Submission to Commonwealth Government COVID-19 Response Inquiry

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December 15, 2023

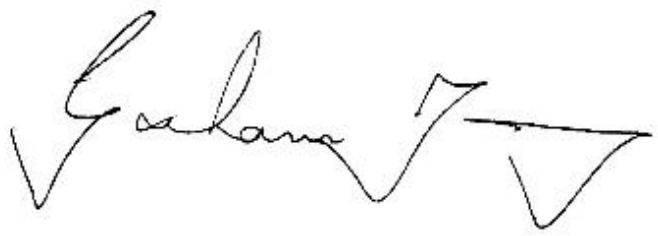
Ms Robyn Kruk AO
Chair
Independent Panel
Commonwealth Government COVID-19 Response Inquiry
Department of Prime Minister and Cabiner
CANBERRA ACT 2601

Dear Ms Kruk,

The Australian Institute for Progress is an Australian think tank based in Queensland that took an early interest in COVID -19 policy. We thank the committee for this opportunity to make a submission on the *Communications Legislation Amendment (Combatting Misinformation and Disinformation) Bill 2023*.

Should you have any queries you may contact me by email graham.young@aip.asn.au, or by phone 0411 104 801.

Regards,



GRAHAM YOUNG
EXECUTIVE DIRECTOR

1. Introduction

The Australian Institute for Progress was formed in 2014 as a think tank. We are interested in a number of policy areas, including science and economics. In early 2020 we became interested in COVID-19 policy, both as a result of COVID-19's potential as an existential threat, and then because of policy errors, their economic impacts, and the lack of scientific rigour behind them.

Initially borders were closed and lockdowns ordered to flatten the curve – that is that the underlying policy was one of achieving "herd immunity" modified by a short-term need to ensure that health infrastructure could deal with the expected load.

In March we wrote to our members broadly supporting government health measures at the time but calling for more data and a flexible decision-making process.

With more data, by April we noted the policy appeared to have shifted to one of elimination and publicly disagreed with a number of government policies, including lockdowns. Early in June we organised an open letter to heads of Australian governments signed by a number of public figures and academics calling for the economy to be re-opened on the basis of cost benefit analysis. We also called for better governance structures.

Our views have not substantially changed since then, and data and subsequent events have tended to confirm them. This submission is not based on 20-20 hindsight, but on very good foresight.

2. Lockdowns did not work

The evidence from around the world is that lockdowns did not work. They didn't stop transmission of the disease and they appear to have caused more deaths than they saved. The only measure that definitively captures both the intended and the unintended consequences of lockdowns is excess deaths. Some excess deaths will be from COVID-19, and some may be from other causes. We can control for some of this by comparing jurisdictions that locked down with those that didn't.

When we do that, we find that Sweden which was an outlier in the OECD in not having a mandated lockdown has performed better than its peers in northern Europe who did, and that Florida, that locked-down but rapidly quickly re-opened after assessing new information did better than California, which had one of the strictest lockdowns in the world.

3. Vaccinations had an equivocal effect

While the relative efficacy of the mRNA vaccines appeared to be good in the first instance their absolute efficacy was small. They were not effective in stopping infection or transmission. The number of adverse events is higher than for any other vaccine, and the risk reward balance in age groups younger than 65 is against the vaccines, and this is recognised in the latest ATAGI recommendation that no one under 65 should have a booster shot. Yet they were recommended for the whole population as a measure to prevent transmission as well as infection and serious illness, irrespective of age. These recommendations led to the various mandates and restrictive practices imposed by governments and businesses, damaging the lives of the few, with no benefit for the lives of the many.

4. The federal government must take primary responsibility for these poor policy solutions.

While many of the solutions were unilaterally imposed by the states, the federal government had a primary responsibility in setting the tone. It also had the ability to over-ride some of these policies, such as vaccine mandates, but refused to do this, even though the Prime Minister expressed his opposition to them.

The federal government further implicitly encouraged the states to continue with bad policies by under-writing the cost to business and individuals of these policies. The Parliamentary Budget Office estimated at one stage that by 2030 the gross government debt would be $800 million more than it would otherwise have been without these measures.

The following are our recommendations as to how we can more effectively and robustly respond to future pandemics.

5. A culture of transparency

Many of the policy errors occurred because views that departed from those of the top health bureaucrats were labelled as "misinformation" and chased from the public square. Citizens, including many policy makers, were robbed of the tools they needed to make good decisions, and correct bad ones.

a. Sharing of information

There is an urgent need for information in the health area to have a standardised format and a schedule for collection that is uniform over the health system, or at least the hospital system. Health authorities also need to be able to tap into sources of de-identified data, such as should be available from pathology labs, for public health uses.

The data should then be made available to the public. Some very good quality analysis was done by citizen journalists and scientists.

b. Information in context

Information should only be shared in context. The “fear porn” distributed nightly on the mainstream media was not conducive to good public policy. If citizens had realised many more people were dying from causes other than COVID-19 it would have given governments more room to move as there would have been less community panic.

c. Random sampling

Random sampling for COVID-19 antibodies should have been undertaken in the community rather than the reporting of raw detection statistics from testing. The latter give an unrealistic idea of what proportion of the population has, or has not, had COVID-19 and then feeds into estimates of infection and case fatality rates. If this had been done, some of the modelling on which the health bureaucrats relied might have been more reliable, or have been discarded.

d. Strong public debate

Debate was discouraged, and even dissident professionals in good standing with their professional organisations were demeaned as “conspiracy theorists”, or sometimes the novel term “cooker”. Some medical professionals were disciplined by the health regulator, or sometimes their employer, for holding heterodox ideas that ultimately proved to be correct. There are many reasons for encouraging robust public debate. One is to ensure that policy is the best it can be, by testing it. Another is to engender trust by the community in the decision-making process. Polls show that trust in all public institutions declined during the pandemic, and have continued to decline.

6. Accountability

During the pandemic, under the legislation, the health minister was in control. This is wrong, although better that a politician who can be held to account by their colleagues, or electors, be responsible than an unelected health bureaucrat, as was the case in most Australian states. The issue extends beyond political control, to the vaccine manufacturers, and ultimately individual citizens.

a. Executive control

This should always rest with the prime minister and cabinet, not a single minister, and the legislation should be amended to ensure this. We do not support the idea of National Cabinet as a decision-making body, although if it wanted to make representations to the parliamentary executive it should be allowed to do so. If the government of the day wanted to convene a type of “war cabinet” so as to involve the opposition, that would be a legitimate matter for them, the opposition, and the parliament. The consensus body that was National Cabinet was not fit for purpose in terms of making good decisions.

b. Vaccine manufacturers

Vaccine manufacturers are indemnified by the commonwealth. We understand this is on the basis that it would be difficult to find a manufacturer prepared to make a vaccine if the risks were uncapped. It is not an argument we accept. All products come with risks which manufacturers have to insure against. Pharmaceuticals are no different. Damages should not be capped. There have to be real consequences for pharmaceutical companies who produce an unsafe or defective product, or one that harms a user through a known side-effect. The costs should not be put onto the taxpayer. This takes away the incentives the manufacturers have to be prudent.

c. Parliament

Parliament should ratify, within at least 28 days, any emergency decisions made by the cabinet (or the health minister if the current situation continues to obtain). Pandemics are not the same thing as war, and parliament should be expected to scrutinise policies being implemented, even after their implementation.

7. Cost benefit analysis

No proper cost benefit appears to have been undertaken on lockdowns or vaccinations. While the lockdowns were a state initiative, the Commonwealth could have exercised some influence over them by doing a cost benefit analysis. Vaccinations are definitely a commonwealth issue and at a simple level, such as what age groups should receive vaccinations, no cost benefit appears to have been done.

As noted above, at one stage the Parliamentary Budget Office calculated that by 2030 the Commonwealth Gross Debt would be $800 million higher because of measures taken during the pandemic. This is a huge cost and as a proportion of GDP similar to what the Australian government spent in one year during World War II. If the money had been spent elsewhere it could have funded 210 years of intensive care beds; increase the amount of cancer funding by 4,000%; fund the combined ambulance services for 280 years; fund the PBS for 68 years; buy 9 million ventilators; and is the equivalent of 4.5 years of total national health expenditure.

Work by Gigi Foster, Paul Frijters and Sanjeev Sabhlok demonstrates that as a result of lockdowns more people actually died than were saved, and the excess mortality statistics tend to prove this. It is also true, as just one example, that there was a greater threat to the lives of healthy young men from vaccine-induced myocarditis than there was from COVID-19.

8. Advisory bodies

a. Viewpoint diversity

Advisory bodies appear to have been generally drawn from too narrow a class of people without sufficient relevant diversity. Hospital administrators are not good at public health because hospitals are not self-sustaining. Epidemiologists do not understand the economic aspects of things. More economists, for example, should have been involved, plus people with an understanding of logistics. There is also a good case for some business and even trade union involvement.

b. Transparency of discussions

On the same model as the Reserve Bank of Australia, the minutes of advisory body discussions should be released so that participants in the process, and the general public, can understand why decisions are being made. There was a shift from a containment strategy “flattening the curve” to an elimination strategy that has not, to this day, ever been explained. This should not be the case.

c. Internal contestability

There should also have been some internal group involved in “devil’s advocacy” so that there is an institutionalised critique of decisions being made. The process is sometimes referred to as “red and blue teams” and is a process used in the military to anticipate problems and avoid group think.

9. Epidemiological modelling

The models relied upon here and internationally were not accurate. Some of the favoured modellers have failed time and again. The best example of this is Neil Ferguson from Imperial College in the UK, but our own Doherty institute at one stage was found to be 400% too pessimistic.

We recommend inviting the modellers whose results were closest to reality to advise on a new national body to validate models; that modeller's forecasts be assessed for accuracy on a regular basis so the government is sure it is getting the best advice; that the computer code of models be made public so colleagues as well as citizen scientists, modellers and others, can assess the models' suitability.

Some of the best modellers were actually not epidemiologists but mathematicians building the models in their own time. *Pro bono* expertise was severely under-utilised during the pandemic.

10. Pandemic plans

We had a pandemic plan based on decades of experience - it didn't involve lockdowns and it did involve protecting the vulnerable. Sweden stuck to the original plan and had a superior result. Some US states did as well, and a number of poorer countries did, because they were too poor to have a choice.

Australia and other rich countries didn't stick to the plan.

There was no explanation why the plan was jettisoned then, and there hasn't been since. This is inexcusable. We support the previous pandemic plan. We believe it should be promulgated and enshrined in uniform legislation so that it would take an act of parliament to do something else.

We also have concerns about the World Health Organization's recent moves to change the International Health Regulations and the Accord so that it can prescribe not only when a pandemic exists, but what measures countries should take. Decisions need to be taken on a national basis and in such a way that they follow well-established medical conventions rather than what the last country (China in the case of COVID-19) did.

11. Human rights

Australia's Human Rights Commission was almost entirely absent during the COVID-19 pandemic, even when the states were coercing their citizens to take vaccines. This was a breach of the Geneva Convention and the commission should have involved itself.

We assume this to be a failing on the part of management and recommend sweeping changes to the various commissioners who failed to take action.

12. Regulatory authorities

The Australian Technical Advisory Group on Immunisation failed in our view to properly approve the vaccines used against COVID-19. The process appears to be one where decisions on whether drugs and vaccinations are safe was in practice outsourced to the United States FDA and other USA bodies. If ATAGI was making its own decisions, why did it approve the use of the mRNA vaccines for pregnant women when there was no human trial to show this was safe?

The Australian Health Practitioner Regulation Agency has too much power over the doctor-patient relationship through its ability to deregister practitioners, and its apparent determination to decide what is, or is not, appropriate medical practice. While malpractice is clearly an issue, there is a wide range of medical practices that are disputed, but which have expert opinion to support them. As long as patients are aware of all the potential risks and benefits it ought to be a decision for the patient and the doctor as to whether particular therapies are used.

This situation will be made worse by the *Health Practitioner Regulation National Law and Other Legislation Amendment Act 2022*.

This act destroys the practitioner patient relationship and makes the paramount relationship between the practitioner and the government. This reverses millennia of medical practice as well as international conventions.

It will also potentially cost people their lives. The off-label use of pharmaceuticals is a common practice in medicine and is a form of innovation. The more dictation of medical practice occurs the less innovation there will be. The doctor becomes no more than a centrally controlled algorithm with a human face.

The legislation appears to arise from practices by the regulator during the COVID-19 pandemic which are being formalised in this legislation. It is a retrograde step.

13. Commonwealth financial policies

The Commonwealth's decision to offer support to individuals and businesses was overly generous and has left Australia in a financially vulnerable position. If another pandemic of a similar scale arose we would not be able to repeat these measures, and in fact might not even be able to implement better measures at a smaller scale.

By shifting the cost of illness from the individual to the government this distorted individual decision making and assessments of relative risk. It was also regressive and did not take account of relative need or wealth. Some individuals received more money than they would have earned working, while some businesses who boomed during the pandemic were also paid COVID-19 relief.

These policies also seem to have replicated since in other areas undermining personal responsibility and resilience.

Furthermore, they encouraged state governments to pursue punitive regimes knowing that the Commonwealth would underwrite the pain. Lockdowns would surely have been fewer and less severe if support hadn't been available.