Submission for Inquiry into Public Health and Other Legislation (Further Extension of Expiring Provisions) Amendment Bill 2021

SUMMARY: The conditions upon which the Chief Health Officer was originally granted emergency powers no longer exist. The fatality rate of SARSCoV2 has proven to be (at worst) in the category of a severe seasonal flu and therefore no longer meets the requirements for a public health emergency under Section 319 of the Public Health Act 2005. Therefore the legislation must be allowed to expire and NOT be extended. If extended, public health measures must also suspend the Covid vaccination program, as it is causing greater harm.

Over a year ago the Chief health Officer (CHO) was given emergency powers because of Covid-19. '*Two weeks shutdown*' to '*flatten the curve*' to allow hospitals to deal with the expected influx of Covid patients. We were counting Covid cases, deaths, beds in hospitals and ventilators. A 2% death rate was predicted and the (elected) Premier, was reported to have been losing sleep over the tens of thousands of expected Queensland deaths. Things were not anticipated to get back to normal until a vaccine was available. Early last year much about Covid was unknown and with that came fear (which was made worse by the media).

In May 2020 the CDC estimated that the fatality rate (IFR) for all infections (symptomatic and asymptomatic) across all age groups is approximately 0.26%. Lockdowns, border closures and mask mandates should have ended there; as this IFR is in the category of a 'very severe seasonal flu' (0.2% to 0.4%) (regular seasonal flu is 0.1% or a typical pandemic like 1957 or 1968 at 0.5% to 0.9%[1] - (which we did not lock down for)). We've had one death in Australia this year, the Therapeutic Goods Administration (TGA) have given provisional approval for 5 vaccines[2] and two treatments (Remdesivir and Sotrovimab). We now know "that oxygenation rather than ventilation appears to be key to recovery"[3] and know for certain that it mainly kills the elderly and infirm while over 99% of people have mild symptoms.

Despite the media fear-mongering, Covid has had no significant effect on our total deaths nationally last year. [4] [5] Even if an additional 67 000 deaths (i.e. 0.26% of 25.6 million) were added to our 'bottom line', we would still have a death rate less than, for example, in 1970 (i.e. 7.8 /1000 vs 8.5/1000 in 1970[6]). At the time of writing, half the country was in lockdown (again). Why? We can't focus and prevent every single death at the expense of the remaining 25.5 million living. Does that seem a proportionate and measured response?

The infectivity (reproduction number or R_0) for the 'wild'/ original SARSCoV2 is 2.43 to 3.10[7], this is equivalent to Ebola or Scarlet fever. The SARSCoV2 fatality rate is also on par with Scarlet fever. While the Delta variant's R_0 is 50%-60% higher[8] than 'wild type' (ie R_0 <= 4.96), Public Health England reports it to have an IFR of 0.1%. and describes this as 'low'[9] - so far making the Delta variant as lethal as a regular seasonal flu and still less infectious than the common cold. And why are we being locked down again?

Additionally Hepatitis B, HIV, Dengue fever, polio, small pox, diphtheria, mumps and whooping cough (refer graphic on p3), all have higher infection and fatality rates. We live with these diseases, we do not lockdown. Measles has about the same fatality rate as SARSCoV2 and a greater infectivity (R_0) of 12-18 (and only children are highly vaccinated!). Has the CHO ever provided a risk assessment of SARSCoV2? Or were subjective and

[1] Fauci emails 16 February 2020
[2] https://www.tga.gov.au/covid-19-vaccine-provisional-determinations
[3] Fauci emails 1 May 2020
[4] https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-2020-mar-2021
[5] 2015-2019 average = 143 017 deaths. March 2020 to Feb 2021 = 143 583 deaths.
[6] https://www.macrotrends.net/countries/AUS/australia/death-rate
[7] https://pubmed.ncbi.nlm.nih.gov/32835209/
[8] https://aci.health.nsw.gov.au/covid-19/critical-intelligence-unit/sars-cov-2-variants
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/993879/Variants_of_Concern_VOC_Technical_Briefing_15.pdf

hysterical terms such as 'deadly infectious disease' used to justify declaring a public health emergency? What has 'satisfied' the Minister that 'there is a public health emergency' and it is necessary as to 'prevent or minimise serious adverse effects on human health'[10]? There appears to be no measureable objective criteria for declaring a health emergency and it is based on 'satisfaction', mainstream media fear-mongering and political grandstanding. What is the justification for continuing these emergency measures for a disease which is no worse than a severe seasonal flu?

Since our first death in March 2020, Australia has had a total of 910 deaths attributed to Covid-19[11]. That's an average of approximately 57 a month. To-date the TGA has been notified of 335 deaths of people who have been recently vaccinated.[12] Until autopsies are performed to exclude vaccination as the cause, we are potentially looking at almost 84 deaths a month. [13] Compare the national reporting rate for adverse reactions of the Covid vaccines of 4.6/ 1000 doses[14] to the number of Covid cases 1.46/1000 tests[15]. If the rationale for the public health emergency is to prevent or minimise serious adverse effects on human health caused by Covid, then surely this then must be extended to suspending the vaccine program as it is causing greater harm.

The Covid discussion is often reduced to death and case statistics. We seldom hear about the other aspects of the pandemic; the effect on mental health, society, schools, unemployment, the public finances and the likely long-term implications of wider economic damage. How does a risk assessment for these compare against the one for SARSCoV2? This isn't just about money, years of experience of recession shows a clear link between economic downturn and public health: the effects are longer term. Most health economists agree that a lower economic hit now means a lower excess death hit later.

Despite what numerous infectious disease experts say, it appears that Queensland's CHO is pursuing an elimination strategy. Why? The Great Barrington Declaration[16] which has over 43 000 signatures from medical practitioners and over 14 000 from medical and public health scientists promotes a strategy to protect the most vulnerable without placing limitations on the rest of society, i.e. 'focussed protection'. Additionally, has our 2020 reaction to 'wild' SARSCoV2 manifested these variants? If we followed the recommendations of the Great Barrington Declaration, would society's immunity as a whole have developed to protect the vulnerable and enhanced our ability to adapt to variants if they occurred?

It's the CHO's job to look at things through the perspective of a microscope and yours to look at the bigger picture. Why is one entrenched bureaucrat able to override the Premier and elected Parliament? If the Health Minister is not up to the job then she should find another position rather than abdicating responsibility to the myopic CHO. The actions of the CHO as our legal Premier has created a 'medical fascism' and has consequences for our society that go beyond just 'health' today and beyond her tenure as CHO.

Even though Covid still exists, the conditions upon which the Chief Health Officer was originally granted emergency powers do not, and she appears to be reluctant to surrender them. The threshold for initiating lock downs, closing borders, declaring hot-spots, mask mandates, social distancing has been dramatically reduced to that of a severe seasonal flu. Does that seem reasonable? I implore you to end this state of emergency and take control of the State and democracy again.

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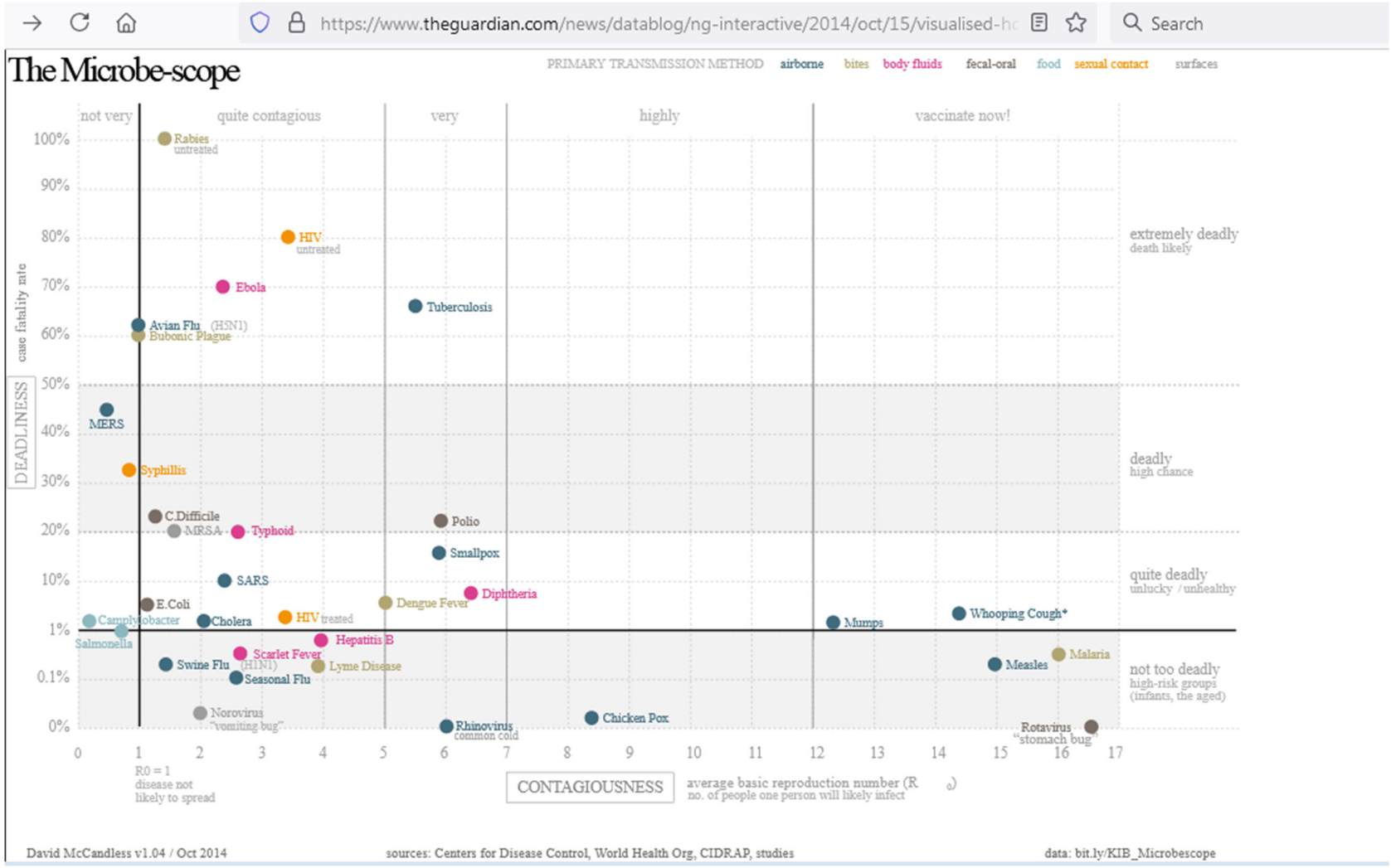
[10] Qld Public Health Act 2005- Section 319 https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2005-048
[11] https://www.worldometers.info/coronavirus/
[12] https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-01-07-2021
[13] Working on March 2021 as beginning the vaccine rollout.
[14] https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-01-07-2021
[15] https://www.worldometers.info/coronavirus/ As at 3/7/21 30734 cases/ 21 109196 total tests = 1.46/1000
[16] https://gbdeclaration.org/



https://www.theguardian.com/news/datablog/ng-interactive/2014/oct/15/visualised-how-ebola-compares-to-other-infectious-disease