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The Art of Crisis Management:

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- curating exhibitions that introduce Australians to leadership and policy challenges in a balanced and non-partisan way through the experiences of the Howard Government (1996–2007); and
- contributing to the civic education of all Australians.

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POLICY PERSPECTIVES

Policy Perspectives is a series of occasional papers published by the Howard Library which aims to reflect critically on policy decisions of the Howard Government in order to provide context and perspective for contemporary policy debates, and facilitate discussion among the policy community and the broader Australian public.

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The Howard Government faced several crises in its eleven years in office, from the beginning of the 'war on terror', through the (almost simultaneous) collapse of Australia's second airline, Ansett, to the scandal of the Australian Wheat Board's dealings with Iraq's leader, Saddam Hussein and the water-front struggles of Australia's stevedoring companies against union control.

How did the Howard Government respond to the crises it encountered; how did it 'frame' these crises for public understanding and support; what role did the media play in explaining particular crises and critiquing Government's

responses; how were the Government's responses evaluated – by it and its critics – after each crisis had passed; was there a pattern from which we can learn to better inform contemporary government responses to crises such as the COVID-19 pandemic, and those that lie in wait?

These questions were the focus of the presentations and discussion at the John Howard Prime Ministerial Library's 2022 annual conference.

Speakers included former Howard Government ministers, academics, media commentators and crisis management experts.



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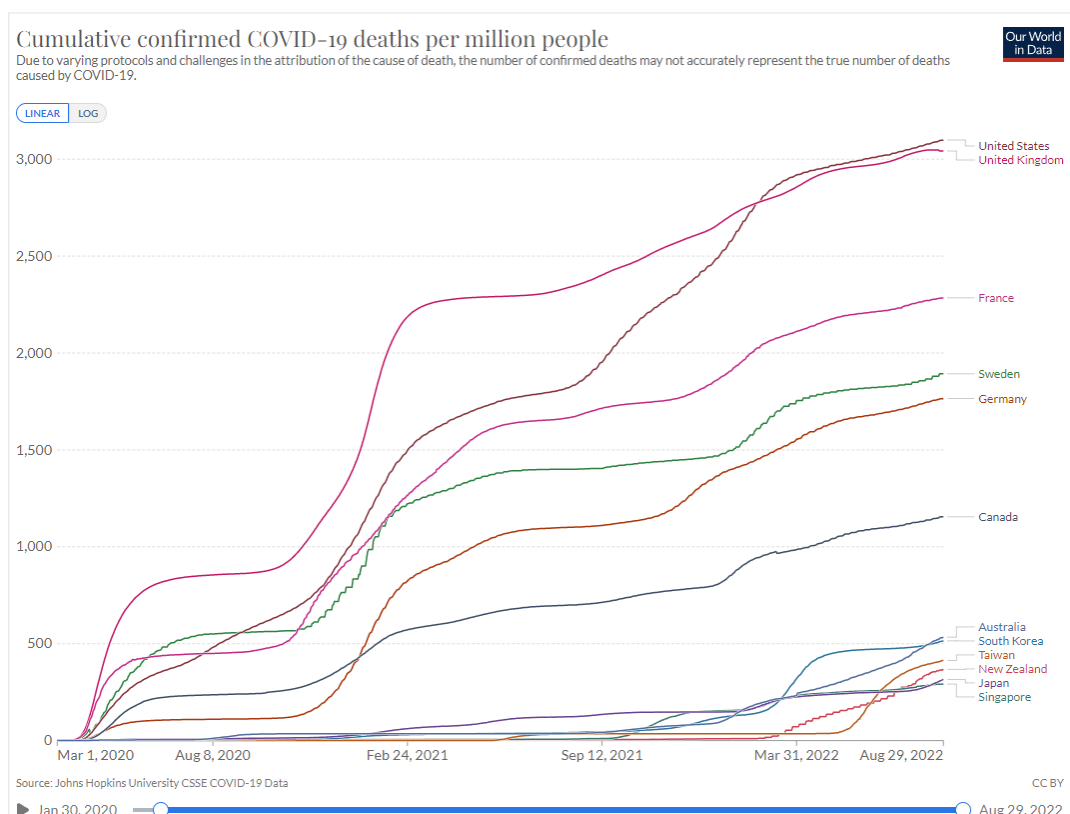
CORONAVIRUS (COVID-19): LESSONS LEARNED?

Professor Peter Collignon AM

DURING 2020 AND 2021, AUSTRALIA WAS SUCCESSFUL AT LIMITING THE SPREAD of repeated reintroductions of SARS-CoV-2. This was achieved by an early closure of international borders – limiting the spread from high prevalence countries/regions (e.g., China, Italy, and the United States of America) – and by quarantining returning international travellers (until late 2021). This was a sensible approach while awaiting high levels of adult vaccination against COVID protecting against death and serious disease. By global comparison, Australia has done much better than most other countries – and are likely to remain among those countries with the lowest number of cumulative deaths related to COVID – but what are the important lessons learned during this global pandemic?

On a population basis until August 28th, 2022, Australia's cumulative death rates from COVID was 530 per million people. This figure is much lower than the 3097 (USA), 1763 (Germany) and 1892 (Sweden) deaths per million people. It is similar to what was experienced in New Zealand, Japan, Singapore, Taiwan and South Korea. Importantly, excess deaths rates (i.e., deaths from all causes and not just COVID) have also been much lower in Australia than nearly all other countries over the first two and a half years of the pandemic (up to August 2022).

Figure 1. Cumulative deaths per million from Covid August 2022



Despite these relatively good outcomes, COVID continues to instil a sense of fear and panic – although it is not hard to see why. Up until mid to late 2021 Australia was relatively well protected from COVID’s worst effects. Through a concerted effort the spread of COVID was kept under control – through long periods of ‘zero COVID’ and limited periods of severe restrictions – with Victoria an exception.

From mid-August to November 2021, the spread of COVID – with the advent of the much more transmissible delta variant – became almost unstoppable. This was despite early lockdowns in many Australian jurisdictions. With our inability to control the spread of ‘Delta’ and after achieving over 95 per cent vaccination in adults, in late 2021 (when Australia reopened its international borders and loosened restrictions) widespread infections started. From December 2021 to August 2022, the initial ‘Delta’ variant wave was followed by three overlapping waves caused by different ‘Omicron’ variants. We unfortunately had over 10,000 COVID-19 associated deaths in the first eight months of 2022. But why are the political and public perceptions – and levels of restrictions – dramatically different to the mindset of mid-2021? I suspect many reasons. Please allow me to explain.

First, we are now a very highly vaccinated population, markedly lowering our risk of death and serious disease when infected. Second, most Australians have likely been infected over the last nine months and have now hybrid immunity. Our individual risk for hospitalisation and death is now ten to twenty-fold lower than in 2020, if we become infected. In 2020 about two per cent of those who were infected, died. Whether our current immunity is from three or four doses of the vaccine, natural infection or by a mix (hybrid immunity), this protection against serious disease likely persists for twelve months or more. On the downside, vaccines are much less effective at stopping mild infections. Onward transmission to others remains common.

Unanswered questions remain

Many unanswered questions about COVID-19 remain. We need to address these so we can better learn how to potentially decrease similar threats in the future. It is also relevant for knowing how best to limit deaths and serious disease in those people most at risk, but without excessive restrictions and consequent harm. These harms include not only social, psychological, economic, and educational but also associated health effects (e.g., delays in cancer diagnosis, surgery, and treatment for diabetes) that may be shown by an increase in ‘excess deaths’, even if COVID deaths are low.

Did SARS-CoV-2 virus escape from the Wuhan lab?

The short answer is we still do not know. A ‘lab leak’ remains a possibility that cannot be excluded, but equally there is no strong evidence available that this is what occurred either. The SARS-Cov-2 virus or its immediate predecessor appears to have come from a coronavirus initially present in bats (in China or Southeast Asia). The unresolved question is how it then infected people and spread so readily. One view is that the virus went from bats to an intermediary animal (so far not found) with the virus spreading to humans. Initial spread occurred either in the wild or via the seafood market at Wuhan, where live animals were sold.

An alternate theory is that it escaped from the research laboratory at Wuhan, which stored viruses and propagated many hundreds of different coronavirus samples from bats and other animals, after their discoveries in wild animals. The latter lab leak theory has caused political and scientific controversy, including when the Morrison Government in 2020 called for an independent World Health Organization (WHO) sponsored review.

We do need to be concerned about lab leaks. These have occurred not infrequently in the past with various viruses including smallpox, influenza virus and SARs-1. In the Wuhan lab (and other labs) there appears to have been ‘gain of function’

experiments done on various viruses to make them more transmissible and/or more virulent. These experiments are justified by research labs in that it helps scientists to better understand viruses and develop better drugs and/or better vaccines to combat novel infections. Despite these promises this has not happened for any novel virus (or even old ones) and patently did not happen with the coronavirus that causes COVID, even though similar viruses were held for some years at the Wuhan lab, and elsewhere.

More worrying is that for a novel virus found in animals to cause infections in people and spread, it must first be able to multiply in people and their cells. With coronaviruses in the Wuhan lab, many viruses were cultured (and therefore virus numbers multiplied exponentially) in cell lines that included both human cell lines and monkey cell lines. This seems to be a very efficient way to adapt a new virus found in animals, to then be able to multiply in people if the virus ever escaped from the lab.

We need much better controls on these types of laboratories and on cell lines used to culture any new animal derived viruses. Much of this work has been done without any obvious benefits. Certainly not the benefits that many argue justifies the types of research and processes done in many of these labs – such as it will help prevent the next pandemic or prepare us better for a new pandemic. No one can claim it helped with COVID-19 or for other infections that have spread in the last two decades before, such as Swine Flu (H1N1 influenza), SARS, bird flu or Ebola.

Who is most infected by COVID?

In the first two years of the pandemic, the age group with the highest infection rates have consistently been young adults aged between 20 to 29 years, followed by those people in the 30 to 39-year-old age group, due likely to their mobility and interaction with larger numbers of people. Children incorrectly continue to be the concern or belief by many, as the major source of ongoing infections in communities. In most data, however, whether based on case numbers or antibody tests, children have generally lower

rates of infection than adults aged 20 to 60 years. Children below the age of ten also have lower infection rates than teenagers. This is quite different to most other respiratory infections (e.g., influenza, RSV), where young children have often had infections at five times or more higher rates than adults. The main reason for children having less infection is likely due to them having less receptors in their nose and airways before multiplying and causing infection (ACE2 receptors), compared to adults.¹

Mortality rates

Age dependent mortality rates is another important aspect of COVID-19. The highest infection fatality rate is seen in those people aged 80 years of age or older, where in 2020, more than one in ten infected people – but not immunised – died. This compares to a much lower infection fatality rate seen in 30-year-olds, where pre-vaccination in 2020, their infection fatality rate was about one per 10,000 infections. In children the fatality rate was even lower. Likely about one per 100,000 infections and even lower still in children who do not have any underlying major health issue when infected.^{2 3}

We still do not know enough on how Covid spreads

The SARS-CoV-2 virus is present in respiratory secretions and in faeces. It can also be found on surfaces after these have had respiratory secretions deposited on them. In theory, the virus can spread via direct contact with respiratory secretions, faecal material or from innate surfaces (via hands and then inoculation of eyes, nose, or mouth). We know that close and prolonged contact indoors is the most important factor involved in the transmission of COVID e.g., within a household or workplace. Higher risk activities are being in air-conditioned or heated rooms with low humidity.⁴ While the SARS-CoV-2 virus is present in faeces, the respiratory route seems to be the overwhelming way COVID-19 is transmitted. Past and current epidemiological evidence suggests that most transmission of COVID-19 in the community is through air,

but this transmission is likely mainly by larger particles (droplets) rather than by aerosols. The latter are much smaller than droplets and can stay suspended in air for many hours and travel much further.

In 2020, over 700 returning (but infected) Australian residents were cared for by New South Wales Health in apartment hotels, over a two-week period, in Sydney. Staff wore surgical masks to protect their airways and face shields for eye protection. No staff members became infected. Surgical masks are said by those concerned about aerosols as giving poor protection against aerosols, compared to N95 respirator masks. N95 masks might give extra protection, but it is hard to see it would be very much, given the low rates of cross infections in our quarantine hotels in Australia that used surgical masks and eye protection properly (especially in NSW where the largest numbers of infected people were looked after). As far as I am aware no one (staff or guests), wearing a surgical mask and eye protection when exposed to someone with an infection, became infected while staying in or working in quarantine hotels in Australia (other than some when exposed in Victoria to an inappropriately used nebuliser).

Staying away from others and work while symptomatic is an important prevention strategy. While those who are asymptomatic or pre-symptomatic, can spread the virus, most spread occurs likely from people who have symptoms. Isolation and social distancing are vital even though this was not done by many people, including healthcare workers in the past⁵.

Suppressing or eliminating COVID-19

When initial interventions to limit the spread of COVID-19 were implemented in Australia (and worldwide), it was intended to 'flatten the curve'. This meant that instead of allowing numbers of new cases to continue to rise per day (as was occurring and often rising exponentially), restrictions and interventions would cause the number of new cases per day to level off. The level and severity of restrictions put in place would be tailored with numbers of new cases

occurring per day such that the health system could cope better.⁶ In Australia, during our first wave in March/April 2020, we did much better than just 'flattening the curve'. The epidemic curve of daily cases decreased rapidly after about March 26 – and we had very low numbers of new cases per day by mid to late April. This resulted in an effective suppression of cases like South Korea during their first wave, and in New Zealand. After this successful suppression, some areas (e.g., New Zealand in March 2020 and then Victoria) started aiming for an 'elimination strategy'. This was done with more prolonged lockdowns compared to other states in Australia. The supposition being that if lockdowns continued so no new cases were seen for two or more incubation periods (i.e., 28 days) then it was likely the virus was eliminated from those areas.⁷

In both Victoria and New Zealand, however, there were subsequent outbreaks of COVID-19 after the initial 'elimination'. Notably, the genomics on new outbreaks that occurred in Australia and New Zealand since late 2020, show all new outbreaks were caused by newly introduced strains. This suggests that everywhere in Australia and New Zealand – including Sydney – with large cases numbers during multiple outbreaks, the virus was eliminated before new strains were reintroduced, and by some states using much less severe levels of restrictions than others. Notably, Japan, South Korea and Taiwan achieved either zero COVID and/or low levels of spread until early 2022, without resorting to widespread lockdowns. Even when achieved, elimination has been and will be very difficult to maintain in large populations over time. By August 2022, China was the only country continuing with this approach. Hong Kong was still aiming for 'dynamic covid-zero', but case numbers in August 2022 were still rising.

The symptoms in people who are aged in their 20s and 30s, are mostly very mild and/or asymptomatic and likely more so if vaccinated. Yet they can still pass on the virus to others. Even if we are not seeing cases, it can still be likely that in some areas there might be ongoing low-level transmission occurring, even if no cases are found for many weeks or even months.

Yet when SARS-CoV-2 virus is eliminated from certain populations, if 'isolation and social distancing' measures are not retained, the virus is reintroduced, spreading rapidly, especially in Winter.

Elimination will be difficult to maintain, given how widespread COVID remains globally. New case numbers can quickly escalate, as evidenced not only by what occurred in Melbourne (in the Winter of 2020), but also in Korea and in Auckland. South Korea, with its control of COVID-19, was like Australia after its first wave, but when South Korea reopened crowded facilities, particularly bars and nightclubs, a rapid increase in new cases ensued, worsening over Winter of 2020/21.⁸

COVID is not going away. It will be present for decades to come. Its spread was delayed but with the more transmissible strains (Delta and Omicron) we cannot stop it from spreading. Nor can we expect to get to COVID-zero. NSW, Victoria, and New Zealand tried but failed – as did Taiwan and Hong Kong. In August 2022, Hong Kong (like the rest of China) was still striving for 'COVID zero', but despite prolonged restrictions, this seems an unlikely achievable or sustainable goal.

Vaccines

Vaccinations have been very effective in saving lives. Data from Australia, the United States, the United Kingdom, Qatar, and Israel show that once someone is fully vaccinated that person receives high levels of protection against death, intensive care unit (ICU) admission or serious disease (hospitalisation) compared to those who remain unvaccinated. Vaccination also decreases mild disease and viral transmission, but much less so. Especially once the Omicron variants become dominant.

Vaccines in use or being used were developed and deployed much faster than previous vaccines and were all novel. Early and large-scale studies showed all to be effective at markedly decreasing death rates and relatively safe. All vaccines, by different means, presented the spike protein component of the virus to our bodies. We then

produced protective antibodies and cellular responses by our lymphocytes.

The Pfizer and Astra Zeneca vaccines were available in Australia from about March 2021, but vaccine supplies were not available in large quantities until October 2021 due to global demand and vaccine supply issues. The Astra Zeneca/Oxford vaccine used encoded deoxyribonucleic acid (DNA) as a template to produce a spike protein delivered by injection of a non-replicating modified adenovirus vector. The Pfizer and Moderna vaccines were messenger RNA based vaccines (stored at very low temperatures). The spike protein was then made from this mRNA template in the body near the site of injection. The Novavax vaccine only became available much later in 2022. This vaccine relied on the spike protein being injected resembling a more traditional vaccine approach.

In Melbourne in the Winter of 2020 when no vaccines were available, the case fatality rate (CFR), was about four deaths per 100 people infected, although age dependent. In those vaccinated, the overall population CFR is well below one per 1000 identified cases, making the population CFRs similar to those linked to seasonal influenza.

Australia was fortunate to have had a large proportion of the adult population vaccinated before COVID spread widely – with over 90 per cent of adults vaccinated by the end of 2021. We also were able to have available to offer to those over the age of 70 years (and at highest risk of death from COVID) vaccination by mid-2021 – before widespread infection with COVID occurred. A rare side effect was noted for the AZ vaccine resulting in the death of about one per million vaccine recipients. This was caused by an unusual clotting or thrombotic event and was found to be more common in younger women. Consequently, older people deferred their vaccination opting for Pfizer vaccines.

In mid-2021, Australia had little or no COVID circulating with an expectation that 'zero COVID' could be achieved. Unfortunately, the Delta variant took hold in August 2021 resulting in many hundreds of deaths among the elderly. The mRNA vaccines also had rare but serious side effects,

mainly inflammation of the heart (myocarditis), occurring more often in younger males.

There seems to have been an expectation in the community that vaccines would have no serious side effects. If you were over the age of 70, your risk of dying if infected with COVID was about one in 50, and if over 80 years of age, there was a one in ten chance of death. Even though the risk of death from the AZ vaccine was about one per million, several older Australians were not persuaded. Inconsistent advice from health experts on age eligibility – as well as an over-emphasising of adverse effects – led to the uptake of an effective vaccine being much less than it should have been. A consequence: the loss of too many lives when the inevitable spread of COVID occurred.

Outside air and ventilation

Outdoors, the risks of transmission of COVID-19 (and many other respiratory infections) are low. Several environmental factors are known to reduce the viability of viruses and other infectious pathogens in the air including variations in temperature, relative humidity, solar ultraviolet radiation, and dilution effects. One agent that reduces the viability of both viruses and bacteria outdoors, germicidal open-air factors (OAF), has not been properly recognised for decades: despite robust evidence that these factors can influence both the survival of airborne pathogens and the course of infections.

The germicidal effects of outdoor air were widely exploited during the late 19th and early 20th centuries.⁹ First, in the treatment of tuberculosis patients who underwent ‘open-air therapy’ in sanatoria; and second, by military surgeons during the Great War. Military surgeons used the same open-air regimen in specially designed hospital wards to disinfect and heal severe wounds among injured soldiers. This method was also used on influenza patients during the 1918–19 pandemic. Later, in the 1950s, open-air disinfection and treatment of burns were proposed in the event of nuclear warfare. During the 1960s, OAF briefly returned to prominence when biodefence scientists conducted

experiments proving that open air has a potent germicidal effect. When this work ended in the 1970s, interest in the OAF again fell away, remaining largely ignored.

The COVID-19 pandemic has revived interest in understanding the transmission dynamics and survival of viruses in the air. The pandemic has also stimulated research in the science and practice of improved ventilation to control respiratory infections. Such work is incomplete without an appreciation of the inactivation of viruses and other pathogens by OAF, prompting urgent further investigation. This work is important as we need to review building design regarding infection control and patient recovery. We need to act without delay. There is sufficient evidence showing public health generally improves if more emphasis is placed on increased exposure to outdoor air.

We do not know how best the germicidal and health effects of outdoor air can be preserved indoors. Given the threat to global public health from COVID-19, antimicrobial-resistant bacteria, pandemic influenza, and novel pathogens, there is merit in investigating whether and how this can be done. If so, ‘rediscovering’ open-air wards and the open-air regimen might benefit patients and staff in hospitals. The OAF will likely also help in reducing the transmission of many infections in schools, homes, offices, and larger buildings.

A program of testing is essential to determine the effects of OAF on the viability of established and emerging pathogens. Research must be carried out to confirm that OAF can be preserved indoors and under what conditions. We need to recognise there is sufficient evidence already showing that public health generally improves if we place more emphasis on increased exposure to outdoor air.

Lockdowns and school closures

Despite the much lower fatality rate in children and lower infectivity risk to others (compared to the age group of parents and teachers) there were prolonged school closures, not only in Australia, but globally. This action resulted in an intergeneration trade-off leaving children worse

off than older adults.

Recent analysis published by the US National Bureau of Economic Research, reveals while lockdowns did likely overall decrease deaths from COVID in most countries, lives saved were mainly those people aged over 70. This age effect was marked more in countries with high per capita gross domestic product (GDP); where even in richer countries, lockdowns did not 'save' many children's lives.¹⁰ In contrast, in countries with low GDP's, lockdowns increased the number of children who died. While some children's lives were saved after avoiding COVID infections, overall deaths increased because of the associated severe socio-economic effects and poorer access to healthcare for non-COVID related reasons.¹¹

The United Nations International Children's Emergency Fund (UNICEF) has also recently shown the detrimental effects COVID restrictions (and associated school closures) had on children. These effects were much worse in low socio-economic countries, where two years or more of schooling has been lost and unlikely to ever be recovered.¹²

In Australia, socio-economic disadvantage has effects both on health and other outcomes related to COVID. Australian Bureau of Statistics (ABS) data shows those in lower socio-economic groups, have up to five times higher mortality rates than those who are more affluent. Many media and other reports also show that many children did not participate in much or sometimes any 'in home' schooling during lockdowns and school closures in Australia. Because of a lack of access to a computer and the internet, and overcrowding in housing, lower socio-economic groups were disproportionately disadvantaged.

Mask mandates

Wearing masks in the community likely decreases the chances of people getting infected with COVID by about fifteen per cent. Surprisingly there are only two studies that have looked at this using good control or comparator groups. This relative lack of good research is one reason there is such controversy.¹³

Good data supporting wearing of mask use in the community remains scanty and while there are many mask studies published, they are generally of poor quality. There are data showing potential benefits but there are also many observational studies that show adjoining regions with mask mandates compared to those that have no mandates, results in little or no differences in the numbers of cases detected on a population basis.

One argument is that cloth and surgical masks are ineffective and that we need the widespread community use of better-quality masks. When this was tried in Bavaria, Germany, however, the widespread use of N95 respiratory masks, did not seem to have an associated lower infection rate with COVID, compared to other regions not using these types of respirators/masks.

Masks are not usually worn in situations where the highest levels of transmissions occur in homes and public areas. Wearing a mask decreases the risk of contracting COVID by a small to moderate amount and should be promoted for that reason, especially the vulnerable in our community. Mask mandates and associated fines for non-compliance, do not make much difference to case numbers nor likely impact numbers in hospitals or dying from COVID.

The Howard era: pandemics and planning

During the Howard Government era, there were several infectious disease threats. In March 2003, the WHO issued a global alert recommending active worldwide surveillance for severe acute respiratory syndrome (SARS). The virus originated in China and large secondary outbreaks occurred in Vietnam, Canada, and Hong Kong. Australia adopted a border control policy and there were 138 people investigated for SARS: 111 suspect and 27 probable. No spread occurred within Australia with only five probable cases reported to the WHO.¹⁴

Another infection was Avian flu (H5N1 influenza). Because of its ongoing spread in birds in Asia (and sometimes elsewhere), spread to or between people was rare, but when people became infected, a case fatality rate of over 25 per cent was realised.

In June 2005, Health Minister, Tony Abbott released the Australian Management Plan for Pandemic Influenza.¹⁵ This plan provided information for an Australian response to an influenza pandemic in the event of an outbreak. The Plan included information on major strategies to be used to respond to a pandemic, an overview of roles of various committees and agencies involved in pandemic planning, key groups involved in pandemic response, information on diagnostic testing, surveillance, disease control measures, communications strategies, and, importantly an overview of response actions.¹⁶

Notably, when the COVID-19 pandemic was declared in 2020, Sweden, South Korea and Japan were among the few countries to follow their respective pandemic plans. Nearly all other countries, including China, Australia and New Zealand used lockdowns and prolonged school closures as public health measures, despite those measures not prescribed in pandemic plans.

What will the near future hold?

The ‘Spanish flu’ of 1918–19 (Influenza A) was much worse than COVID-19 with its associated fatality rates (a case fatality rate of about two per cent but killing tens of millions of people, disproportionately affecting those people aged 20 to 40 years). COVID-19 predominantly causes deaths in the elderly. Even before vaccines, the COVID case fatality rates in people aged 30, was about one per 10,000 cases. With the Spanish flu, the case fatality rate was one to two per cent in that younger age group, but this high mortality was only in the first two years after it circulated widely in 1918.

Spanish flu did not go away after 1920. It persisted for another 50 years or more, with new ‘variants’ appearing frequently. Its very high mortality rate fell to much lower levels after two years, and it became a winter seasonal illness throughout most of the world – as COVID-19 is likely to repeat. Yes, we have had lots of cases in Australia, and our cumulative number of cases per million people, now equals the United States, but delaying the introduction and spread of COVID-19 in Australia, and because of our high

levels of vaccination and now lower virulence in the circulating strains, our cumulative case fatality rate is about seven times lower than in the United States. Australia’s cumulative total rate is likely to stay much lower.

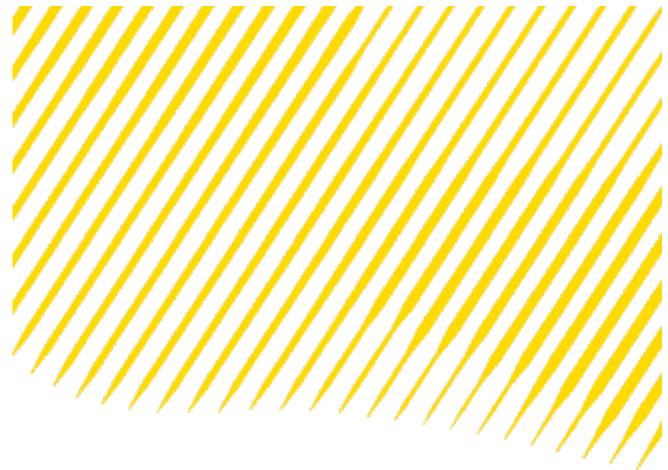
We, do, however, need to better target and protect our most vulnerable. We need to better ensure they are fully immunised with boosters; plus ensure access to early testing and quicker access to antiviral drugs, if infected. These steps will lead, in part, to a decrease in the risk of serious disease and a lowering of deaths resulting from COVID. Prevention is still important. Masks decrease the risk of transmitting infection to others, especially when indoors and in crowded situations. But mask mandates and fines however do not seem to have much effect on the overall community transmission. We need to change our focus from case numbers to more accurate indicators, namely deaths, hospitalisation, and intensive care unit (ICU) numbers, as better indicators. If we want an early warning system, we need early daily reporting of sewage levels of COVID, as this information provides the best indication of the true numbers of cases (and the likely subsequent hospital demands about one to two weeks later).

Australia is now past the worst of COVID-19. We need to be optimistic about the future. Vaccines have been, and are effective, at protecting against death and serious disease. We now have antiviral drugs that decrease the risk of death and serious disease for our most vulnerable citizens. While new strains will continue to appear and be more transmissible, they are also likely to be less virulent. The Spanish flu’s high mortality rates dropped dramatically after two years. We should expect a similar outcome for COVID.



Endnotes

- 1 Peter Collignon, 'COVID-19 and future pandemics: is isolation and social distancing the new norm?', *Internal Medicine Journal*, vol. 51, no. 5, 2021, pp. 647-653, doi: <https://doi.org/10.1111/imj.15287>
- 2 Andrew Levin et al, 'Assessing the Age Specificity of Infection Fatality Rates for COVID-19: Systematic Review, Meta-Analysis, and Public Policy Implications', *medRxiv preprint*, 6 October 2020, doi: <https://doi.org/10.1101/2020.07.23.20160895>
- 3 Peter Collignon and John Beggs, 'COVID-19 fatality risk: Why is Australia lower than South Korea?', *medRxiv* 2020, doi: <https://doi.org/10.1101/2020.05.14.20101378>
- 4 Collignon, 'COVID-19 and future pandemics: is isolation and social distancing the new norm?', pp. 647-653.
- 5 E Tartari et al. 'Not sick enough to worry? "Influenza-like" symptoms and work-related behavior among healthcare workers and other professionals: Results of a global survey', *PLoS One*, 2020, vol. 15, no. 5: e0232168, published May 13, 2020. doi:10.1371/journal.pone.0232168
- 6 S Roberts, 'Flattening the Coronavirus Curve', *New York Times*, March 27, 2020, <https://www.nytimes.com/article/flatten-curve-coronavirus.html>
- 7 MG Baker et al 'Successful Elimination of Covid-19 Transmission in New Zealand', *The New England Journal of Medicine*, 2020, vol. 383:e56, doi: 10.1056/NEJMc2025203.
- 8 Choe Sang-Hun, 'As South Korea Eases Limits, Virus Cluster Prompts Seoul to Close Bars', published online May 9, 2020, <https://www.nytimes.com/2020/05/09/world/asia/coronavirus-south-korea-second-wave.html>
- 9 Richard Hobday and Peter Collignon, 'An Old Defence Against New Infections: The Open-Air Factor and COVID-19', June 20, 2022, *Cureus*, DOI: 10.7759/cureus.26133
- 10 J Herby et al, 'A Literature Review and Meta-Analysis of the Effects of Lockdowns on COVID-19 Mortality', *Studies in Applied Economics* 200, The Johns Hopkins Institute for Applied Economics, Global Health, and the Study of Business Enterprise, <https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf>
- 11 L Ma et al, The Intergenerational Mortality Trade-off of COVID-19 Lockdown Policies, (published online ahead of print, 2022 Apr 24), *International Economic Review*, 2022, <https://onlinelibrary.wiley.com/doi/full/10.1111/iere.12574>
- 12 UNICEF. 'UNICEF, EU CONCERNED ABOUT IMPACT OF SCHOOL CLOSURES ON CHILDREN: 897 MILLION SCHOOLCHILDREN WORLDWIDE WERE AFFECTED BY DISRUPTIONS TO THEIR EDUCATION DUE TO COVID-19 RELATED LOCKDOWNS.', February 1, 2021. Press Release, <https://www.unicef.org/eu/press-releases/unicef-eu-concerned-about-impact-school-closures-children>
- 13 J Conly et al, 'Use of medical face masks versus particulate respirators as a component of personal protective equipment for health care workers in the context of the COVID-19 pandemic', *Antimicrobial Resistance & Infection Control*, vol. 9, no. 1, pp. 1-7, DOI: [10.1186/s13756-020-00779-6](https://doi.org/10.1186/s13756-020-00779-6)
- 14 G Samaan et al, 'Border screening for SARS in Australia: what has been learnt?', *Medical Journal of Australia*, vol. 180, no. 5, pp. 220-223.
- 15 Australian National Audit Office, *Australia's Preparedness for a Human Influenza Pandemic*, Audit Report No.6, 2007-08, https://www.anao.gov.au/sites/default/files/ANAO_Report_2007-2008_06.pdf
- 16 Parliament of Australia, prepared by N Brew and K Burton, 'Australia's capacity to respond to an infectious disease outbreak', Research Paper no. 3, 2004-05, 16 November 2004, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp0405/05rp03



The Howard Library Annual Conference Series

The Liberal-National Party Coalition led by John Howard won office on 2 March 1996 and continued to hold power until 3 December 2007 (after losing the election held on 24 November 2007). UNSW Canberra is hosting a series of retrospective conferences to assess the performance of the Howard Government. Each event provides the basis for collections of essays contributed by principal participants, key public servants, leading commentators and notable scholars drawing on documents in the John Howard Collection held at the Australian Defence Force Academy Library and other papers managed by the Howard Library at Provisional (Old) Parliament House. This series has become the authoritative treatment of the Howard years.

Contributors are asked to focus critically on the Coalition's policies and performance to reveal the Government's shortcomings and failures. This commitment to a candid critique attracts the attention of the press and current-serving politicians, affording the volumes a substantial public profile at the time of their release. UNSW Press is the series publisher.

The first conference covered the 1996 election, the Coalition's readiness for office, the main policy decisions and practical challenges of the first year of the Howard Government, including gun control and ministerial responsibility.

The second conference dealt with the second and third years of the Coalition's first term in office (1997-98) and most of its second term (1998-2001). It canvasses the High Court's Wik decision and native title, the Patricks waterfront dispute, the constitutional convention, the Coalition's near defeat at the 1998 poll, the Government's response to post-independence violence in Timor-Leste and the introduction of the GST.

The third conference focused on the controversial events leading to the 2001 election including the MV *Tampa* crisis, the collapse of Ansett Airlines, the '9/11' terrorist attacks and the invasion of Afghanistan. It looked at the decision to invade Iraq in 2003, the outbreak of the 'history wars', managing the environment and health care, the challenges faced by the Labor Opposition and the rise of Mark Latham.

The fourth conference was concerned with the period October 2004 to November 2007 and examined the Coalition's control of the Senate, the advent of Work Choices, the progress of Indigenous Reconciliation and the Northern Territory intervention, and the election that saw the Coalition lose office and the Prime Minister his seat in parliament.



Our 2022 conference focused on crisis management and assessed the Howard Government's responses to the crises it encountered in its eleven years in office. From the beginning of the 'war on terror', through the (almost simultaneous) collapse of Australia's second airline, to the scandal of the Australian Wheat Board's dealings with Iraq's leader, Saddam Hussein and the waterfront struggles of Australia's stevedoring companies against union control. How did it 'frame' these crises for public understanding and support; what role did the media play in explaining particular crises and critiquing Government's responses; how were the Government's responses evaluated – by it and its critics - after each crisis had passed; was there a pattern from which we can learn to better inform contemporary government responses to crises such as the COVID-19 pandemic, and those that lie in wait? The ensuing papers aim to critically reflect on those policy decisions of the Howard Government in order to provide context and perspective for contemporary policy debates and facilitate discussion among the policy community and the broader Australian public.

UNSW Press Howard Government Series Titles

- I The Ascent to Power, 1996 (released 2017)
- II Back from the Brink, 1997-2001 (released 2018)
- III Trials and Transformations, 2001-2004 (released 2019)
- IV The Desire for Change, 2004-2007 (released 2021)
- V The Art of Coalition: The Howard Government Experience, 1996-2007 (released 2022)



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