I hope that the Inquiry will recommend:

1. Acknowledgement of the problem

As Professor [redacted] says, there are things that we can and should do to reduce the harm that covid is causing. But the first step is acknowledging the problem, so that people understand why it is important to do things differently.

There is so much research that shows that every covid infection causes damage to every body, even in people who are young and healthy. The evidence on this has been clear, for a long time. Here are a couple of examples from 2020 and 2021, showing cognitive damage and damage in children's blood vessels, including in those who have "recovered" from a mild infection:

https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00324-2/fulltext

https://www.chop.edu/news/chop-researchers-find-elevated-biomarker-related-blood-vessel-damage-all-children-sars-cov-2?fbclid=IwAR2cScIki7L3A3y92lehd4SfPymL647I_RrrFNCCf9a1OY1gz-kD4ZJhTZY

There is so much research that demonstrates these concerning consequences. I trust the Inquiry will take into account this evidence and recommend a change to Australia's mindset of complacency about covid.

2. Sharing knowledge about how covid actually spreads

Current health advice tells people to wash their hands or use hand sanitiser to prevent infection. This is useless against an airborne virus.

It is so sad to see elderly people at the supermarkets wiping down the handles of their trolleys (which does nothing to prevent covid) when they are not wearing a mask (which could protect them). So many organisations have notices about their efforts at covid "safety" which are directed to cleaning hands or avoiding touching surfaces. Imagine the improvements to transmission rates if those efforts were instead directed to improving air quality. For many places, this would be as simple as opening windows.

I find it difficult to ask non-experts to take the simple steps that would actually reduce transmission when there is no knowledge about airborne spread. Most people who run businesses want those places to be safe for their customers and employees. Most schools want their students to be safe. They are not taking the actions that would actually keep people much safer because public health has failed to inform them about how covid spreads.

3. Clean air standards

With better knowledge about airborne spread, ventilation could be improved in public places. State governments should take responsibility for upgrading ventilation in schools and hospitals. (Nobody should feel unsafe accessing healthcare. This requires masking in healthcare at a minimum.) But the Federal government has a role in setting standards for public places. Belgian air quality legislation provides a good starting point:

https://www.health.belgium.be/en/closer-legal-framework-indoor-air-quality

4. Better vaccine availability for everyone (including children)

Recent research showed that older versions of COVID-19 vaccines offered little, if any, additional protection, including against hospital admission, regardless of the number or type of prior doses received:

https://www.medrxiv.org/content/10.1101/2023.12.24.23300512v1

Australia needs to move much more quickly to make available the latest vaccines, and to open up eligibility to all who want them. Evidence demonstrates that these are needed at least every six months to not fall too far behind the changing variants. Even if we had to pay for them privately, we would be very happy to do so.

ACIP, the US equivalent of ATAGI, published the evidence in support of its recommendation of making everyone over six months old eligible for the latest vaccines – including taking into account longer term effects of covid, not just acute hospitalisations and death. This evidence is persuasive.

For children, the evidence they relied upon shows the must higher burden of covid hospitalisations for covid compared with other diseases for which immunisation is compulsory in Australia. As a parent, Australia's restrictive approach to covid vaccination seems utterly bizarre to me:

Annual hospitalizations per 100,000 population prior to recommended vaccines compared to COVID:

	Hepatitis A[1]	Varicella[2] (Chickenpox)	Vaccine-type Invasive Pneumococcal Disease[3]	COVID-19[4]
Age	5–14 years	0–4 years	0–4 years	6 months–<18 years
Time period	2005	1993–1995	1998–1999	2021–2022 2022–2023
Hospitalization Burden (Annual rate per 100,000 population)	<1	29-42	40[5]	≤4 years: 92–220 5–11 years: 15–47 12–17 years: 20–80

[1] https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5603a1.htm
[2] Davis MM, Patel MS, Gebremariam A. Decline in varicella-related hospitalizations and expenditures for children and adults after introduction of varicella vaccine in the United States. Pediatrics. 2004;114(3):786-792. doi:10.1542/peds.2004-0012
[3] Centers for Disease Control and Prevention (CDC). Direct and indirect effects of routine vaccination of children with 7-valent pneumococcal conjugate vaccine on incidence of invasive pneumococcal disease--United States, 1998-2003. MMWR Morb Mortal Wkly Rep. 2005 Sep 16;54(36):893-7. PMID: 16163262.
[4] COVID-NET data October 2021 – September 2022 and October 2022 – July 2023. COVID-19 rates have not been adjusted for reason for admission. COVID vaccine first introduced in 12-17 years in May 2021; in 5-11 years in November 2021 and in 6 months – 4 years in June 2022

Source: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2023-09-12/11-COVID-Wallace-508.pdf (slide 14)

More than half of children hospitalised for covid had no underlying medical conditions, and the percentages were highest in younger children:

Source: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2023-09-12/03-COVID-Havers-508.pdf (slide 7)

This evidence demonstrates the inappropriateness of Australia's recommendations: those under five without risk factors cannot access any covid vaccines, despite having higher levels of hospitalisation for covid than older children, and high levels of hospitalisation without pre-existing risk factors. This approach needs to change.

There is no reason to think that Australians are any different from Americans in terms of health impacts. We would all benefit from timely access to current vaccines, including our youngest children.

Last month I tried to access an updated [redacted], but was refused as ineligible (I am [redacted] with no health conditions and already had a booster earlier in 2023). Just days later I caught my first covid infection. It is unfair that I had to face this without the benefit of the most recent vaccine.

Recent research shows that vaccination reduces the risk of long covid by about 70%:

https://www.cambridge.org/core/journals/antimicrobial-stewardship-and-healthcare-epidemiology/article/effectiveness-of-covid19-vaccine-in-the-prevention-of-postcovid-conditions-a-systematic-literature-review-and-metaanalysis-of-the-latest-research/A0B115B5D3AA60846799857B801D116E

We should take into account these longer term impacts and not just assess vaccines against acute hospitalisations and deaths.

It seems to be generally accepted that the lesser impacts of covid today are due to levels of immunity from vaccinations and previous infections. Omicron is not inherently milder (hence, for example, the terrible impact in Hong Kong where many of the elderly were not adequately vaccinated). So my unvaccinated, uninfected[redacted] is in the same position as a[redacted] in 2020 – completely unprotected. Australia made great efforts to protect everyone then, yet nothing is done for him now. At the very least, he should be eligible for the vaccines that have been approved as safe and are shown to be effective in other countries, where children are allowed to access them.

Thank you for consideration of this submission.