



Australia's Health 2022 Supplementary Report 7

Commissioned by People for Safe Vaccines
Presented by Sandy Barrett
Dated 26 July 2022

WHO WE ARE

People for Safe Vaccines is an **Australian not-for-profit committed to promoting vaccine safety and efficacy**, with a membership of **over 3,000 concerned Australians**, including parents of children at risk of injury and injured by certain provisionally registered goods indicated for prevention of Covid-19 on the Australian Register of Therapeutic Goods.

WHAT WE SEEK

Proper due diligence from the government on safe vaccines

True transparency and accountability

Freedom to choose your own medical interventions

Open public debate

OUR OBJECTIVE HERE

This is a further Supplementary Report to our previous reports, which can be found [here](#). The purpose of this supplementary report is to examine the latest report on Australia's Health, prepared by the Australian Institute of Health and Welfare, to garner further insights into the impacts of COVID-19 on our healthcare system and to look at the metrics used in government and industry statistics, to see whether they stack up, or simply lend themselves to prop up their narrative.

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MONEY TALKS

From the outset, due to the economic pressures caused by lockdowns and forecast burden on the healthcare system, financial assistance and in some cases, incentives, were implemented for Universities, Schools, sports and recreation, taxi drivers, family violence, support for temporary Visa holders, international students, Australian Red Cross, Lifeline and other charities impacted by pandemic, asylum seekers, mental health services, Aboriginal and Torres Strait Islander organisations, hotel and hospitality, funding to expand jobs in the Public Service, Arts and cultural organisations, tourism operators, small business, assistance to gaming venues, childcare, farmers, construction, wildlife exhibitors, disability sectors and economic stimulus packages to support local councils.

This was on top of the JobKeeper, JobSeeker and Hardship payments.

Here is a list of some of the early economic stimulus packages of note: -

State	Announcement Date	Announcement overview	Amount	Source
SA	11 March 2020	The SA Government announced a \$350 million stimulus package to help the South Australian economy and jobs.	350,000,000	S Marshall (SA Premier), <i>Unprecedented response and economic stimulus to drive SA jobs, economy in wake of bushfires, coronavirus</i> , media release, 11 March 2020.
WA	16 March 2020	The WA Government announced a \$607 million package to support WA households and small businesses.	607,000,000	M McGowan (WA Premier) and B Wyatt (WA Treasurer), <i>COVID-19 economic response: relief for businesses and households</i> , media release, 16 March 2020.
NSW	17 March 2020	The NSW Government announced a \$2.3 billion health and economic stimulus package.	2,300,000,000	G Berejiklian (NSW Premier), D Perrottet (NSW Treasurer) and B Hazzard (NSW Minister for Health), <i>\$2.3 billion health boost and economic stimulus</i> , media release, 17 March 2020.
TAS	17 March 2020	The Premier announced a \$420 million support package.	420,000,000	P Gutwein (Tasmanian Premier), <i>Investing to sustain a strong economy and local jobs</i> , media release, 17 March 2020.
NT	18 March 2020	The Chief Minister announced a \$65 million Jobs Rescue & Recovery Plan.	65,000,000	M Gunner (NT Chief Minister), <i>The Territory's Jobs Rescue & Recovery Plan</i> , media release, 18 March 2020.
ACT	20 March 2020	The Chief Minister announced an initial \$137 million economic survival package.	137,000,000	A Barr (ACT Chief Minister), <i>Initial economic survival package to support Territory economy</i> , media release, 20 March 2020.

VIC	21 March 2020	The Victorian Government announced a \$1.7 billion economic survival and jobs package.	1,700,000,000	D Andrews (Victorian Premier) and T Pallas (Victorian Treasurer), <i>Economic survival package to support businesses and jobs</i> , media release, 21 March 2020.
QLD	24 March 2020	The Queensland Government announced a \$4 billion package to support health, employment, households and businesses.	4,000,000,000	A Palaszczuk (Queensland Premier), J Trad (Queensland Treasurer), S Miles (Queensland Minister for Health) and S Fentiman (Queensland Minister for Employment and Small Business), <i>Palaszczuk Government unveils \$4 billion package to support health, jobs, households and Queensland businesses</i> , media release, 24 March 2020.
TOTAL			9,579,000,000	

The Federal Financial Relations [COVID-19 Response agreement](#) was implemented to contribute funding to support the Australian health system to respond effectively to the outbreak of COVID-19, with States and Territories national health Funding Pool provided upfront advanced payments from the Commonwealth. "This is in recognition of the costs and burden incurred by state health services (including but not limited to public hospitals, contracting of existing private hospitals, primary care, aged care and any other community expenditure)."

An up-front payment of \$100 million dollars was distributed across the States and Territories based on population size: -

New South Wales	\$ 31,899,187
Victoria	\$ 26,005,094
Queensland	\$ 20,091,356
Western Australia	\$ 10,337,993
South Australia	\$ 6,907,399
Tasmania	\$ 2,106,814
Australian Capital Territory	\$ 1,682,629
Northern Territory	\$ 969,528

The Commonwealth agreed to provide *Hospital Services Payments*, which is a 50 per cent contribution through monthly payments for costs incurred by States, for the diagnosis and treatment of COVID-19 **including suspected cases**.

Also, the *State Public Health Payments* provide a 50 per cent contributions for costs incurred by States, through monthly payments, for **other COVID-19 activity undertaken** by State public health systems for the management of the outbreak.

In July 2022, the *COVID-19 response agreement* was extended to December 2022.

The Australian Government enacted the *Coronavirus Emergency Response Plan* with the NDIS receiving payments between \$1200-1800 per patient per day. *NDIS Pricing Arrangements and Price Limits* which can be downloaded [here](#). Plus, Residential Aged care facilities are given bereavement payments per death, so cashing in on COVID-19 cases and deaths, regardless of whether the test result was a false positive, is there for the taking.

Including citizen payments for COVID-19 positive tests, with so much money up for grabs, you can see why expanding of testing was routinely [encouraged by governments](#), and Public Health Networks such as Public Health Network Gippsland, started encouraging practitioners to operate outside the CDNA guidelines for testing, by ignoring repeat test sample results that are negative and stating that it "is not appropriate to advice a patient that a test is a false positive without prior consultation with the department."

It pays well to keep COVID-19 around, and easy to perpetuate, especially if you're in the business of healthcare.

PERPETUATING THE PANDEMIC

It is easy to see how money has played a big part in perpetuating this pandemic. Statistics that create figures to fool, rather than inform, is keeping the public fooled.

MISUSE OF TESTING

In Australia, the prevalence of COVID-19 is being measured by confirmed cases from the total number of tests. While Rapid Antigen Tests (RAT) have exceeded RT-PCR tests in volume, a positive RAT test is only considered a 'probable' case and therefore requiring a follow-up RT-PCR test to confirm the result.

We know the shortcomings of the RT-PCR test. It was never designed to identify infectivity, yet here we are using it as the gold-standard for detection of an infectious disease. Because this is well known, stringent guidelines must be adhered to when testing sample results. The [Communicable Diseases Network Australia](#) (CDNA) and [Public Health Laboratory Network](#) (PHLN) have gone to lengths to explain them. The rate of magnification used in the RT-PCR test is called the cycle threshold. It is known that tests performed with a [cycle threshold above 35 can create false positive results](#) almost 100% of the time.

Data on the cycle threshold per test is not publicly available, however [NSW Pathology](#) on their website has advised the cycle threshold is routinely 45. If testing is being misused in this way, this can give the impression that prevalence of the disease is much greater than it is.

With NSW being the most populous state in Australia, it would indicate many of the positive cases are in fact false positives, which we also know Public Health Networks have discouraged practitioners from advising.

Considering this, it is noteworthy that prior to the use of the COVID-19 vaccines, prevalence of COVID-19 in Australia was below 1%. It now stands above 13%.

We know that testing was pushed on people without symptoms, test samples have been run at cycle thresholds way above the minimum and false positive results routinely being ignored. This, together with increased testing, muddies the waters of real prevalence of COVID-19 in Australia. But we do know that testing is crucial to perpetuating the cycle, and so it persists.

VACCINE CLINICAL TRIAL STATISTICULATION

Misleading with statistics is called 'statisticulation'. We were told the fast-tracked COVID-19 vaccines were safe and effective. Claims of 95-100% efficacy were made, and these statistics were used to attain provisional approvals.

Director of the Harding Centre for Risk Literacy at the Max Planck Institute, [Gerd Gigerenzer](#), says "Many physicians, patients, health journalists and politicians do not understand health statistics. This collective statistical illiteracy has resulted in serious consequences for health".

In a bid to overcome any natural hesitancy people might have with the speed these vaccines were developed, a particular metric is being used to deceive the public about vaccine efficacy. Relative Risk Reduction (RRR) is this metric, and it only compares the number of sick people in each group to calculate the risk reduction.

When the CEO of AstraZeneca claimed 100% protection against death in the primary analysis of phase III trials, it was on the basis that one death occurred in the placebo group of 11,724 and no deaths in the vaccine group of 12,021. From a total of one death, no deaths in the vaccine group relative to the placebo group is how 100% protection was claimed.

The original Pfizer trial claimed 95% efficacy using only 170 subjects: 8 confirmed cases in the vaccinated group, relative to 162 in the placebo group.

When dealing with such a small number of cases, any change can impact the results significantly and therefore Absolute Risk Reduction (ARR) is a more reliable method for calculating efficacy.

When looking at the Pfizer data, 8 out of 18,198 people in the vaccine group, had COVID-19 symptoms (0.04%) as compared with 162 out of 18,325 in the placebo group (0.88%). After two months, the vaccine reduced the baseline risk from 0.88% down to 0.04%, which is a relative risk reduction of 95% ($0.04/0.88 \times 100 = 4.54 - 100 = 95.45$) but an absolute risk reduction of 0.84%.

A paper title "[COVID-19 vaccine efficacy and effectiveness-the elephant \(not\) in the room](#)" published in The Lancet provides RRR and ARR results side-by-side in Table 1 below.

Vaccine	Relative Risk Reduction	Absolute Risk Reduction
AstraZeneca	67%	1.3%
Pfizer	95%	0.84%
Moderna	91%	1.2%

Not surprisingly, authorities mislead the public by using the ARR metric to convey the harms caused by vaccines, when vaccine harm is being discussed. Gerd Gigerenzer says it can be used as “a deliberate tactic to manipulate or persuade people.”, which appears to be what is occurring here.

The Canadian Covid Care Alliance published [this short video](#) explaining the difference between these two metrics.

This sort of bias, including sample size neglect, creates cognitive biases that affect our decision-making.

TO FOOL, OR TO INFORM?

In our review of the Australian Institute of Health and Welfare (AIHW) 'Australia's Health 2022: data insights' report, AIHW are using the Case Fatality Rate (CFR) to measure disease severity. This ratio of hospitalisations and deaths to substantial case infections does **give the illusion** that severity of disease has diminished, but the actual numbers tell a different story.

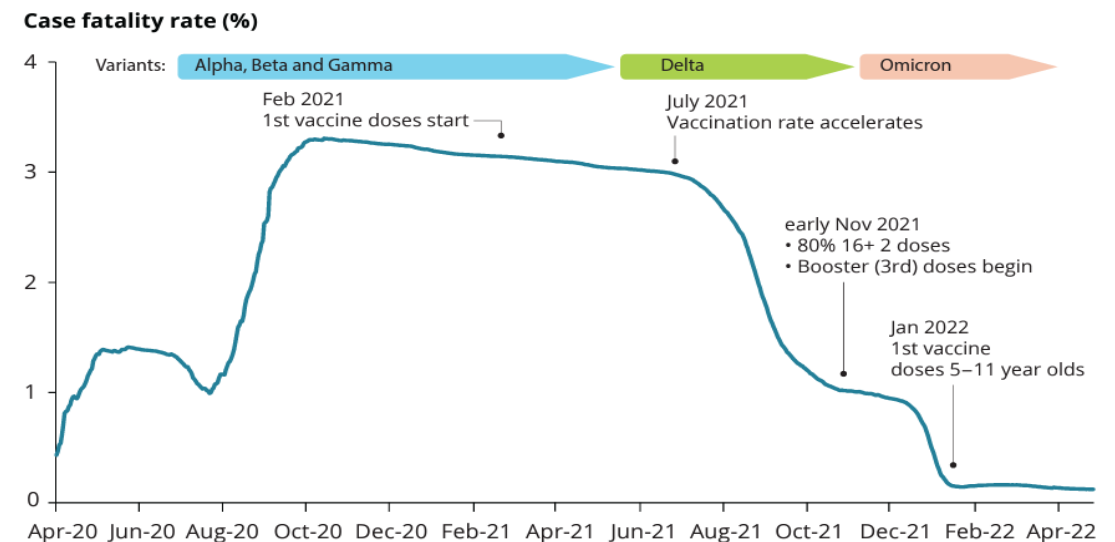
In Australia, COVID-19 surveillance data as of 25 July 2022 shows: -

- 8,731,119 cumulative confirmed cases, 8,335,619 (95%) of those in 2022
- 850,209 hospital admissions, 656,563 (77%) of those in 2022
- 66,305 ICU admissions, 34,053 (51%) of those in 2022
- 11,200 deaths, 8,961 (80%) of those in 2022

A more reliable and accurate method of calculating severity of disease is to compare the numbers per-million population, because you are always comparing results based on the same size population. When using CFR, significant increases in cases will skew the results which appear to correlate with high vaccination rates as can be seen in Figure 1.9.

The report acknowledges that *“Until December 2021, Australia had relatively low infection and death rates from COVID-19, following a broad range of measures put in place to this point. However, toward the end of 2021 and into 2022, this situation changed markedly: the more infectious Omicron variant reached the country around Christmas 2021 and into the summer holiday period, just when public health measures were removed. This resulted in a substantial increase in the number of infections and deaths, though with a lower case-fatality rate than during previous waves of the virus, likely reflecting the relatively high vaccination rates in Australia at that time.”*

Figure 1.9: Case fatality rate, 1 April 2020 to 30 April 2022, Australia



Source: AIHW analysis of COVID Live 2022.

The report states that “Since the start of the pandemic, the CFR in Australia has fluctuated; it peaked at 3.3% in October 2020 and has rapidly declined since July 2021 to 0.1% by 30 April 2022, corresponding to the roll-out of the vaccination program.”

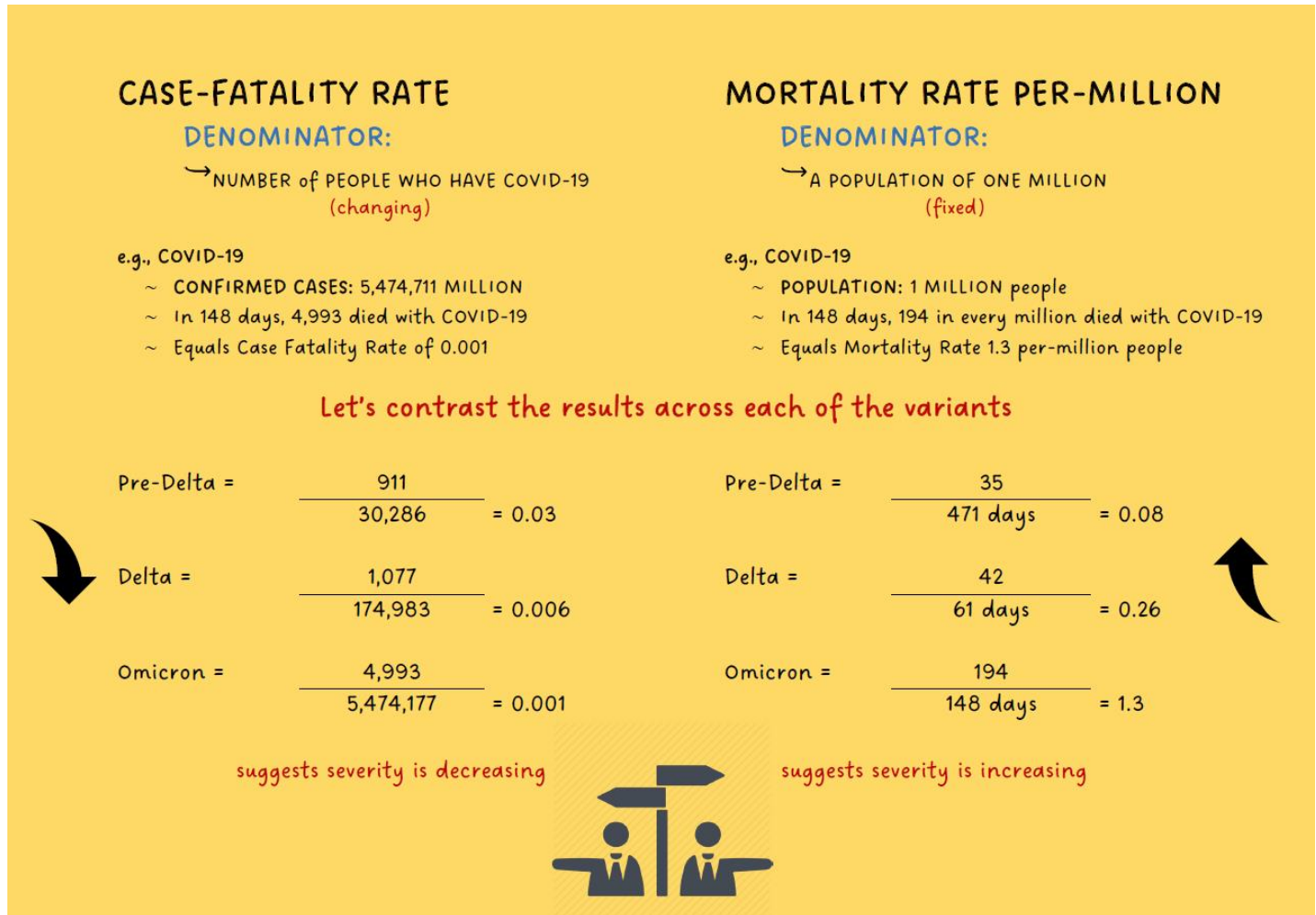
It then goes on to say - “When there is a large number of cases associated with a highly transmissible variant such as Omicron, **even a small proportion of individuals needing care for severe illness could overwhelm the healthcare system.**”

This is where the representation of the surveillance data is distorted, because of the metric used to calculate the case fatality rate.

Despite the report acknowledging that “*the sheer volume of Omicron cases alone could translate into a substantial long COVID burden in a community*” this is ignored when using the CFR metric to determine severity.

A more reliable and accurate method of calculating severity of disease is to compare the number of deaths per million.

Here you can see a visual of how the same data, provides a different impression.



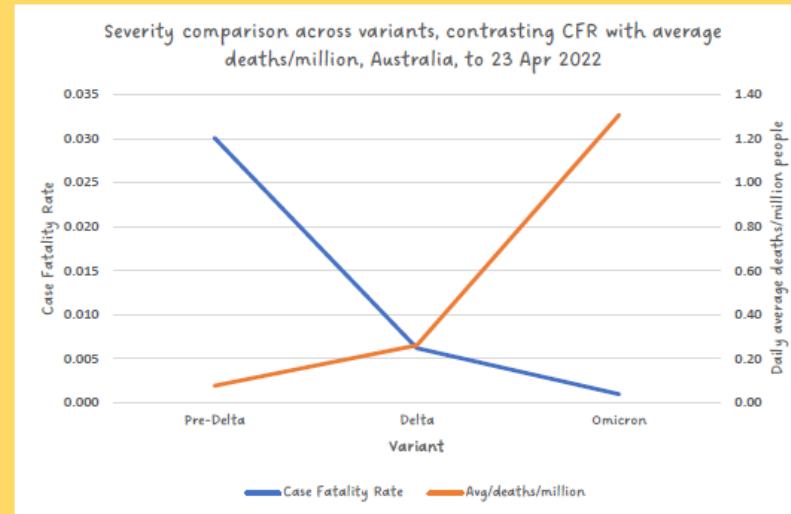
When you compare the variants using a ratio to cases, you get a chart that very much looks like "Omicron" has significantly less severity.

Again, this sort of bias, including sample size neglect, creates cognitive biases that affect our decision-making. Whereas the use of comparisons to a common baseline (such as per-million population) can provide a more accurate analysis.

CFR relies on differing scales of case numbers and across differing durations, provides extreme results that are mistaken for actual trends. This bias selection serves only to support the narrative that the vaccines have been effective in reducing clinical severity and death.

The AIHW report on Australia's Health 2022, coupled with Australian Bureau of Statistics COVID-19 mortality and All-cause mortality report tell a different story.

A contrastive analysis of the two methods show they are diametrically opposed.



Which one is right?

To see the true impact on the population, use the per-million population metric. To compare different time periods, calculate the daily average for each, then your comparison is always consistently based on numbers for a day, and a million people.

On the other hand, with the case fatality rate method, no daily average is calculated, and the denominator is always changing, which is like comparing apples with pears.



AUSTRALIA'S HEALTH 2022

On 7 July 2022, the Australian Institute of Health and Welfare (AIHW) publicly released the ['Australia's Health 2022: data insights'](#) report, which is a collection of 10 in-depth articles on selected health topics, including a focus on the health impacts of the COVID-19 pandemic. The report includes data insights from the start of the pandemic until the end of April 2022.

The report confirms that disease surveillance data used by the media, which is designed for rapid output, has been used at a government level to help define major policy decisions, including the vaccine roll-out.

"The COVID-19 pandemic - and the public health emergency it caused across Australia - have emphasised the health system's need for good-quality health data - data that are timely, reliable, transparent and readily available for decision makers. At a community level, Australians have become accustomed to daily news reports on the number of new and active COVID-19 cases, hospitalisations and deaths. Many people closely followed the country's vaccination progress. At a government level, these data have helped to define major policy decisions to control the spread of the virus, including border control measures; international travel restrictions; lockdown and social distancing rules for businesses, households and individuals; health service restrictions; and the vaccine roll-out."

In relation to COVID-19 surveillance, AIHW use rapid disease surveillance data from Covid Live and Our World in Data. More qualitative data from the Australian Bureau of Statistics has also been used. These are the same data sets People for Safe Vaccines have been analysing for use in our reports.

KEY FINDINGS IN THE REPORT

- The data used by AIHW is the same data that People for Safe Vaccines has been analysing in this series of reports.
- At a government level, these data have helped to define major policy decisions
- 95.5% of eligible population completed a primary course of COVID-19 vaccination at least 3 months ago (See Table 1.1)
- Detection of SARS-CoV-2 by rapid antigen testing (RAT) is officially classified as only a "probable case," as distinct from a "confirmed case" detected by NAAT and antibody tests
- RAT tests are increasingly used and have, since December 2021 accounted for more than half of the total cases reported each day
- Case Fatality Rate (CFR) is being used to create the illusion that the vaccines are reducing severity, when in reality the opposite is true
- Excess mortality has significantly increased in 2022. COVID-19 is now listed as one of the leading causes of death in Australia by the Australian Bureau of Statistics
- Data on hospitalisations presented by Covid Live is the number of people in hospital on a given day, rather than the number of new admissions each day. This measure reflects the severity of the illness, as more severe surviving cases generally stay in hospital longer
- Disease severity is increasing in the younger age cohorts

- Escalating number of cases during the Omicron wave has resulted in staff shortages in health and disability services, which is having an effect on access to essential support
- Public health restrictions that continued into 2022 resulted in a delayed, but rapid, progression of COVID-19 cases during March 2022 in Western Australia
- Levels of psychological distress in the community have increased
- General practitioner visits saw a substantial increase in 2021, placing additional burden on the healthcare system

Eligible Australian population COVID-19 vaccination rates

Table 1.1: Percentage of people who were fully vaccinated (2 doses) and who have received a booster dose for COVID-19 in Australia, as at 30 April 2022.

Jurisdiction	Fully vaccinated (2-doses)			Booster (3rd dose)
	16 and over	12–15	5–11	Eligible population ^(a)
NSW	94.8	79.5	35.3	66.3
Vic	93.9	85.6	39.8	71.3
Qld	92.1	71.9	29.7	62.6
WA	97.4	80.8	38.2	84.4
SA	93.2	78.4	40.1	72.5
Tas	98.8	83.1	50.2	72.0
ACT	>99.0	>99.0	65.4	77.2
NT	88.8	75.0	32.2	75.8
Australia	95.5	80.4	36.9	69.3

(a) Eligible population consists of people aged 16 and over who completed a primary course of vaccination at least 3 months ago (data correct as at 30 April 2022).

Source: Department of Health 2022i.

CONFLICTING DATA

Using the CFR metric to claim that COVID-19 has reduced in severity, puts it at odds with more qualitative data from the gold-standard of statistics, the Australian Bureau of Statistics, which tells us that COVID-19 has become one of the top ten most common causes of death.

Considering the substantial increase in confirmed cases due to the vaccine's failure to prevent, or even slow transmissions, new deaths per million must be considered as a more precise metric for comparison than CFR.

Using the same data with the per-million metric, the reverse is true, which does not conflict with the ABS.

This exact same data provides you with a conflicting picture. So, which one is the most fit-for-purpose? We checked this method with a data scientist and the answer is the number per million.

Table 1.3: Number of deaths in 2019 - 2021 and 2022 year to date for top 10 causes of death in 2019 compared with COVID-19 deaths

Cause	2019		2020		2021		January - February 2022	
	Number	%	Number	%	Number	%	Number	%
Dementia including Alzheimer's disease (F01, F03, G30)	14,604	10.1	14,561	10.2	15,473	10.3	2,662	10.1
Coronary heart disease (I20-I25)	14,028	9.7	13,610	9.6	13,921	9.3	2,201	8.4
Cerebrovascular disease (I60-I69)	9,142	6.3	9,046	6.4	9,150	6.1	1,413	5.4
Lung cancer (C33, C34)	8,499	5.9	8,390	5.9	8,562	5.7	1,432	5.4
Chronic obstructive pulmonary disease (COPD) (J40-J44)	7,045	4.9	6,033	4.2	6,537	4.4	946	3.6
Colorectal cancer (C18-C20, C26.0)	5,091	3.5	5,339	3.8	5,230	3.5	825	3.1
Diabetes (E10-E14)	4,524	3.1	4,934	3.5	4,984	3.3	859	3.3
Influenza and pneumonia (J09-J18)	3,806	2.6	2,148	1.5	2,134	1.4	319	1.2
Prostate cancer (C61)	3,493	2.4	3,587	2.5	3,576	2.4	590	2.2
Heart failure and complications and ill-defined heart disease (I50-I51)	3,261	2.3	3,048	2.1	3,501	2.3	489	1.9
COVID-19 (U07.1, U07.2)	0	0.0	854	0.6	1,212	0.8	2,521	9.6
All causes	144,323	100	142,345	100	149,939	100	26,305	100

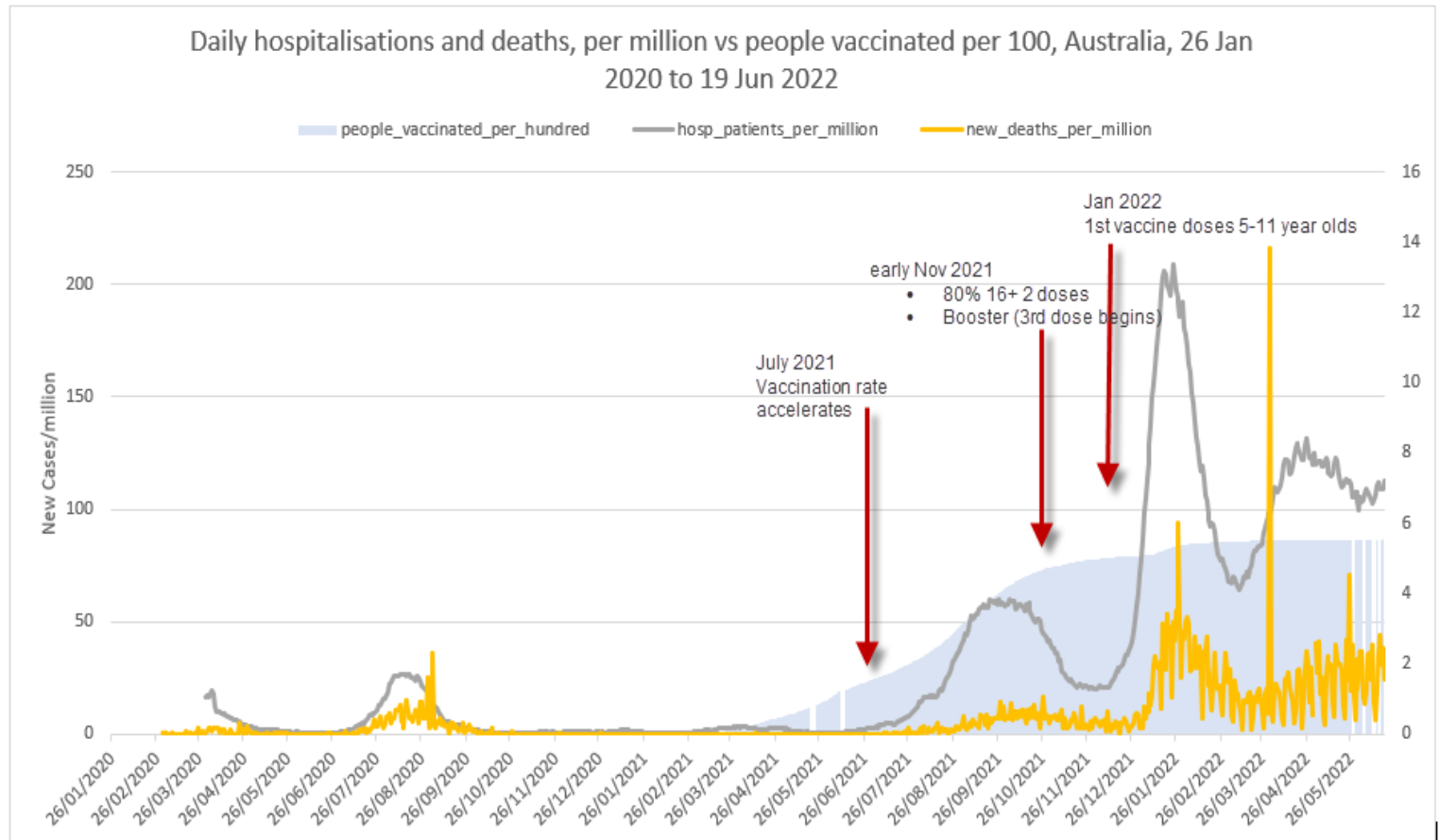
Notes

1. Data are doctor certified deaths compiled by the date on which the death occurred. Data are provisional and subject to change as additional data are received.
2. Data for 2022 include deaths occurring until 28 February and registered by 30 April 2022.
3. Data in this table are not comparable to numbers of deaths published in ABS reports 3302.0 Deaths, Australia and 3303.0 Causes of Death, Australia. For scope differences, please refer to the methodology section of Provisional Mortality Statistics, Australia.

Source: ABS customised report.

The report states “COVID-19 deaths rose from 0.8% of all deaths in 2021 to 9.6% during January and February, which is impacting excess mortality in 2022”.

This combined with the actual number of hospitalisations and deaths increasing in 2022, is placing significant burden on the health system and impacting excess mortality.

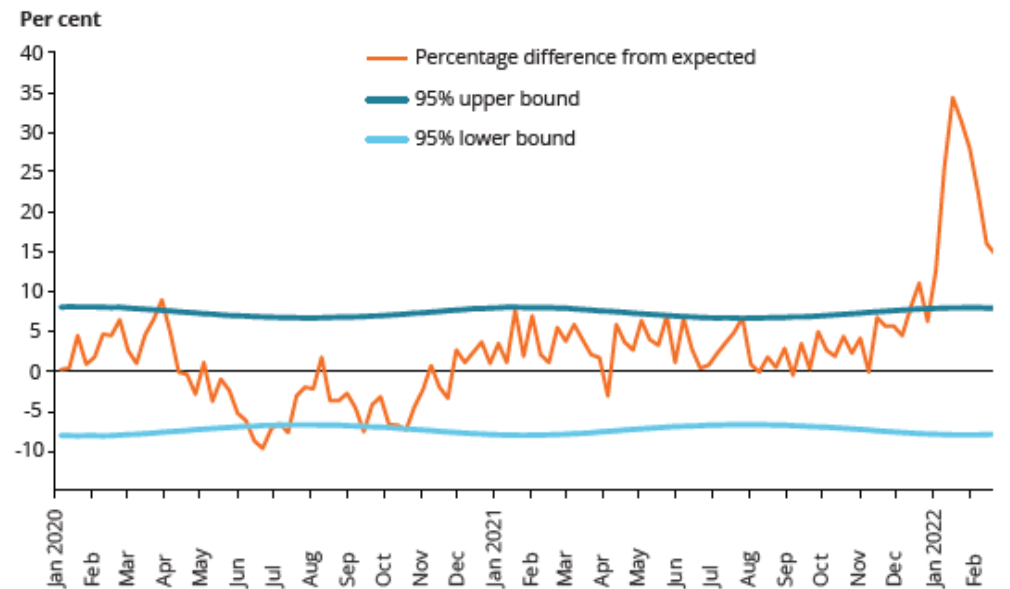


COVID-19 accounted for a higher proportion, though not all, of the excess deaths in January and February 2022. COVID-19 accounted for around half (52%) of the excess deaths in 2022, while coronary heart disease (CHD) and dementia accounted for around 10% each. Over those 2 months, deaths for CHD were 29% higher than expected, and dementia 24% higher. Some other major disease groups with the number of deaths being substantially higher in these 2 months than expected include chronic respiratory conditions (23% higher), stroke (20%) and diabetes (14%).

When representing the data using the correct metric, the surveillance data now correlates to the ABS COVID-19 mortality, and we get a clearer and more accurate depiction of clinical severity. Also, CFR is unreliable because it is dependent on testing rates (which are variable) and in turn less accurate testing methods in the form of RAT are being used.

Because “at a government level, these data have helped to define major policy decisions to control the spread of the virus, including border control measures; international travel restrictions; lockdown and social distancing rules for business, households and individuals; health service restrictions; and the vaccine roll-out”, this unreliable representation of the surveillance data is causing improper major policy decisions to be made and the narrative that these vaccines are effective in reducing severity is being deceptively perpetuated.

Figure 2.3: Excess mortality from doctor-certified deaths per week, January 2020 to February 2022



Notes

1. Data shown represent the difference between the observed and expected deaths (from models) as a percentage of expected deaths.
2. The model uses historical data to predict current numbers of deaths to enable significant deviations from the expected trend to be identified.
3. At least 2 weeks outside the 95% upper and lower bounds of normal variation indicates statistically significant differences. This occurred for 3 weeks in Jun 2020 (lower than expected), 2 weeks in the second half of Dec 2021 (higher than expected) and all weeks in Jan and Feb 2022 (higher than expected).

Source: ABS 2022b.

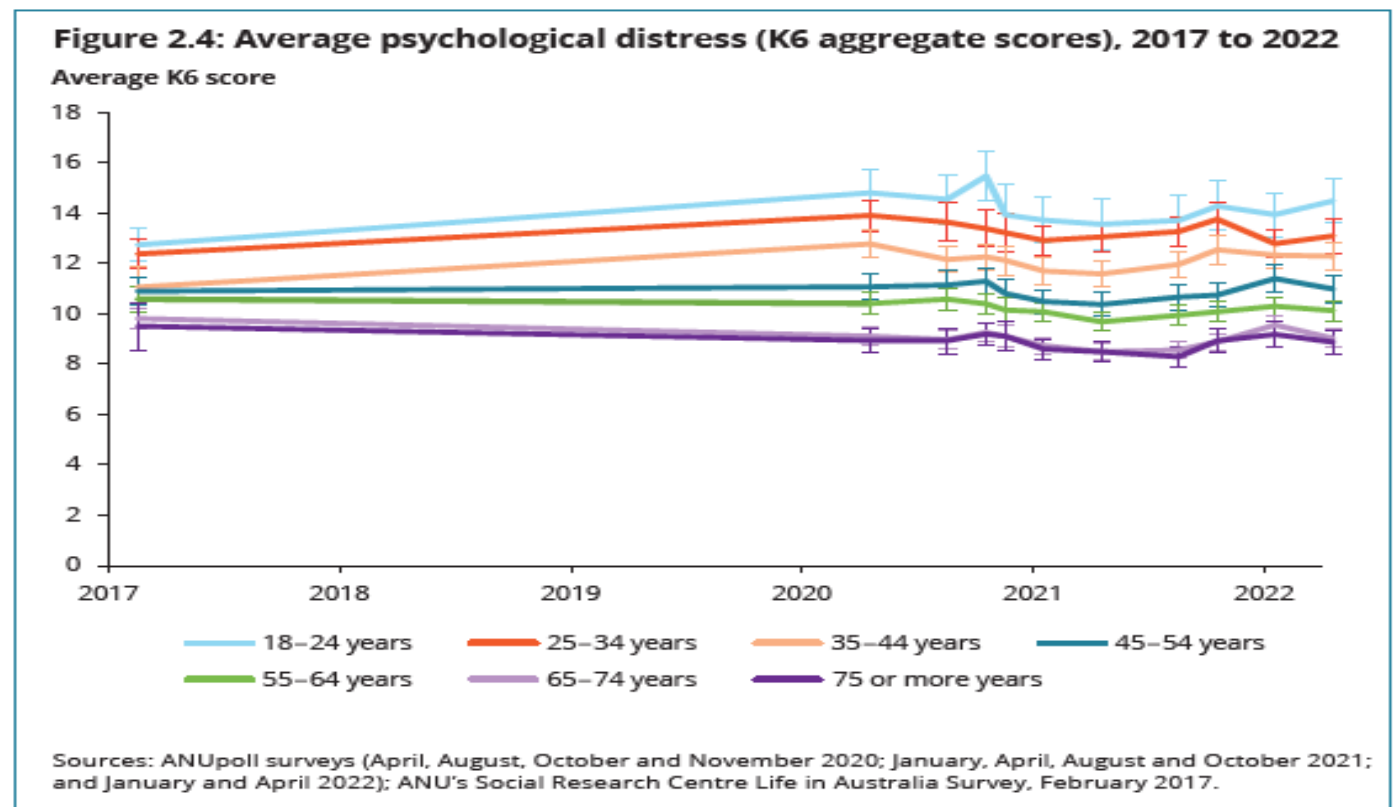
HEIGHTENED DISTRESS, SHORTENED LIVES

Worryingly, disease severity is increasing in the younger age cohorts as the “Years of Life Lost (YLL) per person dying of COVID-19 is estimated to be 15 years (16 and 14 for males and females, respectively) based on the ideal life expectancy used in the Australian Burden of Disease Study. **The percentage of total YLL in people younger than 70 increased significantly in 2022.**”

The report states that “a suite of public health restrictions that continued into 2022 – resulted in a delayed but rapid progression of COVID-19 cases during March 2022 in Western Australia.”

This can also be observed in Queensland when their borders reopened, suggesting that **lockdowns were not protective, but caused massive spikes in severe cases which created a bottleneck of hospitalisations and a significant burden on the healthcare system, all despite vaccination rates in the eligible population exceeding 90%.**

The data of levels of psychological distress in the community had been relatively flat for the 15 years before the pandemic, at 9-11% of males and 13-15% of females. Initial results from the ABS 2020-21 National Study of Mental Health and Wellbeing (for data collected between December 2020 and June 2021) showed that 12% of men and 19% of women were classified as having high or very high levels of psychological distress.



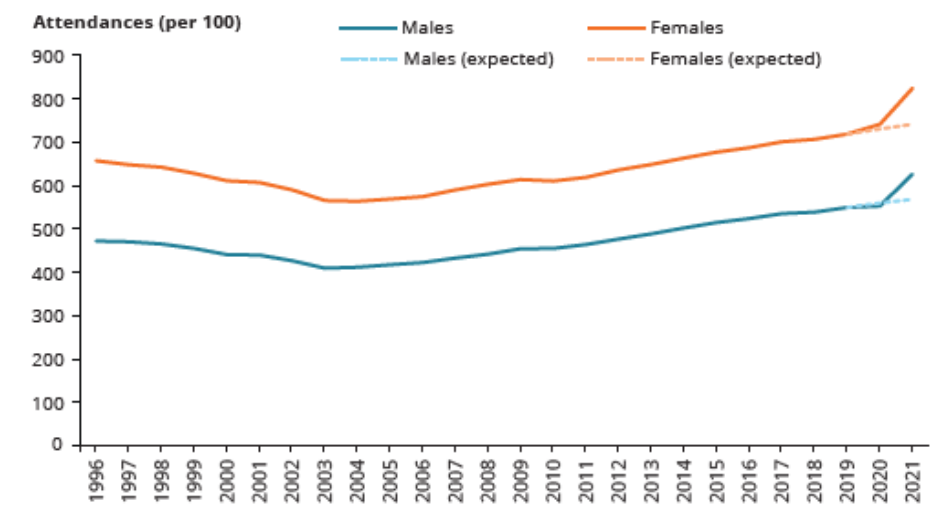
EXACERBATING THE BURDEN

Furthermore, the report states “escalating number of cases during the Omicron wave has resulted in staff shortages in health and disability services which is having an effect on access to essential support”.

On top of increased hospitalisations, General Practitioner visits saw a substantial increase in 2021, attributed to the key role played in the vaccine roll-out.

As GPs provide the majority of primary care in Australia, any changes in service use have important implications for the health of the population and consequently has placed additional burden on the healthcare system.

Figure 2.12: Rate of non-referred GP attendances, 1996 to 2021



Notes

1. Dotted lines are the expected rates based on exponential smoothing projections using the data to 2019. Observed rates for 2021 are above the CIs for the projections, while 2020 estimates are within them.
2. Year is based on the date of processing (processed up until 31 March 2022).

Source: AIHW analysis of MBS data maintained by the Department of Health.

MEASURING PREVALENCE OF VACCINE ADVERSE EVENTS

The TGA monitor vaccine adverse events and publish their findings in [weekly reports](#) made available to the public. Their Database of Adverse Events Notifications (DAEN) system can be accessed via their website. This site provides the means to review and even download adverse events for assessment. Their [latest report](#) provides the following summary: -

Total adverse event reports following immunisation to 10 July 2022

2.2	134,126	60,610,015
Reporting rate per 1,000 doses	Total adverse event reports	Total doses administered
48,272	78,729	6,825
Total reports for Vaxzevria	Total reports for Comirnaty	Total reports for Spikevax
810	672	
Total reports for Nuvaxovid	Total reports for brand not specified	

The same report also informs that 900 deaths have been reported after vaccination, of which 13 are confirmed to relate to the COVID-19 vaccines. The TGA accept that as much as [90-95% of adverse events are under-reported](#).

Even so, there is a reporting rate of 2.2 adverse events for every 1,000 doses (not people) administered.

Ausvax Safety also monitors adverse events using surveys sent to people after vaccination. As of 11 July 2022, from 60,610,015 doses administered, 6,441,844 (10.6%) safety surveys were complete. The survey data says the 44.3% (2,853,736) of those surveyed had reported at least one adverse event and 1% (64,418) reported visiting a GP or Emergency Department. This survey data is only a small sub-set of the population, yet it shows +48-times more than the TGA data.

Thousands of testimonies from people injured after taking a COVID-19 vaccines advise their hospital presentations are routinely discarding the potential relationship between the vaccine and their health problem, which suggests that hospital admissions are being coded incorrectly, or at least no investigation to a causal relationship is done. Clearly adverse events are being hidden, and may also account for the spike in excess deaths.

CONCLUSION

The [National Plan](#) claimed that vaccination, combined with test, trace, isolate and quarantine measures was key to suppressing the virus. In reality, lockdown measures resulted in a delayed but rapid progression of COVID-19 cases, which placed an enormous burden on the hospital system. **Vaccination failed to stop transmission**, which has always been the objective of vaccination.

GP involvement in the vaccine roll-out placed further burdens on the healthcare system and lockdown measures are the likely cause of increased levels of psychological distress.

Case Fatality Rate is the metric being used to claim vaccination reduces clinical severity but does not account for sharp increase in people testing positive for COVID-19, which is the actual cause of the CFR declining. Daily averages per-million people is a more reliable metric, and this shows an **increase in clinical severity**, which is reinforced by ABS COVID-19 mortality and all-cause mortality data.

The reality is that **new deaths, hospitalisations and ICU admissions per million have increased significantly**, meaning the claim that vaccination has reduced clinical severity is completely false and using CFR is a crude and unreliable method of analysis, one that only serves to hide the failings of the National Plan, and perpetuate the government narrative.

There are formal clinical case definitions for Long COVID but, conspicuously, very **little attempt has been made to factor in vaccination status**. It is likely that Long COVID could be linked to the vaccines and under-reporting of **adverse events is being hidden** by incorrect codifying of hospital admissions. Considering the high number of vaccinated people and that these vaccine products are still only provisionally approved, and the medium and long-term data is not yet available, it would seem logical and the responsible, scientific thing to factor vaccination status into the equation when coding all hospital admissions.

The AIHW state *"The broad impacts of the COVID-19 pandemic have highlighted the importance of open, consistent, and transparent data for evidence-based decision making. To date, non-government organisations such as COVID Live, Johns Hopkins University and Our World in Data have led the collation and publication of global data on COVID-19."*

In the spirit of this statement, we say further analysis is required, especially where the representation of **surveillance data creates a conflict with qualitative data like ABS**. The only reasons we can see for this crude method of calculating severity are because it's based on the hypothesis that the vaccines are effective, or to protect that claim despite evidence to the contrary.

Presenting the data in this way is a form of confirmation bias and although it is human nature to impose selection bias on ourselves by choosing the sources we agree with, the fact we agree with them has been tainted by figures that fool us, rather than inform us. This has created a dangerous situation where **misinformation has been entrenched in our views**. Better outcomes are derived from diverse viewpoints and in this case, incorporating divergent information sources with varying opinions, gives a better overall perspective of events.

It has been made possible for citizens to get paid to stay at home, impacting our workforce and supply-chain and thanks to large and ongoing financial stimulus, **COVID-19 has become a business**, especially within the healthcare system, where poor testing is encouraged because exaggerating case and death numbers, can also perpetuate profits. In the same way, fooling people with misleading figures has created such a sense of urgency to vaccinate, that the government has ordered 255 million doses, driving Big Pharma profits skyward.

This is the result of the likes of ATAGI and the [TGA receiving most of their funding from the pharmaceutical industry](#); the very industry that is using misleading figures designed to attain emergency approvals for untested vaccines. Having financial and other conflicts of interest in our government and bureaucracy means the best interests of the public is nothing more than subterfuge for Big Pharama, using our government as a vehicle to higher profits.

Based on our statistical comparisons which use a common baseline of population per-million, we can see that the use of these provisionally approved vaccines has exacerbated the burden on our healthcare system and is likely related to significant increase in mortality from all-causes, and we believe the roll-out should be halted immediately and a thorough independent and transparent investigation be done.

SUPPORT OUR WORK

BECOME A MEMBER

People for Safe Vaccines has been providing ongoing research, education and lobbying efforts to bring about proper due diligence from government on safe vaccines including transparency and accountability. If you would like to support our ongoing work, please become a member today.

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