Submission to enquiry on Covid response in Australia

by Angela Cockburn

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Formation of a National Cabinet was probably a good idea, but had three intrinsic disadvantages:

a) It did not properly take into account the very real differences in demographics between the states, particularly in regard to those states with very large agricultural areas or desert areas, and those with a large number of remote communities.
b) It tried to create cohesion between the states, but predictably ran up against the fierce partisanship of some premiers.
c) A "one-size-fits-all" approach did not accurately reflect the different states' experiences of the progression of the Covid pandemic in Australia.

2

There was an unfortunate tendency to predict the possible progress of the disease in Australia by using the United States' experience as a model. This failed to allow for the very different healthcare approaches between the two countries. The extremely high costs of most healthcare in the US, even for those with insurance cover, has created a situation where a large percentage of the population do not even visit a doctor unless they are really ill; and a situation in which many disadvantaged people work two or more jobs, often service jobs, where they interact with a lot of people on a daily basis, potentially spreading any communicable disease currently active in the population.

The US approach to combating Covid-SARS2 was therefore based on a population that generally presented to the medical system late and only when in real distress, and as a result with a predictably poorer outcome and greater death-rate per diagnosed case.

The original US recommended protocols, involving immediate ventilation at high pressure, were understandably developed in a hurry; but should have been dropped much earlier than they were, as soon as the damage they caused had been identified. They directly contributed to the intial high death-rate.

Australia's robust health system, available to all, with or without insurance, allowed intervention in Covid cases at a much earlier stage in the progression of the disease.

3

Other countries with particularly high Covid death-rates included those where smoking is still a common habit, and, unsurpisingly, some poorer countries - if we can

consider the published statistics, from Africa in particulat, to be an accurate reflection of reality. Australia has actively discouraged smoking for decades (while profiting from the taxation of tobacco products), and Australia does not have poverty at the same culturally ingrained level as - say - Mali.

4

Although the disease in its earliest iteration was certainly more virulent than the later mutations, the panicked official response, boosted by public statements and televised soundbites from grandstanding medical personnel who often appeared to be relishing their time in the limelight, led quickly to scepticism and distrust among Australians generally.

5

The vaccines were necessarily developed in a hurry, with insufficient time for proper testing. Current evidence seems to show that boosting after the third dose is counter-productive, and there is still controversy over which product is the most effective. [redacted]unfortunate annual report, after the first full financial year of active Covid, which gloated over their enormous profits (it *was* a report from the accounts department) did little to inspire confidence in those of us who read it online.

The result of the rush was inadequately tested vaccines with a higher rate of side effects than would normally have been considered medically acceptable. [redacted]were my own experiences after all three shots, after which my doctor suggested I take no additional boosters. Many acquaintances and colleagues have anecdotally reported similar experiences.

Making such a product mandatory was medically dubious and politically stupid. Making a choice of vaccines generally available would not have been.

The initial international propaganda insistence that vaccination would prevent transmission was shamefully misleading and reprehensible. The public - the electors - did not like being taken for fools.

Enforcing vaccination and/or testing as a condition of employment was ridiculous outside of medical settings. Imposing it on teachers, when the evidence was that children were generally at risk of only very mild infections, was arbitary and disgraceful, especially since online teaching rapidly became available as an alternative.

6

Masks were an acceptable precaution on the whole, but again were dehumanising. There was also a general misunderstanding of a bilingual report from a Canadian university, which was thought to recommend the ubiquitous paper surgical masks, but in fact recommended "tissu" - which means cloth or fabric, NOT tissue.

7

Green screens and QR codes were another dehumanising introduction, and highly flawed as a check mechanism. By way of experiment I found I could flash my (genuine) green screen to venue staff at a distance without being queried; and I could

often circumvent the QR code with a bit of mime (one of my phones refused to read them anyway). QR codes were also often laminated for outside posting, or stuck behind window glass, and therefore had reflections across them which rendered them essentially inoperable.

8

Lockdowns were a disaster. My area - the very large [redacted] Sydney - was in lockdown as a whole for months because of a number of cases after a party in [redacted] [redacted] is approximately 1 hr and some minutes away from me. The dehumanising and demoralising effects on people held in this long lockdown are still being felt, and there is a continuing distrust about getting too close to neighbours, reducing chats to cordial nods in passing.

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Overall, the Covid response in Australia had all the hallmarks of an over-large committee, hastily formed, acting on advice from medical advisors eager to make a reputation,

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Failing to provide a full choice of vaccination options was reprehensible.

Regards,

Angela Cockburn