I've been a General Practitioner in Werribee for over 32 years, including a period of time 20 years ago as Director of Medical Services at Werribee Mercy Hospital. My submission is based on my observation as a GP, as a parent, and on what patients and community members have told me. As knowledge about the virus and the response changes some of this submission becomes out of date as I write and even more out of date as it is read.

It has been an unprecedented time in my career. We have been fortunate that we are a few weeks behind China and Europe and have been able to learn from their experiences. The initial response was entirely appropriate, and the terrifying images from Europe particularly showed how vital it was for us to prevent our intensive care units being overwhelmed. In retrospect, the only thing we could have done differently was to quarantine all returning overseas travelers earlier.

The original aim of the restrictions was to flatten the curve to preserve intensive care capacity. This was achieved over two months ago but hospitals have still remained below full operating capacity. Many outpatient departments are still doing phone consults as are Maternal and Child Health Nurses. They should all have been back to full capacity at least a month ago. Phone consults are difficult enough in General practice with patients I am very familiar with. It beggars belief as to how adequate a phone consult can be with a patient that the health practitioner has never physically met. It is my opinion that a lot of this is due to the inflexibility of public departments. It is very easy to shut down but difficult to open. As any GP will say, life is not black and white and we have to be prepared to adapt and change our view as more evidence becomes available. Everyone makes mistakes (I do daily) but we have to own them and learn from them. We showed ingenuity in organizing our workplaces so we could protect patients, staff and ourselves. We had no guidelines from governments. We just got going and modified the work place with signs on chairs, counter shields to protect staff and gloves, masks for clinical staff. I'm amazed hospitals didn't do that until very recently. We continued to see the patients who needed to be seen, in direct contrast to some hospital outpatient departments who shut down entirely. I can only hope that this total shut down doesn't lead to increased deaths in the coming months from delayed diagnoses. Hospital workers have been referred to as heroes. Truth be known they have been very quiet during all this. General practitioners on the other hand have often been criticized unfairly by our Health Minister on multiple occasions. The first instance was Dr Higgins. Enough details about him and his workplace were released to make him easily identifiable, a clear breach of patient confidentiality. He had recovered by the time he went to work and did not infect anyone. The flabbergasted reaction by the Health Minister was unwarranted and to this day there has not been a public apology. Many of my colleagues are still disappointed by the whole incident and many have lost confidence in the Minister. The second instance was multiple comments about influenza vaccines. Whilst many GPs had very limited intermittent supply of flu vaccines the Health Minister posted on social media a photo her being vaccinated and encouraging people to attend pharmacies for vaccination. All this while many GP practices had little or vaccines to give to the vulnerable elderly. It is a perennial problem. A solution is to ensure that in the future GPs are the first supplied so we can vaccinate the vulnerable elderly. It is disgraceful that pharmacies can sell vaccines to the "worried well" before we can immunize all the vulnerable. And to make it worse, when the Health Minister finally accepted that GPs were struggling to obtain vaccines we were blamed. The Minister said we either hadn't ordered properly or didn't have big enough fridges. A third instance was about the initial lack of testing capacity. When asked in Parliament the Minister a capacity problem may be due to GPs hoarding testing kits. She was obviously confused about swabs (which we have) and the testing kits (what the labs use to process the swabs). Further to this, our testing blitz was at least a month too late. At the peak we were getting 2 positive tests per 100 swabs. It's now down to 1 per thousand, and probably lower if we removed the targeted testing of contacts. The fourth insult to General

Practice was the hotel for heroes initiative. It was a very good initiative but inexplicably GPs and their staff (the true front line) were excluded. I found it insulting that an accountant or cook at a public hospital could get funded accommodation but a medical receptionist who was at high risk couldn't.

As a recommendation General Practitioners should be more involved by Public Health. We know patients very well and often know their social connections. A perfect example is the Cedar Meats fiasco. Anyone in Werribee could have told the department that the Burmese community are very tight knit, live close together and speak little English. Contract tracing should have been done in person and with a member of the local community and local council involved. I have no idea if any of my patients have tested positive (apart from the ones I have personally tested, who have all been negative. but would hope that part of the contact tracing involves contacting the person's GP. One solution would be that any tests done at drive through clinics are copied to the GP. Unfortunately, we asked a company doing tests at a local drive through if they could ask the people being tested who their GP was and add it to the test. We were told no.

The testing blitz, while very appropriate, has the unintended consequence of delaying results. This has the potential to cause problems with front line workers and managing the pandemic. Despite marking my own swab (for very minor symptoms which resolved in under 24 hours) as high priority it took over 2 days for a result. Luckily one of those days was a Sunday when I wasn't working, so I only missed two days of work. There is very little spare capacity in General Practice to backfill doctors who are off sick. The other problem with a delay in results is if a person is tested when presymptomatic their contacts don't have to isolate until the result comes back. If the result takes 5 days the contacts could easily have been spreading in the community before the positive result returns necessitating the isolation of the household.

The daily release of numbers is generally very good. As time has progressed there is often the desire for more information. A useful statistic would be how many of the positives are symptomatic, presymptomatic and asymptomatic. The follow on from this is what severity of illness the asymptomatic spread ie do all the people they infect stay asymptomatic or can they become unwell. The allocation of cases to LGA should be according to where the person is, not where they usually reside. It would alleviate a lot of community concern when, for example, a returned traveler is allocated to their regional town (which may have been virus free for months) rather than to a specific category of hotel quarantine.

The community clusters which have the same genomic sequencing as the security guards should be allocate to that cluster to give a more accurate measure of how many cases were due to the abysmal failure of hotel quarantine. Expecting someone with no health background to be super vigilant with infection control is just asking for trouble. With all my experience I still make regular errors with infection control, due to either slackness, being tired or forgetting some of the intricate details eg correct order to take off PPE. I still refer to our chart.

Mental Health has become a huge issue with the restrictions. The number of referrals I have written for teenagers and adults have increased dramatically. Not being able to attend school or play team sport has been a major factor.

IMPROVEMENTS

1. More staff with front line health backgrounds in the Department of Health. It's been shown to be useless at dealing with a health emergency. One of the main reasons is a total lack of understanding as to what happens in the real world. Many people in the department wouldn't recognize a sick person in the tripped over pone
2. Involve GPs from the start. We know how to communicate with people, we know our patients and we are very flexible and adapt quickly as more facts come to light
3. All swabs have to be copied to the person's GP
4. Encourage people to do their own contact tracing (we only have 4 days from onset of symptoms to stop spread)
5. Be smarter with resource use to speed up results eg decrease testing in areas with less than one case to significant symptoms only, and increase testing in areas where a difference can be made eg abbatoirs
6. Form an advisory committee of front line health workers (no administrators) , GPs, hospital nurses, allied health, pharmacists to provide practical advice to the department
7. Involve ethnic community leaders from the very start
8. Ensure all quarantine is supervised by a health professional (not administrator)
9. Learn from overseas. We had a head start so should've ensured safety in high risk areas, eg aged care, abbatoirs, food processing.
10. Trust individual businesses more. Give them guidelines eg 1.5m . It is in their interest to not have cases.

In Summary, my main message is that the Health department is too bureaucratic and has little connection to communities and primary care health workers. Health emergencies depend on messages getting out to communities and procedures implemented being efficient at a micro level. The abject failure of hotel quarantine is a perfect example of this. What was a fantastic idea failed at the implementation stage. I hope everyone learns moving forward.