Coronavirus basics: some questions and answers

These are edited notes from an NTEU Fightback forum on organising for health and safety, held on 12 August 2020.

Q: Most union activists will have no doubt that coronavirus is a serious threat. However, this is not a view that is universally shared. What should we say to workmates who aren't taking it seriously?

I would have thought that this is pretty self-evident by the fact that there have already been over 740,000 official deaths due to COVID-19 worldwide over just the last 8 months of the emergent pandemic, even with most countries around the world implementing quite extreme travel restrictions and lockdown measures.

While approximately 80% of people with COVID-19 will just have a mild to moderate illness that lasts about two weeks, around 15% of cases are severe infections that require oxygen, and around 5% are critical infections requiring ventilation – and the infection fatality rate for COVID-19 is at least 6 times higher than that for seasonal influenza.

And then amongst survivors, COVID-19 can cause lingering debilitating symptoms including post-viral fatigue, 'brain fog' (difficulty thinking clearly), persistent loss of smell and taste, persistent fever, headaches, insomnia, lingering shortness of breath, persistent cough and chest pain, lung fibrosis and decreased exercise capacity, joint and muscle pain, neurological complications, kidney damage and heart damage – including in previously healthy young people, not just those with comorbidities.

The likelihood of a patient developing persistent symptoms is hard to gauge, but data from the 2 million people from the United States, UK and Sweden participating in the COVID Symptom Study suggest 10% to 15% of people, including some "mild" cases, have ongoing symptoms weeks or months after infection, and no one knows long such symptoms will persist. This is what workers are risking when being asked to continue working with inadequate safety measures while there is widespread community transmission.

Q: How is the impact of this virus affected by neoliberalism?

The threat is serious not just because of the direct impacts of COVID-1, but also because there is no slack in the neoliberalised, underfunded healthcare system in Australia. Outbreaks in emergency during the Victorian resurgence have resulted in at least one Melbourne hospital being over capacity and unable to accept ambulances. 'Elective' surgeries and diagnostic procedures – which are actually quite necessary for people to be able to live their daily lives – have had to be cancelled, and cancer diagnoses are down 20-30% this year – which is extremely concerning and means some of these cancers will be diagnosed too late and may be unnecessarily fatal.

These are not choices that should have had to be made. Scott Morrison has committed $270 billion to defence spending over the next 10 years for weapons of war to bully our neighbours and extend the reach of Australian imperialism. This money should be diverted into properly funding healthcare, manufacturing sufficient supplies of PPE of an adequately protective standard to prevent SARS-CoV-2 transmission, properly funding tertiary education, permanently increasing the rate of welfare payments and providing paid pandemic leave for all workers during lockdown, for as long as is necessary to eliminate SARS-CoV-2.

In order to control the pandemic, in the absence of or pending the availability of a vaccine, we should be doing everything we possibly can to minimise all transmission opportunities and bring the numbers down, to reduce the burden and risk for healthcare workers on the frontline, and the wider community. More than 2,000 healthcare workers in Victoria have contracted SARS-CoV-2 since the pandemic began, and the ABC has reported that at least three Victorian healthcare workers have been in intensive care after catching coronavirus at work, including two doctors in their 30s. This is all both unacceptable and preventable.

Q: At the level of public policy and public health, what should we be aiming for?

We should be aiming for elimination of community spread of SARS-CoV-2, so the only places the virus remains is contained inside hotel quarantine, hospital treatment wards and research laboratories. Nationally in Australia, 352 people have died due to COVID-19, including two men in their 30s. We must not allow the daily updates of hundreds of new positive cases and a dozen or more deaths to become normalised, because all are unnecessary. Anything less than aiming for elimination of viral spread is to accept this loss of human life in order to get back to work sooner, for the sake of the economy and profitability.

Before the bungling of hotel quarantine in Victoria through inadequate training of security guards and providing them with inadequate PPE – and indeed using casualised, privatised security staff instead of nurses or other public service staff with some sort of expertise in public health and infection control, elimination of transmission of SARS-CoV-2 within the wider Australian community was a real possibility. We should not just give that up as a lost opportunity, but organise to empower each other to speak up. Workers must be consulted about their own health.

We need to be fighting for optimum workplace health and safety, demanding adequate PPE for healthcare workers so they do not have to continue being infected with SARS-CoV-2 at work, restricting out-of-home work to that which is absolutely essential, conserving PPE for those who critically need it by not using it to enable the continuation of work that is not actually essential, demanding paid pandemic leave so workers can stay at home during lockdown, and fighting for the ability to work from home for as long as is necessary to eliminate the spread of COVID-19 in our community.

Q: How is the virus spread? Early in the pandemic there was a lot of discussion of hand hygiene and hard surfaces – more recently that's been supplemented by a lot of focus on aerosols, can you tell us about that?

In addition to transmission by macrodroplets and contact, there is a growing body of scientific evidence that strongly supports airborne transmission of SARS-CoV-2 infection via inhalation of immediately respirable infectious aerosols or microdroplets (generated by coughing, speaking and from exhaled breath), with studies demonstrating that viable virus can be detected floating in the air 16 hours after aerosolisation. (Useful summary here. Studies here, here, here and here.)

Physical distancing is insufficient to prevent spread in crowded, poorly ventilated indoor spaces. Improving ventilation can reduce the risk of aerosol transmission, and surgical and cloth masks can reduce the number of virus-laden aerosols exhaled by an infected person from entering an indoor space, to reduce the risk for others.

Face coverings have become mandatory here in Victoria under Stage 4 restrictions, and should remain so – and really should be mandated in NSW as well in the current situation. However, these masks are not actually designed for respiratory protection of the wearer and allow air to flow preferentially through gaps around the mask, so while surgical masks might offer protection against macrodroplets and some protection against inhaling fine aerosols, studies suggest they are only 67% effective in preventing SARS-CoV-2 infection.

This is why healthcare workers in high-risk hospital and aged care settings need (and have been repeatedly demanding) properly fitted P2 or N95 respirator masks, to be properly protected against airborne SARS-CoV-2 transmission when caring for all confirmed and suspected COVID-19 patients.

Q: This is probably a good point to go into specifics about this current wave in Victoria, which is being driven by workplace transmission - so let's focus on a particular workplace, Melbourne Uni.

You probably would have heard in one of Dan Andrews' recent media conferences that about 80% of Victoria's new SARS-CoV-2 infections since mid-May have been driven by transmission in workplaces. The largest clusters of infections have been in aged care settings, and in particular workplaces including abattoirs and chilled distribution warehouses. But there have also been significant clusters in education settings – schools of all sorts; in call centres; and in offices. So this is something higher ed workers must take seriously. If we are to eliminate community transmission, the speed and chances of this happening greatly improve if all non-essential out-of-home work is paused for as long as is necessary, and if essential work only continues with optimal health and safety practices in place.

Workers have called a halt to unsafe work in several industries in Victoria in the past few weeks as cases have mounted, taking a stand for the safety of themselves, their families and the entire community, and winning important safety measures before their return. However all of these cases depended on the workers having information about the number of positive cases on their worksites.

So at Melbourne Uni, at the start of the pandemic the University was happy to send out an email to all staff and students informing of isolated, occasional cases when they were returning from overseas and in hotel quarantine, but the more cases there are the less information is released. Now UoM seems to

update its webpage at around 5pm each Friday afternoon, advising of confirmed cases of SARS-CoV-2 amongst Melbourne Uni staff and students in the last week – 12 last Friday; 10 the week beforehand; 11 the week before that – and they're no longer saying these cases 'have not been on campus recently' as they used to. At least one of these positive cases is a medical student who strongly suspects they became infected during clinical placement in a hospital – when students have been conducting swabbing for SARS-CoV-2 testing and contact tracing, with some mentioning being paid minimum wage.

Melbourne University is doing its own contact tracing and reports that anyone identified as close or casual contact has been notified and close contacts are self-isolating in line with DHHS advice, but no information has been provided on whether the confirmed cases have been on campus when they may have been infectious and where that may have been, nor what preventative and response measures have been put in place. If workers are expected to continue working on campus through Stage 4 restrictions, as a number are, when there is widespread community transmission and clusters are occurring where there are concentrations of people in indoor spaces, workers need greater transparency. Access to information will continue to be critical as more staff and students are encouraged to return to the various university campuses with easing of restrictions in the future.

Universities are very large institutions which are supposed to be operating in the public good, so have a significant responsibility to suppress opportunities for viral transmission on their campuses. Melbourne Uni has a population of over 50,000 students and over 9000 staff. As such large institutions, university campuses should be fully shut down for as long as is necessary as an important contribution to any serious viral suppression or elimination strategy, with only the most essential work continuing on campus through lockdown periods.