

# The Great Barrington Declaration

The Great Barrington Declaration – As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.

As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives

normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.

Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19. By way of example, nursing homes should use staff with acquired immunity and perform frequent testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their home. When possible, they should meet family members outside rather than inside. A comprehensive and detailed list of measures, including approaches to multi-generational households, can be implemented, and is well within the scope and capability of public health professionals.

Those who are not vulnerable should immediately be allowed to resume life as normal. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold. Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.

*On October 4, 2020, this declaration was authored and signed in Great Barrington, United States, by:*

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SIGN THE  
DECLARATION

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# Why Was The Declaration Written?

how did the great barrington  
declaration come about?

**Why was the Declaration written?**

The Declaration was written from a global public health and humanitarian perspective, with special concerns about how the current COVID-19 strategies are forcing our children, the working class and the poor to carry the heaviest burden. The response to the pandemic in many countries around the world, focused on lockdowns, contact tracing and isolation, imposes enormous unnecessary health costs on people. In the long run, it will lead to higher COVID and non-COVID mortality than the focused protection plan we call for in the Declaration.

**Who is the intended audience?**

This is an international declaration, written with concerns for the entire world. It was written for the public, fellow scientists, and government officials.

**Who wrote the Declaration?**

The Declaration was written by Dr. Jay Bhattacharya, Dr. Sunetra Gupta and Dr. Martin Kulldorff. A family member and a journalist helped with phrasing, grammar, and proof reading. Nobody else saw the declaration before it was completed in its final form.

### **When was the Declaration written, signed and released?**

The Declaration was written from October 2 to October 4, 2020. It was signed on October 4, after which it was sent to scientific colleagues. It was released to the public on October 5.

### **Who initiated the Declaration?**

Dr Kulldorff invited Dr Bhattacharya and Dr Gupta to Massachusetts to record a video outlining an alternative to the current COVID-19 strategy. While meeting, the three spontaneously decided to also write a short Declaration to summarize the thinking.

### **Why was the Declaration signed in Great Barrington?**

The Declaration was written and signed at the American Institute for Economic Research, located in Great Barrington, Massachusetts. The Institute kindly offered to help with the video recording, providing a location, equipment and a camera man pro bono.

### **How were the co-signers selected?**

After finishing the Declaration, the three authors emailed a few colleagues asking them if they would co-sign. Most agreed. These original 30+ co-signers are listed on the front page, together with others that were added later.

### **Can anyone sign the Declaration?**

Yes. Through the [online form](#).

### **Are all the online signatures real?**

No. Some pranksters added fake signatures such as Dr. Johnny Bananas, Prof. Spon'Ge'Bob SQ.UarePants, Dr. Neal Ferguson, Prof. Ware Thamask,



and Dr. Person Fakename. In a strange twist, one journalist bragged on Twitter about adding fake names, after which other journalists criticized the Declaration for having fake signatures. Anyhow, the fake signatures are less than 1% of the total, and most have been removed from the count tracker.

### **Was anyone paid to write or sign the Declaration?**

None of the authors or co-signers received any money, honoraria, stipend, or salary from anyone for either the Declaration or the video recording.

### **Do the three authors have any conflicts of interest?**

Dr. Kulldorff works on research grants from the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration and the non-profit Fund for Public Health in New York City, some of which is related to COVID-19. He has never accepted or received any funding from pharmaceutical companies, nor from any other large corporation.

Dr. Bhattacharya research funding over the past 22 years of his career has come almost entirely from grants from the National Institutes of Health, the National Science Foundation, the US Department of Agriculture, and participation on contracts with the Center for Medicare and Medicaid Services (CMS) and the Food and Drug Administration (FDA) via a government contracting research group, Acumen, LLC. He has never accepted or received any funding from pharmaceutical companies, nor from any other large corporation.

Dr. Gupta's research funding over the last 30 years has principally been through fellowships and investigator awards from the Wellcome Trust and the European Research Council. She has also received funding from the UKRI, the Royal Society, the Leverhulme Trust, the Emily and Georg von Opel Foundation and the Oxford Martin School. She and Dr. Craig Thompson have developed a novel method for producing a universal

influenza vaccine (derived from a mathematical model) and this has now been licensed and is going through early testing. She does not hold any consultancy contracts or stock shares in any commercial company.

Official Social Media for Great Barrington Declaration



# Great Barrington DECLARATION

Contact: [info@gbdeclaration.org](mailto:info@gbdeclaration.org)

Have questions? [Check out the FAQ](#)

## Focused Protection: The Middle Ground between Lockdowns and "Let it Rip."

Jay Bhattacharya, Sunetra Gupta, Martin Kulldorff

November 25, 2020

Both COVID-19 itself and the lockdown policy reactions have had enormous adverse consequences for patients in the US and around the world. While the harm from COVID-19 infections are well represented in news stories every day, the harms from lockdowns themselves are less well advertised, but no less important. The patients hurt by missed medical visits and hospitalizations due to lockdowns are as worthy of attention and policy response as are patients afflicted by COVID-19 infection.

In a recent JAMA sponsored COVID-19 debate with infectious disease epidemiologist Prof. Marc Lipsitch, Dr. Jay Bhattacharya argued against lockdowns and its collateral damage on medical care and public health.<sup>1</sup> At the conclusion of the debate, the moderator, JAMA editor Dr. Howard Bauchner asked whether there may exist a middle ground in COVID policy. That is the right question. Is there a middle ground between lockdowns – with school, business and office closures, curfews, and isolation – and a laissez-faire "let it rip" approach?

In the Great Barrington Declaration, co-signed now by many thousand medical scientists and practitioners, we laid out such a middle-ground alternative, with greatly improved *focused protection* of older people and other high-risk groups.<sup>2</sup> The aim of *focused protection* is to minimize overall mortality from both COVID-19 and other diseases by balancing the need to protect high-risk individuals from COVID-19 while reducing the harm that lockdowns have had on other aspects of medical care and public health. It recognizes that public health is concerned with the health and well-being of populations in a broader way than just infection control.<sup>3</sup>

This may surprise some readers given the unfortunate caricature of the Declaration, where some media outlets and scientists have falsely characterized it as a "herd immunity strategy" that aims to maximize infections among the young or as a *laissez-faire* approach to let the virus rip through society. On the contrary, we believe that everyone should take basic precautions to avoid spreading the disease and that no one should intentionally expose themselves to COVID-19 infection. Since zero COVID is impossible, herd immunity is the endpoint of this epidemic regardless of whether we choose lockdowns or focused protection to address it.

The premise of the Declaration lies on two scientific facts. First, while anyone can get infected, there is more than a thousand-fold difference in COVID-19 mortality<sup>4,5</sup> between the oldest and youngest. Children have lower mortality from COVID-19<sup>6</sup> than from the annual influenza.<sup>7</sup> For people under the age of 70, the infection survival rate is 99.95%.<sup>8</sup> We now have good evidence on the relative risk posed by the incidence of chronic conditions, so we know that among common conditions, age is the single most important risk factor. For instance, a 65-year-old obese individual has about the same COVID-19 mortality risk conditional upon infection as a 70-year-old non-obese individual.<sup>9</sup>

Second, the harms of the lockdown are manifold and devastating, including plummeting childhood vaccination rates<sup>10</sup>, worse cardiovascular disease outcomes<sup>11</sup>, less cancer screening<sup>12</sup>, and deteriorating mental health<sup>13</sup>, to name a few. The social isolation induced by lockdown has led to a sharp rise in opioid and drug-related overdoses<sup>14</sup>, similar to the "deaths of despair" that occurred in the wake of the 2008 Great Recession.<sup>15</sup> Social isolation of the elderly has contributed to a sharp rise in dementia-related deaths around the country.<sup>16</sup> For children, the cessation of in-person schooling since the spring has led to "catastrophic" learning losses<sup>17</sup>, with severe projected adverse consequences for affected students' life spans.<sup>18</sup> According to a CDC estimate, one in four young adults seriously considered suicide this past June.<sup>19</sup> Among 25 to 44-year olds, the CDC reports a 26% increase in excess all-cause mortality relative to past years, though fewer than 5% of 2020 deaths have been due to COVID-19.<sup>20, 21</sup>

The harms of lockdown are unequally distributed. Economists have found that only 37% of jobs in the US can be performed wholly on-line, and high-paying jobs are overrepresented among that set.<sup>22</sup> By declaring janitors, store clerks, meat packers, postal workers, and other blue-collar workers as "essential" workers in most states, regardless of whether they qualify as high COVID mortality risk, the lockdowns have failed to shield the vulnerable in these occupations. The economic dislocation from the lockdowns has increased the number of households where young adults who have lost their jobs co-reside with vulnerable older parents<sup>23</sup>, which may increase the risk of COVID-related death.<sup>24</sup> In addition, school closures have contributed to shortages of nurses and other medical personnel who stay home to care for their children rather than work.<sup>25</sup> Very clearly, exposing people to the medical and psychological harms from the lockdowns is ethically fraught.<sup>26</sup>

The two main planks of focused protection and the Great Barrington Declaration follow logically from these two facts. For older people, COVID-19 is a deadly disease that should be met with overwhelming resources aimed at protecting them wherever they are, whether in nursing homes, at their own home, in the workplace, or in multi-generational homes. For the non-vulnerable, who face far greater harm from the lockdowns than they do from COVID-19 infection risk, the lockdowns should be lifted and – for those who so decide – normal life resumed.

Lockdown proponents assert without evidence that the only way to protect the older vulnerable population is to limit general community transmission, in effect arguing that focused protection is impossible. We disagree. Standard public health practice regularly seeks creative ways to protect vulnerable people from a host of diseases and conditions that threaten them, and COVID-19 should not be an exception. In many publications<sup>27,28,29</sup> and at the Great Barrington Declaration site itself<sup>30</sup>, we have delineated many practical policies to this end. These include, e.g., frequent on-site testing and limiting staff rotations in nursing homes, free home delivery of groceries for the home-bound vulnerable, providing disability job accommodations for older vulnerable workers, and temporary accommodations for older people living in multi-generational homes. The prospect of effective and safe COVID-19 vaccines offer an additional avenue for

improved focused protection of high-risk individuals, both directly and by vaccinating caregivers. Still, better protection of the elderly cannot and should not wait until a vaccine is widely available.

Inconsistent with the standard pandemic preparedness plans that existed before the COVID-19 epidemic, lockdowns are, and have always been, a radical approach to infection control.<sup>31</sup> Focused protection is the middle ground that will end the pandemic with the least harm to the vulnerable and non-vulnerable alike.

## References

- <sup>1</sup> JAMA Network (2020) *Herd Immunity as a Pandemic Strategy*. JAMALive. Nov. 6, 2020. [https://www.youtube.com/watch?v=2tsUTAWBJ9M&feature=emb\\_title](https://www.youtube.com/watch?v=2tsUTAWBJ9M&feature=emb_title)
- <sup>2</sup> Kulldorff M, Gupta S, and Bhattacharya J (2020) Great Barrington Declaration, Oct. 4, 2020. <https://gbdeclaration.org/>
- <sup>3</sup> Public Health Leadership Society (2002) Principles of the Ethical Practice of Public Health. American Public Health Association. [https://www.apha.org/-/media/files/pdf/membergroups/ethics/ethics\\_brochure.ashx](https://www.apha.org/-/media/files/pdf/membergroups/ethics/ethics_brochure.ashx)
- <sup>4</sup> Kulldorff M. (2020) COVID-19 Counter Measures Should be Age Specific. LinkedIn Memo. April 10, 2020. <https://www.linkedin.com/pulse/covid-19-counter-measures-should-age-specific-martin-kulldorff/>
- <sup>5</sup> Chikina M and Pegden W (2020) Fighting COVID-19: The Heterogenous Transmission Thesis. Mimeo. Carnegie Mellon University. March 16, 2020. <http://math.cmu.edu/~wes/covid.html>
- <sup>6</sup> CDC (2020) Provisional COVID-19 Death Counts by Sex, Age, and State. Nov. 24, 2020. <https://data.cdc.gov/NCHS/Provisional-COVID-19-Death-Counts-by-Sex-Age-and-S/9bhg-hcku>
- <sup>7</sup> CDC (2020) Estimated Influenza Illnesses, Medical visits, Hospitalizations, and Deaths in the United States — 2018–2019 influenza season. Nov. 24, 2020. <https://www.cdc.gov/flu/about/burden/2018-2019.html>
- <sup>8</sup> Ioannidis JP (2020) Infection Fatality Rate of COVID-19 Inferred from Seroprevalence Data. *Bulletin of the World Health Organization*. Article ID: BLT.20.265892. [https://www.who.int/bulletin/online\\_first/BLT.20.265892.pdf](https://www.who.int/bulletin/online_first/BLT.20.265892.pdf)
- <sup>9</sup> Public Health England (2020) Disparities in the Risk and Outcomes of COVID-19. August 2020. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/908434/Disparities\\_in\\_the\\_risk\\_and\\_outcomes\\_of\\_COVID\\_August\\_2020\\_update.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf)
- <sup>10</sup> CDC (2020) Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020. *MMWR*. 69(19): 591-3. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm>
- <sup>11</sup> Ball S, Banerjee A, Berry C, et al Monitoring indirect impact of COVID-19 pandemic on services for cardiovascular diseases in the UKHeart Published Online First: 05 October 2020. doi: 10.1136/heartjnl-2020-317870
- <sup>12</sup> Rutter MD, Brookes M, Lee TJ, et al Impact of the COVID-19 pandemic on UK endoscopic activity and cancer detection: a National Endoscopy Database AnalysisGut Published Online First: 20 July 2020. doi: 10.1136/gutjnl-2020-322179
- <sup>13</sup> Vizard T, Davis J, White E, Beynon B (2020) Coronavirus and depression in adults, Great Britain: June 2020. Office for National Statistics, UK. <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/june2020>
- <sup>14</sup> American Medical Association (2020) Issue Brief: Reports of Increases in Opioid- and Other Drug Related Overdose and Other Concerns During COVID Pandemic. AMA Advocacy Resource Center. Oct. 31, 2020. <https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf>

- <sup>15</sup> Deaton A and Case A (2020) Deaths of Despair and the Future of Capitalism. Princeton University Press. March 17, 2020.
- <sup>16</sup> Alzheimer's Impact Movement (2020) The 2020 COVID-19 Pandemic and Dementia: Deaths Above Average. <https://www.scribd.com/document/483085777/Dementia-Deaths-Above-Average-State-by-State-Table>
- <sup>17</sup> Center for Research on Education Outcomes (2020) Estimates of Learning Loss in the 2019-2020 School Year. CREO Stanford University. October 2020. [https://credo.stanford.edu/sites/g/files/sbiybj6481/f/short\\_brief\\_on\\_learning\\_loss\\_final\\_v.3.pdf](https://credo.stanford.edu/sites/g/files/sbiybj6481/f/short_brief_on_learning_loss_final_v.3.pdf)
- <sup>18</sup> Christakis DA, Van Cleve W, Zimmerman FJ. Estimation of US Children's Educational Attainment and Years of Life Lost Associated With Primary School Closures During the Coronavirus Disease 2019 Pandemic. *JAMA Netw Open*. 2020;3(11):e2028786. doi:10.1001/jamanetworkopen.2020.28786
- <sup>19</sup> Czeisler ME, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1049–1057. DOI: <http://dx.doi.org/10.15585/mmwr.mm6932a1>
- <sup>20</sup> Rossen LM, Branum AM, Ahmad FB, Sutton P, Anderson RN. Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity — United States, January 26–October 3, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1522–1527. DOI: <http://dx.doi.org/10.15585/mmwr.mm6942e2>
- <sup>21</sup> CDC (2020) Provisional COVID-19 Death Counts by Sex, Age, and State. <https://data.cdc.gov/NCHS/Provisional-COVID-19-Death-Counts-by-Sex-Age-and-S/9bhg-hcku>
- <sup>22</sup> Dingel JI and Neiman B (2020) How Many Jobs Can Be Done at Home? National Bureau of Economic Research Working Paper #26948. April 2020
- <sup>23</sup> Evandrou M, Falkingham J, Qin M, and Vlachantoni A (2020) Changing Living Arrangements, Family Dynamics and Stress During Lockdown: Evidence from Four Birth Cohorts in the UK. University of Southampton Eprint Soton. [https://eprints.soton.ac.uk/443865/1/family\\_dynamics\\_during\\_covid\\_19\\_final.pdf](https://eprints.soton.ac.uk/443865/1/family_dynamics_during_covid_19_final.pdf)
- <sup>24</sup> Fenoll AA & Grossbard S (2020) Intergenerational residence patterns and Covid-19 fatalities in the EU and the US, *Economics & Human Biology*, 39. <https://doi.org/10.1016/j.ehb.2020.100934>.
- <sup>25</sup> Bayham J & Fenichel EP (2020) Impact of school closures for COVID-19 on the US health-care workforce and net mortality: a modelling study, *The Lancet Public Health* 5(5): e271-e278, [https://doi.org/10.1016/S2468-2667\(20\)30082-7](https://doi.org/10.1016/S2468-2667(20)30082-7).
- <sup>26</sup> Cristea, I. A., Naudet, F., & Ioannidis, J. P. A. (2020). Preserving equipoise and performing randomized trials for COVID-19 social distancing interventions. *Epidemiology and Psychiatric Sciences*. <https://doi.org/10.1017/S2045796020000992>
- <sup>27</sup> Kulldorff M, Gupta S, & Bhattacharya J (2020) We Should Focus on Protecting the Vulnerable from COVID Infection. *Newsweek*. Oct. 30, 2020. <https://www.newsweek.com/we-should-focus-protecting-vulnerable-covid-infection-opinion-1543225>
- <sup>28</sup> Bhattacharya J (2020) It's Time for an Alternative to Lockdown. Oct. 29, 2020. *The Spectator*. <https://www.spectator.co.uk/article/it-s-time-for-an-alternative-to-lockdown>

<sup>29</sup> Kulldorff M and Bhattacharya J (2020) Lockdown Isn't Working. Nov. 2, 2020. The Spectator. <https://www.spectator.co.uk/article/lockdown-isn-t-working>

<sup>30</sup> Kulldorff M, Gupta S, Bhattacharya J (2020) The Great Barrington Declaration, Frequently Asked Questions. <https://gbdeclaration.org/frequently-asked-questions/>

<sup>31</sup> European Centre for Disease Prevention and Control (2020) Influenza Pandemic Preparedness Plans. <https://www.ecdc.europa.eu/en/seasonal-influenza/preparedness/influenza-pandemic-preparedness-plans>



# FREQUENTLY ASKED QUESTIONS

## lockdowns and collateral damage

**How do you define lockdowns?**

Lockdowns consist of a variety of measures, such as schools and universities that are closed for in-person teaching, hybrid schools, closed or partially closed restaurants and other businesses, restrictions on sports and cultural events, extraordinary travel restrictions, work-from-home orders, cancelled medical and dental visits, curfews, quarantine regulations, etc.

**Do lockdowns have a successful history against infectious diseases?**

Basic epidemiological theory indicates that lockdowns do not reduce the total number of cases in the long run and have never in history led to the eradication of a disease. At best, lockdowns delay the increase of cases for a finite period and at great cost.

**Are governments still using lockdowns?**

At the end of 2020, governments around the world, including many states in the US, continue to restrict normal activities, and some are introducing additional lockdown restrictions. Many schools remain closed to regular in-person teaching, while many businesses, concert halls, and churches are closed or only permitted to operate at partial capacity. Lockdown remains a primary tool used by many governments to address the pandemic.

## What are the physical health impacts of lockdowns?

There are many physical health harms from lockdowns. Medical care visits have plummeted, with people avoiding needed medical care. This includes lower childhood vaccination rates, less cancer screening, skipped cancer treatments, fewer preventive cardiovascular disease visits, just to name a few. Many of the consequences of these missed visits will not show up in the mortality statistics for this year, but is something that we will have to live – and die – with for a long time.

## What are the mental health impacts of lockdowns?

Humans have many needs, including a need for community and ~~for~~ normal social interactions with one another. Mental health has deteriorated due to lockdowns and the fear caused by public health messaging. For example, in Massachusetts, emergency departments have seen about four times more children and teens in psychiatric crisis than usual. One in four young adults in the US seriously considered suicide this past June. Extending the lockdown over an indefinite period of time will multiply these harms.

## What are the harms from closing schools to in-person instruction?

All children have a right to a high-quality education. Adults have a moral obligation to make this happen, and it is morally wrong to ask children to bear a disproportionate burden of the costs of the epidemic. Yet the lockdown policy, and especially school closures, guarantees that children are especially harmed.

Online learning is not a good substitute for in-person teaching. For normal development, children have a strong need to socialize with other children, to make friends, and to play with one another. Schools are also the main point of contact with care systems and provide a refuge for disadvantaged children. Furthermore, the risk from dying from becoming infected by COVID-19 is for children is very low – lower than the risk of dying from the

seasonal flu. Schools do not close due to influenza, and neither should they close because of COVID-19.

### How do lockdowns specifically harm the working class?

Lockdowns especially harm the working class. As essential workers, or just to survive, they must work and be exposed to COVID even if they are at high-risk, building the population immunity that will eventually protect everyone. This, while low-risk college students and young professional lawyers, bankers, journalists and scientists are protected by working from home. Less wealthy people also lack a financial safety net, and food shortages and house evictions lead to excess deaths. Working class children are also disproportionately harmed by school closings, as their parents are less likely to afford tutors, pod schools or private schools. Poorer people also have less access to high quality medical care services, when they become ill, with lockdowns tending to decrease health care access differentially more for the poor. Thus, lockdowns both cause excess overall mortality and increase societal inequality.

### How do lockdowns harm the developing world?

The lockdowns are causing devastating harm to both mental and physical health worldwide. A UN report estimates that an additional 80 to 130 million poor people will suffer from-hunger. Of these, it is estimated that lockdown restrictions have led to 10,000 children starving to death each month. Moreover, an additional 400,000 people will may die from inadequate tuberculosis treatment as a consequence of the COVID-19 strategies. Vaccination campaigns in poor countries that address diseases like measles and polio have been suspended due to the lockdowns, with devastating measles outbreaks as a result. The list could be extended endlessly, with both short- and long-term consequences.

## covid-19 risk

### How Dangerous is the SARS-CoV-2 virus and the COVID-19 disease?

It is important to distinguish between the risk of infection and the risk of death. Anyone can get infected, but there is more than a thousand-fold difference in the risk of death between the oldest and youngest. For old people, COVID-19 is more dangerous than the annual influenza. For children, the COVID-19 mortality risk is less than for the annual influenza.

**With schools closed, how can you say that the mortality risk to children is low?**

To scientifically answer that question, we must look at the only major western country that did not close schools during the height of the pandemic. That is Sweden, who kept day-care and schools open for children ages 1 to 15. Among its 1.8 million children in this age range, there were exactly zero deaths from COVID-19 during this time-period, and only a handful of hospitalizations. During this time, symptomatic children were told to stay home, or sent home if they came to school, but there were no masks used or physical distancing at school.

**Why are so many people afraid of COVID-19?**

Unfortunately, the public health messaging about COVID-19 around the world has created many misperceptions that have spread fear. While older people underestimate their risk of COVID-19 mortality, young people greatly overestimate their mortality risk. Better public health messaging that does not spread unfounded fears based on anecdotes would help correct this situation.

## protecting the old and other high-risk groups

**How can one separate younger and older generations to ensure that the latter are not infected by the former?**

It is not possible to do 100%, but, just as the strategies to date have managed to “successfully” shift infection risk from the professional class to the working class it is also possible to shift infection risk from high-risk older adults to low-risk younger adults. The latter will result in fewer deaths overall.

**Don't the current age-wide lockdown strategies properly protect the old?**

No, on the contrary. There have been many unnecessary deaths, and especially among the urban working class. Current lockdown policies have failed to protect the vulnerable. Concrete examples of these failures include:

- Requiring older “essential” workers and members of the working class that cannot afford not to work to be put in work situations where they may be exposed to the virus.
- Failure to protect nursing home residents from exposure to the virus from staff members, visitors, and other residents.
- No provision for elderly people living in multi-generational homes to be shielded should a family member be exposed to the virus.

**How do we protect the elderly in nursing homes and other care settings?**

A focused protection strategy would include frequent testing of nursing home staff members that are not already immune, testing of visitors, and less staff rotation so that residents only interact with a limited number of staff people. COVID-19 infected individuals should not be sent to nursing homes, and all new residents should be tested. Sequestering of care home residents who have COVID-19 is also important. *(Note: Originally the Declaration specified “PCR testing”, but we have changed that to “testing”, as there are other tests available.)*

**How do we protect older people living at home?**

During high transmission times, older people should be offered home delivery of groceries and other essentials. When seeing friends and relatives, it is best to do it outdoors. Testing should be available for relatives and friends who want to visit. Free N95 masks should be provided for when they cannot avoid potential exposure.

### **How do we protect older people still in the work force?**

People in their 60s are at somewhat high risk, and many are still in the workforce. Those that can work from home should be allowed to do so. For example, teachers in their 60s could teach online courses, or help fellow teachers with grading exams, essays and homework. Those that cannot work from home should be funded to take a 3 to 6-month sabbatical. In addition, workplace disability laws should require employers to provide reasonable accommodations to protect high COVID19 risk workers without losing their jobs.

### **How do we protect older people in multigenerational homes?**

University closures and the economic displacement caused by lockdowns has led millions of young adults to live with older parents, increasing regular close interactions across generations. We know that older people living with working-age adults have higher COVID-19 risk than older people living with other older people. There is no further excess risk if also living with children though. This is the toughest challenge, and family specific solutions must be found. If the working-age household members can work from home, they can isolate together. If that is not possible, the older family member might temporarily be able to live with an older friend or sibling, with whom they can self-isolate together during the height of community transmission. As a last resort, empty hotel rooms could be used for temporary housing.

### **How about younger people with risk factors?**

People with comorbidity risk factors should take the same precautions as somewhat older people without those risk factors.

**For how long must high-risk individuals be careful and/or self-isolate?**

When herd immunity is reached, they can live normally again with minimal risks. How long that takes depends on the strategy used. If age-wide lockdown measures are used to try and suppress the disease, it could take a year or two or three, making it very difficult for older people to protect themselves for that long. If focused protection is used, it will likely only take 3 to 6 months.

**How can older people know when to be extra careful?**

It is essential for public health departments to monitor disease transmission at the local level and continuously communicate this to the public. High-risk individuals can make decisions and take precautions accordingly. This should ideally be done using random population surveys. Information on hospitalizations and mortality should also be tracked. Any monitoring system based on positive test results must account for geographical and temporal variation in testing practices. This type of COVID-19 monitoring is performed in, e.g., New York City.

This information should be conveyed to the population in a nuanced way that does not induce panic but instead provides the basis for an accurate assessment of each person's risk based on their age and comorbid conditions. The goal should be that vulnerable people do not underestimate their risk from COVID-19 infection, and less vulnerable people do not overestimate their risk. Concrete recommendations should accompany the information – including perhaps recommendations to avoid crowds, hand washing, social distancing, and masks when their application to the situation is backed by sound science – that different people might take to reduce their infection risk.

# herd immunity

## What is herd immunity?

Herd immunity occurs when enough people have immunity so that most infected people cannot find new uninfected people to infect, leading to the end of the epidemic/pandemic. This means that the epidemic/pandemic will end before everyone is infected, although it will continue in endemic form with low rates of infections.

## Do you believe in herd immunity?

Yes. Herd immunity is a scientifically proven phenomenon. To ask an epidemiologist if they believe in herd immunity is like asking a physicist if they believe in gravity. Those who deny herd immunity may also wish to join the flat-earth society.

## With COVID-19, can herd immunity be avoided?

No. Sooner or later, herd immunity will be reached either through natural infection or through a combination of vaccinations and natural infection.

## Is the Great Barrington Declaration advocating a 'herd immunity strategy'?

No. Those making such claims in the media have either (i) not read the document, (ii) do not understand the basic principles of infectious disease epidemiology, or (iii) are willfully distorting the public health message for political purposes. For COVID-19, all strategies lead to herd immunity, making it nonsensical to denote one specific approach as a herd immunity strategy just as it does not make sense for airplane pilots to talk about a "gravity strategy" for safely landing a plane. The Declaration advocates a strategy that minimizes mortality until herd immunity is reached. That is done by minimizing the number of older high-risk people in the group that



get infected while maximizing them among those that are still uninfected when herd immunity arrives.

**Does the Great Barrington Declaration advocate for “Letting the virus run free”?**

No, that is a false characterization, as it advocates the opposite. The central tenet of the declaration is *Focused Protection*, where older people and other high-risk groups are better protected than they have been, to ensure that they are not exposed to the virus. Neither does it encourage intentionally exposing anyone to the virus. Letting children and young adults live their lives without lockdown restrictions does not mean that we are letting them die from the virus, just like we do not accuse politicians for letting people die in car accidents when a new road is built. On the contrary, the GBD reduces the considerable collateral damage for less vulnerable people who face more danger from lockdown than they do from COVID-19 infection.

**For COVID-19, what percent of the population needs to be immune to have herd immunity?**

That is impossible to know right now. No respectable epidemiologist will mention a specific percentage needed. It also varies by geography, with a higher percentage needed in urban versus rural areas. It also depends on the strategy used. If people with more contacts are immune, such as traveling salesmen, cab drivers, politicians or party goers, then the percentage is lower.

**What are the current levels of immunity against COVID-19? Is it enough for herd immunity?**

The current levels of immunity vary by location. We know that is more prevalent than the percentage of the population that has antibodies, but we do not know how much more. The time course of the epidemic in several

regions of the world indicate that immunity in the population is playing a substantial role in controlling the spread.

Should people deliberately get infected to generate herd immunity?

No.

Antibodies fade after COVID-19 infection. Does that mean natural immunity fades? How strong will vaccine induced immunity be?

That the antibody response fades over time after COVID infections was already known from a large body of literature.

However, it is also true that antibody response is not the only response our immune systems have in response to infection, and these other immune responses (e.g. the production of specific T-cells) appears to be quite long lasting. You can see this in the fact that that despite an estimated 750 million worldwide to date after 10 months living with the virus, we have seen only a handful of reinfections. If the virus is like other corona viruses in its immune response, recovery from infection will provide lasting protection against reinfection, either complete immunity or protection that makes a severe reinfection less likely.

Vaccine immune responses tend to be less strong than natural immune response, but there are exceptions to that rule. Even after a vaccine is approved for use, we will have to wait a long while (probably at least ten months and longer) to see how long lasting and complete the immunity provided by the COVID-19 vaccines will be. Focused protection is the right way to manage the epidemic while we wait for the vaccine and after.

## standard public health practice

Isn't *Focused Protection* too risky an experiment?

No. *Focused protection* is based on the risk-based strategies outlined in the many pandemic preparedness plans that different countries had developed during the past decades. Surprisingly, except for Sweden, all countries threw their pandemic plans out the window when this pandemic started.

**How were prior pandemics dealt with?**

The focused protection strategy proposed by the Great Barrington declaration is indeed the standard way that societies have dealt with prior epidemics. Letting people who face very little risk from viral infection (but would suffer from the lockdowns) live their lives normally while taking precautions when they interact with more vulnerable people makes intuitive sense – they are harmed by the lockdowns and lifting the restrictions helps them. At the same time, better focused protection for the vulnerable is a moral necessity. Over time, population immunity will build up among the non-vulnerable until the vulnerable will no longer be at high risk of COVID-19 when engaging in normal activities.

**Have contact tracing, testing and isolation been successful against infectious diseases?**

Yes. Contact tracing is of critical importance for many infectious diseases. They do not work for widely spread diseases such as annual influenza, pre-vaccine measles, COVID-19, or, by definition, against any pandemic.

**Is it not better to pursue a ZeroCOVID strategy like New Zealand and South Korea?**

In New Zealand and South Korea, who locked down soon after the virus arrived, a zero-COVID strategy is feasible in the short run through a combination of lockdowns and national quarantine. Since the world is connected, countries that have successfully achieved a zero-COVID goal will need to disconnect themselves from physical exposure – through international travel limitations and required quarantining – for an indefinite period of time. A key decision for them is whether to wait for a vaccine,

that will arrive somewhere between 2 months from now and never, or open the country, at which time the infection will return. Since they have few domestic cases, they are dependent on other countries to develop and evaluate the efficacy of the vaccines they need.

Most countries never had that option, with the virus already being too widespread to achieve a temporary national eradication. Pursuing a zero-COVID policy through lockdowns is then futile, leading to collateral damage with devastating effects on the health of millions around the world.

**What is the role of vaccines in focused protection?**

If wisely used, COVID-19 vaccines are an important additional tool for focused protection. The key is to vaccinate older high-risk people as well as their care givers, such as hospital and nursing home staff. Those who have already had COVID-19 do not need to be vaccinated.

Official Social Media for Great Barrington Declaration



# Great Barrington DECLARATION

Contact: [info@gbdeclaration.org](mailto:info@gbdeclaration.org)

Have questions? [Check out the FAQ](#)

# Signatures

As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

concerned citizens

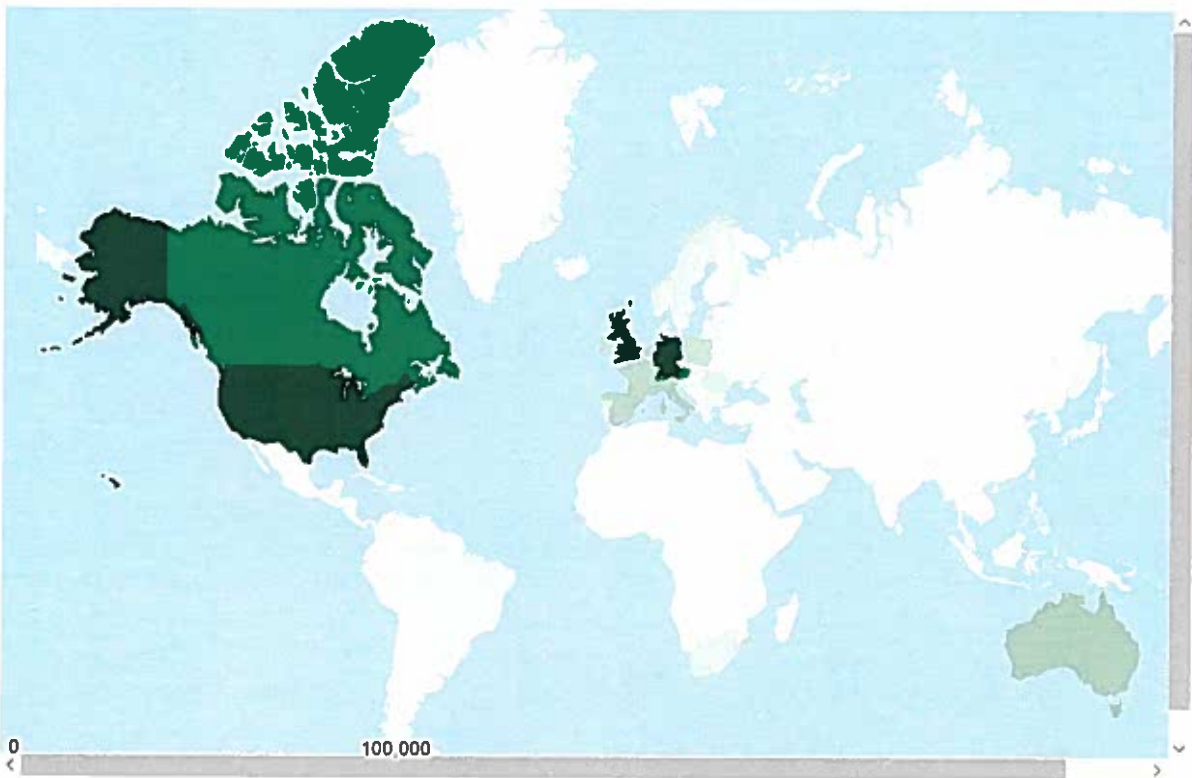
727,145

medical & public health  
scientists

13,290

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40,199



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## The Great Barrington Declaration Is A Spark of Sanity In A Mad World

*The Great Barrington Declaration offers a way forward, but do most Americans have the courage to risk their sense of security to maintain enduring liberty?*

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In an era in which every dubious decision is “due to COVID-19,” we hear policymakers repeating the same mantra: “If just one life is saved,” it’s worth relinquishing our freedoms, our sanity, and possibly our future. More often than not, this ethical dilemma is presented without mentioning the obvious **trade-offs** or long-term consequences.

Imagine you’re an administrative dictator. If you could “save just one life” — or even thousands — by **crippling** the youth, **vaporizing** a million careers, **wiping out** small businesses, crushing your nation’s civic culture, severing the ancient continuity of religious rites, forcing healthy people into paranoid isolation, **traumatizing** an entire generation with viral terror, **ending** hugs and handshakes, **depriving** the elderly of intimate care in their final days, wrecking the national economy, **unleashing** a **dystopian** surveillance **state**, and turning your neighbors into neurotic germaphobes, would it be worth it? It’s a serious question. What if that “one life” was your grandpa?

If my own grandfather had lived to see the destructive madness surrounding the Wuhan virus crisis, he’d no doubt light a Doral 100 and say, “Good Lord, just let me die.”

### The Great Barrington Declaration

As it happens, I was in Great Barrington, Massachusetts, when this germ hysteria got started. As things progressed, the sleepy ski town was suddenly overrun by panicked New Yorkers who escaped to their summer cottages and never went back. Being typical urban scolds, they’<sup>SHARES</sup> show up at the local snops

and shriek about other customers not wearing masks or small children standing too close to them. The locals accused these uptight yuppies of carrying the city's plague to the countryside.

In this idyllic setting of cultural neurosis and mutual disdain, the now-infamous **Great Barrington Declaration** was drafted by three leading experts in the fields of biostatistics, immunology, and public health policy. These doctors advocate for a return to traditional wisdom: Quarantine the sick, isolate the vulnerable, and allow the young and healthy to proceed with caution. Alongside Sweden's courageous example, the document will go down in history as a bold assertion of vitality in a withering world.

The declaration was authored and signed on Oct. 4 by Dr. Martin Kulldorff, professor of medicine at Harvard; Dr. Sunetra Gupta, a distinguished Oxford epidemiologist; and Dr. Jay Bhattacharya of Stanford University Medical School. To date, more than 13,000 medical professionals have added their signatures, along with more than 176,000 members of the public, with thousands more every hour. This concise manifesto is strong medicine for a sick society:

As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection. ... Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.

The authors call for an end to blanket, one-size-fits-all restrictions.

Current lockdown policies are producing devastating effects on short and long-term public health ... leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden.

Keeping students out of school is a grave injustice.

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

Let's pause to consider all the white-collar office jockeys, tenured college professors, and coddled trust fund babies who snuggled up on cushy sofas, glued themselves to laptops, and dismissed the protests of those who were laid off, locked down, and muzzled against their will. "What's so hard about wearing a mask?" they'd scoff, despite the evidence that, **all factors** considered, healthy people have little reason to do so. "Stay home and stay safe!" they yelped, before moving on to the next Amazon 1-Click order.

## The Swedish Approach to Herd Immunity

Meanwhile, in Sweden, the heirs to Beowulf did what any intrepid society would do — they kept **living** their lives, albeit with greater caution. The rare visitor is astounded to find these **naked-face** Swedes going about business as usual.

What did they do differently? The country's lead epidemiologist, Anders Tegnell, simply provided public health guidelines in good faith, rather than sending armed police to **break up** children's playdates or **deploying** Chinese drones to bark orders at pedestrians. No mask mandates, no fearmongering rhetoric, no lockdowns.

Besides, what choice did he have? The Swedish constitution **prohibits** the government from restricting its citizens' freedom of movement. Unlike the yellow dogs of the Anglosphere, Swedes clearly take their freedoms seriously.

Tegnell's **strategy** was to achieve herd immunity, meaning allowing the virus to run its course until enough healthy people are immune to stop the spread to more vulnerable populations. While it's unknown how many people have to acquire COVID-19 immunity to halt the spread, an **analysis** published at Nature Reviews Immunology estimates a threshold between 50 percent to 67 percent of the population.

The study's wary authors speculate that attempting to achieve herd immunity in America, without the aid of a vaccine, would come at a staggering cost of life. It's certainly possible. The infection fatality ratio used in their calculation (0.3-1.3 percent), however, clearly isn't based on a deliberate policy of exposing young, healthy citizens (whose estimated infection fatality ratio is well below 0.01 percent, according to **recent CDC models**), nor does it reflect the successful isolation of the vulnerable, nor recent advances in therapeutics. As usual, the analysts don't weigh potential coronavirus deaths against the lives that will be lost to soaring **suicide rates, overdoses, economic ruin, neglected health**, or other "**deaths of despair**" if current restrictions continue.

So is the Swedish response actually working? The strongest indication is that for over two months now, their coronavirus-related deaths have stabilized at **one or two a day**. What did it take to get there?

Detractors of the whale-hunters' approach frequently compare their death rates (**roughly 582 per million**) to their Scandinavian neighbors — such as Norway (**~51/mil**), Finland (**~62/mil**), and Denmark (**~115/mil**) — all of which locked down and masked up. The problem is that this is a one-dimensional measure.

When we look at current infection rates, the Swedish **numbers** are well below their peak in June, while their neighbors' new cases have **surged** back to springtime **levels** and **beyond**, despite continuous precautions. This supports the argument that heavy-handed restrictions merely prolong the inevitable.

After a harrowing ordeal, today only a tiny number of Swedes are dying from the virus. As it stands, their death toll is just under 5,900 in a nation of 10.3 million people. **Nearly half** of those deaths were in nursing homes or assisted living facilities. The Swedes' sacrifices have not been insignificant, but their experience was hardly the disaster scornful critics predicted. In the long run, the fact that Swedes have maintained their society and their sanity might well be the most important result.

## Adapting to a Dangerous Environment

The Great Barrington Declaration's plan resembles Sweden's arguably successful experiment:

The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection. Those who are not vulnerable should immediately be allowed to resume life as normal. ... Schools and universities should be open for in-person teaching. ... Young low-risk adults should work normally, rather than from home. ... People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.

That sounds far more reasonable than California Gov. Gavin Newsom **urging diners** to pull down their masks to take bites and pull them back up to chew, but of course, no plan is foolproof.

Microbiologist Simon Clarke voiced one of the **stronger arguments** against the declaration, warning that the quest for herd immunity is plagued with uncertainty. He rightly noted that we don't know how long immunity to the coronavirus actually lasts. We also don't know what the long-term damage might be, even to healthy people, and it's questionable whether it's ethical to segregate those deemed "vulnerable" from germ-ridden public spaces.

Fair enough, but how is it more ethical to straitjacket the entire culture, indefinitely, for the sake of a vulnerable minority's already-limited freedom?

If fear of the unknown drives the skepticism toward herd immunity, explain to me how it's acceptable for our leaders to implement six months of bizarre social experimentation fraught with unintended consequences. So far, they've employed forced isolation, mask mandates, vicious social shaming, and media-

induced germaphobia. This approach has no Western precedent, except perhaps medieval superstition, and its proponents offer no feasible projections of holistic outcomes beyond hypothetical “saved lives.”

If one principle has remained constant during this crisis, it's that the numbers frequently follow the politics, rather than the reverse. For instance, back in August, Biden began pushing for a nationwide mask mandate, insisting it would **save 40,000** lives. Come September, Biden's scientific sources had upped that number to a **whopping 100,000 lives**.

At this rate, by Election Day, a draconian mask mandate will save more than a million lives. Who knows? Maybe if we cover with burkas made out of personal protective equipment until the inauguration, God will withhold his eternal wrath, and no one will ever die again.

Our newly minted social engineers are absolutely obsessed with “the numbers.” These insidious numbers are always rising, or about to rise, or once rising and sure to rise again, but how do our esteemed experts quantify a loss of dignity? How do they calculate the degradation of social health? How do they weigh hypothetical saved lives against the observable lost souls?

Perhaps these people have nothing to lose. For those of us who do, a cautious but deliberate path toward herd immunity offers a sane alternative to perpetual neurotic terror. The question is whether most Americans have the will and the courage to risk their sense of security to maintain enduring liberty.

*Joe Allen is a writer and fellow primate who wonders why we ever came down from the trees. A lifelong student of religion and science, he has kept his hands dirty as a land surveyor, communal farm hand, kitchen servant, and for over a decade, climbing steel as an arena rigger. His work appears in various outlets from left to right because he prefers liberty to security. Daily interjections: @EvoPsychosis.*

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