

Studies on COVID-19 antibody response undermine US ‘herd immunity’ policy

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The unstated but nonetheless official US government policy toward coronavirus is “herd immunity”—letting the pandemic rip until so many people have survived the infection that their immunity will block further spread.

This policy is homicidal, in the literal sense of the word. The federal and state governments are allowing tens of millions to be infected by a disease which will kill a large number of them, perhaps millions, rather than undertake the systematic campaign of testing, contact tracing and isolating those infected or exposed, which would halt the spread of the disease before it rages entirely out of control.

After two and a half months of 20,000-plus daily COVID-19 cases, the reopening of the country for business and commerce in violation of the rules set by health agencies like the Centers for Disease Control and Prevention is leading to a resurgence of cases in the Carolinas, Florida, Texas, Arizona and California without attempts to impose new restrictions.

“We can’t shut down the economy again. I think we’ve learned that if you shut down the economy, you’re going to create more damage,” Treasury Secretary Steve Mnuchin told CNBC.

According to a Tucson ICU nurse, writing for a local online paper, *Tucson Sentinel*, “the second wave in Arizona has hit far worse than the first. We have been balancing around full capacity at all times over the past weeks. COVID-19 is real, despite an insane number of people on social media believing the hoax or that it’s just the flu and people shouldn’t worry. I have never looked around my 100 percent full ICU and genuinely thought that there is the possibility of NO survivors.”

But will herd immunity actually provide the population guaranteed protection? The hypothesis on which the policy is based, one that is essentially

unproven, is that those who have the good fortune to survive the infection will develop robust antibodies to prevent second infections. Some recent studies have shed light on this question.

In a recent analysis of 370 individuals with known COVID-19 infections whose serums were held at the New York Blood Center, 96 percent had detectable antibodies to one of the viral proteins. Testing against two other proteins produced by the virus showed 85 and 89 percent of this population had antibodies. Two percent had no detectable antibodies.

Using sophisticated assays, the researchers were also able to quantify the amount of antibody infected individuals produced. As the authors noted, the level of neutralizing antibodies varied over a broad range, with some showing as much as 40,000 times more than others. The concern is that this may correlate with the amount of protection that may be offered, meaning that many people, after surviving COVID-19, will still be susceptible to it again.

Another study conducted in the UK, corroborating the findings in the New York study, noted that up to 8.5 percent of people infected with COVID-19 did not develop antibodies. The study led by researchers at St George’s, University of London and St George’s University Hospitals NHS Foundation Trust had analyzed antibody tests results from 177 patients with previous COVID-19 infections. Those patients that developed antibodies had a stable response for almost two months. Patients having the most severe infections with excessive inflammatory response (mainly those older or with obesity and hypertension) were more likely to develop antibodies, according to the *Daily Telegraph*. The study suggested that asymptomatic patients are less likely to develop a sustained immune response.

Professor Sanjeev Krishna, corresponding author on the paper, said, “We need to understand how best to interpret the results from these tests to control the spread of the virus, as well as identifying those who may be immune to the disease.”

The immunity to the virus is not as robust as had been hoped by investigators, and no one yet knows what level of neutralizing antibodies are required to offer protection. This has considerable implications for vaccine productions, as vaccine efficacy seems to hinge on the ability to demonstrate consistently high levels of neutralizing antibodies.

The WHO, having fumbled a question on asymptomatic patients during one of their press conferences last week, have clarified their statements with data. They stated that 16 percent of people with COVID-19 are asymptomatic, but these individuals can still transmit the infection to others. Determining the proportion of the population that is asymptomatic but nonetheless infected and contagious is critical to knowing how the disease is transmitted. Other studies had indicated that 40 percent of coronavirus transmissions have occurred through people who do not display overt symptoms of infection.

In a recent study published in the *New England Journal of Medicine*, the authors explained that transmissibility of the infections is linked to a high level of SARS-CoV-2 that is shed in the upper respiratory tract, including by those who are considered pre-symptomatic. In a skilled nursing facility in Washington state, a symptomatic health worker tested positive for the SARS-CoV-2 virus by PCR testing, leading to a facility-wide screening on March 13 and then March 20. Among 76 residents at the facility, 48 (63 percent) had positive tests, of whom 27 were essentially asymptomatic.

However, 24 of the 27 asymptomatic individuals would go on to develop symptoms over the next four days. Seventeen of these 24 patients had viable virus cultured up to six days before they developed symptoms. Of note, 26 percent of all the residents who tested positive subsequently died. The authors wrote, “symptom-based screening alone failed to detect a high proportion of infectious cases and was not enough to control transmission in this setting.”

These small studies highlight the difficulty in using symptom-based strategies to control the transmission of

the virus and demonstrate the rapid transmission of the virus once it insinuates itself in locations like nursing facilities, crowded markets, political rallies, choir rehearsals at church, and, of course, large factories.

Recently, the city of Wuhan in China conducted an aggressive campaign to test the entire population over the course of several days, finding several hundred asymptomatic patients. Mass testing of residents of nursing facilities and other congregated populations such as hospitals, mental health facilities and prisons becomes an essential component of a public health strategy to contain the virus.

It is critical that workers at Ford, GM and FCA, or meatpackers, industrial workers in general, demand a much more robust and comprehensive strategy to ensure safe work environments.

The CDC has asserted in its guidelines that “asymptomatic transmission enhances the need to scale up the capacity for widespread testing and thorough contact tracing to detect asymptomatic infections, interrupt undetected transmission chains, and further bend the curve downward.”

But the public health infrastructure in the US is a hollowed-out shell without the resources to carry out such a project. It is not that the resources do not exist in American society. If even a fraction of the trillions of dollars of public funds diverted into the financial markets had been set aside instead for public health, the necessary infrastructure to stem the infection could be set up in a matter of weeks.

The failure to make such an effort is not a mistake or an oversight, but a coldly calculated policy to let countless numbers of elderly and infirm people die, since they are no longer able to produce profits for the financial elite, while forcing large numbers of people of working age back into the factories and other workplaces at terrible risk to their health and lives. It is a deliberate “culling” of the proletarian “herd,” as far as the capitalists are concerned.



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