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TRANSCRIPT OF EVENT

VALEDICTORY: PROF BRENDAN MURPHY AC

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Secretary
Department of Health and Aged Care

Katherine Jones PSM (Chair)
Secretary
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KATHERINE JONES: Welcome everyone this morning. I also acknowledge the traditional owners of the land on which we meet here and acknowledge any Aboriginal and Torres Strait Islander people who are joining us today. It's a great honour to introduce Professor Brendan Murphy to this valedictory address. Again, I just want to acknowledge and thank those departing secretaries and senior officers who are prepared to give us the opportunity to hear their reflections on long and storied careers. Professor Brendan Murphy commenced the Secretary of the Department of Health on the 13th of July 2020. Prior to his appointment, I think as many of you know, he was the Chief Medical Officer for the Australian government, and prior to that he was the chief executive officer of Austin Health in Victoria.

I'm going to list a few things that you are Brendan. I must. I know he is uncomfortable. He is a professorial associate with the title of professor at the University of Melbourne, an adjunct professor at Monash University and at the Australian National University, a fellow of the Australian Academy of Health and Medical Sciences, a fellow of the Royal Australian College of Physicians, a fellow of the Australian Institute of Company Directors, and he was formerly CMO and director of nephrology at St. Vincent's Health and sat on the boards of the Centenary Institute, the Health Workforce Australia, the Florey Institute of Neuroscience and Mental Health, the Olivia Newton John Cancer Research Institute, and the Victorian Comprehensive Cancer Centre. He's also a former president of the Australian and New Zealand Society of Nephrology.

I think Brendan's time as both CMO and Secretary of Health coincided with a historic event that had a global impact but also impacted every individual in our country, every government, every community. He was often, I think, the reassuring and informative face of COVID and the government's response and a significant architect of that response. I think for us, as public servants, our moments in the spotlight like that usually coincide with Senate estimates and are unpleasant. Brendan's was nonstop for several years and added an extraordinary dimension to the leadership that he provided across the service. So really looking forward to hearing the reflections on an extraordinary career and an extraordinary contribution. Welcome, Brendan.

PROF BRENDAN MURPHY AC: Thank you, Katherine. Thank you for the introduction and thank you IPAA for the invitation to give this address. Thanks also to the many colleagues and friends who are here today. There are so many distinguished and important people here I can't acknowledge them, but I just want to call out as I can of these things four people in the row there. My support team over the last four to five years, brilliant and committed young people without whom I could not have done my job, so Jack Dolan and Sophie, Jen Fan, and Lucy Thompson. Brilliant, brilliant contribution. I couldn't have done it without you guys.

As I transition out of full-time employment, I can reflect on how fortunate I have been in my nearly 45-year professional career in the health system and more recently as part of the APS with a great variety of roles and challenges and, most importantly of all, being able to work with brilliant and committed people. It is expected at events like this that one gives a message to younger people. Mine is very simple. Take new opportunities that are offered and sound interesting even if they seem and probably are outside your comfort zone and skill mix.

In 2005, I moved from a clinical academic role into a CEO of a hospital with no real management training and little management experience. In 2020, a very similar move from chief medical officer role to the secretary of the Department of Health with a similar steep learning curve in the processes of government. Both times I was helped by outstanding executives and support staff who taught me so much about processes and ecosystems.

I didn't ever aspire to be the secretary of a department or to do such a role at all. I came to the Commonwealth as CMO really to move back into a more clinical and system reform role after 11 years running a health service. As CMO for three years, I was enjoying working in many reform areas when my predecessor as secretary left much earlier than we expected. It was December 2019, and the then-health minister, Greg Hunt, persuaded me to consider the secretary position. I remember saying to him, remember this was December 2019, that, "I was not as challenged in the CMO role as I thought I would've been because, unlike previous CMOs, I had not had one single public health crisis with which to deal." Three weeks later, COVID hit, so it was clearly my fault.

The then-prime minister and minister decided I should stay on in the CMO role for the first half of 2020 and then move into the secretary role in July of that year when we thought things would be under control, an overly optimistic plan as it turned out. I will talk about COVID later because I think people probably want to hear more about COVID than anything else.

First, given that this is an IPAA event, some reflections on being a seven-year member of the APS. My experience is confined largely to health, but particularly through COVID, through Secretaries Board, National Cabinet, and the like, I've had exposure right across the service. My first reflection is that there is huge intellectual talent right across the APS. We may not have the cultural diversity that we desired, but the diversity in professional and academic backgrounds is strong, certainly in my department, and with increasing representation of people with experience at the coalface.

Compared to hospital staff and even hospital senior executives, APS officers can write well and clearly, if sometimes more than they need to. To this day, I'm constantly impressed by the quality of written briefs and PPs and correspondence and the like. There is, however, despite the efforts for many of us, still a bit of risk aversion often reflected in the practice of multiple levels of duplicative clearance and fear about being too forthcoming in stakeholder engagement. Some of my team would say I'm too forthcoming in stakeholder engagements at times. Efforts to counter risk aversion by reassurance that senior leaders will support and be accountable for the actions of junior officers are not always helped by the adversarial and personal nature of some of the processes of government inquiries or reviews. The search for truth and to identify how things can be done better are not often well served by gotcha moments seemingly designed to humiliate an individual.

In leadership roles, I am inherently attracted to the challenge of building a strong and open and exciting organisational culture where people have a sense of purpose and want to come to work or at least come to work from home. In doing so, there is the potential for a conflict between promoting and growing the local departmental culture as opposed to pursuing the broader objectives of one APS. I had the same conflict as a hospital CEO with the hospital culture and the broader health department culture and objectives had to live side by side.

In the APS context, this needs to be carefully managed. Given the challenges facing health over recent years, I've tended to approach this by concentrating more on my local departmental culture rather than the broader APS reform agenda whilst trying to promote mobility and consistent values across the APS and broad career mobility. But having built now I think a strong culture in the department, my successor may see it as timely to rebalance this. It's certainly true that collaboration across the APS is now very strong. It was enhanced by the necessities of the pandemic. The Secretaries' Board and the informal interaction between secretaries is very strong and effective now.

Before coming to the APS, my experience with ministers was limited and confined to the state system. In the last seven years, I've worked closely with two senior portfolio health ministers, different personalities, but similar in that both are highly intelligent, hardworking, have frightening recall and attention to detail, and are committed to pragmatic solutions. As secretary and CMO, I've also worked closely with two prime ministers, one very closely during the early stages of the pandemic. Both prime ministers have greatly respected the value of expert technical advice, both cares deeply about the impact of their policies on the broader community, and both have shown strong leadership.

I do think there has been much unfair post facto public commentary about the leadership of former Prime Minister Morrison, whom I found to be an effective and respectful leader at a time when such leadership was required. None of us are perfect. But I genuinely enjoyed working with him, and I was particularly struck by how in the early stages of the pandemic he achieved a solidarity and national sense of purpose in the National Cabinet that hopefully will endure.

Of course, there are many other politicians that I've worked with and talked to over the last seven years in many settings including beloved parliamentary processes, some more entertaining than others and some very incisive interrogators. It's a tough life being a politician, but I do genuinely believe that from whatever part of the political spectrum they come from, the great majority are motivated to make a difference according to their view of the world. Of course, party processes and the pragmatic reality of the need to be in government to achieve anything can sometimes derail this purity of purpose. I certainly wouldn't want their job.

Now the COVID pandemic, which people I think want to hear a bit about. I suspect people coming here today would like to hear some of my reflections on Australia's response. I've of course thought about this at some length, and I'm looking forward to being involved in the promised deep review of the national response that the government has committed to undertake. It would, therefore, not be appropriate at this time to preempt this review by providing a detailed critique of our performance. But I can reflect on the sort of issues that such a review might examine and in do so provide some passing thoughts on where the inquiry might go.

I think that most, but clearly not all people, would say that on balance Australia did well compared to other similar high-income countries. We are coming out of the pandemic with a relatively low COVID death rate and a reasonable economy. There will always be debate and various interpretations of excess mortality and overall mortality data, but the mortality we had in Australia prior to the arrival of vaccines was exceptionally low.

There's been a bit of narrative recently that we should have done what Sweden did and not introduced public health and social restrictions in the early phases of the pandemic. But would the Australian community really have tolerated 30,000 COVID deaths in 2020 rather than 2,000, which is what we would've had with a population adjustment for Sweden's death rate? You also need to remember the images of cities like New York with 2% of their population dying of COVID in that first outbreak with makeshift morgues and overwhelmed hospitals. That could have happened in Melbourne or Sydney, and we do need to remember that those measures really did save lives.

There are people who believe we did go too hard with public health and social measures. There are also people who even today say we should be doing much more walking around with personal HEPA filters and wearing masks. The truth, as always, is somewhere in the middle. But the proportionality of the response at each stage is likely to be a major issue for any future inquiry. The inquiry will identify things we could have done better and things that we must do in the future to better prepare ourselves for the next pandemic. These insights will be particularly valuable as we establish the new Centre for Disease Control to prepare us for the next pandemic.

Just some of the other issues the inquiry might look at include how well prepared our public health systems were and their national coordination through the HPPC and the Commonwealth. HPPC worked very well and collaboratively, particularly in the early days, but data systems could have been better, and some states were clearly better prepared than others. National cohesion was not as strong later in the pandemic, and that might be something that the CDC could address in the future.

The use of international border restrictions and supervised quarantine for returning travelers were, in my view, crucial in preventing major outbreaks in 2020 other than in Victoria. Hotel quarantine was always imperfect but mostly worked well when combined with high-quality outbreak response. The inquiry might look at quarantine preparedness for the future. We now have some purpose-built facilities, but arguably we might have overcompensated.

The role of lockdowns as the most extreme public health and social measure is worthy of deep analysis. There has been much commentary about the very long lockdown in Victoria in 2020, although it did effectively stop transmission after many of us thought that might not be possible. Some of the other later lockdowns in other jurisdictions are worthy of analysis. Could they have been a bit reactive and possibly based on a lack of confidence in the local public health response? Internal borders restrictions at state borders, most agreed that they were necessary in 2020 in preventing people leaving Victoria during their big outbreak, but many of the other instances of state border closures are worthy of review of their proportionality and, indeed, effectiveness.

The highly charged and surprisingly emotive topic of aerosol transmission versus droplet spread and the value of face masks and the role of air handling in buildings, with the likelihood now of future changes in air handling standards and much debate about the proportionality of proposals from the now passionate advocates who want to retrofit air handling in all our major public buildings.

How prepared for a pandemic was our single highest risk setting: residential aged care? Despite a lot of preparation early in the pandemic, COVID has had its most severe impact in this sector. Some of the vulnerability related to the specific preparedness for infectious diseases and some to general sector capability issues, some of the responses to outbreaks were necessary to save lives, had significant impacts

on the mental and physical health of aged care residents. Future investment in strategy for better preparedness will need to again consider the right balance between overmedicalizing what a resident's home with the need is to protect them from communicable diseases, including the ever-present seasonal influenza.

Aged care deaths will surely be a topic of deep analysis in the future inquiry. Whilst particularly early in the pandemic severe COVID infection was the direct cause of most or many aged care deaths, later with high-level community transmission in a vaccinated population, a very significant proportion of the COVID-associated deaths in aged care were primarily from other underlying conditions with COVID infection being part of a terminal illness. We often forget that approximately a thousand people per week die in residential aged care, a reflection of the serious comorbidity in this sector. In the light of the relatively low risk of infection in children, the inquiry is likely to examine the proportionality of school closures for very long periods where there's yet unquantified impacts on the educational outcomes of our children.

Then, of course, we come to vaccination. This will be many issues for the inquiry to examine. Had we managed to order more MRNA vaccines earlier, would any of them have arrived earlier than they did? Possibly not if we look at the experience of countries like Japan. When later it was possible to buy lots more mRNA vaccines, did we overcompensate and buy too many, or was that a prudent redundancy provision? Was it right to focus so strongly on those vaccines we could produce quickly and potentially on shore? What would've happened had we not identified so early on the rare complications of the AstraZeneca vaccine? Unlike the UK which had vaccinated a third of its population before they even discovered this adverse effect, did ATAGI overreact? The AstraZeneca issue and the prior unexpected issues with the University of Queensland vaccine were severe curve balls after which we pivoted and compensated with ultimately a technically well-delivered rollout which achieved one of the highest primary vaccination rates in the world.

Of course, there were problems with the rollout worthy of forensic analysis, such as the underestimation of the complexity of vaccinating people in residential aged care and disability settings and some unrealistic early vaccination targets. But our primary care rollout with over 10,000 GPs and pharmacies and associated hugely complex logistics does seem objectively to have been a success.

One of the major personal disappointments for me was how the media talked down our vaccination rollout, headlines of bungled rollout, etc. Mostly through the pandemic, our mainstream media were very responsible. I was personally dealt with very respectfully by the media in all my many, many interactions, and I felt that they generally reported on the pandemic in a balanced and informative way. So, it would be interesting for an inquiry to look at why so many Australians and their media, unlike for example in the UK, were not prouder of our primary vaccination rate of over 95%.

The level of negative public commentary around the vaccine rollout was so significant that government felt the need to bring in a three-star general in full uniform to restore public confidence in the rollout. Yes, I did once say at a press conference, when asked why we were slow in registering vaccines compared to other countries who were using emergency use provisions, that it was not a race, that we were doing registration properly, not trying to beat other countries to approve and release vaccines. That comment in no way meant that we wouldn't roll out vaccines as quickly as we safely could, but that was disappointingly taken out of context, and not just by the media, I would have to say, much to my dismay.

Vaccination mandates will also be subject to scrutiny. Early on when vaccines clearly did impact on transmission requiring health and aged care workers to be vaccinated was sensible. Later with the Omicron variant, when vaccines became much less effective in transmission reduction, were mainly for personal protection, the proportionality, and the persistence of some vaccine mandates for the general population is worthy of debate. Many other issues for an inquiry to consider access to approval of antiviral agents, First Nations outbreak response, the impact and engagement with communities and the disability community.

Then the great unknown, which is Long COVID. Clearly, this is a real syndrome, and people need to be believed and reassured that they will likely get better with the reflection of time and potentially some rehabilitation activity. Most important of all in Long COVID is not to extrapolate Australia's epidemiology from that of other countries whose COVID experience was materially different and not to over catastrophize the potential impact of Long COVID in Australia.

This inquiry will be welcomed. The form it takes is still to be determined by the government. Government is committed to a forward-looking and constructive inquiry, which could take several potential forms, ranging from a royal commission to a white paper like Singapore has just done. Arguably, the latter could be preferable to some of them or adversarial approaches we seem to have seen in past reviews of public policy areas.

One final reflection on the pandemic is on the diverse views of expert public commentators, some very qualified in public health and epidemiology and others who were clearly not but chose to comment, nonetheless. Some of the most extreme views predicting nearly a hundred thousand deaths and proposing long-term severe lockdowns, early on, I suspect were in part driven by personal fear in the commentators. For the public, it was sometimes hard to find a sensible middle ground commentator. It is sort of hard to imagine three years on that there were a series of so-called experts who were seriously pushing the mantra that if in early 2020 we just had the lockdowns hard for 12 weeks and then we could relax everything and go back to normal as we would've eliminated the virus and it would never come back, somewhat naïve to think of in retrospect now.

I was always very conscious that my clinical background was not in public health and epidemiology, and I was heavily reliant on the members of the HPPC and the experts we co-opted to provide wise and balanced advice. It was then my role to communicate that advice to the Commonwealth government and crucially to the National Cabinet and to the public in many interactions. It was a strange and fortunately short-lived experience to become a recognisable public figure after doing so many media. I remember one day doing all four breakfast TV shows, a press conference, radio, and two evening current affairs shows, moving from studio to studio in the Parliamentary press gallery.

People often asked me, "What were the moments during the pandemic that most stood out for me in my memory?" There are many, but in the interest of time, I'll recount just a few. Around 20th January 2020, when we realised that the virus in Wuhan readily transmitted from human to human and was causing severe illness, including in some healthcare workers, a pandemic was then inevitable. We called it early, much earlier than the WHO, knowing that there was little hope of containment.

A very memorable Saturday, the 1st of February 2020, when I opened my iPad and discovered that the virus had spread right across China. Phoned Minister Hunt and the then-prime minister and said I wanted to close the borders to China, a very controversial act not recommended by the WHO and many other like-minded countries. We implemented that by 9:00 p.m., that very same hectic day with about 20 important government meetings occurring virtually over the course of that day.

Friday the 13th of March 2020, when I presented to the last-ever meeting of COAG, I told the first ministers early in the morning that at some stage in the next few weeks we would probably want to reduce some public health and social measures. I then left the COAG meeting, went off to chair an HPPC teleconference in which we decided we needed to start those measures almost immediately. So, I trotted back to the COAG meeting, tapped the prime minister on the shoulder, and said, "Actually, we want to shut the country down now." Following a predictable reaction, the First Ministers regrouped and agreed to form the National Cabinet and meet as often as necessary to agree on consistent, nationwide measures, which we certainly delivered in the first months of the pandemic.

A terrible few days in late July 2020 when the big Victorian outbreak was wreaking havoc in several residential aged care facilities who needed but could not get support. We had to create a direct new Commonwealth presence on the ground in Melbourne in partnership with the Victorian Department in the form of the Victorian Aged Care Response Centre. I called on about 20 of my friends in the Melbourne health system to come and join us in a Commonwealth agency that we set up pretty much overnight to manage and get into those facilities and help control the outbreak and manage the chaos that was there at the time.

This stands out for me as the most difficult time of the entire pandemic, and an extraordinary time in mid-2021 when we had a sudden need to massively accelerate our vaccine rollout to cope with the Delta outbreak in Western Sydney. We sourced within days millions of extra vaccines from Poland and the UK. I remember negotiating with these countries in the middle of the night. We managed to bring in millions of extra vaccines and achieve a vaccination rate of 2 million doses a week, which was quite extraordinary.

Finally, no discussion of our COVID response would be complete without some mention of the curious phenomenon of the anti-vaxxers. This collective includes some doctors, business leaders, politicians, natural therapy advocates, anarchists, and many others, united by a rejection of scientific evidence and a distrust of government and the pharmaceutical industry. Conspiracy theories abound in their thinking, and their psychology is quite complex. They were always around pre-COVID, but their emotions and energy were stoked by the huge national focus on COVID vaccinations, the advent of new MRNA vaccines, and most particularly the widespread of use vaccine mandates. The rage against mandates persisted long after the mandates themselves and has driven an ongoing irrational challenge of the clear scientific evidence that COVID vaccines saved many tens of thousands of Australian lives. The cost to the public purse of many hours spent in parliamentary committees responding to thousands of FOIs defending legal action in the courts, I'm named as a defendant already in one now, maybe someday worthy of quantification, but it's perhaps a price to pay in a functioning and open democracy.

Whilst COVID has dominated these last years, I have had a strong interest in broader health system reform. That's why I came to the Commonwealth. I'm singularly ill qualified in public health, as I've already said. Workforce reform has clearly been required for many years and has been one of my passions. Issues with supply and distribution were clearly exacerbated by the pandemic. When I was CMO, I was fortunate enough to drive and lead the National Medical Workforce Strategy, now accepted by health ministers, but facing a huge challenge in implementation as a necessary system-wide view does not come naturally to many of the players.

We are clearly training too many narrow sub-specialist doctors in Melbourne and Sydney, largely because our big hospitals create training positions to meet their service needs. If we appropriately distributed our medical graduates across the right geography and roles, particularly into the crucial area of general practice, we could and should be self-sufficient. I'm disappointed that the implementation of my Medical Workforce Strategy has been delayed by COVID, and I'll be watching very closely from the sidelines in the hope that all the players, government, hospitals, colleges, and universities play their part in driving these reforms. Of course, workforce reform is much bigger than doctors. We do now have a shortage of nurses and some allied health professionals. Some of this will need to be addressed by more numbers. But more than

ever before, we need to have a serious look at the scope of practice of all healthcare workers and the current commitment from Minister Butler, for the government to do this is very welcome.

The other very welcome and exciting reform that's clearly progressed, particularly in the May budget, is in primary care. Building on lots of foundational work done in the department over many years, government has taken serious steps to support voluntary patient enrollment in multidisciplinary care, along with some reinvestment in GP medical benefits to narrow the gap between the incomes of GPs and that of other specialists. Exciting work is being done to further reduce the cost of medicines and to increase the scope of practice of community pharmacists, including initiatives such as an ongoing funded role in providing National Immunisation Program, vaccines. Progressing these crucial reforms in community pharmacy and in the cost of medicines demonstrates an admirable government commitment to serious health reform.

More needs to be done in primary care as there is another big reform piece: hospitals reform and Commonwealth state relations. It has been interesting and mostly helpful to have the attention of National Cabinet and First Ministers departments in the health reform journey. This is probably not surprising since the National Cabinet was largely created from the need to drive a national health response to COVID.

Aged care reform has also dominated my time as secretary, implementing a huge and very expensive reform agenda as the Commonwealth moves from being a funder and regulator to a much more of a system steward. There's still a lot to be done, but I'm particularly delighted that the government has now agreed through the recently announced taskforce to have a serious look at the long-term sustainability of the aged care system, including some of the current inequities in consumer contributions.

There's a huge amount of implementation work that I will leave to my successor. That's probably always the case in health. I was reflecting to some of my staff the other day that if you're not leaving a lot of unfinished business when you go, you're not on a reform journey. I will be watching from the sidelines over the coming years, but I will be refraining from the temptation as a former public service leader to want to comment in the media on various issues generally without the full information. I will always be incredibly grateful to my predecessor as CMO, Chris Baggoley, who was constantly, throughout the pandemic, asked by the

media to comment on the leadership of the pandemic, and he always declined, a great example to many other public leaders who should follow.

I know that my success for Blair Comley will be supported by one of the best executive teams, if not the best executive team in the APS, in my bias but an evidence-based view, and an amazing team in the department who are part of an APS that is coming out of COVID energised and with a very strong sense of purpose. The Secretary's Board is strong and active and has been energised with recent new blood, even if one of them told Stephen Kennedy and me off for still wearing neckties, something I have done every business day of the last 45 years, but maybe now is the time to start losing this habit. Thank you all for coming and for your collegiality over the last seven years. The APS is in good shape and in good hands. Thank you.

KATHERINE JONES: Thank you, thank you, Brendan. Thank you for a fast-paced reflection but only over a small part of an incredibly long and varied career. My first question goes to... You've been a practitioner, a medical expert, an academic, senior administrator, and CEO, CMO, secretary of department, so quite extraordinary transitions. We talked a lot about career transitions. You encouraged them at the beginning of your address. But I'm really interested in that transition into the public sector at a very senior level. Any reflections you have on that challenge and any thoughts about whether we support and manage people through those transitions?

PROF BRENDAN MURPHY AC: Look, it was extraordinary. Probably the most substantial transition for me was going from a professor of medicine to the CEO of a hospital. I couldn't read a balance sheet. Didn't know what HR was. All I knew was how hospitals sort of work from a clinician's point of view. It was a little bit like that going from CMO to sec... because CMO, as Paul knows, it's a bit of a fun job. You get to play in various sandpits and do reform and others can clean up the sandpit. But the secretary's got a little bit more to it.

In both of those roles, the thing that struck me was, if you've approached them with humility and get the expertise and knowledge from the people around you... If I've had any success as a leader, it's been trying to attract and build good teams around me, get the right executives because you can never know everything. I didn't know anything about machinery of government stuff when I came to the Commonwealth. I didn't know... Sometimes that helps because sometimes you can say, "Well, why is this thing being cleared by seven

	different people?" and that's a good question to ask. But sometimes you must learn. So, I think the important thing is to have humility and to recognise that wherever you go... I'm not one of those people who likes to bring a football team of fellow travelers with me when I move jobs, which is, I think, a somewhat... I'm pleased Blair Comley's not like that either. I think it's quite nice to go into a department and mine the talent and knowledge that's there, and then, if necessary, build new talent and knowledge around you. So, I think it's a matter of being humble and admitting what you don't know and not being ashamed to say, "I've got no idea what you're talking about. Please tell me."
KATHERINE JONES:	That's a great message. With an extraordinary career, lots of different roles, and based on what you've said but also what we've observed, just someone who's come in to make a difference and to reform, when you're doing so much, sometimes you can make mistakes. Any regrets or anything-
PROF BRENDAN MURPHY AC:	Oh, yeah.
KATHERINE JONES:	... you would reflect on and think differently?
PROF BRENDAN MURPHY AC:	Well, the famous one was when I was giving evidence to a New Zealand parliamentary inquiry into COVID. Nobody told me it was being live streamed. I thought it was an in- Mistakes, in the COVID response, I think that the thing that probably I look back on and think I would do very differently is how we vaccinated aged care and disability. We completely underestimated the complexity. We did this from, well, we've got 120 residents. We sent in a team of 20 people. We didn't realise that you must spend half an hour persuading the family of each resident to consent. So that was, I think, very significantly underestimated. Other than that, of course, there'll be lots of tweaks that we could do in our COVID response, but in the broader space, I don't think there's anything that stands out.
KATHERINE JONES:	That's a nice place to be after a 45-year career. I wonder if you could talk a little bit about, as a senior leader, as a senior official, when you're in the middle of a firestorm that ended up going for two years, how you maintained your equilibrium, your resilience. You present yourself as someone who recognises that things will go wrong and not get overly exercised about it, but how did you manage that day in and day out pressure at the peak of that two-year period?

PROF BRENDAN MURPHY AC: People often asked me that. I think particularly in that hectic 2020 where we were building the plane as we were flying it, I think we were just living on this sort of pressure. I remember Jen Fan and I doing National Cabinet papers at 2:00 a.m. for an 8:00 a.m. National Cabinet meeting. It was an extraordinary period. I tried to get a bit of exercise unless I closed the bloody gyms down, which was [inaudible 00:38:13]. I bought a bike because I was stuck in Canberra for all COVID and started riding around the lake, not breaking the five-kilometer rule of course, and tried not to resort to having too many red wines to calm you down. So, I didn't do anything specific. I just kept going.

Again, I can't underestimate the sense of purpose that we saw in the Health Department at that time. You'd go into the National Incident Centre at 2:00 a.m. and find 20 people there on the phone and checking things up and chasing things. So, it really did energise the department. There's a risk to that coming out of that hectic, unified, single purpose to getting back into a broader reform agenda. That's something that the recent capability reviews we've been doing has identified rightly as an issue.

KATHERINE JONES: Great. I'll ask one more question before I open it up to questions from the floor. You've talked about some of the significant reforms that you think are required in healthcare and aged care and you set the framework for them. But I think everyone knows that the federation is a challenge. Working on national reform of that importance is extraordinarily difficult. Any words of wisdom or exhortation to those that are working in that federal space?

PROF BRENDAN MURPHY AC: Look, I think it's a big, huge challenge, and Glen and I were involved with a meeting recently about... because the National Cabinet has taken a welcome interest in this area and health ministers are interested in it. I think one of the key things is that if we're going to get a sustainable and better functioning health system, we must get a strong primary care sector. That is weak now, recognised by the government, lots of big strategies to reinvest and build it up, but it must then be connected to the state and territory hospital systems.

The thing that we're looking at is how we can make that connection more reliable. Now, it depends on good local leadership and interactions. So, we've got to do something structurally to interface a strong primary care sector. There's so much more we could do in primary care that would make the patient's experience better, the system more sustainable. But then if we try and do that in isolation from the states and territories... I think there's a good willingness at all levels of our hospital health CEOs, health ministers, First Ministers to do that. That's a unique opportunity. We need to capitalise on this National Cabinet leadership and try and make sure that we progress reforms we can lead, such as primary care and aged care, and then bring the states on that journey and bring along that interface.

The other thing I think we probably are going to have to look at is the issue of the out-of-pocket cost of a private medical specialist. We've been trying several strategies around that. We've been carefully maneuvering around it. But I think we are going to have to address that in a more explicit way in the future.

KATHERINE JONES: Great, thank you. I'll open it up for any questions. Melissa, down there.

MELISSA COADE: Hi, Secretary. Melissa Coade from Mandarin. I apologise for the pressure the fourth estate put on you. My question goes to Professor Davis's speech last year when he gave us the analogy of the ship. When Katherine Jones described a two-year firestorm, I thought, imagine a ship in a two-year firestorm. What is your view on being a good steward in the face of fear? I'm thinking when it comes to this sort of shift that the department had where it wasn't just disseminating information, but it was truly managing public expectations. Yeah, stewardship in the context of fear.

PROF BRENDAN MURPHY AC: I think that absolutely was a big challenge. Fear, you've no idea then... Well, you obviously you do have an idea. Fear was driving so much of the response of state governments. Some of the chief health officers, I think, were driven by fear. The community was driven by fear. I was very conscious in my communication to be able to try and deal with that fear by being honest with people and be reassuring at the same time, which is a really hard thing.

But in terms of internally in the public service and in the department, I think, whilst we were aware of the fear, I can't overemphasize this incredible sense of purpose. We knew what we had to do. We thought we had to find out what we had to do before we knew we had to do it. But we had a pretty clear direction, and we had a

government that was very determined to stick by the expert advice. So, it was not hard to take that stewardship role because it was very task specific. We knew we had to do aged care. We knew we had to get vaccines. We knew we had to try and corral the national public health response in a consistent way. So, I think sometimes in many ways it was sort of easier to do stewardship in that firestorm because there was no ambiguity about the sense of purpose. I'm not sure whether I've answered your question, but that's a go.

ROB HEFEREN: G'day, Brendan. Rob Heferen, chief executive officer, Australian Institute of Health, and Welfare, one of your portfolio agencies. I have a comment if I could start and then a question. The comments when we saw you on the TV gave a real sense of reassurance to people. I think you see too many ministers, prime ministers, premiers, other health ministers sometimes tend to... there's a sense of giving people what they think people want to hear. When we saw you, there was that calmness, obviously dedication to the cause. I just thought it was really reassuring, and so I want to thank you for that.

Just the question, you spoke a bit about health reform and the challenges we face. Your focus was on primary care. Is that how you see it? When we look at our health system, it's actually pretty good, long-life expectancy. We have quite high levels of comorbidities, but coupled with a long-life expectancy is probably not such a bad thing. Do you think, as a country in particular as maybe a public service or people wanting sort of perfection, is there a risk that we underestimate the benefits are there, overestimate the gaps or challenges and as a consequence kind of lift those into a point of maybe not catastrophize, but overemphasize what might need to be done rather than stepping back and saying, "Well, it's not perfect, but no complex system ever is, so what's the scale of the urgency of the change?"

PROF BRENDAN MURPHY AC: I think that's a very wise comment, as always expected from you, Rob. I think we do tend to catastrophize some of the challenges in the system because health is one of those things where an anecdote becomes an issue, no doctor in a certain town, or there's ramping again at the Royal Adelaide Hospital, which always seems to be the case. Those sorts of things, I think, do tend to get into the media, and the media tend to get on top of that. But I do think there are significant gaps though.

There is evidence that people aren't seeing their GP as much as they were and that they're paying too much and that there's patchiness. I do think, for years, we've looked at these cost growth curves. Now our cost growth in our health system is not as high as many other sectors, but it is continually getting an increasing share of GDP. We know that episodic acute care for chronic diseases where you get admitted to hospital six times with an exacerbation of chronic airways disease that can be managed better in the community and for a better outcome and a more cost-effective outcome.

So, I absolutely agree we shouldn't say... and I do think some people do tend to over-say that the system's broken. It isn't broken. As you say, health outcomes are good, but there are pressure points and gaps. Unless we start the reform journey now, we risk having a sustainable system with greater inequity in the future. But I think that is a wise comment, and we do need to remember that we have good health outcomes now, but they could be at risk if we don't get a more sustainable system for the future.

KATHERINE JONES: I'm going to leap in. I've got another question. You talked a little bit about what we've learnt domestically from COVID. I'm interested in any reflections about the global health architecture and the global response when the next pandemic... which may not look like the last one. Do you think we're sufficiently prepared from a global perspective?

PROF BRENDAN MURPHY AC: I think we'll be better prepared. You'd probably be better to ask Paul Kelly that question. He's been off at WHO dealing with... I think WHO was found wanting in this pandemic. I think their leadership was not strong. They were slow to call the pandemic, slow to react. I think they've reflected on that and agreed with that. They've done several reviews, and they're in the process of revisiting the International Health Regulations and setting up a new pandemic agreement to try and get a more consistent... A great example was border closures. When we closed the borders, I remember our government asked me, "What are other countries doing?" I said, "Well, WHO doesn't recommend it. They say it doesn't work. The UK doesn't support it. They think it's a silly idea." "So why are we doing it?" I said, "Because we think it's a sensible idea, and we think it'll work," and it did work. There's no question that those countries... It's a little bit easier as an island.

So, I think some of those things, all our preparedness for a pandemic was based around pandemic flu and probably the next pandemic will be a pandemic flu. So, I think WHO is on a journey to get better national consistency, having regard to always the issue that sovereign countries must sign on to that approach, so it's a complicated and contested space. But I hope that coming out of that sense of international collaboration, certainly the international sharing of information and ideas is better coming out of the pandemic. The sort of collaborations that Paul and his colleagues will have on a regular basis now that just weren't their pre-pandemic are much better.

KATHERINE JONES: Great.

PROF BRENDAN MURPHY AC: Nobody wants to ask a question.

KATHERINE JONES: Melissa, there you go. Go again.

PROF BRENDAN MURPHY AC: Trust a journo.

MELISSA COADE: Sorry. I did ask the department for an interview. They said no, so I'll use my opportunity. How about just a comment on the way that the state and the Commonwealth were able to work well together? How you'd like to see some of those fantastic synergies stick and space for improvement going forward?

PROF BRENDAN MURPHY AC: I think there's no question that national cohesion was strong in the first half of 2020, but then it did start to fracture. There were local differences. Different states and territories took different approaches. Some of it is based on different advice and different levels of risk aversion in their chief health officer advice. So, I think one of the goals of this in a public health sense, this new CDC, will be to try and lock in in a more structured way that sense of national cohesion. Because of the national cohesion that we got in AHPPC and the National Cabinet in early 2020, that was a collaborative leadership that came because we all came together, and we all agreed to do it. But then local circumstances came in and we did start to see states going off in different directions, despite there being continually at National Cabinet quite a good sense of cohesion.

I think the National Cabinet is cohesive now. I don't go to it anymore. I'm sure Glen goes to it and would know that. I'm hopeful that the National Cabinet has this agility that COAG didn't have. As the first minister said at the time, nothing would come to COAG if it hadn't been through about six other levels of committees in government, and there was no genuine discussion and debate. I think they do like having that genuine

discussion and debate and trying to lead reform. So, we're never going to fix the fundamental issues in our federation. There are two levels of government that are responsible for health. You probably wouldn't design it that way, but it's always going to be like that. So, we've got to work on a way of making sure that those connections and collaborations are strong, and I think there's goodwill at all levels now to make that work. Let's hope it does.

KATHERINE JONES: We'll probably have to finish the questions there, but I can't help asking one last thing. You've told us what you're not going to do when you finish up as secretary. Any idea of what you will do?

PROF BRENDAN MURPHY AC: Well, as I said, I'm not going to do full-time work. I probably will do some stuff that interests me, maybe some projects, possibly a board or two. I've agreed to give all those talks that I said I didn't have time for in the last two years, so I've got six talks lined up in the second half of this year. I'll probably go back to learning Italian and singing again.

KATHERINE JONES: Oh, wow. Well, on that fantastic note, please join me in thanking Brendan for his great reflection.