The Senate

Community Affairs References Committee

Excess Mortality

August 2024

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Terms of reference

Excess Mortality with particular reference to:

(a) Australian Bureau of Statistics (ABS) data showing excess deaths in recent years, with particular reference to:

(i) all-cause provisional mortality data reported by the states and territories to the ABS, and

(ii) the difference between all-cause provisional mortality data for 2021, 2022 and 2023 and the preceding years of 2015 to 2020 (inclusive);

(b) factors contributing to excess mortality in 2021, 2022 and 2023;

(c) recommendations on how to address any identified preventable drivers of excess mortality; and

(d) any other related matter.

Contents

Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
The Department	Department of Health and Aged Care
Heart Foundation	National Heart Foundation of Australia
MWG	Mortality Working Group
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHA	National Rural Health Alliance
RFDS	Royal Flying Doctors Service
YLL	Years of life lost due to premature mortality
YLD	Years of healthy life lost due to living with disease and injury

List of recommendations

Recommendation 1

4.29 The committee recommends that the Australian Bureau of Statistics:

- **include geographic indicators in its excess mortality estimates; and**
- **address gaps in the production and publication of data on excess mortality among Aboriginal and Torres Strait Islander people, people with disability, and people in rural and regional areas.**

Recommendation 2

4.35 The committee recommends that the Australian Government consider the design and compensation arrangements of a no-fault compensation scheme for Commonwealth-funded vaccines in response to a future pandemic event.

Recommendation 3

4.42 The committee recommends that the Australian Government establish the Australian Centre for Disease Control as soon as practicable.

Recommendation 4

4.43 The committee recommends that the Australian Government task the Department of Health and Aged Care with reviewing Australia's public health information communication strategies during the COVID-19 pandemic, to improve the delivery of future public health communication.

Recommendation 5

4.44 The committee recommends that the Senate take note of the following:

- **witness participation in public hearings is critical to the committee inquiry process;**
- **all witnesses who participate in committee public hearings should be treated with respect;**
- **Senators should be reminded of the Resolution on the Broadcasting of Senate and Committee Proceedings.**

Chapter 1
Introduction

1.1 Australia's life expectancy is the third highest in the world, sitting behind Monaco and Japan. Australia's life expectancies at birth have also increased over the last 30 years, from 75.0 years for males and 80.9 years for females in 1993, to 81.2 years for males and 85.3 for females in 2020–2022.[1]

1.2 The leading causes of death in 2021 were also unchanged from 2012: ischaemic heart diseases, dementia including Alzheimer's disease, cerebrovascular diseases, lung cancers and chronic lower respiratory diseases.[2]

1.3 However, in 2020, just like the rest of the world, Australia grappled with the effects of a pandemic that would come to be known as COVID-19. According to the Australian Bureau of Statistics (the ABS), it was evident that when 'COVID-19 hit, it was clear that having frequent, timely information about people who died during the pandemic was important'.[3]

1.4 Consequently, the ABS began intensifying its analysis of death registrations supplied by the state and territory Registries of Births, Deaths and Marriages.[4] From June 2020, the ABS started publishing monthly provisional mortality data to provide up-to-date information to the community and support the government's response to the pandemic.[5]

1.5 The purpose of this inquiry is to explore excess mortality in Australia, including: all-cause provisional mortality data, contributing factors to excess morality in 2021, 2022 and 2023, and addressing identified preventable drivers of excess mortality.

Referral of the inquiry

1.6 On 26 March 2024, the following matter was referred to the Senate Community Affairs References Committee (the committee) for inquiry and report by 31 August 2024:

> Excess Mortality with particular reference to:

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1 Centre for Population, Department of the Treasury, *Submission 35*, p. 1.

2 Centre for Population, Department of the Treasury, *Submission 35*, p. 1.

3 Ms Bindi Kindermann, General Manager, People and Place Statistics Division, Australian Bureau of Statistics, *Committee Hansard*, p. 1.

4 Ms Bindi Kindermann, General Manager, People and Place Statistics Division, Australian Bureau of Statistics, *Committee Hansard*, p. 1.

5 Australian Bureau of Statistics, *Submission 2*, p. 2.

(a) Australian Bureau of Statistics (ABS) data showing excess deaths in recent years, with particular reference to:

(i) all-cause provisional mortality data reported by the states and territories to the ABS, and

(ii) the difference between all-cause provisional mortality data for 2021, 2022 and 2023 and the preceding years of 2015 to 2020 (inclusive)

(b) factors contributing to excess mortality in 2021, 2022 and 2023;

(c) recommendations on how to address any identified preventable drivers of excess mortality; and

(d) any other related matter.[6]

Conduct of the inquiry

1.7 Details of the inquiry were published on the committee's website and the committee invited a number of organisations and individuals to lodge submissions. The committee received 59 submissions, which are listed at Appendix 1.

1.8 The committee also held a public hearing in Canberra on 13 June 2024. A list of witnesses who gave evidence at the public hearing is available at Appendix 2.

1.9 In this report, references to *Committee Hansard* are to proof transcripts. Page numbers may vary between proof and official transcripts.

Structure of the report

1.10 This chapter sets out general information outlining the conduct of the inquiry and provides background information relating to excess mortality in Australia.

1.11 Chapter 2 discusses the provisional mortality data provided by the ABS, focussing on COVID-19 both directly and indirectly contributing to excess mortality across the years 2021–2023. The chapter then examines other areas in which deaths rose, as well as explanations for increased mortality raised by submitters over the course of the inquiry.

1.12 Chapter 3 canvasses preventable drivers of excess mortality during 2021–2023, and then considers recommendations on how to address drivers of excess mortality in the future by exploring preventive health measures, vaccination, and government information and messaging.

1.13 Chapter 4 concludes with the committee's views on the evidence it received and its recommendations.

Acknowledgements

1.14 The committee thanks all those who contributed to the inquiry by making submissions and appearing at the public hearing.

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6 Journals of the Senate, No. 107, 26 March 2024, pp. 3211–3212.

1.15 The committee also acknowledges the large volume of correspondence that it received over the course of the inquiry and thanks all the individuals who took the time to write and share their views and personal experiences on this matter. Statements received as correspondence helped the committee progress its understanding of the issues it considered as part of this inquiry.

What is 'excess mortality' and why track it?

1.16 The Department of Health and Aged Care (the Department) defines excess mortality as:

> … an epidemiological concept typically defined as the difference between the observed number of deaths in a specified time period and the expected number of deaths in the same period.[7]

1.17 The ABS noted that excess mortality estimates have been historically used in a range of studies, for example, to measure the effects of diseases and natural disasters.[8] The Actuaries Institute similarly provided that excess mortality is a key measure of the impact of a pandemic, as it captures:

- pandemic-related deaths (including those not reported as such);
- reduced deaths from defence measures (e.g., Australia's border closures and lockdowns); and
- increases in other deaths that may be indirectly caused by the pandemic (such as those due to delayed medical attention).[9]

1.18 As such, the ABS noted that during the COVID-19 pandemic, it was recognised that excess mortality estimates could 'provide a more complete picture of mortality' rather than 'focusing on deaths due to COVID-19 alone'.[10] It explained that:

> … mortality at the all-cause level can account not only for deaths identified as being due to the virus, but also potentially misclassified or undiagnosed COVID-19 deaths and mortality that may be indirectly related to the pandemic (e.g. relating to social isolation or changed access to health care).[11]

How does the ABS estimate excess mortality?

1.19 As the Department noted in its submission, the ABS is the definitive authority on mortality statistics and data in Australia. As such, in addition to the ABS' reports on annual 'Deaths, Australia' and 'Causes of Death, Australia', the Department also 'commissioned the ABS to produce a series of Provisional

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7 Department of Health and Aged Care, *Submission 1,* [p. 5].

8 Australian Bureau of Statistics, *Submission 2*, p. 4.

9 Actuaries Institute, *Submission 3,* p. 2.

10 Australian Bureau of Statistics, *Submission 2*, p. 4.

11 Australian Bureau of Statistics, *Submission 2*, p. 4.

Mortality Statistics reports and excess mortality reports from June 2020 onwards to provide early indications of mortality patterns in Australia'.[12]

1.20 In its submission, the ABS provided that its excess mortality figures represent a response to the following question: 'How does the number of deaths which has occurred during the COVID-19 pandemic (2020–2023) compare to the number of deaths expected had the pandemic not occurred?'.[13]

1.21 The ABS observed that estimating excess mortality is complex as it is dependent on the expected number of deaths. The ABS provided that the expected number of deaths is an estimate that is forecasted from historical deaths data and stated that the premise is that recent mortality patterns provide an appropriate baseline of what future mortality may look like.[14]

1.22 The Actuaries Institute also stressed that the predicted number of deaths used in excess mortality calculations is an estimate based on certain assumptions, and further underlined that excess mortality can only ever be an estimate, stating that 'it is not, and cannot be, a known quantity'.[15]

1.23 As such, in its submission, the ABS outlined that in order to obtain a 'robust estimated number of expected deaths', methodological decisions must be made regarding the mortality trend (the baseline), as well as the age-structure and size of a population.[16] In its submission, the ABS provided the methodological decisions it made, which are explored below.

Pandemic years were intentionally excluded from the baseline

1.24 The ABS intentionally excluded the pandemic years from its baseline. It explained that the low mortality rate in 2020 was likely an 'indirect effect of the pandemic' due to the health measures that were in place.[17] Consequently, using 2020 in the baseline would mean that estimated excess deaths would not represent 'mortality expected in the absence of a pandemic'.[18]

1.25 As such, the ABS advised that it instead uses data from 2013 to 2019 in its baseline.[19]

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12 Department of Health and Aged Care, *Submission 1,* [p. 4].

13 Australian Bureau of Statistics, *Submission 2*, p. 4.

14 Australian Bureau of Statistics, *Submission 2*, p. 4.

15 Actuaries Institute, *Submission 3,* p. 2.

16 Australian Bureau of Statistics, *Submission 2*, p. 4.

17 Australian Bureau of Statistics, *Submission 2*, p. 4.

18 Australian Bureau of Statistics, *Submission 2*, p. 4.

19 Australian Bureau of Statistics, *Submission 2*, p. 4.

Use of age-specific rates

1.26 The ABS modelled 'age-specific rates' instead of raw numbers of deaths to measure expected mortality figures. The ABS explained that it made this decision as Australia has an ageing population, therefore the number of deaths per year should increase over time.[20] It justified that an age-specific rate 'accounts for the base population as well as the age structure of that population'.[21]

Allowing for the trend in decreasing mortality rates

1.27 The ABS also allowed for decreasing mortality rates due to the improvements in health care and interventions. The ABS explained that this means while an ageing population leads to an increase in overall deaths over time, there is a decrease in the age-standardised mortality rate.[22]

1.28 It stated that this is due to reductions in mortality, particularly in younger to middle-age groups.[23]

Separate modelling for Australia and the states and territories

1.29 The ABS also highlighted that expected mortality and subsequent excess mortality estimates were separately modelled for Australia and the states and territories, which allowed the ABS to consider mortality patterns by jurisdiction and make 'appropriate adjustments'.[24]

1.30 The ABS provided an example where many jurisdictions had 'a severe influenza season in 2017' which caused some excess mortality, which:

> … required some adjustment in the baseline when extrapolating expected mortality for those jurisdictions. These adjustments were not necessary for jurisdictions where no excess mortality was recorded in 2017.[25]

ABS reporting of mortality

1.31 The ABS' annual 'Deaths, Australia' and 'Causes of Deaths, Australia' publications were the key sources of mortality information that were published prior to the COVID-19 pandemic.[26] However, the ABS recognised in its

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20 Australian Bureau of Statistics, *Submission 2*, p. 4.

21 Australian Bureau of Statistics, *Submission 2*, p. 4.

22 Australian Bureau of Statistics, *Submission 2*, p. 4.

23 Australian Bureau of Statistics, *Submission 2*, p. 4.

24 Australian Bureau of Statistics, *Submission 2*, p. 5.

25 Australian Bureau of Statistics, *Submission 2*, p. 5.

26 Australian Bureau of Statistics, *Submission 2*, p. 2; See, Australian Bureau of Statistics, *Deaths, Australia,* www.abs.gov.au/statistics/people/population/deaths-australia/2022 (accessed 11 July 2024); Australian Bureau of Statistics, *Causes of Death, Australia,*

submission that these publications did not meet 'the need for timely insights into patterns of mortality during the pandemic or provide numbers of excess deaths'.[27]

1.32 Hence, as earlier discussed, the ABS began publishing provisional mortality data in June 2020 to address these data gaps. This continued from 2021–22, when the Department provided funding to the ABS to continue provisional mortality reporting due to its importance in monitoring pandemic impacts.

1.33 In its provisional mortality reports, the ABS publishes death registration data after receiving information from the state and territory Registries of Births, Deaths and Marriages. According to the ABS, '[t]hese reports aim to provide early indications of patterns of mortality, rather than fully complete accounts of death'.[28]

1.34 The ABS provided that provisional mortality data informs the following publications discussed below.

'Provisional Mortality Statistics' reports

1.35 According to the ABS, these statistics provide 'timely summary mortality data by week and month of death'.[29] Information is published by age, sex, jurisdiction and selected causes of death.[30]

1.36 The ABS stressed that these monthly reports 'should not be used as a source of official excess mortality estimates'.[31] The ABS explained that this is due to the way that its baseline average is calculated:

> For publications reporting on data up to the end of 2023, the ABS included analysis comparing the most recently occurring deaths to an average number of deaths occurring previously, referred to as the baseline average. The baseline average is calculated as the average number of deaths occurring in a week over a five-year period. For example, for the first two years of the pandemic, the baseline average was calculated from the weekly number of deaths occurring over 2015-2019. The purpose of the baseline average was to provide a simple picture of how current mortality compared to mortality in recent years.[32]

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www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2022 (accessed 11 July 2024).

27 Australian Bureau of Statistics, *Submission 2*, p. 2.

28 Australian Bureau of Statistics, *Submission 2*, p. 2.

29 Australian Bureau of Statistics, *Submission 2*, p. 3.

30 Australian Bureau of Statistics, *Submission 2*, p. 3.

31 Australian Bureau of Statistics, *Submission 2*, p. 3.

32 Australian Bureau of Statistics, *Submission 2*, p. 3.

1.37 In its submission, the ABS also identified that these reports have been 'mistakenly used as a source of official excess mortality estimates', and noted that it provides the following advice in the Provisional Mortality Statistics reports:

> While this publication can provide an indication of where counts of deaths are above or below expectations, it does not provide official estimates of excess mortality. Using the number of deaths from the previous years as the predictor for the expected number of deaths does not take into account changes in population size and age-structures of that population, as well as expected improvements in mortality rates over time.[33]

'COVID-19 Mortality in Australia' reports

1.38 The ABS explained that 'COVID-19 Mortality in Australia' reports include information on deaths associated with COVID-19, as 'recorded on the medical certificate as cause of death'.[34]

1.39 These deaths include both:

- deaths from COVID-19: this captures the people who died directly because of the virus; and
- death with COVID-19: this captures deaths where a person died from a cause other than COVID-19, but the virus was certified as a contributing factor.[35]

1.40 The ABS commented that these reports include information such as whether COVID-19 caused or contributed to death, details of associated causes of death, and also includes detailed demographic information, such as age and sex.[36]

'Measuring Australia's excess mortality during the COVID-19 pandemic' reports

1.41 According to the ABS, these reports provide official estimates of excess mortality every six months. In its submission, the ABS provided the methodology it uses to calculate these estimates:

> The methodology used to produce these excess mortality estimates applies a cyclical linear regression to historical data to produce an expected number of deaths. These estimates account for age-structure, change over time within a population and historical trends.[37]

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33 Australian Bureau of Statistics, *Submission 2*, p. 3.

34 Australian Bureau of Statistics, *Submission 2*, p. 3.

35 Australian Bureau of Statistics, *Submission 2*, p. 3.

36 Australian Bureau of Statistics, *Submission 2*, p. 3.

37 Australian Bureau of Statistics, *Submission 2*, p. 3.

1.42 The ABS underlined that these reports should be used when reporting on ABS figures of excess mortality, and that all excess mortality figures in its submission come from this report.[38]

Broader government publications and activities

1.43 In addition to the ABS' publications on mortality in Australia, the Australian Institute of Health and Welfare (AIHW) also plays a role in publishing and reporting on mortality statistics. In its submission, the AIHW stated that it:

- conducts analysis and reporting of mortality data from the National Mortality Database;
- authors and publishes the annual 'Deaths in Australia report', which provides data on deaths, causes of death and life expectancy;
- annually analyses and publishes excel workbooks and visualisations on historical trends in cause of death in the 'General Record of Incidence of Mortality data' publication, and leading causes of death for different Australian geographic areas in the 'Mortality Over Regions and Time data';
- authors and publishes bespoke reports;
- reports on mortality indicators in the Australian Health Performance Framework;
- conducts data custodian activities;
- responds to data requests for information derived from the National mortality database; and
- links deaths of data from the National Death Index to other health and welfare data collections.[39]

1.44 The Department also submitted that it monitors patterns of death from a range of sources, including the ABS data on registered deaths, and other sources such as:

- the National Notifiable Diseases Surveillance System;
- the Therapeutic Goods Administration's Database of Adverse Event Notifications;
- the AIHW's National Mortality Database; and
- the deaths in residential aged care through the My Aged Care Portal.[40]

Other data considerations

1.45 Some submitters also drew the committee's attention to other important considerations when examining mortality in Australia. For example, the AIHW noted the importance of measuring years of life lost due to premature mortality

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38 Australian Bureau of Statistics, *Submission 2*, p. 3.

39 Australian Institute of Health and Welfare, *Submission 4*, [p. 2].

40 Department of Health and Aged Care, *Submission 1*, [p. 4].

(referred to as fatal burden or YLL), as well as estimates of years of healthy life lost due to disease or injury (non-fatal burden or YLD).[41]

1.46 Consequently, the AIHW suggested that work could be undertaken to calculate YLL for each year from 2020–23:

> Work could be undertaken to calculate YLL estimates based on 'actual' deaths registered (rather than projected deaths) for each of the COVID years (2020–2023) to assess whether there has been excess fatal burden as a result of the pandemic and how this compares to excess deaths for Australia. This may provide additional insight into the impact of COVID-19 on mortality and the health of the population.[42]

1.47 Demographers Associate Professor Tim Adair, Associate Professor Brian Houle and Professor Vladimir Canudas-Romo submitted the importance of using life expectancy as a measure of mortality. They explained that 'when death rates rise, life expectancy falls; when deaths rates fall, life expectancy rises' and subsequently noted that life expectancy is a wisely used measure of mortality.[43]

1.48 Associate Professor Adair, Associate Professor Houle and Professor Canudas-Romo went onto suggest that:

> Compared with the measurement of mortality using age-standardised death rates, which is used by the ABS to calculate excess mortality, life expectancy places greater weight on deaths at younger ages. For example, a death at age 30 will have a larger impact on life expectancy than a death at age 90, whereas for age-standardised death rates the impact will be the same. If most deaths occur at older ages, as they do in Australia, changes in life expectancy can seem relatively small compared with excess mortality measured using age-standardised death rates.[44]

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41 Australian Institute of Health and Welfare, *Submission 4*, [p. 3].

42 Australian Institute of Health and Welfare, *Submission 4*, [p. 3].

43 Associate Professor Tim Adair Associate Professor Brian Houle and Professor Vladimir Canudas-Romo, *Submission 32*, p. 2.

44 Associate Professor Tim Adair Associate Professor Brian Houle and Professor Vladimir Canudas-Romo, *Submission 32*, p. 2.

Chapter 2
Provisional mortality data and contributing factors to excess mortality

2.1 Over the course of the inquiry, the evidence presented to the committee overwhelmingly pointed to COVID-19 as the key contributing factor to excess mortality during 2021–2023. This included deaths both directly and indirectly caused by the virus.

2.2 The nature of the Australian Government's response to COVID-19 meant that 2020 experienced 'negative excess mortality', as fewer people died than expected, while excess mortality was experienced in the following years. This phenomenon is known as 'mortality displacement.'

2.3 This chapter first discusses the breakdown of Australian Bureau of Statistics (ABS) data from 2020–2023, as well as addressing international comparisons and future demographic considerations. It then discusses the various ways COVID-19 drove excess mortality within this timeframe, as well as other drivers raised throughout the inquiry.

Provisional mortality data

2.4 As discussed in Chapter 1, the primary source of provisional mortality data is that offered by the ABS. In its submission, the ABS outlined the discrepancy between expected and observed deaths, as shown in the table below.

Figure 2.1 Excess Mortality Table - ABS

Table 1: Excess mortality by year, Australia, 2020-2023

	Expected deaths (no.)	Observed deaths (no.)	Excess deaths (no.)	Excess deaths (%)	COVID-19 associated deaths(a) (no.)
2020	170,045	164,795	-5,250	-3.1	916
2021	169,048	171,799	2,751	1.6	1,448
2022	170,911	190,856	19,945	11.7	13,287
2023(b)	**112,714**	**119,619**	**6,905**	**6.1**	**4,444**

Source: ABS, *Measuring Australia's excess mortality during the COVID-19 pandemic until the end of August 2023.*

a. COVID-19 associated deaths are as recorded on the medical certificate of cause of death. They include deaths caused directly by the virus and deaths where a person died with COVID-19.

b. Data for 2023 includes deaths that occurred by 27 August and were registered by 31 October 2023.

Source: Australian Bureau of Statistics, Submission 2, *p. 5.*

2.5 Additionally, the Actuaries Institute has a Mortality Working Group (MWG), which provides its own mortality estimates. Its calculations are presented

below, including comparisons to other bodies which made calculations of excess mortality across the same timeframe (i.e., The Economist and Kobak & Karlinsky):

Figure 2.2 Actuaries Institute - Comparison of Excess Mortality Estimates

Table 1 – Summary of Excess Mortality Estimates

	MWG		ABS		K&K		The Economist	
Year	Excess	% Excess	Excess	% Excess	Excess	% Excess	Excess	% Excess
2020	-4,300	-3%	-5,300	-3%	-3,400	-2%	-3,400	-2%
2021	3,800	2%	2,800	2%	4,300	3%	4,900	3%
2022	19,300	11%	19,900	12%	22,100	13%	21,900	13%
2023	8,400	5%	NA[3]		11,800	7%	10,900	6%

Note: K&K and The Economist figures sourced from OWID on 20 April 2024, plus analysis

Source: [Actuaries Institute, *Submission 3*, p. 4]

2.6 As shown above, these different groups present slightly different figures, but all indicate the same trend: Australia experienced negative excess mortality in 2020, a slight increase in 2021, and an increase of more than ten per cent in 2022.

2.7 In regard to excess mortality data, the Actuaries Institute emphasised the inexact nature of such estimates:

> The predicted number of deaths used in excess mortality calculations is an **estimate** based on certain assumptions, and therefore the calculated excess mortality is also an estimate. **Excess mortality can only ever be an estimate** – it is not, and cannot be, a known quantity.[1]

Mortality displacement

2.8 A key term used in submissions and evidence in the inquiry is 'mortality displacement'. In its submission, the Department of Health and Aged Care (the Department) defines mortality displacement as follows:

> … delayed deaths from existing underlying health problems due to reduced circulation of many respiratory and other diseases in 2020 and 2021, which would have otherwise contributed to deaths in those years.[2]

2.9 The ABS links this phenomenon to excess mortality numbers in Australia in recent years:

> As Australia had lower than expected mortality in 2020, it is likely some reverse mortality displacement was experienced. This means deaths that may have occurred in 2020 had 2020 followed usual patterns of mortality, may have instead occurred in later years.[3]

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1 Actuaries Institute, *Submission 3*, p. 2. Emphasis in original.

2 Department of Health and Aged Care, *Submission 1*, [p. 5].

3 Australian Bureau of Statistics, *Submission 2*, p. 12.

International comparisons

2.10 As excess mortality was a global phenomenon in the years following the COVID-19 pandemic, the committee heard evidence which detailed international comparisons of excess deaths.

2.11 In its submission, the Department cited an Australian Institute of Health and Welfare report which found that '[e]xcess mortality in Australia was 4.4% in this period, compared to an average excess mortality of 14% across 30 countries, including the USA and UK'.[4] In addition, the Department referred 2023 OECD report which 'found in 2020-21, Australia had one of the lowest global excess death rates, with the excess mortality rate ranking as 5th lowest of thirty-five studied countries'.[5]

2.12 Furthermore, the Actuaries Institute stated in its submission that:

> Globally, countries with low (or negative) excess mortality in 2020 (like Australia) have generally had lower excess mortality over the period 2020 to 2023 than those with high excess mortality in 2020 (such as the United Kingdom). This is despite the impact of mortality displacement, which makes Australia's excess mortality in 2022 and 2023 look relatively high.[6]

2.13 The Actuaries Institute also provided a table (below) illustrating the relatively low rate of excess mortality in Australia:

Figure 2.3 Actuaries Institute - Excess Mortality International Comparison

Table 2 – Excess Mortality Estimates 2020-2023 – Selected Countries

Year	Australia	Germany	Japan	New Zealand	South Africa	United Kingdom	United States	66 Countries
2020	-2%	3%	-2%	-6%	11%	13%	16%	12%
2021	3%	6%	1%	-2%	36%	9%	17%	21%
2022	13%	10%	8%	7%	7%	8%	9%	9%
2023	7%	5%	7%	3%	6%	8%	0%	3%
2020-2023	**5%**	**6%**	**4%**	**0%**	**15%**	**10%**	**10%**	**11%**

Source: Analysis of K&K data from Our World in Data

Source: [Actuaries Institute, *Submission 3*, p. 4]

2.14 The Actuaries Institute explained the broad trend:

> This pattern (negative excess in 2020, increasing to a large excess in 2022 and a lower excess in 2023) is similar to that experienced in Denmark, Germany, Japan, New Zealand, Singapore, South Korea and Taiwan. A few other countries also reached a peak of excess mortality in 2022.[7]

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4 Department of Health and Aged Care, *Submission 1*, [p. 8].

5 Department of Health and Aged Care, *Submission 1*, [p. 8].

6 Actuaries Institute, *Submission 3*, [p. 2].

7 Actuaries Institute, *Submission 3*, [p. 4].

2.15 The Actuaries Institute gave further context, describing different trends to those found in Australia:

> In contrast, many other countries experienced very high or extremely high excess mortality in 2020 and 2021, with the latter generally being the peak, before excess mortality declined in 2022 and 2023. The total excess over the four years 2020–2023 was generally far higher in these countries than in Australia and most other countries with low excess mortality in 2020.[8]

Data gaps

2.16 Some submitters addressed perceived shortcomings in the existing data, namely a lack of geographic data and First Nations data.[9] These are explored below.

Geographic data

2.17 In its submission, the National Rural Health Alliance (NRHA) pointed to existing shortcomings in ABS data in relation to geographic gaps, stating that:

> despite the breadth and depth of data analysis provided by the ABS, there is no indicator for the impact of excess mortality on rural people ie. excess mortality data is not broken down by a geographic measure such as the Australian Statistical Geography Standard – Remoteness Areas.[10]

2.18 The NRHA also stated that there has been 'a lack of research'[11] in pandemic management strategies for rural Australians, emphasising the importance of this part of the population:

> As a demographic that represents approximately one third of the Australian population, this research and data is incredibly important.[12]

2.19 In order to address this gap, the NRHA urged that 'the ABS analyse and publish data on excess mortality by geography'.[13] Ms Susanne Tegen, Chief Executive Officer of the NRHA, explained in her testimony before the committee the need for such data:

> By increasing the amount of data that is available, by increasing an understanding of health care, not only the healthcare system but also your own health, you are more likely to be able to deal with your own health issues because you have an increased health literacy level. … We need to make sure that [rural people] are not forgotten, and that we have a social

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8 Actuaries Institute, *Submission 3*, [p. 4].

9 See, for example, Royal Australian College of General Practitioners, *Submission 8*, [p. 1]; Associate Professor Tim Adair, Associate Professor Brian Houle and Professor Vladimir Canudas-Romo, *Submission 32*, pp. 7–8.

10 National Rural Health Alliance, *Submission 9*, p. 6. Citations omitted.

11 National Rural Health Alliance, *Submission 9*, p. 6.

12 National Rural Health Alliance, *Submission 9*, p. 6.

13 National Rural Health Alliance, *Submission 9*, p. 7.

> contract to do something about this, rather than having reforms and inquiries, and nothing happening with them.[14]

2.20 The Stroke Foundation, in its submission, made a recommendation for the government to ensure, during times of national emergency, that:

> hospitals maintain geographically defined stroke units staffed by specialised medical, nursing, and allied health professionals, to provide evidence-based, best-practice acute stroke care.[15]

2.21 The AIHW stated, in response to a Question on Notice, that it is currently progressing analyses for the *Health outcomes following a COVID-19 diagnosis by population groups and vaccination status* report, which is due to be released in December 2024. This population will include, among other demographic characteristics, 'geographical areas (state/territory, remoteness area)'.[16]

First Nations data

2.22 The lack of specific breakdown of excess mortality according to First Nations status was also an issue which drew commentary over the course of the inquiry.[17]

2.23 In its submission, the National Aboriginal Community Controlled Health Organisation (NACCHO) commented specifically on this issue, stating that:

> Reporting of ABS provisional mortality data used to show excess deaths, does not include Indigenous status. It is therefore not possible to assess whether excess deaths seen at the whole-of-population level affect Aboriginal and Torres Strait Islander communities at a comparable level.[18]

2.24 NACCHO went on to say that the lack of this data meant the impact of excess mortality on First Nations communities could not be entirely understood:

> Avoidable and preventable deaths already represent a considerable burden on Aboriginal and Torres Strait Islander communities. To date, limited reporting has been available to demonstrate whether (or how) this changed during the COVID-19 pandemic. However, it is critical to highlight the importance of looking beyond the impact of COVID-19 infections to the impacts on preventative health actions (such as the reduction in sexual health screening during the pandemic) and environmental health issues (such as the subsequent increase in overcrowding which does not support good health outcomes).[19]

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14 Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, p. 21.

15 Stroke Foundation, *Submission 6*, p. 3.

16 Australian Institute of Health and Welfare, answer to question on notice, 13 June 2024, (received 4 July 2024).

17 See National Rural Health Alliance, *Submission 9*, p. 3.

18 NACCHO, *Submission 7*, p. 4.

19 NACCHO, *Submission 7*, p. 5. Citation omitted.

2.25 In addition, NACCHO asked for already-existing data to be released, which would help gain a clearer picture of this issue on these particular communities:

> However, while gaps exist, robust data is available on excess mortality for Aboriginal and Torres Strait Islander people in a majority of jurisdictions, and steps must be taken toward public reporting of this data, despite its limitations.[20]

2.26 The NRHA also recommended that the ABS engage with researchers from the First Nations community in order to explore the factors driving this disproportionate rate of excess deaths in relation to COVID-19, and ultimately provide funding and support in order for recommendations.

> Engage with First Nations researchers to explore the drivers behind the disproportionate rate of death related to COVID-19 and provide funded support to address recommendations.[21]

2.27 NACCHO recommended that data collection should align with the four Priority Reform Areas under the National Agreement on Closing the Gap.[22]

Future mortality predictions

2.28 While in the ABS statistics to date, '[p]andemic years were intentionally excluded from the baseline,'[23] the ABS stated that it will, in future, 'produce estimates of expected mortality with COVID-19 included in the baseline'.[24]

2.29 Accordingly, the ABS outlined in its submission its rationale for changing future baselines for excess mortality:

> Firstly, this will provide new insights into mortality expectations accounting for the virus and may be used for policy and planning purposes. The second reason is that the further we are from the start of the pandemic the more factors we have influencing our current mortality profile which should be considered. For example, influenza and other respiratory diseases are again circulating and contributing to deaths in Australia. Thirdly, the older the data used to model a current year of expected mortality, the less robust the estimate will be.[25]

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20 NACCHO, *Submission 7*, p. 4.

21 See National Rural Health Alliance, *Submission 9*, p. 4.

22 NACCHO, *Submission 7*, p. 4. Note that the four Priority Reform Areas are '1. Formal partnerships and shared decision-making, 2. Building the community-controlled sector, 3. Transformation of mainstream institutions, and 4. Sharing data and information to support decision making.' pp. 3–5.

23 Australian Bureau of Statistics, *Submission 2*, p. 4.

24 Australian Bureau of Statistics, *Submission 2*, p. 12.

25 Australian Bureau of Statistics, *Submission 2*, p. 12.

COVID-19 as a driver of excess mortality

2.30 Many submitters expressed the view that excess mortality was driven both directly and indirectly by COVID-19.[26]

Deaths caused directly by COVID-19

2.31 In its testimony before the committee, the ABS stated that 'COVID-19 was the main cause of excess deaths in 2021, 2022 and up to August 2023',[27] adding that:

> In 2020, COVID-19 ranked as the 38th leading cause of death in Australia; in 2021, it moved up to the 34th position; and, by 2022, COVID-19 was the third leading cause of death, marking the first time in over 50 years that an infectious disease was in the top five causes of death in Australia.[28]

2.32 The Actuaries Institute also provided its own analysis of COVID-19 in relation to excess mortality, as seen in the table below:

Figure 2.4 Actuaries Institute - Causes of Excess Mortality

Table 3 – Excess Mortality Estimates by Cause of Death 2020-2023

	2020		2021		2022		2023		Four-Year Total	
	Excess	%	Excess	%	Excess	%	Excess	%	Excess	%
From COVID-19	**906**	*	**1,355**	*	**10,264**	*	**4,630**	*	**17,156**	*
Doctor-certified respiratory disease										
Influenza	(590)	-93%	(660)	-100%	(390)	-57%	(290)	-42%	(1,930)	-72%
Pneumonia	(750)	-28%	(780)	-28%	(430)	-15%	(510)	-18%	(2,470)	-22%
Lower respiratory	(1,280)	-16%	(820)	-10%	(290)	-3%	(660)	-8%	(3,050)	-9%
Other respiratory	(440)	-13%	(10)	0%	70	2%	-	0%	(380)	-3%
All doctor-certified respiratory	**(3,070)**	**-21%**	**(2,260)**	**-15%**	**(1,040)**	**-7%**	**(1,470)**	**-9%**	**(7,840)**	**-13%**
Doctor-certified other diseases										
Cancer	(640)	-1%	110	0%	560	1%	700	1%	730	0%
Ischaemic heart disease	(110)	-1%	830	6%	1,860	14%	660	5%	3,240	6%
Other cardiac conditions	(480)	-5%	440	5%	1,000	11%	910	10%	1,870	5%
Cerebrovascular disease	(90)	-1%	360	4%	480	5%	260	3%	1,010	3%
Diabetes	330	7%	360	8%	840	17%	660	14%	2,190	12%
Dementia	(980)	-6%	(550)	-3%	(120)	-1%	(1,670)	-9%	(3,320)	-5%
Other unspecified diseases	(120)	0%	2,360	8%	3,360	10%	2,300	7%	7,900	6%
All other doctor-certified disease	**(2,080)**	**-2%**	**3,900**	**3%**	**7,990**	**6%**	**3,810**	**3%**	**13,620**	**3%**
Coroner-referred excl. COVID-19	**(140)**	**-1%**	**740**	**4%**	**2,050**	**10%**	**1,430**	**7%**	**4,080**	**5%**
Total	**(4,300)**	**-3%**	**3,800**	**2%**	**19,300**	**11%**	**8,400**	**5%**	**27,200**	**4%**

* There are no predicted deaths from COVID-19 in the absence of the pandemic

Figures shaded green indicate that the observed values are below the 95% prediction interval while figures shaded red are above the 95% prediction interval. COVID-19 data from ABS customised report 2023 and analysis

Source: [Actuaries Institute, *Submission 3*, p. 5]

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[26] See, for example, Actuaries Institute, *Submission 3*, [p. 1]; Associate Professor Tim Adair, Associate Professor Brian Houle and Professor Vladimir Canudas-Romo, Submission 32, p. 6; Australian Bureau of Statistics, *Submission 2*, p. 9; Department of Health and Aged Care, *Submission1*, [p. 5]; Centre for Population, Department of the Treasury, *Submission 35*, pp. 1–3; Heart Foundation, *Submission 25*, p. 2.

[27] Ms Bindi Kindermann, General Manager, People and Place Statistics Division, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 1.

[28] Ms Bindi Kindermann, General Manager, People and Place Statistics Division, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 1.

2.33 As indicated in the table above, COVID-19 represented either the plurality or majority of all identified causes of excess deaths between 2021 and 2023.

2.34 The Actuaries Institute explained the data as follows:

> Unsurprisingly, **deaths from COVID-19 have been the major contributor to excess mortality**, particularly in 2022 and 2023, once the vast majority of the population was vaccinated and Australia was no longer pursuing a suppression/elimination strategy. Across the four years shown, we estimate that the total deaths from COVID-19 of 17,200 make up almost **two-thirds** of the total estimated excess mortality of 27,200. Pleasingly, COVID-19 waves have shown an encouraging trend of reducing mortality impact since early 2022, with each successive wave resulting in fewer deaths than the previous wave.[29]

2.35 In its submission, the Department stated that 'COVID-19 was the main contributor to excess mortality in 2022', citing the *Measuring Australia's excess mortality during the COVID-19 pandemic until August 2023* from the ABS.[30]

Cardiovascular disease and strokes

2.36 The committee also heard about the increased rates of deaths from cardiovascular disease and strokes which contributed to excess mortality.

2.37 In its testimony before the committee, the Heart Foundation clarified the link between COVID-19 and cardiovascular disease, stating that the virus had 'devastating effects on the cardiovascular system'.[31]

2.38 The ABS also stated in its testimony that 'there is an increase of myocarditis in 2022 as an associated cause of death', which is 'generally attributed to COVID-19'.[32]

2.39 In its submission, AIHW also spoke to the rise in deaths associated with cardiovascular disease in the years following the onset of the pandemic:

> [Coronary heart disease] continued its historical decline in 2020, the first year of the pandemic with 16,800 deaths, however this decline stalled in 2021 with 17,400 deaths and then increased to around 18,600 deaths in 2022. After adjusting for age, the [coronary heart disease] death rate (as the underlying cause) increased by 4.3% between 2021 and 2022 (from 50 to 52 per 100,000 population).[33]

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29 Actuaries Institute, *Submission 3*, p. 5. Emphasis in original.

30 Department of Health and Aged Care, *Submission 1*, [p. 5].

31 Professor Garry Jennings, Chief Medical Adviser, National Heart Foundation of Australia, *Committee Hansard*, 13 June 2024, p. 46.

32 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 2.

33 Australian Institute of Health and Welfare, *Submission 4*, [p. 6]. Citations omitted.

2.40 The AIHW stated that this data 'should be interpreted in the context of higher overall mortality in 2022',[34] linking it to the broader picture of excess deaths associated with COVID-19. According to the AIHW's submission, chronic heart conditions represented the most common category of pre-existing among those who died from COVID-19, and the virus itself 'was an associated cause of death for 729 deaths due to circulatory system diseases in 2022'.[35]

2.41 In its testimony before the committee, the Stroke Foundation also spoke to the relationship between COVID-19 and strokes:

> A person who has had a stroke is more likely to get severe COVID symptoms, more likely to get complications and five times more likely to die. That comes out in the statistics around people with comorbidity. The other thing that we know is that if you have COVID you are also more likely to have a stroke.[36]

Diabetes

2.42 Evidence presented before the committee indicated that diabetes reflected one of the largest proportions of excess deaths for any cause, apart from COVID-19.[37] In its submission, the AIHW explained:

> Diabetes remains one of the 10 leading causes of death in Australia contributing to around 22,000 deaths in 2022 (11% of all deaths). Diabetes was the underlying cause of death in 6,000 deaths (28% of diabetes deaths). It was an associated cause of death in a further 16,000 deaths (72% of diabetes deaths).[38]

2.43 In order to illustrate these trends, the AIHW also provided the graph below (N.B. COD refers to 'Cause of Death'):

[34] Australian Institute of Health and Welfare, *Submission 4*, [p. 6]. Citations omitted.

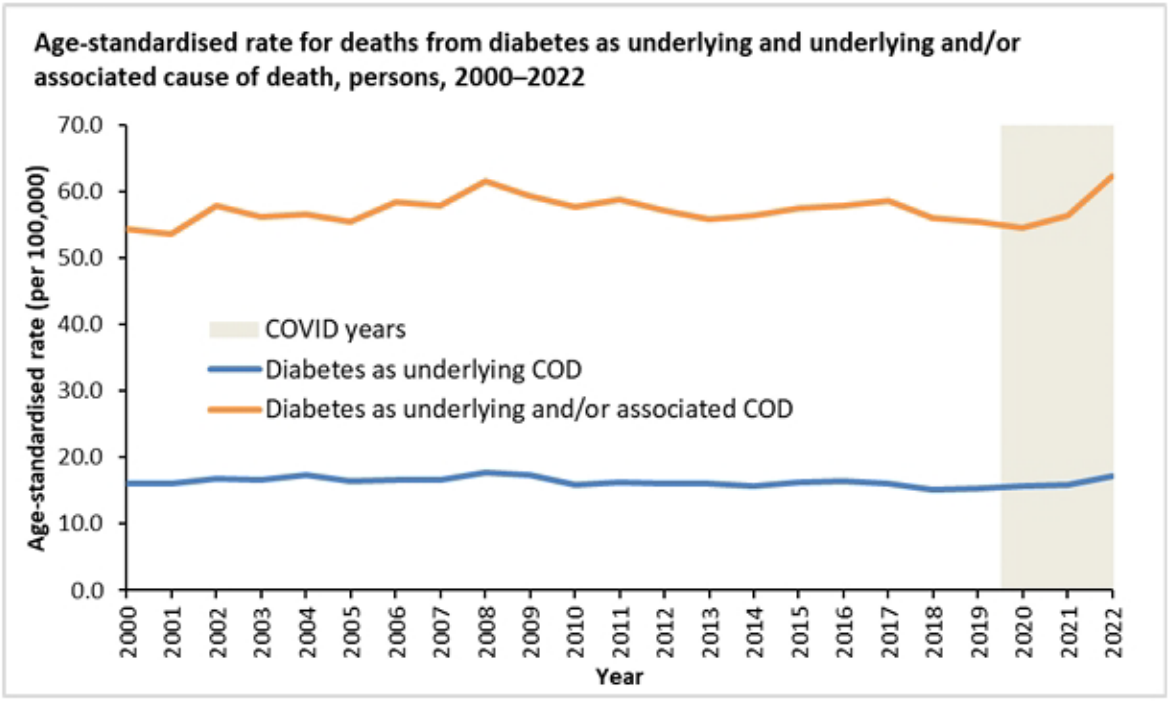
[35] Australian Institute of Health and Welfare, *Submission 4*, [p. 6]. Citations omitted.

[36] Dr Lisa Murphy, Chief Executive Officer, Stroke Foundation, *Committee Hansard*, 13 June 2024, p. 27.

[37] See, for example, Australian Institute of Health and Welfare, *Submission 4*, [p. 7]; Diabetes Australia, *Submission 10*, [p. 1]; and Department of Health and Aged Care, *Submission 1*, [p. 5].

[38] Australian Institute of Health and Welfare, *Submission 4*, [p. 7].

Figure 2.6 AIHW – Diabetes Death Rates



Source: [Australian Institute of Health and Welfare, Submission 4*, [p. 7].]*

2.44 The AIHW went on to give historical context to this data:

> While diabetes death rates (underlying and/or associated cause) remained relatively stable between 2000 and 2020, increases were recorded in both 2021 and 2022. After adjusting for age, the diabetes death rate increased from 54 per 100,000 population in 2000 to 56 and then 62 deaths per 100,000 population in 2021 and 2022, respectively. Like CHD, diabetes is a commonly reported comorbidity in deaths associated with COVID-19 (24% in 2021, 15% in 2022 and 13% in 2023). COVID-19 was an associated cause of death for 121 deaths due to diabetes in 2022. Type 2 diabetes is also the second most commonly diagnosed comorbid chronic condition recorded in hospitalisations that involve a COVID-19 diagnosis behind chronic cardiac conditions (21% in 2022–23).[39]

2.45 As described above, diabetes represented a significant proportion of excess deaths from 2021 to 2023. In its submission, Diabetes Australia recommended that the Australian Government increase investment into diabetes research and strengthen the Australian health system's response to diabetes.[40]

2.46 The Department pointed out that an ageing population, such as Australia's, means an increased risk of diseases including diabetes.[41]

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39 Australian Institute of Health and Welfare, *Submission 4*, [p. 7]. Citations omitted.

40 Diabetes Australia, *Submission 10*, [p. 1].

41 Department of Health and Aged Care, *Submission 1*, [p. 5].

2.47 In addition, the ABS noted that deaths from diabetes were higher during periods of general high mortality during the pandemic, that diabetes was commonly recorded as a co-morbidity among deaths associated with COVID-19.[42]

Dementia

2.48 Dementia also represented a notable factor associated with deaths between 2021 and 2023, as the AIHW outlined in their submission:

> Dementia including Alzheimer's disease was the leading cause of death in females and the second leading cause of death in males in 2022. Age-standardised mortality rates for dementia including Alzheimer's disease increased from 36 per 100,000 in 2012 to 44 per 100,000 in 2019. The rates recorded in 2020, 2021 and 2022 were 41.5, 43,5 and 45.3 per 100,000 respectively.[43]

2.49 AIHW offered further detail on this trend and its relation to COVID-19:

> When interpreting these trends, it should be noted that people with dementia have a greater risk of developing severe illness from COVID-19 and higher risk of dying from acute respiratory infections including influenza and pneumonia. …. Fatal COVID-19 outbreaks have involved many people with dementia.[44]

2.50 In its submission, the ABS also related the increased incidence of deaths from dementia to COVID-19:

> Death rates for doctor-certified deaths for ischaemic heart diseases, diabetes and dementia have been higher during times of high mortality during the pandemic. These are all causes commonly recorded as co-morbidities among deaths associated with COVID-19.[45]

2.51 Further, the Department noted more generally that Australia's ageing population was a contributing factor to excess mortality, as this shift in demographics 'raises the risks associated with dementia, cardiovascular disease, chronic kidney disease, respiratory disease, and diabetes'.[46]

Other issues raised

2.52 In addition to these factors, a number of submitters raised concerns about other issues which were thought to be contributing to excess mortality. These issues, and their potential impacts, are discussed below.

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42 Australian Bureau of Statistics, *Submission 2*, p. 12.

43 Australian Institute of Health and Welfare, *Submission 4*, [p. 5]. Citations omitted.

44 Australian Institute of Health and Welfare, *Submission 4*, [p. 5]. Citations omitted.

45 Australian Bureau of Statistics, *Submission 2*, p. 12.

46 Department of Health and Aged Care, *Submission 1*, [p. 5].

Suicide and mental health

2.53 Some submitters suggested that the government response to COVID-19, in particular the imposition of lockdowns, had a negative impact on mental health outcomes, inferring that excess mortality was driven to an extent by an increase in suicides.[47]

2.54 For example, Father David Smith, an Anglican priest in Sydney who managed a youth drop-in centre targeting local at-risk teenagers, stated in his submission that 'during the lockdowns I became very aware of the stress being experienced by some of the people I was working with.'[48] Father Smith expressed the view that 'the lockdowns had the effect of pushing people who were on the edge over the edge,' and that the lockdowns 'cost numerous lives amongst the more vulnerable members of the community'.[49]

2.55 The committee did receive evidence from the ABS that COVID-19 and the government response negatively impacted Australians' mental health.[50] However, in its testimony before the committee, the Black Dog Institute stated that:

> I'll comment first on the suicide deaths comparing 2015 to 2020 with 2021 to 2022. There were no significant changes from the earlier period to the late period. There were no increases in suicide deaths during the peak of the pandemic. The 2023 national data are not yet available, but we do have preliminary data from New South Wales, Victoria and Queensland also showing no increase from 2020. So that's one way to look at mortality.[51]

2.56 The ABS described suicides as part of a broader class of 'preventable disease from trauma', which in fact decreased during the pandemic.[52] Providing context, the ABS explained that this broad category 'includes road traffic accidents, suicides and also drug-induced deaths'.[53]

2.57 The ABS added, in its testimony, that:

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47 See, for example, Father David Smith, *Submission 22*, [p. 1]; The World of Wellness International, *Submission 12*, [p. 5]; Dr Monique O'Connor, *Submission 18*, pp. 36–38.

48 Father David Smith, *Submission 22*, [p. 1].

49 Father David Smith, *Submission 22*, [p. 1].

50 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

51 Dr Fiona Shand, Associate Professor and Head of Suicide Prevention Research, Black Dog Institute, University of New South Wales, *Committee Hansard*, 13 June 2024, p. 46.

52 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

53 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

> That's certainly not to say that, for something such as suicide, for example, the pandemic didn't affect people. We know that the pandemic did have an effect on people's mental health but, overall, there was a reduction in those. We did see a slight increase in 2022, but for the moment it doesn't look like that's statistically significant excess deaths. It looks more like it's a return to the usual patterns of excess mortality that we would see.[54]

2.58 In addition, the AIHW provided data in its submission which showed that 'the pattern of no clear trend has remained for the pandemic years with age-standardised rates reported for 2020, 2021 and 2022 ranging between 12.1 and 12.3 per 100,000'.[55]

Vaccinations

2.59 The committee received both submissions and correspondence which suggested that COVID-19 vaccination injuries were a potential driver of excess mortality.[56] For example, Coverse, in its submission stated:

> While our organisation does not have statistical evidence that the COVID-19 vaccines have definitely contributed to excess mortality during 2021-2023, we do have evidence of widespread and significant downplaying of vaccine-caused harms, which has concerning implications for current understanding of drivers of excess mortality in Australia.[57]

2.60 However, the Actuaries Institute placed such injuries in a broader health context:

> The available evidence does not support a significant contribution to excess mortality by the adverse side-effects of COVID-19 vaccines. Indeed, the reverse is true: while every such death is regrettable, it seems clear that the small number of deaths triggered by COVID-19 vaccines is a tiny fraction of the number of COVID-19 deaths that they have prevented.[58]

2.61 The committee heard evidence that, while there are 16 cases confirmed by the Department of deaths as a result of vaccine injury, this represents a relatively small proportion of the 69, 788, 192 vaccine doses administered between the years 2021 and 2023, as well as the total number of excess deaths in Australia.[59]

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54 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

55 Australian Institute of Health and Welfare, *Submission 4*, [p. 4].

56 See, for example, Dr Martin P. Stewart, *Submission 26*, [pp. 7–8]; Ms Xin Yin Ooi, *Submission 20*, [p. 2]; Mr Martin Hicking, *Submission 29*, p. 6; Dr Jeyanthi Kunadhasan, Treasurer, Australian Medical Professionals Society, *Committee Hansard*, 13 June 2024, p. 36.

57 Coverse, *Submission 13*, p. 1.

58 Actuaries Institute, *Submission 3*, p. 2.

59 Department of Health and Aged Care, answer to written question on notice, 13 June 2024 (received 26 June 2024); Dr Philip Gould, First Assistant Secretary and Chief Data Officer, Health, Economics and Research Division, Department of Health and Aged Care, *Committee Hansard*, 13 June 2024,

2.62 The Actuaries Institute stated in its submission that vaccinations helped to prevent higher rates of excess mortality:

> Many studies around the world have shown that COVID-19 vaccines reduce the severity of the disease. For example, a recent study "Assessing the impact of Australia's mass vaccination campaigns over the Delta and Omicron outbreaks" presented a conservative estimate that deaths from COVID-19 would have been six times as high with no vaccinations. This meant that almost 18,000 deaths were averted between August 2021 and July 2022 in people aged over 50 by the COVID-19 vaccines in NSW alone. Extrapolating this nationally, more than 50,000 deaths were averted in this 28-week period. **In other words, COVID-19 vaccines have *significantly* reduced excess mortality**. [Emphasis in original][60]

Healthcare access

2.63 Some submitters also expressed concern about reduced access to healthcare during the pandemic.[61]

2.64 In an answer to a question on notice, the Stroke Foundation stated the following:

> The National Heart Foundation of Australia has estimated that 27,000 fewer Heart Health Checks were conducted due to COVID-19.
>
> Specifically, between March 2020 to March 2021, 92,380 heart health checks were undertaken.
>
> The number of heart health checks undertaken has increased steadily since then, and between March 2023 to March 2024, 207,919 heart health checks were undertaken, the highest number since the Medicare Benefits Schedule item numbers were introduced in early 2019.

2.65 Moreover, the Heart Foundation, in its appearance before the committee, emphasised the potential long-term consequences of this change:

> We saw a testing and management of risk factors out in primary care drop significantly, with about a 40 per cent drop in pathology testing for things like cholesterol and diabetes. We saw people delaying attendance at health facilities. As far as severe events like myocardial infarction, we saw much higher acuity and fewer procedures being done to deal with those. There will be a price, and there is a price, that we're paying in the long term for that, because people with more significant damage at the time of their event are going to have long-term chronic illness.[62]

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p. 57. See also Australian Bureau of Statistics, *Submission 2*, p. 14; Actuaries Institute, *Submission 3*, p. 2.

60 Actuaries Institute, *Submission 3*, p. 2.

61 See, for example, National Rural Health Alliance, *Submission 9*, p. 12; Diabetes Australia, *Submission 10*, [p. 3]; Stroke Foundation, *Submission 6*, pp. 1–2.

62 Professor Garry Jennings, Chief Medical Adviser, National Heart Foundation of Australia, *Committee Hansard*, 13 June 2024, p. 45.

2.66 Diabetes Australia, in its submission, also expressed concern about access during the pandemic:

> … in Australia reduced access to primary care, diagnostic and hospital services for diabetes, combined with fear of exposure to the virus in these settings, led to a significant drop in access to usual diabetes care. From the diabetes care perspective, there was a significant and concerted diversion of hospital resources and staff to COVID-19 specific activities, and there was a reduction in HbA1c testing (the main biomarker used to assess long-term glycaemic control) amongst people with type 2 diabetes.[63]

2.67 The Actuaries Institute also listed, among others, the following possible causes of excess mortality:

- delays in patients receiving emergency medical care, supported by statistics on ambulance response times and emergency department treatment times; and
- delays in patients receiving routine medical care, supported by statistics on elective surgery wait times.[64]

2.68 This issue is further considered in Chapter 3 within the context of addressing preventable drivers of excess mortality from 2021–2023.

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63 Diabetes Australia, *Submission 10*, [p. 3]. Citations Omitted.

64 Actuaries Institute, *Submission 3*, p. 7.

Chapter 3
Preventable drivers of excess mortality

3.1 This chapter considers preventable drivers of excess mortality during 2020–2023 in terms of:

- preventable diseases as contributors to excess mortality, including diabetes, cardiovascular disease, and some cancers;
- preventable structural drivers of excess mortality, including geographic health disparities and First Nations' health disparities; and
- Australia's preparedness for future health crises by considering the lessons learnt from the COVID-19 pandemic in relation to preventive health measures, vaccination and public health information.

Preventable diseases as contributors to excess mortality

3.2 In addition to the evidence discussed in Chapter 2 that indicated COVID-19 was the main driver of excess mortality from 2021 to 2023, the committee also received evidence on the potential impact that diabetes, cardiovascular disease, and cancer had on excess mortality during the same period.

3.3 These are explored below to illuminate the extent to which these (sometimes) preventable diseases drove excess mortality and gives consideration as to why this occurred.

Diabetes

3.4 As discussed in Chapter 2, submitters identified diabetes as a driver of high numbers of deaths and excess mortality throughout the pandemic years.[1] For example, Ms Lauren Moran, Director, Health and Vital Statistics Section at the Australian Bureau of Statistics (ABS) discussed diabetes as a driver of excess mortality, as well as its link to COVID-19, at a public hearing:

> There has been some excess mortality in deaths due to diabetes, and some deaths due to diabetes are also considered preventable. Some of these are still likely to be associated with COVID-19 itself—we know that people with diabetes can be highly immunocompromised and more susceptible to infections—but some of that may also be management of health care during the pandemic and not accessing those services.[2]

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1 See, for example, Australian Institute of Health and Welfare, *Submission 4*, [p. 7]; Stroke Foundation, *Submission 6*, p. 1; Diabetes Australia, *Submission 10*, [p. 1]; Professor Albert Reece, *Submission 24*, p. 5; United Australian Party, *Submission 31*, p. 15.

2 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

3.5 Relatedly, in its submission, Diabetes Australia raised concern about the high levels of excess deaths that have been attributed to diabetes. Diabetes Australia drew attention to reporting by the ABS that the baseline average in 2023 for diabetes deaths was 4689, but that the number of deaths were 5609 in 2022 and 5403 in 2023. As such, Diabetes Australia noted that diabetes reflected the largest proportion of excess deaths for any cause, apart from COVID-19.[3]

3.6 In its submission, Diabetes Australia also explored the likely reasons for excess deaths from diabetes where COVID-19 was not the underlying cause or a contributing factor. It cited the Actuaries Institute's COVID-19 Mortality Working Group's findings for 2022, which included:

- The impact of [having had] COVID-19 on subsequent mortality risk, including diabetes;
- Delays in emergency care, particularly at times of high prevalence of COVID-19 and or/influence; and
- Delays in routine care, which refers to missed opportunities to diagnose or treat non-COVID-19 diseases and the likelihood of consequent higher mortality from those conditions in future.[4]

3.7 Diabetes Australia also underlined similar findings from the AIHW, which identified an 'emerging global issue' where people avoided or delayed medical care for diabetes during the pandemic.[5] Diabetes Australia commented on this occurrence in Australia, and noted associated healthcare resourcing challenges throughout the pandemic:

> … reduced access to primary care, diagnostic and hospital services for diabetes, combined with fear of exposure to the virus in these settings, led to a significant drop in access to usual diabetes care. From the diabetes care perspective, there was a significant and concerted diversion of hospital resources and staff to COVID-19 specific activities, and there was a reduction in HbA1c testing (the main biomarker used to assess long-term glycaemic control) amongst people with type 2 diabetes.[6]

Cardiovascular disease

3.8 The committee received similar evidence that pointed to cardiac conditions as leading causes of death and preventable drivers of excess mortality during 2021–2023.[7] At a public hearing, Professor Garry Jennings, Chief Medical Adviser at the National Heart Foundation of Australia (the Heart Foundation),

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3 Diabetes Australia, *Submission 10,* [p. 2].

4 Diabetes Australia, *Submission 10,* [p. 3].

5 Diabetes Australia, *Submission 10,* [p. 3]. Citations omitted.

6 Diabetes Australia, *Submission 10,* [p. 3]. Citations omitted.

7 See, for example, Australian Institute of Health and Welfare, *Submission 4,* [p. 6]; Stroke Foundation, *Submission 6,* p. 1; Heart Foundation, *Submission 25,* p. 9; United Australia Party, *Submission 31,* p. 15; Centre for Population Development, Department of the Treasury, *Submission 35,* p. 1.

discussed the findings of an AIHW report, and told the committee of the preventable nature of cardiovascular disease:

> In that 2022 report, the top five things that were listed on the death certificates were coronary heart disease, on 20 per cent; dementia, on 18 per cent; hypertension, on 12 per cent; cerebrovascular disease, including stroke; 11 per cent; and diabetes, also 11 per cent. It's really of interest that all of these are related to cardiovascular disease. They're either heart disease itself, coronary disease, they're risk factors for heart disease, like hypertension or diabetes, or stroke, another kind of vascular disease … they're all preventable; they're all treatable earlier in life …[8]

3.9 The Heart Foundation informed the committee that cardiovascular disease was the underlying cause of approximately 25 per cent of COVID-19 related deaths from 2021 to 2023.[9] The ABS also identified chronic cardiac conditions (including coronary heart disease) as one of the most common pre-existing diseases among those who died from COVID-19.[10]

3.10 The Heart Foundation noted that during the pandemic, there were 'significant delays in people seeking treatment for cardiovascular emergencies and general health care reviews'.[11] The Heart Foundation expanded that lockdowns and 'stay-at-home' messaging from the government, coupled with a fear of exposure to COVID-19 in a healthcare setting, could have contributed to delays in seeking treatment.[12]

3.11 This aligns with the observed reduced rate of screening, which the Stroke Foundation identified in an answer to a question on notice:

> The National Heart Foundation of Australia has estimated that 27,000 fewer Heart Health Checks were conducted due to COVID-19. Specifically, between March 2020 to March 2021, 92,380 heart health checks were undertaken.[13]

3.12 The AIHW concluded that concluded that ongoing monitoring will be important to determine the impact of COVID-19 on cardiovascular diseases and diabetes, as well as the overall health of the population.[14]

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8 Professor Garry Jennings, Chief Medical Adviser, National Heart Foundation of Australia, *Committee Hansard,* 13 June 2024, p. 45.

9 The Heart Foundation, *Submission 25,* p. 2.

10 Australian Bureau of Statistics, *Submission 2*, p. 10.

11 The Heart Foundation, *Submission 25,* p. 10.

12 The Heart Foundation, *Submission 25,* p. 10.

13 The Stroke Foundation, answer to question on notice from Senator Wendy Askew (received 28 June 2024).

14 Australian Institute of Health and Welfare, *Submission 4,* [p. 8].

Cancer

3.13 Some inquiry participants raised concerns that cancer cases and deaths had increased during the pandemic years.[15] The Department of Health and Aged Care (the Department) explained that cancer deaths have indeed been increasing, but that this is due to increases in population size and 'increasing numbers of people reaching older ages for which cancer incidence rates are higher'.[16]

3.14 As such, Ms Moran from the ABS told the committee at a public hearing that '[s]ome cancers are considered preventable' but noted that in terms of excess mortality, 'we haven't seen an increase in cancer at all'.[17]

3.15 The AIHW also noted that the age-standardised mortality rate for cancer has been declining:

> In looking at trends over the past decade, the number of deaths and age-standardised mortality rates for cancer in 2021 and 2022 are in line with what would be expected based on past trends. While the number of cancer deaths has been steadily increasing, the age-standardised mortality rate (for all cancers combined) has been slowly declining from 169 per 100,000 in 2012 to 159 per 1,000 in 2019, and to around 152 per 100,000 in 2020, 2021 and 2022 (AIHW 2023a; AIHW 2024a).[18]

3.16 Similar to the lower screening rates for Australians with diabetes and cardiovascular disease, the Department also reported on delayed or missed cancer screening and procedures. However, it noted that the impact of the pandemic on national screening programs cannot be quantified without further years of data.[19]

3.17 Ms Moran commented on the potential impacts of missed cancer screening on the population:

> Of course, regarding some screening programs, it may take a long time for somebody to die of cancer, so that's something that we would need to monitor on an ongoing basis, but it certainly hasn't been the case so far.[20]

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15 See, for example, Children's Health Defense Australia, *Submission 14*, p. 16; Dr Robyn Stephenson, *Submission 30,* [p. 1]; Mr Brendan Godwin, *Submission 40,* [p. 4].

16 Department of Health and Aged Care, answer to question on notice from Senator Ralph Babet (received 21 June 2024).

17 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

18 Australian Institute of Health and Welfare, *Submission 4,* [p. 3].

19 Department of Health and Aged Care, answer to a written question on notice from Senator Malcolm Roberts (received 28 June 2024).

20 Ms Lauren Moran, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, *Committee Hansard*, 13 June 2024, p. 3.

3.18 The committee also received evidence that indicated a possible link between COVID-19 vaccines and cancer.[21] In response to this suggestion, the Department stressed that 'neither the [Therapeutic Goods Administration] nor any international regulator has detected any safety signals to indicate that COVID-19 vaccines are associated with any type of cancer'.[22]

Preventable structural drivers of excess mortality

3.19 This section considers preventable structural drivers of excess mortality by exploring the health disparities experienced by Australians living in rural and regional Australia, as well as First Nations peoples.

Geographic health disparities

3.20 Despite existing data gaps (as identified in Chapter 2), Ms Susanne Tegen, Chief Executive Officer of the National Rural Health Alliance (NRHA), confirmed that excess mortality was higher in regional areas compared to metropolitan areas during the pandemic years.[23]

3.21 In its submission, the NRHA informed the committee that the pandemic exacerbated existing health inequities for rural, remote and regional Australians due to 'inadequate health resourcing', where these Australians have a 'lower life expectancy, higher burden of disease, and an increased rate of potentially avoidable deaths'.[24]

3.22 Further, the NRHA raised that on average, rural Australians are more likely to die at a younger age than their metropolitan counterparts, and the rate of potentially avoidable deaths and burden of disease also increase with remoteness.[25]

3.23 The NRHA noted that rural healthcare services have 'less healthcare infrastructure,' such as hospitals and intensive care units, that can support complex cases of COVID-19. As such, it suggested that this 'may have contributed to COVID-19-related mortality in rural Australia'.[26] The NRHA also

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[21] See, for example, World Council for Health, *Submission* 11, p. 6; Children's Health Defense, *Submission 14*, p. 39; Australians for Science and Freedom, [p. 9]; Name Withheld, *Submission 23*, [p. 2]; Dr Robyn Stephenson, *Submission 30*, [p. 1].

[22] Therapeutic Goods Administration, Department of Health and Aged Care, answer to question on notice from Senator Ralph Babet (received 21 June 2024).

[23] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 13 June 2024, p. 18.

[24] National Rural Health Alliance, *Submission 9*, p. 4.

[25] National Rural Health Alliance, *Submission 9*, pp. 6–7.

[26] National Rural Health Alliance, *Submission 9*, p. 11.

contended that delayed healthcare utilisation may have also contributed to increased rural mortality rates.[27]

3.24 The NRHA claimed that 'findings of missed and delayed care' are supported by Australian data for rural and remote areas. It pointed to the Royal Flying Doctors Service's (RFDS) 'Best for the Bush Report 2022', which noted a '25 per cent increase in priority one aeromedical retrievals post COVID-19'.[28] The NRHA commented that this suggests the RFDS was:

> … retrieving patients who were sicker, later in the course of their disease or illness at this time. The RFDS attributes this to additional reductions in access to primary healthcare during the pandemic.[29]

3.25 In order to address geographic health disparities, the NRHA recommended that the development and implementation of a National Rural Health Strategy, which would be 'targeted at achieving outcomes and equity for rural Australians'.[30]

3.26 The NRHA expanded that focussing the National Rural Health Strategy on 'multidisciplinary care that is flexible and responsive to local needs will be a significant measure in driving health outcomes forward'.[31]

First Nations' heath disparities

3.27 The National Aboriginal Community Controlled Health Organisation (NACCHO) noted that avoidable and preventable deaths are already a considerable burden on Aboriginal and Torres Strait Islander communities. It explained that this is owing to a 'broad range of structural, social, commercial, political, environment and cultural determinants' that influence the health of Aboriginal and Torres Strait Islander peoples.[32]

3.28 NACCHO stated that this results in a significant health disparity, where 34 per cent of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is attribute to 'social determinant factors'.[33]

3.29 The health outcomes disparities were mirrored in data highlighted by the NRHA, which illustrates the disproportionate impacts of COVID-19 on First Nations people in all geographic regions throughout Australia:

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27 National Rural Health Alliance, *Submission 9*, p. 12.

28 National Rural Health Alliance, *Submission 9*, p. 12.

29 National Rural Health Alliance, *Submission 9*, p. 12.

30 National Rural Health Alliance, *Submission 9*, p. 14.

31 National Rural Health Alliance, *Submission 9*, p. 12.

32 National Aboriginal Community Controlled Health Organisation, *Submission 7*, p. 5.

33 National Aboriginal Community Controlled Health Organisation, *Submission 7*, p. 5.

> … deaths from or with COVID-19 to 28 Feb 2023 in non-Indigenous people occurred at the highest rate in major cities and reduced with remoteness; in contrast, deaths from or with COVID-19 in Aboriginal or Torres Strait Islander people occurred at a similar rate in major cities and inner/outer regional areas but were **1.3 times more likely in remote/very remote areas**. The death rate was higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people in all geographic regions, increasing with remoteness – **1.5 times higher in major cities and 3.7 times higher in remote/very remote areas**.[34]

3.30 As such, NRHA remarked that COVID-19 deaths data indicated a 'disproportionate burden of death in First Nations people, with increased burden in remote and very remote' areas of Australia.[35]

Australia's preparedness for future health crises

3.31 Noting the above discussion of preventable diseases and preventable structures as drivers of excess mortality, the committee received evidence on potential recommendations to address preventable drivers of excess mortality going forward.[36] These are explored further below.

Preventive health measures and a resilient healthcare system

3.32 Some submitters raised the importance of preventive health measures when discussing potential ways to drive down future excess mortality.[37] For example, the Royal Australian College of General Practitioners stated that the leading causes of death and disability in Australia are either preventable, or able to be delayed by early treatment and intervention.[38]

3.33 Noting the importance of preventive healthcare, the Department outlined existing measures that it suggested 'will likely assist in maintaining downward pressure on excess mortality'.[39] This included:

- ongoing promotion and provision of COVID-19 and influenza vaccination for the population, particularly for high-risk cohorts;
- ongoing infection prevention and control measures to reduce the impact and spread of communicable diseases like COVID-19 and influenza in high-risk settings, like hospitals or aged care homes; and

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34 National Rural Health Alliance, *Submission 9*, p. 7. Emphasis in original. Citations omitted.

35 National Aboriginal Community Controlled Health Organisation, *Submission 7,* p. 8.

36 See, for example, National Aboriginal Community Controlled Health Organisation, *Submission 7,* p. 5; Royal Australian College of General Practitioners, *Submission 8,* [p. 1]; National Rural Health Alliance, *Submission 9,* pp. 13–15; Heart Foundation, *Submission 25,* pp. 12–14.

37 See, for example, Department of Health and Aged Care, *Submission 1,* [p. 6]; Royal Australian College of General Practitioners, *Submission 8,* [p. 1]; Heart Foundation, *Submission 25,* p. 12.

38 Royal Australian College of General Practitioners, *Submission 8*, [p. 1].

39 Department of Health and Aged Care, *Submission 1*, [p. 6].

- opening of Medicare Urgent Care Clinics to reduce the pressure on emergency departments and general practice.[40]

3.34 However, as earlier discussed, access to healthcare services were disrupted during the pandemic. This finding was echoed by the Stroke Foundation, who observed that a variety of factors during the pandemic, such as lockdowns, a diversion of staff and resources to provide COVID-19 specific care, the suspension or cancellation of screening services and health check-ups 'have compromised key aspects of chronic disease management and preventive care'.[41]

3.35 Noting the disruptions to healthcare during the pandemic, some submitters recommended that going forward, the Australian Government should strengthen the resilience of the healthcare system.[42]

3.36 For instance, the Heart Foundation recommended that the government 'should build a framework capable of managing surges in demand caused by pandemic and other emergencies' which should also be able to provide everyday healthcare services. It contended that this would include 'maintaining access to critical services', which would safeguard long-term health 'even during public health crises.'[43]

3.37 The NRHA was of a similar view, specifically in relation to rural healthcare. It recommended planning for periods of increased rural hospital admissions (for example, due to seasonal respiratory viruses) and designing interventions to bolster the healthcare workforce.[44]

3.38 This was echoed by NACCHO, who emphasised the particular need for Aboriginal and Torres Strait Islander communities to be able to access comprehensive primary health care in a culturally safe setting. It noted that Aboriginal Controlled Community Health Organisations are a key part of the preventive healthcare system for Aboriginal and Torres Strait Islander people, as they are 'uniquely placed to address the social determinants of health'.[45]

3.39 The Stroke Foundation acknowledged that the Australian Centre for Disease Control is in the process of being established, which will focus on 'improving

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40 Department of Health and Aged Care, *Submission 1*, [p. 6].

41 Stroke Foundation, *Submission 6,* p. 2.

42 See, for example, The World of Wellness International Limited, *Submission 12,* [p. 12]; Heart Foundation, *Submission 25,* pp. 12–13.

43 Heart Foundation, *Submission 25,* pp. 12–13.

44 National Rural Health Alliance, *Submission 9*, p. 4.

45 National Aboriginal Community Controlled Health Organisation, *Submission 7*, p. 5.

our response and preparedness for public health emergencies'.[46] However, it also recommended that the Australian Government should:

> … work closely with the primary care sector to identify and implement specific solutions aimed at avoiding the suspension or cancellation of screening services, routine health check-ups, and diagnostic tests during times of national emergency, ensuring chronic disease management and preventive care are not compromised.[47]

Vaccination

3.40 Whilst some submitters raised concerns that COVID-19 vaccines caused excess deaths,[48] the Department advised that there is a growing body of research that confirms COVID-19 vaccines 'are very effective at reducing risk of severe disease and death associated with SARVS-CoV-2 infection'. The Department also highlighted that in countries where community-wide infection was occurring, a more rapid roll-out of vaccination was associated with lower excess mortality than those with a slower vaccination roll-out.[49]

3.41 Asthma Australia expressed its support for all immunisation products that may help reduce asthma exacerbations and deaths, and particularly noting COVID-19, influenza and RSV immunisation products as being important to helping people with asthma 'maintain their condition' and 'staying out of hospital'.[50]

3.42 Similarly, the Actuaries Institute asserted that COVID-19 vaccines 'significantly reduced excess mortality' and was of the view that excess mortality would be reduced if there was a greater uptake of vaccination against infectious diseases, such as COVID-19.[51]

Public health information

3.43 Going forward, the Heart Foundation highlighted the need for targeted public health communications during pandemics. It raised the need for all governments to provide 'clear, consistent, and frequent public health

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46 Stroke Foundation, *Submission 6*, p. 3.

47 Stroke Foundation, *Submission 6*, p. 3.

48 See, for example, World Council for Health Australia, *Submission 11*, p. 3; Australians for Science and Freedom, *Submission 15*, pp. 5–6; Mr Peter Blatch, *Submission 21*, [p. 2]; Senator Gerard Rennick, *Submission 27*, [p. 1]; Mr Lex Stewart, *Submission 42*, [p. 1].

49 Department of Health and Aged Care, answer to question on notice from Senator Louise Pratt (received 3 July 2024).

50 Asthma Australia, *Submission 5*, [p. 2].

51 Actuaries Institute, *Submission 3*, pp. 8 and 10.

communications about the safety and availability of medical services' at such times.[52]

3.44 The Heart Foundation also endorsed working with community organisations to assist with disseminating health information to 'build trust and encourage adherence to appropriate healthcare' and noted that 'there needs to be learnings from the COVID-19 pandemic that mainstream health messaging did not reach certain parts of the community'.[53]

3.45 Relatedly, the NRHA recognised the importance of ensuring accurate information is provided by governments equitably across the country, and in formats that are relevant 'to particular populations'. It noted studies that have identified risk factors of lower health literacy being linked to misperceptions about COVID-19 vaccination.[54]

3.44 The NRHA also stressed that it is crucial that the media provide evidence-based information, 'rather than advertorial or promoting misinformation to sensationalise, to the public'.[55]

52 Heart Foundation, *Submission 25*, p. 13.

53 Heart Foundation, *Submission 25*, p. 13.

54 National Rural Health Alliance, answer to question on notice from Senator Louise Pratt (received 28 June 2024).

55 National Rural Health Alliance, answer to question on notice from Senator Louise Pratt (received 28 June 2024).

Chapter 4
Concluding comments and recommendations

4.1 The committee acknowledges that it has heard a wide range of views throughout the course of the inquiry. The committee reiterates its thanks to all organisations and individuals that participated via submissions, documentation and appearing at the public hearing.

4.2 This chapter begins by considering the treatment of witnesses who appeared at the committee's public hearing. It then discusses the interpretation of sources and scientific evidence. The chapter concludes by presenting the committee's views and recommendations.

Conduct of the inquiry and the treatment of witnesses

4.3 Due to a video that was posted by Senator Ralph Babet on social media platforms, the committee believes it is important to comment on the treatment of evidence and witnesses who appear at public hearings. This issue is discussed below.

Video material posted by Senator Ralph Babet

4.4 On 13 June 2024, the committee held a public hearing for this inquiry. The committee invited a range of stakeholders to participate in the hearing, including government agencies, peak bodies and advocacy organisations. A full list of witnesses can be found at Appendix 2.

4.5 On 18 June 2024, following the public hearing, it was drawn to the committee's attention that Senator Babet had published video material from the public hearing on his social media accounts. In the video, the testimony of witnesses from the Department of Health and Aged Care, the Australian Bureau of Statistics, and the Australian Institute of Health and Welfare had been manipulated. Questions posed to witnesses from committee member, Senator Louise Pratt, had also been edited.

4.6 The committee notes that the edits in the video material were misleading as they gave the impression that witnesses were unable to answer questions. As such, the committee found that the video material did not meet the requirements of the Resolution on the Broadcasting of Committee Proceedings, the Senate or the committee. The committee also noted that Senator Babet had used excerpts of committee proceedings in paid posts on the social media platform, Facebook.

4.7 The committee acted swiftly to resolve this matter. The Chair of the committee, Senator Penny Allman-Payne, wrote to Senator Babet on 19 June 2024 to ask that

he immediately remove the video material. This letter can be viewed on the committee's website.[1]

4.8 In the letter, the Chair drew Senator Babet's attention to the Resolution on the Broadcasting of Senate and Committee Proceedings, Resolution 3(6), which states:

> Broadcasts of proceedings of a committee, including excerpts of committee proceedings, shall be for the purpose only of making fair and accurate reports of those proceedings, and shall not be used for:
>
> (a) political party advertising or election campaigns; or
> (b) commercial sponsorship or commercial advertising.[2]

4.9 The committee further drew Senator Babet's attention to the fact that a court may hold the publication of the material does not amount to a fair and accurate report of proceedings under the law of qualified privilege. Consequently, the committee noted that the publication would be unlikely to receive protection from defamation action, as per section 10 of the *Parliamentary Privileges Act 1987*.[3]

4.10 The committee also highlighted that the publication of the video may account to a misleading report of the committee's proceedings, which could be investigated as a possible contempt under Privilege Resolution 6(7):

> A person shall not wilfully publish any false or misleading report of the proceedings of the Senate or of a committee.[4]

4.11 On 19 June 2024, the committee received confirmation that the relevant video material had been removed from Senator Babet's social media accounts.

Letter to the Chair from the Agency heads

4.12 On 26 June 2024, Mr Blair Comley PSM, Secretary of the Department of Health and Aged Care, Ms Teresa Dickinson PSM, Acting Australian Statistician at the Australian Bureau of Statistics, and Dr Zoran Bolevich, Chief Executive Officer at Australian Institute of Health and Welfare (the agency heads), wrote to the Chair. This letter can also be viewed on the committee's website.[5]

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1 Letter to Senator Ralph Babet from Senator Penny Allman-Payne, Chair, dated 19 June 2024.

2 Letter to Senator Ralph Babet from Senator Penny Allman-Payne, Chair, dated 19 June 2024, [p. 1].

3 Letter to Senator Ralph Babet from Senator Penny Allman-Payne, Chair, dated 19 June 2024, [p. 1].

4 Letter to Senator Ralph Babet from Senator Penny Allman-Payne, Chair, dated 19 June 2024, [p. 2].

5 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024.

4.13 In this letter, the agency heads raised further concerns 'about the Senator's actions and the treatment of public officials who engaged with the inquiry in good faith'.[6] They made the committee aware that:

> Some of Senator Babet's followers posted threatening statements towards officials whose official evidence was misrepresented in the edited social media post. For example, statements included reference to 'hunting [witnesses] down' and ensuring they are 'shown the gallows'. This was distressing for witnesses and has the potential to cause harm.[7]

4.14 The agency heads also told the committee that in their view, 'the publication of the manipulated video material does not aid the public debate or the legitimate contest of ideas' and also advised that 'some of the material continues to circulate online through engagement that occurred prior to removal of the original post'.[8]

4.15 The agency heads concluded by recognising their obligations to the Work Health and Safety Act and Regulations, which require them to protect their workers from harm by eliminating or minimising risk. As such, to fulfill their duty of care, the agency heads commented that they 'may need to carefully consider who appears as witnesses for future inquiries from a safety perspective'.[9]

Witness rights and the obligations of Senators

4.16 The committee recognises that all witnesses who appeared at the public hearing did so in good faith and understands that it would have been distressing for witnesses to not only have their testimony manipulated, but to have also received online threats as a result.

4.17 As such, the committee would like to convey its deepest disappointment that this video material was posted.

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6 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024, [p. 1].

7 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024, [p. 1].

8 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024, [p. 2].

9 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024, [p. 2].

4.18 As the committee continues its work in implementing the 'Set the Standard Report', the committee reiterates its commitment to ensuring that all Senators behave in accordance with Senate rules.

Respect for the scientific process and government agencies

4.19 The committee notes the scientific nature of this inquiry, evident in the terms of reference and the subsequent evidence received via submissions, witness testimony at the public hearing, answers to questions on notice and additional information.

4.20 Whilst not a committee comprised of scientific experts, the committee reiterates its respect of the scientific process, legitimate scientific and medical institutions, as well as government agencies and officials, whose submissions and testimony have illustrated that COVID-19 was the key contributing factor to excess mortality from 2021–2023.

Key learnings and recommendations

4.21 This section presents the committee's views and key learnings throughout the course of the inquiry, and associated recommendations.

Calculating excess mortality

4.22 The committee understands that the Australian Bureau of Statistics (ABS) will, in future, produce estimates of expected mortality that includes COVID-19 in its baseline. The committee notes that this means the ABS will be considering how the number of deaths compare with expected numbers now that COVID-19 is an established factor influencing mortality.

4.23 The committee further recognises that including COVID-19 in the baseline will provide new data insights, which can assist in policy and planning purposes, as well as providing insights into other emerging factors that have an influence on mortality.

4.24 Noting the above, the committee encourages the ABS to include COVID-19 in the baseline when calculating excess mortality estimates as a matter of priority, to acknowledge and reflect the post-pandemic reality that now exists in Australia and globally.

The need to address existing data gaps

4.25 The committee notes the identified gaps in excess mortality data in relation to both geographic data and First Nations data, as examined in Chapter 2.

4.26 The committee understands that in some cases, it was a matter of such data existing, but not being made publicly available; in other cases, the issue was a lack of research and reporting on these particular cohorts.

4.27 The committee recognises that these data gaps represent barriers to a fulsome understanding of the issue of excess mortality, and that these discrepancies may

relate to broader inequities and disparities in the Australian health system. As such, the committee recognises that other vulnerable cohorts should also be accounted for in excess mortality estimates, including people with disability.

4.28 As a result, the committee is of the view that these gaps in the existing ABS excess mortality data should be addressed.

Recommendation 1

4.29 The committee recommends that the Australian Bureau of Statistics:

- **include geographic indicators in its excess mortality estimates; and**
- **address gaps in the production and publication of data on excess mortality among Aboriginal and Torres Strait Islander people, people with disability, and people in rural and regional areas.**

4.30 The committee is of the view that it is paramount that data on Aboriginal and Torres Strait Islanders people be collected in line with the four Priority Reform Areas in the National Partnership Agreement on Closing the Gap.

Disparities in rural healthcare

4.31 The issue of disparities in rural healthcare has been drawn to the committee's attention in previous inquiries and is not new.[10] The committee is of the view that rural health inequity is a preventable driver of excess mortality and acknowledges the importance of ensuring rural Australians have equitable access to healthcare, whether that be to everyday health services or to critical healthcare during national health crises.

4.32 Whilst the committee recognises that structural barriers to healthcare and workforce challenges cannot be easily remedied, the committee sees value in the proposal of a National Rural Health Strategy as a way to address this preventable driver of excess mortality.

Compensation for those who have sustained vaccine injuries

4.33 Following the testimony of witnesses and the large amounts of correspondence received by the committee in relation to vaccine injuries, the committee's attention was drawn to the small number of individuals who suffer adverse events following immunisation, and the compensation to which they are entitled.

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[10] See, for example, Senate Standing Committee on Community Affairs, *Equitable access to diagnosis and treatment for individuals with rare and less common cancers, including neuroendocrine cancer*, May 2024, pp. 71, 122 and 123; Senate Standing Committee on Community Affairs, *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia*, May 2023, pp. 12, 14 and 19; Senate Standing Committee on Community Affairs, *Provision of general practitioner and related primary health services to our metropolitan, rural and regional Australians – Interim Report*, April 2022; Senate Standing Committee of Community Affairs, *Availability and accessibly of diagnostic imaging equipment around Australia*, March 2018, pp. 14, 15, 32 and 38.

4.34 The committee recognises that the efficacy and efficiency of vaccine compensation schemes are also important to addressing vaccine hesitancy. As such, the committee believes it would be prudent to review existing compensation arrangements for individuals who have sustained injuries following vaccinations and explore the benefits of a no-fault compensation scheme.

Recommendation 2

4.35 The committee recommends that the Australian Government consider the design and compensation arrangements of a no-fault compensation scheme for Commonwealth-funded vaccines in response to a future pandemic event.

Lessons learnt and future responses to public health crises

4.36 The committee believes it is appropriate to reflect on the lessons learnt over the course of the inquiry in relation to the management of the COVID-19 pandemic, with the view of improving responses to future public heath crises.

4.37 The committee acknowledges that Australia's healthcare systems are vast, complex and exist across multiple jurisdictions. However, the committee holds that the pandemic emphasised the need to explore ways to strengthen the resilience of Australia's healthcare systems, so that it can withstand surges in demand during future public health emergencies.

4.38 The committee is of the view that this was made evident in the disruption to screening services and health check-ups during the pandemic, due to restrictions and a diversion of staffing and resources. Therefore, the committee firstly encourages the Department of Health and Aged Care to monitor the impact of lower screening rates on future excess mortality figures.

4.39 To minimise similar disruptions during any future public health crises, the committee also urges the Australian Government to accelerate the establishment of the Australian Centre for Disease Control as a matter of priority, so that Australia is prepared to respond effectively to public health emergencies when they arise.

4.40 Finally, the committee deems that the government should consider reviewing its communication strategies throughout the COVID-19 pandemic so that going forward, public health communication is provided clearly, consistently and frequently to all Australians.

4.41 The committee notes that the government has commission the Commonwealth Government COVID-19 Response Inquiry to identify lessons learned to improve Australia's preparedness for future pandemics.

Recommendation 3

4.42 The committee recommends that the Australian Government establish the Australian Centre for Disease Control as soon as practicable.

Recommendation 4

4.43 The committee recommends that the Australian Government task the Department of Health and Aged Care with reviewing Australia's public health information communication strategies during the COVID-19 pandemic, to improve the delivery of future public health communication.

Recommendation 5

4.44 The committee recommends that the Senate take note of the following:

- **witness participation in public hearings is critical to the committee inquiry process;**
- **all witnesses who participate in committee public hearings should be treated with respect;**
- **Senators should be reminded of the Resolution on the Broadcasting of Senate and Committee Proceedings.**

Senator Penny Allman-Payne
Chair

Additional comments from Senator Gerard Rennick

1.1 The excess mortality of 2021–23 was a disturbing spike. It needs to be adequately addressed. My recommendations are as follows:

Recommendation 1

1.2 The Australian Bureau of Statistics needs to track and report vaccination status.

Recommendation 2

1.3 The Therapeutic Goods Administration must acknowledge that their testing of the COVID-19 vaccines was insufficient and work to lift their quality assurance.

Recommendation 3

1.4 Adverse events need to be recognised sooner so that faulty products can be recalled. The Australian people should not have their injuries gaslighted.

Recommendation 4

1.5 Pharmaceutical companies should be held responsible for their products. They should be liable for adverse events.

Recommendation 5

1.6 People were disabled by COVID-19 vaccines. In many cases, lives were destroyed. Australians who are unable to live a full and fulfilling life, after doing what they thought was best based on Government advice or to save their livelihoods, should be adequately compensated, not given a hollow promise that it will be considered in the future.

Senator Gerard Rennick
Independent
Senator for Queensland

Dissenting Report from Senator Babet of the United Australia Party

Too many dead, too little inquiry, too much suppression

1.1 The Excess Mortality Inquiry conducted by the Senate Community Affairs References Committee was established with the purpose of understanding the factors contributing to excess mortality in 2021, 2022 and 2023 and making recommendations on how to address any identified preventable drivers of excess mortality.

1.2 The inquiry terms of reference were designed in a way that would empower an inquiry whereby the plethora of potential causes of higher-than-expected all-cause mortality would be investigated. The terms of reference deliberately do not draw any conclusions and invite submissions from diverse perspectives.

1.3 For this inquiry to achieve its intended goal, there needed to be an open discourse free from any censorship or bias. This inquiry was intended to allow input from the public, independent analysts and organisations. The purpose of an inquiry is not to regurgitate government agency responses, but to allow views from disparate sources to be heard.

Too much suppression

1.4 Disappointingly the committee process has resulted in an inquiry that has suppressed the vast majority of views. Just 50 (26.74%) of the submissions received by the committee have been uploaded to the inquiry website for public viewing. A further 137 submissions have not seen the light of day.

1.5 Of the 137 submissions that have not been uploaded for public viewing, 57 were confidential submissions, 14 were name withheld submissions and a further 66 were determined by the committee to be accepted as 'unpublished correspondence'.

1.6 It is common practice for Senate Committees to publish on their website the majority of submissions received for any inquiry. It is wholly unsatisfactory that 66 excess mortality submissions whose authors agreed to public release would be determined by the committee to be 'accepted as unpublished correspondence only'. These submissions have been buried, never to see the light of day. The 14 submissions treated as name withheld should also have been uploaded, without the names of the authors.

1.7 The submissions that the committee chose to suppress by taking as 'unpublished correspondence' include those from professors, doctors, medical specialists, academics, actuarial and subject matter experts, as well as concerned Australian citizens.

1.8 The comprehensive submission provided by Australian Medical Professionals Society (AMPS) has been censored. The original version was not accepted because the committee advised that it comprised of numerous attachments/articles and did not directly address the terms of reference. The AMPS submission was undertaken by a multidisciplinary team of medical, scientific, and academic subject matter experts and required hundreds of hours of research, review, and analysis.

1.9 AMPS have been at the forefront of investigating excess mortality in Australia. Amongst many initiatives, in 2023 they published a book titled 'Too many dead, an inquiry into Australia's excess mortality'. After much negotiation, and what appeared to be a committee determined not to publish their work, a very brief summary of AMPS' research has eventually been published as submission 49. This summary does not adequately reflect the magnitude and significance of their findings. AMPS decided to post their full original submission on their website. This submission includes:

- Evidence of an uptick in all-cause mortality (ACM) with the introduction of Covid vaccines to a zero Covid community,
- An estimate of the true contribution of Covid to excess deaths (29% at most),
- An estimate of the true number of Australian cumulative excess deaths throughout 2021-2023 in the ballpark of 40,000 as opposed to the official Australian Bureau of Statistics (ABS) estimate of 29,601,
- Discussion of how the ABS drastically reduced its excess deaths estimate overnight by changing its baseline modelling,
- Evidence that Covid vaccine injuries and deaths are under-reported in official record keeping,
- A review of the Australian Government's unscientific response to the Covid pandemic and its detrimental impact on health outcomes, likely contributing to excess deaths,
- Evidence that deaths in the vaccine arm of the Pfizer trial were concealed prior to the US Emergency Use Approval (EUA) data cut-off date, plus evidence of a 3.7-fold increase in cardiac events in vaccinated vs. placebo arm subjects.

The full AMPS submission would have been useful to inform both the committee and the public.

Delays and roadblocks plague the inquiry.

1.10 The Senate voted in favour of this inquiry on 26th March 2024, but the inquiry took some time to appear live on the committee website. The committee advised of a glitch, and the inquiry page went live on 2nd April.

1.11 The initial timeframe provided for submissions was far too brief, allowing just one month, including the Easter period. The committee thankfully agreed to

extend the closing date for submissions to the 17th of May (as per Senator Babet's request).

1.12 A one-day public hearing was proposed for the 13th of June 2024 and a draft program was circulated on May 22nd. Senator Babet requested a second day for the public hearing, which was denied. He also supplied the names of 6 organisations and 36 individuals as recommended witnesses, almost all these recommended witnesses were denied the opportunity to present their views and evidence.

1.13 The proposed public hearing program disappointingly consisted largely of government or government funded organisations, providing very little opportunity for independent organisations or individual voices be heard.

1.14 The final program for the public hearings included two witnesses requested by Senator Babet (AMPS and COVERSE). Unfortunately, both the Actuaries Institute and RACGP were late cancellations and unable to attend due to other commitments.

1.15 Many submissions were not uploaded prior to the day of the public hearing, meaning that the Senators were unable to refer to the very important content of those submissions in their questioning.

1.16 One of the many failures of this process has been the lack of transparency around 137 submissions not uploaded for public viewing, of which there are 80 whose authors intended for their views to be made public.

1.17 Many whose contributions have been buried have contacted our office in dismay, their experience has led to a real distrust in the committee process. It is disappointing that this inquiry has lacked true transparency and silenced many qualified voices.

Covid-19 Vaccination as a potential cause of excess deaths

1.18 *97.7% of Australians over 16 received a COVID-19 vaccination. Given this was a new biological therapeutic, never previously used in humans, it is entirely reasonable to ask the question whether it caused or contributed to the excess death toll*.[1]

1.19 We know the COVID-19 vaccines are novel and were fast tracked. Minister Greg Hunt stated on 21st February 2021 that *"The world is engaged in the largest clinical trial, the largest global vaccination trial ever"*.[2]

1.20 The Department of Health and Aged Care stated that *"There is no credible evidence to suggest that COVID-19 vaccines have contributed to excess deaths in Australia or overseas"*. They quoted a paper titled "Effectiveness of COVID-19 vaccination against COVID-19 specific and all-cause mortality in older Australians: a

1 Submission 18, Dr Monique O'Connor, Page 3

2 Submission 31, United Australia Party, Page 23

population-based study" which was published in The Lancet and claimed that *vaccines protected against COVID-19 death and found no evidence that they contributed to higher all-cause mortality*.[3] Senator Babet raised criticisms of this study and supplied a 4-page letter by Dr Wilson Sy and Dr Christopher Neil as evidence. The doctors stated in the letter that "*the paper has serious deficiencies in data integrity, data selection bias, flawed methods of analysis, undisclosed adjustments of results, selective reporting of findings and the drawing of invalid conclusions. The Australian Government has chosen to take this paper as authoritative evidence to justify its health policy, which has been associated with many excess deaths particularly in older Australians, but those deaths have been brushed off without investigation as coincidental, unrelated to vaccination. The paper, in its currently published form, has serious methodological and analytical defects, resulting in errors and misleading conclusions. Therefore, the paper needs substantial revision to address the issues raised, or else it should be retracted*."[4]

1.21 The committee heard evidence that, while there are 16 deaths confirmed by the Department as a result of vaccine injury, this represents a relatively small proportion of the 69, 788, 192 vaccine doses administered between the years 2021 and 2023, and a small proportion of the excess deaths in Australia.[5]

1.22 It is hard to comprehend there being just 16 confirmed deaths from COVID-19 vaccines when you consider the significant reporting of deaths and injuries following vaccination in the DAENS database. As COVERSE states[6], *"Furthermore, these 1,000+ reports (of death) must surely represent only a fraction of the true number, given the reluctance of many in the medical and public health sectors to make reports to the TGA, let alone acknowledge that there may be a connection with the COVID-19 vaccinations."* There have also been reports of more than 139,000 adverse events following vaccination for COVID-19.

1.23 Kara Potter from COVERSE shared with the committee[7] her personal vaccine injury, she stated *"I received my vaccine injury from my third Pfizer shot, which was my booster shot, on 8 January 2022. It started with pericarditis, but the inflammation was much further spread than just in my heart. It went through to my lungs and further to other parts of my body, including my brain over a period of about five months. I was*

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3 Submission 1, The Department of Health and Aged Care, Page 8.

4 Answers to questions on notice #1, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ExcessMortality47/Additional_Documents?docType=Answer%20to%20Question%20on%20Notice

5 Department of Health and Aged Care, answer to written question on notice, 13 June 2024 (received 26 June 2024); Dr Philip Gould, First Assistant Secretary and Chief Data Officer, Health, Economics and Research Division, Department of Health and Aged Care, *Committee Hansard*, 13 June 2024.

6 Submission 13, COVERSE, Page 3

7 Public Hearing Transcript, Page 38

quite acutely unwell. I made multiple trips to hospital. I spent about six weeks overall in hospital trying to recover from just that initial acute injury. Since then, I am now chronically ill and disabled from the vaccine. I am no longer able to work or drive or do many things at all. It affects my whole body, my capacity to think and speak, and my ability to walk. My regulatory system is completely disorganised. It has had a major catastrophic impact on myself and my family." Ms Potter also stated: *"I have had varied levels of support. I was very fortunate. Unlike many people, my GP recognised my injury to begin with. I am actually grateful to my GP that I am alive, because she recognised I had a vaccine injury."*

1.24 The Western Australian Vaccine Safety Surveillance annual report for 2021 clearly shows the heightened risk of adverse events from COVID-19 vaccines. For 2021 the adverse event rate for all non-COVID vaccines was 11.1 per 100,000 doses. For COVID-19 vaccines the adverse event rate was 264.1 per 100,000 doses. The risk of adverse event per dose in Western Australia was 23.79 times greater for COVID-19 vaccines than all other vaccines.[8]

1.25 AMPS states that *COVID-19 vaccines may be contributing to ill health and excess deaths in the population, necessitating additional research*.[9]

1.26 Dr Rado Faletic from COVERSE stated in the public hearing: *"We know, for example, that when the Australian government's Vaccine Claims Scheme was launched there were 10,000 people who signed up to receive information. That's 10,000 Australians who had an adverse reaction serious enough to think they needed compensation. From our perspective and from all of the other bits of information that we've collected, we think that's a lower bound. The true number of people in this country could be 10 times as many as that."*[10]

1.27 The *prevention of transmission is not an approved indication for these products*[11] (COVID-19 Vaccines). Yet, many Australians were mandated into taking these novel products and ended up suffering from life changing adverse events. *Despite overwhelming evidence suggesting physical and psychological harm from the government response, mandates persist* to this day.[12]

1.28 The Australian Bureau of Statistics (ABS) confirmed that *vaccination status is not reported with death registrations and therefore the ABS does not track deaths by vaccination status*.[13]

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8 Submission 31, United Australia Party, Page 23

9 Submission 49, AMPS, Page 4

10 Public Hearing Transcript, page 35

11 Answer to QON, IQ24-000060, Department of Health and Aged Care, Page 5

12 Submission 49, AMPS, Page 2

13 Submission 2, ABS, Page 14

1.29 A question on notice response by the ABS stated *that "vaccination status is not recorded on the death certificate unless the vaccine led to a complication which caused, or significantly contributed to, death"*.[14]

1.30 In March of 2020 the ABS provided guidance for certifying deaths due to COVID-19. The advice stated: *"due to the public health importance of COVID-19, the WHO have directed that the new coronavirus strain be recorded as the underlying cause of death, i.e., the disease or condition that initiated the train of morbid events, when it is recorded as having caused or contributed to death.*[15]

1.31 The Australia Bureau of Statistics stated that*: "vaccination status is not recorded on the death certificate unless the vaccine led to a complication which caused, or significantly contributed to death"*.[16]

1.32 According to Dr Chris Neil, *"literature now reveals the pathogenicity of the spike protein used in these vaccines, with concerns ranging from cytotoxicity to cardiotoxicity, from thrombogenicity to oncogenicity—and I could go on. Three consecutive years into this trend, we put it to you that excess mortality has tragically become the most important signal in pharmacovigilance. Unexplained excess mortality continues globally and cannot now be hidden, receiving attention in peer reviewed articles, in mainstream press and in public awareness. AMPS strongly believes that the inquiry the people of Australia deserve must be full and exacting."*[17]

1.33 Dr Jeyanthi Kunadhasan *stated "as an author in the first peer reviewed data that actually looked at the Pfizer COVID-19 vaccine data, one thing I want to emphasise is that at no point during the (Pfizer COVID-19 vaccine) trial was the intervention lifesaving. We aligned the deaths as they occurred along the timeline and at no point in this trial was this intervention lifesaving."*[18]

1.34 Coercive vaccination, Dr Monique O'Connor contends, *"caused extreme intentional suffering, torture, which is contributing to poor mental health and overall community wellbeing. The mental health needs of those who were tortured are largely unrecognized and unmet. The fact that mainstream mental health and medical care were complicit with vaccine mandates make outreach to those suffering all the more difficult because of mistrust and access to health care barriers."*[19]

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[14] Answer to QON, IQ24-000003, ABS, Page 8

[15] https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1205.0.55.001Main+Features12008?OpenDocument

[16] Answer to QON, IQ24-000003, ABS, Page 8

[17] Community Affairs References Committee, Excess Mortality Inquiry, Public Hearing Transcript, Page 34

[18] Community Affairs References Committee, Excess Mortality Inquiry, Public Hearing Transcript, Page 34

[19] Submission 18, Dr Monique O'Connor, Page 59

1.35 Sudden presumed cardiac arrests in paediatric populations increased from 29% in the 2021/22 Ambulance Victoria annual report to over 40% in 2022/23 annual report.[20]

1.36 All the above is evidence that COVID-19 vaccines may have caused more death and injury than is admitted or considered by the Australian government and in the interests of the truth further investigation must be launched.

Data reliability and availability hampering quality and timeliness of analysis

1.37 It needs to be recognised in times of unprecedented disruption, such as the COVID-19 pandemic, that the government agencies that assume responsibility may not have the depth and breadth of expertise required to best serve the Australian people. The voices of those with a wide range of expertise need to be heard, without fear of dismissal, retribution or disparagement.

1.38 Assoc Professor Tim Adair et al. noted that *"more timely mortality data be available to researchers and the general public. The ABS should report monthly mortality data by age, sex and cause of death, which can enable additional analyses, such as those presented in this submission on a more regular basis, and which can inform policy on a timely basis. They should also consider having those data freely available to users (instead of requiring them to be purchased), which will enable engagement with a range of experts to facilitate a quicker and more in-depth understanding of the impacts of epidemics going forward. It can also build capacity by allowing researchers to train the next generations of demographers on monitoring Australian mortality changes."*.[21]

1.39 Ill-defined deaths were also identified as leading to the evidence on mortality during the pandemic being compromised.[22][23]

Limited investigation of vaccine-related deaths

1.40 The submission by the Actuaries Institute (number 3) stated:

> *"The available evidence does not support a significant contribution to excess mortality by the adverse side-effects of COVID-19 vaccines. Indeed, the reverse is true: while every such death is regrettable, it seems clear that the small number of deaths triggered by COVID-19 vaccines is a tiny fraction of the number of COVID-19 deaths that they have prevented."*
>
> The assertion above refers to a study based on NSW data which declares that any vaccine dose required 2 weeks to provide protective immunity, which they implemented by shifting vaccination coverage (1st dose, 2nd and 3rd dose) two weeks later. Thus, if a person dies in that period, it would be considered an

[20] Submission 18, Dr Monique O'Connor, Page 24

[21] Submission 32, Assoc Prof Tim Adair et al., Page 8

[22] Submission 32, University of Melbourne and Australian National University

[23] Submission 31, United Australia Party, Page 17

unvaccinated death. Submission 42 stated *that "this arbitrary element in the definition of 'vaccination status' compromises data integrity from the start and distorts the interpretation of COVID data"*.[24]

1.41 There are other similar concerns about the methodology used in the paper quoted by the Actuaries Institute[25]. The Actuaries Institute extrapolated its findings to a national number of estimated deaths, without taking into account the variations in COVID-19 transmission in different parts of Australia – for example, Queensland and WA had minimal COVID-19, as referred to in the submission by Senator Rennick.[26]

1.42 Children's Health Defence also presents evidence which suggests that the COVID-19 vaccines were "relatively ineffective in preventing death from COVID-19".[27]

Mental Health and Excess Mortality

1.43 Dr Monique O'Connor who is a medical practitioner, Consultant Psychiatrist with over 30 years medical experience draws attention to *"the extra burden of difficult grief for those bereaved during the pandemic, and the need to reach out to help them"*. She says that *"the mental health of Australians was also harmed by pandemic measures. Death by suicide contributed a small proportion of overall deaths, but the impact of suicide and it's being a marker of poor mental health in the community highlights the immense importance of care for those who are suffering"*.

1.44 The National Study of Mental Health and Wellbeing, published by the Australian Bureau of Statistics in October 2023, covering 2020-2022, indicated 21.5% of Australians met the diagnostic criteria for having a mental disorder within 12-months of completing the survey; and was as high as 38.8% of 16–24 year-olds.[28]

1.45 Measures of severe psychological distress were significantly higher during the pandemic. Rates of severe psychological distress (i.e. those with 'probable serious mental illness') peaked between August and October 2021 when an increase from 10.1% to 12.5% was observed. A change of 1% point represents approximately 200,000 people.[29]

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[24] Submission 42, Lex Stewart, Page 12

[25] Submission 3, Actuaries Institute, Page 3

[26] Submission 27, Senator Rennick, Page 1

[27] Submission 14, Children's Health Defence, Page 24

[28] Submission 18, Dr Monique O'Connor, Page 28

[29] Submission 18, Dr Monique O'Connor, Page 28

1.46 *"The greatest impact of the pandemic on mental health appears to have been for women, young Australians, Aboriginal and Torres Strait Islander Australians, those who live in Victoria, and those who live in low-income households."*[30]

1.47 *"Many factors associated with the pandemic response exacerbated known psychosocial risk factors for suicide, including social isolation, job loss, business and career loss, unemployment, financial difficulty, problems accessing health and mental health services, and uncertainty. Public health pandemic measures (enforced by regulatory authorities, the police and military with threats of criminal sanctions, civil penalties, draconian fines and reputational harm) were traumatising for many Australians. They were contributory to increased exposure to recognised psychosocial stressors causal in the deterioration in mental health of Australians."*[31]

1.48 Australians for Science and Freedom stated: *"In addition to crowding out healthcare, lockdowns kept people away from normal familial and broader social activities, which we know to be protective against various forms of mental disease."*[32]

All our eggs in the 'vaccine' basket

1.49 According to Australians for Science and Freedom *"a significant fraction of excess deaths in Australia since mid-2021 have been classified as covid deaths, (a) it is not clear that these deaths were truly "of" covid rather than merely "with" covid, and (b) it is likely that many of them would have been avoidable with life-preserving care. Prophylaxis and early treatment of covid using known and re-purposed drugs have been known for years to be extremely effective for many years in preventing mortality, even for elderly and ill people, despite being heavily censored in mainstream healthcare and under-utilised by Australia's health practitioners in favour of other, more extreme treatment protocols. These protocols may have directly caused more deaths with covid than would have otherwise occurred".*[33]

1.50 Dr Monique O'Connor, referring to COVID-19 vaccine mandates, said: *"The harm caused by social isolation appears not to have been captured other that for the specific home or hotel quarantine. There is reference to 'Prophylactic measures, unspecified'. There is no clarity on how many suicides occurred following mandated job loss."*[34]

1.51 AMPS questions *"the effectiveness of a vaccine-centric approach and explores the potential benefits of alternative treatments, such as early treatment with drugs like Hydroxychloroquine and Ivermectin, and supplementation with Vitamin D, Vitamin C,*

30 Submission 18, Dr Monique O'Connor, Page 29

31 Submission 18, Dr Monique O'Connor, Page 29

32 Submission 15, Australians for Science and Freedom, Page 6

33 Submission 15, Australians for Science and Freedom, Page 5

34 Submission 18, Dr Monique O'Connor, Page 42

and Zinc. Real-world data from countries using Ivermectin and Vitamin D supplementation have shown promising results in reducing COVID mortality".[35]

Recommendations

Recommendation 1

1.52 The federal government must establish a royal commission to examine the Australian response to the COVID-19 pandemic and the consequential impacts on the Australian community. States and Territories should pass complementary legislation that would enable them to participate in the Royal Commission. The terms of reference for the Royal Commission should be adopted from the Senate Standing Committee on Legal and Constitutional Affairs' COVID-19 Royal Commission inquiry report.[36]

Recommendation 2

1.53 Committees must be made to justify in detail the reasons why each individual submission is not uploaded publicly. All efforts must be made to publish submissions publicly, even if some redaction is necessary.

Recommendation 3

1.54 Integrated data assets held by the AIHW and ABS which include both mortality data and the Australian Immunisation Register data should have been reviewed throughout the pandemic to review any possible connection between higher-than-expected all-cause mortality and COVID-19 vaccination. These same data assets must be made available for independent analysis of vaccination status and mortality.

Recommendation 4

1.55 When dealing with a provisionally approved drug, deaths in interim mortality reporting should be analysed by vaccination status by integrating the AIR data, not just relying on death certificates.

Recommendation 5

1.56 During a declared pandemic, mortality data should be available to researchers and the general public. The ABS should report monthly mortality data by age, sex and cause of death, which would enable additional analyses on a more regular basis, which can inform policy. Data should be freely available to

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35 Submission 49, AMPS, Page 3

36 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/COVID19RC47/Report

users, enabling engagement with a range of experts to facilitate a quicker and more in-depth understanding of the impacts of epidemics going forward.

Recommendation 6

1.57 Extend the COVID-19 Vaccine Claims Scheme and fully review its terms to ensure that victims are adequately compensated.

Recommendation 7

1.58 The federal government must pass legislation which prohibits vaccine mandates.

Recommendation 8

1.59 In the interest of transparency, existing contracts containing indemnification clauses should be release publicly as they create an unquantifiable contingent liability for Australian taxpayers.

Recommendation 9

1.60 According to official data, deaths of young women continue to run at far higher than expected levels, whereas young men do not. The cause/s of this alarming and consistent trend must be immediately identified.[37]

Recommendation 10

1.61 An appropriate independent body should undertake comprehensive review (including with bereaved families) of every report of death following COVID-19 vaccination. This body should also undertake investigations of each serious adverse event following immunisation (AEFI) report to pharmacovigilance authorities including interviewing each patient and undertaking additional specialised testing where possible. All AEFI reports (including those not deemed "serious") should be individually followed-up to determine the long-lasting consequences of their vaccine reactions (which may include death).[38]

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[37] https://www.actuaries.digital/2024/04/05/excess-mortality-5-higher-than-pre-pandemic-expectations-for-2023/

[38] Submission 13, COVERSE, Page 4

Recommendation 11

1.62 A review of the coding of COVID-19 deaths needs to be done, identifying the true impact of COVID-19 on the community, rather than potentially including "with COVID" deaths with deaths directly caused by COVID-19.

Senator Ralph Babet

United Australia Party

Senator for Victoria

Appendix 1
Submissions and Additional Information

1 Department of Health and Aged Care
2 Australian Bureau of Statistics
3 Actuaries Institute
4 Australian Institute of Health and Welfare
5 Asthma Australia
6 Stroke Foundation
7 National Aboriginal Community Controlled Health Organisation (NACCHO)
8 Royal Australian College of General Practitioners
9 National Rural Health Alliance
10 Diabetes Australia
11 World Council for Health Australia
12 The World Of Wellness International Limited
13 COVERSE
14 Children's Health Defense Australia
15 Australians for Science and Freedom
16 Catholic Women's League Australia
17 Dr Mel Timpson
18 Dr Monique O'Connor
19 Australian Alcohol and Other Drugs Council
20 Ms Xin Yin Ooi
21 Mr Peter Blatch
22 Father David Smith
23 Name Withheld
24 Professor Albert Reece
25 Heart Foundation
26 Dr Martin P. Stewart
27 Senator Gerard Rennick
28 Ms Stephanie Eaton
29 Mr Martin Hickling
30 Dr Robyn Stephenson
31 United Australia Party
32 Associate Professor Tim Adair, Associate Professor Brian Houle and Professor Vladimir Canudas-Romo
33 Mr Ralph Pain
34 Mr Frank McManus
35 Centre for Population, Department of the Treasury
36 Name Withheld
37 Name Withheld
38 Dr Stephen English

39 Mr Gary Christian
40 Mr Brendan Godwin
41 Dr Wilson Sy
42 Mr Lex Stewart
43 Shifted Paradigms
44 Madeleine Love
- 44.1 Supplementary to submission 44

45 Name Withheld
46 Clinical Professor Geoffrey Forbes
47 Name Withheld
48 Name Withheld
49 Australian Medical Professionals' Society (AMPS)
50 Australian Neurodivergent Parents Association (ANPA)
51 Confidential
52 Confidential
53 Confidential
54 Confidential
55 Confidential
56 Confidential
57 Confidential
58 Confidential
59 Name Withheld

Additional Information

1 Letter to Senator Penny Allman-Payne, Chair, from the Department of Health and Aged Care, Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, dated 26 June 2024.
2 Letter to Senator Ralph Babet from Senator Penny Allman-Payne, Chair, dated 19 June 2024.

Answer to Question on Notice

1 Answers to Senator Babet's questions on notice by the Department of Health and Aged Care; received 21 June 2024.
2 Answers to Senator Babet's questions on notice by the Therapeutic Goods Administration, Department of Health and Aged Care; received 21 June 2024.
3 Answers to questions on notice by the Royal Australian College of General Practitioners; received 24 June 2024.
4 Answer to Senator Roberts' question on notice taken by the Department of Health and Aged Care at a public hearing; received 26 June 2024.

5 Answer to Senator Askew's question on notice taken by the Department of Health and Aged Care at a public hearing; received 26 June 2024.
6 Answer to Senator Allman-Payne's question on notice taken by the Department of Health and Aged Care at a public hearing; received 26 June 2024.
7 Answers to Senator Babet's question on notice by the Department of Health; received 26 June 2024.
8 Answers to Senator Babet's questions on notice by the Australian Bureau of Statistics; received 27 June 2024.
9 Answer to Senator Roberts' question on notice taken by the Australian Bureau of Statistics at a public hearing; received 27 June 2024.
10 Answer to Senator Roberts' written questions on notice by the Department of Health and Aged Care; received 28 June 2024.
11 Answer to Senator Babet's written questions on notice by the Stroke Foundation; received 28 June 2024.
12 Answer to Senator Askew's question on notice taken by the Stroke Foundation at a public hearing; received 28 June 2024.
13 Answer to Senator Rennick's questions on notice taken by the Stroke Foundation at a public hearing; received 28 June 2024.
14 Answer to Senator Pratt's questions on notice taken by the National Rural Health Alliance at a public hearing; received 28 June 2024.
15 Answer to Senator Roberts' written questions on notice by the Department of Health and Aged Care; received 28 June 2024.
16 Answer to Senator Pratt's question on notice taken by the Department of Health and Aged Care at a public hearing; received 3 July 2024.
17 Answer to Senator Babet's written questions on notice by the Department of Health and Aged Care; received 3 July 2024.
18 Answer to questions on notice by the National Heart Foundation; received 3 July 2024.
19 Answer to Senator Roberts' written questions on notice by the Australian Bureau of Statistics; received 3 July 2024.
20 Answer to Senator Roberts' questions on notice by the Australian Institute of Health and Welfare; received 4 July 2024.
21 Attachment A) COVID-19 Register – Researcher eligibility
22 Attachment B) Overview of the COVID-19 Register project proposal review and access proposal
23 Answer to Senator Roberts' written questions on notice by the Department of Health and Aged Care; received 5 July 2024.
24 Answer to Senator Roberts' written questions on notice by the Department of Health and Aged Care; received 8 July 2024.
25 Answer to Senator Roberts' written question on notice by the Department of Health and Aged Care; received 10 July 2024.

26 Answer to Senator Rennick's question on notice by the Department of Health and Aged Care; received 27 June 2024.

27 Answer to Senator Roberts' written questions on notice by the Department of Health and Aged Care; received 3 July 2024.

28 Answer to questions on notice by COVERSE; received 3 July 2024.

Appendix 2
Public Hearings

Thursday, 13 June 2024

Committee Room 2S3, Parliament House
Canberra

Australian Bureau of Statistics

- Ms Lauren Moran, Director, Health and Vital Statistics Section
- Ms Bindi Kindermann, General Manager, People and Place Statistics Division
- Ms Linda Fardell, Project Manager, Health and Aboriginal and Torres Strait Islander Statistics

Australian Institute of Health and Welfare

- Ms Michelle Gourley, Unit Head, Burden of Disease and Mortality Unit
- Ms Louise Gates, Group Head, Population Health Group

National Rural Health Alliance

- Ms Susanne Tegen, Chief Executive
- Ms Carmen Ellis, Policy and Research Officer – via videoconference

Asthma Australia

- Mrs Doris Whitmore, Interim Chief Executive Officer – via videoconference
- Mr Anthony Flynn, Director, Health Knowledge and Translation – via videoconference
- Ms Angela Cartwright, Policy Manager – via videoconference

Stroke Foundation

- Dr Lisa Murphy, Chief Executive Officer – via videoconference

Australian Medical Professionals' Society

- Dr Christopher Neil, President
- Dr Jeyanthi Kunadhasan, Treasurer
- Dr Andrew Madry

COVERSE

- Dr Rado Faletic, Board Member and Director
- Mrs Kara Potter, Volunteer

Heart Foundation

- Professor Garry Jennings, Chief Medical Adviser
- Dr Dannii Dougherty, Clinical Evidence Manager

Black Dog Institute

- Associate Professor Fiona Shand, Head of Suicide Prevention – via videoconference

Department of Health and Aged Care

- Dr Phillip Gould, First Assistant Secretary – Health Economics and Research Division, Chief Data Officer
- Ms Hannah Harding, Director, Data Analytics and Translation Section
- Ms Kayla Jordan, Assistant Secretary