

PSGR

Physicians & Scientists for Global Responsibility

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Submission

COVID-19 Public Health Response Amendment Bill (No 2)

Submitted to the:

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PSGR would welcome an opportunity to speak to this submission.

Physicians and Scientists for Global Responsibility Charitable Trust (PSGR) work to educate the public on issues of science, medicine, technology (SMT). PSGR work to encourage scientists and physicians to engage in debate on issues of SMT, particularly involving genetics and public and environmental health.

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A. POLICY FORMULATION FOR STATE MANAGEMENT OF PANDEMICS

1. The context for evaluating proposed legislation has two prior ingredients:
 - a. The adequacy of the policy formulation process that has preceded a requirement for legislation; and
 - b. The adequacy of identified endpoints that a proposed legislative initiative does or does not clearly target.

B. POLICY FORMULATION

2. Policy formulation is required by law to identify all relevant options for achieving desirable endpoints that are in the public interest and which protect the person.
3. There is no evidence, readily available, that shows that such policy formulation has been undertaken that complies with those requirements.

C. DESIRABLE END-POINTS

4. For effective state management of pandemic viruses it is well established (since the time of Louis Pasteur) that for a virus ‘the terrain is everything’ - *i.e.* if a virus encounters a strong immune system, the virus is less likely to colonise its victims’ cells successfully; and that person’s cells will in future be well-prepared to reject any future invasions of that virus and its variants.
5. In summary, therefore, it follows that, if a person possesses a vigorous immune system, the virus will not find a ‘terrain’ that is conducive to its further reproduction.
6. It also follows, that a valid policy formulation for management of pandemic viruses must include consideration of state-supported personal healthcare (PHC) programme that helps individual people to prepare their highest-attainable immune function. There is an arguable obligation of government to have such a ‘bottom-up’ programme. [See the UNESCO¹ document at reference ² .]
7. Many of the Principles and Articles in the same UNESCO reference document are highly-relevant and appear to be completely ignored by policy-makers and drafters of related legislation and this Bill.
8. Such a ‘bottom-up’ strategy addresses a compelling cluster of clear and key end-points: it limits the damage that a pandemic virus may otherwise cause; it limits the rate-of-spread of a virus; and it minimises social and economic damage that might otherwise be caused.
9. Such a policy can be extended as a first priority to economically-disadvantaged and those with inherent immune system disadvantages (*e.g.* the elderly, those on poorer diets and those with existing comorbid health conditions). That first priority lowers threats of otherwise overwhelming the health-care system – arguably an important infra-structural issue. ³
10. A state policy that sets out to support peoples’ immune systems has the benefit of:

¹ UNESCO. (2006). Universal declaration on bioethics and human rights. Paris. June 2006. SHS/EST/BIO/06/1 <http://unesdoc.unesco.org/images/0014/001461/146180E.pdf>

² UNESCO. (2006). Article 3 – Human dignity and human rights. 1. Human dignity, human rights and fundamental freedoms are to be fully respected. 2. The interests and welfare of the individual should have priority over the sole interest of science or society.

³ UNESCO. (2006). Article 14, Subsection 2 highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance

- a. denying reproductive territory to a pandemic virus; and
 - b. damping down transmission of a virus to others.
11. It should be obvious that such a ‘bottom-up’ policy option holds out sustainable end-point benefits for tackling pandemic virus infections – especially when compared to a sole reliance on novel and experimental inoculations of unknown safety and efficacy.
 12. A pandemic virus is likely to try to evolve variant adaptations that outwit components used in the inoculations – resulting in a virus re-gaining footholds in those that have had inoculations (the Israel example).
 13. A bottom-up policy option for tackling pandemic viruses also has the benefit of empowering individuals to take command of their own bodies in a sensible way that has many other health benefits that offers a highly desirable benefit of much-lowered demand of state sickness services on most other disease-treatment fronts. The comparative benefit of pursuit of a ‘bottom-up’ health initiative for important matters of social cohesion, mental health and confidence and trust by people in their machinery-of-government should be obvious.
 14. Legislative initiatives in New Zealand (including this latest Bill) seem to be focussed on pushing experimental inoculations to the active exclusion of bottom-up initiatives. The thrust of present legislative initiatives continues to produce massive economic and social harm to people; to polarise society; to take away peoples’ rights; and to use state powers and instruments to both coerce and force a policy onto people that government is supposed to protect.
 15. There has been no evidence made available that such a bottom-up policy option has either been identified let alone given due weight in a transparent policy formulation process used for the taking of statutory powers.
 16. Rather, the evidence publicly available suggests that an inoculation policy was adopted exclusively as a basis for taking statutory emergency powers – of which this current Bill is an example.^{4 5}
 17. Policy decisions made by an administration that do not identify arguably primary policy options with compelling end-points, spawn public suspicion of caprice and arbitrariness and are inimical to the principle of open justice and the rule of law.⁶ Davison CJ proclaimed it a public responsibility of both courts and administrative decision-makers to provide reasons.⁷
 18. It would appear that the present policy framework that informs the taking of statutory powers disregards personal health care (PHC) relevant considerations.⁸

⁴ Ministry of Health 2021. Regulatory Impact Statement Legislative improvements to support the public health response to COVID-19. Undated https://www.health.govt.nz/system/files/documents/information-release/ris_legislative_improvements_to_support_the_public_health_response_to_covid-19.pdf

⁵ MBIE. Regulatory Impact Statement: Coversheet: Legislative Framework for Managed Isolation and Quarantine Undated. <https://www.mbie.govt.nz/dmsdocument/17052-regulatory-impact-statement-legislative-improvements-to-support-the-public-health-response-to-covid-19>

⁶ Joseph, P.A. Constitutional and Administrative Law in New Zealand, 3rd Ed., Thomson Brookers, 2007. p.985

⁷ *Potter v NZ Milk Board* [1983] NZLR 620 at 624 per Davison CJ (HC).

⁸ *Anisminic Ltd v Foreign Compensation Commission* [1969] 2 AC 147 per Lord Reid (HL)

19. It is clear that the approach that has been taken to policy making as a basis for taking legislative powers, that affects citizens' rights is lacking any compelling statement of reasons to justify the taking of such powers.⁹
20. Decision-makers bear an obligation to show candour in their reasoning and processes. They must weigh relevant considerations openly and transparently or risk a finding of no weight being accorded to those reasoning processes.¹⁰
21. It would appear that policy decision-makers have made a reviewable error through not giving proper weight to important options and considerations.¹¹ Decision-makers must not disable themselves from considering information relevant to their statutory function.¹²
22. In summary, it seems that the policy framework ignores fundamental principles of constitutional and administrative law.
23. It is in that context that we suggest your Select Committee should review the requirement for and the provisions included in this Bill.

D. RELEVANT CONSIDERATIONS

24. The COVID-19 Public Health Response Amendment Bill (No 2) strengthens powers, including increasing infringement penalties. Regulatory impact statements have failed to address as a relevant consideration, the fluid state of science in relation to risk and COVID-19.
25. Ignorance and exclusion of these relevant considerations risk absurdities in law. The COVID-19 Public Health Response Amendment Bill (No 2) is overly punitive, inconsistent with existing legislation and unjustified.
26. Measures in the Bill appear to not only restrict human rights, they appear inconsistent with overarching principles for management of infectious diseases, as stated in the Health Act which requires that individuals are protected and that measures are proportionate to the health risk.
27. There is little scientific evidence to support measures to restrict the movement of individuals.^{13 14 15}
¹⁶ For example, there is little scientific evidence that nonpharmaceutical interventions (lockdowns) restricting movement contributed substantially to bending the curve of new cases in England, France, Germany, Iran, Italy, the Netherlands, Spain or the United States in early 2020.¹⁷
28. The measures greatly risk impacting lower-income groups disproportionately. The New Zealand Public Health and Disability Act 2000 requires that measures taken by officials must 'reduce health disparities.'

⁹ *Lewis v Wilson & Horton Ltd* [2000] 3 NZLR 546 at 567 (CA)

¹⁰ *Leiatua v Minister of Immigration*. 26/11/03, Durie J, HC Wellington CIV-2003-485-742, at para 45.

¹¹ *BCNC v Broadcasting Tribunal* [1986] 2 NZLR 620 at 634 per McMullin J (CA)

¹² *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* [1986] 162 CLR 24 (HCA)

¹³ Duhon et al. (2021). The impact of non-pharmaceutical interventions, demographic, social, and climatic factors on the initial growth rate of COVID-19: A cross-country study. *Science of The Total Environment*, 760, 144325.

¹⁴ Fraiman et al. The majority of the variation in COVID-19 rates between nations is explained by median age, obesity rate, and island status. medRxiv preprint <https://doi.org/10.1101/2021.06.14.21258886>

¹⁵ Savaris et al. Stay-at-home policy is a case of exception fallacy: an internet-based ecological study. *Scientific reports*, (2021) 11(1), 1-13.

¹⁶ Chin et al. Effect Estimates of COVID-19 Non-Pharmaceutical Interventions are Non-Robust and Highly Model-Dependent. *Journal of Clinical Epidemiology* (2021)

¹⁷ Bendavid et al 2021. Assessing mandatory stay-at-home and business closure effects on the spread of COVID-19. *Eur J Clin Invest*. 2021;51:e13484.

29. The strengthening of powers and orders have been undertaken in isolation of increased evidence that the public health approach requires top-down and bottom-up measures, which include paying attention to the dignity of the individual.
30. This submission draws attention to the following mandatory and relevant considerations that:
- The case fatality rate does not warrant measures that increasingly contravene human rights, including the right to health. Current measures are arbitrary and unjustified when the international data on risk of hospitalisation and death is taken into account;
 - mRNA vaccines confer limited and short-term protection;
 - All medical interventions carry risks and mRNA COVID-19 vaccination is not without risk;
 - The sweeping of healthy young people and children into a generic, ‘one-size-fits all’ vaccination approach ignores the data that demonstrates this group is at low risk;
 - Clear data demonstrates that natural immunity confers greater protection than current vaccination strategies and that healthy people with natural immunity have broad protection to multiple variants;
 - No steps have been taken to reduce vulnerability through appropriate health-based measures to prevent the immune systems of vulnerable groups.

(A) The Health Act 1956.

3A Function of Ministry in relation to public health: ‘improving, promoting, and protecting public health’.

Part 3 Infectious and notifiable diseases Part 3A Management of infectious diseases: Subpart 1—Overarching principles

92C Respect for individuals

(1) An individual must be treated with respect for the dignity of the individual when any functions, duties, or powers are exercised or performed in relation to him or her under this Part.

(2) The person exercising or performing the functions, duties, or powers must take into account any known special circumstances or vulnerabilities of the individual, to the extent that the protection of public health permits this to be done.

92F, the Principle of proportionality. Where:

Measures applied to an individual under this Part must—

- be proportionate to the public health risk sought to be prevented, minimised, or managed; and
- not be made or taken in an arbitrary manner.

(B) the purpose of the New Zealand Public Health and Disability Act 2000:

- (3) (1) (b) to reduce health disparities by improving the health outcomes of Māori and other population groups.

31. We consider that the proposed bill carries with it significant and detrimental legal, social, economic and political implications. The potential legislation will be discriminatory and disproportionately harm low-income populations and particularly place Māori and Pasifika populations at risk.

32. Any additional legislative actions to enforce isolation, apply penalties and regulate in such a manner which produces a coercive action requiring vaccination is against the protection of human rights is unjustified based on the current data.
33. According to government data, as of October 9, 28 people have died from COVID-19 and 4169 cases have been recorded.¹⁸ New Zealand's case fatality rate (the number of deaths divided by the number of cases) based on official WHO figures cautiously may be observed to be 0.7%.
34. COVID-19 is not the bubonic plague. Age is the largest risk factor for severe or fatal COVID-19. Compared to a 20-year-old, a 65-year-old individual in the United States has a 90x higher risk of death from COVID-19, and an individual 75 years old has a 2003 higher risk of death. Children under 13 years of age generally have mild or no symptoms. Children make SARS-CoV-2 antibody responses distinct from adults. Where infected children develop the MIS-C syndrome, there are successful treatments.¹⁹ A recent study looking at hospitalisations of adolescents reported no deaths across the group.²⁰
35. Systemic poverty and structural racism has resulted in a disproportionate weighting in risk to Māori and Pasifika populations.²¹
36. COVID-19 is a notifiable²² and quarantinable²³ disease. There is an absence of interpretation that can clarify to what degree an infectious disease is 'infectious' or 'quarantinable' in the legislation. This legal grey area creates a space for inappropriate and coercive measures that are ignorant to the degree of risk for different population sectors.
37. The virus Sars-Cov-2 produces symptoms in certain individuals, and it is these symptoms, as a disease progression, that are known as Covid-19. The principal cause of death among COVID-19 patients arises from an uncontrolled inflammatory cascade – a cytokine storm - which produces acute respiratory distress syndrome (ARDS), multiple organ dysfunction syndrome (MODS), and microvascular thrombosis.^{24 25}
38. From an early stage it was recognised that those at most risk – and most likely to be symptomatic would be the elderly and individuals with multiple chronic health conditions – particularly obesity related and heart-related conditions.^{26 27} Diabetes, hypertension, stroke, and ischemic heart disease are risks, as well as the risk of blood clotting. Scientists have recognised the importance of recognising and treating these conditions to prevent the inflammatory cytokine cascade and

¹⁸ World Health Organization. New Zealand situation January 3 – October 8 2021. <https://covid19.who.int/region/wpro/country/nz>

¹⁹ Sette & Crotty. Adaptive immunity to SARS-CoV-2 and COVID-19. *Cell* (2021) 184:861-880

²⁰ Havers et al. Hospitalization of Adolescents Aged 12–17 Years with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1, 2020–April 24, 2021 *MMWR*. 70:23;851- 857

²¹ Steyn et al 2021. Structural inequities and systemic racism. *medRxiv* preprint doi: 10.1101/2020.12.25.20248427;

²² Health Act Schedule 1 Part 1 Section B

²³ Health Act Schedule 1 Part 3

²⁴ Wang 2021. A potential association between immunosenescence and high COVID-19 related mortality among elderly patients with cardiovascular diseases. *Immunity & Ageing* 18:25

²⁵ Ibrahim et al. The characteristics of SARS-CoV-2-positive children who presented to Australian hospitals during 2020: a PREDICT network study. *MJA* 215:5 6 September (2021)

²⁶ Moore et al 2021 Modelling optimal vaccination strategy for SARS-CoV-2 in the UK

²⁷ Malas 2020 Thromboembolism risk of COVID-19 is high and associated with a higher risk of mortality: A systematic review and meta-analysis. *Arthritis & Rheumatology*. Doi 10.1002/art.41285

thrombotic events.^{28 29} Thrombosis is such an enormous problem that scientists have referred to COVID-19 as a thromboinflammatory disease.³⁰

39. From the Spanish flu onwards, it has been very clear that disadvantaged populations are most at risk of bad outcomes in viral pandemics. As a virus progresses through the population, healthier individuals with better nutrient levels from better quality diets are more likely to be asymptomatic, while less healthy individuals, often on low incomes, or who receive subsistence benefits, are more at risk of being symptomatic because of obesity, a disease of poverty and associated poor diets.^{31 32}
40. This legislation has been enacted prior to public availability of rapid antigen self-testing kits (RETs). These are becoming available. The New Zealand public have in general co-operated with distancing and measures to protect elderly and vulnerable populations. RETs reduce ignorance relating to infection status and this ensures that family members and communities can act accordingly to protect vulnerable groups. The legislation is silent on the public supply of these kits which can continue the public co-operation and which also promote trust. RETs should be government funded to ensure that all income groups have equal access.³³
41. This is because the Bill – and the COVID-19 response – is dismissive and evasive of pervasive and persistent ‘dilemmas’ that specifically relate to the *public health risk, the substantial risk of serious harm that 1 or more individuals pose to the health or safety of 1 or more other persons*³⁴ and the ‘*the nature of the infectious disease, including, without limitation, the transmissibility and mode of transmission of the infectious disease*’.

RELEVANT CONSIDERATIONS: CASE FATALITY RATE

42. Countries such as Canada, the United Kingdom and the USA can be used to estimate risk in New Zealand because of similar average ages and obesity rates. New Zealand’s testing rate is similar to Germany and the Netherlands at around 730 tests per 1000 people. The USA, Australia and Canada have tested at a higher rate.³⁵ New Zealand’s level of obesity, a major determinant for health risk, is similar to Canada and less than the USA and United Kingdom.³⁶ New Zealand’s median age, 37 is on par with the USA, Australia and China, while Canada and the UK have an older median age, 40.³⁷

²⁸ Ruocco et al. Mortality Risk Assessment Using CHA(2)DS(2)-VASc Scores in Patients Hospitalized With Coronavirus Disease 2019 Infection. *The American Journal of Cardiology*. (2020) <https://doi.org/10.1016/j.amjcard.2020.09.029>

²⁹ Mahajan et al. COVID-19-Associated Systemic Thromboembolism: A Case Report and Review of the Literature. *Cardiorenal Medicine* (2020) 10:462-469

³⁰ Gasecka et al. Thrombotic Complications in Patients with COVID-19: Pathophysiological Mechanisms, Diagnosis, and Treatment. *Cardiovascular Drugs and Therapy* (2021) 35:215–229

³¹ Korakis et al. Obesity and COVID-19: immune and metabolic derangement as a possible link to adverse clinical outcomes. *Am J Physiol Endocrinol Metab*. (2020) 1;319(1):E105-E109.

³² Michalakos & Ilias 2020. SARS-CoV-2 infection and obesity: Common inflammatory and metabolic aspects. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*. 14:469-471

³³ Schwartz et al. Rapid antigen screening of asymptomatic people as a public health tool to combat COVID-19. *CMAJ* March 29, 2021 193 (13) E449-E452; DOI: <https://doi.org/10.1503/cmaj.210100>

³⁴ Health Act 1956. (2) Interpretation. Public health risk (a)

³⁵ Our World in Data <https://ourworldindata.org/grapher/full-list-cumulative-total-tests-per-thousand-map> October 8, 2021.

³⁶ Our World in Data. <https://ourworldindata.org/obesity>

³⁷ The average age in global comparison. WorldData.info <https://www.worlddata.info/average-age.php>

43. Global case fatality rates appear to be declining.^{38 39} The case fatality rate (CFR) (the number of deaths divided by the number of cases) is strongly associated with median age of the population and the level of obesity. The global Public Health England data in July, 2021, shows that the CFR is somewhere between 0.2% and 2.8%. with the Delta case fatality rate is 0.2%.⁴⁰ New Zealand's CFR, based on official WHO figures cautiously may be observed to be .7%. As of October 9, 28 people have died from COVID-19 and 4169 cases have been recorded. There appears to be a declining trend in the global CFR.⁴¹ When case fatality rate is adjusted for age, radical differences appear. A review of the case fatality rate for hospitalised adult patients demonstrated that once hospitalised, patients under 50 had a 3% chance of death, while patients over 50 had a 19% chance of morbidity.⁴²
44. For New Zealand, who has had more protected borders, this is good news. While our vaccination rates are comparatively low, they are still higher than rates of countries such as the U.K. who did not commence vaccination until December 2020.⁴³

RELEVANT CONSIDERATIONS: LIMITED EFFECTIVENESS OF mRNA VACCINES

45. There is no evidence that vaccination can contain the epidemic.⁴⁴ Policy claims that justify restrictions on human rights or that risk interfering with privacy.
46. The clinical trials for mRNA vaccines were not designed to assess whether COVID-19 vaccines prevented infection with or transmission of Sars-Cov-2.⁴⁵
47. The duration of vaccine protection conferred by the mRNA vaccine is between 3-6 months.⁴⁶
48. Similar viral loads may be carried by vaccinated and unvaccinated people.^{47 48 49}
49. A recent study 'demonstrated that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity'.⁵⁰

³⁸ Hasan et al 2021. The Global Case-Fatality Rate of COVID-19 Has Been Declining Since May 2020. *Am. J. Trop. Med. Hyg.*(2021) 104(6):2176–2184

³⁹ Fan et al 2021. Decreased Case Fatality Rate of COVID-19 in the Second Wave: a study in 53 countries. *Transbound Emerg Dis.* (2021)68(2):213-215. doi: 10.1111/tbed.13819.

⁴⁰ Public Health England. SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 18. 9 July 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001358/Variants_of_Concern_VOC_Technical_Briefing_18.pdf

⁴¹ Fan et al 2021. Decreased Case Fatality Rate of COVID-19 in the Second Wave: a study in 53 countries. *Transbound Emerg Dis.* (2021)68(2):213-215. doi: 10.1111/tbed.13819.

⁴² Alimohamadi et al. Case fatality rate of COVID-19: a systematic review and meta-analysis. *J Prev Med Hyg.* 2021 Jun; 62(2): E311–E320.

⁴³ BBC December 8 2020. Covid-19 vaccine: First person receives Pfizer jab in UK. <https://www.bbc.com/news/uk-55227325>

⁴⁴ Ibrahim et al. The characteristics of SARS-CoV-2-positive children who presented to Australian hospitals during 2020: a PREDICT network study. *MJA* 215:5 6 September (2021)

⁴⁵ Doshi 2020. Will covid-19 vaccines save lives? Current trials aren't designed to tell us. *BMJ* 2020 371 doi 10.1136/bmj.m4037

⁴⁶ Tartof et al. Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: a retrospective cohort study. October 4 (2021). [https://doi.org/10.1016/S0140-6736\(21\)02183-8](https://doi.org/10.1016/S0140-6736(21)02183-8).

⁴⁷ Griffin S. 2021. Covid-19: Fully vaccinated people can carry as much delta virus as unvaccinated people, data indicate. *BMJ* 374:2074: <http://dx.doi.org/10.1136/bmj.n2074>; published 19 August 2021.

⁴⁸ Acharya et al. No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups Infected with SARS-CoV-2 Delta Variant. *medRxiv Preprint* (2021) 10.1101/2021.09.28.21264262

⁴⁹ Riemersma et al. Vaccinated and unvaccinated individuals have similar viral loads in communities with a high prevalence of the SARS-CoV-2 delta variant. *medRxiv preprint* (2021)

⁵⁰ Gazit et al. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. *medRxiv preprint*. 10.1101/2021.08.24.21262415

50. Pervasive uncertainties include the risk of waning and breakthrough infections following vaccination. Breakthrough from fully vaccinated individuals has been recorded in Vietnam⁵¹ Israel⁵²
⁵³ ⁵⁴, the U.S.A⁵⁵ ⁵⁶ ⁵⁷.
51. A recent San Francisco study stated that ‘fully vaccinated were more likely than unvaccinated persons to be infected by variants carrying mutations associated with decreased antibody neutralization...and that ... Differences in viral loads were non-significant between unvaccinated and fully vaccinated persons overall. The authors findings suggested that ‘vaccine breakthrough cases are preferentially caused by circulating antibody-resistant SARS-CoV-2 variants, and that symptomatic breakthrough infections may potentially transmit COVID-19 as efficiently as unvaccinated infections, regardless of the infecting lineage.’⁵⁸
52. In New Zealand breakthrough cases have occurred in Katikati⁵⁹, at Auckland Airport⁶⁰ and at Auckland hospital.⁶¹
53. mRNA vaccines are based on focused immunity that target a single viral spike protein.⁶²
54. Naturally acquired - natural immunity confers equal or better protection than available estimates on vaccine efficacy. Natural immunity, appears realistic for most individuals.⁶³ In order to acquire robust responses individuals do not need to experience a severe infection.⁶⁴
55. Naturally infected people produce a broad range of antibody responses which produce an overarching structural response that is effective against emerging variants of concern. Their antibodies cross-neutralising emerging variants ‘with high potency’.⁶⁵
56. As Cho and colleagues note ‘individual memory antibodies selected over time by natural infection have greater potency and breadth than antibodies elicited by vaccination’.⁶⁶

⁵¹ Chau et al. An observational study of breakthrough SARS-CoV-2 Delta variant infections among vaccinated healthcare workers in Vietnam. *EClinicalMedicine* (2021) 41:101143

⁵² Shitrit et al. Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021. July 2021. *Euro Surveill.* 2021;26(39):pii=2100822. <https://doi.org/10.2807/1560-7917.ES.2021.26.39.2100822>

⁵³ Gazit et al. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. *medRxiv preprint*. 10.1101/2021.08.24.21262415

⁵⁴ Levine-Tiefenbrun et al. Viral loads of Delta-variant SARS-CoV2 breakthrough infections following vaccination and booster with the BNT162b2 vaccine. *medRxiv preprint* (2021) 10.1101/2021.08.29.21262798;

⁵⁵ Brown et al. Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021. *MMWR* 20:31;1059-1062

⁵⁶ Farinholt et al. Transmission event of SARS-CoV-2 Delta variant reveals multiple vaccine breakthrough infections. *medRxiv* (2021)

⁵⁷ Servillita et al. Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California. (2021) 10.1101/2021.08.19.21262139

⁵⁸ Servillita et al. Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California. (2021) 10.1101/2021.08.19.21262139

⁵⁹ MoH. Positive COVID-19 case in the Bay of Plenty. October 9, 2021. <https://www.health.govt.nz/news-media/media-releases/positive-covid-19-case-bay-plenty>

⁶⁰ NZ Herald. Covid 19 coronavirus: Worker at Auckland Airport tests positive. April, 20 2021.

⁶¹ Otago Daily Times. Four new Delta Covid cases; nurse tests positive. August 18, 2021.

⁶² Brouqui et al 2021. COVID-19 re-infection. *Eur J Clin Invest.* 2021;51:e13537.

⁶³ Dan et al., Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection. *Science* (2021) *Science* 371: eabf406

⁶⁴ Nielsen et al. SARS-CoV-2 elicits robust adaptive immune responses regardless of disease severity. *EBioMedicine* 68:103410, <https://doi.org/10.1016/j.ebiom.2021.103410>; published June 4, 2021.

⁶⁵ Wang et al. Ultrapotent antibodies against diverse and highly transmissible SARS-CoV-2 variants. *Science* 373:eabh1766 (2021)

⁶⁶ Cho et al. Anti-SARS-CoV-2 receptor binding domain antibody evolution after mRNA vaccination. doi: 10.1038/s41586-021-04060-7

57. Antibody combinations reduce the generation of escape variants and people with antibodies following natural infection have a broader range of antibodies. Natural immunity confers broader protection than immunity via mRNA inoculation.⁶⁷
58. The evidence that while Delta is more contagious, but that the risk to young people and children reflects a similar profile to early data. Where increases have been reported⁶⁸ – they are small in comparison to risk from car accident, heart disease and other health risks. U.K. case fatality rates for delta indicate that delta is no more severe than earlier Sars-Cov-2 variants.⁶⁹
59. Vaccination after infection may not produce sufficient benefit to justify the intervention.⁷⁰
60. It is not known exactly when a vaccine's effectiveness will weaken against Delta.⁷¹
61. Breakthrough events can occur shortly after inoculation.⁷²

RELEVANT CONSIDERATIONS: mRNA VACCINES ARE NOT WITHOUT RISK

62. Healthy children and young adults are at particularly low risk for bad outcomes from Sars-Cov-2 infection.^{73 74} Their low-risk status was recognised at an early stage in the COVID-19 pandemic.⁷⁵ Adolescents are also at low risk of harm.⁷⁶
63. Children with obesity and associated, often diet-related health conditions are more at risk of experiencing adverse harm from Sars-Cov-2 infection and can be recommended for inoculation^{77 78} in addition to dietary and treatments that improve immune status
64. Recently, a New York Times article drew attention to the fact that many daily activities, such as travelling in a car, pose more risk to the average child than infection with Sars-Cov-2.⁷⁹
65. With their low-risk status, young people and children may be *more at risk* from vaccine harm. While this difference is slight, it can be compared alongside the unknown health risks from prospective ongoing booster regimes, which have not been studied in long term trials.

⁶⁷ Wang et al. Ultrapotent antibodies against diverse and highly transmissible SARS-CoV-2 variants. Science 373:eabh1766 (2021)

⁶⁸ Fisman DN & Tuite AR. Evaluation of the relative virulence of novel SARS-CoV-2 variants: a retrospective cohort study in Ontario, Canada. : CMAJ (2021) October doi: 10.1503/cmaj.211248

⁶⁹ Public Health England. SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 18. 9 July 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001358/Variants_of_Concern_VOC_Technical_Briefing_18.pdf

⁷⁰ Shrestha et al. Necessity of COVID-19 Vaccination in Previously Infected Individuals: A Retrospective Cohort Study. medRxiv preprint <https://doi.org/10.1101/2021.06.01.21258176>

⁷¹ Levine-Tiefenbrun et al. Viral loads of Delta-variant SARS-CoV2 breakthrough infections following vaccination and booster with the BNT162b2 vaccine. medRxiv preprint (2021) 10.1101/2021.08.29.21262798

⁷² Hacisuleyman et al. Vaccine Breakthrough Infections with SARS-CoV-2 Variants. NEJM. 2021. 384:23

⁷³ Bhopal et al. Children and young people remain at low risk of COVID-19 mortality. Lancet (2021) /10.1016/S2352-4642(21)00066-3

⁷⁴ Yilmaz et al 2021. Does Covid- 19 in children have a milder course than Influenza? Int J Clin Pract. 2021;75:e14466.

⁷⁵ Smith et al. Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year: a national study using linked mandatory child death reporting data. Research Square (2021)

⁷⁶ Havers et al. Hospitalization of Adolescents Aged 12–17 Years with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1, 2020–April 24, (2021) MMWR 70:23;851-857

⁷⁷ Harwood et al. Which children and young people are at higher risk of severe disease and death after SARS-CoV-2 infection: a systematic review and individual patient meta-analysis. medRxiv preprint (2021) 10.1101/2021.06.30.212597

⁷⁸ Mertens & Peñalvo. The Burden of Malnutrition and Fatal COVID-19: A Global Burden of Disease Analysis.(2021) Frontiers in Nutrition. 7:619850 doi <https://doi.org/10.3389/fnut.2020.619850>

⁷⁹ Leonhardt June 18. Kids, Covid & Delta. <https://www.nytimes.com/2021/06/18/briefing/kids-covid-and-delta.html>

66. In New Zealand, deaths reported following Comirnaty vaccination are recorded at 68.⁸⁰
67. While Medsafe can question the veracity of the data, there is also an extensive body of scientific data drawing attention to the pervasive problem of the under-reporting of side-effects.⁸¹
68. In comparison, there is strong evidence that the mRNA vaccine carries risk of side effects.^{82 83 84}
69. Recently Sweden and Denmark have paused vaccination for the under 20-year-old group.⁸⁵
70. It is apparent that those who have been naturally infected, and then been inoculated may be at more risk of adverse events.
71. Vaccine failure and waning is associated with age and immunosuppression.^{86 87 88}

RELEVANT CONSIDERATIONS: BOTTOM-UP HEALTH CARE

72. Poverty and dietary insufficiency is closely associated with risk from Sars-Cov-2 infection.⁸⁹
73. It is no longer legally, ethically or scientifically acceptable that public health measures rely exclusively on vaccination and distancing activities.⁹⁰
74. Those most at risk of vaccine failure, including waning and breakthrough infections may likely be the elderly as well as Māori and Pasifika low-income populations. Low-income is directly linked to dietary insufficiency.⁹¹ Food insecurity is far too common and has been exacerbated by the pandemic.^{92 93 94 95} Dietary inadequacy is directly connected to risk for obesity, diabetes and other metabolic diseases. Patients with these diseases are more likely to have low – immunosuppressed - immune systems.

⁸⁰ Medsafe. Adverse events following immunisation with COVID-19 vaccines: Safety Report #29 – 18 September 2021. Published 6 October. <https://www.medsafe.govt.nz/COVID-19/safety-report-29.asp#death>

⁸¹ E.g. Martin & Lucas 2021. Reporting adverse drug events to the Therapeutic Goods Administration. Australian Prescriber. 2021

⁸² Bozkurt 2021. Myocarditis With COVID-19 mRNA Vaccines. Circulation. 2021;144:471–484.

⁸³ Lane & Shakir 2021. Reports of myocarditis and pericarditis following mRNA COVID-19 vaccines: A review of spontaneously reported data from the UK, Europe, and the US. medRxiv preprint doi: <https://doi.org/10.1101/2021.09.09.21263342>

⁸⁴ Pepe et al 2021. Myocarditis, Pericarditis and Cardiomyopathy After COVID-19 Vaccination. Heart, Lung & Circulation. 30:1425-1429 <https://doi.org/10.1016/j.hlc.2021.07.011>

⁸⁵ Reuters October 7 2021. Sweden, Denmark pause Moderna COVID-19 vaccine for younger age groups. <https://www.reuters.com/business/healthcare-pharmaceuticals/sweden-pauses-use-moderna-covid-vaccine-cites-rare-side-effects-2021-10-06/>

⁸⁶ Bajaj 2021 Aging, Immunity, and COVID-19: How Age Influences the Host Immune Response to Coronavirus Infections? <https://doi.org/10.3389/fphys.2020.571416>

⁸⁷ Kimball et al 2021. Influenza Vaccine Failure Associated With Age and Immunosuppression. J Inf Dis 224:2;288-293

⁸⁸ Wang 2021. A potential association between immunosenescence and high COVID-19 related mortality among elderly patients with cardiovascular diseases. Immunity & Ageing 18:25

⁸⁹ Mertens & Peñalvo. The Burden of Malnutrition and Fatal COVID-19: A Global Burden of Disease Analysis.(2021) Frontiers in Nutrition. 7:619850 doi <https://doi.org/10.3389/fnut.2020.619850>

⁹⁰ Marik et al. A scoping review of the pathophysiology of COVID-19. International Journal of Immunopathology and Pharmacology (2021) Volume 35: 1–16.

⁹¹ Patel et al 2020. Poverty, inequality and COVID-19: the forgotten vulnerable. Public Health.183: 110–111

⁹² Graham et al 2018. Hiding in plain sight: experiences of food insecurity and rationing in New Zealand. Food, Culture & Society. 21:3;384-401

⁹³ Ministry of Health. 2019. Household Food Insecurity Among Children in New Zealand. Wellington: Ministry of Health.

⁹⁴ Reynolds et al 2020. Food and vulnerability in Aotearoa/New Zealand: A review and theoretical reframing of food insecurity, income and neoliberalism. New Zealand Sociology 35:1;123-152

⁹⁵ Neuwelt-Kearns et al 2021 The realities and aspirations of people experiencing food insecurity in Tāmaki Makaurau. Kōtuitui: New Zealand Journal of Social Sciences Online. DOI: 10.1080/1177083X.2021.1951779

75. As an example, low vitamin D levels are associated with a poor outcome following infection.^{96 97 98}
⁹⁹ Adjunctive treatment with vitamin D likely improves outcome.^{100 101 102} Yet Māori and Pasifika have some of the highest level of vitamin D deficiency in New Zealand.^{103 104}
76. This bill, if enacted into legislation would disproportionately and adversely impact Māori and Pasifika. Based on the scientific evidence, groups with weaker immune systems are more likely to experience waning and breakthrough infections. These groups are likely to receive disproportionate and unfairly scrutiny under the Act, and their vaccine status may be regarded sceptically and questioned.

RELEVANT CONSIDERATIONS: OBLIGATIONS TO PROMOTE HEALTH EQUITY

77. The Health Act recognises that medicines are important to prevent the occurrence of an infectious quarantinable disease.¹⁰⁵ However no steps have been taken to ensure low-income high-risk groups have access to preventable, prophylactic medicines and adjunctive nutritional treatments¹⁰⁶ that reduce the potential for hospitalisations or death.
78. We recognise that potentially punitive legislation is already in place that ignores the potential for natural immunity, ignores the potential for individual vulnerability to the mRNA vaccine and ignores the potential for vaccines to wane.¹⁰⁷
79. The current government approach appears severely deficient, with an overweighted focus on population control and isolation, and an underweighted focus on protecting vulnerable populations from hospitalisation and death.
80. At home access to multi-target anti-viral and immunoprotective treatments can be provided to high-risk groups to prevent hospitalisation and death.^{108 109 110}

⁹⁶ Shah et al. Low vitamin D levels and prognosis in a COVID-19 pediatric population: a systematic review. QJM (2021)

⁹⁷ Merzon 2020 Low plasma 25(OH) vitamin D level is associated with increased risk of COVID-19 infection: an Israeli population-based study. FEBS Journal 287:17

⁹⁸ Dror et al 2021. Pre-infection 25-hydroxyvitamin D3 levels and association with severity of COVID-19 illness. medRxiv

⁹⁹ Vasheghani et al 2021. The relationship between serum 25-hydroxyvitamin D levels and the severity of COVID-19 disease and its mortality. Scientific Reports 11:17594. | <https://doi.org/10.1038/s41598-021-97017-9>

¹⁰⁰ Lakkireddy et al 2021. Impact of daily high dose oral vitamin D therapy on the inflammatory markers in patients with COVID 19 disease. Scientific Reports. 11:10641

¹⁰¹ Peng et al 2021. Immunological Aspects of SARS-CoV-2 Infection and the Putative Beneficial Role of Vitamin-D. Int. J. Mol. Sci. 2021, 22, 5251. <https://doi.org/10.3390/ijms22105251>

¹⁰² Yisak et al 2021. Effects of Vitamin D on COVID-19 Infection and Prognosis: A Systematic Review. Risk Management and Healthcare Policy 14:31-38

¹⁰³ Cairncross et al 2017. Predictors of vitamin D status in New Zealand preschool children. Maternal & Child Nutrition (2017), 13, e12340

¹⁰⁴ Delshad et al 2019. Wintertime Vitamin D status and its related risk factors among children living in Auckland, New Zealand. NZMJ 132:1504

¹⁰⁵ Health Act 74C. Priorities for Medicines (6) medicine means any substance used or capable of being used to prevent, treat, or palliate a disease, or the symptoms or effects of a disease.

¹⁰⁶ Inclusive of nutrients, as adjunctive nutraceuticals

¹⁰⁷ COVID-19 Public Health Response (Vaccinations) Order 2021. 7A notes a suitably qualified health practitioner can deem it inappropriate for the person to be vaccinated, and the person has been registered. These requirements may be difficult to fulfil for certain groups.

¹⁰⁸ McCullough et al. Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection. Am J Med. (2021) 134(1): 16–22.

¹⁰⁹ Derwand et al. COVID-19 outpatients: early risk-stratified treatment with zinc plus low-dose hydroxychloroquine and azithromycin: a retrospective case series study. International Journal of Antimicrobial Agents (2020) 56, 106214.

¹¹⁰ Anuk et al 2020. The Relation Between Trace Element Status (Zinc, Copper, Magnesium) and Clinical Outcomes in COVID-19 Infection During Pregnancy. Biological Trace Element Research 199:3608–3617

81. In addition to hospital use, prophylactic at home access to vitamin D, vitamin C and safe antiviral medication may be consistent with the principle of mātauranga Māori. Treatment protocols can be targeted to personal need, and they acknowledge the problem of dietary deficiency prevalent in many Maori.
82. Both dietary nutrients and safe repurposed antiviral medications have a long history of use with side effects that are rare. The problems of adverse interactions between generic repurposed medications and existing medications can be more easily targeted and recognised by consulting practitioners.¹¹¹
112
83. There is adequate literature supporting the implementation of multi-target therapies that have potential to reduce inequities in immune-status that promote adverse outcomes, including hospitalisation and death. Both repurposed antiviral treatments and nutritional supplements have a long history of safe use.^{113 114 115}
84. The public health response has focussed on vaccination and non-pharmaceutical measures including masking, quarantine and social distancing. These are without doubt integral to the COVID-19 response. However, the public health response has not taken greater steps in the public interest since December 2019 to improve health outcomes. Substantial ignorance continues to remain regarding the risk profile of the population as there has been a reluctance of Cabinet and Ministry of Health officials to:
 - a. Explain the lower risk to those under 60 who do not have associated health conditions
 - b. Explain the very low risk to young people¹¹⁶ and children.¹¹⁷
 - c. Provide adequate treatments that will improve immune health and reduce risk to at risk elderly and multimorbid populations, particularly in low-income groups
 - d. provided rapid antigen screening measures to reduce public fear and increase knowledge.
 - e. Recognise the seasonal influence of viral pandemics and the relation to vitamin D levels.

E. RESPONSE TO THE CURRENT BILL

85. *The foundations for this Bill and its predecessor are fundamentally unlawful. This legislation should not therefore be passed. In particular we submit that:*

- a. **Clause 4.** The extension of emergency legislation to be removed from the Bill
- b. **Clause 5.** No extended definition of the infringement fee

¹¹¹ Kory et al 2021. Review of the Emerging Evidence Demonstrating the Efficacy of Ivermectin in the Prophylaxis and Treatment of COVID-19. Am J Ther. 2021 May-Jun; 28(3): e299–e318

¹¹² McCullough et al. Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). Reviews in Cardiovascular Medicine (2020) 21:4: 517-530 DOI: 10.31083/j.rcm.2020.04.264

¹¹³ McCullough et al. Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). Reviews in Cardiovascular Medicine (2020) 21:4: 517-530 DOI: 10.31083/j.rcm.2020.04.264

¹¹⁴ Coelho-Ravagnani 2021. Dietary Recommendations During the COVID-19 Pandemic: an Extract. Komp Nutr Diet 2021;1:3–7 DOI: 10.1159/000513449

¹¹⁵ Costagliola et al. Could nutritional supplements act as therapeutic adjuvants in COVID-19? Italian Journal of Pediatrics. 47:32 <https://doi.org/10.1186/s13052-021-00990-0>

¹¹⁶ Havers et al. Hospitalization of Adolescents Aged 12–17 Years with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1, 2020–April 24, 2021MMRW. 70:23;851- 857

¹¹⁷ Bhopal et al. Children and young people remain at low risk of COVID-19 mortality. Lancet (2021) /10.1016/S2352-4642(21)00066-3

- c. **Clause 7.** Sections (11) (a) and (c) are far too broad and unspecified (which risks arbitrariness) as to conform with maxims of accountability and transparency. The degree to which Sars-Cov-2 is pervasive across the population is completely unknown. To create legislation which assumes this is known, is unfounded and unjust. Existing protections have been sufficient, and the virus will be becoming increasingly endemic in the population. Coronaviruses are pervasive and detections of Sars-Cov-2 wild and variant viruses have been detected across a broad range of biological life, from wild animals to waste-streams. The section encourages potentially selective and unaccountable arbitrariness that do not reflect scientific evidence and risk. (4) is anticompetitive and with full awareness that a broad range of anti-viral, anti-thrombotic and immune-protective treatments are required, would potentially be contrary to the protection of public health.
- d. **Clause 9.** Narrowing the scope of exemptions – Section 12 (1) is ungrounded. Firstly, the risk from thrombotic events and other risks to vulnerable populations continues to be uncertain; secondly (and related to the first point) there is no clear evidence concerning the degree to which vaccines prevent transmission and infection.
- e. **Clause 10 (b).** The delegation of discretion to any third party is unjustified and not in accordance with principles of public law.
- f. **Clause 12.** Extension of powers to third parties (relating to road closure, restriction of access to public places and stopping vehicles) should not be granted. Good governance and protection of the public interest requires transparency and third parties unnecessarily obfuscate a straight line of responsibility in what can be politically, socially, economically and culturally difficult circumstances.
- g. **Clause 13&14.** Increased infringement and other fines will disproportionately affect low-income populations. This perpetuates existing inequalities in the population. Instead, generous and free provision to these groups – who have demonstrated the most respect for existing health protective measures – with RETs – and assurance of adequate cover and job security if these groups stay home from work due to symptoms – can substitute harmful and what will increasingly appear to be racist pecuniary measures.
- h. **Clause 23.** Penalties cannot become more pecuniary. Increased financial costs in terms of fines and penalties will result in a disproportionate burden on Maori and Pasifika who are more likely to be at risk from infection, breakthrough infection and vaccine waning due to compromised immune systems.
- i. **Clause 25.** Good legislation and regulations require a clear line of sight for the people governed in order to promote trust. This Section is unnecessary. Incorporation of Section 33B carries with it a risk of arbitrary lower order regulations and guidelines and consequential unfounded activities and regulatory measures that are likely to compromise goodwill and public trust. The tenet of this bill - which does not reflect the scientific literature on risk (including vaccine efficacy, natural immunity and the process by which a virus becomes endemic across populations), - creates concern that consequent regulation will erode human rights, and particularly the rights of vulnerable groups, including children.

OBIGATION TO IMPROVE, PROMOTE & PROTECT HEALTH

86. PSGR respectfully requests that related officials, the Health Select Committee and the drafters of this bill, take steps to address the worrying direction of government that appears unable to recognise and respond with strategic and respectful flexibility to the individual vulnerabilities of the New Zealand public.
87. We hope that this submission will increase the potential for protective public health measures to be taken that recognise that vaccination can never be the ‘silver bullet’ treatment that can best assure the health and safety of the New Zealand population.
88. This submission emphasises:
- a. The elderly, and low-income groups Māori and Pasifika have particular vulnerability;
 - b. Children and young adults have low vulnerability and – scientifically - greater public health benefits are likely to be achieved by permitting these groups to achieve natural immunity;
 - c. Risk profiles are highly variable and that the state should not be taking coercive action to ensure blanket inoculation from mRNA COVID-19 vaccines.
89. This Bill produces absurdities that are likely to contribute to public health harms:
- a. The potential lawful detention of healthy asymptomatic populations inclusive of household members who have prior natural immunity and are less likely to carry high viral loads
 - b. The evidence that lockdowns and pecuniary steps will disproportionately harm disadvantaged households with precarious access to resources.¹¹⁸
 - c. The evidence that vaccination may compromise the potential for a healthy individual to acquire natural immunity rather than shorter term immunity from vaccination
 - d. The potential for young adults and children who are not at risk of adverse COVID-19 to experience adverse health effects, including mental illness.^{119 120 121}
90. There is increasing evidence that the public health policy approach has been disinclined to publicly communicate uncertainties, including the potential for vaccines to wane; for side effects to occur, for mRNA vaccines to be vulnerable to breakthrough infections.
91. These persistent issues, represented in the scientific literature demonstrate that any future government incentives to introduce mandatory vaccination or associated passports null and void as such measures impose human health risks, unduly compromise human rights and do not achieve desired end-points of the obligation of public officials to improve, promote and protect human health.

¹¹⁸ Czymara et al. Cause for concerns: gender inequality in experiencing the COVID-19 lockdown in Germany. *European Societies*, DOI: 10.1080/14616696.2020.1808692

¹¹⁹ Patel et al 2020. Poverty, inequality and COVID-19: the forgotten vulnerable. *Public Health*.183: 110–111.

¹²⁰ Fegert et al. Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child Adolesc Psychiatry Ment Health* (2020) 14:20

¹²¹ Luijten et al 2021. The impact of lockdown during the COVID-19 pandemic on mental and social health of children and adolescents. *Quality of Life Research* volume 30, pages2795–2804 (2021)

92. With current persistent limitations of mRNA vaccines, we request that measures will be taken to ensure equitable access to adequate anti-viral and immunoprotective and home-based medical and nutritional therapies, and ensure a broad spectrum of medical and nutritional treatments are available for hospitalisation – produces profound and sustained inequities for low-income groups, and in particular Māori and Pasifika.
93. Recent scientific evidence demonstrating that the delta variant infects the unvaccinated and the vaccinated at similar rates^{122 123} and is likely to present similar risks of infection should have already been factored into government policy.^{124 125} On this basis vaccination mandates announced 10th October 2021 should be immediately revoked, as they cannot be scientifically justified and will create great hardship to the public by removing essential workers from the workforce and provide no benefit.
94. Recommending vaccination to children and young people on the basis of *reducing transmission*, can not be justified and should be immediately halted.^{126 127} In regards to vaccinating healthy children for their personal benefit, there is insufficient evidence of benefit to justify the known and as yet unknown risks of vaccination,¹²⁸ particularly as natural immunity confers long-term protective benefits.^{129 130 131}
95. Associate professor at the University of California, Vinay Prasad has recently written of how democracy ends, and how policy, legislation and culture shifts towards totalitarianism. He suggests that *‘The key lesson of the coronavirus pandemic is not that the fall of democracy is inevitable, but rather that our policy preferences, and polarization, have set the stage for a series of events where it is possible democracy falls.’*¹³² He outlined core trends which currently exist, which may pave the way towards totalitarianism:
- ➡ The use of strong force, including military force, to combat a respiratory virus;
 - ➡ Public acceptance of restrictions on movement and commerce in the face of respiratory pandemic, with many calls for greater restrictions to be applied

¹²² Riemersma et al. Vaccinated and unvaccinated individuals have similar viral loads in communities with a high prevalence of the SARS-CoV-2 delta variant. medRxiv preprint (2021)

¹²³ Acharya et al. No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups Infected with SARS-CoV-2 Delta Variant. medRxiv Preprint (2021) 10.1101/2021.09.28.21264262

¹²⁴ Gazit et al. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. medRxiv preprint. 10.1101/2021.08.24.21262415

¹²⁵ Public Health England. SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 18. 9 July 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001358/Variants_of_Concern_VOC_Technical_Briefing_18.pdf

¹²⁶ Servillita et al. Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California. (2021) 10.1101/2021.08.19.21262139

¹²⁷ E.g. Dougherty et al. SARS-CoV-2 B.1.617.2 (Delta) Variant COVID-19 Outbreak Associated with a Gymnastics Facility — Oklahoma, April–May (2021) MMWR 70:28:1004-1007

¹²⁸ Marshall et al. Symptomatic Acute Myocarditis in Seven Adolescents Following Pfizer-BioNTech COVID-19 Vaccination. Pediatrics. 2021; doi: 10.1542/peds.2021-052478

¹²⁹ Bhopal et al. Children and young people remain at low risk of COVID-19 mortality. Lancet (2021) /10.1016/S2352-4642(21)00066-3

¹³⁰ Yilmaz et al 2021. Does Covid-19 in children have a milder course than Influenza? Int J Clin Pract. 2021;75:e14466.

¹³¹ Douberis et al. Does COVID-19 Vaccination Warrant the Classical Principle “*ofelein i mi vlaptin*”? Medicina 2021, 57, 253. <https://doi.org/10.3390/medicina57030253>

¹³² Prasad, V. Blog How Democracy Ends. October 3, 2021.

- media presentation of vignettes or anecdotes about overwhelmed hospitals or the untimely death of a young person, without acknowledging the denominator or comparing the risk to other risks we accept.
- The rise of social media corporations means that public dialog increasingly occurs in spaces that can be regulated.
- Increasing acceptance of the regulation and censorship of information
- Cultural emphasis that valorises safety as a virtue above all
- The implications of current measures for future democracy. Caution is warranted as the party that favours stronger application of force during the COVID19 pandemic is vulnerable to misuse of force for a respiratory virus from the counterparty in the future.

CONCLUSION: LEGAL IMPLICATIONS

Measured against the legal parameters and principles referred to at the commencement of this Submission it is clear that the policy framework that has generated both this Bill and its related preceding legislation is grossly faulted when measured against the requirements of constitutional and administrative law in New Zealand; and/or measured against existing legislation; and/or when measured against NZ Bill of Rights; and/or when measured against the United Nations New Zealand undertakings in various documents relating to medical experimentation and human rights.

It is arguably unconscionable for this House to pass this Bill when it should be plain to all Members of this House - and to members of the public who may apply reason to these matters - that the present policy direction is not in the public interest; it is not aligned with the economic interest of New Zealand; it is grossly deficient, if not absurd, in terms of delivering reliable end-points in New Zealand public health; it is not a reliable model for government future and effective management of pandemics; and it does not protect the individual person and their fundamental rights.

It should be noted that the primary duty of government is to protect *the person*; and at law that consideration trumps any claimed and generalised ‘public health’ policy agenda.¹³³

Measured for compliance with the ‘principle of proportionality’, it is plain that policy-makers have given disproportionate weight to a single option (inoculations) that is so great that it cannot be rationally supported – and is therefore unreasonable.

Such is the context and conclusion of our evaluation of this proposed Bill.

¹³³ UNESCO Article 3, Subsection 2. The interests and welfare of the individual should have priority over the sole interest of science or society.