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[redacted]
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Thank you for the opportunity to make a submission to the COVID-19 Response Inquiry.
I am a general practitioner, fellow of the Royal Australian College of General Practitioners, past President of the Australian Medical Association, a former Deputy Lord Mayor of the City of Sydney and former Member for Wentworth. I am an executive member of OzSage.
I have been closely engaged with the COVID-19 pandemic in Australia since the first reports in early 2020 and I am able to provide some broad perspectives from personal and professional experience.
There was a lot that our public health agencies got right during this pandemic, but in the interest of brevity I will focus on some of the areas where there is room for improvement.
When we had the first reports that COVID-19 had arrived in Australia, members of the public were initially told by government that if they had symptoms they should **contact their general practitioner**. At this time, GPs had no diagnostic or therapeutic tools and no **PPE** to protect ourselves. In clinical practice, it was difficult to access masks and other PPE and this initial advice would have put healthcare workers' lives at risk. This must not happen again.
There was a lot of **confusing misinformation** being disseminated, including the classics "SARS CoV-2 is not airborne[i]", "There's no need for masks[ii]", "children under 12 have been proven not to be carriers or transmitters of the disease[iii] and that elusive promise of "herd immunity".
Political decisions were made, and public health advice was provided based on this misinformation, fuelling mistrust in subsequent advice emanating from those sources.
Schools were said to be "safe". It was later established that schools were a major source of community transmission and that there needed to be a major effort to improve ventilation and air quality. Yet insuffucient effort has been made to address this ongoing issue.
With regard to the **vaccine rollout**, doctors and the public were assured that the vaccines would reduce the risk of severe disease, hospitalisations and death from the virus. The information being disseminated emphasised their claimed "safety and efficacy". Of course, early in the rollout of the vaccines, little was known about the potential range of adverse effects of the vaccine.
In the urgency to vaccinate as many people as possible as quickly as possible, patients who had suffered significant **vaccine injury** were encouraged or mandated to have subsequent doses with inadequate evidence for the potential damage this might do to someone who had already suffered an adverse reaction to the vaccine. It was extremely difficult for patients who had been affected to obtain a medical exemption.
Another consequence of the difficulty in obtaining information about vaccine adverse events was that many patients report that they were not believed, or their doctors initially did not recognise the diagnosis or did not have treatment protocols in place.
This meant that patients had to take matters into their own hands and set up advocacy groups such as **COVERSE** to share experiences and provide much needed support[iv].
It also became evident that these were **not sterilising vaccines**, and that while they were reported to provide some protection against severe disease and long COVID, they would not stop infection or transmission or the development of long- COVID.

One of the consequences of over-reliance on the vaccines-only strategy has been an under-reliance on other sensible mitigations such as N95 mask wearing, identification and isolation of infected individuals and financial or practical support for people unable to work or study from home while they isolated for the greater good.
The consequence after the "let it rip" decision by governments in late 2021 was a massive number of infections and excess COVID-related deaths estimated by actuaries to be 20 000 in 2022[v].
People with **"underlying health issues"** and the elderly were left to fend for themselves and made to feel as if their lives and wellbeing were not as valued as the "young and healthy". This created an ongoing **social justice** schism between the "vulnerable" and those who feel they are invulnerable.
It took some time for the diverse presentations of **long COVID** to be recognised.
Early attempts at treating long COVID were largely unsuccessful because of a lack of knowledge of the underlying pathophysiology of the condition and insufficient research to find treatments. We continue to await validated diagnostic tests and treatment protocols.
Some specialist-led clinics were established and there were soon long waiting lists for largely unsuccessful treatment protocols such as graded exercise therapy and CBT.
In my view, it would have been more helpful and accessible for resources to be provided to general practitioners, via the RACGP, and all medical specialists via the RACP with timely updates on international experience in managing patients with this complex and varied condition.
Rather than closing down **long COVID clinics**, it would make sense to create centres of excellence where patients presenting with more difficult cases could be treated by multidisciplinary teams and where focussed research could be conducted.
Despite fit-tested **N95 respirators or their equivalent** being shown to be significantly more effective than "baggy blue" surgical masks, public health facilities persisted in supplying only the surgical masks to staff.
Of particular concern was the decision in 2023 to remove the **mask mandate in healthcare facilities** while the pandemic continued, effectively forcing patients to have to make decisions about seeking medical care versus the risk of contracting COVID-19 while seeking that care.
Finally, access to testing was gradually withdrawn along with reporting of COVID-19 incidence so we are now mostly flying blind and relying on anecdotal community reports.

WHAT NEEDS TO HAPPEN?[vi]

A return to the **PRECAUTIONARY PRINCIPLE and the FUNDAMENTALS OF PUBLIC HEALTH and DISEASE PREVENTION, a COMPREHENSIVE PLAN for RESEARCH, and DEVELOPMENT OF TREATMENTS** to include:

- Early and continuous engagement of primary care
- Effective non-politicised PUBLIC HEALTH MESSAGING about the risks of **Long COVID**, including the limitations of a "vaccines only" approach in preventing Long COVID.
- Access to high quality N95 or equivalent masks with evidence-based targeted mandates including mandated masking in healthcare facilities for the duration of the pandemic, however long that might be.
- A national and international approach to improving indoor air quality including ventilation standards with CO2 monitoring and target levels.

- A concerted and sustained effort to reduce COVID transmission in schools to protect students (especially medically vulnerable children and children with medically vulnerable household members), teachers and school support staff.
- Improved access to testing
- A return to isolation of infected individuals throughout the infectious period
- Expansion of hybrid work and education options with financial and/or practical support for people who are required to isolate while infectious
- Encouragement and funding for research into future preventive interventions including sterilising vaccines
- Expanded availability of affordable evidence-based antivirals with development of more effective treatment protocols for acute infection.
- A national approach to aim for zero COVID transmission in hospitals and healthcare facilities
- Research into the underlying mechanisms of Long COVID and development of diagnostic tests and targeted treatments for Long COVID.
- Development of specific information packages for GPs and medical specialists on Long COVID recognition and treatment options.
- Identification of barriers to reporting of adverse vaccine reactions to the TGA
- Follow up of adverse COVID vaccine events reported to the TGA
- Development of specific information packages for GPs and medical specialists on the spectrum of vaccine adverse events so that patients receive full and accurate informed consent prior to vaccination, and wider recognition of vaccine injury.
- Development of Consumer Medicines Information resources about COVID19 vaccine adverse events
- Research into the underlying mechanisms of **vaccine injury**
- Development of specific information packages for GPs and medical specialists on how to manage patients with suspected or likely vaccine injuries.
- Recognition of long term Long COVID and vaccine injury disability under support and compensation programs including a review of the COVID-19 Vaccine Claims Scheme.
- Continuation of timely publication of COVID-related data so that people are able to make informed decisions about avoiding infection.
- Transparency of national cabinet decisions about pandemic management
- Adoption of the principle “no-one left behind”.

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[i] https://www.health.gov.au/news/deputy-chief-medical-officer-interview-on-sky-news-live-first-edition-on-6-may-2020

[ii] https://www.smh.com.au/politics/federal/no-need-for-face-masks-business-as-usual-says-australia-s-chief-medical-officer-20200223-p543gf.html

[iii] https://www.abc.net.au/news/health/2020-12-25/children-covid-19-coronavirus-spread-transmission-immune/13012550#

[iv] https://coverse.org.au

[v] https://www.actuaries.digital/2023/04/06/covid-19-mortality-working-group-confirmation-of-20000-excess-deaths-for-2022-in-australia/

[vi] Phelps, Kerryn. **Inquiry into Long COVID and Repeated COVID Infections 2022. Submission number 510.** https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/LongandrepeatedCOVID/Submissions