

## COVID-19: BROADER CONCERNS

By mid-March 2020, some public health experts were urging a (US) national lockdown in response to COVID-19 and *flatten the curve*—i.e., to slow the spread of infections and avoid overloading hospital capacity. Legal writers and media outlets, including the New York Times, National Public Radio and the Washington Post, questioned whether the president had the authority to issue such an order. He left the lockdown question largely to governors to decide their state’s policies and strategies. More than 50 lockdown experiments ensued.

Over the weekend, a presidential candidate announced he would issue national lockdown orders if advised “by scientists.” Earlier he announced a national mask mandate would be one of his first actions, if elected.

We previously [reviewed](#) evidence supporting masks as a deterrent to virus transmission. It is thin. A few highlights:

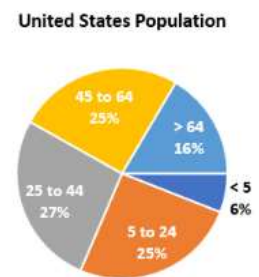
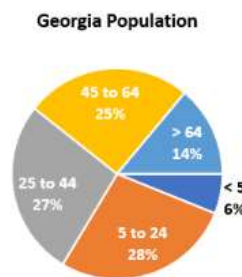
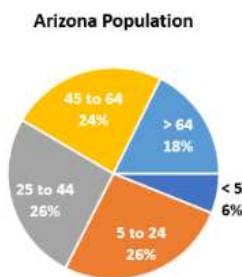
- The CDC’s [Policy Review](#) (May 2020) on nonpharmaceutical measures for pandemics concluded face masks yielded no statistically significant reduction in transmission;
- The CDC’s contact tracing [guidelines](#) (July 2020) noted in a footnote, “masks *may* [italics added] help those who are infected from spreading the infection, there is less information regarding whether masks offer any protection for a contact exposed to a symptomatic or asymptomatic patient. Therefore, the determination of close contact should be made irrespective of whether the person with COVID-19 or the contact was wearing a mask.” It goes on to explain, “Because the general public has not received training on proper selection and use of respiratory PPE, it cannot be certain whether respiratory PPE worn during contact with an individual with COVID-19 infection protected them from exposure....”

This study reviews preliminary evidence from those lockdown experiments, using Arizona and Georgia to compare different executive actions and outcomes. We also review recent medical evidence about the collateral effects of lockdowns.

Like many states, Arizona’s and Georgia’s governors both ordered statewide lockdowns and issued “shelter in-place” orders around April 1, forcing the closure of many businesses, churches and other “non-essential” gatherings. Many of Arizona’s orders are still in-place; most of Georgia’s were lifted beginning late in April.

**A FEW STATISTICS.** Georgia’s population is about 46 percent larger than Arizona’s (10.6 million and 7.3 million, respectively). While Georgia’s median age is in the 35- to 44-years cohort—as is Arizona’s—Georgia’s portion of residents over 64 years of age (14%) is 28% smaller than Arizona’s (18%). This is an important factor in comparing states’ COVID-19 mortality rates.

	Population million	Total Cases (8/15)	Total Deaths (8/15)	Deaths per 100k population (8/15)
<b>AZ</b>	7.279	192,652	4,492	0.70
<b>GA</b>	10.617	235,166	4,669	0.65
<b>US</b>	<b>328.240</b>	<b>5,336,350</b>	<b>161,364</b>	<b>0.33</b>



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**CASES & MORTALITY.** The two states had mixed success “flattening their curves.”

Fortunately, considerably fewer cases appeared than originally forecasted by public health models.

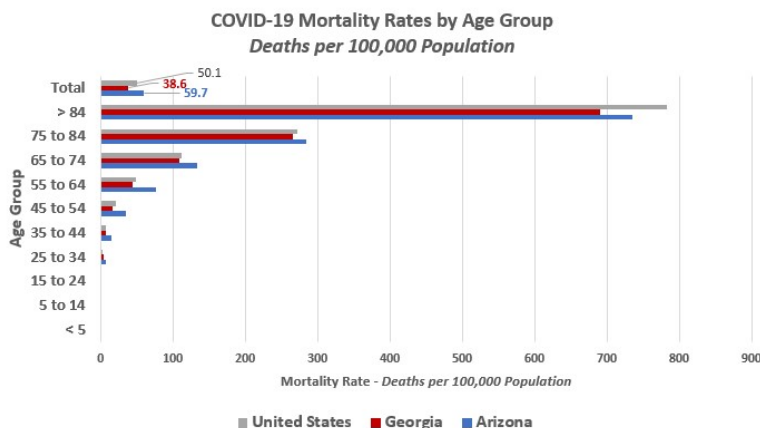
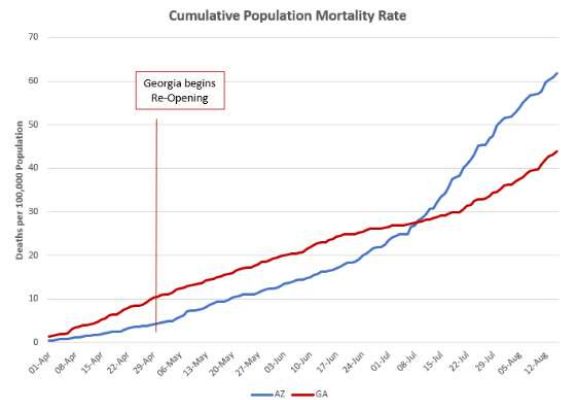
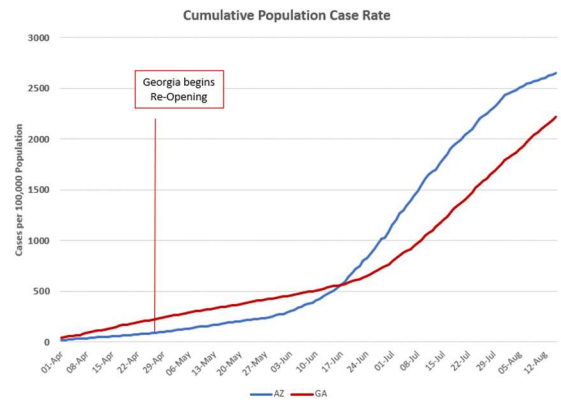
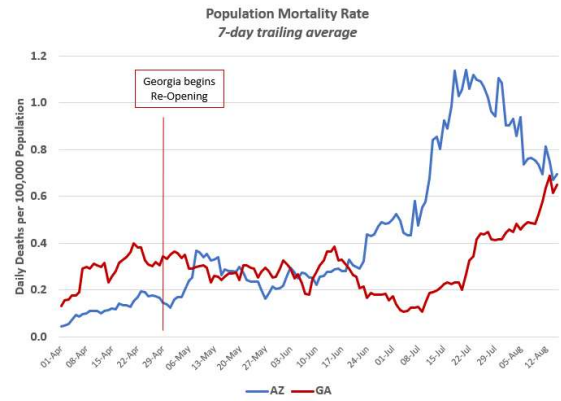
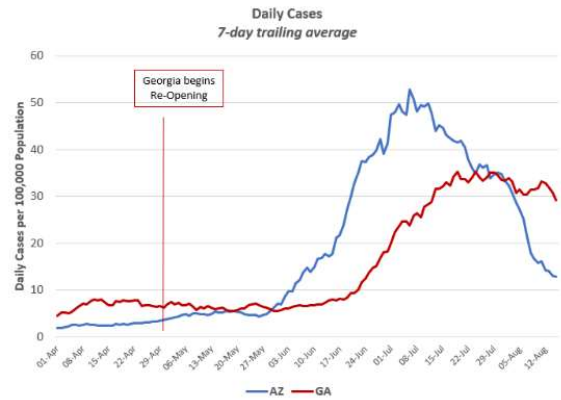
While some large cities saw hospitals crowded with COVID-19 patients; many hospitals, emergency rooms and doctors’ offices saw dramatically lower volume as patients delayed or avoid healthcare interactions.

Summer brought a steep rise in daily cases in both states—in part due to transmission, and in part due to increased testing. Arizona’s increase began in early June; Georgia’s in late June. Since early July, Arizona has seen a decrease in reported daily cases, falling below the Georgia rate (normalized for population) August 1<sup>st</sup>.

On average, Georgia’s population daily case and population mortality rates were greater than Arizona’s until June 17<sup>th</sup> and July 9<sup>th</sup>, respectively. After those dates, Arizona’s cumulative impacts overtook Georgia’s, with no sign of let-up.

Using CDC’s Provisional Death Count data (through August 22<sup>th</sup>, as of August 27<sup>th</sup>), the difference in mortality likely follow from two factors: Arizona’s larger fraction of residents over age 65, and the groups greater mortality rate, compared to younger residents. It is not clear why Arizona had greater mortality rates in all age cohorts.

It is unclear that Arizona’s continued lockdown has had a positive public health effect.



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**LOCKDOWN COSTS.** Data from the US Bureau of Labor Statistics suggests an important effect of extended lockdowns and business closures: Unemployment.

After enjoying unemployment rates of 3.1% for January and 2.7% for February, Georgia’s rate jumped to 4.2% for March and 11.9% for April. The state responded to re-opening with a decrease in unemployment rate to 9.4% in May, followed by a continued decline.

Arizona’s unemployment rates followed an initial similar trend, with low first quarter numbers, followed by a jump to 12.6% in April. Recovery has been slower, perhaps due to the state’s lockdown, with a projected rate of 10.6% for July—nearly 40% greater than Georgia’s.

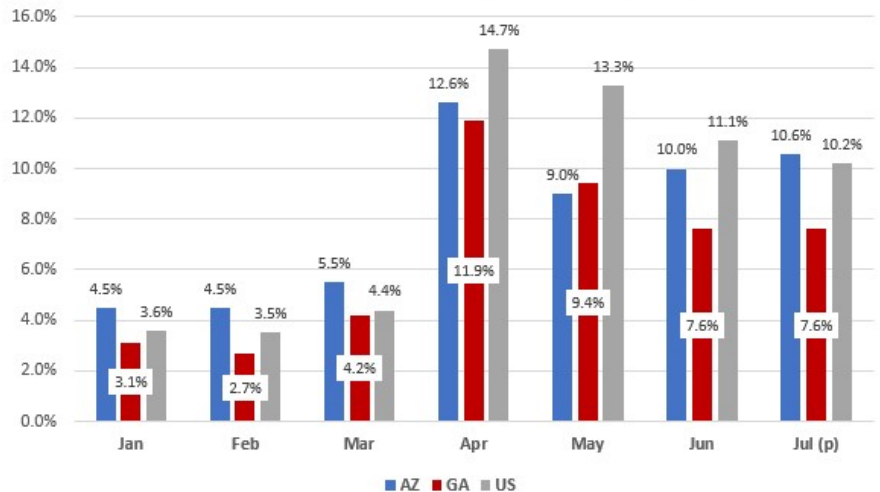
The impact of lockdowns and slowdowns on state budgets likely will be unfavorable. Those data are not yet available.

**LOCKDOWN HEALTH.** In our prior studies we suggested that lockdowns, financial stress and social isolation might have unfavorable health impacts, and that the measurement and reporting of these impacts would take time. Preliminary numbers are starting to surface.

During August, the Journal of the American Medical association (JAMA) published a [research letter](#) reporting a 46% decrease in newly identified cancer cases, comparing the weekly diagnoses counts for January 6, 2019 through February 29, 2020 (more than 250,000 patients) to the period March 1 2020 through April 18, 2020 (more than 20,000 patients). The authors suggested delayed diagnoses may result in less favorable outcomes, including death.

A July 9<sup>th</sup> [press release](#) by the Cleveland Clinic reported, “The COVID-19 pandemic has brought about multiple levels of stress in people’s lives across the country and world ...” Of 258 patients presenting with symptoms of acute coronary syndrome between

**Unemployment Rates**  
US Bureau of Labor Statistics (Seasonally Adjusted)



March 1<sup>st</sup> and April 30<sup>th</sup>, 7.8% were diagnosed with stress-induced cardiomyopathy. The pre-pandemic rate was 1.7%—a 4.6-fold increase.

The CDC [reported](#) August 14<sup>th</sup> that 44% of US adults struggled with mental health or substance abuse issues during June. “The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), ..., self-reported unpaid caregivers for adults (30.7%), and essential workers (21.7%)...”

The same CDC report recounted that 13.3% of respondents said they had started or increased substance use to cope with stress or emotions related to COVID-19.

Brigham and Women’s Hospital [reported](#) “a higher incidence of physical IPV [intimate partner violence], both in absolute numbers and proportion, with more severe injuries... This indicates that victims are reporting to health care facilities in the late stages of the abuse cycle...”

The report goes on to explain, “Social distancing has proven to be effective for controlling the spread of coronavirus but with negative socioeconomic and psychological impacts. Service-oriented economies have seen increased unemployment and a higher



incidence of substance and alcohol abuse and mental health disorders.”

Tyler J VanderWeele of Harvard’s T.H. Chan School of Public Health published a [Viewpoint](#) in JAMA, in which he suggests, “In the early stages of the pandemic, and when information was limited, a cautious approach was arguably most appropriate. As further information becomes available, it becomes possible to make better-informed decisions...” He goes on to consider how one might the balance between lives that might be saved by lockdowns and social isolation and those that might be lost due to the same policies. Both calculations are difficult and highly philosophical, but they are essential to balancing overall public health.

**A REFERENCE POINT.** Traditionally, quarantines involve isolating an infected individual or group to reduce transmission to the broader public. During 2020 most of the US and much of the world experienced an awesome exercise of authority: economic and social quarantine, with the goal of protecting the public from viral transmission. It set a precedent. Which other health “emergencies” will justify the same actions?

We think VanderWeele has the right perspective: in the early stages of a pandemic caution is probably justified. Later actions—e.g., extended lockdowns—should be justified by data and consider broader health issues. The onus should be on the public health “experts” to support their recommendations with data and make the data available to the public.

Ironically, the public health community, including the World Health Organization and the CDC, did not follow this path. Early recommendations minimized the potential serious of COVID-19. Later actions and recommendations like lockdowns and widespread mask requirements seem single-minded (i.e., minimize COVID-19 cases) and lack data support.

It is not clear from the currently available data that extended lockdowns reduced mortality in Arizona;

or that extended lockdowns are worth the collateral health, economic or emotional costs. Georgia is experienced lower mortality rates, despite its early re-opening. It is also experiencing lower unemployment and will likely enjoy fewer collateral unfavorable health-outcomes.

Those lockdown experiments continue.

*Note: This work was completed without commercial sponsorship of any kind from any source. We established a GoFundMe site (<https://gofundme.com/f/just-the-numbers>) to help underwrite our effort to develop independent, politics-free analyses.*

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