PSGR

Physicians & Scientists for Global Responsibility

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

TRANSCRIPT: COVID-19 Public Health Response Amendment Bill (No 2) – hearing of evidence (subcommittee B, 15 October 2021, part IV)

FACEBOOK LINK HERE - AT 1HR 25 MINS (10 MINS)

HEALTH SELECT COMMITTEE MEMBERS IN ATTENDANCE: DR LIZ GRAIG (CHAIR), DR ELIZABETH KEREKERE, DR GAURAV SHARMA, SIMON WATTS.

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Damian Wojcik and I are presenting to you today on behalf of the Physicians and Scientists for Global Responsibility (PSGR). I'll speak firstly, pass the paper to Dr Damian Wojcik to make central points, and finish with the final points. My name is Jodie Bruning, this year I completed research Masters' which looked at the structure of health research policy and how this policy influences research into the environmental drivers of disease. It's quite clear that environmental factors rather than genes, drive risk for both non-communicable and infectious disease. COVID-19 has highlighted that after old age, the overlapping diseases of obesity, diabetes and other metabolic and inflammatory conditions drive an individuals' risk for hospitalisation and death. [1] [2] [3]

Māori and Pasifika families, are not only at more risk of hospitalisation and death from COVID-19, but their incomes are often also most precarious.[4] [5] The coercive pecuniary and human rights eroding measures in this Bill will severely and disproportionately impact these families - because for generations, inequities in their health status have been ignored by the state.[6] [7] [8]

We understand that the parent legislation was established when the risk from Sars-Cov-2 was relatively unknown, and known efficacy of mRNA vaccines were drawn from a narrow range of studies. The current policy fails as the response is not proportionate to the changing data in the scientific literature. Additionally - the Bill contains the potential for severe human rights violations.

Good legislation must fulfill the following requirements: the policy process must be transparent and adequate; and the endpoints must be clear and reasonable. Yet there is no evidence that either of these components of good policy have been complied with. There is no evidence that the documentation in the

Bill digest – has considered the risk profile and pathology of COVID-19 now evident in the scientific literature. The Bill seems to presume Sars-Cov-2 is much more harmful – and the vaccines much more effective than the picture the scientific literature presents us with. There is concrete evidence that the COVID-19 mRNA vaccines wane and that breakthrough events are likely. We cannot identify RIAs or RIS's that incorporate the latest knowledge regarding the potential for vaccines to wane or breakthrough. Nor can we identify data considering the relative risk to healthy young people and children.[9] [10] [11] [12] We see that the Te Pūnaha Matatini modelling excluded these same issues.

Committee members, policy formulation must be proportionate and appropriate to the problem before us. Instead, this Bill – and the policy framework that generated this Bill - is grossly faulted. Nor is it consistent with New Zealand legislation. The Health Act requires that officials defer to core principles in the management of infectious diseases (S.92). Central to this is firstly, respect for individuals; and secondly that measures applied to an individual are firstly, *proportionate to the public health risk* sought to be prevented, minimised, or managed. It states that these measures are not be made or taken in an arbitrary manner. Let us also consider the New Zealand Public Health and Disability Act 2000 – which demands that public servants including elected members *reduce health disparities* by improving the health outcomes of Māori and other population groups.

The current Bill is fundamentally unable to 'promise' that it will reduce hospitalisation and death.

We make 5 points:

Firstly, policy has failed to take an integrated stance to protect vulnerable groups, particularly Māori and Pasifika. Poverty from high housing costs and low wages reduces access to dietary nutrition. [13] [14] Policy has never stepped in [15] to ensure these groups have adequate immunoprotection. The media targets large households – but ignores policy and economic structures that promote malnutrition. [16] [17]

Secondly, these groups are at greatest risk of waning and breakthrough. They are likely to have weak immune systems and be immunosuppressed. Yet their jobs are precarious - They will become the hunted.

Third, it is very clear, even from the Pfizer paid Tartoff study, that vaccines wane in under 6 months. Waning [18] [19] and breakthrough [20] [21] [22] are inevitable. The mRNA vaccine contains only a segment of the virus, the spike protein. A recent study by Wang showed that naturally infected people produce an antibody response – which works in concert to produce an overarching structural response which then can cross-neutralise emerging variants.

Fourth. It simply not anti-vax or a conspiracy theory to acknowledge that the vaccine is fallible in preventing case numbers - and that it carries a health risk. We can see from Ministry of Health data and from the RIAs and RISs that new evidence has *not been incorporated* and that often, we defer to decisions made months

ago by other nations. Vaccine mandates are based a valorised notion of vaccine efficacy that is not based on the evidence presented in the scientific literature in October 2021. [23] [24] [25]

Fifthly, COVID-19 does not follow a clear pathology – symptom profile. Physicians require antivirals, anti-thrombotics [26], corticosteroids, vitamin C for sepsis, to buffer the immune system [26] [28] [29] [30] and prevent the cascading cytokine storm from both hyperinflammation and multiorgan disease - to prevent death. These treatments interact to provide broad-based protection. [31] [32]

Central pillars of adequate public health governance is not just that top-down interventions are put in place to protect population health, but that the individual is respected and can take their own- bottom up - measures. The foundations for the current Bill are fundamentally unlawful and should therefore not be passed.

What does this mean in law? It means that the legislation is arbitrary and unreasonable. Officials – and Radio National - have not paid attention to the relevant considerations of vaccines being – like all medications – fallible. [33] [34] Despite spending $1.4 billion in hope – the Pfizer vaccine can never be the silver bullet. 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. This Bill is not in the public interest.

In this environment, requiring that healthy young adults and children are mandatorily vaccinated, is also unethical, unconscionable and unscientific. Healthy children acquiring natural immunity will reduce risk to others.[35] [36] [37] It's not anti-vax to state 'individual memory antibodies selected over time by natural infection have greater potency and breadth than antibodies elicited by vaccination'. It's quoting the science. Our antibodies generate a greater structural response that is protective from natural infection. Groups who safely acquire broad-based natural will more greatly protect the entire population over the coming years.[38]

Select Committee members will be questioning – if not this Bill – how do we reduce hospitalisation and death? Vaccines can be part of the strategy. But please note, the original clinical trials for mRNA vaccines were not designed to assess whether COVID-19 vaccines prevented infection with or transmission of Sars-Cov-2. Prevention of hospitalisation and death will happen when multi-target medical and nutrient-based therapies are integrated into clinical care and – especially – provided to those with multimorbid health conditions on low incomes. New medications come with a risk of side-effects to existing drugs. By implementing safe repurposed drugs and immunoprotective therapies, the barriers for Māori and Pasifika populations can be reduced –a measure of health equity may be achieved.

We therefore recommend this Bill is withdrawn.