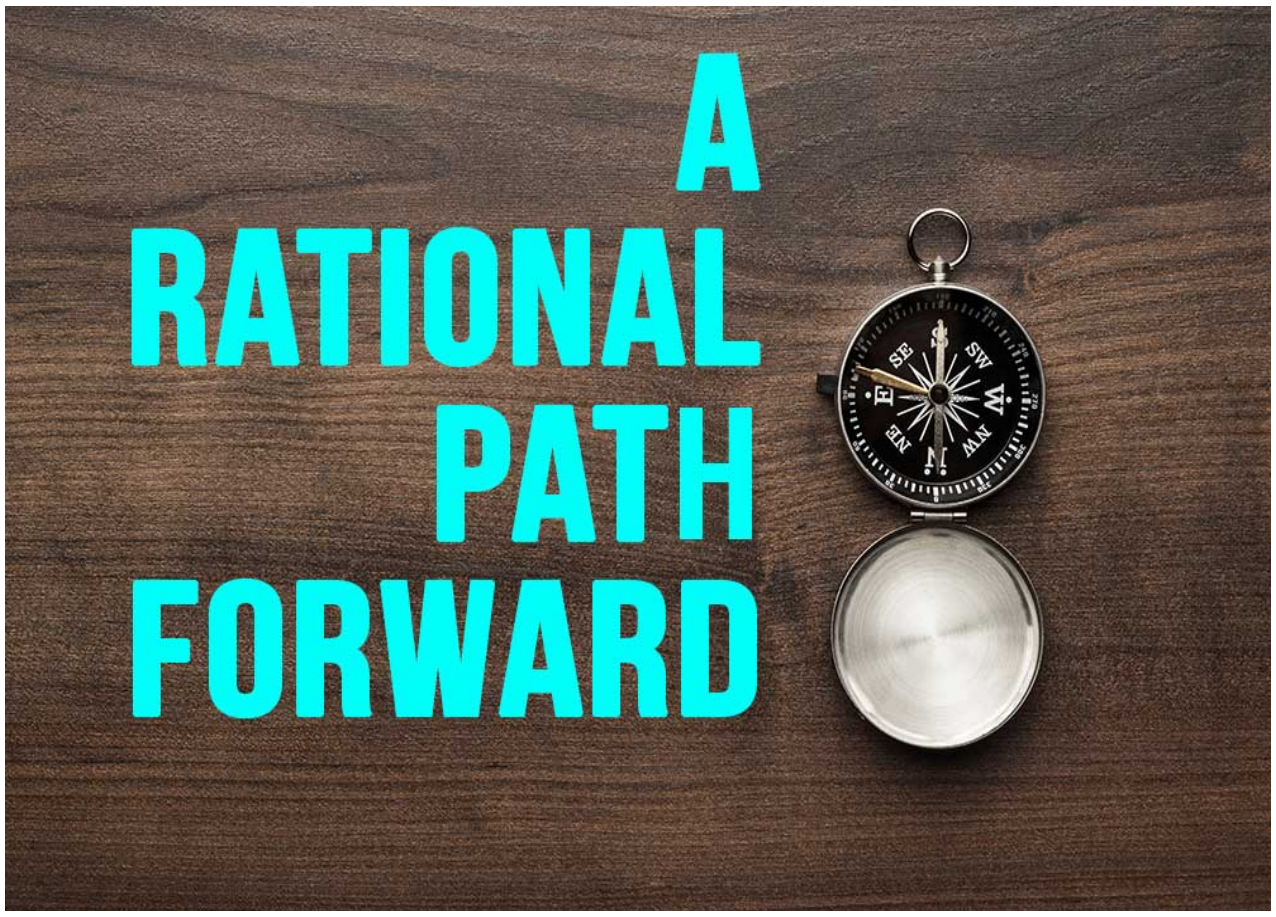

The Great Barrington Declaration laid out the central tenets of a more reasonable, scientific approach to understanding COVID-19. However, something is still missing from the national conversation: There has yet to be a clear articulation of the path forward to normalcy. Specifically, we need to discuss steps that can be taken to address the reasonable and serious concerns around COVID-19 but are properly balanced against the human rights of the citizenry.

The American public has shown a level of compliance with deeply disruptive public health measures that would have been unthinkable just 10 months ago. That compliance has been squandered on an unrealistic and unachievable goal of “stopping the spread.” This has set the country up for failure. The extraordinary nature of the sacrifices required of the public by our public health officials has rendered this failure toxic, in addition to being wholly ineffective in its primary goals. We must redirect the incredible altruism shown by the American pubic towards efforts that will be successful and will have meaningful impact on meaningful public health metrics.

Below we offer ten steps to dramatically improve the current situation that we feel both sides of the divide can agree on. This approach is apolitical and can be used to guide the country out of this crisis.

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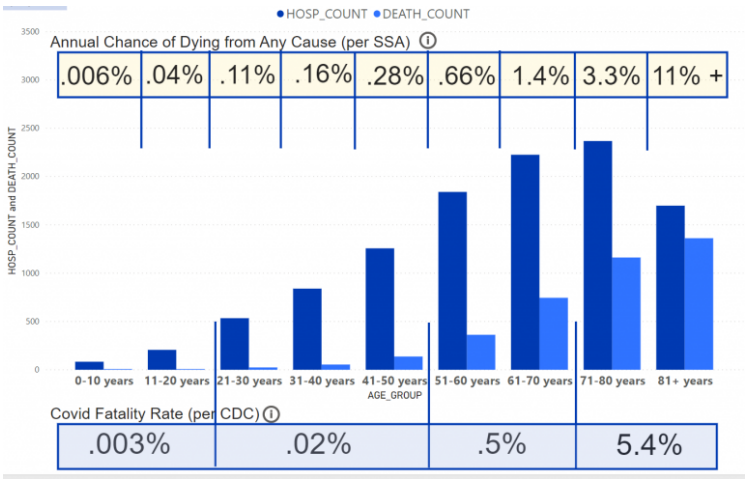
1) Communicate the age-stratified fatality rates

The CDC’s current best estimates for age-stratified infection fatality rates (IFR) are:

- 0-19 years: 0.003%
- 20-49 years: 0.02%
- 50-69 years: 0.5%
- 70+ years: 5.4%

The risk to people under the age of 20 is over 1000 times lower than the risk to those over 70.

Polling has shown that the general population has a poor understanding of the mortality



rate of the disease, dramatically overestimating their personal risk of dying of COVID-19. Until the public understands the actual risks (preferably in the context of other risks that are taken for granted), common-sense measures will continue to be resisted in favor of a pseudo-religious belief in non-pharmaceutical interventions (NPI) that have not been proven to work anywhere. Personal responsibility, combined with the knowledge of facts and accommodations for those who are vulnerable to poor outcomes, should be the centerpiece of all policy implementations.

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2) Re-think the testing strategy

- The commonly-used PCR tests are not calibrated to convey the person's level of contagiousness. It is immoral to quarantine people that are non-contagious and are of no danger to the community. Information about an infection, or even prior infection, is useful for public health officials, but a one-size-fits-all response to case discovery does not serve the cause of public health.
- A shift to rapid antigen testing and away from PCR testing may be a valuable adjustment to the current testing regime, as long as we understand the false positive and negative rates of all approved tests.
- All tests are currently approved under Emergency Use Authorizations, and they should immediately begin the formal approval process that is required for other diagnostic tests.
- Home tests without mandatory reporting to government agencies or healthcare providers should be made available as soon as possible. This accomplishes the objective of making individuals feel comfortable with ascertaining their health status without fear that their condition will be disclosed to others or otherwise used against them; this policy is similar to the current screening policy for sexually-transmitted infections.
- Testing of asymptomatic individuals (unless it is part of a randomized surveillance study) should end. Tests should be used primarily in situations where they are needed to protect the vulnerable–for example, in hospitals and nursing homes.

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3) Stop quarantining healthy people

Contact tracing can be useful for identifying outbreaks, but the current practice of quarantining every contact of someone with a positive test is causing repeated quarantines of healthy people that are disruptive to families and businesses. Public health officials should recommend that people stay home if they have any symptoms. With the threat of quarantine removed, people will be more likely to be honest about their activities and contacts.

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4) Restore in-person schooling and normal activities for children

It has been established that children are not a significant infection vector of COVID-19. The educational, psychological, and sociological damage done to millions of children worldwide due to school closures is incalculable. We recommend opening schools for in-person education, everywhere, immediately, without masks or social distancing. In areas where the community is resistant to a full reopening, a phased reopening can allow those who identify as vulnerable or live with someone who is vulnerable to gradually become more comfortable with in-person learning. Accommodations can also be provided to staff, teachers, or students who identify as immunocompromised.

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5) Acknowledge that all work and institutions are essential

By defining some workers as essential and others as non-essential, the government is not only choosing economic winners and losers, but also which lives and livelihoods are expendable while we wait for the vaccine. This is not a decision for the government. Each individual must be given the information necessary and the agency to make these decisions for himself or herself. Such an approach will naturally result in those workers at lowest risk bearing the immunological burden, rather than those who are unable to work from home, which is what is occurring now. Businesses must be allowed to operate freely and without interference. If a business is to be closed, it must be done with due process and must be based on transparent and unambiguous data that demonstrate specific problems in that specific business. Also, liability protection is needed to allow businesses and institutions to operate without fear of lawsuits.

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6) Recognize naturally-acquired immunity

Naturally-acquired immunity to COVID-19 is rarely officially acknowledged, and the CDC recently claimed that a vaccine is better than natural immunity. This is deeply unscientific and incredibly harmful on many levels. We must cease denying the overwhelming scientific evidence that our immune systems respond to SARS-CoV2, that infection is broadly protective against future infection, and that there are many people who do not contract COVID-19 due to cross-immunity from prior similar infections. The campaign against naturally-acquired immunity, and antibodies in particular, is singularly bizarre in the face of a vaccine “solution” that triggers a naturally-occurring immune response. This has been so misreported that much of the public views COVID-19 similarly to AIDS—constantly mutating in order to avoid and stymie our bodies’ natural defenses. We don’t currently have any evidence that SARS-CoV-2 mutates rapidly, and in that case, a vaccine would be useless—as it is against AIDS.

This misperception will prove particularly problematic when it comes to vaccine distribution. First, if we persist in ignoring the resistance afforded by naturally-acquired immunity, we will give vaccines to millions of first responders who have already been infected. Second, work-from-homers, who have been shielded from the virus thus far, will be jockeying for preferential position for the vaccine despite the fact that many of

them likely have lower overall risk due to wealth-conferred health. Once again, it is imperative that we inform people of their real risks and ensure they understand that the vaccine is triggering the same mechanisms of protection that would occur naturally.

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7) Require that mandates be supported by evidence and balanced against their costs

We believe strongly that encouraging positive hygiene habits (healthy eating, exercise, washing hands) is a positive approach that public health officials can rightly influence. Social distancing can be a proper tool to help mitigate spread, but mandating public social distancing has had a dramatic negative effect upon the population and needs to be re-examined. It is established science that masks do not stop the spread of this virus. While COVID-19 is a “novel” pathogen, the virus size and method of spread are the same as similar respiratory viruses. If public health officials are going to make the claim that masks have been shown to work, studies in the general population with control groups must demonstrate that the science has changed. If these studies exist, they should be widely circulated and explained.

The non-pharmaceutical interventions that have been implemented during this pandemic have routinely been implemented near, at, or after major outbreak peaks, which have created the illusion of impact—e.g., in NYC. Because of this temporal association, it is necessary that NPIs be temporary and their removal tied to specific metrics such as peak hospitalizations from prior years. Once levels drop below a clearly-defined threshold, NPIs must be removed to avoid unnecessary collateral damage and avoid the problem of conflating their implementation with the natural course of the disease.

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8) Report COVID-primary hospitalization data clearly and in the context of previous flu seasons

Hospital (general & ICU) usage must be clearly delineated between those who have COVID-19 as a primary diagnosis and those who are hospitalized for another reason and have a positive COVID-19 test. Moreover, the “primary COVID-19” number should be the primary metric to determine whether any short-term community-wide mitigation efforts need to be undertaken. Furthermore, detailed and accurate dates, demographics, and severity measures should be published along with any hospitalization data.

As with other data, hospitalization numbers must be contextualized using prior years’ hospitalizations. It is important that people have an understanding of the prior hospitalization rates and how COVID levels compare to those. Ideally, we should be benchmarking against bad flu seasons, as this will give people a reasonable barometer for comparison.

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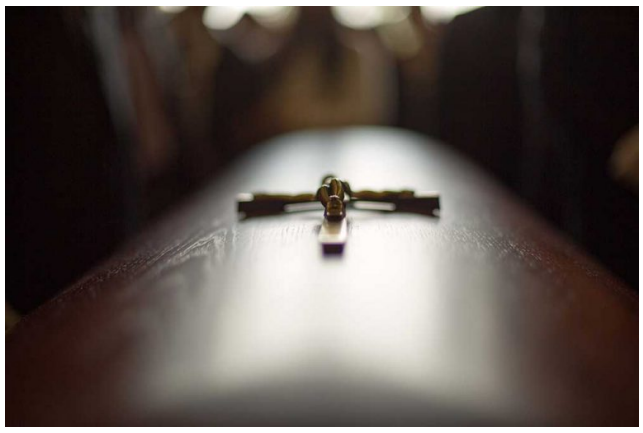
9) Keep separate statistics for deaths “from” and “with” COVID

Today, per guidance from the CDC, anyone that has ever had a positive COVID-19 test is counted as a COVID-19



death, even if the final cause of death was unrelated to COVID-19. COVID-19 deaths need to be tallied like other diseases, and COVID-19 (typically pneumonia or ARDS) must be the primary cause of death. Furthermore, detailed and accurate dates and demographics should be published in a uniform manner across all geographic entities. A first pass effort could simply separate death certificates with COVID in Part 1 (conditions leading directly to death) from those with COVID in Part 2 (other significant conditions).

It is important that the date of death be included in all death reports because deaths from months ago are often incorrectly used to justify new mitigation measures.

COVID-19 deaths must also be contextualized. Just as people know the daily deaths from COVID-19 in their state, they ought to know the daily deaths from flu in the country or state at the peak of a bad flu season. This will help to reduce their fear.

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10) Limit the emergency powers of government

Emergency declarations and powers are meant to deal with just-in-time events where the legislature does not have time to act. COVID-19 is no longer this type of an emergency and is likely already endemic. As such, it is time for emergency powers to cease and for the legislatures to resume their role and pass laws regarding how governments should deal with these pandemics. Transparent investigations into the actions to address COVID-19 and their results must be conducted so that we may learn and address successes and the serious failures.