



Hon Yvette D'Ath MP
Minister for Health and Ambulance Services
Leader of the House

1 William Street Brisbane Qld 4000
GPO Box 48 Brisbane
Queensland 4001 Australia
Telephone +61 7 3035 6100

Mr Neil Laurie
Clerk of the Parliament
Queensland Parliament
George Street
BRISBANE QLD 4000

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Dear Mr ~~Laurie~~ *Neil*

I write in response to your letter regarding petition number 3579-21, tabled in Parliament on 14 September 2021, in relation to the efficacy of mandated mask wearing and lockdowns.

SARS-CoV-2, the virus that causes COVID-19, is a highly transmissible, airborne respiratory virus. The Delta variant has this year become the dominant variant globally and nationally.

The COVID-19 pandemic has resulted in over 226 million infections and over 4.6 million deaths worldwide. It is an enduring emergency. This virus spreads rapidly and has caused severe illness and death and overwhelmed hospital and health systems in every country where it has taken hold. Public health protections are a crucial control strategy to protect the community from both the health impacts but also the social and economic impacts of the pandemic.

Queensland draws from a suite of Public Health Directions and measures that are designed to provide ongoing targeted protection from exposure to COVID-19 due to community transmission events or periods of elevated risk both within Queensland and interstate in other jurisdictions. Throughout the pandemic, restrictions have balanced the needs of the community and business against the immediate risks posed by COVID-19.

Mask wearing is a widely adopted and accepted measure to slow the spread of COVID-19 and along with physical distancing, performs a baseline protective function to reduce COVID-19 transmission, particularly during periods of increased risk.

Regarding viral particle size, while it is true that the SARS-CoV-2 virus itself is only about 0.1 μm in diameter, viruses do not leave the body on their own. A mask does not need to block particles that small to be effective. Viral transmission happens via pathogen-transporting droplets and aerosols, which range from about 0.2 μm to hundreds of micrometres across. Face masks filter small airborne particles which carry viral particles, including respiratory droplets, even if these particles are smaller than the pore size of face masks. Small airborne particles do not move in a straight line and collide with the fabric fibres while passing through the mask.

I note the Danish paper referred to in the petition, by Bundgaard et al (2021), with the stated objective 'to assess whether recommending surgical mask use outside the home reduces wearers' risk for SARS-CoV-2 infection in a setting where masks were uncommon and not among recommended public health measures'. I also note that this paper has been subject to a number of criticisms, and is subject to limitations, acknowledged by the authors themselves, including inconclusive results, missing data, variable adherence, patient-reported findings on home tests, no blinding, and no assessment of whether masks could decrease disease transmission from mask wearers to others.

It is important to remember that the understanding of SARS-Cov-2 and the widespread use of public health measures has developed very rapidly in a relatively short period of time. Many verified and endorsed published scientific studies and public health interventions have demonstrated the efficacy of masks in preventing COVID-19 transmission. Multilayer cloth masks or nonmedical disposable masks for community use are widely recommended. It is agreed that face mask use is most important in indoor spaces and outdoors when physical distancing cannot be maintained.

Regarding lockdowns, these are among the most stringent public health measures that have been used to limit the spread of COVID-19. The petition refers to the Lancet paper, by Chaudhry et al (2020), which states that 'full lockdowns and wide-spread COVID-19 testing were not associated with reductions in the number of critical cases or overall mortality'.

In this paper there was no comparison between the impact on COVID-19 spread with lockdown conditions versus no lockdown. Of the 50 countries examined, 45 had imposed some form of lockdown by the reference date. However, the paper did find that government policy of full lockdowns (versus partial or curfews only) was strongly associated with recovery rates, and the number of days to any border closure was associated with the number of cases per million. The authors suggest that full lockdowns and early border closures may lessen the peak of transmission, and thus prevent health system overcapacity, which would facilitate increased recovery rates.

In Queensland, lockdowns are time-limited, targeted and eased as soon as it is safe to do so, to minimise adverse impacts on individuals, businesses and the Queensland economy. Early, stringent and short lockdowns if outbreaks occur were recently endorsed by National Cabinet (31 July 2021).

Lockdowns in Queensland require all non-essential activities to cease for a time-limited period in targeted high-risk areas. This type of lockdown immediately reduces the movement of people within, into and out of these areas and allows for comprehensive contact tracing and testing to occur. It buys time for contact tracers to determine the size and scale of the issue associated with known and emerging cases, without additional community exposure occurring at the same time. This puts the public health response on the 'front foot' rather than the 'back foot'. Within a proven 'test, trace, isolate and quarantine' approach, ring-fencing current cases by identifying and isolating close contacts prevents a wider outbreak. This is supported by scientific evidence and has been demonstrated multiple times in Queensland.

When challenging the impact of public health measures, it is also important to recognise the impact on communities should these measures be abandoned. The impact of many thousands of Queenslanders losing loved ones to COVID-19 and overwhelm of Queensland's health system and flow on effects cannot be overlooked.

I trust this information is of assistance to the petitioners.

Yours sincerely



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