COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

SENATE SELECT COMMITTEE ON COVID-19

Australian Government's response to the COVID-19 pandemic

(Public)

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SENATE

SENATE SELECT COMMITTEE ON COVID-19

Tuesday, 2 June 2020

Members in attendance: Senators Davey, Dodson, Gallagher, McCarthy, Paterson, Patrick, Siewert, Watt.

WITNESSES

BENNETT, Mr Shane, Acting Deputy Secretary, Social Security, Department of Social Services

BORG, Mr Michael, Chief Executive Officer, Outback Stores

BRAHIM, Mr Kevin, Acting Deputy Chief Executive Officer, Operations and Delivery, National Indigenous Australians Agency

BULMAN, Mr Ryan, Group Manager, Economic Policy and Programs, National Indigenous Australians Agency

CAMPBELL, Ms Kathryn, AO CSC, Secretary, Department of Social Services

de TOCA, Dr Lucas, Acting First Assistant Secretary, COVID-19 Primary Care Response Team, Department of Health

EDWARDS, Ms Caroline, Acting Secretary, Department of Health

EXELL, Mr Blair, Deputy Chief Executive Officer, Policy and Programs, National Indigenous Australians Agency

GRIGGS, Mr Ray, AO CSC, Chief Executive Officer, National Indigenous Australians Agency

HEFREN-WEBB, Ms Liz, Deputy Secretary, Families and Communities, Department of Social Services

JEFFRIES, Mr Sam, Group Manager, Central Region, National Indigenous Australians Agency

MATTHEWS, Mr Gavin, First Assistant Secretary, Indigenous Health, Department of Health

RULE, Ms Catherine, Deputy Secretary, Disability and Carers, Department of Social Services

Evidence from Mr Borg and Mr Jeffries was taken via videoconference—

Committee met at 13:01

CHAIR (Senator Gallagher): I declare open this hearing of the COVID-19 Select Committee. Today the committee will hear evidence from the Department of Health, the Department of Social Services, the National Indigenous Australians Agency and Outback Stores, as set out in the circulated program. Today's hearing will focus on Indigenous matters but may cover other matters under the terms of reference.

Information on procedural rules governing public hearings and claims of public interest immunity have been provided to departments and agencies and is available from the secretariat. I understand that we have a couple of short opening statements to be heard. The opening statements have been circulated via email, and with the agreement of the committee they will now be published. I will hand now to Mr Griggs, as Ms Edwards doesn't have an opening statement.

Mr Griggs: Dhawura nguna dhawura Ngoonawal. Yanggu ngalamanyin dhunimanyin, Ngoonawalwari dhawurawari Dindi wanggiralidjinyin. This is Ngunawal country. Today we are all meeting together on Ngunawal country. We acknowledge and pay our respects to the elders. I also extend that respect to all Aboriginal and Torres Strait Islander senators and fellow witnesses present today.

Briefly, all I would like to do, in addition to the opening statement that we tendered at the last hearing, is to thank Senator McCarthy for her comments in the Senate recently about the work the agency had been doing and in particular the support to the briefings of the opposition during the main part of the crisis. That's all I have to say.

CHAIR: Thank you very much. Mr Borg, would you like to make your opening statement?

Mr Borg: Yes. I have submitted the opening statement. I won't talk through all of it, but I'll go through a bit of it because it does set some context. Firstly, Chair and senators, thank you for the opportunity to provide an opening statement today on behalf of Outback Stores. Outback Stores is a wholly owned Commonwealth company, governed by an independent board of directors, currently managing 40 remote community stores across South Australia, Western Australian and the Northern Territory. Outback Stores is a service provider only, and all profits for stores are retained by the owners. Outback Stores works in line with not-for-profit principles and does not request any ongoing funding from state or federal governments. In regard to COVID-19, firstly I'd like to acknowledge the high level of collaboration between the community leaders that we work with and our team as we work through what can only be called a challenging set of circumstances in the past few months. And I mean that. We've had really good collaboration at all levels out bush in the last few months.

Leading into March the focus was on community members staying on country, the lockdown of biosecurity zones and the impact of the government's initiatives to support the economy. We knew that, from this activity, we'd be faced with many challenges as an organisation. Our focus first and foremost was on ensuring the safety of Outback Stores employees as well as the community members working and shopping with the stores that we manage. Secondly, a significant amount of emphasis was placed on food security and ensuring that community members had consistent access to core products. In addition to this, a priority for the business was to work with all stakeholders and influence further positive outcomes in relation to food affordability. So, really we were heavily focused early on supply and food security and then really drove home some additional work on affordability.

The term 'price gouging' has been used recently within the industry, and I just want to state for the committee, to make sure everyone understands it, that unequivocally Outback Stores demonstrates no evidence of such behaviour—in fact, quite the opposite, with the team working on adding value by reducing prices to benefit community members across the stores we manage. Furthermore, in regard to food security, the Outback Stores team has worked tirelessly in supporting stores to maintain a high in-stock performance, whereas across the country it appeared that retail struggled to maintain supply of stock to outlets around more highly populated regions due to unprecedented demand.

What I will say there is that through that period of time, when lots of metro outlets were struggling to maintain stock levels, we and our team in the business that we managed did a good job of making sure that stock was kept up for the communities we manage. Outback Stores partnered with other industry leaders, including the Arnhem Land progress association and the Community Enterprise group of Queensland. In addition to this we worked closely with the federal and Territory governments, and we're heavily involved in supporting independent remote community stores across the country outside of our network.

We also worked with corporate retailers that support our industry, working closely with manufacturers to prioritise supply for remote communities. This is where we have seen Woolworths and Coles assisting remote communities and putting their stock as a priority to service remote communities, which I thought was an outstanding outcome. The stores that we manage on behalf of communities have seen a sales uplift of an average of 95 per cent, and this was coming from the first one-off stimulus payment of $750 that was given to welfare recipients. The additional ongoing payment of $550 per fortnight that was released in late April has seen a consistent trend at just above 75 per cent growth on the previous year throughout the month of May. They are significant increases to any retail environment, and certainly when you're trying to manage remote communities out bush it creates some challenges. Outback Stores worked with the supply chain partners to meet individual specific needs of the community stores aligned to our business. Well in advance of the stimulus releases, Outback Stores managed sites, procured stock and worked to ensure that food security was guaranteed across the 40 stores we manage.

Regarding pricing, Outback Stores, as always, has a focus on ensuring that we continue to improve affordability, specifically on food, for Indigenous Australians who live in remote communities. Throughout this pandemic Outback Stores actually drove prices down on essential items such as fresh produce, tinned food, frozen vegetables, cooking oil, flour, cereal, soap, sanitary products and—to help out down in the desert—winter goods, including blankets and clothing. In addition to this, on the request of some communities, specific pricing structures were adjusted, or goods were sourced to suit certain needs of particular remote locations. Outback Stores was challenged at times when national availability of some items was poor. This meant that alternative products had to be procured, at a higher cost and price, such as sanitiser, toilet paper and rice, which incurred additional costs from suppliers.

In summary, whilst we have challenges still to face due to COVID-19, Outback Stores is committed to the customers it serves and will continue to collaborate externally to help the broader network of remote community stores across the country. In closing, I would like to take the opportunity at this moment to recognise the work of the team at Outback Stores and more specifically recognise the resilience, the dedication and the commitment of our store managers working out on country and supporting communities throughout this pandemic. Thank you.

CHAIR: Thank you very much, Mr Borg. We will now go to questions. Ms Campbell, thank you and your team for answering the questions on notice. You had very short notice and have done a very great job of getting this information before the committee. My reading of the data that you've tabled in relation to recipient numbers and outstanding claims for Newstart allowance, the jobseeker payment, and youth allowance is that over the last month—I think since the last figures the committee was provided—the number of recipients has increased from 1.346 million to 1.640 million.

Ms Campbell: Mr Bennett may have the detail of those numbers again for you. So you're interested in knowing the difference between—

CHAIR: My reading of the numbers is that in the last month about 300,000 people have become jobseeker and youth allowance recipients. Is that correct?

Mr Bennett: I believe the last data we gave you was as at 24 April, which reflected 1,346,172 people. The data that's been provided is as at 22 May, and that reflects 1,640,773 people.

CHAIR: So an increase of 300,000 people. I know you were working on estimates at the last hearing. How are the estimates that you had in terms of extra funding required for jobseeker tracking?

Mr Bennett: Previously when we had this discussion, we talked about, rather than necessarily having a track which implies that some forecast has been done, we did costing assumptions associated with the costing that reflected there would be 1.7 million at the end of September.

CHAIR: You're almost there now, in May. Has this changed your thinking about where we might be in September?

Ms Campbell: We rely on the Treasury to do the unemployment benefit recipient numbers, and so we work with the Treasury to give us guidance on those. We feed back, of course, the information that we see from the actual results and then the Treasury provides us with an update on the unemployment benefit recipient numbers—the UBR number.

CHAIR: Has that been updated?

Ms Campbell: Not at this time, no.

CHAIR: When would that normally happen?

Ms Campbell: We work with Treasury on a regular basis. Mr Bennett might be able to say when we're expecting the next update.

Mr Bennett: As part of the normal process that we go through working with Treasury associated with economic updates, we previously, prior to COVID, used to get it three times a year. I'd have to take it on notice at the moment to associate it with when we're expecting the next update.

CHAIR: In terms of what you're seeing, it seems to me that, if you look at it week by week over the last month, 250,000 people joined jobseeker and about 50,000 joined youth allowance. Are those increases stabilising?

Mr Bennett: If you were to look at the difference—particularly between 8 May and 22 May for the jobseeker payment—you'd certainly see that the growth has stabilised, and, in some payments, it started to fall away, depending on people's circumstances.

CHAIR: But, essentially, from 28 February this year to now, you've seen a doubling of the recipients on jobseeker and youth allowance. They're pretty staggering and distressing numbers that I don't think any of us would have expected to see.

Mr Bennett: Certainly, the growth in these figures is consistent with the other commentary that's been out there associated with what's happening in the economy.

CHAIR: Okay. Thank you. Senator Watt.

Senator WATT: Ms Campbell, we've talked in previous hearings about the significant pressure that your department has obviously been under, particularly running Centrelink and Services Australia—the services in response to COVID-19. I'm interested in some of the other activities the department has had to undertake at the same time. In particular, I'd like to know what costs have been incurred this calendar year in administering the online compliance initiative, better known as robodebt.

Ms Campbell: The online compliance initiative is administered by the agency Services Australia. We did ask the committee whether Services Australia were to attend today, and I understood that they were not required, so we can take that on notice.

Senator WATT: You and I have got a lot of history with robodebt, Ms Campbell. I think we first met at the Senate inquiry for robodebt. You were the secretary of DHS when robodebt was first introduced. You'd concede that, even this calendar year, administering robodebt and dealing with the legal action surrounding robodebt has been a significant drain on government resources in the middle of the COVID pandemic?

Ms Campbell: I don't have that information at hand. We can take it on notice.

Senator WATT: As the Secretary of the Department of Social Services and formerly the Secretary of DHS, would you agree that it would have been better to have those resources available to assist people with COVID-19 rather than having to pursue the robodebt scheme?

Ms Campbell: I think Minister Robert made it clear early on that debt recovery was going to be suspended during this period. The government provided additional resources to Services Australia in order to administer and support people during this very difficult stage. I don't have the numbers with me, but Services Australia has employed a significant amount of staff to deal with the increased workload. We can take that on notice and provide that data to you. But Services Australia has also taken secondees from other parts of the Public Service, including the Department of Social Services, and there have been some 2,000 other staff redeployed from around the Public Service in order to deal with the surge in work. So I consider that Services Australia does have enough resources to deal with these issues.

Senator WATT: The government announced its intention to refund $721 million late on Friday afternoon. Were you or your department involved in discussions around that decision?

Senator PATERSON: A point of order, Chair.

CHAIR: Yes, Senator Paterson.

Senator PATERSON: Senator Watt made a sterling effort in his first few questions to attempt to connect them to the terms of reference of this inquiry of COVID-19, but that last question was clearly in no way relevant to our terms of reference about COVID-19. Senator Watt is also asking questions to a witness about her previous role in the Public Service, not her current role, and that is generally not in order.

Senator WATT: If I can respond, I would submit that any work that is being undertaken by this department or any other department right now is relevant to COVID-19, because any work being done that's not about COVID-19 reduces departments' ability to work on COVID-19. I think it's completely in order to pursue this line of questioning. And I don't have a lot of questions.

CHAIR: In the interest of getting through this—I think I have allowed wide-ranging of questions in line with the terms of reference, which are very broad—Senator Watt, if you can remain within the terms of reference of the committee, that would be appreciated. I would also say that there is nothing to prevent Senator Watt from asking a public official questions that relate to previous roles. But if you could perhaps finish up as soon as you can and sit within the terms of reference.

Senator WATT: Thank you, Chair. Ms Campbell, when did you become aware of the government's intention to announce the refund on Friday afternoon?

Ms Campbell: I had provided advice to ministers in the lead-up to that decision.

Senator WATT: When did you become aware of the decision to make the announcement around the refund?

Ms Campbell: I think I became aware on Thursday.

Senator WATT: Do you know when the decision was made to announce the refund?

Ms Campbell: We'll need to take that one on notice, when the exact decision was made.

Senator WATT: But you were informed on Thursday afternoon or morning?

Ms Campbell: I can't recall; we can take that on notice.

Senator WATT: Okay. A decision was obviously made, at the latest, on Thursday, possibly earlier, but was only announced late on Friday afternoon. Is that the sequence of events, as best you know them?

Ms Campbell: The announcement was made on Friday afternoon.

Senator WATT: And it was certainly made before the Prime Minister's press conference at 3 pm on Friday.

Ms Campbell: The announcement—I'll just check—

Senator WATT: No, the decision to refund was obviously made before the Prime Minister's press conference at 3 o'clock on Friday afternoon.

Ms Campbell: The decision was made before Minister Robert made the announcement.

Senator WATT: We have discussed this issue at length in previous Senate inquiries, and I just had a look back at some of the transcripts of those hearings. On 8 March 2017, when you were still the secretary of DHS, I asked you whether Treasury and Finance were riding your department hard to achieve the savings from the online compliance initiative, and you said that they were constantly monitoring your department. I take it, then, that there was significant pressure from Treasury and Finance to realise those savings.

Ms Campbell: I don't recall having said that. I don't have that transcript with me. But I would note that the Department of Finance monitors everyone's estimates and spending profiles. That's their role.

Senator WATT: On 18 May 2017, again during another Senate committee hearing, I put to you and your officers a decision of the AAT, which had been handed down in March 2017, that found that the robodebt methodology 'is not consistent with the requirements of the legislation'. So you knew from at least March 2017 that there were significant doubts over the legality of the robodebt scheme, didn't you?

Senator PATERSON: Point of order, Chair. Senator Watt is now not even attempting to disguise his questions or to connect them in any way to COVID-19 let alone the Indigenous matters that are before the committee today.

CHAIR: Thank you, Senator Paterson. Senator Watt, you're almost out of time anyway but can you remain within the terms of reference of the committee, please.

Senator WATT: Okay. Minister Robert has had lots to do in responding to COVID-19, ensuring that Australians are receiving services that they need, and so have you and your department, Ms Campbell. In September last year Minister Robert said the government had not received any comment from the department to say anything other than, 'What we are doing is lawful.' Is that correct, Ms Campbell?

Ms Campbell: I think you may be alluding to a different department now, and I'm not sure I'd be able to answer that, because in September—

Senator WATT: Putting it simply, have you, either in your current role or in your former role as the secretary of the Department of Human Services, ever advised ministers of concerns about the legality of the robodebt scheme prior to this calendar year?

Ms Campbell: That goes to the legal advice around which this case revolves. It's currently before the courts. I think it would be inappropriate to talk about that legal advice while the matter remains before the court.

CHAIR: Senator Watt, a final question.

Senator WATT: Ms Campbell, did you ever brief ministers on that AAT decision that I referred to, handed down in March 2017, that questioned the legality of the robodebt scheme?

Ms Campbell: Again, we're talking about the legal advice around a case which is before the courts and—

Senator WATT: I'm not asking about legal advice, I'm asking about a decision of the AAT. I'm not asking about legal advice regarding that decision, I'm asking whether you ever briefed ministers about that decision which questioned the legality of robodebt.

Ms Campbell: I would need to take that on notice. I provide a lot of advice to ministers and briefings to ministers and I can't recall what happened—

Senator WATT: I would have thought that's a pretty significant one that underpins hundreds of millions of dollars of savings per year. And you don't remember?

Ms Campbell: I'm saying I need to take it on notice because I cannot recall, and I would not want to mislead the committee.

CHAIR: Thank you, Ms Campbell. Senator Watt, I'm going to have to leave it there and hand to Senator Paterson.

Senator PATERSON: I have some questions about the biosecurity restrictions that were put in place in remote communities. I asked about this at a previous hearing of the committee, and we heard about the rationale for the introduction of these measures to protect vulnerable remote communities in particular. We also heard in previous hearings that, thankfully, that and other measures have been successful. Could I have an update on whether any of those restrictions are in place still and, if so, what is the time line is for removing them?

Ms Edwards: I will start and then Mr Matthews or Dr de Toca can provide the detail. There was a biosecurity determination put in place which restricted mobility in various areas of remote Australia in four states. There have been numerous amendments after that time—some to do some technical changes, some to do unforeseen impacts, some to remove some smaller areas and, in particular, one amendment which will remove all of the areas in the Northern Territory, effective this week—

Dr de Toca: This Friday.

Ms Edwards: So that's in place to come into effect on Friday, which will remove all of the restrictions under the biosecurity law and replace them with other arrangements that the Territory has in place. We're also continuing to look at requests from Queensland and Western Australia about the next steps for the determinations insofar as they affect those states.

Senator PATERSON: Perhaps, on notice, you could provide a time line of those measures, when they were introduced and how they've been amended.

Ms Edwards: We can certainly provide—we can tell you now, but I know your time is probably limited—all the amendments that have come so far.

Mr Matthews: Probably the only thing to add is that, as Ms Edwards said, the four jurisdictions that still have restrictions in place with the Northern Territory, all those areas, will come out from 5 June, at the end of this week. That's guided by a framework, agreed through national cabinet, for states and territories to consider the range of things they need to work through to inform their request of the Minister for Health to lift those under the Biosecurity Act 2015. Dr de Toca can talk through that framework, if need be—

Senator PATERSON: That would be helpful, actually.

Mr Matthews: but that is there to give states and territories a guide about the matters that would have regard to how we want to work with states around that process.

Dr de Toca: As the acting secretary and Mr Matthews have indicated, the determination has been in place since 26 March with further amendments happening on 8 April and 24 April and a third one on 15 May which includes that the trigger for all designated areas in the Northern Territory be withdrawn from this Friday. The amendment, including the considerations around the NT, was done considering the remote framework with the Prime Minister on 15 May. That included a number of considerations that needed to be put in place for easing the restrictions, essentially. The national Aboriginal and Torres Strait Islander Advisory Group on COVID-19, which we've mentioned in previous meetings, developed a number of conditions that needed to be taken into consideration accounting for the epidemiology, the capacity for the health system to respond and the capacity for public health to respond to outbreaks. It is very consistent with the *Pandemic health intelligence plan* and other documents that the Australian Health Protection Principal Committee and other expert groups have developed for informing our next steps as we move into the next stages of COVIDSafe functioning.

The current framework that was used to inform the decision for the Northern Territory includes four main areas of consideration. It looks at the epidemiological situation and not only the current state of the outbreak but what the surveillance capacity is in that particular area, and what the public health system capacity is, including evacuation, laboratory capacity testing and contact tracing. It then goes to health system capacity: the capacity to treat severe cases but also to scale up the workforce, having systems in place for isolation, hospital surge capacity, primary care et cetera. And then, very importantly, local decision-making: what are the communities; do they have access to information; are they including governance structures; are they informing this process? Then it considers other external considerations, such as the state of flu vaccinations, considerations around tourism and the overall governance in place.

This is meant to be used by each community, each region and each jurisdiction to assess the level of readiness to replace their protection of the remote areas that restrictions confer at the moment with other measures to ensure that the risk of an outbreak is minimised, but also there is the capacity to identify and rapidly respond to an outbreak. They form the basis of the initial recommendation that the jurisdiction puts to the Department of Health which then analyses and provides advice to the Chief Medical Officer in his capacity as Director of Human Biosecurity. This then informs the minister's decision on the removal of the restrictions or any other amendment to the determination.

Mr Matthews: I was just going to add that the framework is on the Department of Health's website as well. I'm sure we could table a copy if the committee would like to see it as well, but it is publicly available.

Senator PATERSON: Just to be clear: these biosecurity restrictions were put in place at the request of state governments and are only being eased also at the request of the state or territory governments.

Ms Edwards: We're working very, very closely with states and territories, and the requests have been made, and also with Aboriginal people and groups and with the AHPPC and on their advice. Obviously, they're legal decisions made by the minister under the relevant legislation—

CHAIR: Excuse me, Ms Edwards. Senator Watt could you please mute your microphone. Thank you.

Ms Edwards: I was just making the point that obviously they're statutory decisions made by Minister Hunt, but the process has been a very collaborative and consultative one relying very heavily on state and territory views, certainly with their agreement, with the National Indigenous Australians Agency and with the advisory group and so on. But, yes, the state views are obviously absolutely paramount. What they're doing instead to ensure the safety of remote residents is a key element in considering any changes to the determination.

Senator PATERSON: I'm also interested in remote community testing for COVID-19. Can I have an update on what measures were put in place to ensure that testing was able to be done if needed?

Dr de Toca: Testing is a key criterion and a key condition in the framework. Access to timely and effective testing is a key consideration when we are looking at communities' preparedness to identify and respond to an outbreak. Testing for COVID-19 has been occurring in remote communities since the beginning of the outbreak with a mix of approaches, depending on the geography, location and jurisdictional arrangements. Up until recently, all of that testing was occurring by traditional laboratory based polymerase chain reaction testing—like anywhere else in Australia—which, in some communities, required a specimen to be collected in community and then transported to a major city, which was working relatively well in some areas with a delay of a few days, not dissimilar to what you would encounter in other regions. However, in the more remote locations, especially with reductions in travel and reductions in overall flights around the country, the turnaround for a specimen collected in the community to make it to the laboratory, to then be processed and to come back, could extend to over a week and 10 days in some cases in some northern areas of the country. The fact that in some of those communities the turnaround for a test result could be impracticably long was identified very early on as a risk by the advisory group and the Management Plan for Aboriginal and Torres Strait Islander Populations. Of course, there is a risk in terms of transmission of not being able to identify cases early. However, there is also the risk of the disruption that this causes in communities, especially in those communities where the capacity to isolate safely in the community is limited because of infrastructure needs or a lot of people living in the same house. And that is why part of the systems that we put in place, including the aeromedical retrievals package that Mr Matthews talked about in the previous hearing, were about facilitating the early evacuation of suspect cases so that the isolation and the turnaround for testing could occur in areas where quarantine could practically be achieved, which is often in regional urban centres—a significant degree of disruption to community members that have to leave the community, to date, to receive a negative result, because there hasn't been a case in an Aboriginal or Torres Strait Islander person in a remote community.

That is why, in partnership with the Kirby Institute and the Flinders University International Centre for Point-of-Care Testing, Minister Hunt, Minister Wyatt and Minister Coulton announced the Australian government's Remote Point of Care Testing Program. This is making technology to provide PCR, polymerase chain reaction, the same type of test that you would receive in a laboratory but at the point of care in remote communities. The intent is that 83 remote communities across the country—selected in consultation with the jurisdictions' Aboriginal community controlled health services and the peak bodies for Aboriginal health in each state and territory—will achieve a coverage that means that no remote community remains more than a two- to three-hour drive away from a test. Those that have access to laboratory based testing are not as much of a priority as those communities that do not have effective access to laboratory based testing.

That rollout commenced from April. We currently have nine sites operational across three jurisdictions. The first two tests occurred last week in Western Australia with very good results, with evacuations prevented and significant disruption to community avoided. We are finalising the allocation of the final 20 sites this week with the expectation that the full program will be rolled out by the end of June, covering, as we said, 83 communities and significantly changing their capacity to respond by reducing that testing delay from up to 10 days in some locations, to under an hour, without compromising on the specificity, sensitivity or safety of the test.

Senator PATERSON: So just to recap: from up to 10 days to under an hour?

Dr de Toca: Correct.

Senator PATERSON: That's an incredible improvement. There was a lot of information in that answer, but I think you also said in there that there has been no positive test for COVID-19 in a remote Indigenous community? Is that right—did I hear you correctly?

Dr de Toca: Yes. One of the best stories to date, as part of this response, is that there has not been a case in an Aboriginal or Torres Strait Islander person in a remote or very remote community. There have been a small number of cases in remote communities. They have all been in non-Indigenous persons, in most cases, associated with essential services or other personnel who were already in quarantine by the time they were identified. So, to date, collectively we—the Aboriginal community controlled health sector, the states and territories and the Commonwealth working together—have been successful in keeping COVID-19 outside of Aboriginal and Torres Strait Islander remote communities.

Senator PATERSON: That is very good. Touch wood, let's hope it remains that way.

CHAIR: Senator Paterson, just a couple of minutes warning.

Senator PATERSON: Thank you: I only had one other matter that I wanted to pursue. I'm interested in the GP respiratory clinics that were being set up. Can I have an update on that, please?

Dr de Toca: As to respiratory clinics in general or Aboriginal and Torres Strait Islander aspects in particular?

Senator PATERSON: Yes, please.

Dr de Toca: On 11 March, as part of the health plan to respond to COVID-19, there was an announcement establishing 100 GP respiratory clinics across the country in urban, regional, rural and remote locations to work together with the fever and COVID-19 clinics that the states and territories were establishing—which were partly funded by the Commonwealth in a fifty-fifty cost-sharing arrangement under the National Partnership Agreement—to provide specialised centres that could provide a holistic assessment for people presenting with respiratory symptoms. It is important to clarify that these clinics weren't set up as testing centres. They are GP-led respiratory clinics that have to have a GP on site at all times and have a clinician and a multidisciplinary team, looking after people presenting with respiratory symptoms. They provide an assessment of that presentation if indicated which—with the current enhanced testing recommendation from the Communicable Disease Network Australia—means essentially anyone with a compatible presentation is provided with that testing.

As of today, we have 127 clinics open across all states and territories. The rollout occurred in partnership with the Primary Health Networks, which did the initial identification of potential need and sites in collaboration with the local health district. The department then proceeded to assess site suitability based on a range of issues, and, after infection prevention and control assessments were undertaken by a contractor or the government, the sites have been established. After the initial rollout, it was clear that, if we were to complement the state and territory clinics and achieve good coverage across the country, we needed more than the initial 100, which we are able to achieve at the moment with the same funding envelope as the original announcement. As I said, as of today, 127 of those have been established, of which 12 are operated by Aboriginal community controlled health services. To date, our clinics have provided 89,000 assessments for people presenting with respiratory symptoms and conducted 75,000 tests. The proportion of people seen in those clinics identifying as Aboriginal and Torres Strait Islander people slightly exceeds population parity but, of course, that becomes much higher when we look at those clinics that are specifically run by Aboriginal community controlled health services, which at the moment is around 10 per cent of all the clinics nationally.

Senator SIEWERT: Ms Campbell, the department has just provided an update on some of the data. Is it possible for the committee to receive more regular updates and a breakdown of payments by type and payment? Is it possible to receive that on a weekly, biweekly or monthly basis so that we get a clearer picture of the data in real time but also of the specific demographics against payment type?

Ms Campbell: We can take that on notice and get back to the committee on that. We are just trying to work out the data to make sure it is cleansed and accurate. We'll check about how we can do that. We'll get back to the committee on that.

Senator SIEWERT: That would be very much appreciated. Thank you. I want to go to the issue of testing and follow up on a couple of Senator Paterson's questions. I notice from the NACCHO submission that they recommend that the government improve data collection practices in Aboriginal and Torres Strait Islander identification so that information can be used to provide accurate reporting and screening and testing programs and outcomes for testing, including in pathology. I take it that the point they are making in their submission is about access to timely data and the ability to know how many Aboriginal and Torres Strait Islander people have been tested and, therefore, how many have been infected. They say there is no way of identifying the national level of testing for COVID among Aboriginal and Torres Strait Islander people. How do you plan to make that data available in a more timely manner?

Dr de Toca: The identification of Aboriginal and Torres Strait Islander status in pathology collection data is a vexed issue that the health authorities, the Aboriginal community controlled health sector and the Commonwealth have been dealing with for quite some time, including in other contexts and at previous hearings—in the context of syphilis outbreaks et cetera. The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 have made a very clear commitment that they want to make the most of their enhanced capacity for working together on longstanding issues that these crises constitute to try and resolve it, at least for COVID-19 data if not more broadly.

The identification of Aboriginal and Torres Strait Islander status in positive cases is very good at the moment; it is above 90 per cent in the nationally reported data in the national dataset, and that is part of what the public health units in each state and territory do when they follow up on any positive cases. The issue remains how to ensure that every test, every pathology form and every pathology result that is reported includes that

identification. That has also been identified by the Communicable Diseases Network Australia as a priority in what they do, and some states and territories have achieved some inroads in resolving it.

The issue is not so much that there is no timely release of the data; it is more about ensuring that the data can be collected and collated nationally. The identification needs to happen at the point where the specimen is collected. The physician performing the collection needs to record that that person is or is not Aboriginal, so the form that the pathology collection system has needs to have a space for that. That has to be recorded in the laboratory while they are doing the test and then it has to be reported when the test is conducted. With Australia's myriad public and private pathology providers, every different agent, every different form and every different clinician doing the collection would have to record it at each step to ensure that that is reported up. It is happening in public laboratories in some locations. For instance, the Northern Territory have achieved very good coverage of Aboriginal and Torres Strait Islander identification in pathology forms for their public laboratory and they can confidently look at the testing rates in Aboriginal and non-Aboriginal people in their jurisdiction. But we are still working on how we can achieve that nationally with the mix of public and private pathology providers we deal with.

Mr Matthews: We have made that a requirement as well in the GP respiratory clinic context. It is a requirement that the GP respiratory clinics collect that data and put it in, so that side of things is reasonably well covered.

Senator SIEWERT: I don't understand why you can't make the private organisations do that as well. If they are performing these tests, surely it should be a requirement for the private organisations to be doing the same thing.

Ms Edwards: If we can just go back one step: obviously we want identification as Aboriginal or Torres Strait Islander to be universal. We want people to feel comfortable to identify—so they take the form on Medicare and so on—and that's a project that's been ongoing. In the COVID sense, as Dr de Toca has been talking about, there are people referred from a private doctor, there are people going to state clinics and there are people going to our clinic—and we haven't actually nailed making sure that all of those have the right things in place. It's a good point, and it's one that we are trying to retrofit to make it work. But, at the moment, the core problem is that we don't have a reliable underlying Aboriginal identifier across the Medicare system; and that's something we need to get back to making sure really happens.

Senator SIEWERT: In the context of COVID, do you have a specified time by which you're hoping that will be achieved?

Ms Edwards: As Dr de Toca said, in terms of people who have been found to have COVID, we have good data—and really reassuring data in terms of lower level of infection among Aboriginal people than non-Aboriginal people. That's a good thing. In terms of the testing, it is an enormous task to do. I would have to say that our attention has been directed slightly elsewhere, but it is a task that we will continue to do. As to whether we can fix it during the current pandemic, I hope that we don't have a second wave, and so it becomes a much lesser issue, but it is one we will continue to work on.

Dr de Toca: It is a higher priority but it is a collaborative effort with the states and territories on what everyone is collating. It is definitely one of the things that CDNA is looking at as a matter of priority, and we are having positive conversations with the private providers as well. Everyone recognises that this is an important thing to resolve. But, as Mr Matthews said, we do have indications in different datasets—GP respiratory clinic datasets, some jurisdictions like the Northern Territory and anyone who would be receiving point-of-care testing—that, even though it is not the Holy Grail of a consolidated national overview of every test that is happening, it does give us an indication of the testing rates in samples of the population and it does not give us a concern that the testing rate is lower.

Senator SIEWERT: Can I move on, please, to remote food security. Mr Griggs, I'll start with you. Can you let us know the status of the work on developing a basket of goods for remote communities? Where is that at?

Mr Griggs: That's currently underway and planned to be delivered to the minister at the end of this month.

Senator SIEWERT: Okay. Will it be released publicly? What happens to it once it's with the minister?

Mr Griggs: The intention would be that the minister would pass that to the House committee that is doing the inquiry into food pricing.

Senator SIEWERT: That goes to the food-pricing inquiry as a public document?

Mr Griggs: That's my understanding.

Senator SIEWERT: Okay. Is that straight away?

Mr Griggs: I believe so. The issue for us here is that, as you know, several jurisdictions run basket-of-goods analyses. Your own state does, I think, on a two-yearly basis. I think the Northern Territory does on, again, a two-yearly basis. This is an interim snapshot from our perspective. It's not got the full methodology that those surveys do. We intend to develop that in the next phase. The challenge we have, of course, is that jurisdiction by jurisdiction is fine but we don't have a picture across remote Australia, and that's what we're trying to gather with this snapshot at the moment.

Senator SIEWERT: Thank you. What's the reporting date for the supermarket inquiry?

Mr Griggs: I believe it's 30 August. I will get back to you if that's incorrect.

Senator SIEWERT: Thank you. I want to go to the issue of price gouging and to Outback Stores. You made a comment about not having any evidence of price gouging. Can you outline on what basis you make that comment? I've had people reporting issues of price gouging and I've actually seen the cost on some of the goods, which I would suggest—well, I know—are significantly higher than in metropolitan areas. I would like to know what definition of 'price gouging' you're using and the evidence on which you're making those comments.

Mr Griggs: Before Mr Borg answers, 30 October is the reporting date for the committee.

Senator SIEWERT: Thank you very much.

Mr Borg: There's no doubt about it: prices in remote communities are high on many products due to many reasons. I look forward to the inquiry that's taking place at the moment to make sure that groups like Outback Stores can demonstrate our model and how we function. What I will say is that we pride ourselves on focusing on wanted products and high-volume products to ensure that remote communities are able to purchase those products at reasonable value compared to some of the large retailers. We will always have examples of some general merchandise lines that are high and some premium products that may be high from a retail-pricing point of view. In the COVID-19 response, we held our price structure reasonably well right through the two months of April and May, and in many cases we reduced prices. We did have examples where we were not able to purchase some goods that we would normally purchase. A good example of that would be toilet paper. At times, we were substituting a product and we could only get our hands on products like a Kleenex 45 pack. We traditionally would run another product of toilet paper where the price would be $3.99. In this scenario, through COVID-19, we were paying a higher cost and had to reflect a similar margin.

To your question around price gouging: we always reflect the same margin on goods. Even if we get a higher cost price from a supplier, we reflect the same margin in standard practising. Price gouging really reflects where people are opportunists and raise a price above normal processes. That's how I see price gouging.

Senator SIEWERT: So how do you know that didn't occur in the Outback Stores? I've got a receipt for a very, very high price that somebody's paid for, for example, toilet paper, for biscuits, for meat and for tinned food. I've compared the prices that you'd pay in a metropolitan area to the prices that somebody's paid on a receipt. They're significantly higher. So I'd suggest that there has been price gouging going on. That's why I want to know what efforts you've made and how you can be very definite in saying price gouging hasn't occurred.

Mr Borg: Let's be very clear: there's been no price gouging at Outback Stores. We have good processes in place where we manage our pricing all the time. We certainly placed more specific focus on that through COVID-19. In fact, we've seen our gross profits across our stores drop where we've actually brought pricing down. As a couple of examples: we were chasing items that were unavailable nationally, like hand sanitiser. We actually paid a higher price. That doesn't mean Outback Stores is price gouging; it means that we paid a higher cost price. In this example specifically, we sold that product at cost, and the stores that we manage made no profit on those items at all in trying to keep the price down. Outside of a couple of areas where availability was a struggle, we drove prices down significantly across the board to assist in this process.

Senator SIEWERT: How did you check that prices were what you said they should be?

Mr Borg: We get to see our prices regularly in our system and we get to manage weekly our price increases or decreases in our system. I can reflect, take it on notice and provide documentation that shows that we weren't increasing any prices outside of our standard processes through the COVID-19 period.

Senator SIEWERT: What was the maximum price for toilet paper per roll?

Mr Borg: I know the example you're talking about. For that example, the roll price of toilet paper was 90c. If you look at corporate retail at the same period of time, you see Woolworths and Coles were both selling packs of nine or 12 at similar value. I don't disagree that it's a very high price per roll for a 45-pack of toilet paper that could probably supply a whole community. That's the only pack size that at that time we were able to get our

hands on. Like I said, normally we'd sell a four-pack or a 12-pack at 55c a roll. So I understand the complexities around it, but at no stage was price gouging taking place at Outback Stores.

Ms Edwards: Dr de Toca has just asked me to correct a minor error he made. He mentioned that the final amendment to the final remote community determination happened on 15 May. It was actually 24 May, so apologies.

CHAIR: Thank you for that correction. Senator Dodson.

Senator DODSON: My question is around housing initially, and then I want to make some inquiries about the constitutional matters. Can I understand what the reasons were for the closure of First Nations communities, particularly under the Biosecurity Act?

Did they relate to poor and overcrowded housing, the challenges of social distancing, the lack of health services, poor sanitary conditions and water quality? Why were those communities closed? What were the reasons behind the closures, and were they key factors in the decision?

Ms Edwards: The determination in relation to remote communities was made under the Biosecurity Act and, of course, it complied with the very strict criteria that are set out in the act. The Minister for Health made the determination on the advice of, and at the request of, state and territory premiers and first ministers and also in consultation with, and with requests from, representative Aboriginal groups in relation to concerns about the severe risk of Aboriginal people, especially in remote areas, suffering severe disease as a result of COVID. The minister also took into account the advice of the chief medical officer, who in turn had the views of Aboriginal people and the states and territories in mind but, mostly on assessment of the epidemiology at that time, which, as you would recall, was at a time when we were concerned there might be much higher numbers and much greater risk to Australians generally, and with efforts being made to protect what was believed to be—and asked for as—a particularly vulnerable group. As to whether particular issues to do with the conditions in communities were taken into account—not to my knowledge was any detail about the particular conditions taken into account but, really, the advice of states and territories and Aboriginal peak bodies as to the risk of disease and infection. Of course, the difficulties in doing social distancing and the distance from health services, hospitals and so on were relevant factors to the consideration of the health issues.

Mr Matthews: Probably the only other thing to add is that, in terms of, as Ms Edwards said, the states and territories did take that range of factors into consideration in providing advice around the areas to be put in. That did lead to, for example, some of those things being taken into consideration particularly if you look at the Kimberley, with Broome inside the zone. They had to allow patterns of mobility between communities and into some of those larger zones and some of the larger towns et cetera to access services, food and those types of things as well. That would have been part of the thinking of the states and territories as they framed their advice to the Commonwealth.

Senator DODSON: The point I'm trying to get to is these known social indicators. We know there's poor housing and we know that overcrowding occurs. That's one of the key social indicators in the health battle, yet we saw it as necessary to close off these communities and then we moved people from communities outside of remote areas back to those communities, where there was very little hope of social distancing or maintaining the other protocols required. What was the judgement being made here?

Mr Matthews: I think the judgement is that, obviously at the time that the restrictions went in and with the community prevalence, the restrictions were really a way of ensuring that COVID-19 did not enter into the remote communities. Obviously, a lot of the social determinants you talk about in remote communities increased the risk profile of people in those communities. So, in essence, the remote restrictions were a risk management tool to ensure that COVID-19 did not enter into those areas. There were a range of factors in remote communities, and it was probably one of the prime things we could do—and this was acknowledged by many of the Aboriginal leaders at the time, who were also calling for these types of restrictions because of that protective factor—to ensure that it would reduce the risk of COVID-19 entering the communities.

Senator DODSON: Was there any testing undertaken for those removed from the fringes of the towns back to the communities?

Mr Matthews: Not specifically. Once the restrictions are in place, the restrictions have a range of rules about entering the communities in those biosecurity zones. We have a handout that can explain that available on our website, and it has a nice graphic about the rules for entering. But, in a general sense, the determinations require people entering the biosecurity areas to undertake 14 days of self-isolation prior to going in—with some exemptions, obviously, for essential workers that also require a range of things to ensure they're safe. There are some provisions for local decision-makers to bypass those rules if they're having regard to advice from a

biosecurity officer. But, in general, people are required to do 14 days self-isolation once the restrictions are put in place.

Senator DODSON: I understand that. My question was about the fringe dwellers who were around the towns and who were then assisted back into the communities. Were they tested before they were dropped back into the communities?

Mr Matthews: It's a bit difficult for us to say without knowing the specifics of the cases but, as I said, before the restrictions—

Senator DODSON: People from Broome, for instance, were shifted back to Fitzroy local communities. Were any of those people tested?

Mr Matthews: That would be a matter for the states. We would need to find out from the Western Australian government, who would have undertaken that process. It's not something facilitated by the Commonwealth at that point, so we wouldn't have that detail here.

Ms Edwards: That wasn't something that was required or part of the determination. The determination had effect on people where they happened to be when it came into effect. We could seek information from Western Australia about what the plan was, but—

Mr Matthews: We are aware that some jurisdictions would have assisted some people outside the zones before the restrictions came in if they wanted to return before the restrictions came into place, so part of the communications were around that. And, of course, the risks around that were something the state would have had regard to, but I'm not aware of whether they have or haven't applied testing. It's something that would need to be asked of the Western Australian government.

Dr de Toca: The important point, as Ms Edwards and Mr Matthews said, is there's nothing in the Commonwealth determination that would have triggered any removal or displacement of people back into the remote areas. As Mr Matthews said, the communications were very clear that, at that time, based on the epidemiology in urban locations and regional centres versus remote communities, there was strong messaging that the safest place to be for an Aboriginal person from a remote community was their remote community or their homeland because there was no transmission in remote communities and there was transmission in some parts of urban areas. So there was messaging around that, but there was nothing in the determination that triggered that removal. And, even if, in those areas, jurisdictions or other organisations were supporting and assisting voluntarily people who wanted to return to their designated areas once the determination was put in place, they would still have to observe the 14-day quarantine period that is stipulated in the determination for people to return to their designated area.

Senator DODSON: You'll recall that the specifics of Broome were that the mining company had evacuated their employees to self-quarantine in the town and it was in the self-quarantining process that people were being moved from the town back out to these communities. That may well be a matter for Western Australia. I want to just go to another question, and this may be a question for Mr Griggs. In the reconstruction, in terms of attention to these social factors that are well known—housing and overcrowding, poor sanitation, poor water and the deficiencies in health services—are they going to be addressed in the post-COVID environment or are we just going to let these communities retreat to the appalling social conditions that they're surviving under at the current time?

Mr Griggs: As you know, the responsibility for housing is a state matter. It's not a Commonwealth matter except in the Northern Territory, where, because of the Aboriginal land rights act, which I know you're very familiar with, there is a legislative requirement for the Commonwealth to remain involved in the management of housing in the Territory. And we do that through the national partnership agreement with the Northern Territory on remote housing, where the government has committed $550 million over five years to reduce overcrowding in the Territory. Certainly, when we negotiated the latest version of that agreement, the Commonwealth pushed very hand for the Territory land councils to be involved in the management of that agreement. They form part of the joint steering committee for the agreement, so I fully expect that the land councils, through the joint steering committee, will articulate those sorts of issues.

Senator DODSON: I understand that, Mr Griggs, and thanks for your answer, but we are still under the threat of a pandemic. We know that there are appalling conditions in these communities, but we retreat, in your answer, back to Commonwealth-state niceties whereas, in other arenas, there is collaboration going on between the governments to address the circumstances that could give rise to a second wave or a pandemic as the borders open up and more access goes forward. So why is it that we don't address those potential causes that could wipe out communities, like overcrowding, sanitation, poor water and the lack of medical services?

Ms Edwards: Senator, obviously the social determinants of health for Aboriginal people and for everyone are absolutely fundamental and very much at the core of work we do in Aboriginal health generally—work that was in place before COVID and will continue to go ahead with COVID and after COVID. So that you don't go away with the impression that the determination made under the Biosecurity Act was in any way the only measure put in place by the federal government in collaboration with the states and territories in order to combat COVID in relation to remote communities and Aboriginal and Torres Strait Islander people generally, I would just like to make it clear that it was part of quite a broad package of measures, because we are absolutely aware not only of the risk of a second wave, which all of our measures are working hard against, but also of the particularly severe impact that would have in remote communities and would have if—which, luckily, has not been the case—it was prevalent amongst Aboriginal and Torres Strait Islander people in the community generally. We would be happy to revise the various measures that are in place in addition, if you would like. We have given answers to that effect previously, but it is only one. The amendments that Minister Hunt has made in relation to the Northern Territory and is expected to consider in relation to Western Australia and Queensland will be on the basis that very strong protections are in place, notwithstanding the amendment to the biosecurity determination. Mr Griggs, did you want to comment?

Mr Matthews: I would add one thing, just to finish on health, before we go back. Senator, you may recall in estimates towards the end of last year, before COVID started this year, there was some discussion at estimates around the funding model for the primary health clinics and the Aboriginal community controlled sector, in particular, where the government had provided an extra $90 million over three years to the primary healthcare system. That has been applied across the services on the basis of the number of times and episodes of care but also looking at the cost of services and health needs. Obviously, under that framework, remote areas come out as fairly high needs. So a reasonable proportion of that $90 million will also support the provision of health services in remote clinics. So there are things underway in the health space to strengthen services, particularly in remote communities.

Senator DODSON: I will ask Mr Griggs a totally different set of questions to those I would ask the health people. Mr Griggs, when did the NIAA become aware of the statement by the minister that there would be no referendum conducted within this parliamentary term?

Mr Griggs: I don't believe the minister has made that statement.

Senator DODSON: Well, he made a statement, I think last week, that it was very unlikely that there would be a referendum, and in recent days he made a contrary statement, which was a bit more optimistic, saying that there won't be in this term of the parliament. My question is really about the allocation of the funds. There has been about $188 million—

Mr Griggs: It's $160 million, Senator. Are you talking about the contingency reserve for the referendum?

Senator DODSON: Yes.

Mr Griggs: It's $160 million.

Senator DODSON: If there is no referendum this year, what is going to happen to that money?

Mr Griggs: My understanding is that it stays in the contingency reserve. So it is not time limited in that sense.

Senator DODSON: So it won't be ploughed into something else? What will happen to the $7.3 million? Has any of that been used for consultations on the referendum issue?

Mr Griggs: On the referendum, no. That has mainly been focused on voice. We haven't spent a great deal because, obviously, COVID has, as I mentioned to the chair last time, changed the way that we've had to do the interactions on the development of the voice and have had to move into a virtual environment.

Senator DODSON: Mr Calma said that he hopes that one of the three committees that he oversights will be reporting in July/August. Will that report be made available to the public?

Mr Griggs: I don't think the report will be, because that forms part of the cabinet consideration for the options, which is stage 1 of the process. My understanding is that, following a decision by government about what options are taken on the road, those options will be made public. But I don't have any detail on what other documentation will be made public at this stage.

CHAIR: Senator Dodson, this is your final question. I will come back to you later in the hearing.

Senator DODSON: I was going to ask whether the $7.3 million is also secure.

Mr Griggs: We are working very hard to make sure that that's the case, Senator.

Senator DODSON: So it may not be?

Mr Griggs: No; I'm confident it is, but we've got to go through a process—that's all I'm saying.

CHAIR: Thank you, Senator Dodson. I will come back to you later in the hearing. Senator Patrick?

Senator PATRICK: Thank you, Chair. Ms Edwards, I will perhaps start more broadly and then I will go to the effects of COVID-19. What's the Department of Health's evaluation of the consequences of the United States withdrawing support for the World Health Organization?

Ms Edwards: I will just pull up the right brief. I'm not sure I can comment directly on any reaction to what another country might have done. That's outside of our portfolio. But I would say that the Department of Health and the government are supportive of the work that the World Health Organization does in relation to COVID and generally. We recognise the role of the WHO in coordinating the global response to the pandemic and generally. It has great technical expertise, field presence and convening power to make it a central player, and it's an important partner with Australia in the Indo-Pacific. We have great respect for the work it has done to support preparedness.

Senator PATRICK: So, obviously, we will continue to support the WHO and continue to reap those benefits?

Ms Edwards: We're committed to being part of the WHO processes. Obviously from time to time we have views about things that it does and attend forums and so on. We're supportive of the work that the WHO does, especially in our region.

Senator PATRICK: This is perhaps a more targeted question. What do you think the impact of the US withdrawal from the WHO will have on global efforts to combat the COVID-19 pandemic?

Ms Edwards: I'm not sure I can comment either on the detailed expertise of how the WHO works and the impact of the US's involvement with it or on the timing or expectation of how the US is going to proceed. I would really have to defer comments to my colleagues at the department of foreign affairs. But I'm happy to take the question on notice and confer with them and report back.

Senator PATRICK: Obviously your department interacts with a number of people who are working with the WHO and so, in that sense, your department will have at least some direct effect, even if it's from the loss of finances. Programs, no doubt, will be cut as a result of the US effectively withdrawing funding.

Ms Edwards: The way such an important country as the US interacts with the WHO will definitely have an impact on its operations, but I'm just not in a position to know what that impact will be and how it will affect us. I'm happy to take it on notice.

Senator PATRICK: Thank you very much. What about in relation to the development of a vaccine under the WHO auspices? Obviously they're clearly focusing on that, and we and a number of other players are focusing on that.

Ms Edwards: There is an enormous focus worldwide on the development of a vaccine. There are a whole range of potential candidates, including ones we're investing in directly here in Australia. Having an organisation like the WHO involved in those things is an asset, but I couldn't comment on what impact any changes in its support or otherwise from another country might have. It's just outside my field of expertise, I'm sorry.

Senator PATRICK: Does that have an impact, for example, if a vaccine is developed in the United States? I understand inside the WHO there were discussions taking place about fair distribution and so forth. You might have to take that on notice as well.

Ms Edwards: I really do. Obviously there are discussions about how we could make sure there's fair distribution of a vaccine, particularly access to it in Australia—and we would be very keen to ensure that. I would have to take on notice exactly how the role of the WHO works and how this might impact it.

Senator PATRICK: In relation to the COVID-19 vaccines, I think the minister made an announcement today of $66 million being spent.

Ms Edwards: Yes, he did.

Senator PATRICK: I'm just wondering what that does in terms of the total now that has been spent on research and vaccine related work.

Ms Edwards: That investment includes in relation to a vaccine but is not limited to that. The $66 million is in four areas: investing in a vaccine, investing in antiviral therapies, clinical trials for potential treatments of COVID-19, and improving the health system's response to COVID-19 and potential future pandemics. It includes vaccine work but is not limited to it.

Senator PATRICK: What's the total for vaccine work since the pandemic started?

Ms Edwards: I had a briefing last week. I'm having trouble keeping up, I'm here so often with you. Ms Rishniw talked about $43 million out of the MRFF for research and it included $3.35 million in vaccine research for the University of Queensland, $2 million for a competitive grant opportunity and $13.65 million for vaccine development not yet allocated. You'll have to forgive me if I haven't quite integrated that with today's announcement, so I'll take on notice the extent to which that has moved on.

Senator PATRICK: Thank you very much, Ms Edwards. I want to move to a time frame—and, obviously, how long is a piece of string? What is the expectation of the earliest that we're likely to see a vaccine from Australian sources?

Ms Edwards: I don't think I have any update other than the speculation that has been in the media and so on that the Chief Medical Officer has referred to previously. There was 12 to 18 months, if ever. That was the number. We're all hoping that Australian ingenuity will do something much quicker, but I don't have an update. I expect the experts would be reluctant to speculate. It all depends on how these candidates go in trial.

Senator PATRICK: What is the department doing in terms of planning for production in the event that a vaccine is developed here in Australia or even overseas? What have we got standing by ready to go into production for vaccines?

Ms Edwards: I would have to take that on notice or we could take it up at a further hearing when I've got the right officers with that sort of expertise with me.

Senator PATRICK: Okay. Has the department developed any policies, plans or guidelines for the distribution of a vaccine, be it an indigenous sourced vaccine or international vaccine, once a vaccine has been developed? What would those broad guidelines be?

Ms Edwards: It has been a matter discussed, both within the department generally and with some of our partners who we talk to about vaccine development, but we don't have any guidelines or so on at this point. I'd expect that that would be the sort of thing we would get international collaboration and expert advice on, but it has not been put in place at this point. We've been very busy doing the COVID response and investing in people with vaccine expertise. But, again, I'll take that on notice in case someone in the Chief Medical Officer's group can assist.

Senator PATRICK: I'll go to some Indigenous matters. I'm not sure whether this was answered before. How many Aboriginal and Torres Strait Islanders have been affected by COVID-19?

Dr de Toca: As of the last published data in the weekly communicable diseases intelligence update that is provided by the Department of Health, there have been 59 confirmed cases of COVID-19 in Aboriginal and Torres Strait Islander people in Australia—none of them in remote or very remote communities.

Senator PATRICK: How is the treatment taking place in respect of those very remote communities? Has it just been self-isolation, have we had to send medical experts or have they been transported to a hospital?

Ms Edwards: There have been no cases of Aboriginal or Torres Strait Islander people having COVID in remote or very remote areas to date, we're happy to say. We do have a whole range of plans in the event that there is—and we hope it doesn't happen—but to date we've had no cases in those locations.

Senator PATRICK: Sorry, I misheard the answer.

Ms Edwards: That's fine. It's a difficult line.

Senator PATRICK: In relation to travel restrictions, I think you said at the start of the hearing that the travel restrictions in relation to remote areas are going to be lifted; is that correct?

Ms Edwards: There has been an amendment to the determination, which means that they will be lifted entirely in the Northern Territory as of this Friday. We're in discussions with Queensland and Western Australia about the extent to which there might be changes in those areas, but we haven't worked through the analysis of those yet. There has been a change to at least one area in South Australia, and we're continuing to talk to them about what might happen next. I think we went through the process of checking that there are arrangements in place to ensure the protection of people in very remote communities.

Senator PATRICK: Jurisdictionally, who's responsible for those sorts of decisions—is it the NT government that is under federal control and the states under independent control? How does that work?

Ms Edwards: All of the states and territories have capacity to put in restrictions for health purposes with their own residents, but there's also a power in the Commonwealth Minister for Health, which has been enlivened by the fact of the pandemic and a determination under the Biosecurity Act. The remote community determination, which is in place and which has been amended from time to time, is made by Minister Hunt under that law. That overrides any other law while it's in place. As Dr de Toca and Mr Matthews have been saying, all of the actions to

put that determination in place have been done, talking very closely with state and territory governments about what they're doing and might do and how they would complement, and also with Aboriginal peak organisations.

Mr Matthews: As Ms Edwards said, generally the restrictions are put in from the Commonwealth end and they're implemented. As well as the states providing advice to the Commonwealth about which areas to cover, the states and territories are responsible for the implementation of those restrictions.

Senator PATRICK: I want to just move more broadly to border restrictions. Obviously each state has adopted a different approach. Does the Department of Health have any view from a medical perspective as to the effectiveness? Has any modelling been done in and around border closures? It seems to be topical now. There are questions as to whether or not those restrictions should be lifted.

Ms Edwards: The medical advice, which has been provided to the government, is everything that has been agreed by the AHPPC. I'm not aware of any specific view that it has had in relation to state border restrictions, but I will have to take that on notice if there's anything that I'm not aware of.

Senator PATRICK: We have had the example of the Prime Minister being very adamant in respect of schools staying open and the differences across the states. That has been aired publicly. Does the same situation exist in respect of interstate travel? Do the Commonwealth and each of the states have a particular view? Clearly there are differences in their views, because there are different measures at each of the borders.

Ms Edwards: The Department of Health doesn't have a view about those things.

Senator PATRICK: Has the Department of Health done any modelling in respect of the border closures to look at what the impact would be in terms of the spread of the pandemic and, indeed, controlling the spread of the pandemic?

Ms Edwards: Not that I'm aware of.

Senator DAVEY: Thank you all for attending today. I have a couple of questions for the NIAA. I would like an update on the package that was announced by the minister in early April to support Indigenous businesses and communities on the back of the COVID-19 pandemic. According to that announcement, $50 million is to go to Indigenous Business Australia. Can you provide a bit of an overview of how this money is going to be targeted, and, if possible, how it's going to be rolled out, whether any has gone out to date, and what processes will be put in place?

Mr Bulman: The $50 million for Indigenous Business Australia targets three areas. The first thing to keep in mind is that it's available for all Indigenous businesses, not just the clients of Indigenous Business Australia. Any business can contact IBA. IBA will do a rapid assessment of their business needs. The main thing they're going to be doing is linking those businesses into some of the Commonwealth's mainstream packages, which might be the cash flow boost assistance or the JobKeeper payment, among other things, or even some of the state related packages. Then, if there's still a gap in the businesses' cash flow et cetera, IBA can administer either a working capital grant or loan, or a combination of the two, to prop up the businesses for this period. The take-up has been quite successful. They've had 592 businesses come through the system already since the announcement. One hundred and forty-two of those have moved through the rapid assessment, with the remainder still ongoing, and 32 of the working capital grants or loans have been applied already.

Senator DAVEY: Is the program designed to keep people employed and linked to those businesses, or is there potential for job creation opportunities through this?

Mr Bulman: It's to keep the businesses alive during this challenging period—keep all their employees, as far as possible, engaged and keep the businesses alive and running. It's a bit of a multiple strategy.

Senator DAVEY: Can you provide an assessment of how Indigenous businesses have fared through this crisis. We haven't seen the health outcomes that we were perhaps preparing for, particularly in Indigenous communities, which is a good thing, but we have seen economic impacts across Australia more broadly due to all of the preparations we put in place for those health outcomes. Are you able to give an overview of how Indigenous businesses have been coping?

Mr Bulman: It's still early days. The majority of Indigenous businesses are in our major cities and regional areas, so they're impacted in the same way as all other Australian businesses—quite heavily. Indigenous Business Australia and our other partners, such as Supply Nation et cetera, have been working closely with the sector. I don't think we have hard evidence to date of the absolute impact on each thing, but the mainstream packages that the government have put out, augmented by Minister Wyatt's Indigenous business package, have been of great assistance. We're seeing some good results.

Mr Griggs: As of last Friday, IBA have had over 600 inquiries from Indigenous businesses. One hundred and sixty-nine of those have been referred to undertake the rapid assessment that Mr Bulman talked about earlier, and 40 working capital packages have already been approved. That's an indication of the interest in the scheme from Indigenous businesses, but it doesn't quite answer your question because, as Mr Bulman said, we don't quite have that picture yet.

Senator DAVEY: With hindsight, post COVID-19, might we do a review of Indigenous businesses specifically so that we can formulate future programs and preparedness for any future health crises that may occur?

Mr Bulman: Absolutely. We're always focused on looking at that. The government has in place a 10-year Indigenous business support strategy as well, which builds the capability of new business entrepreneurs in particular in areas where business is more vulnerable, like remote Australia. We're going to continue to build on that strategy, and that backs in with our Indigenous Procurement Policy, which drives the demand for Indigenous businesses. So, we've got a strategy in place, but obviously, as we move through this process, we'll continue to look at it.

Senator DAVEY: Great. Another part of the package that was announced was $25 million to look at how Indigenous workers could help address workforce shortages where the usual workforce is unavailable. I've had discussions with my Territory colleagues about shortages, particularly with the absence of seasonal workers, given they are not able to come into the country. Is that what you foresee this package helping to alleviate? Also, how do the current remote community travel restrictions play into that in terms of potentially preventing Indigenous workers from being able to shift to where the work is?

Mr Bulman: That's exactly what this type of package will do. We've got $25 million allocated over the next two years to target areas where there's a large Indigenous workforce that might be able to move into jobs that have become available. We've been working with the NT government's department of industry and agriculture as well as our colleagues across the department of employment and in the Commonwealth to identify such areas—for example, the Katherine area, where the loss of seasonal workers has had an impact on mango and melon farming. So, for an area like that, we might be able to draw on Indigenous labour from areas where there might be high unemployment rates and move them into those industries to support farmers. At the moment, we're identifying three or four key locations to start trialling this work. But, again, this is going to be paced out as the biosecurity restrictions are wound down and we have a better understanding of what the needs of the different sectors will be and the opportunities there will be to activate the Indigenous workforce to support them.

Senator DAVEY: I also want to ask a couple of questions about boarding schools that I've asked other departments during the course of this inquiry. We know that boarding schools have been working with state and territory health authorities in developing strategies for reopening boarding houses. I also know that there are a lot of Indigenous students that take up the opportunity of staying in boarding houses. If there are still restrictions in place on travel when they return to school, I'm concerned about how that might impact on their ability to come home during school holidays. Have any contingencies been put in place to allow Indigenous students to continue homeschooling until restrictions have been completely lifted so that they don't miss out on either their education or that important family connection?

Mr Griggs: I think the answer is a mixture of all of those. I'll get Mr Exell to talk you through that because he's been pretty close to this issue.

Mr Exell: Working closely with Services Australia and the department of education, for us one of the key areas of the movement of students from boarding schools back to their homes was a real focus, and a safe travel plan was essentially put in place for every student, moving from the school to their home location, to ensure that those requirements around quarantine or isolation were safely met and to ensure that the movement of students from school to home was done safely. To answer part of your question—that element will also be considered, if students have returned to boarding school, for future breaks or term breaks. That practice was very important and worked well, and it's something that will be continued into the future.

What we're seeing in terms of the overall return of students from remote and very remote communities to boarding schools is a bit different in each state or territory. It varies according to the practices of the boarding school itself and indeed then the interplay with overall state requirements for travel. Essentially, students won't be returning if there isn't a process that can guarantee that movement from their community through to the boarding school. It also needs to be done in a manner consistent with those schools' arrangements. But you're right: we are seeing some limited flights in and out of some areas. That's seeing a different approach and, I guess, a staged return of those students. Where that is occurring, we're also working with the boarding schools to provide that

ongoing support for those students, in the locations where they may be, to ensure that ongoing education, where we can. But that's not easy in all locations, given wi-fi and a range of issues.

Mr Griggs: And remember the scale that we're talking about: around 5,000 Aboriginal and Torres Strait Island kids study away from home and about 3½ thousand—3,600—come from remote and very remote communities.

Mr Exell: Services Australia provided some numbers: around 500 students have already returned to their boarding schools.

Senator DAVEY: But obviously their families and the schools have worked together to try and ensure that there is continuity of contact and an ability to travel.

Mr Exell: Yes.

Senator DAVEY: Thank you, Chair. I know we've got further senators on the line, so I'll finish there.

CHAIR: Thank you, Senator Davey. You've set an exemplary standard there! Senator McCarthy.

Senator McCARTHY: Thank you, Chair. I'd like to go to a couple of questions to give the Senate inquiry an understanding about prisons and hostels—I think I can go to you on this, Mr Griggs—and then on mental health. Firstly, on our processes with First Nations people in prisons across the country, what has the COVID process been and what's happening post-COVID in terms of visiting arrangements?

Mr Exell: Thanks for your question. I guess the key part of the answer is that NIAA doesn't look after corrections; that's the responsibility of states and territories.

Ms Edwards: It's a matter for states and territories as to how prisons are managed and so on, but there has been guidance issued by the AHPPC in relation to COVID-safe practices in prisons.

Senator McCARTHY: I understand that it's a jurisdictional care, but you have taken an overarching approach in terms of COVID. If there's a particular focus around the prisons, are you able to provide that for the committee, on notice?

Ms Edwards: I can take it on notice, but I can also direct you to the fact that it's publicly available, as I understand it. It would be of the same ilk, in relation to other businesses, as where there's medical advice which is published. Just like supermarkets set up their queuing, in a similar way there's guidance in relation to prisons, which states and territories will take on board in making sure they have safe environments for prisoners. But we don't have any direct role in managing that process.

Senator McCARTHY: Okay. Has the NIAA received any concerns or complaints about how the COVID-19 process has been carried out in relation to prisons?

Mr Exell: I'm not aware of any directed to us.

Senator McCARTHY: I'd like to go to Aboriginal hostels. What plans have been put in place to safeguard people in hostels run by Aboriginal Hostels Limited?

Mr Griggs: I'll take that on notice for AHL to answer. I know they have done a lot of work over the last couple of months, but I don't want to verbal them, so I'll take that on notice, if that's okay.

Senator McCARTHY: Thanks. Would you also be able to either respond yourself or have hostels respond—I understand the government has used money from the Aboriginal Benefits Account to respond to COVID-19 in the Northern Territory. Is that correct?

Mr Griggs: Yes, that is correct. That was part of the $123 million package that Minister Wyatt announced in early May. There was $4 million to each of the larger land councils—the Central Land Council and the Northern Land Council—and $1 million each to Anindilyakwa Land Council and Tiwi Land Council.

Senator McCARTHY: What kind of reporting process has been put in place in relation to those funds?

Mr Griggs: Mr Bulman can give you some quite detailed information on how the land councils have been spending their money in that respect.

Mr Bulman: A total of $10 million was transferred to the Northern Territory land councils, and the purpose of the money, just to go back, was to support those people that were self-isolating out in communities or even going out further, back to country and homeland. There's been a big push from the two mainland land councils to make sure their countrymen have access to a lot of small wares such as chainsaws, cooking equipment, blankets, bedding et cetera. They have regular monthly reporting in place. We know, for example, that in the Central Land Council region, with the upcoming winter, they've been responding to their members' calls to put in place heavy-duty camping equipment such as sleeping-bags and blankets. To date, they've distributed around 3,800 blankets and another 2,340 heavy-duty sleeping-bags to support people while they're self-isolating out on community.

Across all four land councils, $5.2 million of the $10 million has been expended or contracted, and it's just steadily rolling out in all regions.

Senator McCARTHY: Thank you. I guess I'd still come back to my initial question, though. The funding has come largely from the Aboriginal Benefits Account. Why has it had to come from the ABA and not from general government revenue?

Mr Bulman: With the ABA, we're responding to calls from land councils et cetera for extra support. It's passed through their traditional stream of funding to land councils—it's under section 64(1) of the Aboriginal land rights act—to give them extra resourcing to respond to the needs of their members.

Senator McCARTHY: Yes, I understand how it works. I guess I'm asking why it is that in a crisis—a pandemic that's affected all Australians—you haven't chosen to provide funds from government funding, as you have done with other sectors of the Australian community, rather than from what is ordinarily used for general needs in the First Nations community.

Mr Bulman: Territorians have access to all our measures, but, given the unique ability of the Aboriginal Benefit Account to benefit Aboriginal people in the NT, we've utilised that for additional support in that region, with the support of the land councils to deliver on that. So we're in a unique situation where, with the Aboriginal Benefits Account, we're able to benefit the Aboriginal people in the Northern Territory, above and beyond the rest of the measures that have been rolled out in the Territory and elsewhere in Australia for Indigenous peoples.

Senator McCARTHY: Could I go to funding for mental health. The government has allocated $3 million for Aboriginal and Torres Strait Island people for mental health through PHNs. I want to understand the process in which the government provided funding for mental health and why it's gone to PHNs.

Mr Exell: While my colleague is looking for the brief, can I correct a previous answer I gave? I've just been advised by our agency that the—

Senator McCARTHY: Sorry, who is this?

CHAIR: This is Mr Exell.

Mr Exell: It was actually I who answered your previous question about us having received any complaints from corrections. I have just been advised by our agency that we have received a complaint about treatment in custody, so I might take that on notice and come back to you with details.

Senator McCARTHY: So you have received a complaint about treatment in custody during the COVID-19 crisis?

Mr Exell: Correct. I have been made aware that we received at least one, so I will take that question on notice and come back to you with a comprehensive answer.

Senator McCARTHY: And whilst we're here?

Mr Exell: I will endeavour to do that.

Senator McCARTHY: Okay, Ms Edwards, I think I'm—

Ms Edwards: In the meantime, Mr Matthews has informed me he knows way more about this than I do.

Mr Matthews: We don't have anyone here from our mental health area, but I think you're referring to the recent announcement around mental health, which did include $3½ million for Indigenous mental health, which will flow through the Primary Health Networks. So that will be injected into there. A significant amount of the Indigenous mental health funding does run through the PHNs, so that is a strengthening of an existing framework; it injects further funding into that system. The details will be worked through with the PHNs for the PHNs to use flexibly in providing mental health support in the regions.

Senator McCARTHY: It's going through the PHNs. Why is it that it didn't it go through the ACCHOs?

Mr Matthews: As I said, that one is a decision—it's just the way the funding has worked. A lot of the mental health funding does run through the PHNs currently. The mental health work for Aboriginal and Torres Strait Islander people does work through PHNs now, so it is an additional injection into that existing process, noting that, obviously, a lot of what the PHNs do is to make arrangements with ACCHOs and Aboriginal community controlled health services locally. Quite a reasonable proportion of the funding does go to ACCHOs. Obviously, the sector has—for some time, I think—been looking to ask questions around those arrangements. That discussion is ongoing with government. But, at the moment, that is an additional injection into the existing funding.

Senator McCARTHY: Did funding for mental health in response to the bushfires go to the ACCHOs or to NACCHO?

Mr Matthews: There was funding, in the bushfire context, that did go directly to the Aboriginal community controlled sector. That was to support a limited number of areas that were directly affected by the bushfires. At the time, going through those Aboriginal community controlled health services was seen as the fastest way to provide support into those areas.

Senator McCARTHY: So you're saying that, on one hand, you're strengthening the system by going through PHNs when, in actual fact, you already had a precedent set by sending the mental health funding directly to the ACCHOs, yet you're not doing it in this situation where it's even faster for ACCHOs to be dealing directly with First Nations people as opposed to PHNs.

Mr Matthews: I think that, obviously, the majority of the mental health funding does run through the PHN system at the moment. There was some funding, in the bushfire context, provided directly through to the ACCHOs, but, as I said, it was a decision of government for the $3½ million to go into and through the PHN network, noting that a large amount of the money does find a way through to the Aboriginal community controlled sector through the PHNs. As I said, there is an ongoing discussion where the community controlled sector is seeking to discuss those arrangements more broadly. I'm sure that discussion will continue with government.

Senator McCARTHY: Can I go to some of the social-distancing and movement restrictions of funerals. I guess this is more a general question, knowing that these areas do come under each state and territory jurisdiction. Clearly, lots of communities were asked not to hold funerals. This would have been done through a lot of the land councils for fear of the spread of COVID. I would like to know if the NIAA or other agencies have received any feedback on the need to work with hospitals or morgues to ensure the burial or cremation of bodies. If so, how many areas are we looking at that may need attention immediately?

Mr Griggs: Again, I think it's a fairly mixed picture across the country. In a number of areas, we've seen funerals go ahead and we've seen live streaming of funerals. But, in other areas, we've seen very few funerals take place. The Tiwis, I think, is a good example of where families have decided that they wanted people who live in Darwin, for example, to be able to come up to the Tiwis for the funeral. So I think it's a bit of a mixed picture. It's hard to give you a nicely packaged answer on this one. I don't know if Mr Exell has got any other points.

Senator McCARTHY: Sorry—we know funerals have been postponed. I'd like to know if the agency or others are aware of the extent to which there are families who are waiting to bury their loved ones, given there are some concerns around overcrowding in morgues or the ability to keep those bodies appropriately kept until burial.

Mr Exell: I am aware that there are, in some locations, some pressures on those morgues, as you're saying. I'd have to take on notice the specific arrangements, practices or additional support that's being considered at the appropriate level on those. I'm sorry; I don't have the details on those arrangements.

Senator McCARTHY: If you can—it's not a trick question.

Mr Exell: We know that.

Senator McCARTHY: These are really important concerns.

Mr Exell: I know.

Senator McCARTHY: There is the reality that flights have been suspended in our communities—even in Arnhem Land, for example. Bodies are usually transported. Therefore, if they haven't been able to be transported, it means there's clearly a build-up in our local hospitals and morgues. I'm conscious, as I said, that these are perhaps jurisdictional matters, but I'm also aware that the NIAA does assist in all these areas. It would be good to understand whether you have received any concerns or issues around it, so thank you.

Mr Griggs: We have been working very closely with the land councils, particularly in the Territory, on this issue.

Senator McCARTHY: Okay, thanks for that. Could I go to the issue of superannuation. Do you have figures on how many First Nations people may have accessed the superannuation program?

Ms Edwards: I don't think any of the agencies here today would have access to that data. I don't think Social Services would either. That program is managed by the Treasury, so you might want to direct your question to them. I don't know whether Services Australia has those figures, but it's definitely a policy owned by the Treasury.

Senator McCARTHY: Is there no interest or involvement with the NIAA at all to want to understand that?

Mr Griggs: It's not that there's no interest; it's just not been an immediate issue for us.

CHAIR: Senator McCarthy, we're up against it. We will have a break at three o'clock. There is probably time for one more question, but I will come back to you in the rotation.

Senator McCARTHY: I ask about the Community Development Program. Because of the suspension of mutual obligation, how many fewer social security penalties and suspensions were issued in the CDP in April 2020 compared to April 2019? You may want to take that on notice.

Mr Griggs: We will take the comparison on notice.

Mr Bulman: We will take the comparison on notice, but no penalties were applied in April 2020.

Proceedings suspended from 15:00 to 15:11

CHAIR: The committee will resume its hearing into the Australian government's response to the COVID-19 pandemic, and I will hand the call now to Senator Siewert.

Senator SIEWERT: I'd like to continue where Senator McCarthy left off, which was on the CDP program. At the very end, when we stopped for the break, I think the agency confirmed that no CDP participant had received any penalties. Can you tell me from what date that was?

Mr Griggs: In the context of that question, it was April.

Senator SIEWERT: To be clear, it was in the context of the question, and I thought that was from April. Could you just confirm from what date that was?

Mr Griggs: We answered that during the month of April there were no penalties.

Senator SIEWERT: That was during the month of April. What about in May and prior to that?

Mr Bulman: The minister announced on 23 March that any suspensions or penalties that were currently in place would be lifted, and that was done, with Services Australia's support, immediately. Throughout the period from 23 March to today there haven't been any penalties or suspensions applied in the CDP context.

Senator SIEWERT: In the CDP context, is there a date for when the penalties will start again, or when mutual obligations will start again?

Mr Bulman: There are two elements here. There are mutual obligations, which sit with the department of employment, and Minister Cash will make announcements about those. The latest advice is that across the country mutual obligations will gradually ease back into place from 8 June.

In CDP specifically, we've got a range of steps in place where we've asked service providers, even when mutual obligations are in place, not to apply penalties or suspensions at this point in time. That's linked to biosecurity measures. As jurisdictions lift their biosecurity measures, we'll start to gradually ease-in activities again—working with participants to put in place job plans, re-engaging them after this period where there hasn't been much engagement—and then down the track we'll enter back into full business as usual. We haven't confirmed a full date yet, but it will be state-by-state specific.

Senator SIEWERT: Just to make sure I'm clear on this: are you saying that mutual obligations as they apply to CDP will be rolled in on the same basis as they're being rolled in across the country? Is that how I interpret what you just said?

Mr Bulman: Mutual obligations are a national system but they get applied locally by each program, whether that's jobactive, in urban and regional areas, or CDP, in remote areas. When we're rolling out CDP, when we're returning to business as usual, we will ask service providers to continue not to apply suspensions or penalties for a period until we know that jobseekers are re-engaged, activities are ready to go and the biosecurity and safety measures and risk assessments are in place. We envisage, after biosecurity border measures are lifted, a period of a month, say, when we communicate to all jobseekers and work them through their plans and activities, then a period of setting up new activities for people to participate in—those that take into account social distancing et cetera. And we'll work through each community.

Mr Griggs: It's a gradual process.

Mr Bulman: It's a very gradual process to ease it back in.

Senator SIEWERT: I'm fully aware that mutual obligations are a process across the country, but from what you've just said there will be a different process for CDP.

Mr Bulman: Each region, each program, will ease it in, depending on the circumstances of the program.

Senator SIEWERT: Who determines that?

Mr Bulman: The minister responsible for the program. In our context, in CDP, it will be Minister Wyatt.

Senator SIEWERT: Sorry; could you be clear? Which minister will be responsible? Will it be Minister Cash or will it be Minister Wyatt?

Mr Bulman: Minister Wyatt will be responsible for the arrangements that take place in CDP.

Senator SIEWERT: Thank you. Could I go now to issues around justice. I know that we have touched on some of these issues but I would like to be clear. Is the agency considering any national strategy to enable early release of First Nations prisoners who are high risk but who, in particular, have chronic health issues—those on remand, those who are elderly, children and those at increased risk of COVID-19?

Mr Exell: The Attorney-General's Department is the lead department for that approach. We have worked with Attorney-General's on some aspects, but the lead is Attorney-General's.

Senator SIEWERT: Could you tell me what aspects the agency has been working on?

Mr Exell: The one in particular—and I referred to it in earlier conversation around boarding school students—was looking at the safe travel plans and giving some advice and information through Attorney-General's about how they operated and how they could be used to support released prisoners to return to their home or location of living.

Senator SIEWERT: Okay. So when you were talking about boarding school you were talking about the same process?

Mr Exell: Correct.

Senator SIEWERT: That's for travel back—

Mr Exell: That's right.

Senator SIEWERT: But what about ensuring prisoners' early release? Have you been involved in any discussions?

Mr Exell: No.

Senator SIEWERT: A-G's?

Mr Exell: That will have to be a question for the Attorney-General's Department.

Senator SIEWERT: So, just to be really clear: the agency hasn't been involved in any process, a national strategy, to look at early release of prisoners who are at risk?

Mr Exell: That's my understanding.

Senator SIEWERT: Can I ask why not?

Mr Exell: Because that's the responsibility of the Attorney-General's Department—

Senator SIEWERT: Yes, but you have the responsibility—

Mr Exell: and jurisdiction. Sorry, Senator.

Senator SIEWERT: But you have responsibility for First Nations people.

Mr Exell: But the implementation issues are jurisdictional.

Senator SIEWERT: Yes. I'm asking about a national strategy to get a coordinated approach. We've got a national cabinet at the moment. Has there been any national approach or discussion around looking at a coordinated response or a national strategy to encourage the early release of, particularly, people with chronic health issues at risk from COVID who are a low risk to release?

Mr Exell: As I've said, that's a question for the Attorney-General's Department.

Senator SIEWERT: No—I asked you just then: have you been involved in any discussions? That's a question for you.

Mr Exell: I have not been involved in a direct discussion with the Attorney-General's Department.

Senator SIEWERT: Has the agency?

Mr Exell: I'll take that on notice.

Senator SIEWERT: Have you been involved in, or have you looked at, the issue that occurred in Tennant Creek where local residents were complaining about intimidation from police in terms of travel restrictions and social distancing?

Mr Exell: Sorry—we've moved now from a corrections sort of question to a broad question around the implementation—

Senator SIEWERT: Yes, to a broader question.

Mr Exell: I'm not aware of the specific incident you're referring to.

Mr Griggs: Mr Jeffries might be.

Mr Jeffries: I'm not aware of the specific issue that you've raised. I can take that on notice and come back to you.

Senator SIEWERT: Okay. I'll also do a bit more detail. If you're not aware of it, there's no use pursuing it now. I'll put questions on notice as well, with more detail.

Mr Jeffries: Thank you.

Senator SIEWERT: I think this question will be for DSS. I want to ask about disability support workers. I've had some concerns raised with my office around disability support workers for First Nations families. Concerns have been raised of shifts ending early; inadequate PPE; hygiene protocols not being followed; and lack of replacement staff for families where, for example, a worker has had to isolate themselves. I've also had reports of First Nations families having been asked for more money and having given away artwork in response. Are you aware of these reports?

Ms Campbell: I am not aware of those reports. I would expect that the NDIA would first become aware of those reports, and they haven't advised us of those. But we can take those questions on notice and ask the NDIA and get back to you.

Senator SIEWERT: Thank you. That would be much appreciated. In terms of specific supports for First Nations families with disabilities, have there been additional supports provided, and, if so, what are they?

Ms Campbell: Ms Rule will be able to answer the broader NDIA question about the specific additional supports that have been available during the coronavirus.

Ms Rule: There haven't been any specific measures as they relate to Aboriginal and Torres Strait Islander people in the disability space. There have been a series of general measures about increased support to people with disability that apply to all people. These have included things like: changes to pricing arrangements; access to an allowance or being able to purchase things like IT equipment on their NDIS plans; an ability to change servicing arrangements—a whole series of measures, which I think we've talked about previously, around all people with a disability, but nothing specific in relation to Aboriginal and Torres Strait Islander people.

Senator SIEWERT: What about additional access to PPE, which has been quite difficult to get hold of, particularly at the beginning of the pandemic in regional and remote areas?

Ms Rule: There have been, again, a series of general measures around access to PPE. We've worked closely with our colleagues in the Department of Health. The NDIA has access to the National Medical Stockpile, and we have been distributing PPE from that stockpile to NDIS providers. There's a process where NDIS providers can request that access, and those requests have been actioned and that PPE really has started flowing. We are hearing much less noise about that being a problem now than at the start of the pandemic.

Senator SIEWERT: I've got a couple of questions again for Outback Stores. Sorry I'm skipping around; I'm trying to make use of my time. Mr Borg, you commented in your opening statement about the increase in expenditure following the stimulus package and the supplement. I'm wondering if you have a breakdown—and you may need to take this on notice—of the sorts of things that people have been purchasing with both the stimulus and the supplement, which would give us an idea about where people are prioritising their expenditure and how much it has helped communities.

Mr Borg: There has been a general trend across the board of an increase, and what we have seen is definitely a higher proportion of sales in general merchandise and apparel—so, high-end goods. We've been selling a lot of whitegoods and a lot of clothing, and a lot of just normal, general merchandise items: washing baskets, mop buckets—those sorts of items. That has been on a high scale. If the percentage was about a 95 per cent lift on the normal trend, I've seen about a 35 to 40 per cent lift on food and a slightly higher increase on confectionery, at about 50 per cent. At a maximum scale, we've seen general merchandise at about a 200 per cent lift on our previous year. Once again, I can provide you with some further information and more specifics there, but generally: food at about 45 per cent and general merchandise, at the far extent, at over 200 per cent. Out of that mix, there's been an 80 to 90 per cent increase across the total business.

Senator SIEWERT: Is that across all of your stores or in specific areas?

Mr Borg: That's generalised across all of our stores, but we have many formats of stores. We have stores that are treated as roadhouses in Western Australia. We have stores that are close to regional hubs, too. So in the Katherine district, up in the Broome district and close to Alice Springs we have probably seen a higher uplift on

some food items where generally those communities would drift in and out of regional hubs on weekends and so on. So it is a little bit of a different mix, but the numbers I've given you are across the 40 stores.

CHAIR: Senator Siewert, your final question.

Senator SIEWERT: In terms of looking at the impact it has then had on the businesses, in terms of the extra expenditure, how much of that would be the additional increase in prices because of the COVID pandemic?

Mr Borg: I would say: very minimal. As I touched on before, there might be two or three examples where, for a short period of time, we had to procure goods at a higher cost. As to the example before, of toilet paper, it was three or four days where we were out of the basic packs that we'd normally stock. To your question previously, around how we've managed that through the pandemic: all pricing is managed through our head office and not managed through the individual stores. So we have a really large control over what is happening with pricing across all stores in our communities.

Senator SIEWERT: I'll put some more questions on notice. Thank you.

CHAIR: Thank you very much, Senator Siewert. Senator Dodson.

Senator DODSON: I have some questions about the future testing strategy in remote communities. Is this testing going to be on the basis of some sort of community surveillance or just when someone displays symptoms?

What is the frequency of these tests if they're going to be performed, and what's the goal of the numbers?

Ms Edwards: The testing regime that's in place has been what's been worked out carefully through AHPPC. The current testing regime is that anybody who has respiratory symptoms, however mild—if you have a slight cough or sore throat or a sniffle—you should go and get tested so we can have the broadest possible testing regime to make sure we pick up any errant community transmission cases. In addition to those people with respiratory symptoms, there is a practice of testing all residents and staff in any aged-care facility where a case may have been detected in order to make sure that, if there is a case of a resident or staff in an aged-care facility, we get on it very quickly and stop the spread in what we know is a particularly vulnerable position. Some other reasonably small studies propose some patients going in for elective surgery and so on who are asymptomatic. At this stage there is no proposal to do asymptomatic tests in Australia. I imagine if there were an outbreak in a remote community, we would probably have a higher level of testing to make sure we avoid any sort of spread in another vulnerable community, just as we do in an aged-care facility.

In relation to the idea of surveillance, there has been a lot of talk around doing what's called serological testing, which is blood testing for people who might have had the virus at some time in the past. That's being used in some countries where there has been a high prevalence of COVID-19 to try and figure out how many people might have had it and nobody ever knew they did. There is no current proposal to do that sort of testing in Australia, as a function of not being very clear about exactly when those tests become accurate—how long ago since you had the virus—and also because we are very confident of a very low rate of infection in Australia because of our current positive testing ratio. So that is not proposed at this time. It might be that, at some time in the future, that will be something we would like to do, such as testing samples of blood and so on, but it's not currently. There's no plan to surveil test in Australia at the moment. We're really looking mostly at people with symptoms and then contacts of anybody infected in a particularly vulnerable group, such as aged-care facilities and probably remote communities as well.

Senator DODSON: I suppose as the movement restrictions are taken down or eased off, particularly in remote communities, it's going to be inevitable, it seems—as we've seen in the schools and in the meatworks and other places—that there will be outbreaks. So what's going to be the response to these remote communities in those situations?

Ms Edwards: I think the Chief Medical Officer and other state and territory officers have been clear that we do expect outbreaks. We've actually had remarkably few to date, but that's exactly why having very comprehensive testing of symptomatic people and contact-tracing processes are in place. In addition, because we know that people in remote communities are particularly vulnerable to severe disease, there are additional efforts ready in order to deal with any outbreak—

Senator DODSON: Yes, my question is: as the restriction to the boundaries are withdrawn and taken off, that's likely to create the instances of outbreaks that we've seen in other places in Australia. What's the strategy to deal with that? What's been done to equip those clinics in these remote places? What's the equipment that's been put there?

Ms Edwards: That's what I was just getting to. First there's the Australia-wide approach, because an outbreak, wherever, is responded to incredibly quickly. In addition we have some particular measures in relation to remote communities, which Dr de Toca can tell you about now.

Dr de Toca: We can go systematically through the different approaches, but, in a nutshell, acknowledging that the specifics will vary in each region and remote community, essentially the first step is that as the restrictions are eased we need to make sure that everything is in place to prevent that outbreak from happening. I understand, as the senator indicated, that if restrictions are eased and there is any increase in cases then there is an increased risk of outbreaks, but the first one is still to try to prevent an outbreak happening in a remote community. Part of that is being achieved by movements that jurisdictions are taking to replace, as Ms Edwards indicated earlier, their biosecurity restrictions with other Chief Medical Officer directions or other instruments within the public health legislation that enable them, if not in the same manner as the biosecurity restrictions, to still limit some degrees of movement in and out of remote communities, which different jurisdictions are considering to apply. But beyond that—

Senator DODSON: Can I get to something practical?

Dr de Toca: Yes.

Senator DODSON: Do you know where Balgo is?

Dr de Toca: Yes.

Senator DODSON: What happens if there's an outbreak at Balgo? You've got the Tanami—

CHAIR: Sorry, Senator Dodson, you just dropped out there for a moment. If you could just go back to what you were saying?

Senator DODSON: I was asking about the practicalities of a place like Balgo, where we have the Western Australia and Territory border as an intersect, with a lot of movement of Aboriginal people across the borders. It's no good someone talking about someone in Canberra giving an order when an outbreak occurs in Balgo. I want to know what the practical things are that are going to be done in Balgo to help those people identify someone who's got the virus, how to isolate them, and then what's going to happen to the community.

Ms Edwards: Back in March, with the first health responses, this was totally in our minds from the very beginning. From March it was announced—specific things, practical things in addition to the community-wide issues. Those include remote community preparedness grants. There's funding made available—$5 million—to be allocated to remote and very remote communities so they could take the steps they needed to minimise exposure. As Dr de Toca says, step 1 is to keep it out of remote communities, which we have been successful on so far.

Secondly, we've put in the mechanism to ensure we can have early medical evacuations and mobile respiratory clinic development. So if there is an outbreak in Balgo, we need to be quickly on the spot and make an assessment. Do we need to evacuate that person in order to ensure that they can be self-isolated and get the treatment they need? Is there a position in the community where it is very difficult to isolate them from other people? So $52.8 million is available to increase the capacity of existing aeromedical service providers for that sort of early retrieval and evacuation.

In addition, Dr de Toca talked about the point-of-care of testing, so that we have best-practice PCR testing within two hours of any community in Australia. So they don't have to wait for a sample to be flown to Perth, tested there, and have the result come back; we can do it quickly, which does two things. It means we can get on the outbreak really quickly and it also minimises the distress to the community, who might have to take radical measures to isolate from one another while they're waiting for the test result.

Those are three of the very practical things we're doing. In addition, as we have been trying to explain, we are working really closely with the ACCHOs sector and with other Aboriginal groups to make sure we're providing people with the skills and information and support they need in order to help prevent any outbreak.

Dr de Toca: Just to be clear on the very practicalities, acknowledging, on top of what Ms Edwards said, that the specifics in each community will vary: I can say that in Balgo in particular the capacity for early evacuation with increased RFDS capability is already in place and has been tested. In Balgo in particular, the Kimberley Aboriginal Medical Services clinic there was the first primary care centre in Australia to conduct a point-of-care testing for COVID-19, on 21 May. That actually prevented that evacuation from happening. So the capacity to identify cases early, fly them out early if needed for appropriate isolation in a regional centre that can actually support that, and then an enhanced services strategy for that community, aided by point-of-care testing, would be the first approach, acknowledging that those plans are being managed and implemented by jurisdictions and the

local organisations. Balgo is a good example, because the early medical evacuation and retrieval capacity is in place and has been tested, and they were the first cab off the rank for point-of-care testing.

Senator DODSON: Is there sufficient PPE equipment and tests available at the Balgo clinic, for instance, if it happened tomorrow?

Ms Edwards: In relation to testing, all of the point-of-care testing that we're rolling out has been rolled out with sufficient consumables. As Dr de Toca said, Balgo is one of the places, and they have plenty of testing equipment in order to do those tests.

Senator DODSON: That's PPE as well?

Ms Edwards: PPE is allocated depending on outbreaks, as opposed to just sending it out everywhere. So there are arrangements in place to ensure we quickly deliver the right amount of PPE to anywhere there is an outbreak.

Mr Matthews: Just to add to that, if there is an outbreak in somewhere like Balgo, obviously the state government also has a significant amount of resources that they would bring to bear. So the public health units from Western Australian Health would also, as part of their planning for the biosecurity areas to come out, ensure that they have rapid response capability to put their public health teams into in the area to assist with the contact tracing and also to supplement the medical workforce and those types of things to respond to that. That's part of the planning for those restrictions coming off—to ensure there is that capability to fly people out, do the testing and get that surge and rapid response capability into the communities.

Dr de Toca: Just to confirm, masks from the National Medical Stockpile have been distributed to Aboriginal community health services, including the Kimberley Aboriginal Medical Services, which runs the Balgo clinic. We have confirmed from camps that the stock is sufficient to cover the foreseeable future. But also, to be 100 per cent clear, every time we dispatch the cartridges to operate the point-of-care test they come with all the required PPE for each one of them. So we don't send them separately to ensure that we guarantee that every test that is performed is done with the utmost safety for the operator and for the patient.

Senator DODSON: How many capsules would be available at Balgo for the point-of-care testing?

Ms Edwards: I think the senator is talking about cartridges?

Dr de Toca: We'll have to take that on notice. The cartridges are delivered fortnightly or monthly, depending on remoteness allocation. We are also making sure that we are prepositioning additional protective personal equipment and additional cartridges in key regional locations so that the RFDS or other aeromedical providers can rapidly deploy additional supplies if a first case is identified. That way the aeromedical retrieval team that effects the first evacuation of a confirmed case can also deploy additional PPE and additional cartridges to expand their capacity to help communities respond to the outbreak.

Senator DODSON: What training has been provided to the local nursing staff or health workers?

Dr de Toca: The rollout of the point-of-care tests includes a significant training component. The program meets the requirements of the National Pathology Accreditation Advisory Council for accredited or safe conduct of tests outside of our laboratory at the point of care. So operators, who are often nurses, as you say, need to receive direct training—training of the trainers and specific basic training—from the Flinders International Centre for Point-of-Care Testing with ongoing support, external quality assurance and quality control that they have to perform regularly to maintain their accredited status. In fact, the first test that happened in Balgo, because it was the first cab off the rank in the program, was supported by the trainer that delivered the training on videoconference supporting the operator in the conduct of the test. That's specifically for the testing.

More broadly, on top of what we know public health units and local jurisdictional arrangements are doing in terms of increasing the training capacity of local clinicians to respond to COVID cases, the department has been rolling out online infection prevention and control and specific COVID-19 management training modules. Over 800,000 people have completed their general foundational one. And we are progressively rolling out Indigenous-health-specific modules. The first two came on line on 4 May and 8 May. The first one has been completed by over 16,000 people. They go from the overall epidemiology of COVID to contact tracing targeted at remote practitioners, AHPs and AHWs, in remote communities. There are going to be upcoming ones on the appropriate use of PPE and other topics. The modules are reviewed by the advisory group. The first one has been endorsed by NATSIHWA, the National Aboriginal and Torres Strait Islander Health Worker Association, so that it actually counts as continuous professional development for Aboriginal health practitioners to maintain their AHPRA registration.

Senator DODSON: Is the national Indigenous advisory group going to be sustained going forward? That may not be a question to you, Dr de Toca; that may be for someone else. I'm asking about the national Indigenous advisory group on COVID-19. Is that going to be sustained going forward? For how long is that being sustained?

Dr de Toca: Yes, it is a question for me, as I co-chair the group with Dr Dawn Casey from NACCHO. The terms of reference of the advisory group currently don't have a deactivation trigger. I think it is our overall understanding that by the time the Health Sector Emergency Response Plan is deactivated some of these groups will need to review what the plan moving forward is, but we're not at that stage at all. The group is playing a crucial role in maintaining the communication channels and ensuring that the response is coordinated and has a very agile way to address any emerging issues. We are reviewing what the frequency of the meetings should be moving forward, but we have no plan to wrap up in the foreseeable future.

Senator DODSON: This is my last question. Can the pandemic plans that are meant to be developed for each community be made available to this committee so we know what the plan is for each of those remote places?

Mr Matthews: The overarching plans et cetera we can make available, as in the national COVID plan and the management plan that we've put together nationally. A lot of the planning documents that we've got we can provide to you. Once you get down to the community-level plans, they are generally being facilitated by the jurisdictions with the relevant communities. So they are not necessarily ours as such to promulgate. We would have to go and get all of that information from the states and territories to do it. Obviously it would be quite a large exercise, noting the number of remote communities is reasonably large. We don't have them in a job lot that we could simply give you because they have, generally speaking, been developed in states in partnerships with communities.

Ms Edwards: In that regard, I understand that NACCHO is responsible for the service-level pandemic planning, as it should be. So that would be at a very granular level through the community controlled sector. We could certainly ask them about those. The extent to which any of them could be, or should be, made public would depend on community views and so on and what is in them. But we don't hold that planning at a very central level.

Dr de Toca: As the secretary says, there are several levels for each health centre, especially ACCHOs, which have a higher proportion of accreditation under the Royal Australian College of General Practitioners standards than mainstream general practices. One of the accreditation requirements is to have a pandemic plan, although not specifically for COVID. So ACCHOs would have a health-service-level plan as part of their business continuity procedures. We don't have access to that. It is something that belongs to that independent organisation. Then there is the community-level planning that Mr Matthews was referring to that is undertaken or led by jurisdictions with their communities and organisations. Then there is the national management plan that sits under the Health Sector Emergency Response Plan.

CHAIR: Thank you, Senator Dodson; we have to leave you there. Senator Paterson?

Senator PATERSON: Other than wondering what happened to Senator Watt, I don't have any more questions at the moment. But I believe Senator Davey does.

CHAIR: That's even cheeky for you, Senator Paterson. Senator Davey?

Senator DAVEY: I just have a couple of questions. I hope that I can get some direction on this. The first is on the importance of getting messaging out in particularly remote Indigenous communities. I note a lot of really remote communities don't have access to our mainstream media, but First Nations Media Australia plays an important role with remote Indigenous broadcasting services and the like. I note we've provided almost a quarter of a million dollars this financial year to help support its contribution to getting messaging and information out to Indigenous communities about COVID. Are you happy and satisfied with how health information is being delivered into these remote communities? Is it in a way that you believe is actually resonating?

Mr Matthews: We would say that we've undertaken a number of actions and communications. I guess it's probably up to others to judge whether they think it's enough, but we do think we have done quite a lot on the communications front for remote communities. I'll leave it to NIAA to talk about the money provided directly to First Nations Media Australia, but from the Department of Health and the federal level we obviously have the broader communications nationally as part of the national communications campaign. Then we had also engaged an Aboriginal communications company to assist us with the remote communications aspect of that directly, and that has resulted in—we've put a number of things in place through that to basically make sure we get the comms into remote communities as strong as we can. We have produced a number of radio scripts that have gone out predominantly through First Nations media. They've been translated into about 15 languages through that process so that they can be read out on local radio stations as a direct way, and that obviously works very well in remote

as a prime way that people access information in remote communities. We have produced a number of posters. We do have some examples here of things that we've produced—well, it probably doesn't work as well to show you some of those things, seeing as people are here virtually—but we have a number of specifically designed posters and messaging that we've promulgated out that can be used in communities for the same reason, designed specifically for that and tailoring the national message through it to ensure that it resonates with our Aboriginal and Torres Strait Islander people, particularly in remote areas. We've obviously used videos and social media fairly actively through that, again through using our broader comms and also our Aboriginal specific comms company, and also we have a series of e-newsletters that go out that have been accessed by a range of people. It's all really trying to put out a significant amount of information through a range of channels—really, covering posters in communities, radio, social and the newsletters—and sort of looking at influencers and leaders et cetera that can promulgate those messages. So it has been using a range of mechanisms really to ensure that we put that message in.

Senator DAVEY: Are those mechanisms specifically targeted at only the remote Indigenous communities? I note the Wiradjuri nation is the largest nation on the eastern seaboard and covers a vast area including larger, more urbanised areas. Can they access messages in their language?

Mr Matthews: A lot of our in-language material is geared towards remote as a general—that's probably where the language is predominantly stronger, out through remote, and that sense that English being not their first language et cetera is more relevant in remote than it is in the urban and regional settings, which can be a little bit different. And there's trying to keep the same consistent messaging as well around the basic hygiene rules that people are trying to promulgate around washing your hands and social distancing and those sorts of things—those core tenets are the same. So the broader messaging that runs in urban and regional areas is similar. Community controlled health services in urban and regional areas have helped tailor that message locally, and obviously state and territory governments have done a lot through urban and regional areas as well, so it's not just the Commonwealth messaging either.

Senator DAVEY: Are you satisfied that it's having an impact, that it's actually encouraging people to adopt, for example, hygiene practices and social distancing?

Mr Matthews: I think it's very difficult for us to provide you with a really direct answer to that because obviously it's pretty early; we don't necessarily know. I think what we would say is we feel like we've put a number of things in place that supplement what the states do. I think we're in a fortunate spot in the epidemiology, as Dr de Toca talked about, in that only about 59 or 60 Aboriginal and Torres Strait Islander people have had COVID nationally, so on one level you could say hopefully that has been broadly effective, but I don't know that we would say that's—it's not like we've done a robust evaluation or something like that.

Ms Edwards: On the back of my very modest team, I think I'd just add: we think we've done an enormous amount of work to try and do as much as we can in collaboration with states and territories and with the Aboriginal controlled sector. Having said that, of course, we are open to other ideas, and we certainly welcome them in relation to any community where we think the messaging hasn't been as good or there are other ideas of how to do it. I think there has been from the very beginning an absolute commitment to try and make sure we keep Aboriginal and Torres Strait Islander people safe, because we know of the additional risk of severe disease, particularly in remote communities, and it has obviously been a key focus for the Department of Health, as you've heard today.

Senator DAVEY: Yes, certainly—and I do congratulate the department for recognising how important it is to communicate in language, particularly in those remote areas. I'm also interested in the response—and it's not a health response specifically, but it does go a long way to help support mental health in remote and Indigenous communities, because we know how important art is in these areas. We've heard a lot about the arts industry more broadly through this crisis. But specifically, when it comes to Indigenous visual arts centres, which are often the cultural backbone of their remote industries, they've been hit hard by the inability of visitors to come and visit with the travel restrictions but also with social distancing in and of themselves. The government announced $7 million for Indigenous visual arts centres to be provided through the Indigenous Visual Arts Industry Support program. Are you getting any feedback that that may be assisting, particularly as to the mental health link?

Ms Edwards: I don't know that we've heard anything specifically about arts centres, but it's a good question.

Dr de Toca: Representatives from the Department of Health attended a teleconference that the relevant department organised with all the peak bodies representing the art centres across our remote communities. Dr Gallagher from the national incident response division and I attended, just to ensure that those peak bodies and the art centres that, as you mentioned, do play a very significant community role beyond their business capacity, had up-to-date information on COVIDSafe, return-to-work plans and how to safely navigate that new

environment as restrictions ease, but we also followed up to ensure that all the communications that we were just talking about were directly fed through those art centre peak bodies so that they could be communicated onwards.

Senator DAVEY: Excellent. So there is actually a passageway for information—you're utilising both First Nations Media Australia and the information they produce, which is in language and culturally appropriate, and then you're passing that through cultural centres such as local Indigenous arts centres as well to help distribute messages.

Dr de Toca: Yes, and we cannot underemphasise the importance of the work that ACCHOs, local communities, land councils and local organisations have played with very clear messaging—that is, community tailored and appropriate communication—very early on, even before the national specifics of the Aboriginal and Torres Strait Islander targeted campaign started. So a lot of what our role has been is not only producing material that could be shared and contributed but also making sure that we are sharing the key messages so that those community organisations can tailor their messaging and can make sure that it's culturally and locally relevant while still adhering to the main key messages that the national campaign needs to be consistent about.

Senator DAVEY: I have one final question. You raised the ACCHOs—they're feeling a lot of extra pressure through this crisis. There's a lot of responsibility on their shoulders. Have you got support mechanisms in place for the workers and the volunteers through the ACCHOs to support their mental health needs as they're trying to support the needs of their communities?

Mr Matthews: Yes. We have a few things to support ACCHOs generally; we'll get to that. Firstly, we've put some additional resourcing into remote ACCHOs. As we talked about at one of the previous estimates, it was about $5 million that we put in for remote preparedness grants, and that was really to assist them from a planning point of view. We would hope that has some impact in terms of additional resources and ensuring that ACCHOs feel a little bit better prepared, and that will obviously help how they feel about it. I think particularly things around the broader planning around evacuation and point-of-care testing—one of the side benefits of those types of things is, again, we would think they would have a positive benefit in terms of health workers feeling more comfortable that those things are in place to either evacuate themselves or other people quickly and get tests quickly and those types of things, so there's more of a known environment. We'd say some of those things will help fairly well.

With workforce, we have some programs, particularly in the Northern Territory, to assist organisations in temporary workforce—if doctors need to leave or health staff need to leave for breaks and bits and pieces—that can supplement those workforces, and we're looking to do a little more around that at the moment. We're working on something a little bit further around that, and that gives some other aspects to it. And then there is some funding as part of one of the announcements around mental health for mental health support for frontline health workers. From memory, it was a few million dollars—I think about three. I'd have to check that, but please don't take that as a given. I think it's roughly $3 million, and that's to support mental health for frontline health workers. Of course, Aboriginal community controlled health workers can also access that. So we think there are a range of practical things as well as a little bit directly through some of the mental health money.

Senator DAVEY: Thank you. I have nothing further.

Ms Edwards: Excuse me, Chair. I think I might have said before that NACCHO was responsible for service-level pandemic plans.

CHAIR: Yes, I think you did.

Ms Edwards: I misspoke. NACCHO has been supported to help coordinate those. Obviously, they're the responsibility of services.

CHAIR: Yes, okay.

Ms Edwards: I've been corrected, so I apologise for that. NACCHO has enough to do.

CHAIR: Thank you. Senator Patrick?

Senator PATRICK: Thank you, Chair. Hopefully, I've got my technical problems sorted now. I have some questions, again, for Ms Edwards. There have been some reports in relation to elective surgery being conducted against, effectively, the orders of the health minister. My understanding is that for a period during the COVID peak, to preserve PPE and make sure hospitals were prepared for potential COVID patients, there was a requirement to stop all level 3 and non-urgent level 2 elective surgery and that there may have been some breaches in relation to that order.

Ms Edwards: It was a decision of the national cabinet on 25 March, on the advice of the AHPPC, to suspend all non-urgent elective surgery. That isn't all elective surgery; it's in categories and so on. It is surgery that could

be deferred without serious immediate health concerns to the patient. I had heard some anecdotal reports—a small number of reports, by the way—that in some states and territories there was elective surgery continuing which wouldn't have complied with that, but that's a matter for the relevant state or territory to pursue, and I'd have to defer to them as to whether that happened, whether it was investigated and what happened with it. Since then, of course, the national cabinet has made a decision to allow states and territories to relax the elective surgery suspension, and the states and territories, and the private hospitals within those jurisdictions, are at various stages of relaxing and allowing additional elective surgery.

Senator PATRICK: My understanding was that the Commonwealth was paying some of the private hospitals, at least, money to, in effect, not conduct the surgery, so we might have a situation where we've got Commonwealth money being expended to stop something happening and yet money is being taken to then do the very thing that they've been paid not to do.

Ms Edwards: Two things happened. One was that the national cabinet decided to suspend elective surgery. At about the same time, the Commonwealth agreed with the states and territories to provide funding through the states and territories, who would have agreements with private hospitals to ensure they were paid, effectively, a minimum viability amount. A private hospital still doing some elective surgery might also—and we thought it would happen at higher rates if there were many more COVID cases—do some COVID related work. If, adding those two things together, there were still not really enough funding for the private hospital to be viable because of the elective surgery suspension, there'd be a payment. But those payments don't go directly from the Commonwealth; they go to the states and territories, who are responsible for the agreements with the private hospitals. So if there were—and I don't have any final view on whether there was or not—any breach by a private hospital of the elective surgery suspension while it was in place then it's a matter for the states and territories, through the agreement they've got with them, to chase it up.

Senator PATRICK: I understand that you can detect this through Medicare data matching. Is that correct?

Ms Edwards: I'd have to take on notice the extent to which it might be possible to check that. It would depend. It's quite a complex data matching anyway, so I'd have to take on notice the extent to which data matching might be a useful tool to check compliance with this agreement. I don't know the answer.

Senator PATRICK: Sure. Could you also take on notice how much level 1 elective surgery—which I think was allowed—and urgent level 2 surgery took place during that period that you mentioned? Obviously we would expect none for level 3, but is there any advice the department has—and I accept you don't have knowledge of it—that there in fact were breaches? If there were breaches, what remedial action is being taken in respect of those?

Ms Edwards: I will absolutely take it on notice. There would be some reporting that we've got through the national partnership. I would be very surprised if we hold any information about the extent to which there were breaches or breaches were investigated, but we'll certainly come back on notice with anything we do know.

Senator PATRICK: Okay. I also have a concern that it was reported in the paper that someone at Macquarie University Hospital may have reported some unauthorised or improper elective surgery and that the whistleblower is being chased. Of course, the Commonwealth has very strong views on whistleblower protection. I imagine that possibly they're covered by either the corporations law, the new whistleblower legislation or, alternatively, state legislation. But is there anything the Commonwealth can do—noting that the Commonwealth provides money to Macquarie University Hospital—to make sure that we do not pursue people who blow the whistle on unauthorised conduct?

Ms Edwards: I'm not aware of that instance at all. I can certainly take it on notice to tell you what we're aware of, if anything, and I can also take on notice what the Commonwealth knows about the recourse for whistleblowers in circumstances such as that—if they existed, if you see what I mean. So I'm happy to come back to you with what we know but, again, I'm not aware of it at all.

Senator PATRICK: I accept that it is complex. Thank you for that. Another issue that has been raised is the use of masks. I've seen a fact sheet that the Department of Health has issued in relation to masks. Basically, the impression I get is that the Commonwealth's position is that masks on public transport, for example, are not necessary. Is it correct that that is the position of the government at this point in time?

Ms Edwards: I will defer to the fact sheet, which would have been drawn directly from the AHPPC, but it's certainly the case that there's no recommendation at the moment that masks should be worn by general community members. My focus has been, as you know, on ensuring that the masks held in the national stockpile are for those who definitely do need masks in healthcare settings. It's one thing the AHPPC is regularly looking at. One of the real issues that arise, as I understand, is that use of masks, and all PPE, depends entirely on how

well you use them—so being trained in order to put a mask on properly and not to touch it, which can actually have the perverse effect of causing infection and so on. But I would defer to what's on our website. Perhaps I could take it on notice to come back in the event that there's something new that hasn't been on the website, but I'd be very surprised.

Senator PATRICK: Sure. It's just that, in comparison to other international jurisdictions, we seem to have taken a different approach. I accept what you said: that the AHPPC has formed a view. My understanding is that that view may have been informed by the Infection Control Expert Group. As such, I'm wondering if you can take it on notice to provide the committee with the advice that that expert group had provided to the AHPPC and any other advice they may have taken. I'm a bit concerned that maybe we haven't had contested advice in relation to this.

Ms Edwards: I will certainly take it on notice to provide anything that I can. Of course, as we've talked about before, I wouldn't be able to provide anything that was prepared for consideration by national cabinet. I don't know if there is or not, but I just make that clear. I would note that the advice of the AHPPC has served Australia very well to date, and we've got a lot of confidence that it's very robust.

Senator PATRICK: Well, we wouldn't know, because we're not allowed to see it. On the point of advice to the AHPPC, that advice could not be covered by cabinet-in-confidence because it is not for the purpose of cabinet submission. I accept that, as it's gone through the AHPPC, there's an argument that their advice to cabinet is protected by cabinet-in-confidence, but that protection does not flow all the way back to the original roots; it goes to a clinician—

Ms Edwards: I'll take it on notice, because I don't even know if there is any such advice, so we may as well not debate that now.

CHAIR: In addition to that—again, we had this discussion last week—it may be that just being deemed cabinet-in-confidence does not mean it cannot be provided to this committee. There needs to be a public interest immunity claim around that.

Ms Edwards: I appreciate that. I just wanted to foreshadow that, if it comes back, I will have to consider those issues as we go forward.

CHAIR: Sure.

Senator PATRICK: Thank you for your assistance, Chair. I simply make the point that this would have been advice provided to the AHPPC, not cabinet, so just take that into consideration when you answer that, please. The final question I have relates to the COVIDSafe app. You can tell me how many times it has been downloaded if you wish.

Ms Edwards: If you ask me, I'll tell you.

Senator PATRICK: Has it gone up since the last time we talked?

Ms Edwards: Yes, it has.

Senator PATRICK: I'm sure it's slowed a little bit.

Ms Edwards: At 6.30 am this morning, 2 June, there were 6,174,008 registrations on the app.

Senator PATRICK: Thank you. This question goes to the success of the application. I was under the impression that there are some state health authorities that have now used data from the app. Is that correct?

Ms Edwards: That's my understanding, but I only know when states have made those assertions themselves. Victoria in particular made a public statement that it had used the app data in order to locate contacts it otherwise would not have known about, which is exactly what we want to happen. I'm also aware that because lots of states and territories have had no new infections for a long time—which we should all be celebrating—there's no cause for them to use the app. But they are all able to use the app—it's all set up and all connected—and all have the training arrangements in place.

Senator PATRICK: I know you don't have access to the data, quite properly, but, as the funder of the activity—it's a joint Health and DTA application—clearly you'd like feedback on how well the application that you've funded is working. I've been watching the tech sites which are suggesting that there's been difficulty. Indeed, on the 1.5 metre test, basically the application is unable to properly verify that. We know that it's got a capture area of about 10 metres—the bluetooth range. Do you have any information as to performance with respect to being able to measure the distance of the contact?

Ms Edwards: My advice from the DTA is that the app is operating as expected. It's collecting digital handshakes and then is able to show the digital handshakes of contacts who were within 1.5 metres for 15 minutes

or more. My advice from the DTA is that it works as intended, in that way. I understand, as the data administrator, they have done some checking to make sure those sorts of things are happening. I don't have access. I'm obviously not allowed to know, other than to be assured that it is working. I hope, as you do, that we will never have need to use it to any large degree because there'll be so few infections in Australia—we can only hope. But in the event of a significant outbreak, we are very confident it will be a very useful tool to augment that public health response.

Senator PATRICK: I understand the DTA has done some testing and the community has asked for some of that test information. This is really operational success. It goes to the state health departments who feed back to you as the supplier or as the controller of the app. This is working well or is it not? I'm wondering what sort of feedback you're getting from the health departments to describe their happiness or otherwise as the end users of the app?

Ms Edwards: As I said, Victoria made a statement about a particular case. There have been very, very few cases anywhere else. But state leaders and health officers are making public statements frequently, encouraging people to download the app. I haven't heard anything other than keenness to be involved in the app project from all of the heads of state health departments. Our success means that there is, at the moment, very little need for this contact-tracing aid, and I hope that remains the case.

Senator PATRICK: Just to be clear: there are state leaders that are pushing for the download, and that's part of the take-up campaign as opposed to the very narrow question I'm asking, which is about performance as measured by health officials—not by politicians but by health officials—as to its actual use. Maybe you could take on notice whether you've had any feedback at all—not from the DTA but from state health authorities—as to the performance of the application?

Ms Edwards: I can certainly take it on notice, but, as I said, there is no real data from lots of jurisdictions because they haven't had any cases. Victoria in particular put out public information, and we've had nothing but positive views about it from the bureaucrats in the health departments and from the medical officers who are involved in it. I don't think there'd be much more to come back to you on because of the happy situation we're in, with so few infections.

Senator PATRICK: I accept that.

CHAIR: Senator Patrick, a final question, or is that—

Senator PATRICK: That was it.

CHAIR: Thank you very much.

Senator PATRICK: Do I get an exemplary tick?

CHAIR: You do. You've done well. No feedback really helped that section! Senator McCarthy.

Senator McCARTHY: Could I firstly go to Mr Exell to see if he's been able to find an answer to my initial question about the complaints in the prisons?

CHAIR: We're just having a reshuffling of witness arrangements.

Senator McCARTHY: Okay, thank you.

Mr Griggs: We've had a number of letters that mention correctional issues. I'd like to go through them and determine what falls into your question about a complaint and get back to you on notice, if I can.

Senator McCARTHY: So you're not going to answer now? I'm having a little bit of trouble hearing you.

Mr Griggs: What I'm saying is that there has been some correspondence relating to this matter, but, as to whether we would classify them as complaints or not—I just want to answer your question properly, so I'd prefer to do it on notice, if that's okay.

Senator McCARTHY: Okay. Which jurisdiction has the matter been raised in?

Mr Griggs: There are several letters that have raised issues—I think across WA and the Northern Territory, so a couple of jurisdictions—but we will give you the detail in the response on notice.

Senator McCARTHY: Thank you, Mr Griggs. On the internal and external border controls, I want to ask a quick question around ongoing risk, particularly relating to the Torres Strait Islands and their relationship with Papua New Guinea. Do we know with any certainty the prevalence of the coronavirus in Papua New Guinea?

Mr Matthews: I don't have any information with absolute certainty on the prevalence in Papua New Guinea.

Ms Edwards: We would rely on the World Health Organization's figures for Papua New Guinea. I don't think I or anyone has a real handle on exactly how effective their public health response is, and their capacity. We would be relying on the WHO numbers, which I—

Mr Matthews: There has been work, obviously, on the issue of the potential for spread of COVID-19 from PNG through the Torres Strait Islands. Border Force are very active—much more active than normal, as I understand it—through that area and have pretty much reduced the movement from PNG through the Torres Strait region. A lot of the preparations that we talked about through the day obviously apply through the Torres Strait Islands as well, in terms of preparedness, evacuations and those sorts of things. As far as I understand it, there is also some work through Foreign Affairs and Trade with PNG around those matters. That would be worth directing to the Department of Foreign Affairs and Trade to look at what their assistance has been through PNG, partly for that reason as well: stopping the movement of people down through the Torres Strait region.

Senator McCARTHY: On health, Mr Matthews: what kind of focus has there been with the Torres Strait Island communities regarding preparation, not only for themselves, should a person come across from PNG? Has there been any focus from a health prospective?

Mr Matthews: Yes. There are the broader preparations and work through the local planning processes. That's something they've looked at through the Torres Strait and the PNG potential. That's obviously through the health clinics in that region. Parts of our preparedness grants and those sorts of things have worked through the Torres Strait. There's remote evacuation, and funding strengthens the network that way. We're hopeful around the testing and tracing. There's still a bit of work to do with Queensland around that, but that's progressing fairly actively at the moment through those preparations. And, of course, the state government is also doing quite a lot. We're aware from discussions with Queensland that they're also actively looking at the issue of preparedness and response through the Torres Strait.

Senator McCARTHY: Thank you very much, Mr Matthews. In the time we have left I'd like to get to IAS, which would be I think NIAA, and also to the areas around the coronavirus supplement and cashless debit card, just to give people there a heads up. While we're waiting for a bit of movement there, Mr Griggs, is there any possibility that you'd be able to table the correspondence you spoke about in relation to the prisons?

Mr Griggs: Can I actually see it first, Senator, and then, depending on privacy and all those sorts of issues, I will make best endeavours.

Senator McCARTHY: Thank you very much. I'd like to go to the IAS. Mr Griggs, is NIAA currently rolling over expiring funding agreements for 12 months rather than entering into new agreements, because of COVID-19?

Mr Griggs: In terms of the IAS, there are two streams of work in relation to COVID. As I mentioned at the last hearing, we have gone through and contacted 99.5 per cent of the 1,161 organisations that receive funding from us to try and understand how their activities have been impacted by COVID: whether they can continue to deliver their services, whether they have to modify the way that they deliver. What we have gone through and tried to understand is do we need to adjust our KPIs with deliverables that we expect of those grant recipients? About 26 per cent of those organisations have come back to us with an intention to submit a variation or an adjustment. We've got about 300 requests that have come in; 177 of those have been finalised, with 85 of those resulting in variations. Not every single one results in a variation, because we go through the particular circumstances with the organisation. The primary aim of that has been to make sure that those organisations remain viable through the pandemic and are available to stand up and resume the services that they provide to communities once the restrictions are lifted. Obviously, the disruption has mainly been due to the remote travel restrictions and how people can actually deliver, particularly face to face, services or youth diversion programs, for example, where social distancing impacts the way that a service may have traditionally been delivered, particularly if it's a sporting based approach to youth diversion activities.

We've gone through in great detail with every single funding recipient, or 99.5 per cent, I'm advised, of the organisations to understand their circumstances. We are continuing to go through our ceasing grant process. That continues and we've just finalised—Mr Brahim might have the numbers on how many organisations—it is over 300, I believe—

CHAIR: Mr Brahim is shaking his head!

Mr Griggs: He is shaking his head; he's not particularly helpful to me at the moment!

CHAIR: I wouldn't continue down that path, Mr Griggs!

Mr Griggs: The terms of those negotiated agreements continue to vary, depending on the requirement. There hasn't been a blanket 12-month rollover. There are occasions where we've gone back to a three-year commitment or started a three-year commitment with organisations that were seeking that.

Senator McCARTHY: Thank you. I will put some more questions on notice around that. We appreciated some of the briefings that we had with you over last couple of months. You may recall in one of them you

mentioned that Centrelink offices were closing—that there were eight closures: six in the Northern Territory, one in Queensland and one in the Kimberley. I just thought I would check whether those offices are going to reopen.

Mr Griggs: I have not had an update on that. I will take that on notice.

Senator McCARTHY: Thank you. Because of the coronavirus supplement, many people in remote communities are actually receiving adequate income support, perhaps for the first time. When the coronavirus supplement ends, what's the government going to do to replace the income by creating jobs?

Ms Campbell: The government's been very clear that the coronavirus supplement was a short-term measure that was put in place to deal with this, and it's in place until September.

CHAIR: Ms Campbell, do you have data on how many Indigenous Australians are in receipt of the coronavirus supplement?

Ms Campbell: I don't think I've got it here, but we could take that on notice and give that to you.

CHAIR: That would be useful. Sorry, Senator McCarthy.

Senator McCARTHY: Thank you, Chair. Have you seen any change in the wellbeing of children and families since the supplement was introduced?

Ms Campbell: Wellbeing of families, I don't know that—it's been in place for a short period of time. I don't think we've had any surveys undertaken.

Senator McCARTHY: Will you? [Inaudible] what impact the supplement has had?

Ms Campbell: We do have the longitudinal studies—I'm just trying to remember what it's called, the longitudinal studies of Indigenous children. I think it's LASIK. We can look at how that's going. But, of course, it has been very difficult to have researchers in the field during this period because of the biosecurity areas and the restrictions on travel, so we haven't got anyone in the field doing that sort of survey work at this time.

Senator McCARTHY: Have you or NIAA provided any advice, or has any advice been sought by the minister, about not reverting to the old Newstart or jobseeker rate when the coronavirus supplement ends?

Ms Campbell: I think we've given evidence before that this supplement was put in place for a short-term period and it's due to end in September. We haven't provided any advice contrary to that.

Senator McCARTHY: Does Mr Griggs want to comment? In relation to First Nations people, anecdotally, certainly from my perspective with constituents up here, there has been some terrific feedback on families' ability to really look after themselves and have purchasing power as a result. We've heard from Outback Stores and other retail areas about that. I am just wondering, Mr Griggs, if there is any view from NIAA in regard to First Nations people and the supplement.

Mr Griggs: No, I don't have anything to add to Ms Campbell's evidence.

Senator McCARTHY: A quick question on the cashless debit card: can I ask perhaps the NIAA if you've done any assessments or provided any advice to the minister in relation to the effectiveness of the card in the last few months?

Ms Hefren-Webb: Sorry, I wasn't sure whether you were asking the NIAA whether they had provided—

Senator McCARTHY: I was asking the NIAA, but I'm also happy to hear your response too if you would like to respond.

CHAIR: I think in the interests of time we'll go straight to Ms Hefren-Webb.

Ms Hefren-Webb: As you'd be aware, there is an evaluation underway. We are due to receive that report in the next month or two, and we would anticipate that being the time when we would provide some advice about the impact of the card in the communities—in three communities: Kalgoorlie, Kununurra and Ceduna. There has been a baseline study done and released on the impact of the card in Bundaberg-Hervey Bay, as you're probably aware, but it will be some time before the longer term impact of the card the can be assessed.

Senator McCARTHY: Thank you very much. I'm conscious of time. Thank you, Chair.

CHAIR: Thank you, Senator McCarthy. You're free to put questions on notice. Before people leave, I have a couple of questions for you, Ms Campbell. You've taken on notice the number of Aboriginal and Torres Strait Islander people getting the coronavirus supplement. Could you also take on notice how many additional Aboriginal and Torres Strait Islander people have needed to claim unemployment benefits.

Ms Campbell: We will take that on notice.

CHAIR: My final one would be—I'm not sure if you might have this with you today—what the current fortnightly outlays on unemployment benefits are at the moment and whether that can just quickly be divided into jobseeker and coronavirus supplement.

Mr Bennett: I'll have to take that one on notice.

CHAIR: Could you, please. It would be fantastic if you can, if you don't have that information with you.

On behalf of the committee, can I thank everybody for appearing today. I know the way we conduct these hearings means witnesses do spend a period of time here that is longer than most committee hearings, but we do appreciate it, particularly those who are repeat visitors to this committee, Ms Edwards, not to name anyone in particular. Looking at the forward program, you will be relieved to see that you don't feature as prominently going forward.

That concludes today's proceedings of the committee's inquiry into the Australian government's response to the COVID-19 pandemic. I thank all witnesses who have given evidence to the committee today. Witnesses are reminded that answers to questions taken on notice are due in 10 working days. Can I also thank the committee members today. We've stretched right across the country—Perth, Broome, Darwin, Melbourne—and it's all gone pretty well. To broadcasting and the committee staff: thank you very much. The committee stands adjourned.

Committee adjourned at 16:31