OzSAGE statement on deaths in Australia from COVID-19

We must care about and respectfully acknowledge deaths due to COVID-19, disclose data on mortality objectively, and talk about the causes with scientific authenticity and integrity.

OzSAGE calls on state and federal governments to implement consistent full and transparent reporting of deaths, and OzSAGE urges that deaths due to COVID-19 are not presented as normal, insignificant, unimportant or occurring in people whose lives are less worthy.

We call out the false analogy of COVID-19 being like a common cold or even like influenza, with no further mitigations required. Influenza or the common cold do not result in 500 dead Australians a week, ambulance ramping, mass cancellation of life changing surgery for thousands, thousands being in hospital each day and work absence due to illness that is so severe that supermarket food supplies are disrupted.

Magnitude of death toll and alternatives

OzSAGE calls on all governments to acknowledge that the death rate from COVID-19 in 2022 is massive and unacceptable.

Further, it should be acknowledged that a **vaccine-plus** strategy, including breathing safe clean air and relatively minor social measures (such as mask mandates), are morally, scientifically and socially imperative. It is not a case of "massive deaths or lockdowns" – there is a balance whereby mortality could be vastly reduced by using the ***ventilation and vaccine-plus*** strategy. A "push-through while doing nothing" strategy causing this surge of deaths is particularly ill-conceived as this will not be the last variant or wave of the pandemic. There is no COVID-19-free future to push through to.

In the end, what really matters is doing all we can to reduce as far possible the number of preventable deaths. The only 'acceptable number' is as low as we can reasonably go. There is substantial room for improvement on vaccination rates (boosters and 5-11), high quality mask access and use, expanded, free and easily accessible testing, contact tracing, support packages for those in most need, improved and sustained community engagement and communications during the public health response and, most especially, in airborne mitigation strategies including provision of safe indoor air. Only when we have done all we can to put these measures in place, including with an embedded culture of ongoing improvement and rapid incorporation of new knowledge and tools, can we say we've done all we can to minimise the COVID-19 death rate. Two thousand deaths in just over one month are clearly far too many.

Importance of maintaining respect for individual deaths

While public health deals in population level response, the value attached to each human life must be maintained. It is reasonable to expect that a similar level of resource would be devoted to prevention of COVID-19 deaths as is for other preventable causes of death.

Disclosure and release of death data

In order to properly track the trajectory of the pandemic, there must be transparent reporting on deaths, among other important outcomes. The data must have integrity and be timely, sufficiently detailed, and annotated with its limitations and omissions.

The scope of reporting should note where SARS-Cov-2 contributions were direct and primary or secondary, and indirect, and include relevant maternal, infant and antenatal deaths.

Segmentation of data for demographics, comorbidities, and other important categories is critical for planning responses and detecting inequities. During the Delta epidemic in 2021, NSW Health reported deaths at home, and OzSAGE tracked these, noting many younger people died at home, including people in their 20s and 30s. It was never clear why – did the ambulance not arrive on time? Were they told they did not need hospital? Were hospitals too full to accept younger people?

We recommend the following data be collected and reported:

Minimal data set for accountability in COVID-19 mortality reporting:

- Area - state, city, regional, remote, postcode
- Place of death
    - Residential Aged Care Facilities
    - Other congregate living
    - Hospital
    - Hospital in the home
    - Ambulance service
    - Waiting at hospital
    - Other healthcare
    - Home
    - Congregate living
    - Other
- If under healthcare supervision the context and path of care
    - In palliative care prior to COVID diagnosis
    - Palliated due to COVID
    - In ICU
    - Ward care with advanced supportive treatment (eg high flow nasal oxygen)
    - Standard ward care
    - Hospital in the home (HITH) or
    - Community COVID positive pathway
- Age
- Maternal, infant and foetal (after 20 weeks) death
- Vaccination status and number of doses
- Gender
- Aboriginal or Torres Strait Islander status including failure to record
- Government support scheme – e.g., unemployment, DSP
- Disability status including, inter alia, NDIS participants

Further data set for forensic and research analysis, noting that some of these cannot be collected for the whole population and require sophisticated insight, could further include:

- Cause
- Contributing factors
- Time from diagnosis to death and analysis of access to early treatments
- Finer details of the fields to be ideally included above
- Co-morbidities using standard definitions of International Classification of Diseases

- Treatments being received at time of death
- End of life goals
- Life expectancy
- Advanced care directive prior to current COVID-19 illness or after diagnosis

Interpretation of death data

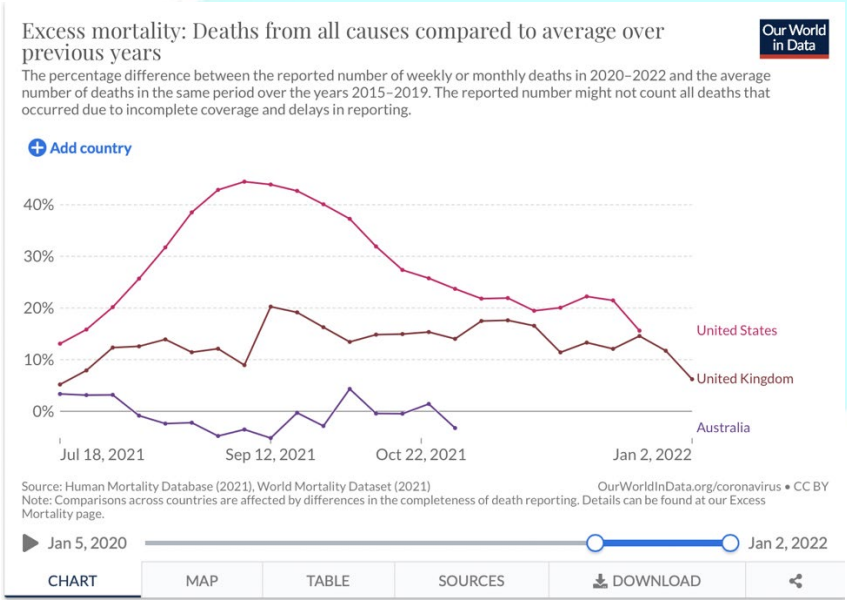
A central tenet of modern healthcare systems, and an ethical standard, is the avoidance of preventable disease and death where it is reasonably practicable to do so, which means that the analysis of deaths should in part be a check to see if systems need to change or if policies or social determinants of health are creating worse outcomes than could otherwise be achieved.

The contextualisation of this mortality data will affect how the media and public responds, and what policy makers decide to do. There is a cycle of decisions and actions, outcome, reporting and interpretation, consequence, which then feeds back into decisions and actions.

Comparison with previous death rate

The measurement of excess mortality, the death rate in a similar population in comparison with prior periods, is another useful measure that circumvents some arguments about causation. Different contributions to excess mortality (deaths above the expected rate) both positive and negative need to be understood. For example, if the rate of death from cardiac disease or trauma increases in a particular city because the hospitals are overwhelmed with COVID-19 admissions, these deaths may well be attributable indirectly to COVID-19. Also, if the population itself restricts its activity, this will reduce excess mortality independent of policy settings.

Because of the delay between policy implementation and deaths, and the delay in reporting of mortality for the entire population, estimation of the excess mortality rate will take some time to reflect updated policies. The deaths attributable to easing of restrictions in Australia, for example, are not showing in the reported data below yet, because the majority of deaths occurred in 2022. This impact will be seen in the months to come.



Excess mortality comparison with higher resolution of July 2021 to October 2021 in Australia and to now in UK and USA.

The above chart has been incorrectly referenced to imply that Australia is still doing well on this metric in 2022, when we fact we only have excess mortality data for Australia until October 2021. It is likely this data will show a convergence with high COVID-19 countries during 2022. Almost half of all deaths during the entire pandemic have occurred in 2022. Outdated data on excess mortality should not be used to provide false reassurance.

Comparison with other causes of death when aggregated

In determining an appropriate attitude and policy response to the high rate of COVID-19 deaths, it is useful to consider what society has accepted as reasonable for other causes of death.

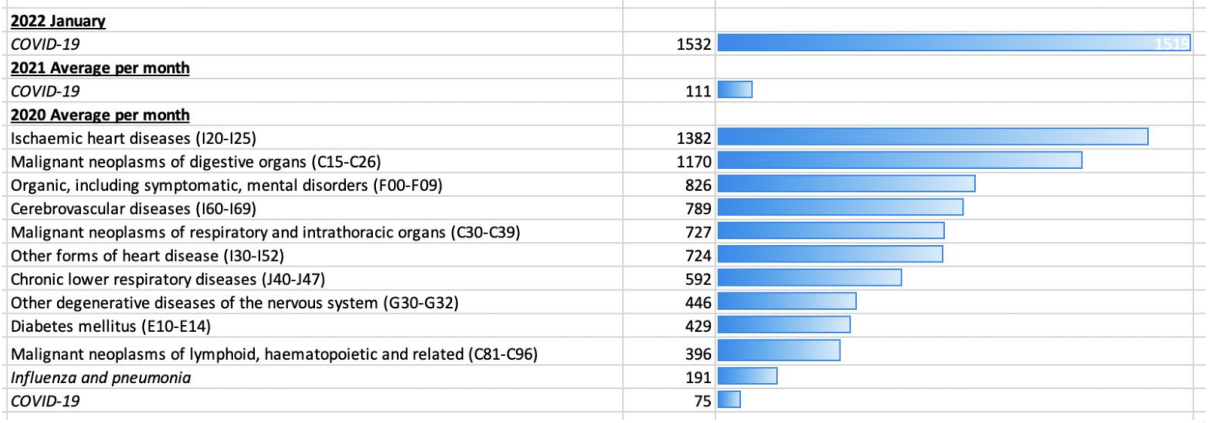
The caveat around any societal standard is that there are known areas in need of improvement, for example Aged Care, First Nations health and mental health generally, meaning that some baseline death rates were already unacceptable pre-pandemic.

Some comparisons, such as that with the common cold, are clearly specious and pointless, but influenza deaths for example, the road toll, air travel deaths, and industrial fatalities are all measured and reported. For comparisons with influenza, these should be made in a valid manner, with the same unit of measurement (eg laboratory confirmed cases) for both COVID-19 and influenza. Many estimates of influenza mortality are indirect, and this is not a valid comparison to laboratory confirmed COVID-19.

Further these are areas in which extensive risk management is applied to reduce deaths to an "acceptable level". In addition to absolute numbers we should consider trends that are being achieved with concerted effort and investment such as those in cancer, cardiovascular and other infectious disease.

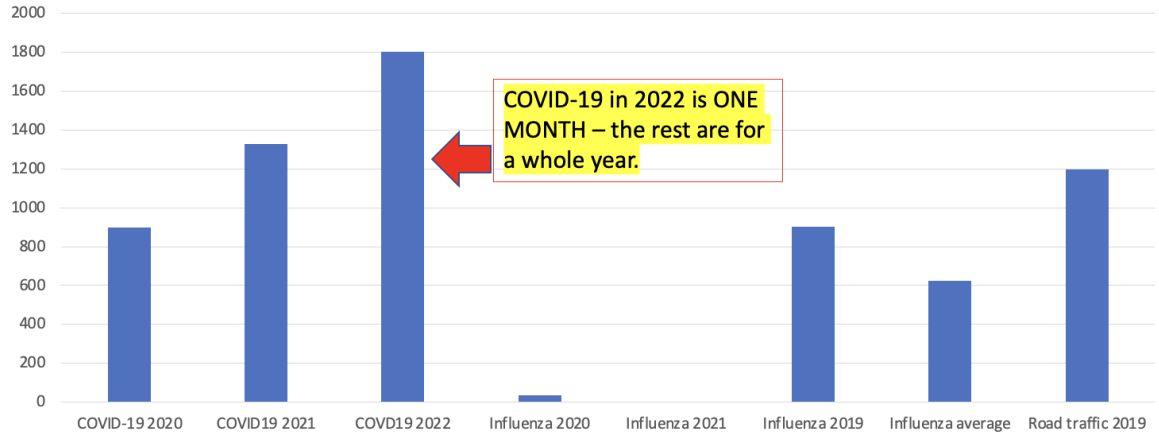
These comparisons provide an important perspective and help avoid the cognitive trap of normalisation and psychological acceptance of high death rates. The graph below shows the deaths from COVID-19 compared to road deaths in 2019 and the worst recent influenza season in 2019, as well as the 5-year annual average number of influenza deaths.

Australian monthly deaths put COVID-19 in context:



Source : "Underlying Causes of Death (Australia)" : Australian Bureau of Statistics at https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-download and https://covidbaseau.com/historical/?title=National%20COVID-19%20Deaths&return=https://covidbaseau.com/deaths/

Australian deaths from COVID-19, influenza and road accidents.



*Laboratory-confirmed influenza deaths recorded by the National Notifiable Disease Surveillance System over the past five years – the worst recent season in 2019 and 5 year average from 2016-2021 are presented.

Dealing with factors that can make severe disease and death from COVID-19 more likely

There are a number of disabilities, comorbidities and demographic factors that may contribute toward death from COVID-19 in some cases but this does not diminish these deaths and does not provide an excuse for not preventing COVID-19 for those people. Each one of these deaths is a tragedy and each one represents a foreshortened life. Death may also occur in people who have no known prior health problems.

This is not a simple matter to gloss over because

- A comorbidity ("underlying condition") will most often be completely irrelevant to death from COVID-19.
- Comorbidities are very common, affecting at least half of the adult population, and are often treatable so that they impact neither quality nor quantity of life.
- The course of COVID-19 is complex, and may result in complications that seem to be independent, for example stroke and heart attack which are common vascular complications of COVID-19, and even falls in the elderly.
- Health system overload can kill people with non-COVID conditions. Someone who needs elective surgery for cancer may die because they cannot get the surgery soon enough to stop the cancer spreading, because hospitals are full. Or someone who has a cardiac arrest may die because the ambulance was delayed arriving.
- Someone living with even quite severe disability and/or chronic disease may report a quality of life that is valuable to them and their loved ones, and may value their potentially shortened life even more than another person who does not have these health issues.

People who are in palliative care for example, may not be dying imminently, and may regard any suffering they currently experience as well worth it. To have their life further shortened by a preventable disease is no less tragic than for a healthy person.

If that person's underlying conditions do contribute to a poor outcome from COVID-19, that is more reason to have protected them, not a reason to be less concerned with their welfare and death.

Avoiding narratives that diminish the importance of deaths

Decision makers who also collect and distribute information on death rates may at times be essentially reporting on their own performance, and thus have an apparent conflict of interest when choosing which mortality data to report and how to characterise it.

Data should be reported independently from narrative and explanation by those who have a role in political or public health decision making.

When releasing data on deaths the following commentary should not coincide with:

- Dismissive treatment of death rates as being in some way "encouraging" or positive in any way, if they are less than on previous occasions or less than some models predicted or less than in other places.
- Reference to disability, "underlying conditions" or age, as this is commonly taken by reasonable listeners to mean that the death was inevitable and COVID-19 was inconsequential.
- Use of the word "but". For example, "the patient clearly died as a result of COVID-19 infection, *but* she was old".
- Reference to the deceased receiving other treatments for life-threatening conditions as this again implies poor short-term prognosis.
- Making statements about "dying with COVID-19" rather than "from COVID-19" without transparent data on attribution. That would be similar to saying someone who died of a heart attack died "with smoking" but not "from smoking".

These issues should be fully evaluated, discussed and the focus returned to prevention of unnecessary death where practicable and the remedy of inequity. However this is demonstrably not possible with the typical news conference release of information, which is typically perfunctory and tailored to a government narrative.

Recommendations:

1. Validated mortality data should be reported independently and regularly by health departments outside of the press conference cycle.

2. Datasets should be standardised across jurisdictions with a minimum set of parameters (breakdown by age, State, vaccination status, number of vaccine doses and place of death – hospital or home).

3. Access to data for research should be as open as possible and facilitate independent academic forensic review of the causes, contributors and context of deaths.

4. Death rates should be appropriately contextualised with reference to excess mortality, and a relevant range of other causes of death. Trends in excess mortality should be monitored and reported.

5. Factors that contribute to severe COVID-19 disease and mortality such as underlying conditions are complex and they should not be used as excuses for failures in preventing deaths where that was reasonably practicable given an optimal response.

6. Narratives about the cause of death and the impact of COVID-19 deaths should be independent of data releases, and should not over-emphasise any contributing factor, such as comorbidity or age.

7. Analysis as to whether these deaths are preventable with reasonable efforts and resources should be independent, open and rigorous.

8. Individual deaths must be respected. The importance and worth of every person is equal.

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