the last point I would make—but Dr Killen may have others to add—is just that point about parliamentary scrutiny. While we are not legal experts, the bill does include greater provision, as we understand it, for parliamentary scrutiny of measures brought forward under the bill and that, when public health orders are issued, they are received by parliament, allowing for a process of contesting those and asking specific questions including how they protect individual rights and also the needs of some of the most vulnerable in the community.

Dr Killen: I will just add that throughout these discussions we have to remember that it is approximately 20 per cent of our community that are living with disability at the moment and more again are impacted by the restrictions placed upon people with disabilities by COVID, if you also consider people who are carers, people in the community sector who are working very regularly with people with disabilities, who are then also restricted in their movements and their activities.

If we do not have public health measures in place, that is a large amount of the community that is impacted and unable to live life in a fulfilling way because they are put more at risk. I think we are all starting to acknowledge as well that COVID is a disabling condition and that rates of disability might also go up as we go through the pandemic and more and more of the community will be impacted if we do not take strong public health approaches to protect vulnerable members of our community.

THE CHAIR: I have a quick follow-up in particular when it comes to the workforce. We have heard from the Attorney-General and then the Chief Minister who elaborated in more detail about the ACT's right to work, because the right that a number of people have invoked is that this will challenge their ability to work. The government has given some assurance that public sector workers would be redeployed but we know, from the organisations you represent, a lot of the workers are not government workers but are working for not-for-profits providing services to, in particular, people

with a disability.

What would ACTCOSS say or what would ACTCOSS's position be if there were Canberrans currently working in the disability support space who were able to get a vaccine, chose not to get a vaccine, but still wanted to or felt entitled to continue to work in that role providing care or support to people with a disability or who are immunocompromised?

Dr Killen: That is a really important question to ask. I think it is a minority of people in our sector—I think that is important to acknowledge at the outset—and obviously in the Canberra community we have a very small amount of people who object to vaccination in the first instance and, from what we have seen from the community sector as well, it is very small. But it does occur, and I think organisations are grappling with those same kinds of redeployment plans for staff in that instance.

We would suggest that education is probably the first approach that we need to take, making sure that education campaigns are targeted towards particular people rather than broad education campaigns, and then I think it is important again to remember that people with disabilities who require carers also have a right to ensure that the people providing them with care are safe for them to be around. Adam, did you want to add anything to that?

Mr Poulter: I think you have covered the main points, Gemma, but just to emphasise that point that we are discussing regularly across the sector, including with organisations that are providing services to disabled people, and they do not report high rates of vaccination hesitancy at all.

Also I think we have seen the positive aspect of explaining why vaccination is important and why it is important to safeguard the rights and the health status of the disabled people that they are serving, and actually those that may have been hesitant several months ago have moved on. This is not something that we are seeing in any large measure in that workforce.

MR MILLIGAN: We know that, as you mentioned already, some 20 per cent of people living in the ACT have some form of disability. Obviously, it is important that we have supports in place to support those people living with a disability. Details in regard to support offered to these people within the bill seem to be missing, particularly supports for people that might have a cognitive impairment and whatnot. What would you recommend that the government should be doing in this space to provide the supports that are needed for people with a disability that might find it difficult to understand and to comply with any COVID direction? What types of supports should they be looking at delivering or providing?

Dr Killen: Certain organisations in the community sector, for example Advocacy for Inclusion, have so far done substantive work through the pandemic to make sure that mandates and directives are translated into easy English for accessibility measures. I think it is a very key thing to make sure that messaging is always in easy English and that education is readily available and accessible. Do you have anything that you want to add, Adam?

Mr Poulter: With regard to the bill, there is perhaps a limit to issues that the bill can cover in significant detail, but as it is rolled out the consultation with the sector and with the expert organisations in this area is really important to try and make sure that the education reaches the most vulnerable, including those with a cognitive impairment, and that dialogue with government—with the Community Services Directorate and the Health Directorate—around how we can best do that is maintained and strengthened.

Dr Killen: I will just add, as an example: we saw vaccination rates in the AMC go up quite significantly once Justice Health was also partnering with community sector organisations that people in the prison trusted. I think partnership is really important for making sure that people are hearing important messaging around public health from people that they already trust and work with on a regular basis, and I think that is true across communities with cognitive disabilities as well.

MR MILLIGAN: In effect, it alludes to what you put in your submission already about clear communication channels and whatnot. In effect, the government should establish clear channels with service providers like yourself and also include consultation with you prior to potentially, hopefully, a new health directive being announced. Would that be ideally the process that you would like them to follow?

Mr Poulter: Yes, that is exactly the process. We have seen some positive examples in the past around that. To pick one—a coordinating mechanism is perhaps too grand a word—the COVID-19 response was established between government agencies and the community sector where we used a regular, weekly meeting across the peak bodies and the ACTCOSS members in the sector to canvass their concerns and issues and then feed those back to the Health and Community Services Directorate and get responses and channel communication back. I think that kind of engagement is very positive, and we already do see a good spirit of collaboration and increasing partnership with the directorates that we have mentioned. So I think we can try and build on those to try and tackle issues like this.

The other issue we would mention is that sometimes, as a new mandate comes in, for the community sector organisations, it can be challenging to implement that straightaway. So the point that you made, Mr Milligan, about early consultation is the ideal time to do it and then give enough time and dialogue on how we can roll those mandates out and make sure that support reaches the most vulnerable and it reaches them in a way that is most appropriate to their circumstances.

THE CHAIR: In the remaining few minutes I want to draw your attention to some evidence that we heard in the session just before. The conversation was heavily focused on some of the issues for our business community and the economy more broadly. Many might think, instinctively, that there might not be many intersections between your organisation and the people that you advocate for and business and the economy. But a conversation I have heard a lot about throughout the committee's hearings—and it is mentioned in a lot of our submissions—is this shadow lockdown, people who are not forced to stay home or not participate in the community but who are making the choice based on their own risk assessment. It would appear to me that those people would overlap quite heavily with the people being served by organisations that you represent.

I just wonder if you would reflect on that and what opportunities you might see from your member organisations about how the government can help provide support to those people whom we do want to be able to engage in our community, socially and economically but in a healthy and safe way. What more do you think we could be doing?

Dr Killen: I think, as a starting point, the continued mask mandates indoors have been helpful and, where testing is accessible, that has also been helpful, and the times when testing is timely and accessible. The thing that we hear from the community sector a lot at the moment is that they want accessible RATs available, particularly for the workforce but also for moving around within the community, and that their clients also want access to RATs. I think that is something that everybody in Canberra and probably around the country is saying that they want as insurance for participating in the community. Adam, have you heard anything in particular as well?

Mr Poulter: No. I think you have covered the main issues there and also the underlying point, which is that these people want to re-engage with the economy but sometimes they are scared to do so. Where we can see public health support reaching out to them—reaching homes to provide vaccination, providing RATs to organisations that work with these groups on a priority basis—all these measures are very helpful in reaching people and helping them to feel more confident to re-engage with wider society and the economy.

THE CHAIR: It might be a question on notice—I do not want to necessarily put you on the spot—but the very specific point I am trying to get at here is that we have heard from a lot of businesses who have seen a massive downturn in their business, particularly businesses who trade in creating spaces for people to gather and socialise, which in a pandemic is particularly challenging.

I would think it valuable, through this committee process, to provide some advice to those businesses even about what they could do, or what government needs to do, to support them, to create safe, health and accessible spaces because that surely is good for their business, as well as it is good for mental, social and physical health and all that they are advocating for. I would find it really useful—I am sure the committee would, too—if that was a reflection through your organisation that you might be able to help us with.

Mr Poulter: Thanks for that really interesting and practical question. One thing I would say, as a general comment, is that across a large number of businesses there will be some that are putting in place good practice already around these measures. Trying to draw that out will be helpful—and to take the challenge given to us—and say squarely that yes, we will seek to get back to you with advice on these issues and also, as we do that, to try and reach out to peak business groups as well. As I say, they may have some very good practice already that they can share and some thoughts on these issues.

THE CHAIR: It sounds like I am sending you away with homework. I apologise. But we have the same ambition, I suspect.

Mr Poulter: It sounds like good homework to me.

THE CHAIR: Tremendous. That being so, I would like to thank you both for appearing before the committee today and providing evidence and giving your advice. It is very much appreciated. In the coming days the committee's secretary will forward you a copy of the transcript of today's hearing, which you can sight for accuracy. Let us know if we have got it wrong. Additionally, if there are any questions you took on notice or any more information or context you think would help with the committee's deliberations, feel free to send that through. Otherwise, this particular session is wrapped up. Thank you again.

Short suspension.

SHARMA, MRS ANNETTE
LEE, MS THERESE
RAJAK, MR ALEKSANDAR

THE CHAIR: Welcome back, friends, to the final session of today's public hearing of the Legislative Assembly Standing Committee on Health and Community Wellbeing inquiry into the Public Health Amendment Bill 2021 (No 2). This afternoon we will be joined by a roundtable of panellists who will provide some more information on their understanding of and relationship to the legislation being considered before the committee will take questions.

On that, I am more than happy to allow each of our two groups to make an opening statement of no more than five minutes. I will pick the screen on my right where I see three individuals, if you would like to start us off with a five-minute opening statement.

Ms Lee: We are here in a private capacity as residents of the ACT. We are very concerned about the government's amendment to the bill going ahead. The bill proposes a regulatory scheme which can operate in the absence of a public health emergency, and we fear that this change may represent the thin edge of the wedge, removing our rights to decide, without coercion or force, what substances are safe and appropriate to put into our bodies in order for us to work, be educated, access health and even attend social gatherings.

We need to protect our community from excessive, disproportionate or unsafe procedures that, as in the case of vaccination, cannot be reversed or could lead to serious future health issues. Mandatory vaccination is a permanent action. Once it is done, it is done. At the very least, the public need to be fully informed of all the risks and benefits, including possible long-term as yet unknown consequences.

The directions set out on page 7 of the explanatory statement call for regular reviews, but how can this be considered an appropriate safety measure when vaccination cannot be reversed? The reviews will be of no use to the people already injured, their families and employees. In our opinion, there are not sufficient safeguards in place to protect human health and human rights.

The power to issue vaccine directions breaches at least three of the statutory rights protections in the ACT Human Rights Act and in international treaties. These are the right to protection from experimentation and medical treatment without consent, right to work, rights in work, and right to privacy and reputation.

Importantly, we should be looking at a broader range of evidence to inform our decision in relation to COVID-19 management, including utilising successful prevention strategies—for example, optimising vitamin D levels, which is our reference 8, and early at-home treatment strategies that have been shown to reduce hospitalisation and deaths by up to 85 per cent. That is in references 7, 8 and 9. We should be acknowledging the low effectiveness of the current vaccines in reducing transmission and infection rates. That is in references 12 and 13. We should be considering the accumulating evidence of serious adverse events and fatalities

associated with the provisionally registered MRNA adenoviral vaccines currently in use in Australia. We should be investigating the possibility of an increased impairment to the immune system with each subsequent COVID-19 vaccination.

It is clear from what is happening in the community that the vaccines are not preventing catching of the disease, nor transmission of COVID-19 to others. So how can one section of the community, that is the unvaccinated, be marginalised or segregated when they are no more likely to spread the disease than their vaccinated counterparts?

In conclusion, there is a concern that this amendment bill is in breach of human rights in light of how the power may be used. There is evidence in our submission of safe, effective but underused early treatment protocols that are already available.

In addition, there is growing evidence worldwide that the risks outweigh the benefits of the current vaccines for many people, particularly for children. Furthermore, there is the opinion of highly credentialed and experienced doctors throughout the world who are challenging the rollout of these vaccines because of serious safety issues. We are facing an impending global chronic crisis.

THE CHAIR: Thank you very much for your opening statement. I will defer now to Mr Rajak for his opening statement for no more than five minutes. Take it away, sir.

Mr Rajak: Thank you for inviting me to speak today. Likewise, I am also a private citizen and, at the risk of repeating some of what has already been said today, I will try and cut mine down a little. In preparation for today, though, following the publication of the written submissions, I have spent a considerable amount of time reading the submissions. Something that I was rather surprised with, which led me to read submission after submission, was the fact that every submission that I read was negative regarding this bill; that is to say that, in every submission that I went through, 100 per cent of the people that responded were opposed to this bill. I think, as just a simple layperson, that is an incredible message to the ACT Legislative Assembly that this community does not condone the huge social implications and changes to our community standards and rights that are threatened by this bill.

Although there are many reasons that I oppose the bill, I think one that deserves particular attention—and it has briefly been mentioned already today—is the purpose of the bill, as set out in the explanatory memorandum on page 4. To summarise—I will not read the whole thing—there is a statement in there which is particularly important to me which says "measures to suppress or prevent the spread of COVID-19 within the community". I do not think it can any longer be argued, in any credible manner, that COVID-19 vaccines suppress or prevent the spread of the disease. That is not to say that they are not effective or anything like that, but they do not suppress or prevent the spread. On that basis alone, that being the purpose of the bill, I cannot see how we can proceed on this basis that the vaccine mandates should apply.

Further, I think that it is a gross overreach of power that is looking to be granted to the minister and the Chief Health Officer under the bill. In my view, the power to force a citizen into isolation is akin to detention. Forcing a person into isolation is a form of home detention and imprisonment. And it is not the role of the executive to make such

orders. This is something ordinarily left for courts. In my view, these extraordinary powers are a breach of the separation of powers between the executive and particularly in this case the judiciary, as it sidelines the judiciary and provides the executive with court-style powers.

I was going to mention a number of human rights but some have already been mentioned. I might just summarise and, if I can, mention section 8 of the ACT Human Rights Act which states under subsection (2):

> Everyone has the right to enjoy his or her human rights without distinction or discrimination of any kind.

Under subsection (3):

> Everyone is equal before the law and is entitled to the equal protection of the law without discrimination. In particular, everyone has the right to equal and effective protection against discrimination on any ground.

This bill clearly, and without any doubt, will give power to the minister and the Chief Health Officer to discriminate against sections of the community, particularly those who choose not to be vaccinated, those that cannot be vaccinated and even people who present with symptoms that are similar to those described for COVID-19. But I think the bill seeks to muddy the water with respect to human rights in that it states in the explanatory memorandum on numerous occasions that it is trying to strike a balancing act between individual freedoms and the response to the pandemic.

To that, my response is that we either believe in individual human rights as inalienable rights that cannot be removed or we do not. So it is my view that should this bill be enacted, it will render our human rights not rights but mere privileges in the control of the minister and Chief Health Officer. I do not think that is an acceptable way to move forward.

THE CHAIR: Thank you for your opening statements. As chair, it is my responsibility to kick off with the first question. I am happy for anyone to answer it but it particularly goes to a point raised in your opening statement, Mr Rajak. I too have read all of the submissions and I note that there is a substantial amount of opposition to the bill as people understand it.

One of the things in those submissions which upon closer inspection I have been slightly challenged by is that people are rightly concerned that they might have their right to work restricted, that they cannot go to work or, even broader than that, this would actually involve someone pinning them down and giving them a vaccination.

Over the course of today and in our earlier public hearing, we put some of these direct concerns to the Human Rights Commissioner and to the minister et cetera, and we were advised that everyone in the ACT has a right to work and that there were efforts made to ensure no-one was to lose their job but were to be redeployed if they made the choice for themselves not to get a vaccination.

I suppose it is typical politician style, is it not, of a long sentence there with a question at the end. But I just wondered if you would mind reflecting on that. With more

information, do you think that perhaps some of the impressions or falsehoods that are laid out in some of the submissions might lead others to draw some other conclusions?

Mr Rajak: I do understand where you are heading with that but I would point to the fact that there are many occupations where people cannot be redeployed. I appreciate Canberra obviously has a huge public sector but in terms of the private sector, if mandates were extended there, I do not see how it would be possible for people to be protected from losing their jobs because of a decision to not be vaccinated. To me, I think that it is a gross invasion.

THE CHAIR: I appreciate that. I am more than happy for our other group to reflect on that question, if you would like.

Mrs Sharma: I think I would just like to add that—

THE CHAIR: Sorry, it is very soft on your end. We might need to turn the volume up or for you to be closer to the screen, whichever is easier.

Mrs Sharma: Can you hear me now?

THE CHAIR: It is a little better, yes.

Mrs Sharma: I would just like to add that, in the explanatory statement for this amendment, there was mention of the large proportion of the ACT public that might be affected by the amendment of mandating vaccines. If you consider the number of people employed in aged care, disability services and the hospital sector in the ACT, we are talking about a very large number who would be affected and would have to make a decision between taking a vaccine and losing employment.

I agree with our previous speaker that this is a very serious consequence, and we cannot minimise that consequence because it does take away our right to work and does take away the type of workplace that we are engaged in. I do think it is a serious threat to a person's human rights.

MR PETTERSSON: Thank you to all of you for making time to speak to this committee. Having read through your submissions, my question to both groups is: what do you think the ACT government should do to manage the spread and impact of COVID-19? I will invite Mrs Sharma's group to go first.

Ms Lee: First off, I think further vaccination is not going to manage the spread, because it is spreading just as much in the—

THE CHAIR: Sorry, I am having real difficulty hearing you. I am not sure if everybody else is. We are having a fair bit of sound trouble.

MR PETTERSSON: Yes, it is not very loud.

THE CHAIR: Perhaps, whilst adjusting the sound, should we invite Mr Rajak to give some reflections on that question?

Mr Rajak: Sure.

MR PETTERSSON: I will just ask the question again. What do you think the ACT government should do to manage the spread and impact of COVID-19?

Mr Rajak: From my perspective, I thought the ACT government actually did quite a good job in 2021 specifically in dealing with the pandemic. But I am certainly not an advocate for isolation and for lockdowns or anything of that sort. But it was clear that the ACT government did stop the spread with its measures.

There is another thing that I think the ACT government did really well, and most specifically the Chief Minister in his daily addresses. He spoke on numerous occasions about human rights and how, here in the ACT, we had an approach that actually consulted people and allowed people to make their free decisions. I think that is what has actually helped the ACT get to the vaccination rates that it has, because they have not been coercive.

We have all seen the images that are coming from around the world in places that do mandate vaccinations and other measures as well. We have not had any of that in the ACT. From my perspective, I think the ACT has actually done a very good job here and I think that they can keep on the same course and they do not need these types of coercive and overarching powers because they have done a much better job, in my view, than others around the world.

MR PETTERSSON: Just as a quick follow-up, I understand your strong views when it comes to vaccines but I just want to focus in on what measures you do think we should have.

Mrs Sharma: Can I reply to that question?

MR PETTERSSON: Sure.

THE CHAIR: Yes, of course.

Mrs Sharma: I would just like to say that we see a shift in focus onto treatment, especially early treatment, as being fundamental to reducing the number of hospitalisations, the seriousness of the infection and the duration of the infection. We feel that for some reason, which we do not quite understand, there has been insufficient attention globally on very effective treatments which have been used in countries such as India, Mexico and other places where they have had incredible success with antivirals, antibiotics, improvement in vitamin D levels, zinc levels, vitamin C levels—all contributing to improved outcomes.

We would encourage the government to expand its focus and look at some of the excellent research that is being done globally which will improve outcomes for ACT citizens and, in fact, for all Australians, because there is a very immense load of scientific data which has proven that outcomes can be substantially improved with some fairly simple measures.

MR PETTERSSON: I have one last supplementary before I hand over to Mr Milligan. In terms of trying to reduce the spread of the disease, are there any measures that you support that would do that?

Mrs Sharma: I think we need to recognise that natural immunity is a very powerful protective aspect and that, in settings like aged-care facilities, we should be relying on staff who have had COVID, who have natural immunity, who can safely administer services to aged-care residents. That is something that has been largely overlooked and ignored. For those people to be mandatorily vaccinated seems totally unnecessary to us. As we said, we are just asking for a broader, more inclusive incorporation of the science that is established globally into methodologies that can be used in our own territory.

MR MILLIGAN: As you are well aware, these new powers in this bill going forward give the government the power to require people to be vaccinated to work, to be in an activity or attending a place or work in particular places. What alternative would you suggest that the government put in place then for it to still be allowable for an unvaccinated person to attend work or an activity or a place, without being vaccinated, but also ensuring the health safety of the public? Would you suggest that they would have to return a negative RAT or a PCR test every day to then be able to attend? Have you thought about that, what that might look like and what the alternative would be?

Ms Lee: I think that is a much better option because a negative RAT or PCR test would show that on that particular day—and usually they only request them every third day—they are safe from spreading COVID in that environment; whereas, if someone is fully vaccinated in a healthcare facility, aged-care facility or any employment situation, they can be fully vaccinated and have a viral load of COVID and be shedding it to others.

A negative test is a much safer option to prevent the spread than vaccination, and that is why the unvaccinated should not be discriminated against because they are no more likely to be spreading it than the vaccinated.

MR MILLIGAN: Mr Rajak?

Mr Rajak: Yes, I completely agree. That was one of my points as well that I wanted to raise earlier. To me, as I see it, that is the only way forward and it is the best protection the government actually has. There are already many private companies, and even public sector departments as well—I can think of one in the ACT that is already doing that—requiring anyone entering the facility to test at least once every second day. Like the speakers before me mentioned, vaccination does not rule out spread. So the testing of absolutely everybody, to me, is the only logical way forward if we want to suppress the spread.

MR MILLIGAN: If that was the case, would we still be doing this in the next year or would this still be the case in the next five years or 10 years even, or would it start to cease when hopefully it comes to the day when, let us say, COVID is not as prevalent out in the community?

Ms Lee: The other thing that will play into that is the development of herd immunity.

That has not been achieved at all through the vaccination process to date. That was the hope of the vaccination process, that it will develop herd immunity, but it has not happened.

With the prevalence of Omicron in the community and the high transmissibility of it, but with the milder symptoms, we are developing a population that hopefully will have natural immunity not only to that variant but, as the scientists and doctors speaking about this are saying, they should also, with natural immunity, be immune to any future variants. Natural immunity is actually the key to the end of the pandemic.

There are highly credentialed doctors who are also seeing children as the hope for this, because with the response of their innate immune systems, with their robust immune system and the very mild response they have to COVID—the creation of immunity amongst children who are always together; you cannot isolate them in a park—and with the development of this immunity in the children, that will be like a buffer and will help us to also cope with a milder disease and establish herd immunity as well. That is why it is very important to not suppress the innate immune system.

THE CHAIR: My final question is, I guess, both earnest and personal. I am appealing for a bit of help here because I sympathise with many of the things that you have said this afternoon. But I am sure you will appreciate that, if you go looking for a pile of wisdom in a politician, you will be left wanting. We have to rely on expert advice and people whom we trust know what they are talking about.

In particular, I have been struck by the submission from the Human Rights Commissioner who, while providing some pretty useful recommendations on how to improve the bill, is in broad support of the bill. I would just appreciate a bit of advice from all of you for someone in my position who is trying to reconcile the support for the bill from someone whom the government and the community have trusted as an authoritative figure on the protection of human rights in our city with some of the evidence that you have presented today. I am struggling to reconcile the two and I would appreciate some help.

Mrs Sharma: Can I just briefly say that I think that, if you were to look at some of the very highly credentialed scientists and doctors such as Dr McCullough and recognise that he has 600 published articles and is a highly experienced, highly respected professional doctor that is very experienced in this field, you would begin to ask the question: why are we not listening to those voices? Why are we selectively choosing the experts that are informing some very critical decisions about substances that are being injected into our body, especially our children's?

We see that there needs to be more balance; we need to give commonsense attention to some of the voices that are very experienced in this field who are advising and making very sound recommendations but who are not really reaching the ears of government administrators.

Ms Lee: We have provided today two links—particularly the one to Dr Peter McCullough who is a cardiologist and immunologist with enormous experience in working with COVID patients as well. If you can, take the time to listen to that, even the first 15 minutes, as he is such a recognised expert and he is not reaching us

through any of the media in Australia. People of his calibre are just not featuring at all in the planning that is going on in Australia and probably in other countries as well. He is not getting any airtime with us but he is out there, he is producing videos, talks and papers all the time. That is why part of our submission is to broaden where the evidence is being gathered as to how to handle this pandemic.

It seems to be very narrow. It is all coming from a source—these doctors, these experts—but there is a whole range of other experts out there, all over the world. We have referenced several of these groups in our submission and, if they can be accessed, I think a lot of your questions would be answered.

THE CHAIR: I appreciate that; thank you. I am conscious of the time but I do want to give Mr Rajak an opportunity to reflect on the question, if he would like.

Mr Rajak: I can certainly appreciate the position that you are in. I am somewhat dumbfounded by the commission's position. I must admit, I have not gone through their submission but, to me, I just do not understand how they could possibly get to that.

Not having been prepared for that specific question, if I could take it on notice, I am sure within 24 hours I would be able to provide you with numerous references of human rights specialists from around the world that would actually have a contrary opinion to the suggestion that mandatorily vaccinating the population is within human rights.

Off the top of my head, I can think of many instances. One is—and it has been thrown around a lot—the Nuremburg Code. Another is the Charter of the Universal Declaration of Human Rights. I am sure that experts in these matters would not have the same opinion as those from the ACT Human Rights Commission.

Having said that, and at the risk of repeating myself, I completely appreciate your position as a politician, but what I would say is that there are experts of all forms around the world and they all have the right to an opinion. But your job, as I see it, is that you are responsible to the population that elects you. I think it is very important to be conscious of the fact that, even if the ACT Human Rights Commission has made certain recommendations, not that they should be ignored, basic constituents should also have a voice as well.

THE CHAIR: Thank you, Mr Rajak. I appreciate that. I think that is actually a perfect note for us to wrap up today's proceedings—a little late but I have never been known for being on time. I would really like to thank you for appearing before the committee today and providing your evidence. With the groups before us today, we have heard from politicians and peak groups who appear before the Assembly regularly but I think this is a demonstration of the parliament operating at its best when we purposely create these spaces to talk to a diversity of people about a diversity of views.

You have given up your time freely this afternoon and on behalf of the committee we are very grateful for that. You will receive a copy of the transcript of today's proceedings, and that is an opportunity to correct anything that was misspoken or mis-

said that you would like to correct for the record; so please do take advantage of that if you wish. Additionally, the committee is happy to take, as exhibits, any further information that you have noted during your presentations this afternoon as points on notice.

On behalf of the committee, thank you to everyone who appeared today, everyone who has made submissions and contributed to this important process. It informs the committee's work and will hopefully assist us in preparing good recommendations to government. This public hearing is now adjourned.

The committee adjourned at 5.04 pm.