

The background of the cover is a grayscale photograph of a person's face, showing their eyes and forehead, with a hand visible at the bottom. The person appears to be wearing a face mask, though only the top edge is visible.

the
**Global Policy
Institute**

www.gpilondon.com

Policy Report

CONFUSION IN COVID-19 COMMUNICATIONS IN THE UK

Global Policy Institute:
Dr Michael Lloyd

September 2021

Policy Analysis *for a Changing World*

About the Global Policy Institute

The Global Policy Institute is a London-based think tank on international affairs. It was originally founded in August 2006 as a research institute at London Metropolitan University to analyse the issues of globalisation and to formulate innovative policy solutions. It is now an independent Institute based in the City of London, and draws on a rich pool of international thinkers, academics as well as policy and business professionals. The Institute gives non-partisan guidance to policymakers and decision takers in business, government, and NGOs.

CONFUSION IN COVID-19 COMMUNICATIONS IN THE UK

Policy Report | September 2021

GLOBAL POLICY INSTITUTE (GPI)

Dr Michael Lloyd
Senior Research Fellow

Disclaimer: The views and opinions expressed in this paper are solely those of the author(s). The Global Policy Institute does not take institutional positions, and publication of this report is not an endorsement. Our fellows are encouraged to conduct their own research, reach their own conclusion, and advance, when appropriate policy recommendation based on this research.

Introduction

For some time now I have been concerned about the often inadequate and misleading information presented to the British public over the past 18 months, by politicians, by the senior medical-science bureaucracy, and, unfortunately by a proportion of virologists, behavioural scientists, and epidemiologists. Some of this reluctance to divulge information is perhaps understandable. The underlying specialist scientific, technical, and statistical risk (and uncertainty) information is difficult to communicate directly to the public.[1] However, it is possible to provide a more accurate, if simplified, picture of the key elements in the overall picture of the Covid pandemic and its evolution over time, to the current situation going forward. The necessity of doing so is urgent during the current transition from dealing with the SARS-Cov-2 virus as a pandemic to dealing with the virus as endemic in the population, with the burden placed, substantially, on the less-constrained behaviour of the general public.

As the pandemic has progressed, and in the current situation, moving into the autumn in the UK, there seems to be a form of psychological panic arising over Covid-19. The panic appears to be overwhelming the medical bureaucrats, and a number of the scientists and epidemiologists, significantly amplified by a mainstream media that does not challenge authority. The view might be characterised as that the world is involved in a Manichean struggle between humans and a superhuman adversary, rather than dealing with a tiny piece of protein that cannot continue its existence outside an animal, including human, host. Hence, at the same time is substantial opening up of the economy and society, fear-mongering about Covid is continuing.

The problem has been confounded by the fact that the earlier lack of clarity in the public messaging has led to considerable concern and confusion among the population, at a time when it is essential to be aware of the required actions to be taken over the next six to nine months. The concerning situation on the vaccination of children is a case in point. This issue involves serious ethical issues and is evidence of not only misleading information being provided, but of crucial information being withheld by the government and the medical-science fraternity.

Preparations for the Pandemic

Most nations, including the UK, have for a few decades prepared pandemic exercises. The UK Cygnus was a 2017 pandemic exercise in preparation for a potential major flu epidemic. [2] The essential aim was to assess how the health and social care services would cope with major surges in epidemic cycles.

A key element in the 2017 planning was the “triaging” of the UK population to assess how, under extreme stress on health care provision, various segments of the population would be distinguished for treatment. Inevitably, with constrained hospital and other health services,

prioritisation of specific population segments would be required, based on the potential for recovery and survival.

It may be argued that the use of life-years, used as the principal metric effectively to decide on resource allocation in Cygnus, is arbitrary and inadequate, and makes no attempt to assess an individual's contribution to their family or to society more widely. It may be argued that to go beyond this crude attempt to quantify the allocation of health care resources would move into making unsustainable ethical judgements, except perhaps for the "frail elderly", as defined by doctors. However, it could equally, and perhaps more persuasively, be argued that whatever broad national level or local level guidance is issued, the final treatment decision should be left in the hands of the clinicians treating the patient, following discussion with close family members, if possible.

The key decisions, which were required from consideration of Cygnus, should have been, an urgent attempt to expand the provision of both physical space and equipment, together with a parallel increase in available staff, including volunteers. It should have led to an immediate increase in funding aimed at providing a higher level of the specialist health care services required, in addition to advising the general public on how to treat flu at home effectively. Notwithstanding the fact that Covid19 is not the same disease as flu, they are sufficiently similar for the above expansion of services to have been initiated.

However, a review of Cygnus in 2019 reached the conclusion that a pandemic was unlikely to occur. This position was in contrast to some of the East Asian countries, such as Taiwan, whose earlier pandemic planning had been shown to have failed in the Sars-1 epidemic and was updated. Evidently, this was not done in the UK, and further problems were created by the mismanagement during the first 6 months of 2020, aspects of which are set out in an Amnesty Report.[3] The unpreparedness illustrated in this report is stark.

This criticism is not meant to, in any way, underplay the need to deal with the virus and the severity of Covid19 for a proportion of the population, especially, but not exclusively, those with co-morbidities. However, surely a sense of perspective is required. As sensible voices are urging, the UK is transitioning, over the next nine months, from a pandemic mode of dealing with Covid to an endemic mode. This transition needs to be clearly explained to the general public, in relation to both risks and benefits.

Epidemiological Modelling

To an extent, the response to the pandemic has been led by advice provided by epidemiologists. The selective publication of the results of the models, despite their manifest failings - including the uncertainty of key assumptions and the acute sensitivity of the models, as indicated below - has stimulated a sense of foreboding about the virus and the disease it can induce. The foreboding has morphed into a mix of misinformation and fear-mongering by leading politicians, by some in the medical-science bureaucratic establishment, and by

much of the mainstream media.

One principle underlying any modelling of scenarios is to understand that all models are substantially flawed (indeed one might say they are simply wrong). However, if correctly structured and interpreted they may provide useful guidance. (As an economist the author understands this principle. It is not clear that all epidemiologists are similarly aware of their models' flaws).[4]

During the first few months of the pandemic, it may have been excusable that some of the assumptions fed into the models were uncertain because of the unknown characteristics of a novel virus. Nonetheless, epidemiological models have been around for some time. (One feature that emerged during the first few months was the surprisingly high number of academic epidemiologists across UK universities).

However, despite some apparent improvement in the assumptions, such as moving away from substantially random individual interactions to advanced network-modelled interactions (though still subject to population and geographical errors), other flaws remain. Among them are the assumptions made about the efficacy of the virus, which, when small differences in vaccine efficacy are used in sensitivity analyses, often lead to substantial differences in the case-number scenarios produced. Estimates of contagion used in the models, derived from virology studies, are subject to significant error, especially with the development of variants.

The regression analysis used in the core of the models is subject to the well-known problems such as auto-correlation, multi-collinearity, and the uncertainty built into the probabilistic term, and a host of others. There are statistical techniques and procedures for overcoming these problems, but modelling is still subject to wide ranges of error. Hence, the provision of best case, worst case, and central case estimates. The central case is usually the one presented, though there is no more guarantee that this will be the actual case in the real world, than the best or worst cases.

The main lesson is not to cease providing models, whose assumptions may be improved over time, and may be increasingly freed from technical errors. It is to avoid too much reliance being placed on the models, especially given the sensitivity of the scenarios produced by the models. Unfortunately, this scepticism is absent in UK political and media discussion, and in some cases by the modellers themselves.

Testing: Its Practice and Purpose

Testing has two potential functions. First, to confirm a symptomatic case when presented. Second, to test for pre-symptomatic cases and asymptomatic cases (these latter cases are considered to be as high as a third of Covid cases). However, it is important to recognise that unless there are definitive symptoms present, the Covid PCR tests cannot test for infec-

tion, simply for the presence of a certain minimum viral load, that is assumed to provide evidence of the presence of infection. Clearly, if symptoms of the disease are present then confirmation by a pharyngeal sample PCR test has added value.

The minimum viral load is assessed using a complex methodology. Involving producing DNA from the RNA virus sample, and a successive round of heating and cooling, involving enzymes, and using a modal number (most frequently targeted number of cycles across UK labs) of 30 centrifuge cycles to confirm the presence of sufficient fragments of the SARS-Cov-2 complementary DNA, ostensibly confirming a Covid diagnosis.[5] This number of cycles or less would mean a low cycle threshold (Ct) and a correspondingly high viral load indicating a strong possibility of infection, at the time of the test being taken. Beyond 35 cycles would be in the territory of erroneously high Cts.[6]

Notwithstanding the modal/typical number of cycles being used, cycles of up to 45 being used have been found in many labs. This means that this high Ct is indicative of a low viral load and may have provided a misleading positive result, especially of post-recovery from Covid or in an asymptomatic person. It could also, but more rarely, given that symptoms will soon emerge, be a pre-symptomatic person.

This inconsistency of the PCR testing across UK laboratories is little advertised and potentially disturbing. It may mean that the number of cases announced may be higher than it should be, and that the potential for the manipulation of these figures in certain localities is possible.

The direct PCR test takes at least 24 hours for the result. However, there are also now more rapid, 15-30 mins, indirect lateral flow tests. This involves the pharyngeal sample tested for the presence of antibodies which are specific to proteins, antigens, from the SARS-CoV-2 virus. These tests are not as reliable as the PCR tests in terms of specificity, and they are unable to distinguish between infected people who are no longer transmitting the virus, and those who are still infectious.

The main purpose of the tests is to identify those who have a sufficient viral load as to be capable of transmitting the virus to others with whom they may come into close and prolonged contact. These individuals are traced and then instructed to self-isolate for a prolonged period, though the length of this period has come down from the original 14 days to an absolute minimum of 5 days. The aim is effectively to replicate the objective of lockdowns, that is to break the cycle of transmission and contagion.

In some extreme high-risk settings, especially hospitals and other health care settings, the testing regime will need to be strict and be accompanied by other measures, such as a PPP (personal protective equipment).

It is important to understand that even if people are in contact with infected individuals, and are thus at risk of becoming infected, most will not actually become infected. The factors involved, as indicated in the next section, such as the intimacy and regularity of

contact, the amount of viral load carried by the infected person, the strength of immune system of those in contact, etc, are all determinants of infection.

One aspect of the tests, rarely now commented on, is the invasive nature of the sampling of the viral load by the insertion of long probes into the pharyngeal passages. Not only can this be unpleasant and painful, but it may result in failure to detect a sufficient viral load for PCR testing purposes. It is estimated that the use of lateral flow tests, because of this factor are, not surprisingly in the hands of the general public, less than 60% reliable. Given this situation, it is both surprising and concerning that saliva, breath, or blood (finger prick) tests have not been developed.

The Virus and Its Variants

During 2021 there has been much discussion, and induced fear-mongering, over the emergence of a number of variants of the original virus, identified and sequenced, in China. The first of these variants was identified and sequence in the UK, the so-called Kent variant, now termed the Alpha variant. The current concern is over the Delta variant which seems currently to be becoming the dominant global strain.

There is much confusion over the evolution of the variants and their relation to the still underlying infective virus. The SARS-Cov-2 virus remains effectively the same, the variants, as might be expected, are more contagious. The increased level of contagion, related biologically, to modifications in the surface Spike protein which permits the virus to invade cells, is difficult to assess. The procedure employed to ascertain the increase in contagion entails deciding what proportion of the apparent increase in the number of cases may be attributed to increased human contacts, the residual is the contagion attributed to the increase in delivery of viral load because of the modification in the Spike protein.

A recent study[7] suggested that although initially Alpha variant was considered, from virology studies, to be 80% to 100% more contagious than the original Wuhan strain, it is now considered to be only 30% to 40% more contagious. (It is true that this result - which will likely be replicated with the Delta variant – may be contrasted with the higher estimate from virological studies.[8] However, it is not clear how the high percentage is calculated with any degree of certainty from virological examination of a small sample of patients who had recovered from infection with the variants).

Variants tend to arise from prolonged infection in a patient - a number of months – during which time large numbers of mutations occur, leading eventually, in a few cases, to the emergence of a new variant[9] and carried into the community by hospital staff, including, inevitably, passing it on to some non-Covid patients

Hence, though it is often suggested that variants are linked to a high prevalence of cases, this factor alone is unlikely to be the direct cause of the emergence of variants. Hence,

though a high number of cases will increase statistically the chances of infection, it is the increased potential for a long-lasting infection to provide the reservoir for new variants. If infections are eliminated rapidly (which most are) then the likelihood of significant mutations is reduced.

A further problem is that there tend to be a significant number of immuno-compromised individuals in the UK population. It has recently been estimated that around one-third of the UK population have one or more co-morbidities, overlapping with the third of the population who are clinically obese. Added to this problem is the nature of the SARS-Cov2 virus, which, though it first attacks the blood cells in the lungs, it may invade blood cells in other organs of the body, causing blood clots in various organs, with often equally damaging consequences.

Although there are likely to emerge further variants, like the current set of variants, the new variants are likely to be those where successive mutations of the Spike surface protein will occur that will prevent antibodies “sticking” to the virus and rendering easier the invasion of cells.[10] Notwithstanding the emergence of further variants, the underlying virus remains, and is unlikely itself to mutate significantly, if it is to remain viable[11] during its endemic phase (discussed in the next section).

The issue, therefore, is how via either natural immunity, either original or acquired by infection, or by immunity acquired by vaccination, a substantial proportion of the population are protected from further significant infection. We will, first examine the often-neglected issue of natural immunity.

Natural Immunity

It is sometimes suggested that protection against the virus, and the disease, may only be achieved through vaccination. This is by no means the case as natural immunity does offer protection. We all have two immune systems: an innate one (including antibodies) and an adaptive one (including B-Cell and T-Cells, so-called killer cells), the innate immune system tends to be stronger in the young, the adaptive immune system tends to be stronger in the elderly, with healthy middle-aged people having a reasonably good balance of innate and adaptive immune systems. Despite the novelty of the SARS-Cov2 virus a proportion of the population studies have shown[12] that between 20% and 50% of the population will have T-Cell immunity against the virus. Given that it is widely accepted that 25% of Covid cases are asymptomatic[13] it seems not unreasonable to assume that one-quarter of the population will have a moderate level of immunity against Covid, sufficient to prevent severe disease and death.

Indeed, taking account of the 75% of the population who have had two jabs, the 15% to 20%, who have already contracted Covid and survived, there is a substantial level of immunity in the UK population, sufficient to have reduced the risk of contracting anything other

than the mild disease. However, insofar as the Covid-19 virus becomes endemic then 100% population immunity is not possible (see herd immunity below).

Clearly, the level of viral load, combined with the adequacy of the immune system, is the key factor in determining the severity of the disease experienced by the individual. This factor will influence how rapidly a given viral load will be eliminated by the individual. Exposure to small viral loads is probably quite common, but infectivity (that is invasion of cells) will be rapidly prevented by the immune system. It is important to recognise that the body's defensive immune system goes beyond the oft-mentioned antibodies, which stick to the virus, plus other elements of the innate immune system. The body also launches B-Cells and T-Cells in a comprehensive attempt to destroy the virus, as it invades cells regardless of whether that virus has been seen by the immune system before.

Unfortunately, in the case of Covid, and other diseases, an over-reaction of the immune system can itself damage vital organs and hormonal mechanisms, and in some cases, lead to death. This is a severe problem of the virus and has led to the drug treatments targeting moderation of the patient's over-active immune response (the so-called cytokine storm).

Clinical data, suggest that generally the upper respiratory tract viral load peaks at around 5 days after symptom onset.[14] It is plausible therefore that if the virus is clearing from the body within five days of the onset of symptoms, then the chances for recovery are good. Unless re-infected, as can happen in some clinical settings. If the virus lingers in the body for a substantial length of time, then problems may arise, not only for the individual, but also for the whole population.

As we move from the pandemic to the endemic phase, likely to occur over the next 7 to nine months, then natural immunity will take over the role of protection, supported by vaccination at one or two-year intervals. (Indeed, the recent Oxford study, discussed and referenced in the next section of this paper, suggests that "those infected after second vaccination appeared to gain an antibody boost"). In the endemic phase, though uncertainty persists in any forecasts, it seems likely that Covid-19 will become a mild disease that will be caught in childhood, with the gradual development of widespread natural immunity over a period of years. The virus will remain viable in the majority of countries, with sporadic outbreaks needing to be strictly controlled, especially in relation to vulnerable communities. In some countries, mainly in the developing world, the virus is likely to become endemic in wild animal populations (as is Ebola), with potential spread to human populations.[15]

N.B. Obviously, these are only broadly quantitative arguments and further, more precise, research and quantification are required.

Vaccinations and Treatments

It was imperative that vaccines to prevent serious Covid-19 illness were developed as rap-

idly as possible, given the unknown nature of the virus and its evolution. Lockdowns were a difficult palliative measure to reduce contagion, until accelerated vaccine development could provide vaccines that were sufficiently safe to be administered, though currently still under emergency licensing protocols. The pharmaceutical companies involved requested and were provided with indemnity.

All the vaccines were targeted, *inter alia*, to replicate elements of the surface Spike protein of the virus which enabled it to enter human cells, via nasal and pharyngeal passages. It appears that the mRNA vaccines, such as the Pfizer-BioNTech, are marginally more comprehensively efficacious than vector vaccines such as the Astra-Zeneca, though it is possible that the mRNA vaccine immunity, in terms of antibodies, may last for a shorter period. However, the Astra-Zeneca vaccine appears to have higher levels of serious adverse side effects, such as blood clots, especially for those aged below 40 and for women.

The messaging about the safety of vaccinations provided to the general public is inadequate. Media and public health messaging suggesting that the vaccines are “safe”, though understandable to avoid significant “vaccine hesitancy”, is misleading and treats the general public as being unable to make a balanced judgement about relative risk. With a low prevalence of the virus, the balance of individual risk for a healthy, 45 to 50-year-old woman who avoids crowded indoor spaces, may be in favour of not being vaccinated, especially not with the Astra Zeneca vaccine. Nor is such an unvaccinated person any more significantly likely to transmit the virus than a vaccinated person. Given that vaccination is not mandatory, the attitude of demonising and scapegoating such a person is neither warranted on health grounds and unethical in community terms. This position on vaccines is becoming not only misleading, but also potentially dangerous and unethical. The question of ethics is also important when consideration is being given to the vaccination of healthy young people (16 and 17-year-olds), and more seriously to 12 to 15-year-olds, and even 1 to 11-year-olds.

It is important to recognise, even if Jonathan van Tam doesn't appear to, that to be proposing to vaccinate children in order to protect the adult population is unethical.[16] You should ask another person to authorise a medical intervention on behalf of someone else. This case is even stronger for healthy children as they are highly likely not to exhibit either any symptoms or potentially very mild symptoms. Less than 5% of all Covid cases are in children and very few develop severe symptoms, including those with underlying health conditions. As far as deaths of children are concerned, they are incredibly rare (see Nature),[17] equating to a risk in 1 in a million.

Notwithstanding the above argument, it has also been suggested that children are susceptible to “Long Covid” syndrome. The problem here is that there is not yet any clear clinical definition of Long Covid. The issue is discussed below in the section on Treatments. There is also an absence of any accurate figures of how many clinically diagnosed cases, including whether or not there are co-morbidities, across which age cohorts. To assess the potential impact on children, which is not likely to be large, is impossible without further detailed

age-cohort data. The lack of useful, accurate data is typical of the data problem which has bedevilled Covid since the outset of the pandemic, and which should have been resolved by now.

It should be noted that all of the vaccines in current use in the UK are licensed by the Medicines and Healthcare Products Regulatory Agency (MHRA) as having only temporary licensing and the pharmaceutical companies producing and supplying them have been indemnified against law-suits. This does not mean that these vaccines are unsafe for the majority of the population, but it does mean that regular and widespread publicity should be given to the results of the “yellow card” reports of adverse vaccine effects, up to and including deaths associated with the vaccines. This publication should be accompanied by the balance of risks between catching Covid and the separate risk of severe illness, for various age cohorts. This work is done by the JCVI and should be published as above. There are risks, as we know, from the JCVI publication of those for the age cohorts that led to the recommendation that under-40s should be offered only the Pfizer mRNA vaccine, unlike the other 23, mainly western, countries who banned it for all under 55s.

More recently, the JCVI recommendation for only one vaccination being offered to those healthy teenagers aged 16 and 17, was because of the small, but non-negligible, risk of myocarditis, and the significant uncertainty in the data. Again, the lack of wide public provision of adequate and regular yellow card data reporting, including by the mainstream media, is scandalous. Dr Tess Lawrie, and her team at Evidence-Based Medicine in Bath, has provided an excellent breakdown of the data on adverse reactions from the vaccines from the Yellow Card database.[18] One might not agree with Lawrie’s conclusion that the vaccine programme should be halted, but clear information on adverse reactions, including serious ones should be made available, and broken down by age-cohorts.

A further ethical issue raised by the proposal of offer a third “booster” vaccination to over 50-year-olds. There is no clear medical-scientific evidence for the necessity for this third vaccination. At a time when there is an urgent need for vaccination of populations in developing countries, though with some signs of the UK following, is the use of “domestic” vaccine passports, for entry into certain social/community venues. This issue is considered in the next section. The most recent study, published August 16, 2021, is somewhat confusing in its analysis and conclusions, possibly because of attempting to encompass too many objectives.[19] The study concludes, probably correctly, as indicated in the next-but-one section below, that herd immunity is likely to be unachievable. However, vaccination is recommended because of the potential infection of the unvaccinated by the vaccinated, linked to the higher viral load from the Delta variant in nasopharyngeal passages. Here is not the place for a critique of the study, not yet peer-reviewed, though the extremely broad focus, may lead to specific areas of criticism, for instance, the suggested diminution in vaccine protection, linked to viral load as measured by a standardised PCR test.

Clearly, vaccines after two jabs appear to provide around 60% protection against re-infection and, crucially, an estimated well over 90% protection against serious disease. Ironically,

there is mixed messaging from the authorities on the current Covid situation. On the one hand there is maximum pressure being exerted to persuade people to get vaccinated, including quasi-coercion, blackmail, bribery, and guilt-tripping. Yet on the other hand it is argued that, even two jabs do not protect you from infecting others or becoming infected oneself. People are, not surprisingly, confused. Essentially, if you have been double-vaccinated, healthy, and avoid too many crowded indoor environments, you will have to be extremely unlucky to be reinfected. This is equally so for people who have acquired natural immunity through infection.

Of course, it will be argued that such a person may be capable of infecting others. However, the likelihood of the person spreading the virus would appear also to be very unlikely, given that any viral load carried, whatever its level, would be neutralised by his/her active, full immune system. There are also, supposedly, “super-spreaders”, who, especially in an indoor crowded environment, would be of concern. However, identifying them before an event is virtually impossible.

Currently, there would appear to be no valid scientific reason for the delivery of a so-called “booster vaccination” for the over 50s. (This is the age-range selected for the provision of the flu vaccine). To justify this provision, an assumption is being made that antibody levels will fall over time and/or viral loads will increase, due to the Delta variant, and hence protection will be reduced. However, as has been indicated above there is no reason to suppose - except for those with serious co-morbidities or who may be classified as “frail elderly” – that total immunity will reduce sufficiently to warrant a third vaccination, at this stage. Especially, as protection against severe disease is assured, even for the Delta variant. The fact that pharmaceutical companies have apparently already developed such a vaccine, despite the lack of strong evidence about its necessity, is concerning. It is not clear who is driving the agenda for chasing extra vaccinations to cover potential new variants, though clearly pharmaceutical companies will profit. The JCVI appears to be coming under pressure from some in the medical establishment and from some senior politicians, to authorize the third vaccination.

Treatments

There is little media coverage of other treatments for Covid, yet there are a number, beyond the standard (and effective) provision of oxygen, using various methods of delivery. A review of treatments, effective and non-effective, was provided in a recent BMJ article.[20] Dexamethasone, a cortico-steroid which acts to suppress an overactive immune system by reducing inflammation in severe illness, is perhaps the only one widely known.

Insofar as the Covid vaccines may be seen as prophylactic, rather than as a treatment for the severe manifestation of Covid, then there is an alternative: Vitamin D. The properties of Vitamin D, and the necessity of maintaining a high level in the body has been known for some time, though this fact is not well-advertised. The most recent advocacy of Vitamin

D, including as a prophylactic for Covid, comes from a Royal Society Report of December 2020.[21]

Three new drugs - all immune-suppressive in action, and already used in the treatment of other illnesses – have been selected by the WHO to be tested as potential treatments for Covid-19 patients. Ivermectin, a cheap, off-label parasite drug that is widely used in developing countries is currently undergoing trials in the UK.

A monoclonal antibody drug Ronapreve has recently been approved in the UK as a treatment. However, because of its high cost it is not clear how its therapeutic use will be prioritised. The drug has to be injected for protection for around 12 months and might as well be regarded as a form of vaccination.

One aspect of treatments that is not being discussed is the potential role of general practice in delivering home-based treatments for Covid-19. Indeed - as the Amnesty report indicated in relation to care homes, general practitioners, usually active in treating illnesses among care home residents - were side-lined and effectively have been afforded no role in treating Covid-19. The exception was when they were needed to deliver the vaccinations. GPs have, of course, been active in dealing with patients suffering from non-Covid related illnesses. In the future, insofar as home-based Covid-19 treatments are discovered, the role of GPs may change. Of course, their role will always be important, as with flu and other viral infections, in providing advice in how to deal with viral infections, and perhaps in future, specifically in providing prophylactic treatments, including vaccinations, though also in encouraging, and in some cases prescribing, significant amounts of Vitamin D to be taken, especially from October to May.

A further Covid-19 issue, which will require treatment outside hospitals, is that of so-called “Long-Covid”. One has to be care about the statistics[22] on long-covid, given the self-reported nature and varying length of persistent symptoms. In the latest survey, 945,000 people reported symptoms such as fatigue (53%), shortness of breath (35%), muscle-ache (30%), and loss of smell (28%), lasting for over four weeks. The prevalence was greatest in people aged 35 to 69 years, females, people living in the most deprived areas, those working in health or social care, and those with another activity-limiting health condition or disability. The ONS survey of 20,000 self-reported, long-covid sufferers estimated that just under 14% still reported symptoms after 12 weeks. It should be said that post-viral symptoms such as those reported, especially fatigue, do occur after any viral infection, a varying across individuals. However, the need for appropriate medium-term, and some cases, long-term, treatment in managing symptoms is evident.

Herd Immunity

The term “herd-immunity” is used loosely in relation to human populations, to imply a similar protection from infectious disease as is reached in the very different circumstances of diseases in livestock herds. It is a misleading term used out of context. However, a high-

level of protective immunity, is probably close to being achieved in the UK. One indicator is that 92% of adults have antibodies against the virus (ONS). Almost 75% of adults have had two jabs, plus a further 15% to 20% have already had Covid, mostly the young under 30 years of age, who will have not only antibodies, but also immune memory covering the deployment of B-Cells and T-Cells. If this is not the case, then the vaccines will have not proven to be effective. Hence, though 100% herd immunity is not possible, except for isolated small communities or countries.

One can state with a high level of confidence then that a combination of a high level of immunity in the UK, coupled with a decreasing prevalence of the virus, imply a low level of population risk. This combination suggests that the UK population is moving to being well-protected against any substantial, national Covid outbreak. Hence, the risks of Covid-19 becoming prevalent as a severe disease in the UK is currently extremely unlikely, certainly for the healthy segment of the population.

In this situation, it is difficult to understand why the public cannot be similarly reassured, and why the vaccination of children of 12-15 years, and younger, is even being contemplated, except, as now for those children who are immune-compromised and vulnerable. The risk level, both of contracting severe illness and of widespread contagion, is currently low. Clearly there is a considerable level of policy hysteresis within the political and medical-science bureaucracy fraternities, in the UK, as well as some other countries. including the US and are reluctant to alter the policy focus.

Meanwhile, Canada, Australia, and New Zealand, appear to be aiming achieving a zero-Covid, non-endemic situation. This view appears to be based on inadequate scientific evidence, given what we are learning about the virus in a global environment, and, additionally, involves some bizarre ethical reasoning.

Vaccine “Passports”

Various ethical issues are also raised in relation to the suggestion of “vaccine passports” being used in selected “domestic”, as opposed to international travel, situations. The position is more serious in France and some other countries (such as Israel and Lithuania), where governmental panic appears to have overcome a sense of proportion in relation to the number of cases of the Delta variant. The number of current cases in France - though only 50% of the population have been double-vaccinated.

The French situation of requiring, and rigidly enforcing, vaccine passes (or proof of a cleared Covid infection) to enter venues accommodating more than 50 people. This blatant discrimination is being opposed, in France (and in Italy), with pensioners burning symbolic green passes in public. In New York City, even a negative Covid test is no longer accepted. The Lithuanian Parliament recently introduced a ban on the unvaccinated receiving any medical treatment and on using public transport, although after strong protests some of

these restrictions have been lifted. However, similar draconian measures remain in place in Latvia and Estonia. Given the information we have on the Delta variant, and the moderate number of cases occurring in the UK, to introduce such restrictive legal measures in the UK would be disproportionate and should be opposed.

Vaccine passports for international travel are more difficult to oppose as the levels of vaccinations in many countries are far lower than in the UK. However, a commitment needs to be made to see them phased out progressively by the end of 2022, except for a few countries where prevalence has not been reduced. Comparisons with vaccine proofs of Yellow Fever vaccinations for some countries is misleading. For most people the comparable severity of Covid, with a generally accepted infection fatality rate (IFR) of 0.2% is far lower than for yellow fever, with an IFR of 30%. It is also the case that the yellow fever vaccine has proven to be substantially safe over 80 years, unlike the current Covid-19 vaccines. Moreover, one can choose whether to travel to the relatively small number of countries that require the yellow fever vaccine, it is not in any way comparable to having to show a Covid vaccine passport to enter a coffee shop or local restaurant.

The need for international travel vaccine passports - and the other unnecessary onerous and costly PCR tests, supplementing the vaccine passports - can be reduced in the time-scale suggested, provided developed countries and vaccine developers and producers ensure a rapid vaccine supply at acceptable prices and do not require 100% vaccination. Additionally, health service funding is required for developing countries, to ensure efficient delivery of the vaccination programmes. As has been reiterated by the WHO, the pandemic can only be controlled via a global effort to reduce the incidence of Covid-19.

An Overview: Going Forward

Given the above summary analysis what would seem the appropriate strategy for moving forward in the UK over the next nine months, from September 2021?

First, some scientists are warning of an upsurge in cases in September/October, linked to the suggested rise in cases as the schools go back and the already wider lifting of restrictions (there should be some evidence from Scotland where schools go back earlier). Notwithstanding these concerns, the UK should concentrate, in the autumn, on delivering an effective flu jab to the over-50s and avoiding a major resurgence of this disease in the winter, based, hopefully, on vaccines that cover whatever flu variant will emerge in 2021.

Second, clear information should be provided to the general public indicating that the country is achieving a high degree of protection against serious Covid-19 disease. This milestone, achieved by a combination of vaccination and acquired natural immunity, reduces the population risk, and permits a transition from pandemic mode to endemic mode. However, this transition will take a further 9 months to be completed and will require caution to be exercised in terms of contact in crowded indoor settings. There will also be sporadic Covid

outbreaks, taking place in certain localised situations. As in Far-Eastern countries, clear procedures should be put in place for identifying and dealing with these local outbreaks, for instance, advising vulnerable adults, in certain restricted local areas, to avoid crowded indoor spaces and travelling beyond their local area, for a limited period.

Third, vaccinations of healthy children should be postponed indefinitely and so should so-called booster vaccinations for over 50-year-olds, unless specifically requested by individuals via their GP surgeries. Clear information should be provided on the risks of becoming infected (low to moderate) and the separate risk of severe disease (extremely low). From the end of September, Covid vaccinations should be administered, only if requested, without undue pressure being applied via coercion or bribery.

Fourth, PCR testing should not be required in the UK before international travel, unless insisted on by the destination country. The UK should come into conformity with the EU in terms of international travel arrangements as far as testing is concerned.

Fifth, a concerted attempt should be made by the medical-science fraternity, senior politicians, and the media to raise the level of public debate and discussion of Covid-19, with some focus also on sixth forms in schools, colleges, and universities. Hopefully, if properly conducted it will reduce the current massive confusion about Covid-19 in the minds of the general public.

Conclusion: It's Not Too Late to be Honest

The missing information, the unbalanced public presentations - and in some cases the lies of omission - coupled with the medical establishment and government, apparently holding conflicting views of what decisions to take, is not only debilitating, given the need for cooperation from the general public, but unforgivable.

No-one should pretend that handling a pandemic, originating from an unknown virus, was going to be easy for any government, and so it has proved. However, a combination of an over-reliance and over-confident use of significantly flawed epidemiological modelling; an uncritical use of the medical-science results by the medical bureaucracies, and a general failure of scientific understanding on the part of senior politicians and their advisers, including behavioural scientists, has led to a damaging lack of understanding and confidence in the UK population. (It should be said that many other countries have not fared much better). The consequences of many more people distrusting their governments, and the scientific advice being provided, could be profound.

The pandemic has still to run its course in many developing countries, some of which require funding to improve their health services, not simply vaccine supply. In the UK, with its strength in biological sciences, and a superior if inadequately funded health service, it is now time to be honest about a number of key issues, as we transition in the UK, and eventually globally, to management of the virus as an endemic pathogen.

What is required, in terms of key actions is spelt out in the above Overview. Yet what is also required is honesty and consistent messaging on the part of the four principal actors: 1) scientists who must indicate what they know to be the case with a high degree of certainty, and when they do not have the certainty, do not speculate (especially on the media); 2) medical bureaucrats (at all levels) who need to inform themselves better on the prevailing science and to act with some ethical awareness; 3) decision-making politicians who also need to become better informed on scientific matters (this means putting in some intellectual effort), and, finally, 4) the media, who need to not ask experts to give categorical answers or to speculate, and to interrogate politicians with intelligent, well-informed questions and, occasionally, when deserved, informed ridicule.

With honesty from these actors and a better-informed public there is a chance that learning to live with the virus will represent a practicable route out of the pandemic. Covid-19 - though for some can be damaging, and for a tiny proportion, of mostly elderly, infirm, individuals, can be fatal, even with available treatments - is not a serious disease for the vast majority of reasonably healthy adults. The disease for healthy children is effectively innocuous for those under 15 years of age. Moreover, in the UK - and probably in the rest of Europe, though sadly not yet in some other parts of the world - we are entering the transition period from the pandemic situation to one where the virus becomes endemic. Managed carefully, this transition, over the next 9 months, and the relief it should engender, should also enable a substantially more honest, informed public debate about moving forward than has hitherto been the case.

N.B. There is no attempt to discuss either the threats to the wider health of the nation via indirect non-Covid health treatment issues or the economic impact of the pandemic.

Endnotes

- [1] BMJ 2020;371:m3731
- [2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927770/exercise-cygnus-report.pdf
- [3] <https://www.amnesty.org.uk/care-homes-report>
- [4] <https://cassandravoices.com/science-environment/science/this-is-science-which-should-go-on-trial/>
- [5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/926410/Understanding_Cycle_Threshold__Ct__in_SARS-CoV-2_RT-PCR_.pdf
- [6] <https://www.publichealthontario.ca/-/media/documents/ncov/main/2020/09/cycle-threshold-values-sars-cov2-pcr.pdf?la=en>
- [7] <https://www.nature.com/articles/s41467-020-19818-2>
- [8] Science, July 22, 2021; DOI: 10.1126/science.abj0113
- [9] Kemp, S.A., Collier, D.A., Datir, R.P. et al. SARS-CoV-2 evolution during treatment of chronic infection. *Nature* 592, 277–282 (2021). <https://doi.org/10.1038/s41586-021-03291-y>
- [10] file:///C:/Users/Michael/OneDrive/Anna/Is%20there%20a%20limit%20to%20how%20much%20the%20coronavirus%20can%20mutate_%20_%20Live%20Science.html
- [11] <https://doi.org/10.1038/s41467-020-19818-2>
- [12] BMJ 2020;370:m3563
- [13] <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0249090>
- [14] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7323671/>
- [15] BMJ 2021;372: n494
- [16] <https://www.sciencedirect.com/science/article/pii/S0022347621000287>

[17] <https://www.nature.com/articles/d41586-021-01897-w>

[18] <https://www.conservativewoman.co.uk/doctors-damning-evidence/>

[19] <https://www.ndm.ox.ac.uk/files/coronavirus/covid-19-infection-survey/finalfinal-combinedve20210816.pdf>

[20] BMJ 2021;373: n1109

[21] <https://royalsocietypublishing.org/doi/10.1098/rsos.201912>

[22] <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/5august2021>

Global Policy Institute (GPI)

Policy Analysis *for a* Changing World

109-117 Middlesex St,
London E1 7JF,
United Kingdom

Tel: +44 (0)20 8065 0324
Email: office@gpilondon.com
www.gpilondon.com