Discredited policy of coronavirus “herd immunity” placed in stark relief

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1 June 2020

Last week, the *New York Times* published a sobering piece on the prevalence of the coronavirus in the population headlined, “The World Is Still Far from Herd Immunity for Coronavirus.” They wrote, “Official case counts often substantially underestimate the number of coronavirus infections. But in new studies that test the population more broadly, the percentage of people who have been infected so far is still in the single digits.”

The threshold for population immunity to the coronavirus, one that naturally drives down the growth of community transmission, remains speculative, but consensus has placed it above 60 percent and some cite over 80 percent. Current seroprevalence studies for antibodies to SARS-CoV-2 in the population have recently been estimated (modeling via Imperial College London):

- New York City, 19.9 percent have antibodies—May 2
- Boston, 9.9 percent—May 15
- London, 17.5 percent, with the UK’s national average at 5 percent—May 21
- Madrid, 11.3 percent, with Spain’s national average at 5 percent—May 13
- Barcelona, 7.1 percent—May 13
- Stockholm, 7.3 percent—May 20
- Wuhan, 10.0 percent of returning workers—April 20
- US national average, 4.1 percent—May 21

However, these estimates must be taken with a considerable grain of salt. Even the Centers for Disease Control and Prevention (CDC), whose absence during the pandemic has been underscored by many epidemiologists and scientists, has gone on record recently writing:

> Serologic test results should not be used to make decisions about grouping persons residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities. Serologic test results should not be used to make decisions about returning persons to the workplace. In most of the country, including areas that have been heavily impacted, the prevalence of the SARS-CoV-2 antibody is expected to be low, ranging from less than 5 percent to 25 percent, so that testing at this point might result in relatively more false-positive results and fewer false-negative results.

This poses a conundrum in that the individual testing positive for antibodies does not have a definite guarantee they are truly protected. For those that do carry antibodies, the length of time such immunity remains present is unclear. For instance, immunity to SARS after exposure seems to wane after two years. “It cannot be assumed that individuals with truly positive antibody test results are protected from future infection,” the CDC writes in their updated guidelines. “Serologic testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity are established.”

Sweden was hailed as the poster child by those such as opinionated *New York Times* columnist Thomas Friedman, who advocated for “a surgical-vertical” herd immunity policy. Such a policy would attempt to isolate and protect the vulnerable while placing the younger and healthier layers in harm’s way to eventually acquire population immunity to protect the economy from the catastrophe caused by national lockdowns. “Wait a minute!” he wrote. “What the hell are we doing to ourselves? To our economy? To our next generation? Is this cure—even for a short while—worse than the disease?” These statements consciously sought to establish state policy on the pandemic.

So, what did happen in Sweden? The government’s lack of intervention and call for “personal responsibility” to slow the spread resulted in a 10-day average of almost 600 daily new cases in April, two to six times higher than the peak of its neighbors, who quickly decelerated the infection rate in their respective countries by imposing strict limits on economic activity and population movement.

The cumulative deaths in Sweden had reached 350 per million by mid-May and continue to rise (now at 435 deaths

per million). In contrast, Denmark, Finland, Norway and Iceland have kept their numbers under 100 deaths per million and have virtually halted the rise in the number who succumb from the infection. It is not surprising that many have now emphatically decried Sweden's experiment as untenable and insane. However, the commercial doors have been flung open, and workers have been forced back to the factories and warehouses.

Imperial College, based on their latest modeling projections, estimated that the prevalence of COVID-19 in the US population is approximately 4 percent. With 331 million people in the US, this means that 317 million people remain vulnerable because they have no natural immunity. Accepting the minimum threshold of 60 percent to achieve population immunity, this begs the question: can the working class face an assault on its communities and neighborhoods 15 more times than what it has already been through? Put another way, is the policy of herd immunity being proposed by the ruling class to save its profits and wealth, strangulated by the lockdowns, worth the social catastrophe of culling the working class until sufficient numbers have been infected that the natural course of the infection will burn itself out?

The first reference within the scientific community to population immunity (concepts now understood as herd immunity) from a viral pathogen was made in published observations in 1933 by a Baltimore physician, Dr. A. Hedrich, in an article titled, "Monthly estimates of the child population susceptible to measles, 1900-1931."

He found that the incidence of measles in Baltimore would fluctuate, having a periodicity of two to three years. Just before a major outbreak, the fraction of the population under the age of 15 that was susceptible ranged from 45 to 50 percent. When the epidemic began to fade, the proportion of vulnerable children had fallen to 30 to 35 percent. He concluded that when the population immunity grew above 55 percent, the measles epidemic became contained.

Authors of a public health statement, "Epidemiologic basis for eradication of measles in 1967," published in March 1967 when efforts were being made to eliminate measles from the US, wrote, "It is difficult to estimate whether the threshold of herd immunity for an average American city now would be higher or lower than Hedrich's estimate for Baltimore 30 to 70 years ago. Obviously, a considerable variability must be assumed for this threshold from urban area to urban area and within varying ethnic and socio-economic groups in a single urban area. There is no reason, however, to question the validity of the basic assumption that the occurrence of measles epidemics depends upon the balance of immunes and susceptibles …"

The authors of the 1967 article concluded that in addition to the routine and universal immunization of infants and school children, they endorsed intensive efforts on the part of local, state and federal health authorities to develop practical surveillance efforts and infrastructure for immediate epidemic control by "verifying the diagnosis, trace the source of infection, detect other unreported cases, and determine exposed susceptible contacts."

The primary goal of this universal vaccination and public health program was to establish a high level of population immunization. "If such immunization programs are carried out promptly and effectively, an epidemic of measles can be contained within two to three weeks. The continuation of an epidemic longer than three weeks is a clear indication of the inadequacy of the planned program." It warrants observing that these assessments and prognoses were provided over 50 years ago, although federal funding issues impeded the initiation of a broad measles program in the US once a vaccine was available. Measles is six times more contagious than SARS-CoV-2.

Minus a vaccine for broad-based public immunization against the coronavirus, fundamental public health measures—contact tracing, testing, tracking, isolation and treating—remain the cornerstone of curbing the ravages of the pandemic. Given the present technology and medical advances, a collaborative effort to find a vaccine or therapeutic is of primary concern. Such initiatives must quickly be scaled and delivered on a global basis according to guidelines established by medical experts and epidemiologists.

Calls for a policy of herd immunity come from the most reactionary voices within the financial oligarchy who use the media to provide social or scientific credibility for their deadly agenda. The implications for the US are that 1.4 million more people will have to die, 3 million to 5 million more people will be hospitalized, with many more convalescing at home and needing care from their family, before the population as a whole could expect the virus's growth to become naturally subdued. Public health measures have already proven much more effective and manageable in many countries, calling into serious question the unhinged policies being promoted. The doctrine of herd immunity is an explicit policy for a socioeconomic pogrom.