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HEALTH

America Has Lost the Plot on COVID

We're avoiding the hardest questions about living with the coronavirus long term.

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We know how this ends: The coronavirus becomes endemic, and we live with it forever. But what we don't know—and what the U.S. seems to have no coherent plan for—is how we are supposed to get there. We've avoided the hard questions whose answers will determine what life looks like in the next weeks, months, and years: How do we manage the transition to endemicity? When are restrictions lifted? And what long-term measures do we keep, if any, when we reach endemicity?

The answers were simpler when we thought we could vaccinate our way to herd immunity. But vaccinations in the U.S. have plateaued. The Delta variant and waning immunity against transmission mean herd immunity may well be impossible even if every single American gets a shot. So when COVID-related restrictions came back with the Delta wave, we no longer had an obvious off-ramp to return to normal—are we still trying to get a certain percentage of people vaccinated? Or are we waiting until all kids are eligible? Or for hospitalizations to fall and stay steady? The path ahead is not just unclear; it's nonexistent. We are meandering around the woods because we don't know where to go.

What is clear, however, is that *case numbers*, the metric that has guided much of our pandemic thinking and still underlies CDC's indoor-masking recommendation for vaccinated people, are becoming less and less useful. Even when we reach endemicity —when nearly everyone has baseline immunity from either infection or vaccination— the U.S. could be facing tens of millions of infections from the coronavirus every year, thanks to waning immunity and viral evolution. (For context, the flu, which is also endemic, sickens roughly 10 to 40 million Americans a year.) But with vaccines available, not every case of COVID-19 is created equal. Breakthrough cases are largely mild; 10,000 of them will cause only a fraction of the hospitalizations and deaths of

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So if not cases, then what? “We need to come to some sort of agreement as to what it is we're trying to prevent,” says Céline Gounder, an infectious-disease expert at New York University. “Are we trying to prevent hospitalization? Are we trying to prevent death? Are we trying to prevent transmission?” Different goals would require prioritizing different strategies. The booster-shot rollout has been roiled with confusion for this precise reason: The goal kept shifting. First, the Biden administration floated boosters for everyone to combat breakthroughs, then a CDC advisory panel restricted them to the elderly and immunocompromised most at risk for hospitalizations, then the CDC director overruled the panel to include people with jobs that put them at risk of infection.

On the ground, the U.S. is now running an uncontrolled experiment with every strategy all at once. COVID-19 policies differ wildly by state, county, university, workplace, and school district. And because of polarization, they have also settled into the most illogical pattern possible: The least vaccinated communities have some of the laxest restrictions, while highly vaccinated communities—which is to say those most protected from COVID-19—tend to have some of the most aggressive measures aimed at driving down cases. “We’re sleepwalking into policy because we’re not setting goals,” says Joseph Allen, a Harvard professor of public health. We will never get the risk of COVID-19 down to absolute zero, and we need to define a level of risk we can live with.

Scientific experts have been reluctant to make that call themselves. For one, there is real scientific uncertainty ahead. We don’t know how much immunity may continue to wane, how long the effects of a booster last, the exact incidence of long COVID in the vaccinated, or if a new variant will upend even the best-laid plans.

But the level of COVID-19 risk we can live with is also not an entirely scientific question. It is a social and political one that involves balancing both the costs and benefits of restrictions and grappling with genuine pandemic fatigue among the

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planes, trains, buses, and taxis in and to locked-down cities are being suspended; even vaccinated travelers are subject to mandatory quarantine. But are we willing to go that far? Currently, no. "This is the point at which we then have to start looking at ourselves and asking the hard question: Exactly how hard do we want to work to help how many people?" says Bill Hanage, an epidemiologist at Harvard. By we, he means all of us and, in particular, the public officials who represent us. "I can give you a policy, and I can tell you, okay, if you do that, I think you will have that outcome," he says, but public officials need to first define what that policy is supposed to achieve.

One plausible goal is to focus on minimizing COVID-19's impact on hospitals. A collapsed health-care system means more people will die, not just of COVID-19 but from other treatable diseases and injuries. Elsewhere in the world, like in the U.K. and Germany, leaders have explicitly tied their policies to containing hospitalizations rather than all cases. But in addition to hospitalizations, Gounder suggests we should also consider the risk of long COVID. "I think for people that is the big question. We just don't know enough," she says. Preliminary data suggest vaccines do reduce the risk of long COVID, but exactly how much is unclear given the uncertainties in diagnosing it.

Once we've defined what we are trying to prevent, we can define thresholds for lifting and, if necessary, reinstating COVID-19 measures. This can actually be quite tricky if the goal is minimizing hospitalizations, a lagging indicator that gives you a picture of the past rather than the present. By the time hospitalizations start to rise, a bigger increase may already be baked in with people already infected but not yet sick enough to see a doctor. What to track instead?

Here are some answers I got from scientific experts: hospitalizations and deaths, but stratified by age and vaccination status; a combination of vaccination rate and local transmission; a combination of vaccination rate and hospitalizations; a combination of long-COVID cases, hospitalizations, and deaths; a combination of case growth rate, testing uptake, vaccination rate, and hospitalizations. If this seems confusing,

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transmission is moderate, as defined by the CDC, for at least three weeks, (2) hospitalization numbers are low and stable, and (3) 80 percent of the total population is fully vaccinated or eight weeks have passed since COVID-19 vaccines have been available for kids age 5 to 11.

If we are in fact going to try keeping hospitalizations stable, one reason to define this goal now is to untangle this mess of what data to track. Then, we can get to outlining specific tactics in the weeks and months ahead.

In the absence of a coherent strategy, our attention has focused on a policy change we know is coming: vaccines for kids under 12. COVID shots for kids 5 to 11 were authorized last week, and data for those ages 2 to 4 are expected before the end of the year. For some families, this will bring real relief and soon. Vaccinated parents, living with vaccinated children, who have vaccinated grandparents, can worry that much less about the virus's worst impacts, and start behaving less cautiously.

But on a population level, as policy makers should be thinking, tying pediatric vaccinations to the end of restrictions doesn't necessarily make sense, if we are trying to keep hospitalizations down. Vaccinating kids will protect them individually and help dampen transmission from and among them—but this policy lever simply has limited impact on hospitalizations.

To prevent hospitals from being overwhelmed, the key group we need to vaccinate is really the elderly. The risk of hospitalization for an unvaccinated person over 80 is 25 times that for an unvaccinated person under 18. A *Financial Times* analysis of data from the U.K. found vaccinating 25,000 children had the same effect on hospitalizations as vaccinating just 800 adults over age 60. Unvaccinated elderly adults are just that much more likely to become severely ill with COVID-19. You can't compensate for a low vaccination rate among older adults by vaccinating more people in younger groups, says Müge Çevik, a virologist at the University of St.

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The U.S. still has too many unvaccinated elderly people—or rather, parts of the U.S. do. States such as Vermont and Hawaii have done well, given almost 100 percent of people over 65 immunized at least one dose. But in Idaho, Arkansas, and Mississippi, the percentage is languishing in the 80s. Even small differences in this percentage can have an outsize impact on hospitalization outcomes. For example, two communities with 90 versus 99 percent of the elderly vaccinated actually have a tenfold difference in the number of people at risk for hospitalization. "You don't need a lot of infections in the unvaccinated over 65 to give you a problem," Hanage says. During the summer wave in the U.S., the community vaccination rate in people over 65 correlated with hospitalization trends. The trend, he says, is "extremely clear."

One country that has excelled at vaccinating its elderly population is Denmark. Ninety-five percent of those over 50 have taken a COVID-19 vaccine, on top of a 90 percent overall vaccination rate in those eligible. (Children under 12 are still not eligible.) On September 10, Denmark lifted all restrictions. No face masks. No restrictions on bars or nightclubs. Life feels completely back to normal, says Lone Simonsen, an epidemiologist at Roskilde University, who was among the scientists advising the Danish government. In deciding when the country would be ready to reopen, she told me, "I was looking at, simply, vaccination coverage in people over 50." COVID-19 cases in Denmark have since risen—under CDC mask guidelines, the country would even qualify as an area of "high" transmission where vaccinated people should still mask indoors. But hospitalizations are at a fraction of their January peak, relatively few people are in intensive care, and deaths in particular have remained low.

Crucially, Simonsen said, decisions about COVID measures are made on a short-term basis. If the situation changes, these restrictions can come back—and indeed, the health minister is now talking about that possibility. Simonsen continues to scrutinize new hospitalizations everyday. Depending on how the country's transition to endemicity goes, it could be a model for the rest of the world.

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over, and we might consider strategies sustainable over the long term. Better ventilation, for example, can make indoor spaces safer against all respiratory viruses, not just COVID-19. And even without mask mandates, people who feel at risk can still voluntarily mask up. In the longer term, Çevik says, we also need less focus on policies that work by "reducing small risks among many" and more on policies targeted at the people most affected by COVID-19. During the pandemic, the virus has disproportionately sickened people who are poor, who are less likely to be able to work from home, and who are less likely to have space to isolate from their family at home. When COVID-19 becomes endemic, it will likely, as many diseases are, continue to be correlated with poverty.

"Pay much more attention to who and why people are at risk," says Stefan Baral, an epidemiologist at Johns Hopkins University. Baral says public health needs to go back to its traditional roots, where tackling disease also means reforming the living and working conditions that make people more susceptible. For example, universal paid sick leave and free voluntary isolation spaces can help minimize the impact of COVID-19, as well as many other diseases.

Hard questions lie ahead, and the answers require political will. But first, we have to stop avoiding them. We need a goal.

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