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Lockdown’s ever changing moods

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Being Right

By Jemy Gatdula

Or rather, moving goalposts. Normally those resorting to it do so because their cause is weak. Or with regard to important issues, a losing argument. Thus,

environmental activists went from preventing pollution to preventing depleting resources to preventing global warming to preventing climate change. Or abortionists, contraceptives, euthanasia activists going from eugenics to population control to “compassion” to being a “choice.”

Now, the pro-lockdown crowd is doing the same to justify the lockdown: from to flatten the curve, to avoid overwhelming hospitals, to squashing the curve, to complete testing, to wait for a vaccine, to save every single life.

The ambiguity of each term provides the added benefit of being easily sidestepped or argued against, particularly whenever the public perceives that such a goal is becoming dangerously close to being attained.

ON CASE FATALITIES

Interestingly, now that people are beginning to recognize the actual low lethality of COVID-19 and that hospitals around the world are actually not being overwhelmed, the pro-lockdown crowd are now resorting to questioning the fatality (CFR or IFR) numbers’ significance vis-a-vis positive case numbers, dismissively explained away as the “logical” course of the death rate going down because testing is going up.

The low lethality rate of the coronavirus, particularly when compared with other causes of death in the Philippines, has been discussed elsewhere and will not be repeated here. Suffice to say, as journalist Alex Berenson demonstrated, using the Center for Disease Control data, of COVID-19’s similarities with a Category 2 flu season. For which no lockdowns were issued for the latter.

In any event, the argument that the CFR will go lower because more tests are happening misses the point: the lethality of the coronavirus is actually much lower than previously reported, and data on the CFR should be read alongside pneumonia or flu, as well as other causes of mortality, when making policy decisions.

When asked for comment, Dr. Jude Verzosa, Chief Medical Officer for Rainier Health Network, former adjunct Assistant Professor at AT Stills University, who specializes in population health management, pointed out that "it is easy to misinterpret the decreasing CFR in the Philippines and minimize it as a consequence of more testing." Nevertheless, "the CFR is a poor forecast model because it is used for worst-case scenarios. Policymakers should be way past discussing CFR at this point. Moreover, focusing only on death as a measure of the effect of the pandemic overlooks morbidity and mortality from other causes as well, including poverty."

Indeed, looking at the data from the Department of Health (DoH), we have (as of July 16, marking the fourth month of the lockdown), shows 1,643 COVID-19 designated deaths. Which makes it, on average, 411 deaths per month. Compare that with the 300 Filipino deaths monthly by suicide, or the 1,000 from car crashes. From the DoH's own 2018 data, 2,038 die from tuberculosis, 2,775 diabetes, 2,788 hypertensive diseases, 4,745 cerebrovascular diseases, 4,817 pneumonia, 5,039 cancer, and 6,178 from ischemic heart disease.

And also compare all that with the 4 million Filipinos infected with the Spanish flu in 1919 — 80-90,000 Filipinos died from that flu in that period.

UNICEF reports that 2,850 children die monthly from malnutrition. In 2019, between Jan. 1 and Oct. 19, 371,717 dengue cases, with 1,407 deaths, were reported through the DoH routine surveillance system, with a CFR of 0.38%. Of the deaths, 535 were children five to nine years old.

We didn't shut the economy then for those deaths. And neither were schools.

But apparently we're moving to a ridiculous policy conclusion that the only justified reason for the lockdown to be lifted is if the human race is rid of death for all time.

ON MILD AND ASYMPTOMATIC CASES

That we have an above 90% mild or asymptomatic COVID-19 cases should be welcome news. But not so for the pro-lockdown crowd. They're "spreaders!" they shout. But that again misses the point: It is the less than 1% presumably that would need COVID-19 designated treatment and facilities, which is data good to know for policy making. The problem — as is likely happening — is when mild or asymptomatics with a non-COVID-19 serious health condition needing hospital care is lumped into the COVID-19 hospital occupancy count, which not only raises public fears but screws up decision making.

On this issue, Dr. Verzosa says that "emerging data suggests that there is no conferment of lasting B cell immunity from COVID-19 (though studies on T cell-mediated protection shows enormous promise. But I digress). The argument on lockdowns preventing herd immunity may be challenging to defend. However, this does not mean the opposite; that because there may be no lasting immunity, lockdowns are necessary."

ON HOSPITAL OCCUPANCY RATES

One valid cause for concern is that the NCR COVID-19 hospital occupancy is rising to critical levels. But even then, there is a bit of a red herring mixed in that. As of July 22, four months had already gone by since the pandemic started. Which means time to prepare, stock-up, gather more data, and gain experience. There is therefore a disconnect and a problem when the NCR is allowed to register rising numbers of 76.4% COVID-19 hospital occupancy (with ICUs at 74.18%), while the national COVID-19 hospital occupancy rate is at a stable 52.8% (with ICUs at 53.29%), with an above 99% of the cases being mild or asymptomatic cases, and an IFR of .2%. This is palpably not a COVID-19 problem. This is mismanagement.

For context, Dr. Verzosa points out that "the way hospitals utilize beds in the United States is very different from the Philippines. There are strict clinical eligibility criteria that must be met prior to a patient's admission to the medical floors, so insurance coverage is assured. The length of hospital stay is

monitored and audited as well. Even stricter criteria exist for ICU admissions. As an example, a patient being admitted for chest pain suspicious of a heart attack needs to be evaluated and treated for the same within a three-night stay from the time of presentation, or risk the institution getting penalized for poor quality care from national governing bodies and non-payment from the insurers. These guardrails are meant to set high expectations on care quality and timeliness of its delivery based on evidence-based standards.

“That said, in the Philippines, the important thing to discuss by policymakers and insurers with the hospital administrators is not so much the occupancy rate of the hospitals in a region but rather HOW the beds are utilized. It will likely be that more beds can be made available for the right kind of cases, like COVID-19 patients with severe symptoms.

“This may not sit well with my physician colleagues in the Philippines because admissions are a source of payment there, and physicians are share-holders of their affiliated hospital(s). The problem is more profound than that of the effects of the pandemic. In fact, the pandemic sadly highlights it. As you have said, it may be mismanagement. It also is likely the structure and the economics of healthcare in the Philippines. (Not that healthcare here in the US is not a disaster in itself for other reasons, too).”

LOCKDOWNS DON’T WORK

And we finally move to the core issue: Do lockdowns work? No, they don’t.

Study upon study shows it has no effect on the overall containment of the pandemic, particularly mortality levels. In this regard, one thing that really helped the Philippines is its youthful demographic: median age of 25.7 years old, with 90% of the population between 0-54 years of age. It is most likely this reason why the Philippines has a low deaths per million (17.28, at a low 75th place). This despite having one of the most populous, densest cities in the world.

As Dr. Verzosa points out: “Evolving data suggest that … community/country lockdowns do not seem to decrease mortality from COVID-19. Though we know it slows down the rate of transmission, it does not reduce the risk of dying from the disease overall. Creating policies centered only on death as a measure of the effect of the pandemic overlooks morbidity and mortality from other causes, many of which cannot yet be fully appreciated. The only way out of a lockdown is to consider data on the morbidity and mortality of a plummeting economy as well as non-COVID related diseases as its indirect effect.”

Even *The Lancet* now recognizes this fact. A study published July 21 found that lockdowns have no effectiveness on the virus’s overall mortality rate: “Lockdowns were not associated with reductions in the number of critical cases or overall mortality.” The WHO representative in the Philippines was also reported saying that contact tracing, instead of hard lockdowns, should be the focus.

Lockdowns don’t work. That much is certain. If one looks at the top 10 countries with most deaths per million (as of July 24), eight imposed strict lockdowns and all 10 have median ages far higher than the Philippines. Most of the deaths Sweden had were from the elderly population, which was the same result that strictly locked-down New York had.

Dr. Verzosa best sums it up: “You can’t replace poor population health management with a lockdown.”

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