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"Lessons from the COVID War": An Incomplete Analysis of U.S. COVID-19 Policies

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During the first three years of the COVID-19 pandemic, the U.S. experienced about 16 percent of the deaths attributed to COVID-19 worldwide in less than 5 percent of the world's population. More than 1.1 million people died in the U.S. and more than 6 million were hospitalized.

Anticipating a COVID-19 commission on the U.S. handling of the COVID-19 pandemic, the former Executive Director of the 9/11 Commission assembled a group to investigate the U.S. effort to contain the extraordinary harm done during the pandemic. Congress did not approve a commission but the group, with private foundation support, produced a book titled "Lessons from the COVID War" [1]. Consisting of 34 members, the authors call themselves "The COVID Crisis Group".

The war analogy is inappropriate for analysis of the pandemic as noted by Dr. Elana Naumova in 2020 [2]. The war book authors refer to the corona virus, SARS-CoV-2, as an invader. But viruses are sequences of chemical code without brains or means of mobility. Those that evolve to infect human cells are conveyed by the behavior of the infected and other people in their environment. There was no deliberate invasion by the virus and no evidence that it was spread deliberately. The authors correctly note that the first human infections identified in China were from contact with animal carriers in the wild, a meat market that sold wild animals, or a lab studying viruses. We are unlikely to learn which with any certainty.

By the third week in January 2020, it was known that SARS-CoV-2 was easily spread by exposure to aerosols of the breath of the infected and that some 3 percent of people with known cases in China had died. At that time, the U.S. Centers for Disease Control and Prevention (CDC) had identified only one case in the U.S [3]. The book discusses the spread of the disease, the faulty tests deployed by the CDC in February 2020, and the resulting delays in screening for asymptomatic cases. Initial airport screening of passengers from China was based on symptoms only.

Testing, Tracing, and Quarantine

Missing in the book is the compelling evidence that obsession with the asymptomatic cases led to mass testing at pharmacies, drive-thru, and other sites that resulted in increased travel by those who tested negative. Many became infected during those travels. Testing advocates assumed that tracing the contacts of those who test positive, testing the contacts, and urging all who test positive to quarantine themselves for 14 days would reduce the spread of the virus. Those assumptions were mistaken in much of the U.S. because of too few tracers and the lack of cooperation in identifying the contacts of many of the infected. The tracing system was overwhelmed as indicated by the number of cases relative to the number of tracing personnel on a given day in each U.S. state. Based on the estimated time needed by tracers per case in a CDC manual, on about 7 out of every 10 days there were more cases than personnel had enough time to interview the infected and their contacts [4].

A CDC study of contact tracing in 13 health departments in 11 U.S. states and an Indian Health Service unit found that less than 60 percent of people who tested positive were interviewed and only a third of those named contacts. Of the contacts who were traced, less than half agreed to follow up [5]. That means that only a small minority of the contacts of people with positive tests were traced and tested, much less quarantined.

In mid-November 2020, seeing the lengthening lines at test sites on television, I hypothesized that many people were not there because of symptoms or suspected exposure but to decide whether to travel during the holidays. Data on daily negative tests predicted hospitalizations 14 days later among countries and U.S. counties from which data were available in 2021. The problem was not confined to holidays [6]. Studies of negative tests and COVID-19 deaths 25 days later yielded the same results from March 2021-March 2022. If increased testing were in response to surges, surges in cases, hospitalizations, and deaths would have preceded increases

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in tests. An average of 208 extra miles was accumulated in the week following each negative test in U.S. counties [4]. According to a CDC study, two-thirds of the people tested at drive-through sites and pharmacies did not have symptoms [7].

Before President Biden took office, I sent the results of my peer-reviewed research on hospitalizations to a member of his COVID-19 advisory committee who promised to send it to the other members. That person and two others to whom I subsequently sent reports on the testing problem are coauthors of the COVID wars book but the problem is unmentioned in the book. I also sent it to several Biden appointees responsible for health policy but none responded. Legislation before and after Biden took office repeatedly called for increased mass testing. Tens of billions of dollars were allocated by Congress for mass testing during the Trump and Biden administrations. Political resistance to masks, physical distancing, and vaccines also contributed to the U.S. toll but was independent of the testing problem [4].

A second assumed justification for mass testing is to adjust preventive policies such as school, business, and other closings and openings based on the proportion testing positive. Basing local policy on positivity rates assumes, unlikely, that those who choose to be tested are representative of the population in the community. Comparison of positivity rates at various stages of the pandemic indicates that the correlation of positivity with subsequent cases is too varied to be reliable [4]. Sampling wastewater is more likely to indicate the actual prevalence of the virus in a community and avoid the problem with mass testing [8] but the wastewater testing alternative is not mentioned in the COVID war book. It merely calls for improved biomedical surveillance.

Lessons from Abroad

Much can be learned from the policies and methods used by countries that contained the virus far more effectively than others. They get too little attention in the war book. The authors mention a few European countries, Japan and South Korea that did better than the U.S. but dismiss some of the democracies that better contained the spread of the virus as "island countries". The U.K., an island country, had a death rate near that of the U.S. Based on democracy scores that are higher than the U.S., I found eight countries that had COVID-19 death rates a small fraction of those in the U.S. and U.K. -- Australia, Finland, Iceland, Japan, New Zealand, Norway, South Korea, and Taiwan [4]. Finland, Norway, and South Korea are not islands. The war book credits the U.K. with good COVID-19 surveillance by the National Health Service using free testing without noting its excessive COVID-19 death rate.

Among the evidence that mass testing led to increased exposure by those who tested negative is what happened in Slovakia. That country has a democracy score similar to the democratic countries that substantially contained the virus and had a similar COVID-19 death rate until it changed its policy of testing the symptomatic and vulnerable to mass testing. After it tested about 80 percent of the population in late 2020 and early 2021, its COVID-19 death rate soared to 50 times that of the average among previously comparable countries in 2021 [4].

Five of the eight most successful democratic countries did not require nationwide shutdowns but concentrated their prevention efforts in areas where the virus was spreading. A majority did not resort to mass testing until late in the pandemic and cases rose afterward in all but one of those that did [4]. Screening at international airports was a major factor in the countries that best contained the spread of the virus. A study of international air traffic found a very strong correlation between initial virus spread and travel among countries [9]. The virus spread among countries mainly by air travel but within countries predominately by road and other modes of travel. A majority of the more successful democratic countries enforced mandatory quarantine of international passengers who were symptomatic or tested positive, e.g. [10], but the U.S. quarantine policy was advisory [11].

Some of the war book author's descriptions and analyses of the White House, Congress, and government agency responses to the pandemic are worth reading. It is the mentioned omissions that diminish the usefulness of the book in future pandemic response planning.

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