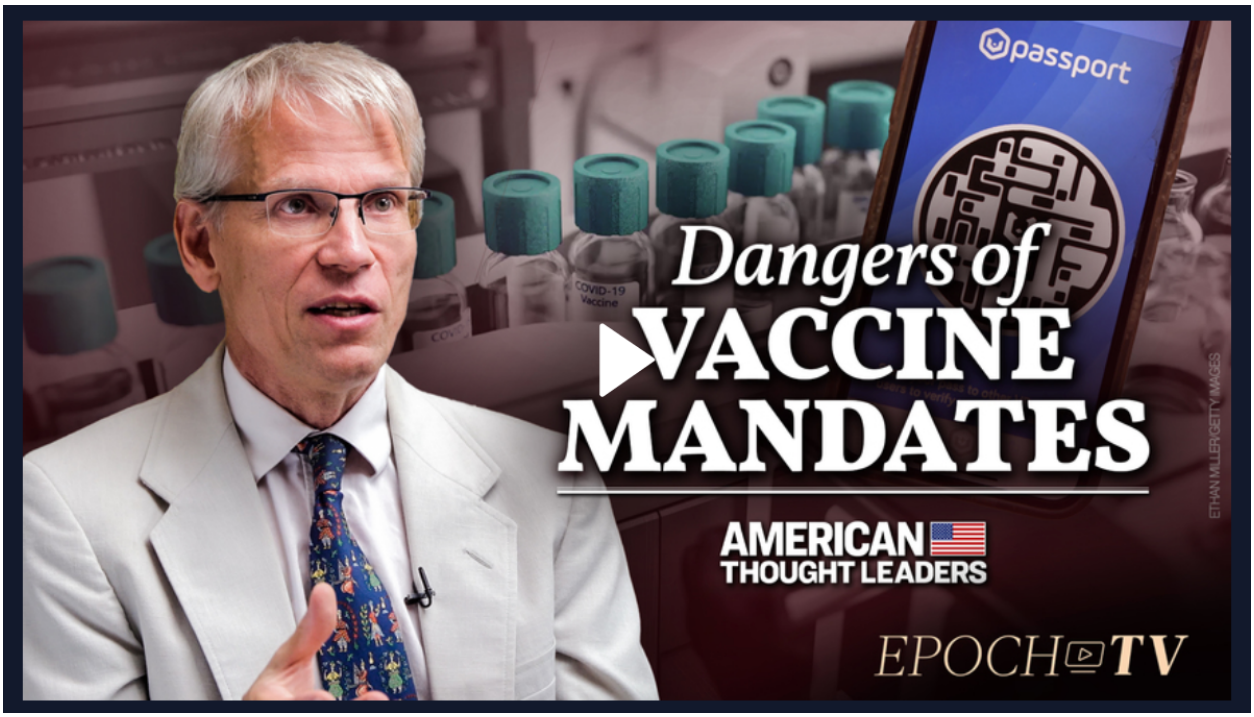

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Harvard Epidemiologist Martin Kulldorff on Vaccine Passports, the Delta Variant, and the COVID 'Public Health Fiasco'

"Those who are pushing these vaccine mandates and vaccine passports … they're doing so much more damage to vaccine confidence than anybody else," says Dr. Martin Kulldorff, one of the world's leading epidemiologists.

In this episode, we sit down with Dr. Kulldorff for a deep dive on COVID-19 immunity, vaccines, the Delta variant, and why he believes the global COVID response has been the "biggest public health fiasco in history."

Dr. Martin Kulldorff is a professor of medicine at Harvard Medical School and a biostatistician and epidemiologist at the Brigham and Women's Hospital. He helped develop the CDC's current system for monitoring potential vaccine risks, and he is also one of the co-authors of the Great Barrington Declaration, which argued for "focused protection" of the most vulnerable, instead of lockdowns.

Jan Jekielek: Dr. Martin Kulldorff, such a pleasure to have you on American Thought Leaders.
Dr. Martin Kulldorff: It's a delight, thank you for having me.
Mr. Jekielek: We're about a year and a half into the coronavirus pandemic. We've had lockdowns. We've had an emergence out of lockdowns right now in places like New York. We were getting closer to some kind of semblance of normality, and now we have the Delta variant and there's discussion of lockdowns again.
We have countries that actually have been in perpetual lockdowns. You've described the global COVID response as, and I'll quote you here, "The biggest public health fiasco in history." That feels like a big statement to make. Tell me more.

Dr. Kulldorff: I think it is, without a doubt. There are two aspects of that. One is, while anybody can get infected by COVID, there's more than a thousand-fold difference in the risk for death between the oldest and the youngest. So with the naive belief that these lockdowns would protect everybody—which now, obviously, we know that didn't work—a lot of people got COVID, and a lot of people died.
But there was this naive belief that they would protect the older people. Because of that, we did not implement basic public health measures to actually do what was necessary to protect those older high-risk people. And because of that, many of them died unnecessarily from COVID. The other aspect of it is the collateral damage from these lockdowns.

For example, children didn't go to school. The children are at miniscule risk from this disease in terms of mortality. They can get infected for sure, but the risk from COVID for children is less than the risk from annual influenza, which is already very low for children. So for them, this is not a risky thing. And one example is Sweden.

From the first wave in the spring of 2020, Sweden was the only Western country that did not close down all the schools. So schools and daycares were open for children ages 1 to 15. Among the 1.8 million children in Sweden during this first wave, there were exactly zero deaths from COVID. And that was without using masks, without social distancing and without any testing. If a child was sick, they were told to stay home. That was it.

So this is not a serious disease for children, which we should be very grateful for. Also young adults have very low risk for mortality from COVID. But the collateral damage has been enormous from these lockdowns.

Cardiovascular disease outcomes and heart disease has been bad during this pandemic because people don't go to the hospitals. The health care that they need is just not available, like for diabetes patients, for example.

Cancer has actually gone down in 2020 and 2021, but that's not because there is less cancer. It's just that we're not detecting them. And if we're not detecting them, we're not treating them either. This is nothing that shows up in the statistics this year, except to a very small extent. But let's say women who didn't get their cervical cancer screening might now die three or four years from now, instead of living another 15, 20 years.

So the collateral damage on public health from these lockdowns is something that we're going to have to live with and die with for many, many years to come, unfortunately. Then of course, there's the mental health aspect, which has been enormous and tragic.

This has really been an awful response to the pandemic which goes against the basic principles of public health that we have followed for many decades. So it's very unfortunate.

Mr. Jekielek: That's very interesting. You would think that the basic principles of public health would be implemented and enforced in this situation. So why has that not been done?

Dr. Kulldorff: That is a very good question. To be honest, I don't know the answer. To me, as a public health scientist, it's stunning that we suddenly threw out these principles we have used for decades to deal with public health issues. One is, public health is about all health outcomes. It's not just about one disease like COVID. You can't just focus on COVID and then ignore everything else. That goes against how we do public health.

Another thing is we have to look at it long-term and not just short-term. People were obsessed with the mortality for a particular month, comparing countries and so on. But what's important is not the count for a particular month, it's long-term overall mortality during the whole pandemic until it's over.

Another thing is public health is about everybody in society. With these lockdowns, we have protected the Zoom class who can work from home—people like you, journalists, people like me, scientists, but also bankers and attorneys.

While those who prepare food, people in supermarkets, in the meat factories, people who make sure we have electricity, they have had to work. So the burden has been put on the middle class and the working class.

And of course the burden is also put on children who need education. It has long-term consequences if you don't give children the proper education, and schools are very, very important.

For rich people, they can put their kids in a private school, or they can hire a tutor or they can afford to have one parent at home to homeschool them. That's

not possible among those less affluent. So the working class children have been especially hard hit by this response to the pandemic.

Mr. Jekielek: You're saying that the effect of COVID or the risk of COVID for this young age group is less than that of annual influenza? I don't think that is something that's generally known.

Dr. Kulldorff: By now it's about 350 or so reported deaths by COVID in the U.S. for children. We don't even know how many of those are truly COVID, because nobody has bothered to go through all those electronic health records, which I think CDC should do, as Marty Makary, a professor at John Hopkins has been urging, but that hasn't been done. So we don't know exactly how many, but it is at most 350.

If you look at annual influenza, basically two seasons or one-and-a-half years, if we look at the annual influenza, depending on the severity of the particular strain, the particular year, between 200 and 1000 children die from annual influenza every year. Of course, every death is very tragic, whether it's influenza or COVID.

And of course, death of children is especially tragic, but we never closed down schools for the annual influenza. Actually there would be more rationale for doing that because the influenza is actually spread a lot by children.

So the schools and children are one of the drivers of the spread of influenza, but the opposite is true about COVID. Most children who are infected get it from some adult. The children are not very good at infecting others, so it makes no sense to close schools. We saw that from other countries who have kept them open. We should never, ever close any of the schools for COVID.

As we go forward, they should be open. We should let the children be children. Education is very important and we should let them get that in-person education. We know that both teachers and students have said that online teaching is

certainly not as good as having personal teaching, but it's also not good for their social development and hanging out with their friends.

Mr. Jekielek: We've been hearing a lot about the Delta variant, a lot of scary headlines about the Delta variant. Maybe we're going to need to go back into lockdowns in the U.S. You've described some of the collateral damage and some of the issues. What do you think about this discussion that's happening now?
Dr. Kulldorff: For any virus, there are going to be mutations, so there are going to be variants. And some variants will be more successful than other variants in spreading among the population. Therefore it's not surprising that you have variants and some variants sort of takeover. This is not at all surprising. The Delta variant may be somewhat more contagious, but that's not the game changer.
What would be a game changer is if you've got a variant that started to kill young people, started to kill children. The Delta variant is not doing that. What would also be unfortunate is if you have a variant where the natural immunity that you have from COVID or from a vaccine doesn't work with the variant.

But we know that if you've had COVID, you have very good immunity, not only for the same variant, but also for other variants, and even for other types of cross immunity to other types of coronaviruses.

We know for example, that if you had a COVID-19 SARS-CoV-2, you have also have immunity to SARS-CoV-1 which we had earlier, a few years ago. It also provides protective immunity to the other four common coronaviruses that are endemic that we've all been exposed to, and that we will continue to be exposed to.

So I don't see any problem with Delta variants or any other variant that changes anything. It's not a game changer.

The best approach is to make sure that our old people get vaccinated to protect them. And then we should not have lockdowns. We should let people live their normal lives.

And if they are an old person who hasn't been vaccinated, they should get it, and then wait two weeks. And two weeks after vaccination, they are protected and they can also participate in society. But until they are vaccinated, of course, all people need to be very careful.

Mr. Jekielek: I want to talk about natural immunity in a moment. This is very important because there's been a lot of different messaging about that. But before we go there, in places like Florida and Louisiana, for example, right now there is a surge in cases. Your thoughts?

Dr. Kulldorff: It's important to differentiate between cases and mortality. The fact that somebody tests positive is not necessarily a worry, and it's something that we would expect. It's something that's going to continue to happen. Because as COVID-19 becomes endemic, people are going be infected. If you test them, they're going to test positive.

They may even have the virus replicate before the immune system kicks in. Maybe some of them might even spread it. But as long as people are asymptomatic or mildly symptomatic, this is nothing that we should worry about.

What we do have to worry about is mortality and also hospitalizations. The benefit of being immune, whether it's because you had COVID or because you're vaccinated is not to avoid being infected and test positive. That is going to happen.

The key thing is if you had had COVID already, or if you are vaccinated, that protects you against severe disease and mortality and death. We can see that cases on mortality are starting to decouple out now.

For example, in the UK, there was a wave of cases that peaked in the mid-July. It was a very sharp increase and now it's going down sharply. For mortality it is just a tiny blip. So this is a contrast to before the vaccines and before focused protection, when cases rose and their mortality also rose in parallel. But the vaccines and the immunity from people who've had COVID is decoupling that.

We can see it in Sweden, which had the first wave. In the second wave there were increasing cases, and there was also an increase in mortality corresponding to that. But then there was a third wave that peaked in April. There was a third wave of cases, but mortality just kept going down and it's now has been close to zero for more than a month. So there was also a decoupling.

That was actually the Delta variant that was the third wave. That was predominantly the Delta variant that was the increasing proportion of those cases in the third wave.

We see the same thing here in the U.S. now in the summer wave that we see in the southern states. There has been quite a few increases in cases. For the mortality there's a blip because not everybody's vaccinated, not everybody has had the disease, so not everybody's immune.

So there's a little bit of a blip, but we don't see the same close correspondence between cases and death as we've had in the past. So that's a very positive thing and a very good thing. It shows that we are on our way from the pandemic phase to the endemic phase.

We will always have COVID-19 with us. It's not going to go away. We can't eradicate a virus like this, so it will always be with us. When people get exposed to it for a second time, a third time, a fourth time, the immune system helps, making sure that it's not a serious illness or death.

Of course, new people are born every year and they are susceptible. They haven't had it. So when children are born, they don't have the immunity to this particular virus, but we know that it's very mild for children.

So it's a very good thing that this virus is not harsh on children when they get it the first time. If there's some way you try to stay away from it until you are 80 and haven't been exposed to it—that would be impossible—but if you could do that, then of course, when you're 80 and susceptible, you would be of high risk. But as long as you're very exposed as a child, and your immune system was built up, then the next time you will be protected by the immune system.

Mr. Jekielek: You mentioned that the virus will always be with us, so to speak. I'm very curious about that because it appears that in some of the public messaging, we're attempting to eradicate the virus entirely. Let's put a placeholder on that for a second. I want to talk about the natural immunity that you mentioned.
There's been a lot of conflicting messaging about natural immunity. You're saying that it's strong and vibrant and useful. Yet at the same time, there's a kind of push to vaccinate people, whether or not they have natural immunity. Am I seeing this correctly? What's going on?

Dr. Kulldorff: First of all, we expected that we would have good natural immunity from a virus like this. So it's not a surprise that we do have it. There have been studies showing that we have good immunity from having COVID before. People can be reinfected and test positive, but there's very few cases where somebody had it and then they get the serious disease afterwards. There are millions of people who have had COVID.
So if this was a common thing, it would have shown up all over the place, but it hasn't. So it's very rare. Once you've had it, you have good protection from your immune system for a serious disease or for mortality. There has been some direct comparison.

There was some data from Israel that came out recently showing that if you have had a vaccine, you're 6.7 times more likely to be reinfected than if you have had the COVID disease itself. So we would expect that you get better immunity from the disease than you do from the vaccine. And of course, there's only that one study.

We don't know exactly, but we can confidently say that having had the disease at least gives you as good and probably better immunity than the vaccine. Empirically, we know that if you have a disease, you have at least one-and-a-half years of good immunity, because the virus has been with us for that amount of time. So we know that there's long lasting immunity from having had COVID disease.

From the vaccine, we have less information because it only came in December. So it's a bit over half-a-year. So we know that there's good immunity for six months. Hopefully it's longer, but we don't have the same amount of data, the same evidence as we do for a natural immunity from actually having the disease naturally.

But for public health scientists, it's very surprising that this is not recognized. We are forcing people who had the disease, who have good immunity to take a vaccine, even though they have an immunity that's better than, or at least as good as those who have only had the vaccine.

At the same time, there are a lot of people who need these vaccines who are not getting them. People in India, Nigeria and Brazil, where a lot of older and especially poor people do not get the vaccine because they don't have enough doses.

So those are the ones we should emphasize being vaccinated. Then we should view this as a global effort to vaccinate the old everywhere in the world, instead of vaccinating people that already have very good immunity against the disease.

Mr. Jekielek: You mentioned that people are being forced to take a vaccine. I don't know of anyone in the U.S. actually being forced to take it directly. Tell me what you mean when you say that.
Dr. Kulldorff: There's a push both for vaccine passports and vaccine mandates. If people want to have a job and stay at the job, they are required to take the vaccine or they'll be fired. If they want to study at the university, many universities are requiring vaccines for all the students.
So there are these vaccine mandates and vaccine passports. In New York City, for example, now they're requiring restaurants to require vaccinations for people who go to the restaurants.

That is a very coercive way to get people to vaccinate. And that's very bad for public health. One question is, "Why do you coerce people who are immune or people who are young, who have very small risk, when the vaccines are much more needed in for older people in other places?" So that's an ethical aspect of it. I think it is very unethical to do so.

The other aspect is that if you force something on people, if you coerce somebody to do something, that can backfire. Public health has to be based on trust. If public health officials want the public to trust them, public health officials also have to trust the public. I've been working on vaccines for almost two decades now. One thing that we've always tried to do is to maintain good confidence in the vaccines.

For example, measles vaccines are very important, as well as polio vaccines. There is a small group of people who are very vocal, who don't like vaccines, but they haven't really been able to put any dent in the confidence in vaccines. It's very high in the U.S. So we've been very successful in maintaining that confidence.

But right now with these vaccine mandates, and vaccine passports, this coercive thing is turning a lot of people away from vaccines, and not trusting them for

very understandable reasons. “Why do you have to force somebody to take the vaccine, if it’s so beneficial to you?” That’s one rationale.

Those who are pushing these vaccine mandates and vaccine passports—vaccine fanatics, I would call them—to me they have done much more damage during this one year than the anti-vaxxers have done in two decades. I would even say that these vaccine fanatics, they are the biggest anti-vaxxers that we have right now. They’re doing so much more damage to vaccine confidence than anybody else.

Even if they manage to coerce somebody to get the COVID vaccines, because of people saying, “Okay, I have to take it because I need to go to a university or I have to, because I want that job, or I want to go to restaurants,” even if they manage to get those people to take the COVID vaccine, it will turn them off from public health. It will make them distrust public health and turn them off from other vaccines that are not mandatory.

So it has ripple effects in other aspects of public health that are very unfortunate. I’m a native of Sweden. so I know a little bit about Sweden. Sweden has one of the highest vaccination rates in the world, and the highest confidence in vaccines in the world.

But there’s absolutely no mandate. It just doesn’t do it that way. It’s completely voluntary. If you want to have high confidence in vaccines, it has to be voluntary. There shouldn’t be any mandates.

Mr. Jekielek: Let’s talk about this. You said there’s a thousand times difference between the risk of a young person to that of an old person, broadly speaking. So where is the cutoff ? Is there a high risk area? I assume you would suggest that most people should be vaccinated. And there’s a very low risk area. Tell me how that works.

Dr. Kulldorff: The way I reason about this is that whenever there's a new vaccine on the market or a new drug for that matter, we know that it works. We know there's efficacy. We know about common adverse reactions.
For some vaccines, you might have some sore arm or some rash or a fever, for example. But we don't yet know about rare but serious adverse reactions when the vaccine or the drug is first approved. It takes a couple of years to do that.

So now, if we look at somebody who is 76 years old, if they get infected by COVID, it's not extremely high, but they could very well die from COVID. So then if it's a small risk from the vaccine, it's a no-brainer.

The protection from COVID is much more important than even if there is a small risk from the vaccine. So people in their 60s, 70s, 80s, should, in my mind, definitely take the vaccine, because the benefits are large. There might be some small risk, but the risk is very small.

On the other hand, if we then go to the other side of the spectrum to the children, we know that the risk of mortality from this is minuscule. They can get it, but many will be asymptomatic, or they will only be mildly asymptomatic.

The risk from serious consequences is very, very small. So then even if there is a small risk of serious adverse reactions from the vaccines, we don't know what the balance is. We didn't know that when the vaccines came out, but we learned more and more about the adverse reactions.

We now know that in young people, including children, Pfizer and similar vaccines can cause myocarditis, which is an inflammation of the heart. That's something we would like to avoid. So it's not at all clear for children, what is the balance of the pros and the cons of these vaccines?

So, there could, of course, be another adverse reaction that we don't know about yet. So to vaccinate children at this point doesn't make sense. You asked about

the cutoffs and I don't know where that is, because it's sort of a gradual thing. It's clear cut on these two ends, but the middle is less clear.

I can't say what that is, but we have to be honest about those things. Let's say you're 25 and you have very low risk for mortality from COVID. On the other hand, if you work in a hospital or as a nursing home staff, then you should certainly have the vaccine, not necessarily for your own protection, but to protect the older people that you're working with in the nursing home or in the hospital.

Mr. Jekielek: What about this case then? This is probably a case many people are asking themselves about today. You have a older relative, for example, a grandmother. Grandma has been vaccinated with one of the vaccines and you have a small child or a 25-year-old, or a 30-year-old that wants to visit with grandma. For that reason, should they be vaccinated? How do we think about that?

Dr. Kulldorff: Grandma should be vaccinated. That's the important thing. That's what is going to protect her, whoever she meets. I'm sure grandma wants to see her grandchildren and she should do that and she should enjoy them. When it comes to COVID, the children are not very good transmitters of the disease. Now, if you're old or you're frail, your immune system goes down. A lot of old people die from some coronavirus that most of us are able to handle because we still have a good immune system.

Who knows where that older grandma will get that virus from. It doesn't have to be COVID, it could be something else. It could be the flu, but it could be one of the other coronaviruses or any other virus.

They will catch it from somebody, somewhere, but we shouldn't start blaming children, for example, if it was a child who happened to be the carrier, or if it was somebody in the supermarket, or maybe the neighbor. It could be any of those things, but we have never started to blame these people for killing grandma and we should never do that.

Mr. Jekielek: I want to reiterate this because this is not commonly known. We keep seeing these headlines that this politician, despite being vaccinated, has tested positive for COVID. Apparently that's a normal thing. Grandma could get it from someone that's vaccinated, someone that's not vaccinated, or could be exposed to it somehow. It's not clear that how much the vaccination would help with that.

Dr. Kulldorff: Yes. The immune system works to prevent serious disease and death, but it doesn't prevent you from being exposed or from having the virus enter the body, because the immune system can't go into action until the virus is in the body.

And depending on how long it was since you had COVID or since you had the vaccine, the time it takes to beat off the virus when it comes might vary. If you have had it very recently, you still have all these antibodies and it might be very quickly taken care of.

But if it has been some time ago, the virus may still start reproducing in your body and your cells before the immune system kicks in and takes care of it. For somebody that has had COVID or has had the vaccine and tested positive for COVID, that's what you would expect to happen. So there should be no headlines about that.

If we did that with all the viruses that we have—we deal with dozens of them—if we tested for all of them, and if there was a headline as soon as a politician tested positive for one of them, a scary headline and scary newspaper article, then we would all be hiding under our beds all the time.

We can't do that. This is part of society and part of the situation that we deal with all these viruses. We have an immune system and that is a beautiful thing. It's a fantastic thing, biologically. It's a fantastic thing, how it operates. We have lived with that for hundreds and thousands of years, and we should continue to do that.

What's new with this COVID-19 is that it was a new virus where everybody is susceptible. Nobody has immunity towards this. There are some people who had cross immunity from other coronaviruses. When so many people are susceptible, they then get these waves and this pandemic.

It started in Wuhan in China, but then there was an outbreak in northern Italy, as well as in Iran. As soon as I heard about those outbreaks in northern Italy and Iran, it was clear to me that this was going to be a worldwide pandemic, because nobody knew how it arrived there.

We don't know who brought it there. It was clear that this was very contagious and that it would eventually reach all parts of the world. And that's exactly what happened.

Mr. Jekielek: There seems to be a focus on this concept of breakthrough infections and as if that would be a significant problem with respect to the efficacy of the vaccine. Is this some kind of misconception?
Dr. Kulldorff: Yes, I think it is. I don't think we should be so preoccupied with that. The key thing is that both natural immunity from having had Covid as well as the vaccines protect you from having severe disease and death. That is the most important thing.
We expect that even if you have immunity, you can still be exposed and you can still get the virus in your body because the immune system doesn't go into action until the virus is in there.

And depending on how long it was since you had the vaccine or how long since you have had COVID, your immune system might react really quickly, or the virus might actually start to replicate in the cells, so it will take little bit longer. But your immune system is still there taking care of it, and protecting you from a bad outcome.

Mr. Jekielek: Tell me about this—that it will always be with us. There's a lot of confusion about policy and what it's actually trying to accomplish. Are you seeing the policies trying to eradicate this virus entirely? Is that even possible? You said earlier that it's not possible. What should be the goal, if that's not correct?
Dr. Kulldorff: For example, Australia has had a goal of eradication. You can see it in two ways. You can see that, no, they haven't succeeded because they still have it. Or you can say that they've been very successful because they've done it six times. Every time there's a lockdown they eradicate it, and then they repeat and eradicate many times. No, it's not possible to eradicate it. It will be with us.
The key thing is once we all have immunity from having the disease or from the vaccines—usually if you have the vaccines, you're going to be exposed the second time—you will hopefully improve your immune responsive even more. That is going to happen. It will be like the other four coronaviruses that we are already dealing with and that we have dealt with with a long time.

There are only two diseases that have been eradicated. One is smallpox, which took a normal effort, but it was also a much better candidate. The other one that we have eradicated is rinderpest, which is a disease in cattle.

Those are the only two diseases that have been eradicated. For a long time we have been fighting to eradicate polio. I think it is possible to eradicate polio and we should continue those efforts during this time.

Mr. Jekielek: What about the countries or states that are in these successive stages of lockdowns? Is this a kind of a "lockdown forever" model? What can they expect, if as you said, this virus will be in those societies forever? It seems there are huge, as you mentioned, collateral costs to doing that.
Dr. Kulldorff: The question I'm going to have to ask Canada and Australia is, "What's the end game?" Because you can't keep locking down forever. Australia had an advantage because it's a seasonal disease.
It's a smart thing that Australia was to position themselves in the southern hemisphere, because COVID came when it was the winter in the northern

hemisphere, when it spreads very easily. So in the northern hemisphere, it was impossible to suppress it.

Because Australia got it in the summer, they were able to suppress it their first summer, which was winter for us. They closed the borders with hard quarantines. So they had the advantage of being able to do that, and quite successfully. On the other hand, they weren't able to keep it out. It comes back and they have to keep doing the lockdowns.

So without a vaccine, they would then have to do that forever, which doesn't make any sense. We were very lucky, that has been a huge success during this pandemic, because there have been so many fiascos.

But the vaccine has been a huge success, to quickly get a vaccine. What Australia must do now is to say, "Okay, everybody should be vaccinated. All the older people should be vaccinated." Then remove the lockdown and open up. Protect those older people who are at high-risk through vaccines. If they don't want to get vaccines, they have to protect themselves through physical distancing.

But they should get the vaccine and then open up and it will be endemic in Australia, just like in every other country. But obviously, because they have suppressed it so much, they don't have the same levels of immunity as we have, for example, in the U.S. or in the UK, or in Europe.

Mr. Jekielek: That's pretty fascinating. Basically, you're saying that by doing the lockdowns, you're just delaying the inevitable process. Do I understand that correctly?

Dr. Kulldorff: Yes. There's of course a lot of damage during this process. So you could argue and say that you do this serious suppression until you get the vaccines. With that logic, they should now open up. But then the question is how long is it worth waiting for the vaccine? And the collateral damage from the

lockdowns is quite severe. It has been severe in Australia, and even more so in Canada.
Maybe it's worth doing those lockdowns for two months until you get the vaccine, but to wait a whole year, there's too much collateral damage from the lockdowns on public health, as well as on education and other aspects of society. It's too much damage so it's not worth it.

It would have been better for us to do focused protection or protecting those who are vulnerable and do a good job at that, which we didn't do.

Mr. Jekielek: Jumping into these collateral damages, you mentioned the mental health costs. I remember reading the statistic, which I've said a number of times in interviews, in this one study 25 per cent of teenagers had suicidal ideation, one in four. I didn't even know what to think about that. Can you expand on the mental health collateral costs?
Dr. Kulldorff: Yes, that's very tragic. The normal number was like 4 or 5 per cent and now, it's 25 per cent. So that's very tragic. And we have had a lot of mental health consequences. There's also been opioid overdoses that have increased now. Of course, a lot of that is not very measurable, because a lot of it is hidden. As a society, we have to really try hard to repair the damage and overcome that. Not just psychiatrists and psychologists and counselors, but all of us have to take on that role with our neighbors, with relatives, and with people at work. The church and other religious organization have an important role to play in helping.

That's something that we collectively as a society have to try to repair—all that mental health damage that we have seen during this pandemic.

I have three children, my oldest is 18. I was never worried about him because of COVID because he's young, and in effect he would do well. But I was very concerned about his mental health. So I was urging him through the whole pandemic, "Yes, go out. Play basketball with your friends, hang out with them and

do these things. Do these activities. " Because that was my concern. I wanted him to have a normal life as much as possible.

Mr. Jekielek: A number of people I've spoken with, including on this show, have mentioned that with the CDC and the FDA, some of the data that should be collected to get the full picture of the reality of this disease and the vaccines simply isn't being collected. What do you think about this?
Dr. Kulldorff: That's true, unfortunately. There are a few key things that should be collected. It's the role of CDC to do that. One is to take regular surveys of the prevalence of immunity of antibodies, as well as T-cell immunity, so that we know what is the level of immunity in the population in different states, but also random surveys, across the country, and over time.
Spain did that in the spring of 2020, they did a random survey of 60,000 people, different ages and different locations. It has been done in some places. My colleague, Jay Bhattacharya, did an early survey in Santa Clara county, but those are things that CDC should do. They should do it across the country and at regular intervals. So that's one thing.

Another thing that we failed to collect data on is the reported COVID deaths. Many of them are truly due to COVID, but some are not. Some died with COVID. We don't have a good idea of how many belong to each group. So it might be the primary cause, it could be a contributing cause, or it could be completely unrelated.

Again, we can't do everybody, but we could do random surveys from different places and different age groups to see how many of those who were reported to have died from COVID actually died from COVID, rather than with COVID. For children, there's about 350 children who have reportedly died from COVID.

We should examine everybody, as has been proposed by Marty Makary from John Hopkins University. It's something that CDC could easily do. They have the resources. They have the personnel to do that and go through the health records

and see how many of those actually died from COVID versus from something else, but with COVID. You need this kind of basic information during a pandemic to help decide what strategy to use. This data hasn't been collected the way it should have been.

Mr. Jekielek: What about on the vaccine safety side of things? This is actually a big area that you've been involved with for a long time.
Dr. Kulldorff: The best system we have for having vaccine safety is the vaccine safety data link, which is run by the CDC. It's an excellent program. I've been involved in it for almost two decades, developing many of the methods that are being used. They use electronic health records to see exactly who got vaccinated, and who didn't.
Then they know exactly what happened to them afterwards. Did they have a stroke or a seizure or a heart attack so many days after the vaccine? Then you can compare that with what would be expected by chance, because you also know what is the background population of those who didn't get the vaccines.

So that's a very good system and it's being used very well for COVID. The only problem is that it covers 10 million people, about 3 per cent of the U.S. population. So that sample size is such that it takes time to get the information.

The VAERS system, [Vaccine Adverse Event Reporting System] which is the more well-known system is less reliable because those are spontaneous reports. Anybody can report in, so there's under-reporting.

But it also doesn't have any good denominators. It's hard to come up with what the expected numbers should be. There's been a lot of misconceptions and misunderstanding about this system because each report is publicly available.

So you see there were so-and-so many heart attacks or so-and-so many deaths after the vaccine, but they obviously are going to be just by chance. So CDC reports those raw numbers of how many there were, and that's sometimes

misunderstood to mean that all of those were actually caused by the vaccine, which is not correct.

So what CDC is not doing, which the CDC should do, is to get some kind of a denominator. It's not so easy to do, but it can be done. Is this actually something unusual that we have to be worried about, or if is it just by chance?

If you give a million people a vaccine, some of those are just going to die the next month, and it had nothing to do with the vaccine. There's a certain number of people who die every month. So there's been a lot of misunderstandings about it. When CDC does give some kind of background rates, it invites people to misunderstand it and draw wrong conclusions from the data.

Mr.Jekielek: There does seem to be a spike in reporting in the VAERS system. I was looking at a graph that shows a baseline of reporting, and then COVID vaccines come along and there's a big spike in reporting. What does that mean?
Dr. Kulldorff: I'm not surprised by that, or that the spike is bigger than you would expect. I'm not surprised that it's increasing and that you get more reports from COVID vaccines than from the average vaccine. Because most vaccines are given to children and not very much tends to happen. They show up usually very healthy. And if they have any infection or something, that's usually not reported. But when you give vaccines to people in their 80s, health events happen to people in their 80s. So you will expect that there's a lot more deaths by chance. There's a lot more events when older people get a vaccine than when younger people get a vaccine.

So in that sense, I'm not surprised that there is a spike. Obviously a lot of this is because it's a new vaccine, and there's a lot of attention on it. So that can also increase the reporting.

With the virus, there's a lot of bias in terms of who reports, how much people report, and what do they report? That has to do with the reporting nature of the

system. So that's why the vaccine safety data link is much better because it's not based on people reporting something.

It's based on the normal behavior of going to the hospital and to the doctor for whatever you have, so there's less bias there, Because if you have a heart attack, you go to the hospital, whether or not you have the vaccine or not. It's recorded whether or not you have a vaccine.

So there's all this reporting bias that makes VAERS a difficult system to use. It's still very important for things like happened soon after the vaccine. For example, we know that the COVID vaccines can cause anaphylaxis, usually within 30 minutes after the vaccine. We know that from the VAERS system.

As long as people hang around, and they can get the proper treatment, it's not life-threatening. So for those things, it's useful. But for many other things, the VAERS system is not very useful, especially the way that the data is presented at the moment. It could be done much better.

Mr. Jekielek: You're one of the authors of the Great Barrington Declaration. That's where you outline this idea of focused protection with Dr. Jay Bhattacharya and Dr. Sunetra Gupta. There's a significant backlash to getting this information out and making it prominent. Tell me about what you've experienced.

Dr. Kulldorff: First of all, there was nothing really novel in that Great Barrington Declaration, because it basically said the same thing as the various pandemic preparedness plans that different countries had prepared before COVID. So there was nothing new or novel. There was nothing there that we hadn't said before, or that other people hadn't said in similar works.

What was very frustrating was that in the media, there was this perception that there was a scientific consensus in favor of lockdowns. However, my colleagues and I, plus other infectious disease technologists, the majority thought that lockdowns were not the right approach, and that focused protection would be

more important. But when anybody spoke up, they would be ignored or silenced, or, “Oh, that’s just one crazy person.”

So what we did with the Great Barrington Declaration, there were three of us who stayed together, and we all have been working with infectious disease technology for a long time. So they couldn’t dismiss us for not being in the right field of science. Coming from Oxford, Stanford, and Harvard, they’re all reasonably respectable universities, so they cannot dismiss us because of that.

So that was the goal—to take what a lot of people already thought and make it impossible to ignore. And I think that has succeeded. There was a huge backlash from the media, from some politicians, and also from a few fellow scientists. But there was also enormous support.

So very quickly we got over 10,000 signatures, co-signers who were scientists, public health scientists, and technologists. At the same time, we have received 850,000 plus signatures from the public as well, in total.

So there was a lot of support from the scientific community and from the medical community for the Great Barrington Declaration, but it was vilified in the media. And at the time in October of 2020, our philosophy was to make it clear that there was no scientific consensus for lockdowns. Then they can say whatever nasty things they want about us.

To get that message out, that there is no scientific consensus for lockdowns, was the most important first step at that time. And I think that we succeeded.

So in that sense, we’re very pleased with the outcome. There were personal attacks, but we maybe expected that. I’m surprised that it was mischaracterized and vilified for things that it wasn’t, instead of taking it as a serious discussion of how to better protect the older people.

We had some very concrete proposals, which obviously had to be adapted to the different countries. We had some very concrete proposals for people in nursing homes, and for people living alone at home.

That discussion never happened, unfortunately. That's tragic because that would have saved many lives during the second wave that we knew was coming. That's why we wrote the declaration in October, because we knew that we're having another wave now in the winter in the northern hemisphere.

But there was censoring by Twitter, by Facebook and by Google-owned YouTube. So as a simple [inaudible] scientist, it was a bit of a shock to suddenly be in such a situation. I thought I would be a simple scientist for the rest of my career, and then I would retire. So it's a very strange situation to be in, but that's what happened.

Mr. Jekielek: Why do you think they were so determined to censor you and these other scientists.
Dr. Kulldorff: Because they don't have any good public health arguments. They couldn't respond with public health arguments saying that we should do it because of this or that, because the lockdowns go against the principles of public health, while the focused protection that we proposed is very much aligned with traditional public health thinking.
So they really didn't have any good scientific or public health arguments. If you don't have that and you still want to push back, and you can't ignore it anymore, you can't silence people anymore, then you have to use either slander, or you have to use censoring.

Mr. Jekielek: But why not just consider what you were proposing?
Dr. Kulldorff: That's a good question. I don't know, because there's no public health reasons for it. So that's politics. And I don't understand what the politics behind that was. There must be something, but as a journalist, you probably understand politics better than I do as a scientist.

So there are not public health reasons for it. There's no biological reasons for it, and no scientific reasons for it. Obviously there's some political issues going on, which I really don't understand. Other people will have to try to figure it out and explain it, but that's outside my area of expertise.

Mr. Jekielek: But the cost of it is some countless number of lives?
Dr. Kulldorff: Yes. The collateral damage is enormous and it's long-term. We're going to have that with us for a long time, unfortunately.
Mr. Jekielek: There's a curious element here. The implementation of these vaccines, effectively does this sort of focused protection, doesn't it?
Dr. Kulldorff: Yes.
Mr. Jekielek: That's very interesting how things played out.
Dr. Kulldorff: Yes. When the vaccine came out, that was the best tool available for focused protection or protecting the old. There were other things we could do before that. But of course, when the vaccine came, that was an ideal tool for protecting the old high-risk people. So that was a very good thing, it was a great thing. And I think the vaccines have saved many lives.
Mr. Jekielek: What I'm saying is that in some way the Great Barrington Declaration was actually implemented despite being so maligned.
Dr. Kulldorff: It was in many places. It was implemented in terms of the vaccines, and in terms of other ways to protect the old. There were some places that implemented it, for example, Florida.
Mr. Jekielek: Directly in that case, right?
Dr. Kulldorff: Yes. With the vaccines, most places did put some emphasis on the older people, but it's a little bit varied. For example, Sweden and Florida put a lot of emphasis on getting the oldest. They had a very strict order in which they distributed the vaccines. In Sweden, there were even some people who lost their jobs because they sneaked in and took care of the vaccine when they weren't supposed to, because they hadn't reached their age group yet.
In India, a lot of young people got vaccinated before the old people. So it's varied in different places. But in many places, thankfully, they focused the vaccination efforts on the old people, as well as the caretakers of the old people.

Mr. Jekielek: You said something earlier that I want to build on here. I pulled something from one of your writings. Here's what you wrote, "Ultimately, lockdowns protected young low-risk professionals working from home, journalists, lawyers, scientists, and bankers—on the backs of children, the working class, and the poor.
In the U.S., the lockdowns are the biggest assault on workers since segregation and the Vietnam war. Except for war, there are few government actions during my life that have imposed more suffering and injustice on such a large scale."

Dr. Kulldorff: It's very sad and tragic. There's a fair amount of hypocrisy going around. For example, there was one tweet from about a year ago. This was from a fellow academic who said, "Well, here's one thing that everybody can do. When you take an Uber, roll down your window." Well, everybody cannot take an Uber. Taxi drivers are among the most exposed to the virus, in terms of different occupations.
So here we have a person, a very pro-lockdown public health scientist, who still wanted to have that convenience of taking an Uber and not realizing that they're privileged. While the person driving that Uber, they don't have a choice. They have to feed a family. The scientists have had the privilege of taking an Uber or a cab, while children are not allowed to go to school.

So it's a disconnect among those, who I would say are in a minority of the scientists who were favoring or arguing for lockdowns, but there's a disconnect because of the life they lived with being able to work comfortably at home. I've been able to work very comfortable at home, and most generalists have as well.

Another example is the New York Times had a story about what you can do. You should order your food online. Well, that was the recommendation to the Zoom class who can order online. It wasn't a recommendation to the people that actually deliver that food, or to the people who were cooking the food in the kitchen or the restaurants.

So there has been a really huge disconnect between the scientists and journalists and politicians on one end, and the majority of the population that has lived a very different life where they have lost jobs. Small businesses have gone under, while the big businesses have flourished. It has been driven by fear, this whole thing. I don't know what the rationale is, but it has been driven by fear.

When I was my 20s, I worked for human rights organization in Guatemala, and the way that the military dictatorship kept control over the population was through fear. They made sure that not only the leaders of the opposition were hit, but also the regular people. So it would be a fear within the whole population.

With COVID, there has also been this driving fear about COVID. For example, older people should be very cautious and take precautions because they are high-risk. But a lot of young people have gone around being fairly fearful of this virus, even though it poses much less risk to them than many other things that they do in the daily life. Driving a car has a risk with it and so on.

So it's a very strange time we have entered into. It's a strange from a personal perspective, but it's also strange as a father, and with neighbors. It's also very strange being a scientist with this very illogical situation, where basic principles of public health are thrown out the window, while the working class is thrown under the bus.

One of the principles that would probably help is that this is about everybody in society. Public health should take care of everybody, not just a small group of people.

Mr. Jekielek: On this theme, another thing that you said earlier, that it it's unethical to encourage or force younger people to get the vaccine, when there's older people around the world who don't have access to it. Those vaccines could be better used for the people that need the focused protection. Tell me more about this.

Dr. Kulldorff: Yes, it is a problem. It is unethical. So now we are giving the vaccine to people in the U.S. or in western Europe, to people who have had COVID already. So they already are immune. They don't really need the vaccine. We're giving you to students were forced to take it to go university classes, even though their risk from COVID is very, very small.
At the same time, there are many older people, poor people in India, in Africa, in Brazil, and in South America who do not have access to the vaccine and who are dying because they don't have the vaccine.

So while we have been successful when it comes to doing a vaccine rollout to prioritize the older people within the U.S., and within most countries in Europe, we have failed on focused protection when it comes to the vaccine on a global scale.

I don't understand how a university can demand and require a young student—who probably had COVID and they have natural immunity—to take the vaccine. Even if they haven't had COVID, they are at a very small risk, but they are forced to take the vaccine if they want to go the university, while there are older people around the world who have not had the chance to get this vaccine yet.

It's unscientific, because it's basically denying the existence of natural immunity from having had COVID disease. And it's unethical because it's leading to more death in other countries. So I think the universities should all change their policy to not having any of these vaccine mandates, if they want to live up to the age of enlightenment where we actually believe in science, including natural immunity, as well as behaving in an ethical manner. It's very surprising that universities would make these requirements.

Mr. Jekielek: Presumably, as these vaccines have been effective at protecting the old, they would provide some sort of opportunity for vaccine diplomacy. That's usually described in a more pejorative sense in terms of, for example, what China

has been doing. But in this case, I imagine it would be seen very positively by people in these countries that need it.
Dr. Kulldorff: Yes, and it would be the right thing to do.
Mr. Jekielek: We've received all this conflicting information from public health authorities. And in some cases, the guidance didn't seem to have much to do with public health policy. There is a general distrust that I've been hearing all over the place, the general feeling that there isn't a trust in these agencies which are responsible for these things, from the WHO, all the way down. You say trust is so critical. So what happens now?
Dr. Kulldorff: It's not a surprise that the trust has plummeted for public health agencies and public health officials because of these mixed messages, and also things like not taking a natural immunity from having had COVID disease into account and still forcing people to vaccinate.
So it's very understandable that the trust has come down. Both within the scientific community and the public health community, we have a lot of work to do to regain that trust. It's going to take a long time, but it is important to do that and to try to regain that trust.

The only way to do it is, one; to be very honest and straight with people, two; to trust the public, and three; to actually listen to the public and not just make public health policy based on the Zoom class, which is like scientists and journalists and their neighbors.

But to really listen to everybody in society and especially those who are less affluent workers, and of course children and old people. That's a third failure during this pandemic. Public health officials have a tendency to dismiss people when they have concerns. For example, not listening to them when it comes to vaccines. Vaccines are one of the greatest inventions of mankind as they have saved countless lives.

But when people are concerned about the safety, that's a serious things. I'm obviously very sad about it because a lot of what I do in science is to study the

safety of vaccines, but I had to take people's concerns seriously, and then to be honest about it. So as public health scientists, we have a lot of work to do for many years to come to regain that trust, because the loss in trust is very understandable.

Mr. Jekielek: Dr. Martin Kulldorff, it's such a pleasure to have you on.
Dr. Kulldorff: It's been a delight talking to you. Thank you so much.
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