Name: Anonymous

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am a consumer or user of care services (consumer)

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   To a great extent

2. What are the reasons for your answer?

   For all intents and purposes, there is no regulation of infection prevention and control for high consequence airborne pathogens, including COVID-19, influenza, etc. So any interaction with the healthcare system is unknown (rolling the dice), and must therefore be assumed to carry significant risks of unnecessary morbidity or mortality. Because of belligerent ignorance of basic science and transmission modes (which I have very significant expertise in), gross recklessness and negligence in clinical standards, systemic ignorance of effective mitigations, and of the impacts of infection on incidence of both acute and long-term severe event risks and chronic/complex diseases (and drivers for healthcare system overload). State WH&S laws are widely totally ignored, as state regulators are criminally complicit (by breach of their legislated duties) in the illegal failure to enforce existing regulations; deferring to ACSQHC, who with CDNA, ASID, AHPPC, (and formerly ICEG), undermine the standards, that are followed by NSW Health CEC and others.

   As a consumer, I'm required to now guess in advance, as to whether any particular provider will abide by any regulations at all (weak as they are), and then do what I can to compensate for widespread medical malpractice. None of it should have to be my job at all, and it's vastly more burdensome and economically inefficient to have 'personal responsibility' attempt to manage institutional failings, but it now involves me: 1. Carrying my own CO2 meter to check air quality levels (including in wards, operating/procedural rooms, waiting areas, etc.) to know whether there's so much thick secondhand air, that I should just walk out instead of bearing the (quantifiable) infection risk; 2. carrying a high-flow portable air purifier because inadequate fresh air ventilation is the norm, not the exception (and carrying sufficient batteries too, as hospital mains power is not available

unless devices are certified by local facilities); 3. wearing a fit-tested respirator mask at all times, including when sleeping (because almost nobody else is generally doing anything); 4. using a portable Far UV-C (222nm) irradiation lamp if needing to remove RPPE (e.g. to eat or drink, or for clinical access); 5. monitoring weekly community infection rate reports to assess timing and risks/opportunities to delay care vs attending unsafe facilities (while factoring in poor timeliness of updated vaccine procurement/deliveries relative to circulating variants (poorly matched), and weak durability of protection due to rapidly waning antibodies & high mutation rates); 6. carrying an anemometer to check airflow of ventilation outlets & returns (as, e.g,, I've often found shared rooms with beds at negative pressures to shared toilets, etc).

Add to that, if I'm unable to drive to/from an appointment, then I can almost guarantee that public transport and taxi services won't comply with bare minimum public safety standards either. So frequently healthcare access just isn't an option at all, even during an emergency. Which then risks conditions remaining undiagnosed or untreated and then escalating in severity, or affecting recovery rates and productivity elsewhere. Knowing that access and quality of healthcare services is frequently unreliable or unavailable should I need it, also impacts my choices elsewhere (including whether to self-isolate including WFH, or going to conferences, in-person meetings, etc.). Managing outbreaks within my social network, caused by lack of IAQ standards in shared public spaces, is also personally costly. It affects where I can meet to eat, drink and socialise, knowing that government has undermined and sabotaged evidence-based IP&C more broadly.

Effectively, patients are now left with zero expectation that their basic and fundamental rights can or will be upheld. It's not just difference in regulation that's problematic. It's the intentional refusal to implement any - and it's costing our society and economy dearly.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

Very little

4. What are the reasons for your answer?

I would have answered "to a great extant" if they were any good. But given the Federal Government's extremely poor leadership on safety and quality regulations in health, and overall weaponised malicious incompetence - I'm quite certain that more alignment there will only result in further alignment to the worst practices and standards imaginable, spreading their direct harms and malfeasance even further (if that were possible, given they've now brought States to their heal too). It was of course our Federal Minister for Finance (former Acting Minister for Health), who directly misled Parliament as to transmission modes, in the Senate Select Committee's 2022 Inquiry into COVID-19 Response. The obstruction and refusal to hold any Royal Commission into the pandemic response, even after >60,000 excess deaths, proves that our government has zero interest in probity, integrity, justice, productivity, fairness and equity, accountability, or in responsible and effective public governance. I could point to endless examples of direct corruption and serious conflicts of interest. So what good could further alignment to a hyper-corrupt organised crime operation do?

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

What collaboration? I was the co-author of an open letter to governments (Federal and States) in February 2021, calling for an evidence-based response to airborne transmission of pandemic pathogens; signed by 450 experts, including the world-leading scientific authorities in the field (and 50 with PhDs in directly subject-matter relevant topics), directors and representatives from all levels, of every branch of healthcare front-line and leadership, clinical and administrative; plus relevant external authorities - legal, technical, economic, social, regulatory.

We received a one page form letter non-response from Federal Health, claiming they disagreed (including their disagreement with the fundamental scientific fact that COVID is airborne), and they provided zero evidence whatsoever of why. Didn't even want a conversation about it or any issues, even after our recommendations were published on the front cover of the Medical Journal of Australia.

It was entirely volunteer organised and our work was unfunded. It was managed by informal online communication from solutions-driven self-starters, putting service before self.

No outcome was achieved, except now as historical documentation of successive government's wanton destruction of public health and the economy, from their pigheaded arrogance, corruption, and willingness to ignore the best expert advice.

2. What are the benefits of pursuing greater collaborative commissioning?

Plenty of potential opportunity, but none likely possible in this political environment. We're now on the worst possible timeline, in a reality imitating art situation, between the plots of the almost documentary films "Idiocracy", "Don't Look Up!", and "The Godfather".

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

Yes, read "The Ambulance Down in the Valley" by Joseph Malins (1895).

Butler needs to get out of Cabinet and stick to Elvis impersonations instead. He can take Gallagher, Chalmers, and Albanese with him.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Corruption, regulatory capture, and the refusal to acknowledge basic medical, scientific and economic evidence.

Australia's now another Trumpian post-fact dystopia, with health policies outsourced to corporate consulting firms, aligned to anti-public corporate PR agencies, populist Kremlin-backed disinformation campaigns (biowarfare by other means), QAnon's MAGAt

bioterrorists rioting with guillotines against health, and the far-right libertarian anarcho-ultracapitalist 'think tank' foreign interference operations run by billionaires, party donors, oil & gas lobbies, and their advertiser owned commercial media machines (who ideologically can't think anywhere past their next quarterly bonus rounds). and compromised state media and bureaucracies.

Australia's path from here, is decay into autocracy of even more insane puppets of ever more powerful feudalist oligarchs, who'll keep widening social divides, and by the time you realise it's just Musical Chairs, you'll all be on the unstoppable slippery slope to living as impoverished serfs and dying like medieval peasants. Civics education in values, ethics, and democratic institutions is already so far out the window, that nobody remembers what Australia was anymore, The new regimes already convinced you that disease is good, and mass deaths are fine. Mateship and a fair go? 🤣 More like throw everyone you can under the bus, while running Instagram campaigns about your deep love and care for them.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

Clean drinking water. We didn't tell people it's just a personal responsibility. We fixed the open street sewers and provided water treatment.

HIV in the 80's. We actually told people to use condoms, instead of lying about transmission, and just telling people to wash their hands.

Mandatory smoke alarms everywhere. Fire kills orders of magnitude fewer people than infectious diseases. We could have made CO2 monitoring alarms mandatory too, especially in public shared spaces, to eliminate super-spreading of COVID, flu, RSV, pertussis, mycoplasma, TB, and soon HPAI 'bird flu', measles, etc. But apparently impossible with this new weak-minded generation of anti-science degenerates.

Immunisation passports at borders. Instead we now have measles import programs.

'Towards Zero' road safety campaigns, instead of 'health vs economy' acceptable megadeath promotion of COVID, and dehumanising the elderly, those with disabilities, medical conditions, etc., as useless eaters worthy of death by 'plague'.

Seat belts and ANCAP ratings against collisions. Maybe you can do something about the stuffy air-less public transport buses too, that are super-spreading disease everywhere.

'No Jab, No Play/Pay'. (Before you started appointing closet antivaxxer clowns to ATAGI).

Life. Be in it. (with Norm).

“Who knows? Mum knows. How do you think she got this far?”, nutrition campaign.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

   We already told you how. Since then, there's things like the "Safer Shared Air Project Report" too.

   So what's the point to keep saying it? You know this survey is all just consultation theater for marketing purposes, to better align the donor grifting programs to the PM&C's propaganda nudge units.