COVID-19—a very visible pandemic

I read with interest the Correspondence by Johan Giesecke.1 Applauding the Swedish model, Giesecke posits a “relaxed strategy” or the development of herd immunity as the way forward in dealing with the COVID-19 pandemic. He recommends that the crucial task is not to stop the spread, “which is all but futile, but to concentrate on giving the unfortunate victims optimal care”. Given the drastic adverse economic consequences of the lockdown globally, the advocacy of herd immunity as a way out appears attractive. However, considering the current mortality rates of COVID-19, coupled with low critical care capacities for dealing with the pandemic, not only in low-income countries but also in some high-income countries, and the availability of alternative strategies to prevent its spread, I believe Giesecke’s recommendation to be flawed.

For one, the prescription of a relaxed strategy is entirely predicated on the trajectory of COVID-19 cases in Sweden. It is clear that Sweden’s decision to pursue a herd immunity strategy was taken after accounting for factors unique to its demographic. In fact, it was precisely owing to its herd immunity was initially adopted as the strategy, decided in late March, 2020, to depart from its earlier policy position and enforce a strict lockdown.1 For that reason, it would be a fallacy to compare the mortality rate of Sweden with that of the UK and Spain—both countries that introduced lockdowns (on March 23 in the UK and March 14 in Spain) well after the number of deaths in each country due to COVID-19 exceeded 100.1,4 An appraisal of the effectiveness of the herd immunity strategy would be better facilitated if Sweden’s mortality rates were compared with that of countries that imposed lockdowns early on in their COVID-19 trajectories. Drawing on data from the European Centre for Disease Prevention and Control’s COVID-19 global overview, notable examples of such countries are, as of July 15, 2020, Denmark, with an average of 9.1 deaths per 100,000, Czech Republic, with an average of 2.7 deaths per 100,000, and Norway, with an average of 4.3 deaths per 100 000 between Jan 1 and May 13, 2020.

More crucially, proposing a “relaxed strategy” overlooks the real possibility of health-care systems being overwhelmed, especially in countries with susceptible populations and few resource settings. The implementation of such a strategy would risk the admission of at least 16% of the population to hospitals for the management of critical illness.5 Current critical care facilities in most countries are grossly ill-equipped to handle such numbers, and health-care systems could crash. Even cities with sophisticated infrastructure, like New York, NY, USA, and Lombardi, Italy, saw the collapse of their health-care networks at their peak of the pandemic. What also appears to have been discounted is the neglect and consequential death that patients not infected by COVID-19 will probably suffer with health-care systems being overwhelmed all at once.

Giesecke states that there is little we can do to prevent the spread of infection, an assertion not based on facts. It bears noting that countries that are more populous than Sweden (with a population of approximately 12 million people) have effectively controlled the spread of infection. South Korea (with a population of approximately 51.6 million people) and Taiwan (with a population of approximately 23.8 million people) managed to stabilise the increase in number of infections, despite steering clear of bringing economic activity close to a complete standoff. South Korea has been practising fast testing, high-tech tracing, and zero-tolerance isolation as the three pillars to manage the COVID-19 crisis.6 Similarly, Taiwan has adopted a strategy of border control, case identification, and containment.7 In both South Korea and Taiwan, the aforementioned measures have also been complemented with mandatory mask-wearing, one of the remnants of the 2003 severe acute respiratory syndrome experience.8 There is now considerable emerging evidence that wearing a simple surgical mask could be effective in preventing transmission.9

I agree that a hard lockdown strategy will only slow down and delay, but not entirely eliminate, cases of the infection. Indeed, countries might not be able to afford to enact lockdown with no end in sight. However, concurrence on these counts that the adoption of a “relaxed strategy” or the pursuit of herd immunity is most conducive is unconvincing, particularly in countries with inadequate critical care capacities and few resources to build such capacities quickly. Instead, I suggest that the optimal strategy, even in a setting with scarce resources, would be to test, isolate, and contact trace, alongside an emphasis on universal mask-wearing, hand hygiene, and physical distancing.

I declare no competing interests.

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For COVID-19 global overview data see https://qap.ecc.europa.eu/public/extensions/COVID-19/COVID-19.html

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