Denis Rancourt vs Tim Anderson on the 2020 pandemic

COVID-19

Dr Denis Rancourt (Canada), a pandemic sceptic, engages in written debate with Dr Tim Anderson (Australia), a public health advocate. They both make opening statements, then have two responses each, before making closing statements.

Proposition: 'SARS-COV-2 merits suppression measures in order to combat the virus rather than the herd/community immunity approach'

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Denis Rancourt: opening statement, 6 October 2020

"Does SARS-CoV-2 merit suppression measures in order to combat the virus rather than the herd/community immunity approach?"

The events of COVID-19 can be analysed by unembedded critical commentators following different stances, or using different filters. Examples of useful analytical stances include:

COVID-19 is caused by a particularly virulent and transmissive viral respiratory disease pathogen. The death rate in a given population will depend on the effectiveness of government-coordinated mitigation interventions and treatment practices. Therefore, the hospitalization and death rates are a measure of intervention effectiveness in a given State jurisdiction.

Irrespective of anything else, the questions of virulence (infection fatality rate) and transmissivity (contagiousness) can be answered by unbiased scientific enquiry, assuming virulence and transmissivity to be properties of the pathogen, for a given societal structure.

The presence of a massive and coordinated information and recommendation (propaganda?) campaign, integrating government departments and health institutions, can be objectively ascertained, and it is both real and unprecedented in magnitude. In-effect this campaign serves to justify: harsh mitigation measures, censorship and surveillance, severe travel and trade restrictions, a large slowdown of the global economy, and a massive and accelerated effort to develop a vaccine. Are there geopolitical drivers, and what might they be? Or is the campaign

simply a rational and apolitical response to a palpable public-health threat, in the other extreme?

Large numbers of excess all-cause deaths have occurred in many State and local jurisdictions (and have not occurred in many other infected jurisdictions). Can it be established by scientific enquiry whether these deaths are primarily due to a new pathogen (SARS-CoV-2) or primarily due to the imposed mitigation measures, in the given societal structures? Can the quality of government be evaluated in terms of the lethality of the mitigation measures themselves?

Now, Professor Anderson and I want to debate whether SARS-CoV-2 merits special suppression measures versus business as usual, as, I will venture, would probably have occurred if no pandemic was declared.

One reason that we can even have this debate is that SARS-CoV-2 is not particularly virulent, nor is it more contagious than influenza, which is highly contagious. Folks are not dropping in the streets from SARS-CoV-2, not even in the USA. I do not know anyone who knows anyone who has died of this thing, and virtually all of my social contacts report the same. If SARS-CoV-2 were evidently deadly, in real observable terms for most people, then the debate would be over. There would be an obvious need to do more than the usual. Likewise, with an exceptionally virulent and contagious pathogen, the effectiveness of various mitigation measures would easily be ascertained. With SARS-CoV-2, the weakness of the pathogen allows for endless debate, spin, and policy uncertainty.

In that sense, the nature of the instant debate itself puts a limit on the presumed dangerousness of SARS-CoV-2. Unlike imperialism, war, global exploitation, and so on, in terms of human misery, this is largely an academic exercise, if it is confined to the virulence of SARS-CoV-2.

In my own on-going research, I have examined COVID-19 through the lens of each of the four stances outlined above. My main research articles have been:

Evaluation of the virulence of SARS-CoV-2 in France, from all-cause mortality 1946-2020 (20 August 2020) (with Marine Baudin and Jérémie Mercier)

All-cause mortality during COVID-19: No plague and a likely signature of mass homicide by government response (2 June 2020)

Masks Don't Work: a Review of Science Relevant to Covid-19 Social Policy (11 April 2020)

Face masks, lies, damn lies, and public health officials: "A growing body of evidence" (3 August 2020)

I also authored a Report for the Ontario Civil Liberties Association (ocla.ca), entitled "Criticism of Government Response to COVID-19 in Canada" (18 April 2020); and co-authored an OCLA letter to the WHO, entitled "WHO advising the use of masks in the general population to prevent COVID-19 transmission" (21 June 2020).

Regarding virulence, the infection fatality rate (IFR) is a scientific question, which cannot be answered merely by using socio-political inferences. The IFR is the number of deaths attributed to the pathogen (SARS-CoV-2), occurring within a relevant time period, per proven infection in the corresponding relevant time period, in a given population.[1]

The IFR must be discerned from the case fatality ratio (CFR), which is the number of deaths, within a relevant time period, per number of diagnosed medical "cases", which are confirmed and actual illnesses, in a given population. CFR is a measure of clinical severity. Here, I should stress that a "case" is not a "PCR positive", as misused in the media, and that the evaluation must be based on a population, without selecting only the most ill individuals presenting themselves to hospitals. At the start of the COVID-19 saga, a large uncorrected CFR, estimated from hospital cases in Wuhan, caused the initial panic.

An authoritative and detailed recent study of the IFR for COVID-19 is provided by Professor John Ioannidis.[2] Professor Joseph Audie reviewed the Ioannidis study, in relation to a demonstrably faulty evaluation of IFR revised and concocted by the CDC (dated 10 July 2020).[3] The CDC published re-revised estimates on 10 September 2020.[4]

Both Ioannidis and Audie conclude that SARS-CoV-2 is not more virulent than a "bad"-season influenza. Ioannidis puts it in these terms, in its socio-political context:
"Based on the IFR estimates obtained here, COVID-19 may have infected as of July 12 approximately 300 million people (or more), far more than the ~13 million PCR-documented cases. The global COVID-19 death toll is still evolving, but it is still not much dissimilar to a typical death toll from seasonal influenza (290,000-650,000), while "bad" influenza years (e.g. 1957-9 and 1968-70) have been associated with 1-4 million deaths. […] COVID-19 seems to affect predominantly the frail, the disadvantaged, and the marginalized – as shown by high rates of infectious burden in nursing homes, homeless shelters, prisons, meat processing plants, and the strong racial/ethnic inequalities against minorities in terms of the cumulative death risk."

The revised (10 September 2020) CDC best-estimates of the IFR [0.003%, 0-19 years; 0.02%, 20-49 years; 0.5%, 50-69 years; 5.4% 70+ years] are comparable to and smaller than the values for the mild 2009 (H1N1) influenza pandemic [0.00066%, 3-19 years … 0.22% (0.05%—4%), 60+ years].[5]

Therefore, by now, the numbers are in: SARS-CoV-2 is not an extraordinarily deadly respiratory disease pathogen.

This is to say nothing about the unsolved problem of inflationary bias in attributing medical deaths to COVID-19, which is the numerator in the IFR ratio. The latter bias is documented to be particularly severe with deaths of elderly persons having multiple comorbidities. It also says little about the problem of the questionable premise of virology that mortality is primarily due to the genetics of one guilty viral strain, rather than being primarily due to vulnerability of the host population (subjected to an ecology of pathogens), including vulnerability to violent government interventions.

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[1] https://www.medrxiv.org/content/10.1101/2020.05.13.20101253v3
[2] *Ibid.*
[3] https://www.researchgate.net/publication/343889424_Review_of_calculated_SARS-CoV-2_infection_fatality_rates_Good_CDC_science_versus_dubious_CDC_science_the_actual_risk_that_does_not_justify_the_cure_-_By_Prof_Joseph_Audie
[4] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119689/

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Opening statement: The pandemic deserved a social response

by Tim Anderson

I ask readers to reflect a little on health systems and the ideas behind them, and not just react to particular measures. To simply react to the crisis as 'lockdown vs no lockdown', and complain how it affects individual liberties, misses that.

The 2020 pandemic has shown us massive failures in western neoliberal health systems – privatised, heavily commercialised, lacking in preventive capacity – and this deserve analysis.

I suggest we learn from the experience of independent countries, those well organised on principles of humanism and social solidarity, e.g. China, Vietnam, Cuba, Venezuela and Syria. Their actions during the pandemic have some important lessons.

It is important to go beyond the fantasies that the current epidemics were not serious public health threats, which demand a social response. Cynical responses which cry 'the data is all wrong, scientists should not be believed, public health systems want to poison us all' both miss the neoliberal failures and prevent us from engaging in social responses.

1. On the broad debate:

I have read some of the material that my colleague Denis Rancourt has written on this subject. I disagree strongly with his idea that all viruses are part of a regular winter cocktail, with little difference between them.

Demonstrable, collective medical science is important, and differs in character from political debate, which is mostly constructivist and argumentative.

Differences between diseases are important. Some affect the young and others the old. Many epidemiologists say, "if you've seen one pandemic, you've seen … one pandemic" (Osterholm; Horton). That is, "COVID-19 doesn't behave like flu, which doesn't behave like Ebola" (Spinney). We know now that COVID19 is not only linked to respiratory illness but also vascular and neurological illness.

It simply entrenches ignorance to say: 'we can ignore all contemporary public health data' (because of the chronic uncertainties), and 'we can ignore medical science consensus' (in favour of our chosen dissidents). We should engage with the best available evidence.

The consequences of denying the pandemic, as do a western liberal minority, are that people assist the neoliberal privatising project and self-exclude from meaningful engagement in many real issues: how to manage particular quarantine regimes, social security, medical regimes, etc.

Pandemic deniers run parallel slogans to those of neoliberals like Boris Johnson and Donald Trump: 'no worse than a flu', natural herd immunity', 'the cure is worse than the disease'. This denialism is not really a 'left' position because it begins by rejecting preventive health measures (e.g. quarantine and vaccines, at the centre of all public health systems) and its justifications generally capitulate to individualism ('my liberties above all').

2. On the proposition:

'Does SARS-CoV-2 merit suppression measures in order to combat the virus rather than the herd/community immunity approach?' I say yes, the 2020 pandemic was a serious health crisis which required prompt protective measures to contain the spread and mitigate the illness and death.

This should be understood in principle, first, before moving to criticise the various quarantine and hygiene measures taken by particular governments. It is always important to not conflate principles with particular political actions.

Protection of populations could not be achieved by simply allowing the disease to run its course and hope that some sort of natural immunity might result. That would have allowed many millions to die. I will briefly address the science on the danger of the virus and why 'herd immunity' is only really viable with the help of a vaccine.

We can debate the science on excess mortality, vaccines, face masks, lockdown casualties, and so on, later.

Epidemiologists calculated a range of Infection Fatality Rate (IFR) estimates, a few months into the pandemic. They suggested IFRs between 0.2% and 1.3%, but the consensual area is between 0.5% to 1% (Verity et al; Basu; CDC; Bhattacharya; Mallapaty). That is, about 5 to 10 times the seasonal flu, not inconsistent with the more than one million COVID19 deaths reported from 200+ countries and territories in seven to eight months of epidemic, compared to an average of 400,000 annual deaths from flu globally, in recent years (Paget). No responsible health official can afford to just cherry pick the most optimistic estimates.

On acquired immunity, measurements of antibodies to COVID19 in some of the hardest hit European cities and New York show 10% or less, plus some higher levels T-cell reactivity (Jones and Helmreich; Pitt; Woodley). That is far too low for any sort of 'natural' herd immunity which, given COVID19's highly contagious nature, has been suggested to require 85%. Observed natural levels of antibodies or T-cell reactivity do not yet come close to that (Pitt; Doshi). This is where the 300+ vaccine candidates try to do better. Let's see how good they are.

3. Neoliberal failures and independent responses

This is my characterisation of the approach taken by neoliberal countries (UK, USA, Sweden, Brazil):- they stripped their public health capacity, decades before this crisis;- they developed societies of privilege and exclusion, fuelling distrust and resentment;- they delayed for many weeks state responses to the epidemics, allowing contagion to spread;- they imposed quarantine controls very late, using police and not health officials;- they generated both contagion and prolonged 'lockdowns' – the worst of all worlds.

What did the more independent countries (China, Vietnam, Cuba, Venezuela, Syria) do?- they built and extended public health systems; – they extended universal guarantees and made more inclusive

systems;- they promptly imposed protective quarantine measures, led by health personnel;- they generated shorter 'lockdowns' which, with testing and tracing, could be more focused.

Why should we not reflect on why Cuba and Syria (e.g.) imposed quarantine measures before they had a single infection, while the UK and the USA waited 7-8 weeks? The first two contained their epidemics, the latter two did not.

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Denis Rancourt: FIRST RESPONSE, 10 October 2020

"Does SARS-CoV-2 merit suppression measures in order to combat the virus rather than the herd/community immunity approach?"

Our opening statements were made separately, blindly. We now proceed one after the other. I am going first.

"On the broad debate" Tim tars me as being a "pandemic denier". I do not deny that there has been a large wave of deaths in an epidemiological context of viral respiratory diseases.

My focus has been to research why the all-cause-mortality-quantified excess deaths have been so different from one jurisdiction to the next (state to state in the USA, province to province in Canada, region to region in France, country to country in Europe, and so on); and the ways in which "science" and "medicine" are misused in the palpable global propaganda campaign, including the propaganda by government public-health directives, law and enforcement.

"On the proposition" Tim advances that SARS-CoV-2 is undeniably more virulent than influenza, and that there is a "scientific consensus" on this point. Both are demonstrably false.

Regarding virulence of the pathogen, Tim quotes incorrect early estimates of the infection fatality rate (IFR), and does not quote the latest CDC summary of IFR values, nor does Tim quote the most complete critical review made by Professor Ioannidis (see my opening statement). Tim follows this by stating: "No responsible health official can afford to just cherry pick the most optimistic estimates."

Regarding comparison to influenza, Tim fails to appreciate the complexity of the epidemiology of influenza, and the difficulty in calculating meaningful (unbiased) mortality burdens, using statistical models.

Average mortality from epidemic influenza varies 20-fold from locality to locality, and mortality from seasonal influenza varies 100-fold and more with age. The highly-cited longitudinal field study of Loeb et al. (2000) found an influenza-outbreak case fatality ratio (CFR) of 8% in 5 care homes in Toronto over 3 years, a hard number large enough easily to have been the nucleus of a pandemic propaganda campaign. For other cities, Loeb et al. noted: [1]

"Rates of pneumonia as high as 42% and case-fatality rates exceeding 70% have been reported in outbreaks due to influenza virus. [their references 8 through 10]"

There is also an extensive scientific literature showing that elderly people are not significantly protected from influenza by vaccination, despite the pressures of the massive vaccine industry on the scientific establishment.

Regarding "Neoliberal failures and independent responses", I reject Tim's simplistic proposition that a difference in "COVID deaths" between "neoliberal countries (UK, USA, Sweden, Brazil)" and "more independent countries (China, Vietnam, Cuba, Venezuela, Syria)" is caused by decimated medical systems in the West versus responsible medical care management in his list of non-neoliberal (communistic?) countries.

I expect that three factors are more important than Tim's "they promptly imposed protective quarantine measures", etc., to explain differences in excess all-cause mortality in the March-April catastrophe period. I use all-cause mortality because the attributed-death statistics are notoriously unreliable.

First, an important factor in comparing Western and non-Western nations is the degree to which the elderly population is housed in care homes versus family homes. There is little doubt that care homes are killing fields for viral respiratory diseases, and that WHO air-ventilation standards "for Infection Control in Health-Care Settings" are not being followed.[2] Ventilation is crucial where there are groups of vulnerable people.[3], [4] Natural ventilation will be abundant in homes in hot climates.

Second, viral respiratory disease transmission operates via aerosol particles, which are stable in air only in low absolute humidity conditions. I have reviewed the relevant established science in my articles. This explains: why viral respiratory disease transmission is highly seasonal and predominantly occurs in winter in mid-latitude countries, with reversal in our summer for mid-latitude Southern Hemisphere countries (their winter). Viral respiratory diseases virtually do not transmit in hot and humid (equatorial) countries, or in hot and humid seasons or environments.

For example, if you wanted high transmission in Texas in the summer, you would have to confine the interacting population to air-conditioned closed spaces. Likewise, if you want summer transmission in hospitals, you have to air-condition the air in common areas, and reduce humidity "to control mold and bacterial cultures", while not paying attention to ventilation as a means to remove aerosols.

Third, confinement, psychological stress, and social isolation of elderly people in care homes or elsewhere are deadly, as is introducing infected patients from hospitals into the care homes. I have reviewed the established relevant science in my articles. In my papers and interviews, I have explained why we should interpret the March-April excess all-cause mortality events (e.g., 30,200 accelerated deaths in France) as having been caused by the government response measures, not any virus acting in an undisturbed society.

So, the simple idea that the funding model of the national health-care system explains the pandemic deaths is not a useful generalization. I agree that the Western countries are vicious and irresponsible towards their own populations. I believe the highest-level driver is geopolitical.

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[1] https://www.cmaj.ca/content/cmaj/162/8/1133.full.pdf
[2] https://www.who.int/water_sanitation_health/publications/natural_ventilation/en/ (WHO seems to have filed this under "Water sanitation hygiene", rather than highlight its relevance to COVID.)
[3] https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa939/5867798
[4] https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa939/5867798#supplementary-data

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First response to Denis Rancourt's 6 October statement and his 10 October response

by Tim Anderson, 11 October 2020

In response to the opening statement and first response by Denis, let me first list the matters on which I agree. I agree that the danger and contagion of COVID19 can and should be determined by "unbiased scientific enquiry"; that there are "large numbers of [unexplained] excess all cause deaths" in many jurisdictions; that the infection fatality ratio (IFR) is "a scientific question, which cannot be answered merely by using socio-political inferences"; and that IFRs (the fatality rate of all infected, not just those presenting as ill) must be distinguished from the initially inflated case fatality ratios (CFRs).

Given the nature of western opinion on many big debates – strong, often tending to abusive – few are likely to change their minds based on our arguments. Yet our agreement on the need for independent scientific arbitration is important because readers will have reference to our sources and perspectives.

Nevertheless I say Denis is in error in several matters of method and substance.
On method, his first error is to introduce personal anecdotes in an attempt to prove a general proposition: "I do not know anyone who knows anyone who has died of this thing", he says, suggesting it cannot be very dangerous. This proves nothing, any more than the fact that I do personally know of such deaths and illnesses. Trying to prove the general from the particular is a basic logical fallacy.

His second error is to mix insinuations of a global conspiracy (without evidence) with an argument over 'virulence' which founds itself on scientific evidence. The vague back-text undermines his scientific logic and provides an alternative 'escape route' in case his recourse to science fails (i.e. 'where there are excess deaths there is another 'obvious' cause').

The third problem is his cherry picking of scientific estimates. All the scientific reports (including Ioannidis, on whom Denis relies) admit a large degree of uncertainty over many aspects of COVID-19. That means we should have regard to the range of scientific estimates on COVID IFRs. I did that in my opening, citing a range of 0.2% to 1.3%, with a consensus of between 0.5% and 1%. The seasonal flu IFR is commonly said to be about 0.1%.

In substance, Denis relies for his 'no worse than a flu' argument on Ioannidis, corroborated by some correspondence he had with an academic friend, Joseph Audie. He also claims the Washington based CDC revised its estimates in September to fit in with Ioannidis. Yet Denis does not report these cherry picked sources accurately.

John Ioannidis is a scientist who (with colleagues including Jay Bhattacharya) has engaged in political lobbying of the Trump administration since mid-March, to prevent a 'lockdown', based on his 'relatively harmless' view vs likely economic damage. Several of his arguments are now touted by Trump (see Stephanie Lee).

But his COVID19 predictions are poor. On 17 March Ioannidis predicted "about 10,000 deaths" in the USA from COVID-19. By that time the US government had reported just 121 deaths, one month later it was 38,000 deaths, six months later more than 200,000. In mid-July Ioannidis revised upwards his IFR estimate to a median 0.27% – but as much as "0.90% in locations exceeding 500 COVID-19 deaths per million". That is, a median rate almost 3 times the seasonal flu. Audie's letter mentions this but Denis does not.

He also wrongly claims that the US CDC in September revised its IFR estimates to figures "comparable to and smaller than" that of the 2009 Swine Flu. Not so. The 10 September CDC report cited by Denis says it relies on the European IFR calculations by Hauser et al, which range from 0.5% to 1.4%. The Audie letter bemoans the fact that the CDC in July presented "a second and higher estimate of 0.65%", a figure confirmed in late September by congressional testimony from CDC Director Robert Redfield:

> "The preliminary results on the first round show that a majority of our nation—more than 90 percent of the population—remains susceptible … [and] that the overall COVID-19 infection fatality rate (IFR)—the share of Americans infected by the virus who will die as a result—is about 0.65 percent" (in Sullum, 29 September).

So is the "massive and coordinated information and recommendation (propaganda?) campaign" mentioned by Denis (i) that of Ioannidis and Trump, who play down the epidemic, or (ii) that of the CDC, which cites international studies to maintain that COVID19 is 6.5 times more deadly than the seasonal flu? The US state is clearly divided on the matter.

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On the new matters raised by Denis in his 10 October response, first there was no need for me to "tar", him as a 'pandemic denier'. He does that himself in his Facebook group 'Denis Rancourt denying everything', where he says "I deny climate, vaccine, face masks, COVID-19, medicine, pedagogy, … everything!"

Denis spends some time on why he thinks so many people have died in aged care homes in the COVID era. I welcome his suggestions for the reform of aged care. But we know the Swedish voluntarist and 'herd immunity' approach did not work. Swedish health official Anders Tegnall admitted in August that older people in Sweden were worst hit than those in neighbouring countries (Holroyd 2020).

My emphasis on public health systems is not simply about a "funding model", but about values and systems. I have explained this in several articles and it has relevance for the important debate about the costs of 'lockdowns', which are mainly in delayed or denied health care, plus child nutrition and schooling.

So health systems remain at the root of the important debate about 'costs of the virus vs costs of the lockdown'. A British tabloid story in July, citing an unpublished government report, headlined '200,000 deaths' in Britain from the 'lockdown'. Most of these were said to be in delayed health care. Those who read through to paragraph 20 might have noticed the same

report was said to have predicted 500,000 COVID19 deaths “if the virus had been allowed to run through the population unchecked” (Knapton 2020). Public health matters.

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Denis Rancourt, arguing against the proposition, responds to Tim Anderson's first response from 17 Oct:

Tim spins a narrative about COVID-19, which is primarily intended to validate the state practice of medicine in select socialist jurisdictions ("China, Vietnam, Cuba, Venezuela, Syria"), while invalidating the state practice of medicine in select neo-liberal jurisdictions ("UK, USA, Sweden, Brazil").

Tim is focussed on political doctrine, and thus unable or unwilling to address my criticisms of his partisan views about COVID-19. I reiterate my criticisms below.

Likewise, it appears that Tim (who is in Australia) is significantly mistaken in terms of what actually occurred in Syria, according to a report by on-site investigative journalist Eva Bartlett.[1] Are Tim's interpretations of the actual events for other countries also mistaken?
Tim and I share disdain for the mass crimes of empire, and admiration for Cuba, which brilliantly practices diplomacy by humanistic medicine, but I cannot accept Tim's baseless arguments about COVID-19.

State medicine has a potential to be harmful, in both socialist and neo-liberal systems, not least via its paternalistic religion-like mesmerizing of the population. Medicine most everywhere has been modelled into a state religion, which creates an unhealthy dependence, and a debilitating perception of one's own body and place in the world.

In neo-liberal jurisdictions, the influence of Big Pharma is devastating, with prescription-drug addictions, and population-scale use of chemotherapeutic, psychotropic and palliative drugs. Most published research validating marginal benefits from these drugs is false.[2] It is no accident that the third-leading cause of death in the West is medical "error", not counting error-free "treatment".[3]

In addition, vaccines are generally a global industry of harmful exploitation, enabled by the captured WHO and CDC. It is a trillion-dollar industry, which supports the USA dollar as a global currency.[4]

The jurisdictions that are somewhat independent of the USA are not immune to the institutions captured by Big Pharma, nor to the global propaganda about the pandemic, because these jurisdictions know that fear can lead to war, and vaccines can create vaccine borders against trade and cooperation. Transmissible pathogens are a powerful pretext for total isolation and vilification of nations. Thus, except for Belarus that proves the rule, China and Russia must at least appear to take the West's pandemic seriously, and they must develop their own vaccines.

Tim's theory about COVID-19 is that a difference in "COVID deaths" between "neoliberal countries (UK, USA, Sweden, Brazil)" and "more independent countries (China, Vietnam, Cuba, Venezuela, Syria)" is caused by decimated and badly managed medical systems in the West versus responsibly managed and values-based medical care in his list of non-neoliberal countries.

Tim's theory is at odds with three main facts, which I have amply described in my articles and already spelled out in this debate:

Viral respiratory diseases transmit highly in low absolute humidity conditions (in the winter of mid-latitude nations), not in humid (near equatorial) environments.
The deaths mostly occurred in elderly persons in care homes (inter alia because these care homes were infected by transfers from hospitals, and are hot spots of transmission).[5] Therefore, one cannot compare societies with many elderly persons in care homes with societies in which elderly parents live more in nuclear families.

Viral respiratory diseases transmit in closed facilities (hospitals, care homes, schools, etc.) having inadequate exhaust-ventilation, such as in cold climates or with air-conditioned spaces. Hot-climate spaces with natural ventilation are more ventilated.

Tim's narrative is a basket of apples and oranges.

Regarding the infection fatality ratio (IFR), Tim relies on Verity et al. (2020), which was published online on 30 March 2020. The article does not report measurements of the IFR. Rather, the authors infer a tenuous IFR using Bayesian inference theory:
To estimate the infection fatality ratio we fitted to data on infection prevalence from international Wuhan residents who were repatriated to their home countries…
Verity et al. obtain a large IFR estimate.

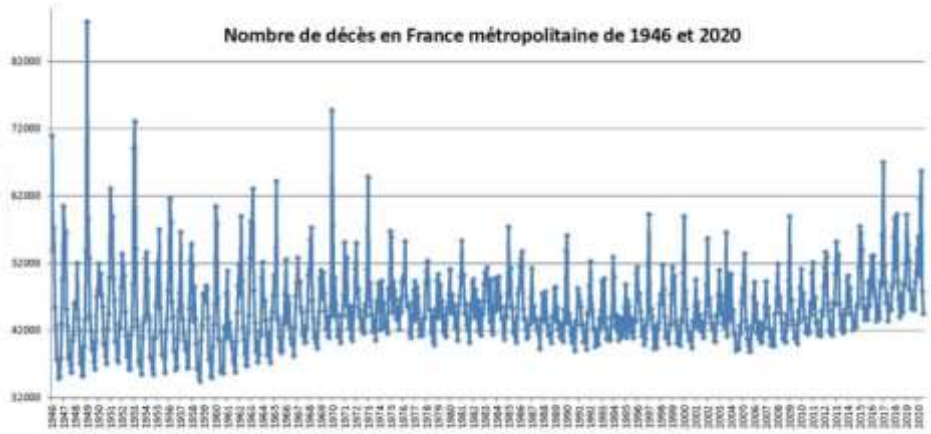
In contrast, Ioannidis, which I cited, calculated actual IFR values from seroprevalence data, and critically assessed such measurements in 36 studies and 7 national estimates. Ioannidis is one of the world's leading medical researchers. Tim argues that Ioannidis' numbers are the result of bias since the scientist tried to communicate his findings to the president of the USA, and expressed concern about the deleterious effects of lockdowns.

The main problem, however, is that to believe Tim, one has to forget the science about viral respiratory diseases prior to 2020. Non-pandemic influenza is a highly contagious disease that often devastates care homes for elderly persons, and I have already cited some of the studies of care-home influenza epidemics, in this debate. Case fatality ratios (CFR) and IFR are exponential with age, as is the case with COVID-19, and no worse.

Pre-COVID-19 care-home epidemics occurred by accident. Whereas, with COVID-19, care homes were systematically infected by transfers from hospitals, following the March 11th suggestions by the WHO to prepare hospitals for a pandemic, under conditions in which care workers fled out of fear. No wonder death counts were high in March-April-May.[6] [7] It is difficult to correct for these systematic effects in calculating an IFR that is intended, by definition, to be a characteristic of the viral pathogen in an unperturbed society. As such, many IFR evaluations will be overestimates. In addition, there has been a large positive bias in attributing deaths to COVID-19, in this propagandised pandemic, which also inflates calculated IFR values.

Instead of addressing my points about influenza and care homes, Tim relies on the bare uninformed statement: "The seasonal flu IFR is commonly said to be about 0.1%".

Finally, this figure from my latest article should put all of this in perspective.[7] It is the all-cause mortality by month in France from 1946 to 2020. The winter-burden mortality from viral respiratory diseases, primarily, is seasonal, and historical population-health status plays a dominant role throughout. An extra peak occurs in August 2003, which corresponds to a heatwave that killed 15 thousand. The last peak is the COVID-19 episode:



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[5] Video, 16 October 2020, Le Stu-Dio: "COVID-19: CRIMINAL MISMANAGEMENT? RANDY HILLER – DENIS RANCOURT" *[LINK UPDATED -ED]*
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Second response to Denis, 26 October 2020

Tim Anderson

I want to make some points about 'immunity' before addressing the second response by Denis. The rejection of preventive health measures has drawn on simplistic ideas about immunity, such as that

surviving a one-time contact with any new virus confers life-long immunity. But while some viruses can be controlled by natural immunity, others evade attempts at either Darwinian immunity or immunity by vaccine. Some like HIV/AIDS cause chronic persistent disease and in others, including COVID19, there is reinfection. Immunity comes from two factors: developing specific antibodies to the virus and activating a general immune response. Yet after some months we know that COVID19 antibodies in heavily affected cities are only at about 10%, a long way from the necessary levels for 'herd immunity' with a highly infectious disease (Jones and Helmreich; Pitt; Woodley; Doshi).

To counter my advocacy of public health systems, Denis attacks 'state medicine', by which he lumps together socialized health systems (like that of Cuba and Syria) and Big Pharma-privatised systems (like that of the USA). He does not seem to notice the difference, saying "state medicine … in both socialist and neo-liberal systems … creates an unhealthy dependence, and a debilitating perception of one's own body and place in the world." This is libertarian stuff loved by the Trumps and Boris Johnsons of the world. Denis criticizes 'Big Pharma' but sides with them in dismissing socialized medicine.

He then presents his own two part theory. The first part claims that COVID19 is a typical winter 'low- humidity' respiratory disease; the second part is that the deaths "mostly occurred in elderly persons in care homes", linked to the poor ventilation in those homes. One obvious problem with this 'low humidity' disease theory is that five of the top ten countries reporting infections and deaths (India, Brazil, Colombia, Mexico and Peru) have substantial tropical populations. On the 'most deaths in aged care homes' side, Fiore did report that "about half of Sweden's 5,730 deaths occurred among those in elder care homes". However the other half (almost 3,000) amounts to more than double the combined deaths in ALL the other Nordic countries (1,343); and Sweden's institutional care rate is much higher than that of Brazil, Peru and India. I am afraid this is just another western, orientalist theory.

Denis refers to my citation of the IFR for a seasonal flu as about 0.1% as an "uninformed statement", apparently miffed that I have not sufficiently addressed his theory about influenza and care homes. However we have both relied on much the same data. Denis cites Ioannidis to speak of "a typical death toll from seasonal influenza" of 290,000-650,000, and I cite Paget which gives the same data, which averages to about 400,000 flu deaths per year. Yet after 9 months of pandemic, and the various quarantine regimes, the reported COVID10 death toll of almost 1.2 million is three times that.

Denis says I rely on Verity et al, from 30 March, and that this is too old. In fact, in my opening statement I cite five sources: Verity et al; Basu; CDC; Bhattacharya; and Mallapaty. In my first response I point out that even the sources Denis relies on (Ioannidis and the CDC) give higher IFR estimates than Denis accepts. No need to repeat all that here.

Finally, responding to my citation of policy and practice in Syria, Denis suggests I am "significantly mistaken". He refers to a Facebook article by Eva Bartlett (who blocks me on Facebook) in which she abuses me as "a deluded person living far removed from reality" and falsely asserts (without any reference) that I defend "brutal lockdowns". Readers of this debate might recall my opening statement which says it is important to distinguish principles of public and preventive health and to "not conflate [those] principles with particular political actions". There have been all sorts of inappropriate and repressive responses; but we are discussing principles here. Eva's main argument is that Syrian policy re COVID19 was "nominal" and not strictly enforced. But examples of crowds can be found everywhere. She misleads people by suggesting that the Syrian government did not take the pandemic seriously, and that Syria's early closure of the borders, the curfew, school closures and so on had little to do with the country's low levels of infections. Syrian policy and

practice is detailed in my June article, listed below. Denis should not have tried to prove a point simply by citing an unreferenced Facebook post.

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Denis Rancourt, arguing against the proposition, closes his argument:

Tim's position is anchored in his beliefs that:

a. A new virus ("SARS-CoV-2") has been discovered that is unlike any other viral respiratory disease virus.

b. The deaths assigned to have been caused by COVID-19 are due to the new virus.

I address these beliefs below.

On this basis, Tim advances his main thesis that a difference in "COVID deaths" between "neoliberal countries (UK, USA, Sweden, Brazil)" and "more independent countries (China, Vietnam, Cuba, Venezuela, Syria)" is caused by decimated and badly managed medical systems in the West versus responsibly managed and values-based medical care in his list of non-neoliberal countries.

Tim is not deterred by differences between his two select groups of countries, which affect viral respiratory disease propagation and deaths. Repeating myself, the said differences are in three areas:

Absolute-humidity-dependence of aerosol stability in air (viral transmission)
Care-homes institutional structure, and populations in care homes (hot spots)
Closed space aerosol-exhaust ventilation dependence on climate and air-conditioning (climate)
For Tim, these differences, and decades of the underlying science, are my "two part theory". Tim appears to be oblivious to the logical deconstruction of his main thesis, which I have made.

Likewise, Tim ignores analyses based on the (national and regional) hard numbers of all-cause mortality by time, and prefers "the reported COVID-19 death toll of almost 1.2 million" unscientifically collected and tabulated by the WHO.

Coming back to the debate question: Were extraordinary government-imposed measures warranted? Would business as usual have been preferable?

By the measure of accumulated science and established practice prior to 2020, this was not a pandemic. It was a massive propaganda campaign and social interference, in the normal presence of viral respiratory disease.

Such propaganda campaigns are regularly engineered by Big Pharma and its Finance collaborators to continually invent epidemics,[1] and this is allowed/enabled because there is globalization and geopolitical utility. Russia and China must go along with the West's propaganda, as I explained in my Round 2 response.

In fact, "COVID-19" deaths occurred irrespective of "SARS-CoV-2". Virtually any respiratory disease virus or collection of viruses in the viral ecology of our bodies would have served the same purpose. They all kill vulnerable, sick and weakened individuals in the same way; notwithstanding the industry of finding medical particularities of "SARS-CoV-2". Influenza is similarly associated with a spectrum of relatively rare exotic medical complications.

In terms of deaths, the 2020 non-pandemic was a globally-instigated unprecedented assault against working and middle-class, largely institutionalized, elderly and socially/medically fragile populations.

The all-cause mortality shows sharp surges in deaths that followed the 11 March 2020 WHO global recommendation for hospital clearing as "pandemic" response, across the world, in those jurisdictions that sent hospitalised infected elderly persons into the community, including locked down care homes.[2][3][4][5]

The mechanism that made care homes and institutions for sick and elderly persons into killing fields includes the following elements:[2][3][4][5]

- infection seeding by hospital transfers into the care homes
- universal lockdowns of the care homes
- denied specialized medical treatment to the residents of the care homes
- reduced staffing and staff abandonment in the care homes, and negligence
- collateral effects of the universal lockdown of the care homes: extreme social isolation, psychological stress, reduced aerosol-exhaust ventilation, lost oversight of the institutions by family-members

This was a mass crime.[2] Tim prefers to make an ideological argument.

Tim is incorrect to suggest that I reject "preventive health measures". I agree with the usual social and science-based practice of voluntarily staying at home when one has symptoms of a transmissive respiratory disease, as a way to slow the rate of transmission in the community at large. This practice includes being told to stay at home by colleagues and supervisors. It also includes voluntarily abstaining from visiting elderly parents and grandparents during one's symptomatic period and prior to symptoms if another person in the nuclear family has symptoms. It is a case-by-case and contextual approach, adapted to particular needs and priorities.

A universal lockdown on care homes is an entirely different beast, and has not previously been globally imposed, nor is it scientifically demonstrated to give a net benefit. In fact, the experience of COVID-19 unambiguously demonstrates a massive harm from this protocol, especially when combined with infecting the cares homes using hospital transfers.

Likewise, I oppose universal lockdowns of the general population, universally enforced masking,[6][7] universal "social distancing", and the universally imposed so-called "sanitary practices" of compulsive handwashing and surface cleaning. There is no demonstration of benefit from these laws and rules, which are an attack on society.

There wasn't even a legitimate pandemic. My research suggests that if the extraordinary and universally applied measures had not been enacted, then no excess deaths would have occurred beyond those of a regular flu season. The post-March-11th "COVID-peaks" that I first identified in the all-cause mortality data for the USA and Europe would not have occurred.[3]

In the context of this debate, "herd/community immunity" refers to the business-as-usual natural coping of individuals and society constantly challenged by respiratory disease viruses, as has been the case for thousands of years. In technical terms, the concept of "herd immunity" was introduced by vaccine manufacturers as a pretext for universal vaccination programs, rather than individual personal-choice "protection". After all, if a vaccine is effective, then it should protect the vaccinated individual. The idea is that sufficiently large vaccination coverage prevents rapid spread through a population, and reduces the likelihood that late pockets of vulnerable (not immune) individuals will be infected by the pathogen in question. Thus defined, "herd immunity" is a device to sell universal vaccination.

In my view, we have not entered a new area in which human health on the planet suddenly, after 4 billion years of animal co-evolution with viruses, depends on universal distribution of viral respiratory disease vaccines; nor have we entered a new scientific era in which the gargantuan vaccine industry has discovered how to make effective, beneficial, and safe viral respiratory disease vaccines. The industry is a wasteful cash cow, which causes much harm and deters away from real health and quality of life initiatives.

If you want to help vulnerable and oppressed populations and social classes, then stop structurally and directly attacking vulnerable and oppressed populations and social classes.

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Final statement in the Denis v Tim debate

Tim Anderson

Returning to the question I repeat: COVID19 was a serious public health threat which required a social response. A Darwinian style 'herd immunity' response, where the old and ill (the main victims of this particular virus) were simply left to die, would have been monstrous and deeply unethical.

The prospects for any widespread 'natural' immunity to COVID are receding. A British study found that between 20 June and 28 September the numbers of those antibody positive fell from "almost 6% to 4.4%" (Alford). Antibody levels even in the hardest hit cities have rarely exceeded 10%, far too low to contain a highly infectious virus. Britain and Sweden are not far apart. Sweden's public health authority admitted in September that, by mid-June, less than 12% of Stockholm residents, and only 6% to 8% of the Swedish population, had COVID antibodies (Vogel).

Our understanding of any new virus should be informed by collective medical science, not just cherry picked sources. This is not the same as social or political argument; there are valuable broad agreements in medical science, because it is far more demonstrable than social science. In my opening I gave five sources for estimated IFRs (Infection fatality rate) for COVDI9 (most between 0.5% and 1%). Denis challenged one of these and misquoted his own sources (Ioannidis and the CDC) as I noted earlier. The CDC accepts an IFR of 0.65%, 6 to 7 times that of the seasonal flu. And now we also have the 'long COVID' illnesses, especially amongst public health workers.

We also see nearly 1.2 million reported COVID19 deaths, after nine months of pandemic. Paget demonstrated an average global seasonal flu death toll of about 400,000 per year, over the past decade. We already have three times that and, after 12 months, we will likely have four times that, even with preventive measures. Globally, reported deaths remain constant at about 5,000 per day.

The good news is that, in many countries which have faced epidemics for many months, the proportion of those dying has fallen considerably. This seems mainly due to (i) improved treatment of what multiple studies now show to be as much a vascular as a respiratory disease (Kavanagh), and (ii) very high levels of testing, showing many asymptomatic cases in younger people but also lower death rates amongst older people (Dorling; Hendrie; Oke, Howdon and Heneghan).

Those denying the seriousness of this disease have been left behind in social debate. How can deniers credibly engage with these questions, when their starting point (often unchanged since March 2020) was that there was no real public health threat?
- How can we meet the demands of students for a safe return to classes?
- How and when can quarantine measures be safely rolled back?
- How can we support 'long COVID' sufferers including the public health workers?

Denis can present his idiosyncratic theories that the problem was (i) a seasonal winter flu in cold countries, or that (ii) the deaths were mostly to do with the poor ventilation in aged care facilities. But in my view he will miss the real challenges.

The same applies to those who have been swept up in the baseless anti-vaccine scare campaigns, endangering the lives of children (e.g.) over the measles vaccine. International travel now requires COVID tests and soon that will include COVID vaccination. They demanded the same of us with smallpox vaccine in the 60s and 70s and they will do it again with COVID, with reason.

I repeat my initial point, we should first address the in-principle matters of public and preventive health, before moving to engage with particular political stupidities. I have harshly criticised the use of police in the second wave quarantine regime imposed in my home town Melbourne, but I accept that some sort of quarantine was needed. 'Lockdown v no lockdown' was always a childish comparator – it led people to obsess over symptoms and not causes and encouraged them to ignore questions of 'when, how and by whom'. I say the roots of the current crisis should be looked for in the failures of public health systems.

Finally, whatever anyone thinks about our debate, we have left a record of our sources which honest and curious people can use to check the facts for themselves.

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