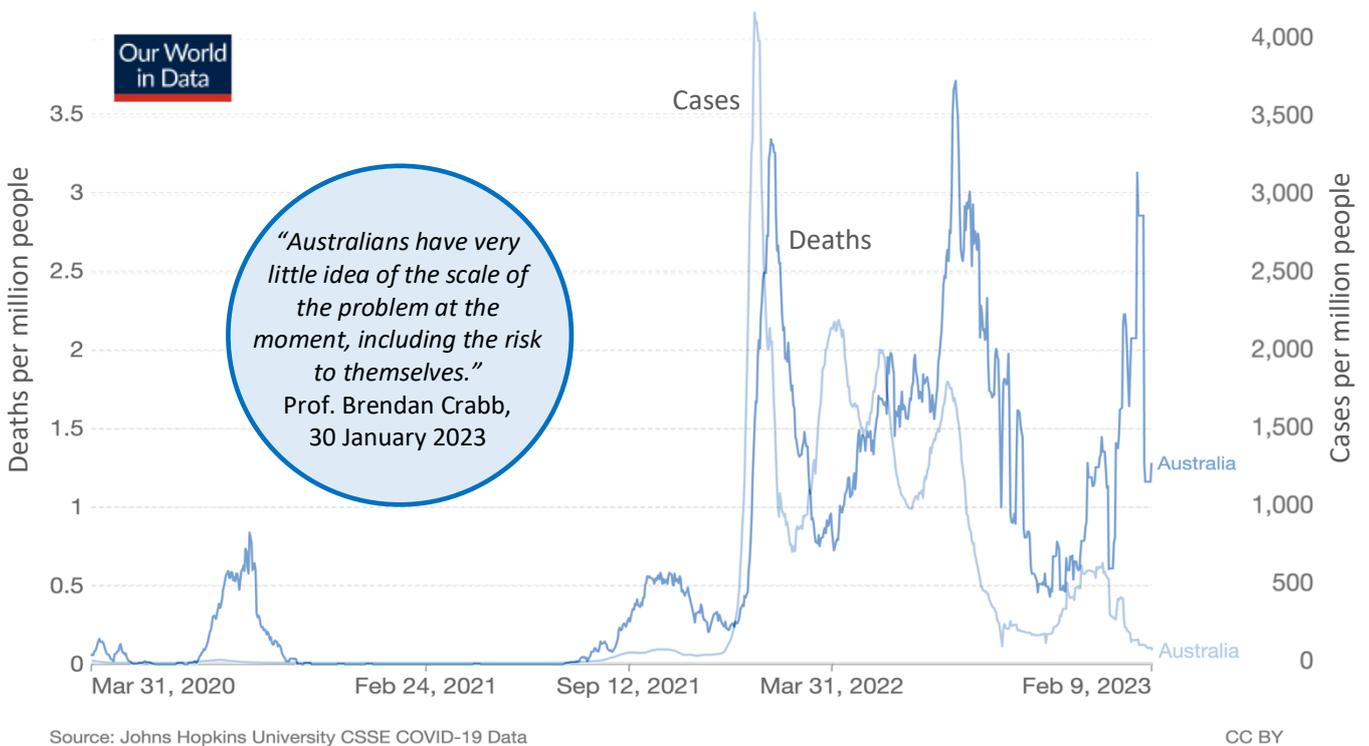


**COVID-19 ISSUES FOR CONSIDERATION**  
**PREPARED BY PAUL MAHONY – UPDATED 12 FEBRUARY 2023**

**MY POSITION**

- Based on evidence from esteemed academics and practitioners in the field of public health presented in this paper and my paper of 11 December 2022, I fear COVID-19.
- That fear stems partly from the current lack of concern about the disease by governments around Australia, despite alarming levels of adverse impacts. As an example of those impacts, the chart below highlights the high number of COVID-19 deaths compared to reported cases.<sup>1 & 2</sup>

**THE REALITY OF COVID-19 IN AUSTRALIA**  
 50 times the hospitalisation rate and 50-100 times the death rate of influenza



**DAILY NEW CONFIRMED AUSTRALIAN COVID-19 DEATHS PER MILLION PEOPLE (DARK BLUE) AND DAILY NEW CONFIRMED AUSTRALIAN COVID-19 CASES PER MILLION PEOPLE (LIGHT BLUE).**

*7-day rolling averages. Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the number of deaths caused by COVID-19. Due to limited testing, the number of confirmed cases is lower than the number of infections. The chart is a composite of two separate charts prepared by Our World in Data, with comments and labels added by Paul Mahony. Linear scale. Our World in Data copyright designation CC BY 4.0, <https://creativecommons.org/licenses/by/4.0/>.*

Source of quotation and hospitalisation and death rates: Prof. Brendan Crabb, Burnet Institute, cited in "Enthusiasm for COVID-19 vaccine slows as fifth jab nears" by David Crowe, Sydney Morning Herald, 30 January 2023.

## KEY POINTS

1. COVID-19 compared to influenza:<sup>3</sup>
  - 50 times the hospitalisation rate
  - 50-100 times the death rate
2. 5% of those infected will suffer from long COVID.<sup>3</sup>
3. The risk of long COVID, cardiovascular disease, pulmonary disease, clotting and other blood disorders, neurological disease, mental health problems and musculoskeletal disease increases with each infection.<sup>4 & 5</sup>
4. By 20 weeks following Pfizer booster preceded by 2 Astra Zeneca injections, there is zero protection against Omicron.<sup>4</sup>
5. Ditto for Moderna booster preceded by 2 Pfizer injections.<sup>4</sup>
6. The BA.5 subvariant is 3 times more effective at evading our body's defences than the original Omicron (BA.1) variant.<sup>4</sup>
7. At 12 months after infection, the risk of heart attack, stroke, blood clots, sudden death and other complications is about double that of people who were never infected.<sup>6</sup>
8. Chronic complications, including heart failure, strokes and dementia, can occur even after mild infection.<sup>6</sup>
9. Long COVID is predominantly a vascular disease, not a respiratory illness, potentially with significant implications for every organ of the body.<sup>11</sup>
10. Despite the alarming details shown above, Prime Minister Anthony Albanese and his advisers have said COVID-19 is no longer exceptional and should be treated like other respiratory infections, with a resultant relaxation of isolation rules by state and territory governments.<sup>7 & 8</sup>
11. Governments around Australia appear to have a strategy whereby everyone other than the most vulnerable should be infected.<sup>9</sup> (Queensland's chief health officer has specifically said it was probably "necessary" for us to be infected.<sup>7 & 8</sup>)

## COMMENTS FROM PROF. RAINA MCINTYRE, KIRBY INSTITUTE, UNSW, 16 NOVEMBER 2021<sup>10</sup>

"COVID-19 will never be endemic. It is an epidemic disease and always will be. This means it will find unvaccinated or under-vaccinated people and spread rapidly in those groups. It will display the typical waxing and waning pattern of epidemic diseases. [Chart supplied.]

Cases rise rapidly over days or weeks. No truly endemic disease does this. This is the reason governments prepare for pandemics - the propensity for epidemics to grow rapidly can stress the health system in a very short time. Here is the pattern, classic epidemic. [Chart supplied.]

Every epidemic infection follows this pattern unless eliminated by vaccination or mitigated by non-pharmaceutical measures. Natural infection NEVER eliminated any infection. Not smallpox, which displayed the same pattern over 100s of years. [Chart supplied.]

Not measles, still epidemic in many countries. See Australia before and after a major measles control campaign. Elimination is a technical term, means prevention of sustained community transmission. Countries that met WHO elimination criteria still see outbreaks of measles. [Chart supplied.]

So don't be surprised as we see this pattern continue for SARS Cov2. Vaccines, masks and other public health measures are needed. There is hope for better vaccines, schedules and spacing of doses but we must be agile and pivot with the evidence."

#### COMMENTS FROM PROF. BRENDAN CRABB, BURNET INSTITUTE, 28 DECEMBER 2022<sup>9</sup>

##### EXTRACT 1:

Prof. Crabb responded to host Amy Mullins question regarding the Australian government's announcement of 30 September 2022 that COVID isolation rules would be lifted. Amy said: *"Brendan, let's first of all talk about where Australia stands at the moment in terms of COVID-19 and its transmission because, what's really interesting to me is that there was a kind of significant moment on September 30 when national cabinet met and Paul Kelly, the chief medical officer, gave a speech, as did Anthony Albanese the fairly new prime minister of Australia, and there was essentially a very interesting/odd message, which is that it's time to move away from COVID exceptionalism and we should be thinking about what to do to protect people from any respiratory disease. So basically conflating COVID-19 with the flu or a cold or any other type of respiratory virus. So with that context or that prompt as a starting point, where do we stand now with that moment, September 30, where iso rules were lifted to now, in the start of December."*

"Well, I had quite a bit to say on that day that you're talking about. I used the word 'distressed', on national ABC television actually, which is a strong word but I genuinely felt it. And the main reason I was distressed and the main reason I also said I think I found it illogical and wrong, is that COVID is exceptional. There is no way, shape or form you could describe it as anything other than exceptional. You know, conflating it with other infectious diseases as you say. Of course, influenza is a disease that was used, I think specifically used, we'll treat it like the flu. Well, you know, this year we've had something like 300 influenza deaths and 1,700 people or so have been to hospital for influenza. It's a very serious disease. I used to work on it and of course it can be worse than that. Two or three times worse is not unusual. It's a really serious disease. But COVID is 40 to 50 times worse. 40 to 50 times more deaths, 40 to 50 times more hospitalisations. [Note: Prof. Crabb has since updated those figures.]

On the very day that Paul Kelly said that and the Prime Minister repeated it, we had more people in hospital for COVID than we've had in for flu for the whole year. So it's enough to just make you collapse with disbelief, that's how serious it is. And that's not catastrophising, it's just a fact of life. So this 'COVID is not exceptional' seems to be a particular and deliberate approach to downplay it."

##### EXTRACT 2:

"Maybe the strategy is to get infected . . . Clearly, they don't want vulnerable people to get infected . . . but I think for the rest of us, you'd have to conclude that the strategy is to get infected, to build up immunity on top of our brilliant vaccine immunity that all governments can be rightly proud of. So 'we think this hybrid immunity thing is our way out of it'. Unfortunately, it's proven to not only be wrong from the start.

Can I just say it is never okay to get infected with a pathogen as a part of your strategy to not be infected with that pathogen. Never, no infection, RSV, influenza, herpes simplex virus, never ever. And I

doubt anyone will come out and say that was the deliberate strategy but everything's pointing to 'it is quite okay to have our kids get infected, most of whom are not vaccinated anyway, it is quite okay to have those who are not elderly or immunocompromised get infected, in fact it's a good thing'. That's the message, really, that's being delivered to me. So it's never good in the first place because you're being infected with a pathogen that's doing things that you know about and that you don't know or were worried about, long COVID related issues, for everyone, not just for those who are most vulnerable.

But the second and most important point is that it's not working. The worst wave we had for the year was July-August-September, not January-February. We had more hospitalisations and more deaths in July-August-September That's worth dwelling on for a moment because we had much better vaccination by that stage. We had almost no one boosted in our January wave. We had almost 50 per cent boosted by our July-August wave. We'd also had most of Australia infected. Therefore with this magical hybrid immunity protection on top of their vaccination. We also had a good drug from April onwards to be used."

#### **COMMENTS FROM PROF. BRENDAN CRABB AND PROF. MIKE TOOLE, BURNET INSTITUTE, 2 JANUARY 2023<sup>7 & 8</sup>**

"The arrival just over a year ago of the new and different-looking Omicron variant of COVID-19 brought much hope that this would usher in the end of the pandemic.

That hope was based on two assumptions: that Omicron led to milder disease than earlier variants, and that its extraordinary capacity to spread fast would mean that the wider population would rapidly be exposed to this 'milder' virus and further boost the immunity that 95 per cent of Australian adults already had through two doses of the vaccine.

And so the 'hybrid-immunity' strategy was born. The idea was that we could ease off public health measures that were perceived as restricting so much of society, and let widespread infection do most of the work. The prime minister at the time, Scott Morrison, encouraged us to 'push through' the first Omicron wave, and Queensland's chief health officer went as far as to say it was probably 'necessary' for us to be infected. What followed was by far the worst public health disaster in Australia since World War II.

There are no flags at half-mast, however, for the approximately 15,000 lives lost in 2022 (compared with just over 2000 in the previous two years), no national day of mourning, little empathising at the deep daily impact COVID-19 has had on millions of more 'vulnerable' Australians, little concern over what chronic COVID-19 disease might do and is doing to the wider population."

#### **COMMENTS FROM DR. RAE DUNCAN, CONSULTANT CARDIOLOGIST AT NEWCASTLE UK'S FREEMAN HOSPITAL IN OPEN ONLINE BRIEFING WITH DR. DAVID NABARRO, SPECIAL ENVOY OF THE WORLD HEALTH ORGANIZATION (WHO) DIRECTOR-GENERAL ON COVID-19, CO-DIRECTOR OF THE IMPERIAL COLLEGE INSTITUTE OF GLOBAL HEALTH INNOVATION AT THE IMPERIAL COLLEGE LONDON<sup>11</sup>**

PART 1 ([https://youtu.be/Vwt93\\_Lg128?t=1951](https://youtu.be/Vwt93_Lg128?t=1951)):

"I'm going to start by saying something slightly controversial. I cried today, and the reason I cried is because I was on the phone to a patient, and this is a patient that Clare Taylor who can't be here because she's dealing with another emergency, and I have a mutual involvement in. And I have permission to spend a couple of seconds explaining why.

This is a patient who is a young male, who is in his thirties, I'm going to call him Ben but that's not his real name, and he, this is just a classic example of what we're seeing in the clinic. So Ben, that's not his

real name, was in his early thirties, he was fit and healthy, he's ex-military, running his own business, engaged to be married, and then COVID hit.

Now, he didn't die from COVID but he was affected. He had a heart attack in his thirties and he has subsequently had a roller coaster of what is potentially a complete nightmare. He's had ongoing symptoms, he's gone from running his own business and being engaged to being largely, he's house-bound, largely bed-bound, he's had to move back in with his parents, he now has no home, he has no fiancé, he has no business.

To make things worse, there's still a lack of understanding in the medical communities about how to investigate this condition properly and how to manage it properly. And one of the issues is, a lot of the standard imaging tests and blood tests come back negative. And that's not because the patient's okay, it's not because it's all in their head, it's not because there's nothing wrong. It's because COVID, I mean we know this now and no doubt David Fedson will talk about this in a lot more detail, but long COVID is predominantly a vascular disease, not a respiratory illness, and it is predominantly a disease of the microvasculature as well.

What we're seeing with long COVID is we're seeing it enters the respiratory tract, then in the blood vessels you're getting this chronically stimulated immune response, you're getting maladaptive innate immune response, you're getting chronically stimulated T-lymphocytes that are chucking out lots of cytokines in response to the viral antigen spike protein, and they are becoming chronically stimulated and you're getting immune exhaustion so therefore you're probably at increased risk of further infections because you're becoming immunocompromised through reduced productive T cell activity.

In addition to that, these pro inflammatory cytokines are inflaming the inner linings of the blood vessels called the endothelium. That then triggers another where you get platelet activation, which are the molecules involved in blood clotting, and it triggers the coagulation cascade, and you end up with this cytokine and clot soup. Now in long COVID these clots are very small, they're amyloid microclots. The other thing that's important to mention is they are not normal clots. In the presence of spike protein, fibrin, which is the molecule that's involved in the clotting, becomes mis-folded, and it becomes mis-folded into an amyloid formation. And when it does that, it also traps other molecules inside it, so you end up with these fibrin amyloid microclots that are resistant to fibrinolysis, which means the body is struggling to break them down. And if you make too many of these clots, what we believe is happening is these clots are getting sequestered or stuck, we think, in the capillary vascular beds, and when you have enough of these, it is obstructing the flow of oxygen to every single organ in your body, and that is what is causing the symptoms of long COVID.

But in addition to that, we think the clots themselves are immunogenic, and so you get inflammation at the site in the capillaries, the capillaries are not as well protected as the larger blood vessels because they don't have tunica adventitia or tunica media and so they become inflamed. Then you get this disruption of the capillary integrity and you get leakage of the inflammatory molecules into the other organs and you get organ damage. For example, there's lots of evidence now showing damage, neural inflammatory damage in the brains of individuals with long COVID, in the hearts of individuals with long COVID. But in addition to this, you've got all these profibrotic tendencies where you end up with things like heart attacks, strokes and various other issues.

Now, when it comes to the long COVID, this is one of the things we're not talking about, so although the death rates are going down, the disability rates are going up. We have 148 million people with this condition now.

I spoke to this gentleman on the phone today. He had clearly seen multiple different doctors. He clearly had undiagnosed postural orthostatic tachycardia syndrome that has been completely missed, and he's very disabled as a result of it. And when I sat him down and we talked him through it and we did the tests that a lot of other medics are not doing because they're maybe not specialists in this area, he

cried. I've had a 30-year-old man sobbing his heart out to me on the phone. Sorry, I'm actually getting quite emotional about it.

This is happening all the time, and some of it is treatable if we can just get a better campaign of education, which is what we're trying to do through the World Health Network to train other doctors so that we can get it accepted that there are tests you can do that can diagnose some of these abnormalities, and there are treatments we already have, there are lots of treatments we're still testing, but there are treatments we already have that can help reduce the level of disability. And this is the message we need to get out. But the other message that we need to get out is that there's very clear evidence from the published literature that reinfection increases your risk of long COVID substantially. So we have to have some sensible public health mitigations because I have seen the inner linings of people's blood vessels, I've seen the torn endothelium. That's after one and two infections. I have no idea what their bloods going to look like after ten."

PART 2 ([https://youtu.be/Vwt93\\_Lg128?t=3912](https://youtu.be/Vwt93_Lg128?t=3912)):

"I'm just going to very very briefly talk about the cardiovascular risk and the update with regard to the research and where I think we need to go. If it's okay, and I won't take more than a few minutes, I have a couple of slides . . . I'm going to skip through the first slides but obviously I'm a cardiologist as well as doing a lot of work with long COVID. I have significant concerns about the cardiovascular side effects that we're seeing not just in long COVID patients but in anyone that's had COVID.

I'm not going to go into too much detail these are some landmark studies. I'm not going to go through all of them but basically there are loads of them now with millions of patients. All of them are showing that there's a significant risk of cardiovascular events following COVID infection. This is myocarditis in one of my own patients that I reproduce with permission. There's also significant evidence that even if you are not getting cardiovascular complications after your first infection or long COVID after your first infection there's a significant risk that you may get it after subsequent infections. And reinfection increases your risk of long COVID, cardiovascular complications, neurological complications, GI (gastro intestinal) complications, endocrine complications, long COVID, hospitalisation and death.

So two and a half years into the pandemic from a heart perspective, what do we know? We know that if you catch COVID even if you're asymptomatic with index infection even if your index acute illness is mild and you're non-hospitalised, you are at increased risk of acute coronary syndrome, myocardial infarction (heart attack), cardiomyopathy, cardiac arrest, heart failure, atrial fibrillation, atrial flutter, postural orthostatic tachycardia syndrome, myocarditis, pericarditis, pulmonary embolus (which is blood clots in the lungs that Claire's been talking about, and a lot of these are getting missed because we're seeing them in a different pattern, they're micro emboli and they're not being picked up with a standard test and we need to change the tests we're doing) deep vein thrombosis, stroke and TIA (transient ischemic attack or mini stroke).

For one minute I just want to talk about what is the potential longer-term outlook though going forward now obviously I can't see anything for certain because it's not happened yet but I can make an educated guess and it's not just a guess it's based on science and this is my concern. My concern is that COVID as we already know now is causing endothelial damage. Endothelial damage is damage to the inner lining of our blood vessels so it's inflammation of the inner lining of our blood vessels. Now the virus is doing this through both direct infection and through the host response via cytokines. There are loads of publications now confirming that patients who have had SARS-CoV-2 and you don't necessarily need to just have had long COVID this is just anyone who's been infected to some degree or another may have endothelial dysfunction.

Why are we worried about this as cardiologists? Well I'm worried about it for two reasons. I'm a cardiologist but I also have a specialist interest in long COVID. Endothelial dysfunction as you can see here is one of the key players in the development of long COVID, and we've talked about that previously and I'm not going to it now, but also endothelial dysfunction is the precursor event for the development

of atherosclerosis and that is the disease process that causes cardiovascular disease specifically heart attack, angina, stroke, vascular dementia, and peripheral vascular disease.

So even if the mild infection, sorry, even if the acute infection is mild, even if people are not dying from it, even if they're vaccinated to some degree, SARS-CoV-2 still is not and never has been just a cold, because this is about the longer-term implications. And what we know from the science already is that there is clear evidence of cardiovascular and thrombotic complications in acute COVID, there is clear evidence of cardiovascular and thrombotic complications in the medium term, in the 2.5 years we've had to study this. But going forward, I think there may be a significant risk of cardiovascular complications in the longer term and this most likely is going to be mediated through endothelial dysfunction and it needs urgent research.

I hope to God I'm wrong. I've never wanted to be more wrong in my life but what we're seeing so far is that COVID is causing endothelial dysfunction and what we need to find out is, is it causing endothelial dysfunction in absolutely everyone who's getting infected and if it is, is it healing by itself or not? Because worst case scenario if everybody's getting endothelial dysfunction and if it's not healing and if we've got 605 million people infected who've been infected with COVID around the globe and we do nothing about this, then my concern is that we're going to see a tsunami of cardiovascular disease over the next few decades and by that, I mean heart attack, stroke, vascular dementia.

So with that in mind I am worried that we've lifted lots of (or) all COVID restrictions in many countries without putting in any mitigations to stop reinfection because we know reinfection makes the matter worse. And really, I think there has to be some very sensible Public Health discussions at a country level, maybe at a global level, about what we do about this going forward because COVID's not going anywhere it's not going to go away and we have to learn to live with it as Maria quite clearly said, safely."

**ABC 7.30, 23 JANUARY 2023: LAURA TINGLE INTERVIEWS PROFESSOR BRENDAN CRABB FROM MELBOURNE'S BURNET INSTITUTE, FRONTLINE DOCTOR ASSOCIATE PROFESSOR NADA HAMAD, AND ECONOMIST RICHARD DENNISS FROM THE AUSTRALIA INSTITUTE<sup>12</sup>**

**Laura Tingle:** If I could start with you Brendan Crabb, what is the current public health strategy for dealing with COVID? Is it working and what are its flaws?

**Brendan Crabb:** Well our current approach to COVID in Australia is to let it run in the so-called healthy population. That means unfettered transmission largely in the wider population while trying to protect those who are deemed vulnerable. So the elderly, those who are immunocompromised, and so on.

It's clearly not working. We're on our fourth wave in a twelve-month period. There's no obvious let-up. The virus is getting ahead of that strategy and we're going to need to change to an anti-transmission strategy, which is highly achievable, and I think all of what I've just said is hardly known in the community, and the most important message is, we really can do this without significant disruption.

**Laura Tingle:** Richard Denniss, can we estimate the overall impact of COVID on the economy at the moment and what impact is it particularly having on the labour force?

**Richard Denniss:** Look, we can estimate it but unfortunately we're not even collecting accurate data at the moment on the number of people with cases, so it's very hard to project exactly what the economic impacts are. To give you a sense of it, if the average person with COVID takes five days' off work when they get a case, then for every million cases of COVID that's five million days of sick leave, and if ten per cent of that million people are getting long COVID, that's 100,000 cases of long COVID. Now, the Australian industrial relations system really isn't set up for usually healthy middle age people to be

taking large amounts of time off work, so what we're going to see is significant impact on labour supply. To put it into context, we're talking about as many people being sick as we want to bring in a skilled migrants to Australia, so if you think we need skilled migration to cope with the skills shortage, COVID is causing a skills shortage like that most days of the week, and then there's the harm to people or employers who either are taking lots of sick leave or who don't have any sick leave to take.

**Laura Tingle:** Nada Hamad, how is COVID affecting the capacity of the frontline health system?

**Nada Hamad:** I think it's a really good question in terms of capacity specifically because we need to understand the capacity of the healthcare system to begin with wasn't exactly full of excess capacity. We were always very close to the limits of what we could offer in terms of demand of the public. Now COVID created a new problem in terms of demand, so we were quite fixated on the number of patients who were coming in with COVID, how we were going to isolate them, how we were going to protect staff and other patients, but what we didn't account for was how do we manage the morbidity, not just so much the deaths but what happens to patients who have complications after COVID. And so it's essentially a new chronic illness because even if you don't consider long COVID a major issue, there are patients who are coming in with other complications after having had COVID and really, we haven't accounted for that, not to mention the labour shortage we just heard about. Certainly having frontline staff infected with COVID, the families affected. I mean sick leave for your own individual health care is one thing but when the majority of the workforce is essentially women particularly in nursing, they have families they have to look after as well and so the impact is disproportionately borne by women in this workforce and I think the capacity to deliver the quality of healthcare we are accustomed to is certainly challenged in a big way, and I certainly don't think the narrative that we are in a post-COVID world and that we can go back to everything being like it was before is a realistic one.

**Laura Tingle:** Brendan Crabb, the journal Nature published a comprehensive survey of global findings about long COVID last week. What does it tell us about who is affected and what sort of impacts it has on the body?

**Brendan Crabb:** This was a pretty landmark synthesis of the hundreds if not thousands of publications that have come out over the past few years, and long COVID has real mechanistic, molecular and cellular underpinnings. It's sobering, the nature of that damage not just to the respiratory tract that the virus infects but to other organs and tissues in the body, your brain, your heart, the blood vessels that go to all tissues in the body and most significantly your immune system itself, which renders us potentially susceptible to other infections, which might be a key reason why we're seeing surges in other infections. So very sobering and, in the end, quite hopeful though. Knowledge is power, and we now know so much more about what underpins long COVID. This paper really calls for the sort of clinical trials and research to take that to solutions. But in the end it's pretty clear that the only way to prevent long COVID is to not get COVID, and reinfections are so important. Every time you get reinfected, you increase your chances of long COVID, so it's another reason to change our strategy to be anti-transmission.

**Laura Tingle:** Richard Denniss, what are the implications of long COVID for the economy longer term but also for the budget?

**Richard Denniss:** Well, just as COVID affects all different parts of the body, unfortunately if affects all different parts of the economy and the budget. So, first up, if we've got hundreds of thousands of people off sick on a regular basis, their incomes will be lower or the profits of their firms will be lower, which means that government revenue is going to be lower. So COVID is going to be a drag on economic growth for as long as we have it. Then there's the fact that more people going to the doctor more often, more people with more ongoing illness means we either have to spend more on healthcare or we all

have to accept even lower standards of healthcare. So how much will it cost the budget? Well, I suppose it depends on how much we really want to keep ourselves safe.

**Laura Tingle:** Nada Hamad, what do we know about the impact or long-term health consequences of the current infections from COVID?

**Nada Hamad:** I think this is an excellent question because it goes back to, what is the impact for the individual potentially long-term. The easy answer to the first part is well, long-term recurrent infections, we don't know. We don't know what it means if you have 3, 4 or 5, 6, 7 or 8 infections. But what we do know from this early part of the pandemic is even one infection has longer-term implications for the majority of people. So 70% of people who in one study were surveyed or reviewed for organ disfunction, 70% of them had at least one single organ affected longer term, you know, 2 months or a year after COVID. And for a third, there was multiple organs involved. And that is aside from long COVID.

And so, you can imagine if we were to do an educated guess, what would happen if you had multiple infections. I personally have had COVID three times, and the reason is it's very hard to mitigate against transmission. It's hard for me to go out and go places and not get COVID. And so, the long-term implications are still unknown.

Now, if we knew once upon a time early on that asbestos caused significant risk of lung cancer, if we knew for example that smoking caused lung cancer, we wish we would have done something sooner. And that something we all want to do is prevent rather than cure.

And so, at the moment, there are simple things we can do to mitigate that unknown risk, because most certainly it's unrealistic to expect there won't be accumulating health damage or health issues longer term with multiple infections. So what I would think most Australians are very reasonable, very practical, very pragmatic and proactive, and I would say if we're doing some protection, if we're wearing seat belts, masking, ventilation, boosters, that is something we can all do, and it's not about limiting your life entirely, it's about living your life slightly differently to minimise that risk. Have the party outside, make sure when you're going somewhere, ask about the COVID safety aspects. These are all very doable, achievable mitigating risk factors, instead of accepting blindly an unknown risk that is likely to affect most of us because most of us have been infected with COVID.

**Laura Tingle:** Brendan Crabb, health minister Mark Butler told 7.30 last week the advice process from ATAGI aims to have approvals in place for new boosters in winter. How does our vaccine approval process line up with those overseas now, and what do we know about the effectiveness of the boosters in general and in terms of preventing long COVID?

**Brendan Crabb:** I don't know why we have such difficulty in getting vaccinated. What I can say is vaccines tend to be still a very good news story. They're offering remarkable protection still against severe disease if your vaccination is up to date. That means you're boosted within the last 3 to 6 months or so. And that's why those regular boostings are so important and of course maybe unknown to many is that the recent versions of the vaccine that incorporate, so-called bivalent versions that incorporate more recent strains I think work better than I would have predicted. So the sooner we can get hold of those, the better, and the more research can be done in this space. We certainly need better vaccines, we need ones that protect against all variants. We need ones that protect against transmission, nasal sprays and so on, but vaccines continue to be a good news story. We've just got to find ways to get them to Australians more easily.

**Laura Tingle:** Well finally Brendan Crabb, there's considerable COVID weariness in the community. You aren't advocating, or none of you are advocating a return to lock-downs or emergency restrictions but what is it we can and should be doing?

**Brendan Crabb:** We have this sort of bizarre circumstance at the moment where we're in the midst of the worst public health disaster since the second world war, we're running at 17% of Australians dying more than has happened in the past. Normally we have less people die every year, that's why life expectancy increases, and yet the flip side is everyone's kind of unaware of that or doesn't care about it, not much is happening about it. So I think the most important thing to change people's attitude to getting boosted, to getting tested, and to wearing a mask and to getting ventilation into businesses and schools, is for the prime minister to stand up and say, you know what, we're changing tac, COVID is exceptional, our current strategy isn't working well enough, and we'd like to save thousands more Australians, we'd like to prevent hundreds of thousands of cases of long COVID. We can do that with a reduce transmission strategy, come with us on that journey. It's not about rule changes, it's about a mindset shift and then the government making those available, making vaccines available, making masks, high quality masks available, promoting the use of ventilation and filtration devices in our buildings and most importantly because it's going in the wrong direction, making testing available. You can't get treated if you're not tested. You can't protect those around you if you're not tested and know you're positive.

It's really not hard to make a big difference, but it is going to take an attitude shift from the top to achieve anything given the bind we're in.

**Laura Tingle:** Brendan Crabb, Nada Hamad and Richard Denniss, thank you so much for your time tonight.

## CONCLUSION

I do not want to be part of a widespread experiment in hybrid immunity and will continue to take preventative measures.

## SOURCES

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- <sup>1</sup> Our World in Data, “Coronavirus (COVID-19) Deaths”, <https://ourworldindata.org/covid-deaths>
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- <sup>3</sup> David Crowe, ““Enthusiasm for COVID-19 vaccine slows as fifth jab nears”, Sydney Morning Herald, 30 January 2023, <https://www.smh.com.au/politics/federal/enthusiasm-for-covid-19-vaccine-slows-as-fifth-jab-nears-20230127-p5cg2d.html>
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