FIRST-PRINCIPLES REVIEW OF PUBLIC HEALTH

SANJEEV SABHLOK, PhD Economics

Former Commissioner and Secretary to the Government in India.

Former senior economist in the Victorian Government, Melbourne.

sabhlok@gmail.com

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My background

- **Career 1: India**: Started at age 22 in 1982 as a member of India's senior executive service.
  - Managed large government organisations.
  - Resigned in January 2001, with the goal of setting up India's first genuine liberal party.
- **Career 2: Australia**: Worked in Melbourne in Victorian government agencies since March 2001 including for 15 years as a government economist in the Victorian Treasury
  - Specialised in economic and regulatory policy.
  - Studied a range of policy areas intensively (both work related and from general interest).
- **Life's focus pre-covid:** Before covid I was focused on policy and reforms in India:
  - Published articles & books, started a think tank in India in 1998, and India's only liberal party in 2013
  - Was working on many books, including a policy book for practicing economists.

Blind spot: Public health policy

- Most economists have a blind spot for public health – it ranks low in the overall scheme of things. I never had any reason to think much about it.
- When lockdowns started in China and Italy, I felt that they were **wrong at many levels**. I wrote against lockdowns idea within the Treasury in February 2020 and publicly in my *Times of India* blog from 6 March 2020.
- In September 2020 I resigned to protest the police state created by Premier Dan Andrews and his chief health officer.
- Have written numerous articles on this topic in newspapers in India & Australia, appeared on TV, contested elections to national and state Parliament. Among my longer pieces of work:
  - a book *The Great Hysteria and The Broken State* (October 2020).
  - a detailed complaint to the International Criminal Court in November 2020.
  - Cost Benefit Analysis of Australia's lockdowns with Prof. Gigi Foster in 2022.

Empirically, I was wrong in my risk-based recommendations of 2020

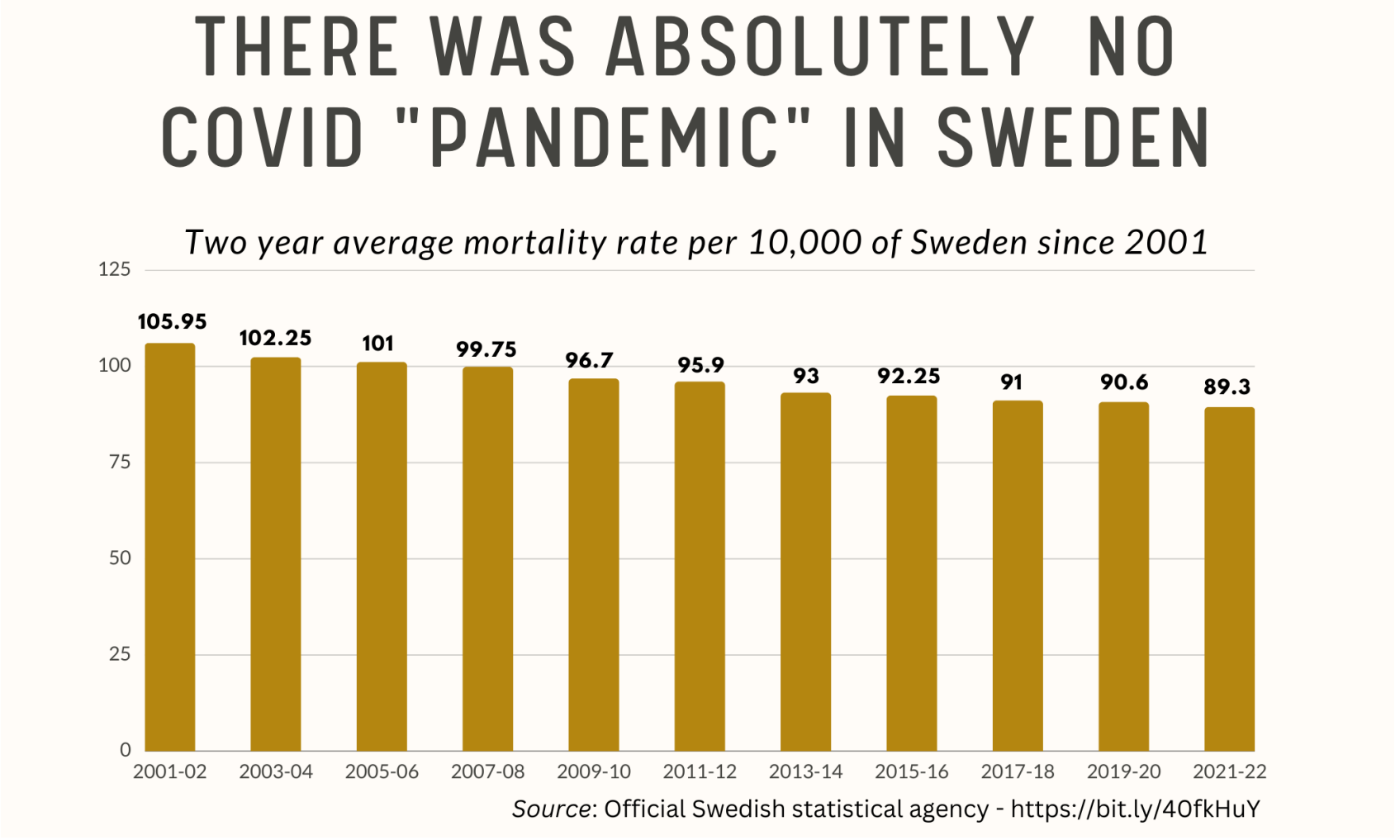
- On 6 March 2020 I wrote about age-based risk management
  - The young should continue to work, the elderly should shelter
  - Broadly similar sentiments were expressed by others, e.g. in Victoria's pandemic plan, by Anders Tegnell and later in the Great Barrington Declaration.
- But I was wrong (and they were *all* wrong)
- Quarantine of the healthy people is destined to fail due to human factors
  - Almost all aged care centres were soon infected by covid
  - The elderly with weak immune systems, died
  - The survivors almost lived like prisoners – severe mental harms caused to them and their families
- The level of isolation expected during lockdowns is possible in hunter-gatherer society, not in modern society (Paul Frijters).

Medical science can only take us so far

As a species that has completely transitioned away from hunting and gathering, we need to internalise a **new social compact** according to which:

- Science enables us to live to 80 years and beyond but we cannot also expect to achieve the kind of isolation from ordinary respiratory viruses that a hunting-gathering society provides.
- We can't have our cake and eat it, too.
- Trying in modern society to isolate ourselves from respiratory viruses is a dangerous delusion – that causes far more harm than good.

It is a different matter that there was no pandemic – only hysteria



Immediate vs. underlying cause of lockdowns

- The **immediate cause** of the Great Hysteria was the strategic calculation of **Xi Jinping**.
  - China gained enormously by planting fake videos for a non-pandemic.
- Tedros (of WHO) and Neil Ferguson (modeller) were key drivers of the Great Hysteria, which led to a clamour across the world for lockdowns.
- But there's a much bigger **underlying cause: Public Health**
- Except in Sweden, public health blindly followed and even promoted lockdowns
- **PH actions during covid are not an accident:**

1) There is vast ignorance in PH about quarantines
2) It personally benefits PH practitioners to promote such policies

Without public health's *active* support, lockdowns could not spread outside China

PH gravitates to worst-case scenarios

- Terror has been used by PH at least since the 14th century to increase its powers
- For example, the WHO Bulletin admitted in 2011 to the following:
  - the "culture of fear" in PH
  - "worst-case thinking" during the avian and swine flu.
  - "The pandemic policy was never informed by evidence, but by fear of **worst-case scenarios**".

PH has no interest in science (empiricism). It prefers models and "ethics".

- Over the past 650 years, there have been thousands of instances of quarantine across the world, including of mass-quarantines (lockdown).
- PH health has **not even once attempted any systematic empirical analysis of quarantine effectiveness** (since the lifetime work of Dr Charles Maclean 200 years ago – I'll come to that later)
- Instead, it has been mass-producing "models" and thousands of books on "ethics".
- Its claims to represent science are the biggest scam in the history of science.

US National Academies (2020) believes in assessing the **effectiveness of quarantine** through **models**!

No empirical analysis whatsoever.

Source

TABLE 7-2 Summary of Findings on the Effectiveness of Quarantine from 12 Modeling Studies

Disease	Quarantine Likely Effective?	Notes
Ebola	Yes	Two studies find quarantine can drive R_e <1[a] (D'Silva and Eisenberg, 2017; Peak et al., 2017).
Hepatitis A	Yes based on 1 study	One study finds quarantine can drive R_e <1 (Peak et al., 2017).
Influenza A/ H1N1	Maybe	Two studies. One study finds quarantine can drive R_e <1 (Peak et al., 2017). Another study focuses on delaying the epidemic peak and suggests that quarantine can possibly be effective depending on the specific features of the pathogen in the population and the level of intervention (An der Heiden et al., 2009).
Middle East respiratory syndrome (MERS)	Yes	Two studies find quarantine can drive R_e <1 (Ahn et al., 2018; Peak et al., 2017).
Pertussis	No based on 1 study	One study finds quarantine is unlikely to drive R_e <1 (Peak et al., 2017).
Severe acute respiratory syndrome (SARS)	Maybe	Seven studies. Three studies identify situations in which quarantine may not be effective in driving R_e <1, with effectiveness depending on the pathogen's basic reproductive number (R_0) in a given population (less likely with higher R_0), the likely effectiveness of isolation of symptomatic individuals as an alternative strategy, the likelihood of there being individuals who are asymptomatic but contagious and the fraction of those individuals, and the ability to quickly identify a large fraction of exposed individuals for quarantine (Day et al., 2006; Hsieh et al., 2007; Peak et al., 2017). Four studies find (or in essence assume [based on models of past limited outbreaks]) that sufficiently effective, properly scaled and targeted, or potentially dynamic quarantine policies can drive R_e <1 (Feng et al., 2009; Gupta et al., 2005; Mubayi et al., 2010; Podder et al., 2007).
Smallpox	Maybe	Two studies. One study finds quarantine is unlikely to drive R_e <1. Another study finds that early initiation of quarantine that removes a large fraction of exposed cases can likely avoid an epidemic resulting from a smallpox bioterrorism attack (Meltzer et al., 2001; Peak et al., 2017).
Measles	Yes/maybe based on 1 study	One study finds that despite measles having a high R_0, if there is a sufficient level of background immunity, it may be possible to use quarantine to end an outbreak quickly. However, with lower levels of background immunity, quarantine is unlikely to drive R_e <1 or to do so quickly (Enanoria et al., 2016).

It is well known in PH that there is no scientific (empirical) analysis of previous quarantines

A paper in 2007 admitted this:

> "Although the potential benefits of NPIs are supported by mathematical **models**, **the historical evidence for the impact of such interventions in past pandemics has not been systematically examined**".

Source: https://www.pnas.org/doi/10.1073/pnas.0610941104

Q&A

Sweden's coronavirus strategist

What evidence is the approach based on?
It is difficult to talk about the scientific basis of a strategy with this type of disease, because we do not know much about it and we are learning as we go. Lockdown, closing borders — nothing has a historical scientific basis, in my view. As a society, we are more into nudging: continuously reminding people to use measures. Closing down everything would be counterproductive.

Tegnell's claim that there's **no historical scientific basis** for lockdowns is correct

But he has no books or papers to support his claim

- There is not a single book in PH that studies any historical instance of quarantine with an empirical lens to assess *all* relevant scientific factors.

Prof George Annas predicted in 2007 what happened in covid

[I]t is quite remarkable that **some public health officials still embrace draconian nineteenth-century quarantine and compulsory treatments**.

Public health officials also seem to believe that the military and police forces can effectively control the behaviour of Americans in the event of an epidemic or bioterrorist attack.

To the extent that this faith in coercion remains alive in the public health community, **it is predictable that public health officials with the power to arbitrarily quarantine people in an emergency will use it immediately**, whether it is warranted or not.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2267247/

My prediction: Public Health killings can never be stopped: they'll only increase over time

- There is a **stable equilibrium** in which PH stokes hysteria, the public clamours for protection and PH "supplies" their "need" even as it *permanently and further* increases its political and financial power.
  - Step 1: Create terror and hysteria
  - Step 2: Pretend to have a solution (entirely imaginary: no science needed)

FIRST-PRINCIPLES REVIEW OF PUBLIC HEALTH

PH is fundamentally impossible

- By end-2022 I had realized that PH is fundamentally broken. Criminality and fraud are its hallmark.
- PH has enjoyed a long honeymoon with the public, who assume that it is for their good. The halo around PH has allowed it to get away with murder for 650 years.
- The scope of modern public health is not supported by the **information constraints and incentives** it faces. There is an inevitability about its bad behaviour.
- In December 2022 I outlined the case for disbanding public health in my *Times of India* blog (in 4 parts):
  - The case for disbanding public health in its current form – Part 1
  - The case for disbanding public health in its current form – Part 2
  - The case for disbanding public health in its current form – Part 3
  - The case for disbanding public health in its current form – Part 4
- I summarized this argument in a post on *Mises Wire* in December 2022: The Case for Disbanding Public Health Agencies

The need for a first-principles review of public health

- Public health is one of only three policy areas in Australia which are not subject to a cost-benefit analysis (CBA) test. The other two are environment (particularly climate change) and town planning.
- But a CBA should only be the pointy end of a more basic, **first-principles review**.
  - A first principles review assumes that there is no government. It then seeks to identify any problem with that situation, and works out a remedy for the supposed problem.
  - There has never been a first principles review of PH.

My review has begun a few months ago

- In early 2023 I decided to commence a full-fledged first-principles review of PH
  - a deep dive to determine whether PH should exist, and its appropriate scope and powers
  - will require me to form a thorough understanding of the discipline, its history, its incentives, its information barriers.
- This is the first such review in human history.
- I expect it to take 2 to 4 years of full time work.
- I tried to get this up as a PhD project (or Fellowship) at some university so I can be partly funded. Couldn't find any university, so I've asked for donations: GofundMe.

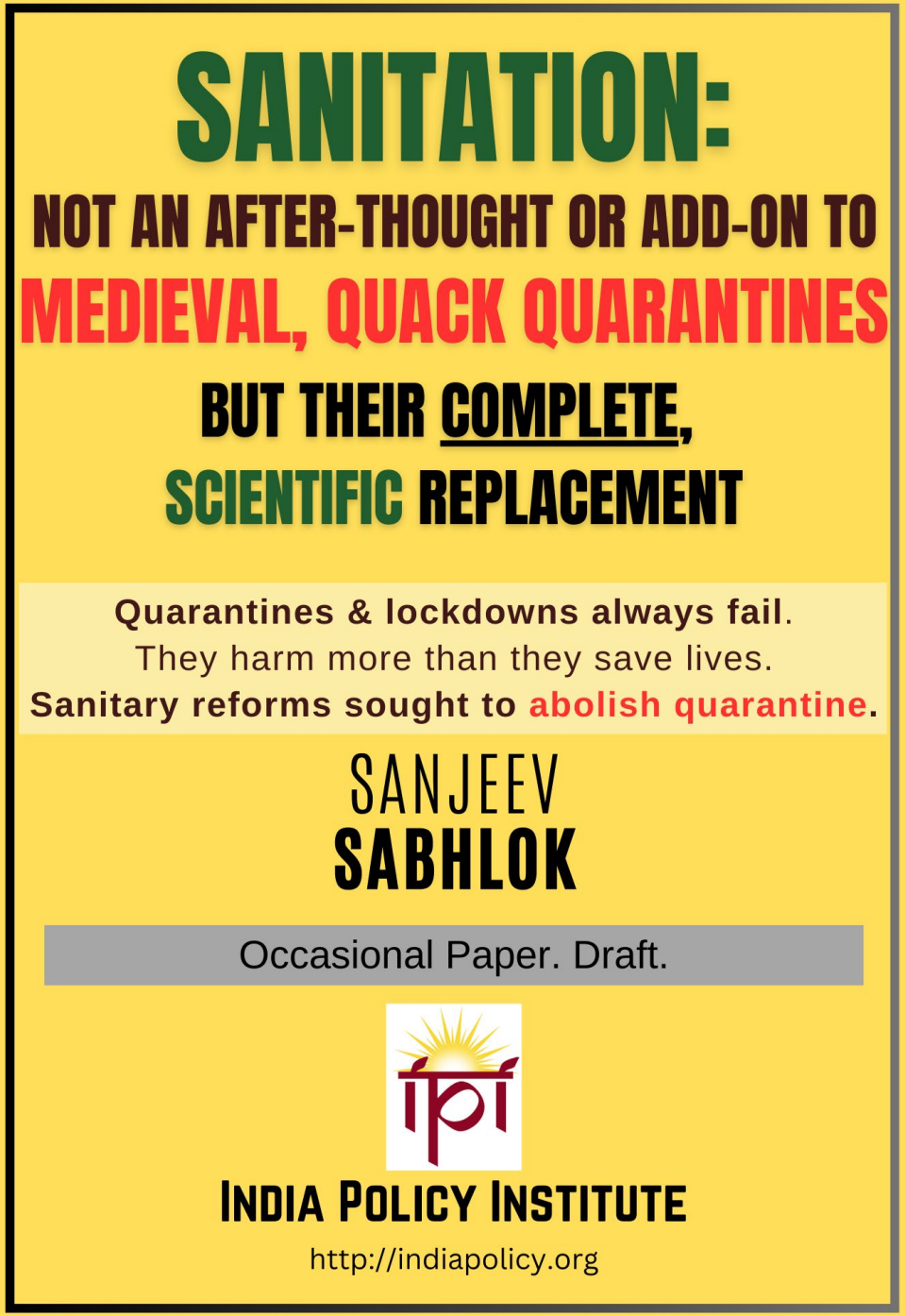
Currently planned output: Five books, four working papers, many TOI blog posts

- The review has grown from one (planned) book to five:
  - **Book 1:** The chronic criminality of public health
  - **Book 2:** Quarantine is a fool's errand
  - **Book 3:** No science, only ideology and theology
  - **Book 4:** Recommendations from Books 1, 2 & 3
  - **Book 5:** First principles review of public health
- I expect to write at least four working papers, with the first of these currently underway:
  - **Paper 1:** Sanitation: Not an after-thought or add-on to Medieval, Quack Quarantines but their Complete, Scientific Replacement

PAPER 1:
DISCOVERY OF
CHARLES MACLEAN,
THE SCIENTIFIC FOUNDER OF PUBLIC HEALTH

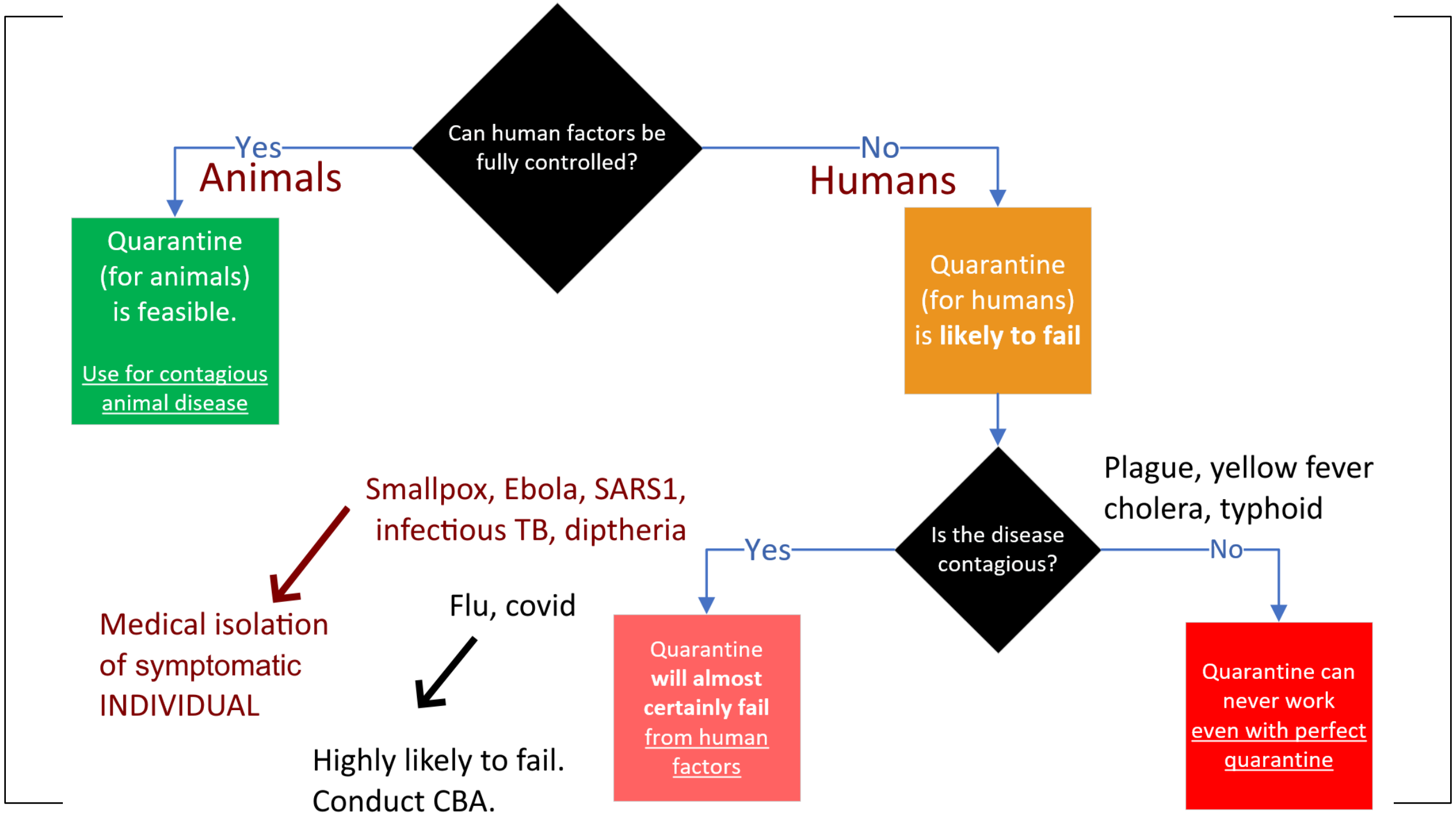
What's the scientific basis for quarantine?

- The two most important scientific questions before PH are :
  1. Do quarantines work?
  2. Do they create a net positive benefit for public health and wellbeing?
- Yet, there's not a single book in the PH literature which scientifically investigates the hundreds of episodes of quarantine in history.
- Paper 1 aims to fill this gap – being the first comprehensive, scientific study of quarantine and lockdowns.



PAPER 1

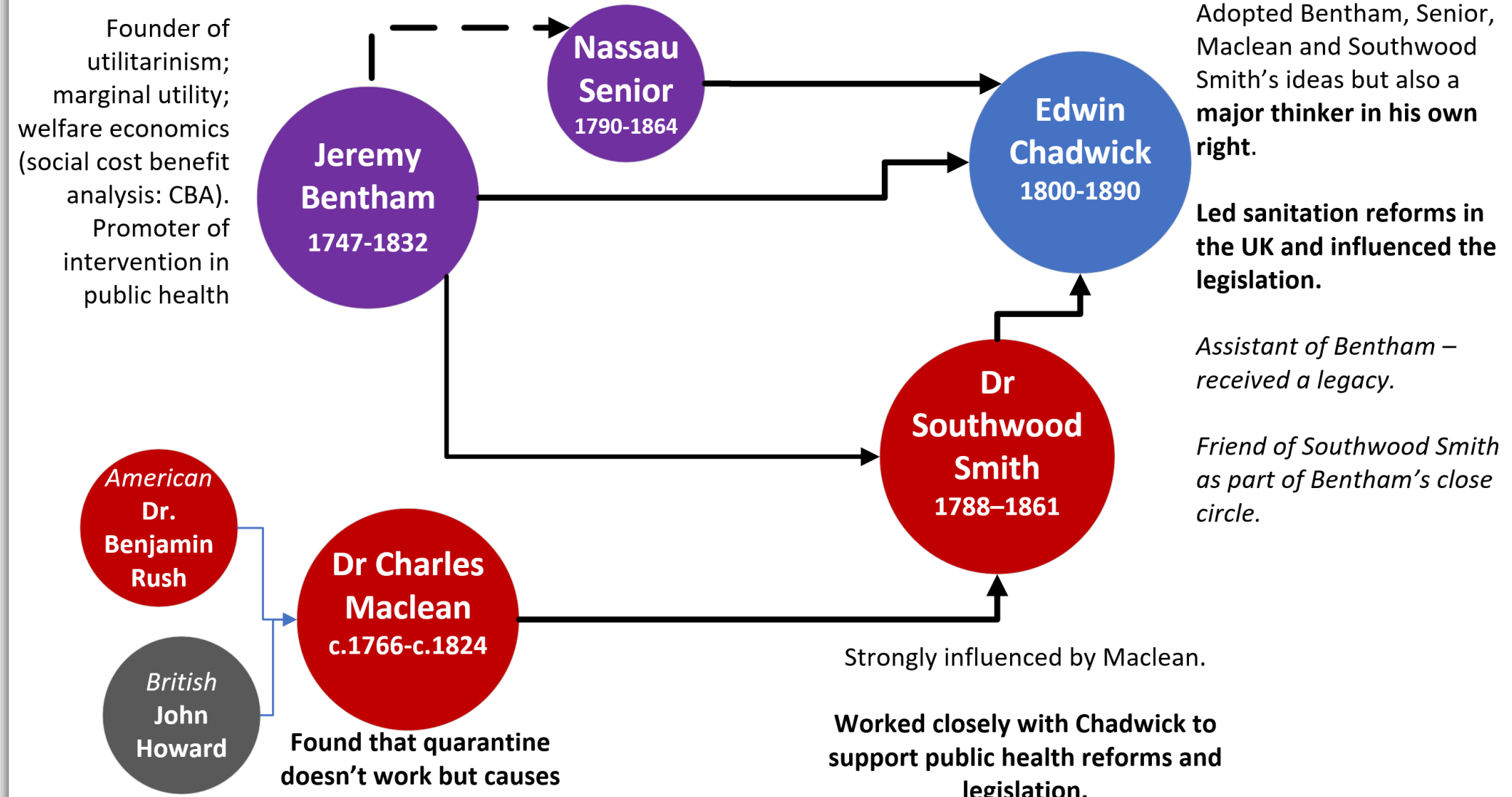
- It's been a shock to discover that the Sanitarians, who founded public health, were not just promoters of cleanliness /hygiene; they were **insistent on the abolition of quarantine.**
- The evidence for both their demands came mainly from the work of Dr Charles Maclean.
- His main contribution: that **human factors** make quarantine virtually impossible
  - This basic truth is typically brushed under the carpet by public heath.


Can human factors be fully controlled?
Yes
Animals
Quarantine (for animals) is feasible.
Use for contagious animal disease
No
Humans
Quarantine (for humans) is likely to fail
Is the disease contagious?
Yes
Smallpox, Ebola, SARS1, infectious TB, diptheria
Medical isolation of symptomatic INDIVIDUAL
Flu, covid
Highly likely to fail. Conduct CBA.
Quarantine will almost certainly fail from human factors
No
Plague, yellow fever cholera, typhoid
Quarantine can never work even with perfect quarantine

The discovery of Dr Charles Maclean, MD

- Almost no one has heard of Dr Charles Maclean, whose empirical and scientific work underpinned the Sanitary movement.
- He is cited extensively by Dr Southwood Smith and Edwin Chadwick, who led the Benthamite public health reforms movement.
- Maclean was also enormously influential globally in the 19th century.
- His main findings and work:
  - quarantines have never worked – mainly due to human factors.
  - plague lockdowns increased both plague and non-plague deaths (he examined excess deaths from the plague lockdowns)
  - conduct of the first CBA of quarantine to prove that quarantine cause great harm

The origin of modern public health

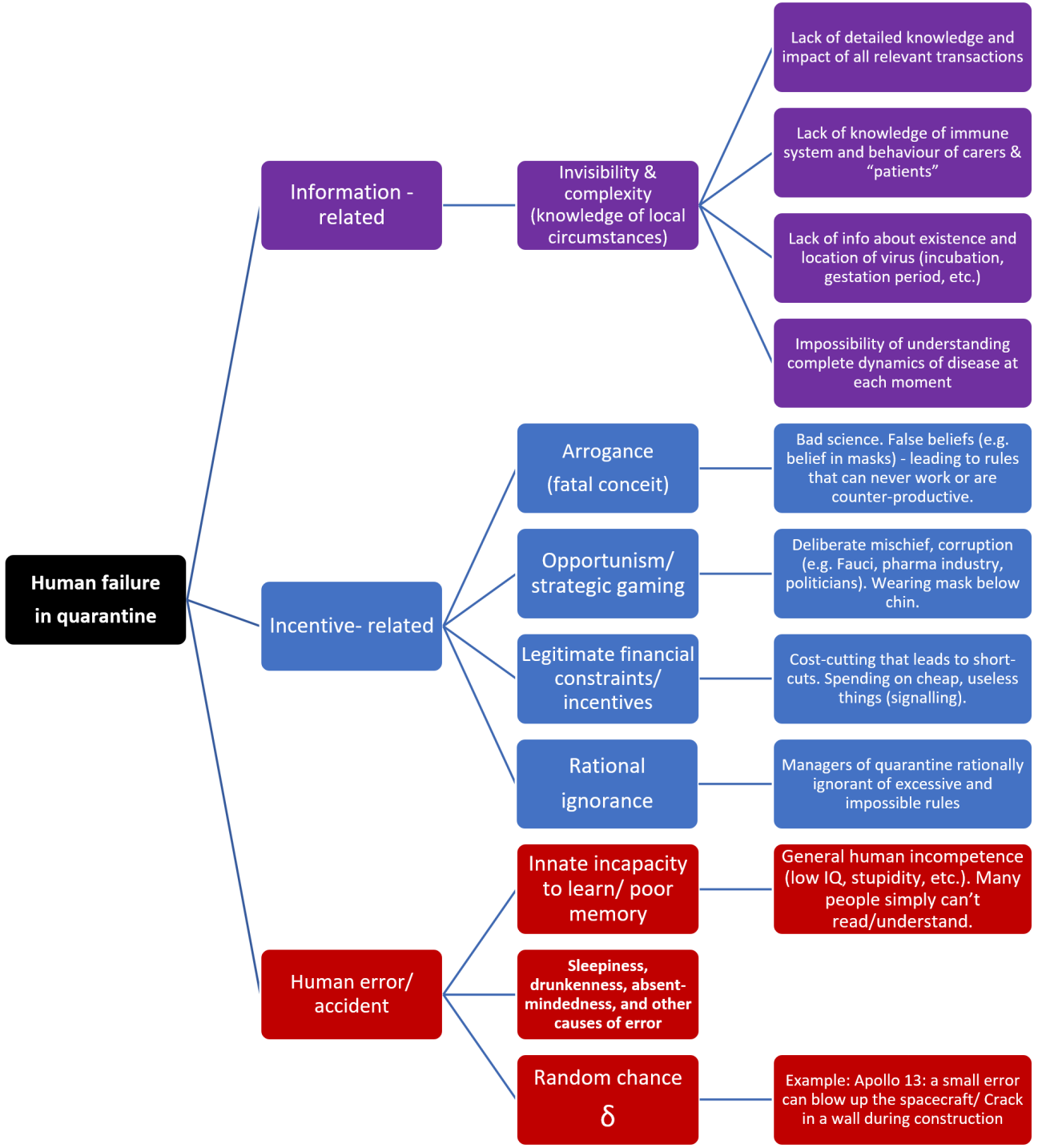


But!
Maclean has been scrubbed from the PH literature

- Maclean's work was extremely inconvenient to the entrenched quarantine establishment.
- PH has blanked out Maclean and reverted to the full-blown pre-Maclean era of quarantines.
- Maclean's sophisticated research methods have been all cancelled.
  - His empiricism, CBA, analysis has been cast out in favour of models and "ethics".
- Canards and innuendo are used in the PH literature (in the few instances where Maclean is referred to) to discredit his work. His work is thoroughly misunderstood and misrepresented.

Human factors make the failure of quarantine almost inevitable

- I've detailed many examples
- It is amazing that PH has spent not the slightest attention to understanding these issues



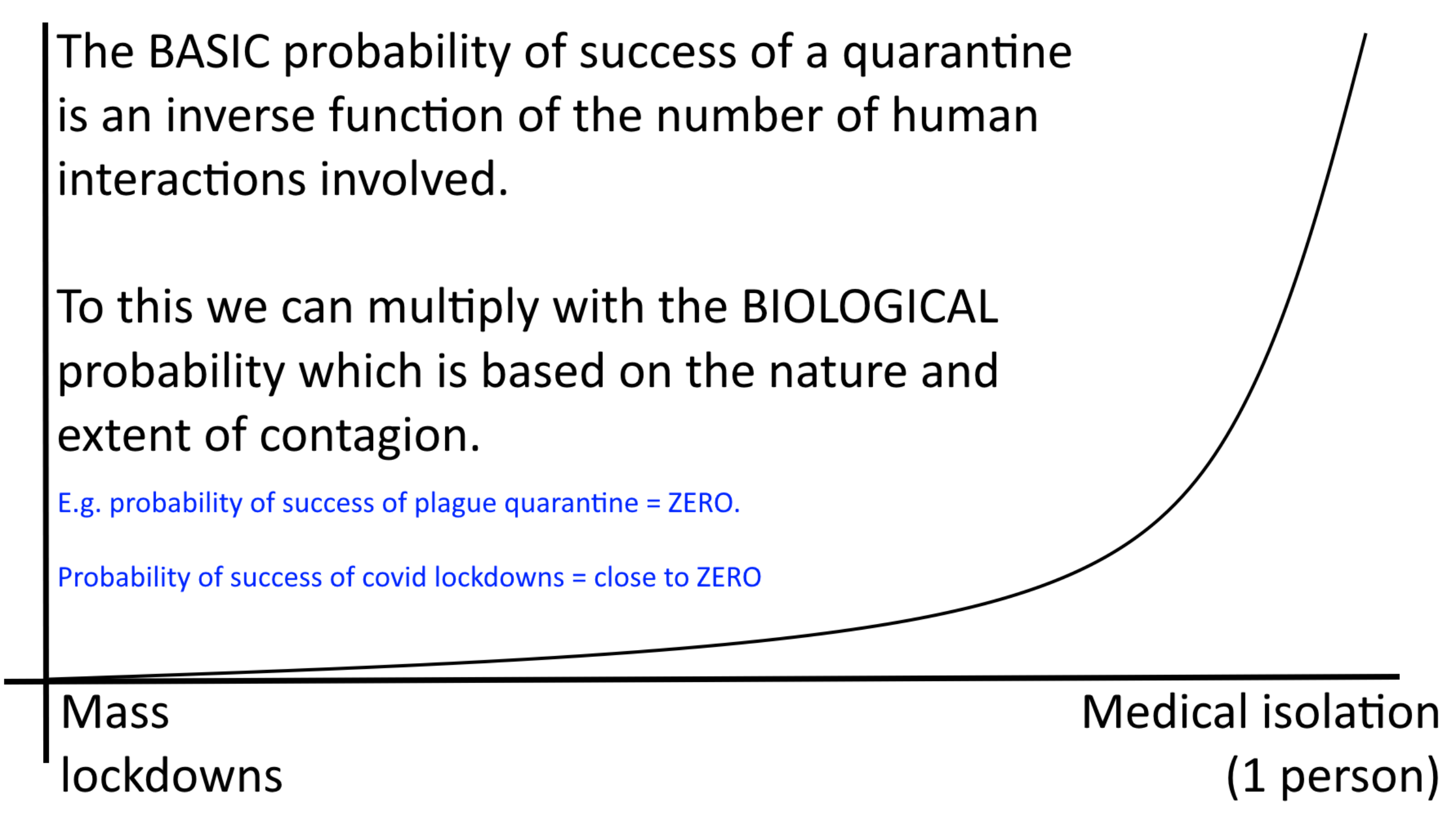
Imagine the effort to locate 100ml of bomb material. Now try locating a virus.

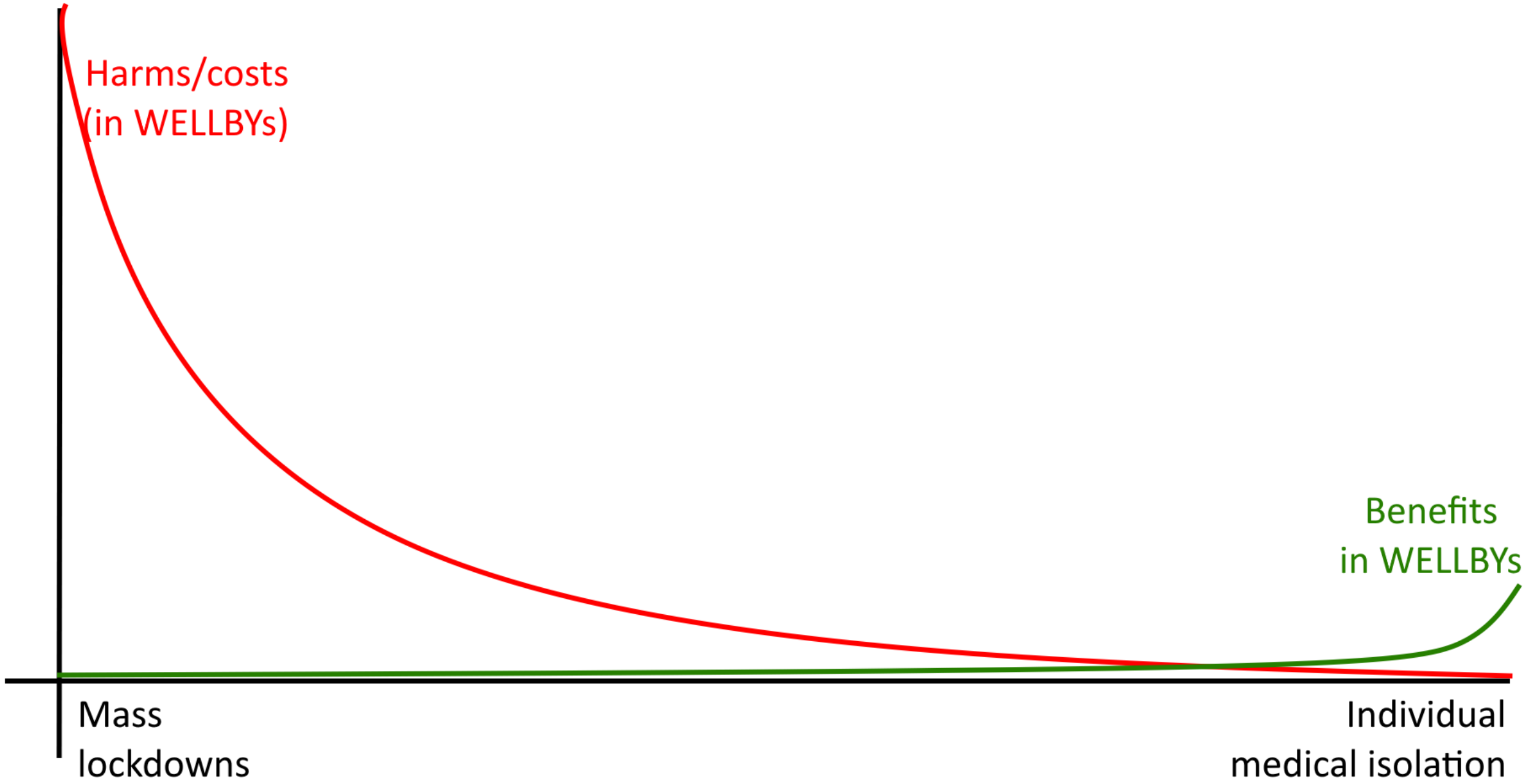
The BASIC probability of success of a quarantine is an inverse function of the number of human interactions involved.

To this we can multiply with the BIOLOGICAL probability which is based on the nature and extent of contagion.

E.g. probability of success of plague quarantine = ZERO.

Probability of success of covid lockdowns = close to ZERO




Harms/costs
(in WELLBYs)
Benefits
in WELLBYs
Mass
lockdowns
Individual
medical isolation

GENERAL PRINCIPLE FOR INTERVENTION DURING A PANDEMIC: WHEN BENEFITS>COSTS

In modern language, implement quarantine when $WELLBYs\ saved > WELLBYs\ lost$

For a CBA we need to be able to convert wellbeing into a monetary value

- In 2019 Paul Frijters proposed a method called **WELLBY** that is now becoming widely adopted.
- A natural name for the **well-being experienced over one year** is a Well-Being-Year (or WELLBY).
- The WELLBY captures the sorts of harms to human wellbeing that are difficult to capture in traditional ways, such as lost relationships, heightened anxiety, or lost motivation.
- With the WELLBY, governments now have an empirical measure of the impact of policy on wellbeing.

WELLBY – a definition

- One WELLBY is defined as a one-point increment on the answer scale for life satisfaction enjoyed for one person for one year.

EXAMPLES

- If life satisfaction increases from 5 to 6, we count it as an increase in one WELLBY.
- If life satisfaction decreases from 7 to 6, it is counted as a decrease in one WELLBY.

Maximum of six WELLBYs in one healthy life year

Calculating the number of WELLBYs in a healthy life year

- The life satisfaction level for someone who is very healthy is roughly an 8 out of 10.
- The life satisfaction level at which people are indifferent between living on or not at all, is around 2 (a life-satisfaction of zero is worse than living).
- There can be a variation of life satisfaction between a maximum of 8 and a minimum of 2 in a given year.
- This figure (8 minus 2) yields a potential **maximum of 6 WELLBYs in a given year.**

Converting WELLBYs into QALYs and then into dollars

- WELLBYs have the advantage that they can be converted to QALYs, and thereby into dollars.
- Because they can be easily incorporated into standard cost-benefit methods, WELLBYs are now being used by the UK government and others as the basis of judging the quality of the life impact of public policy.

Conceptual relationship that captures probability of success and benefits/harms

$$Benefit\ of\ quarantine\ or\ isolation = WELLBYs\ saved = f(P_s(I^{-1}), E_{Q,M,O})$$

- where Ps = probability of success of quarantine (which is an inverse function of I, the weighted total of different kinds of human interactions under quarantine; $E_{Q,M,O}$ =effect of quarantine on deaths from quarantine disease Q (generally expected to be a reduction except for non-contagious disease like the plague), on mental health M, and on other health and disease factors O.

$$Cost\ of\ quarantine\ or\ isolation = WELLBYs\ lost = f((1 - P_s)(I^{-1}), E_{Q,M,O})$$

- In general, the more stringent and wider the quarantine/lockdowns, the larger the costs. While collateral harms from other diseases are invariably part of quarantine, in many cases quarantine also increases deaths from the quarantine disease.

Implement quarantine when $WELLBYs\ saved > WELLBYs\ lost$.

Current recommendation: Abolish quarantine/lockdowns

- Hospital quarantine must also be abolished (disrupts public health)
- **Separate medical isolation facilities to be built and maintained** as an insurance program, funded by the government
- Medical isolation to be managed via the Police, with individual orders issued, and full *habeas corpus* rights
- Home isolation for diseases like the flu and covid
- For a few diseases a vaccine can be demanded at the border (smallpox, Ebola, yellow fever) when coming from an infected country.

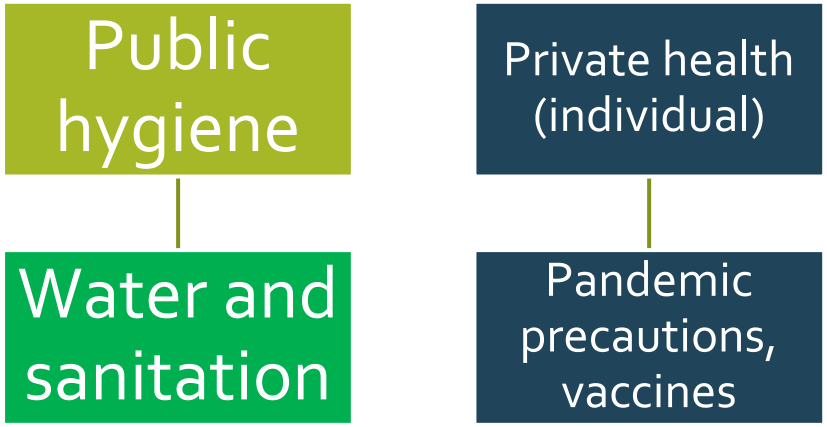
OVERVIEW OF MY CURRENT POSITION
RE: PUBLIC HEALTH INTERVENTIONS

Summary of analysis of public health (PH)

"Service" provided by PH	Science	CBA	Conclusion
Clean water	Chadwick and (particularly) Snow's work.	Hugely positive	RETAIN. Call it **Public Hygiene**. By plumbers and engineers, no doctors.
Sanitation	**Maclean's** work	Hugely positive: Proven to work by S.Smith and Chadwick with CBA	RETAIN. Ditto as above.
Border closures	**Maclean**: Do not work **Henderson**: Not even even for smallpox	e.g. Foster-Sabhlok - Hugely negative	ABOLISH
Quarantine/ lockdowns	**Maclean**: Extremely harmful **Henderson** – sketchy objections	e.g. Foster-Sabhlok - Hugely negative	ABOLISH THE WORD "QUARANTINE"
Medical isolation	Helpful in specific cases, e.g. Ebola. Not in almost any other case.	Hugely positive in specific cases (Ebola, etc.)	RETAIN. Transfer to the **Police** assisted by ordinary doctors.
Mandatory masks	**Cochrane**: Do not work even without counting harms	e.g. Sabhlok & Gavrilis – multiple regression proves net harm	ABOLISH
Epidemiological models/ ethics	No underlying science, no link with reality.	Hugely negative	ABOLISH
Contact tracing	Helpful in AIDS, STD – but should be voluntary.	Probably beneficial for some diseases + in early stage of flu, etc.	LARGELY ABOLISH – but this could be a potential PH function
Vaccines	Highly effective in some cases, not so in others	Individual CBAs for each vaccine, for each person type; can demand vaccines at border for a few diseases	ABOLISH - a part of private health. Government MUST NOT PROCURE (severe corruption).
Paternalistic interventions	PH takes scientific health knowledge and transmits to the public	The "truth" is not known in perpetuity. Let doctors advise.	ABOLISH

CURRENT SYSTEM

FUTURE SYSTEM



Medical isolation is part of private treatment. Almost no NPIs; some contact tracing

Thanks!

Happy to take questions