Why “living with the virus” is a bankrupt strategy for fighting COVID-19

The case for a global elimination strategy

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The *World Socialist Web Site* and the International Workers Alliance of Rank-and-File Committees are holding a forum October 24 with leading scientists to discuss what is required to bring an end to the coronavirus pandemic. This requires a full-on political struggle against the policy pursued by the ruling elite all over the world, now under the rubric of “living with the virus,” although this was described last year as attaining “herd immunity.”

The more primitive form of the “herd immunity” argument, put forward by Brazilian President Jair Bolsonaro, British Tory Prime Minister Boris Johnson and former US president Trump, is that nothing should be done to fight the virus that in any way interferes with, or even inconveniences, the profit-making of the capitalist class.

A slightly more sophisticated argument has emerged in the wake of the development of multiple, highly effective vaccines, which goes something like this: the combination of the natural immunity conferred by contracting and surviving COVID-19 and the immunity conveyed by vaccination will make enough of the population immune that the virus will lack sufficient hosts to propagate itself. SARS-CoV-2 will then die a natural death.

This ignores several inconvenient, but fully proven, scientific facts about the nature of SARS-CoV-2, and particularly the Delta variant—to say nothing of possible new variants—and the experiences derived from more than 18 months of efforts to combat the pandemic.

Above all, there is the stark realization that it may not be possible to achieve the threshold for ending the pandemic despite a high level of population immunity from previous infections and vaccinations. The modeling done by Dr. Malgorzata Gasperowicz shows that a strategy based on vaccination only will lead to continued community transmission, because the transmissibility of the Delta variant is much greater than for the previous variants.

This is being objectively verified now in real-world experience. Ireland has fully vaccinated 90 percent of its adult population, which means population immunity from COVID vaccines is at 75 percent.

However, Ireland is seeing a rise in cases of COVID among the elderly. Professor Kingston Mills, an immunologist at Trinity College Dublin, told the *Irish Times* that breakthrough infections were occurring among those who received their doses more than six months ago. The current seven-day average is spiking again, with more than 1,600 infections per day.

Additionally, data from SeroTracker, a global SARS-CoV-2 seroprevalence dashboard built by researchers from Canada and the UK, found that by March 3, 2021, the seroprevalence of SARS-CoV-2 antibodies from England, Wales, Scotland and Northern Ireland ranged from 22.3 to 34.6 percent. Even taking into account that some survivors of COVID-19 were later vaccinated, so there is an overlap between infection totals and vaccination totals, the immunity in the population from both sources combined is considerable.

Britain, of course, is being ravaged by the latest surge in COVID-19, accounting in the recent period for more daily cases than France, Germany, Italy and Spain combined.

Infection confers little immunity

On the other end of the spectrum are countries that have endured repeated ravages from the virus with virtually no vaccination and find no build-up of immunity in the population due to infection.

In Iran, a country of 84 million people, there have been 5.77 million reported COVID-19 cases and 124,000 reported deaths. However, these numbers clearly underrepresent the real state of the pandemic in Iran. According to a recent study in preprint from the University of Oxford, excessive deaths reached 241,000 by mid-September, when the fifth wave of the pandemic was receding. Astoundingly, in several provinces the attack rate exceeded 100 percent. In several provinces like Kurdistan, North Khorasan, and Qazvin, the attack rates reached between 150 and 200 percent.

According to the CDC, the term “attack rate” is often used as a synonym for the risk of getting the disease during a specified period, such as the duration of an outbreak. It is defined as the percentage of an at-risk population that contracts the disease during a specified time interval. If population immunity was reaching a threshold of immunity, the at-risk population would theoretically be falling.

When the authors calculated the overall population attack rate over the course of the pandemic, they said, “Our results are striking as they show very high attack rates across the country with more than 100 percent attack rates in 11 provinces. … Our findings of high attack rates in several provinces show that herd immunity through natural infection has not been achieved in the population even after nearly 20 months since the start of the Iranian epidemic. This is likely due to substantial reduction in protection against repeat infection over time due to waning immunity, increased chance of reinfection with variants of concern, or a combination of both.”

Professor Nancy Delagrave from Montreal, tweeted a cautionary note regarding the above study, “Let me repeat this: On average, it was estimated at the end of January 2021, the citizens of Sistan and Baluchistan had been infected on average 1.2 times in a year. But the combined fourth and fifth wave were still the deadliest and each person have COVID 2.5 times overall on average.”

In India, before the staggering spring wave that killed close to 5,000

people per day, SARS-CoV-2 had already spread widely throughout the country. A national serosurvey reported in January 2021 found that 21.4 percent of adults and 25.3 percent of adolescents were carrying antibodies to the virus. In New Delhi, the seropositivity ranged from 40.1 percent to 62.2 percent across eleven districts. Public health officials had expected that this level of immunity would have conferred some level of herd immunity from future outbreaks. This was, like many previous assumptions, erroneous and deadly.

New Delhi was among the cities hardest hit by the Delta variant during the spring wave. By mid-April, daily cases had risen to more than 20,000 per day, and the health system had crumbled. Essentially every hospital was turned into an entire COVID care-only facility. Medical students and physicians from alternative professions were enlisted to render medical assistance.

A subsequent analysis of population seropositivity in Delhi found that by July the figure had risen to 87.5 percent of the unvaccinated population. As the study notes, "Overall, the genomic and epidemiologic data were most consistent with the hypothesis that a new variant with higher infectivity, Delta, was driving the unexpected overwhelming surge in Delhi." They also found among those previously infected, between 10 percent and 50 percent were reinfected with the Delta variant.

In the US, before the late summer wave, scientists had estimated that because of the combined effect of previous infections and vaccines, approximately 83.3 percent of the population had some level of immunity. In three short months, the surge that continues to ripple through the Midwest, Southern and rural communities led to 10 million more infections and 114,000 additional deaths, despite the high levels of community immunity. In fact, during September, COVID-19 rose to the second leading cause of death in the US.

In a report published in *Nature* in March 2021, scientists were already recognizing that the threshold to reaching herd immunity would be elusive under the current circumstances. Lauren Ancel Meyers, an epidemiologist and executive director of the University of Texas Austin COVID-19 Modeling Consortium, stated at the time, "We're moving away from the idea that we'll hit the herd-immunity threshold and then the pandemic will go away for good: The vaccine will mean that the virus will start to dissipate on its own. But as new variants arise and immunity from infections potentially wanes, we may find ourselves months or a year down the road still battling the threat and having to deal with future surges."

In a recent report in the *Guardian*, anecdotal reports of people in the UK catching COVID-19 two or three times are becoming common place. Citing new analyses, they wrote, "unvaccinated individuals should expect to be reinfected with COVID-19 every 16 months, on average." These corroborate evidence cited in the Oxford study on Iran. As Stephen Griffin, associate professor of virology at the University of Leeds noted, "If you've got high-level of prevalence, and frequent exposure to the virus, as you have in schools, you are going to see more and more people getting reinfected despite having been double vaccinated."

New sub-lineages of the Delta variant

Events are taking over these assessments on the Delta variants as new strains of this particular iteration of the coronavirus are paving way to possibly more transmissible and virulent lineages.

A recent concerning development has found a Delta sub-lineage of the coronavirus dubbed AY.23 rose rapidly in Singapore during July, completely displacing the "ancestral" Delta strain. By mid-August, Singapore witnessed a dramatic surge in cases with daily infection rates three to four-fold higher than the initial waves in 2020, with approximately 3,000 new cases each day. Hospitalizations have soared over the month. ICU admission has climbed from less than 50 patients to now 372. Essentially, all cases are now associated with locally transmitted cases. Seventy-five percent of all cases in July were among the vaccinated and partially vaccinated.

Despite these developments, the government decided to pivot to a strategy of living with the virus. More than 80 percent of the population had been fully vaccinated, and the country aimed to reach 90 percent before the winter months. They had begun to allow dining-in at restaurants, lifting some of the working-from-home rules and raising group sizes to five for those fully vaccinated. However, these recent developments have led the health authorities to pause the opening of their economy.

Another Delta subvariant of concern is the AY.4.2 lineage that rapidly began to climb in the UK during July 2021, accounting for almost 10 percent of sequenced viruses currently. Approximately two-thirds of the country has been vaccinated, and one-sixth has been infected previously, meaning that infections continue to soar despite a considerable population immunity.

As the graph below demonstrates, the rapid rise in the AY.4 lineage implies that it can evade the current level of immunity and is a better fit for the UK population than the previous Delta strain. Since the beginning of summer, the UK has faced persistently high community transmissions, with daily cases exceeding 40,000. On Monday, new cases of COVID almost reached 50,000.

According to the *Financial Times*, Jeffrey Barrett, director of the COVID-19 Genomics Initiative at the Wellcome Sanger Institute in Cambridge, and Francois Balloux, director of the University College London Genetics Institute, said that AY.4.2 could be 10 to 15 percent more transmissible than the original Delta, which came to dominate the pandemic in the few short recent months.

A strategy for elimination

The attempts to call for a policy of herd immunity to allow the virus to become endemic pose immense dangers for the working class. Experience is emerging that herd immunity in the context of changing variants and waning immunity, as well as unequal distribution of the COVID vaccines, implies the pandemic will continue to disrupt life and livelihood for possibly many more months or years.

Bringing an end to the pandemic cannot be left to the "natural" workings of infection-derived immunity combined with mass vaccination—and in half the globe, mass vaccination remains years into the future, if ever, because of the inequality in the distribution of vaccines and the health infrastructure to deliver them.

Moreover, population immunity is by no means the only, or even the preferred method of stamping out a deadly communicable disease, as historical experience has shown. Elimination or eradication of a disease can be achieved through the scientific combination of targeted vaccination campaigns and public health measures, whose characteristics must be tailored to the nature of the disease.

In a recent publication in *BMJ Global Health*, Dr. Michael G. Baker and his colleagues at the University of Otago, Wellington, New Zealand, observe that population immunity was never achieved with smallpox. The ring vaccination strategy, the vaccination of all suspected individuals within a prescribed area around an outbreak of smallpox, was employed to bring the last case of the disease to an end in 1977. By creating a buffer of immune individuals, the disease could be contained from spreading to

other regions. This can also be achieved by the globe. As experience with waning immunity and evolving variants is growing, vaccines function as stopgap measures that buy humanity additional time.

Baker et al. highlight that through coordinated global cooperation, the world eradicated smallpox, rinderpest (a disease of cattle), and two of three poliovirus serotypes. With the elimination of malaria in China, 40 countries have now been certified as malaria-free. Measles, mumps and rubella have been eliminated in many countries, with global measles deaths having declined by more than 80 percent over the last two decades. But the same political indifference and inadequate prioritization are seeing the resurgence of these diseases deemed technically feasible to eradicate. Effective preventative vaccines are widely available.

In the case of coronavirus, countries that include Australia, China, New Zealand, Singapore, Taiwan and Vietnam demonstrated that the disease could be eliminated even before vaccination was available. Border control, physical distancing, the universal wearing of masks, a high level of testing with rapid result turnaround, genomic sequencing, contact tracing, infrastructure for isolation and quarantine, and, most importantly, political will were required.

The authors wrote, “On our scoring for eradicability using a three-point relative scale across 17 variables … it does seem to put COVID-19 into the realms of being possible [when compared to smallpox and polio], especially in terms of technical feasibility.” In fact, the authors considered eradicating COVID-19 more feasible than polio. However, the concerns they cited were with vaccine hesitancy among the population and the emergence of more transmissible and immune-evading strains. More problematic, they concede, is achieving the “necessary international cooperation” as evidenced by “vaccine nationalism” and government-mediated “anti-science disinformation.”

The principal barrier to the elimination of COVID-19 off the face of the globe is the profit-driven system of health care, and the division of the world into rival nation-states: in other words, capitalism.