

BRIEF19

A daily review of covid-19 research and policy.

POLICY BRIEFING

New analysis: 130,000-210,000 United States coronavirus deaths were avoidable.

This week, the National Center for Disaster Preparedness, out of Columbia University, [released](#) a chilling analysis of the cost in human lives that resulted from the federal government's missteps during the pandemic response. The analysis acknowledges pre-existing conditions within American healthcare, namely inequitable access to care, a broken system, and vast health disparities among minority groups, but lays the blame at the feet of the administration in no uncertain terms: "...an Administration that has publicly denigrated its own public health officials – and science more generally – thereby hamstringing efforts by its vaunted public health service to curb the pandemic's spread." The report breaks this down into four key failings:

- Insufficient testing capacity: after initial supply shortages limited effective testing, a lack of cohesive data gathering and analysis made contact tracing and epidemiologic study impossible
- Delayed response: there was no unified federal lockdown plan, and the recommendations that were released occurred after the virus was able to spread unchecked
- Lack of mask mandate or guidance: the White House [blocked](#) plans from the U.S. Postal Service (USPS) to ship 650 million masks, for free, in February, and the lack of use, approval, or encouragement of masks from the very top could lead to hundreds of thousands of more deaths.
- Politicization, leadership vacuum, and the failure of top officials to model best practices: the administration allowed partisan politics to override scientific evidence and "mocked" well-established public health guidelines.

The report does give proper due to some unavoidable factors, including population distribution, demographic changes, and comorbid conditions as confounding factors when compared to other countries. But the overall flavor of the analysis is to assign blame where blame is due. *The National Center for Disaster Preparedness. [26 October 2020.](#)*

—Joshua Lesko, MD

Final vaccine rollout recommendations from National Academies of Science.

In early September, the National Academies of Science, Engineering, and Medicine [unveiled](#) draft guidance for a phased vaccine rollout schedule. This week the final framework was [published](#). The paper acknowledges that many of these recommendations are being made despite a number of undetermined variables, such as vaccine efficacy in subpopulations, other mitigation efforts and the ever-changing nature of the covid-19 pandemic. Because of such questions, the steps delineated require flexibility and ease of implementation.

The paper outlines that given the anticipation of limited quantities at the outset of a vaccine release, allocation plans must be equitable and perceived as such. The highlighted principles of the plan include ensuring maximum benefit, mitigation of health inequities, fairness, transparency and evidence-based practice.

Finally, in determining allocation of vaccines, the following risks were considered: that of acquiring infection, severe morbidity and mortality, negative societal impact and the risk of transmitting infection to others.

With these variables in mind, the following phased approach of vaccine allocation has been recommended:

- Phase 1a: high-risk healthcare workers and first responders.
- Phase 1b: people of all ages with comorbidities that put them at significantly higher risk; older adults in aggregated living facilities.
- Phase 2: K-12 teachers, staff, and child care workers; critical workers in high-risk settings; people of all ages with comorbidities that put them at moderately higher risk; people in homeless shelters or group homes for individuals with disabilities; people and staff in jails, detention centers, prisons, and the like; all older adults not in Phase 1.
- Phase 3: young adults; children; workers in industries important to the functioning of society not included in Phase 1 or 2.
- Phase 4: everyone else who did not qualify in previous phases.

The paper concludes by discussing the various scenarios under which this framework may need to be implemented. It focuses on time scales of vaccine availability, efficacy, acceptance by the public, number of different vaccines, distribution networks, pandemic status and the social, economic and legal contexts. The authors have admirably tried to address every possibility against every backdrop but acknowledge the limitations in forecasting every scenario. *The National Academies of Science, Engineering, and Medicine*. [30 October 2020](#).

—Joshua Lesko, MD

Perspective: compounding crises abound in the United States.

The [numbers](#) are stark. In nearly every state covid-19 cases are climbing. The average number of deaths per day is up ten percent. The White House Chief of Staff has [said](#) the virus is “beyond control.” But even this does not paint the entire picture. Cases have been surging for the past few weeks, and public health experts agree that death counts are a lagging indicator, often trailing several weeks behind the current case data. As the weather turns colder, the fear is another surge of need for hospitalization and critical care that threaten to swamp hospitals.

But the [danger](#) is not just in the lack of physical resources; rural centers have been hit especially hard with healthcare worker infections, further limiting already strained systems without a ready source of replacement personnel. Discussions are already underway regarding again limiting elective procedures and clinic visits, but there is no way to compensate for staff quarantines. With a vaccine candidate likely not available until early next year, the one option available is finally taking seriously the long-standing social distancing and masking [guidelines](#) advocated for by leading experts. *Various*. [28 October 2020](#).

—Joshua Lesko, MD

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Brief19 is a daily executive summary of covid-19-related medical research, news, and public policy. It was founded and created by frontline emergency medicine physicians with expertise in medical research critique, health policy, and public policy.