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A Sensible and Compassionate Anti-COVID Strategy

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The following is adapted from a panel presentation on October 9, 2020, in Omaha, Nebraska, at a Hillsdale College Free Market Forum.

My goal today is, first, to present the facts about how deadly COVID-19 actually is; second, to present the facts about who is at risk from COVID; third, to present some facts about how deadly the widespread lockdowns have been; and fourth, to recommend a shift in public policy.

1. The COVID-19 Fatality Rate

In discussing the deadliness of COVID, we need to distinguish COVID *cases* from COVID *infections*. A lot of fear and confusion has resulted from failing to understand the difference.

We have heard much this year about the "case fatality rate" of COVID. In early March, the case fatality rate in the U.S. was roughly three percent—nearly three out of every hundred people who were identified as "cases" of COVID in early March died from it. Compare that to today, when the fatality rate of COVID is known to be less than one half of one percent.

In other words, when the World Health Organization said back in early March that three percent of people who get COVID die from it, they were wrong by at least one order of magnitude. The COVID fatality rate is much closer to 0.2 or 0.3 percent. The reason for the highly inaccurate early estimates is simple: in early March, we were not identifying most of the people who had been infected by COVID.

Those who talk about the economic harms of the lockdowns are accused of heartlessness. Economic considerations are nothing compared to saving lives, they are told. So I'm not going to talk about economic effects—I'm going to talk about the effects on health, beginning with the U.N. estimate that 130 million additional people will starve this year as a result of the economic damage from the lockdowns.

"Case fatality rate" is computed by dividing the number of deaths by the total number of confirmed cases. But to obtain an accurate COVID fatality rate, the number in the denominator should be the number of people who have been infected—the number of people who have actually had the disease—rather than the number of confirmed cases.

In March, only the small fraction of infected people who got sick and went to the hospital were identified as cases. But the majority of people who are infected by COVID have very mild symptoms or no symptoms at all. These people weren't identified in the early days, which resulted in a highly misleading fatality rate. And that is what drove public policy. Even worse, it continues to sow fear and panic, because the perception of too many people about COVID is frozen in the misleading data from March.

So how do we get an accurate fatality rate? To use a technical term, we test for seroprevalence—in other words, we test to find out how many people have evidence in their bloodstream of having had COVID.

This is easy with some viruses. Anyone who has had chickenpox, for instance, still has that virus living in them—it stays in the body forever. COVID, on the other hand, like other coronaviruses, doesn't stay in the body. Someone who is infected with COVID and then clears it will be immune from it, but it won't still be living in them.

What we need to test for, then, are antibodies or other evidence that someone has had COVID. And even antibodies fade over time, so testing for them still results in an underestimate of total infections.

Seroprevalence is what I worked on in the early days of the epidemic. In April, I ran a series of studies, using antibody tests, to see how many people in California's Santa Clara County, where I live, had been infected. At the

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time, there were about 1,000 COVID cases that had been identified in the county, but our antibody tests found that 50,000 people had been infected—i.e., there were 50 times more infections than identified cases. This was enormously important, because it meant that the fatality rate was not three percent, but closer to 0.2 percent; not three in 100, but two in 1,000.

When it came out, this Santa Clara study was controversial. But science is like that, and the way science tests controversial studies is to see if they can be replicated. And indeed, there are now 82 similar seroprevalence studies from around the world, and the median result of these 82 studies is a fatality rate of about 0.2 percent—exactly what we found in Santa Clara County.

In some places, of course, the fatality rate was higher: in New York City it was more like 0.5 percent. In other places it was lower: the rate in Idaho was 0.13 percent. What this variation shows is that the fatality rate is not simply a function of how deadly a virus is. It is also a function of who gets infected and of the quality of the health care system. In the early days of the virus, our health care systems managed COVID poorly. Part of this was due to ignorance: we pursued very aggressive treatments, for instance, such as the use of ventilators, that in retrospect might have been counterproductive. And part of it was due to negligence: in some places, we needlessly allowed a lot of people in nursing homes to get infected.

But the bottom line is that the COVID fatality rate is in the neighborhood of 0.2 percent.

2. Who Is at Risk?

The single most important fact about the COVID pandemic—in terms of deciding how to respond to it on both an individual and a governmental basis—is that it is not equally dangerous for everybody. This became clear very early on, but for some reason our public health messaging failed to get this fact out to the public.

It still seems to be a common perception that COVID is equally dangerous to everybody, but this couldn't be further from the truth. There is a thousand-fold difference between the mortality rate in older people, 70 and up, and the mortality rate in children. In some sense, this is a great blessing. If it was a disease that killed children preferentially, I for one would react very differently. But the fact is that for young children, this disease is less dangerous than the seasonal flu. This year, in the United States, more children have died from the seasonal flu than from COVID by a factor of two or three.

Whereas COVID is not deadly for children, for older people it is *much* more deadly than the seasonal flu. If you look at studies worldwide, the COVID fatality rate for people 70 and up is about four percent—four in 100 among those 70 and older, as opposed to two in 1,000 in the overall population.

Again, this huge difference between the danger of COVID to the young and the danger of COVID to the old is the most important fact about the virus. Yet it has not been sufficiently emphasized in public health messaging or taken into account by most policymakers.

3. Deadliness of the Lockdowns

The widespread lockdowns that have been adopted in response to COVID are unprecedented—lockdowns have never before been tried as a method of disease control. Nor were these lockdowns part of the original plan. The initial rationale for lockdowns was that slowing the spread of the disease would prevent hospitals from being overwhelmed. It became clear before long that this was not a worry: in the U.S. and in most of the world, hospitals were never at risk of being overwhelmed. Yet the lockdowns were kept in place, and this is turning out to have deadly effects.

Those who dare to talk about the tremendous economic harms that have followed from the lockdowns are accused of heartlessness. Economic considerations are nothing compared to saving lives, they are told. So I'm not going to talk about the economic effects—I'm going to talk about the deadly effects on health, beginning with the fact that the U.N. has estimated that 130 million additional people will starve this year as a result of the economic damage resulting from the lockdowns.

First, herd immunity is not a strategy—it is a biological fact. Even when we have a vaccine, we will be relying on herd immunity as an end-point for this epidemic. Second, our strategy is not to let people die, but to protect the vulnerable. We know who is vulnerable, and we know who is not vulnerable. To continue to act as if we do not know these things makes no sense.

In the last 20 years we've lifted one billion people worldwide out of poverty. This year we are reversing that progress to the extent—it bears repeating—that an estimated 130 million more people will starve.

Another result of the lockdowns is that people stopped bringing their children in for immunizations against diseases like diphtheria, pertussis (whooping cough), and polio, because they had been led to fear COVID more than they feared these more deadly diseases. This wasn't only true in the U.S. Eighty million children worldwide are now at risk of these diseases. We had made substantial progress in slowing them down, but now they are going to come back.

Large numbers of Americans, even though they had cancer and needed chemotherapy, didn't come in for treatment because they were more afraid of COVID than cancer. Others have skipped recommended cancer screenings. We're going to see a rise in cancer and cancer death rates as a consequence. Indeed, this is already starting to show up in the data. We're also going to see a higher number of deaths from diabetes due to people missing their diabetic monitoring.

Mental health problems are in a way the most shocking thing. In June of this year, a CDC survey found that one in four young adults between 18 and 24 had seriously considered suicide. Human beings are not, after all, designed to live alone. We're meant to be in company with one another. It is unsurprising that the lockdowns have had the psychological effects that they've had, especially among young adults and children, who have been denied much-needed socialization.

In effect, what we've been doing is requiring young people to bear the burden of controlling a disease from which they face little to no risk. This is entirely backward from the right approach.

4. Where to Go from Here

Last week I met with two other epidemiologists—Dr. Sunetra Gupta of Oxford University and Dr. Martin Kulldorff of Harvard University—in Great Barrington, Massachusetts. The three of us come from very different disciplinary backgrounds and from very different parts of the political spectrum. Yet we had arrived at the same view—the view that the widespread lockdown policy has been a devastating public health mistake. In response, we wrote and issued the Great Barrington Declaration, which can be viewed—along with explanatory videos, answers to frequently asked questions, a list of co-signers, etc.—online at www.gbdeclaration.org.

The Declaration reads:

"As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

"Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings, and deteriorating mental health—leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.

"Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

"Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.

"As immunity builds in the population, the risk of infection to all—including the vulnerable—falls. We know that all populations will eventually reach herd immunity—i.e., the point at which the rate of new infections is stable—and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

"The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.

"Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19. By way of example, nursing homes should use staff with acquired immunity and perform frequent PCR testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their home. When possible, they should meet family members outside rather than inside. A comprehensive and detailed list of measures, including approaches to multi-generational households, can be implemented, and is well within the scope and capability of public health professionals.

"Those who are not vulnerable should immediately be allowed to resume life as normal. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold. Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sports, and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity."

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I should say something in conclusion about the idea of herd immunity, which some people mischaracterize

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as a strategy of letting people die. First, herd immunity is not a strategy—it is a biological fact that applies to most infectious diseases. Even when we come up with a vaccine, we will be relying on herd immunity as an end-point for this epidemic. The vaccine will help, but herd immunity is what will bring it to an end. And second, our strategy is not to let people die, but to protect the vulnerable. We know the people who are vulnerable, and we know the people who are not vulnerable. To continue to act as if we do not know these things makes no sense.

My final point is about science. When scientists have spoken up against the lockdown policy, there has been enormous pushback: "You're endangering lives." Science cannot operate in an environment like that. I don't know all the answers to COVID; no one does. Science ought to be able to clarify the answers. But science can't do its job in an environment where anyone who challenges the status quo gets shut down or cancelled.

To date, the Great Barrington Declaration has been signed by over 43,000 medical and public health scientists and medical practitioners. The Declaration thus does not represent a fringe view within the scientific community. This is a central part of the scientific debate, and it belongs in the debate. Members of the general public can also sign the Declaration.

Together, I think we can get on the other side of this pandemic. But we have to fight back. We're at a place where our civilization is at risk, where the bonds that unite us are at risk of being torn. We shouldn't be afraid. We should respond to the COVID virus rationally: protect the vulnerable, treat the people who get infected compassionately, develop a vaccine. And while doing these things we should bring back the civilization that we had so that the cure does not end up being worse than the disease. ■