SUBMISSION TO COMMONWEALTH GOVERNMENT COVID-19 RESPONSE INQUIRY

I welcome the opportunity to contribute to the COVID-19 Response Inquiry. I write as an Adjunct Professor in Humanities with special expertise in forms of social contagion, wide interdisciplinary expertise including in trauma and public feeling, and the social dimensions of science. My family of origin are all medical scientists, including a [redacted], a [redacted], and a [redacted]. I also have a much older partner, and three friends who suffer from various forms of [redacted] two linked to COVID-19. I am a long time feminist and member of LGBTIQ groups, as well as advocacy group Cleaner Air Collective. My submission meets the scope of the inquiry in addressing opportunities to establish and implement best practice in public pandemic communication and action in a national context. I note that some of what I will say will run counter to public statements already made by members of the Panel.

Public Health and trust in government

In times of crisis, especially in a pandemic in which one person's actions directly and indirectly affect many others, public health and safety prioritizes collective well-being—such as protection from the spread of disease—over individual autonomy. In doing so, it ultimately fosters equity, individual autonomy and opportunity for all, as well as the survival and well-being of society as a whole. This is, after all, precisely what government and governance exist to do. And doing it requires high levels of sustained trust in both, and, crucially, in the professional and technical expertise that make them possible.

[redacted] says eminent feminist philosopher Professor [redacted], [redacted]' In a pandemic, personal choice is never simply that. Humans are necessarily **interdependent:** this is the reason societies exist. For societies to survive and thrive, and for social cohesion and trust in government to be sustained, we need actively to promote an ethos of **mutual care** rather than an unconstrained free-for-all of 'you do you', a *Lord of the Flies*-like scenario instantiated in the idea of 'individual responsibility' and 'user pays' principles applied to public health. In the long run, the idealisation of sheer individualism serves no one.

An ethos of mutual care means recognising that societies – dense networks of interconnection - are only as strong as their weakest connections. This means not only those most at risk from the consequences of severe disease, but also all those who are most exposed to constant reinfection and therefore to the risks of longer term damage entailed in that, long suspected and now confirmed by numerous studies. This includes families with school age children, teachers, healthcare workers at every level, including aged care and childcare, essential workers such as bus drivers, and all those in public-facing modes of employment including in cafes, bars and restaurants and in the Public Service. The 'weakest links' are very numerous indeed, and are comprised especially by women who do most of the care work essential to a functioning society, and children who spend most of their day in congregate settings. This makes transparency and equity issues key to the ethos of mutual care that underlies the very concept of Public Health.

Transparency in public messaging

In this context, transparency means providing the best, clearest and most accurate advice according to evidence available, revised – and if necessary, corrected – as better evidence becomes available. This is not what happened, and it is not what is happening now. Instead, the

public has been left largely unaware that transmission is airborne, that reinfection poses any serious risk to health, or what the most effective protections in addition to vaccination might be.

Transparency first of all requires open and frank acknowledgement that although COVID-19 is no longer considered by WHO to be a Public Health Emergency of International Concern, WHO nevertheless recognises that the COVID-19 pandemic has not ended and also that it is unlikely to be declared over in the near term. In fact, Australia is now undergoing its third major COVID surge for 2023, and it is rapidly becoming clear that the JN.1 variant, which is causing exponential growth in cases worldwide, is likely to do considerable damage here. However, the federal government officially refers to the pandemic in the past tense as if the threat of serious disease has passed. This is clearly misleading at best, not to say dishonest.

Worse, infection began to be normalised when CMO [redacted] assured the public that a combination of high levels of vaccination and infection would bring about what he called 'hybrid immunity' to the virus. Yet that is not what transpired, and in fact, in although case numbers fluctuate, people continued and still continue to suffer acute illness, to be admitted to hospital, and even to die. Worse still, reinfection has become progressively more common and with it comes a higher risk of adverse sequelae like strokes, heart attacks, diabetes, kidney problems, chronic fatigue and immune dysregulation **especially in younger people**, making the population more susceptible to bacterial, fungal and other opportunistic viral infections, whether or not symptoms of initial infection in individuals were 'mild' and whether or not some infections were asymptomatic. The numbers of deaths during the acute stage of the disease might continue to decline, but equally, they might not, given the advent of new and radically different variants. Of enormous concern is the longer term problem of major decline in population health that now faces us, diminishing our ability to deal with other crises.

In order for Australians to have the opportunity to adequately assess both the individual and societal risks of infection, **I call upon this Inquiry to recommend a wide-ranging, open and honest public health campaign** directly addressing misinformation about – now disproven - herd or hybrid immunity, and droplet rather than airborne transmission. It should also provide information about asymptomatic transmission, and the most effective protections in addition to vaccination: clean indoor air, P2/N95 respirators, nasal sprays and so on. And it should dispel mistaken notions that blue surgical masks, handwashing (although it is good for other things) and physical distancing offer sufficient protection from COVID-19. It should also address the legal duty of employers to provide safe workplaces – especially in schools, healthcare, aged care and childcare – and it should outline what to do should this not happen. This campaign should have special versions addressing particular ethnic communities in their various first languages and should be co-designed by them. It should be disseminated on every broadcast medium, in print, and on all social media platforms and fronted by trusted public figures, as the hugely effective HIV campaigns once were. I stress that this is absolutely crucial to maintain trust as the longer term effects of the infection become increasingly palpable, and to build a base of understanding should possibly unpopular mandates become necessary in the face of coming epidemics of avian flu or other infectious diseases. I would argue that supposed unpopularity in the current instance is not mainstream but actively manufactured by online bots and troll farms and needs to be equally actively countered. Here the advent of JN.1 offers us a chance to reset.

Transparency in governance

In addition to downplaying increasing evidence of the longer term damage to health by infection, especially repeated, National Cabinet and AHPPC together removed all mitigations

and protections including isolation requirements, PCR testing and RAT reporting requirements, and even mask mandates in healthcare, rendering hospital and GP visits utterly unsafe not only for those deemed 'vulnerable', but for everyone. Therefore, to ensure transparency and to maintain trust in governance and to enable Australians to assess whether decisions made on their behalf were and are supported by high quality evidence and fully justified, **I call upon this Inquiry to recommend that minutes of all past and any future meetings of National Cabinet pertaining to public health and the pandemic and those of AHPPC, be made public immediately.** Likewise, ATAGI's advice about vaccinations has been slow, confusing and contradictory, and eligibility seems to have been determined by what was ordered and when, rather than on health grounds. **I also call on this Inquiry to recommend the immediate publication of minutes of the meetings of this body.**

Trust in Expertise

Public Health requires trust in independent scientific and professional expertise. Yet this has been undermined by politically-based decision-making and public messaging and by politically-constrained public health officials, while the advice of independent experts (notably OzSage members) has been actively ignored. Government misinformation has infected even GP clinics, to the extent that many overwhelmed GPs, who have little time to read papers in complex multidisciplinary medical science in their family time of an evening, are passing it on to concerned patients seeking answers to questions about their own health. Specialists are not exempt from this. And it is reinforced by hospital administrators and practice managers who look to cut costs by reducing even the most minimal PPE and who (I am told by medical friends including one very senior one) will bully medical staff into compliance with the result that nosocomial infection is sky rocketing. All this undermines trust in particular medical advice and professional expertise more broadly. **I therefore call on this Inquiry to recommend that professional organisations play an active role in educating and supporting their memberships about best practice in airborne infection control and the reasons why it is needed.**

Questions of evidence and the disappearance of data

It is true that not all studies are of equal quality. But the insistence on RCT as gold standard is misplaced. The ever-changing and rapidly developing pandemic requires a more agile response. Clinical observation by respiratory physicians, immunologists, nephrologists and others is hugely undervalued, yet older clinicians with decades of experience often embodied a sentinel intelligence about what was to come. They were and are still ignored or dismissed. The weight of evidence about the long term, likely cumulative damage done by COVID-19 infection now seems overwhelming, regardless of the acknowledged limitations of particular studies. As with global heating, we have to ask, how much evidence is enough? The precautionary principle needs to be applied, especially where the stakes are as high as they are now.

Similarly, airborne infection requires different expertise, and aerosol scientists (notably, internationally renowned expert Prof [redacted]) and engineers. **I call for this Inquiry to recommend a response led by them which urgently prioritises a national clean air infrastructure program.** Finally, data must be systematically collected including via easily accessible free PCR testing and transparently reported according to national standards which must be rapidly developed. Without data there can be no science, no transparency, and no accountability. To fail to adequately collect it endangers our democracy. As for costs: as with the climate crisis, we must adequately model **the costs of inaction.** And, as with the climate change, they will likely dwarf the costs of decisive, transformative action now**. I call for the Inquiry to recommend greater transparency in and public release of all data and modelling relevant to this and future pandemics.**