The Israeli Public Emergency Council For Covid-19 Crisis
December 26, 2021

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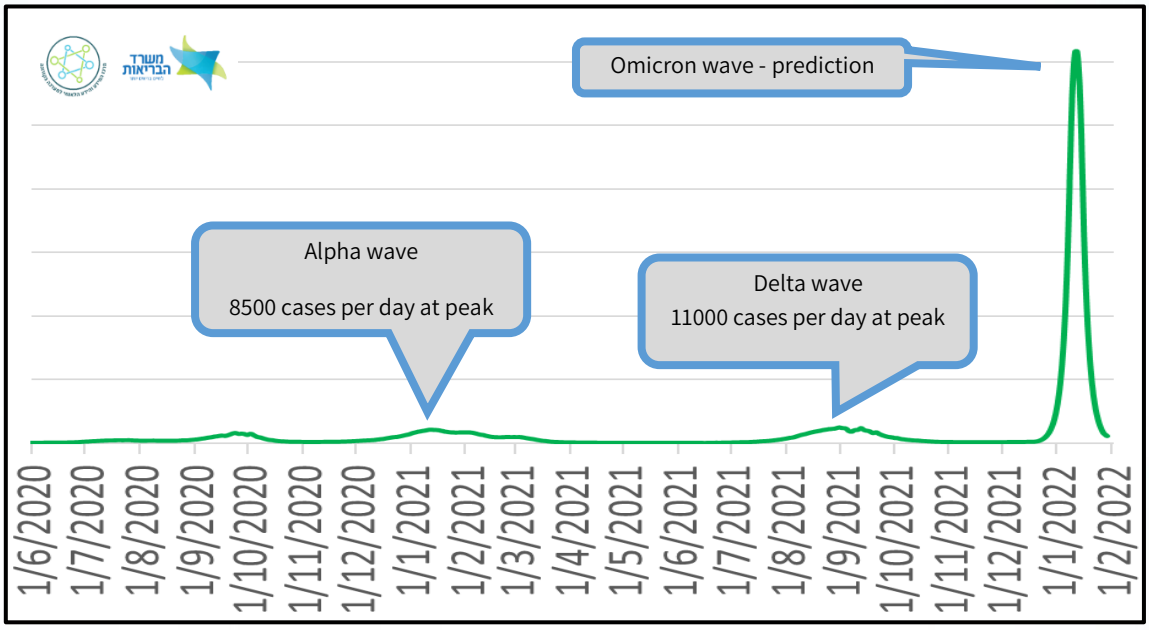
The Omicron variant—just before pressing the "panic button"

Examining findings from the world, realistic forecasts and ways of coping

In recent days, the Ministry of Health has presented its forecasts in light of the Omicron wave. The essence of the Ministry of Health's claim is that even though there is evidence that the Omicron variant is less virulent than previous variants, its rate of spread is so rapid that we are facing unprecedented records in the number of cases. The Ministry's presentation was based on a collection of data from around the world—and concluded in a very gloomy forecast.

Just before you press the panic button, just before activating severe measures whose health, welfare and economic costs are impossible to comprehend, and which have failed time and time again, we invite you to look and re-examine the data. To convince you that the data is worthy of another examination, we begin with the forecast itself, given by a team of Ministry of Health advisers, which, according to what is written in the presentation, is a simulation based on data from England.

Ministry of Health forecast (23.12.2021)—about 5 million cases within a month



According to these data, the Omicron wave is expected to be **30 times higher** than the Delta wave, namely **about 350,000 cases per day (about 4% of the population daily)**, and during the forecasted "breakout" month, about 5.5 million Israelis will be infected with the virus. Over the course of one month, four times more Israelis will be infected with the virus than the number of Israelis who have been infected over the last two years of the COVID crisis. And since these figures are based on forecasts from the UK, it means that the UK forecast is for **3 million British people to be infected per day**.

If you are experiencing deja vu, if this seems absurd to you—this is not accidental. The forecasts presented by the Ministry of Health were written by **the same experts who predicted a million infections and 100,000 deaths within two months** in March 2020 [1-3]. This is the same team of advisers who, time and time again, wave after wave, presented apocalyptic predictions—which did not come true. If that is not enough, they base their predictions on a British group of experts that includes Professor Neil Ferguson who predicted 150,000 deaths from "mad cow disease," when at the end only about 200 people died from it [4]. This is the same team that predicted for Sweden 100,000 deaths by July 2020 (when in reality there were

about 5,500). These are the same advisors who, the day before the restrictions were lifted last July in England, where at that time there were about 50,000 confirmed cases per day, predicted a catastrophe and an increase to 100,000-200,000 confirmed cases per day [5,6]—whereas in fact the complete opposite happened—the number confirmed cases began to decline immediately after the restrictions were lifted and stablized. Like the British team, the Israeli team also has **a long history of hysteria**.

If the numbers seem unfounded to you—you are right. The numbers are unfounded. In light of this, we hope that you will choose to spend an additional 5 minutes examining the data gathered from the world—in the appropriate context.

The burden equation

The Ministry of Health explains that the burden on the healthcare system is the product of two parameters: speed and spread times the rate of serious illness. In their view, the rate of infection (3-4 times) is not balanced by the decrease in severity (times 2), and therefore an unusual burden "the likes of which has not been seen" is expected.

This equation fails in every parameter: high transmission speed does not require a wide spread. Although it is possible and even likely that we will see records in the daily number of cases, world data so far suggest that it is likely that the total number of infected cases will not necessarily be greater than during the waves of previous variants. Omicron waves that rose sharply also came to a halt abruptly. More importantly, the decline in the severity of the variant is highly significant, and its lethality has fallen far below 2 times less than the previous variant. This is reflected in a drop in hospitalization rates, severe illness, death, and the number of required hospitalization days.

What is most surprising is that the Ministry of Health has chosen to completely ignore the **high vaccination rate** in Israel, which should reduce the need for hospitalization even further. Does the Ministry choose to deny the effectiveness of the vaccine and believe that the vaccine will have no effect on the severe illness?

In the section, we will present the existing information about Omicron and its significance for the morbidity forecast in Israel, and also suggest actions that should be taken; more importantly—we will detail the actions that should be avoided, due to their uselessness and harmful effects.

South Africa—the main source of information for the world

South Africa has experienced the most rapid increase in cases, but contrary to the Ministry of Health's claim, the rate of a spread does not necessitate spread because despite the rapid rise, the peak of the wave also came quickly, and the data indicate that the spread has already begun to moderate throughout South Africa. Despite breaking the record for the daily number of cases, the total number of cases in this wave is lower than in previous waves—due to the rapid appearance of the wave.

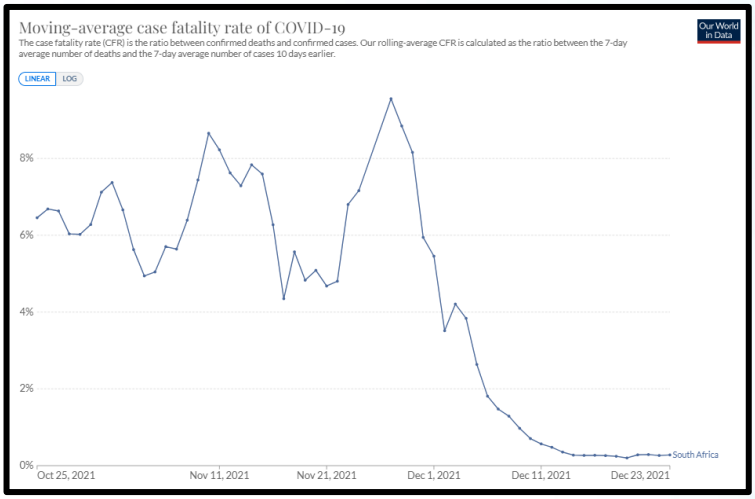
The Ministry of Health justifies the rapid containment of the virus in South Africa through two factors, which it says are irrelevant in Israel: the young age of the population, and the high percentage of individuals with antibodies following recovery. These claims are fundamentally wrong:

1. The median age in South Africa is lower by only about two and a half years than the median age in Israel [7].

2. In South Africa, it was reported that about 45% of the population were antibody carriers, while in Israel a reasonable estimate according to the serological surveys before the Delta wave, and given the Delta wave

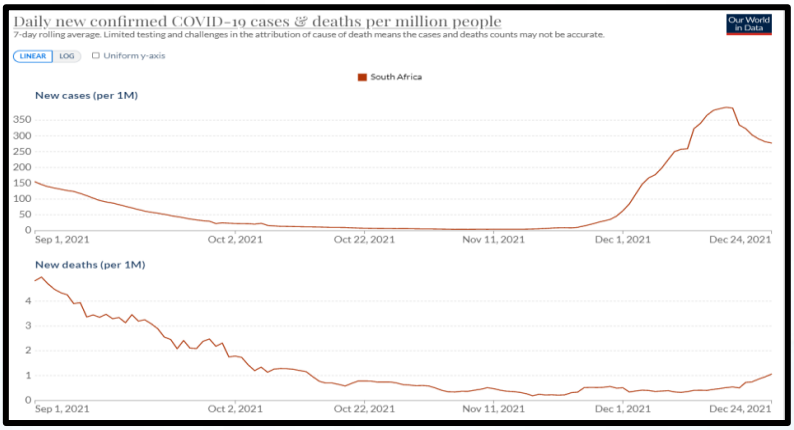
itself, is that over 30% have recovered from COVID. In addition, in Israel 180 doses of the vaccine were given to every 100 residents—and in South Africa only 60 [9]. The percentage of individuals with antibodies in Israel, following recovery or vaccination, is currently over 80%, much higher than in South Africa. For unclear reasons, **the Ministry of Health has chosen to present assessments that completely ignore the immunization of the population in Israel**.

More importantly, **the Ministry of Health has again chosen to measure a statistic that has no clinical significance –the number of positive cases**, instead of dealing with the number of patients who require medical assistance. True, the peak of the wave came within 3 weeks, not within 11-14 weeks, **but at the peak of the wave in Africa, despite its speed, the number of hospitalized patients was only about half than those hospitalized during the Delta wave [10], and the death toll was only about one-tenth of the death toll during the Delta wave.** In other words, **the burden on the healthcare system was lower than it was during previous waves.**



This fact is clearly supported by the statements of the health authorities in South Africa, that **the severity of Omicron is not "most likely lower," as indicated in the presentation of the Ministry of Health, but less significant, by a factor of at least 4** [11, 12]. This is most noticeable in the mortality rate among individuals with verified cases, that since the discovery of Omicron has fallen from over 8% to only 0.3%—**a 25-fold decrease** (which still includes deaths as a result of the Delta variant).The health authorities in South Africa also report that the **average length of hospitalization has shortened significantly** [11,14], which both indicates the lower severity of the Omicron variant, and constitutes an encouraging figure when it comes to the lower expected burden in relation to previous waves.

The Chairperson of the South African Medical Association, Dr. Angelique Coetzee, in an interview she gave on 12.12.21, more than a month after the onset of the outbreak in South Africa (where the variant was also discovered), reported that doctors have not seen a real increase in hospitalizations, and that in many hospitalizations counted as COVID, the virus is not the cause of hospitalization [15]. She further explained that they have not seen the cytokine storm that often leads to serious illness and death, and reports that at the point in time of confirmed Omicron deaths, and reports that at the point in time in which she was interviewed, there were no verified cases of death as a result of Omicron, and the few who died and were Omicron carriers, died of other background illnesses [14].

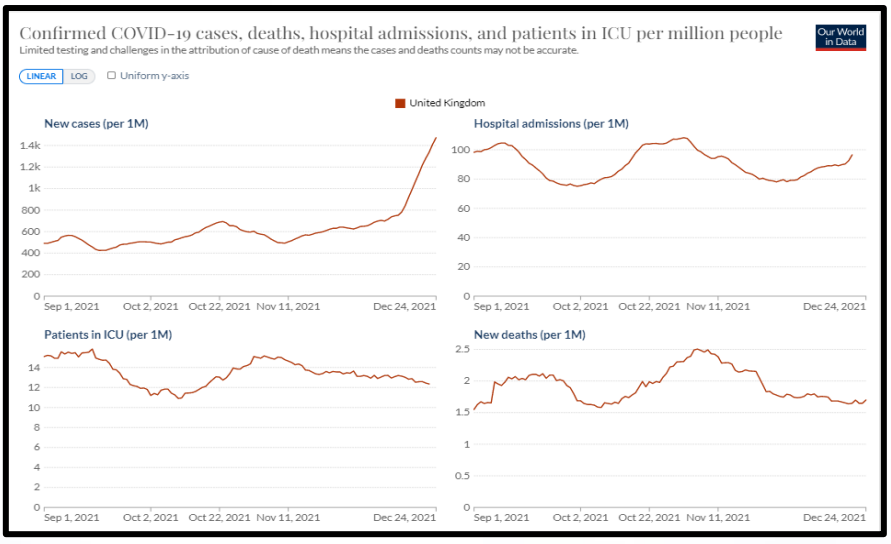


Omicron was detected in South Africa about two months ago, and it has been a month since it was discovered that Omicron is responsible for over 80% of infections in South Africa. The halting of the wave in South Africa occurred without any additional restrictions, and yet the Omicron wave is the mildest wave experienced by South Africa. Significant evidence of this is the announcement by the authorities in South Africa in recent days [16] that not only are they not imposing new restrictions, but they are also eliminating the requirement to isolate, as well as testing that is not based on symptoms and other investigations, and are discontinuing the "chain breaking" approach, which has failed in all countries [17,18].

Omicron in Britain

The arrival of Omicron in the UK was accompanied by a sharp rise in the number of cases, and the UK experienced new records in the number of verified cases (although the claim that every day about 1% of the UK population was infected, which appeared in the Ministry of Health presentation, is unfounded—the correct figure is 0.16%) [19]. This increase, as of this point in time, was not accompanied by a real increase in hospitalization rates, and although these are expected to increase to some extent (due to the delay between the time of contracting the virus and hospitalization time), the increase is not likely to reach the dimensions of previous waves. Moreover, there is no upward trend in intensive care (which is an early marker of mortality) or an increase in mortality. UK data, therefore, constitute further encouraging confirmation that despite the high number of cases, the morbidity load as a result of the Omicron variant is lower than the loads associated with previous waves.

It should be noted that the current slight increase in hospitalizations in England is consistent with the normal wintertime increase, regardless of COVID.



The effects felt in London and throughout England are not the result of the virus—but the result of isolation policies and the tendency toward apocalyptic predictions spread by the same team mentioned at the beginning of this document—the same policy that causes much harm, and whose ability to prevent spread is minute, as we have seen in previous waves, even for less contagious variants. Even the difficulties and disruptions presented by the Ministry of Health are only predictions, again—by the same team of consultants who gained much publicity around the world of the same scale as their mistakes [20]. The present-tense language ("The medical staff can no longer cope with the workload") projects panic that encourages the reader to forget the title "British scenario."

Application of international knowledge to the Israeli scenario

It is evident that the Omicron variant is more contagious, and therefore creates a fast and high wave. The verified daily cases will likely reach the numbers of the Delta wave, and even pass them (especially given that vaccines are not a significant factor in reducing the number of cases). However, the wave also subsides faster, and the area below the wave curve (i.e., total cases) is not expected to be significantly larger than previous waves, and may be even smaller.

The Ministry of Health is seeking to implement severe preventive measures to curb the wave, arguing that once the wave begins to accelerate, it will not be possible to stop it. This argument is incorrect for two interrelated reasons:

1. The steps proposed by the Ministry of Health have been taken in many places around the world—and have failed. Moreover, the countries with the most draconian measures (for example Australia) do not show better results in the outcome of the pandemic.

2. The call for the implementation of these measures was articulated in the same terms, and under the same apocalyptic threats again and again, also in the previous waves and with the advent of each new variant. These repeated threats lead to hasty and arbitrary actions that lack scientific foundation.

The Omicron wave has been in Israel for about 3 weeks, and the growth rate of each wave is particularly fast at the beginning of the wave: it is likely that after another short period of acceleration, we will see a slowdown in growth, until the wave reaches a peak and breaks. The data do not indicate the possibility of severely ill patients doubling every two days—not even close to it.

It should be noted that in light of the low number of tests in South Africa in relation to the population, it is possible that the actual number of cases is even significantly higher than what was detected because most of the infected individuals were asymptomatic or had very mild symptoms and were not tested. If this is indeed the case, it will be expressed in Israel in an even higher number of cases, but with an even smaller mortality rate.

What not to do

1. **Do not close the sky.**

Closing the sky is an action of no epidemiological significance, as evidenced by the fact that it was not done around the world in the wake of the Omicron waves. The total number of cases coming from Ben Gurion Airport is limited by a "ceiling" due to two reasons:

a. All passengers are tested prior to boarding the plane, so that only that small percentage of inaccurate tests or those that are exactly in the window where the test is unable to detect the infection will board the plane. That tiny percentage is likely to be detected in Israel, thanks to the post-landing test. In any case, those passengers go directly into isolation, and do not infect the population.

b. Even without "red countries," the number of passengers arriving each day is limited, and if the Ministry of Health predicts tens of thousands of cases in Israel every day, the impact of the approximately100 cases that may be added from Ben Gurion Airport every day is completely negligible.

It is worth noting that the existing practice of isolating positive cases from abroad in hotels is devoid of any medical logic—is an Omicron carrier infected in Amsterdam more dangerous than an Omicron carrier infected in Hadera? This policy is economically costly, and a more significant cost is violating the individual rights of citizens. In addition, there is strong evidence regarding the ability of the virus to spread through the ventilation systems of hotels [21,22].

2. Do not invest in breaking the chain of transmission.

The breaking of the chains has failed all over the world since the onset of the pandemic. Austria, which has been portrayed as a model for chain-cutting by government advisers, has recently surpassed Sweden, which has not adopted this policy at all, in the number of deaths per million. Especially in the case of Omicron, with its shorter incubation period and fast transmission, the "cutting" of the chains constitutes an unnecessary waste of resources.

This is evidenced in the fact that South Africa has announced that it is stopping contact tracing and quarantining of close contacts [16].

3. Do not increase the pressure to get vaccinated.

The effectiveness of the vaccine against Omicron has not yet been established, but it seems that there is a reduction in its ability to prevent transmission: Evidence is accumulating from around the world that vaccinated individuals are getting infected at high rates [23,24], and may possibly be infected more than non-vaccinated individuals [25]. However, it seems that the vaccine still has a considerable ability to prevent severe illness, and in the end—this is the purpose of the vaccine.

It should be noted that the third wave (December 2020-January 2021) was halted when the rate of vaccination in Israel, with two doses, was only about 3.5%. Today, about 70% of people in Israel are already vaccinated, and there is no reason to believe that continued immunization will slow down the wave. Moreover, data from around the world clearly indicate that higher immunization rates in the population do not prevent or reduce [26] waves of infection (for example, in South Korea [27], with 84% immunization in the general population. and 92% among those eligible for vaccination).

4. Do not tighten the green pass.

In accordance with the previous section, if there were still doubts about the epidemiological benefit of the green pass, with the Omicron any doubt is removed. Vaccinated and non-vaccinated individuals infect at similar rates [23–25], and the green pass has no meaning beyond being a punitive measure against non-compliance with the Ministry of Health's recommendation to get vaccinated, to get a first booster, and so on—soon a second booster. Especially in light of worldwide data about the infection of vaccinated individuals with Omicron, the moral-legal harm done by the green pass to democratic society is even more severe.

5. Do not accelerate the fourth dose operation.

This step has not been studied in terms of efficacy or safety, and it constitutes reckless and unscientific conduct. The risk is high, not only due to the possibility of cumulative toxicity and an increase in side effects, but also due to evidence from around the world that vaccinated individuals suffer from a period of reduced protection in the first days after vaccination [28], and vaccinating the high-risk population during the peak of a pandemic wave can lead to increase in the amount of infection among the most sensitive population.

6. Do not shut down the education system.

By no means should the education system be shut down. The State of Israel is facing an unprecedented crisis in the face of the alarming numbers of children and youth suffering from mental illness. The significant increase in the rate of eating disorders, depression, drug use and violence [29-36], in parallel with the increase in the number of dropouts from school, a 3-fold increase [37]—with all these numbers on the rise—teaches us an important and unambiguous lesson: school must remain open—for everyone [38].

<u>What should be done</u>

1. "Whoever is sick—stays at home."

The feeling of "false security" that exists among vaccinated individuals causes harm: Since it has become clear that vaccinated individuals become infected and transmit COVID, it is important that citizens know that

regardless of their vaccination status, they must stay home during illness—even mild illness—and get tested. Educating the public on this subject has been of value for many years and will also help to manage the flu and other common winter illnesses. In the world, it should be noted, these are well-known protocols, which nevertheless do not conform with the work ethic and the image of the Israeli who "comes to work sick and does not take sick days."

Repeated evidence from around the world shows that the role of patients suffering from symptoms is immeasurably greater in the spread of the pandemic than the role of the "verified" asymptomatic cases [39-41]. Using the simple rule of "whoever is sick—stays at home" will make it easy to treat most cases of infection, without investing billions of resources in locating asymptomatic carriers who hardly contribute to the spread of the virus.

2. Making the first and second doses accessible to at-risk populations who have not yet been vaccinated

Although the vaccine does not help in reducing transmission, it is evident that it still plays a significant role in reducing severe illness. Therefore, sectors and groups of at-risk populations must be identified, and the vaccine should be made accessible to them. At this stage, individuals getting vaccinated should be instructed to significantly reduce social contact in the first days following vaccination, in light of the evidence of negative immune efficacy in the days after vaccination [28]. Also, in light of the serological surveys and the expectation of a significant wave of infections, there is an argument to be made for serological tests to be performed prior to vaccination. This is especially important in light of evidence that recovering patients who have been vaccinated suffer from more significant side effects [42], while the effectiveness of the additional protection provided by the vaccine has not yet been sufficiently demonstrated in the study.

3. Encouraging at-risk populations to be cautious, and developing safe alternatives for them.

In an effort to minimize the harm to citizens' routine lives as much as possible, those at highest risk of serious illness should be advised to avoid closed and crowded spaces, and authorities should develop alternatives for activities for them, which they can enjoy with increased safety.

4. Create "green spaces," not "green passes."

Given that the vaccine does not protect against transmission and does not prevent infection, as can be seen even more clearly since the appearance of the Omicron, it is clear that there is no longer any point to having the "green pass," and we should thus **move from "personal protection" to "area protection."** A mandatory **rapid testing procedure (regardless of vaccination status)** should be implemented at the entry to places where there is a high concentration of at-risk populations (such as hospitals and nursing homes) and at places where there is a high risk of transmission (such as events with many high-risk individuals and psychiatric hospitals).

5. Development of reliable indices for measuring burden

Given the expected prevalence of Omicron, it is likely that the increased number of positive cases in the population will also be reflected among those who come to hospitals for any other reason (broken bones, dehydration, exacerbation of chronic diseases, etc.). This means that patients who go to the hospital for reasons that have nothing to do with COVID may test positive for the virus. This means that Omicron will become **much more common as a background condition**, and so we will see even more hospitalizations "with COVID" as opposed to "due to COVID" [14,15]. To develop reliable indices to measure the load caused by COVID, it is important to define criteria for mortality due to COVID (for example, death due to respiratory sufficiency and inflammatory profile in the presence of a positive COVID test in the 30 days preceding death), and for COVID hospitalization (for example, the reason for hospitalization is respiratory symptoms in the presence of a positive test in 10 days prior to referral) and to adjust criteria for critically ill patients, as is customary in the World of Health Organization.

6. Strengthening the healthcare system and integrating the use of new drugs

Both ends of the treatment spectrum must be promoted: on the one hand, community medicine solutions (such as home hospitalizations) should be promoted in order to deal with the multiplicity of "double morbidities" (flu and COVID carriers or individuals with mild COVID illness). On the other hand, action must be taken to increase the capacities and capabilities of intensive and advanced treatment units. Developing these capabilities will also constitute a long-term investment for future epidemiological crises.

At the same time, actions must be taken for the development, research and procurement of drugs to treat and prevent serious illness and mortality as a result of the virus.

Summary

1. The narrative of the takeover of the Omicron variant is not about illness but about cases: All the evidence from around the world shows that the virulence of the Omicron variant is at least 3 times lower than that of previous variants—and is most likely much lower. Therefore, the fear of the Ministry of Health about multiplicity of cases is well founded, but meaningless—**the healthcare system does not care for positive cases, but for sick individuals**.

2. Despite the speed in which the wave has formed (compared to previous waves), and although there may be new records for the number verified cases per day, the wave is expected to be narrower, and it is likely that the total number of infected individuals will be similar or lower to that of previous waves. Given the decline in severe rates of illness due to Omicron, there is no reason to assume that the system will crash, and it is **unlikely to even reach the loads observed in previous waves**. At this point it is important to emphasize the importance of developing reliable indices for identifying morbidity "due to COVID" as opposed to "with COVID," in light of the rising prevalence of Omicron in the population, resulting in it being a coincidental finding that would "paint" many hospitalizations with COVID, even though those hospitalizations would not have a real link to the virus.

3. The current assessments repeat the errors of past assessments: they exaggerate the rate of transmission to unreasonable levels, unprecedented in the world, and do not recognize encouraging data about a reduction in the severity of the variant. In addition, and most puzzlingly, they do not at all weigh the effect of vaccines on hospitalizations, severe illness, and mortality. **Continuing to work according to these "doomsday" scenarios results in frightened, unrestrained, wasteful and inefficient conduct**, which causes the public to lose confidence in the system and results in lower compliance with the government's recommendations and guidelines.

4. There is no reason to go back to those same drastic measures, with very limited efficiency and very high cost, that the government used in previous waves. **It is important to opt for a more efficient conduct**, which recognizes the mildness of this variant, and also recognizes the limitations of the tools for preventing the spread of a respiratory virus with aerosolic (spray) distribution mechanisms.

5. It is important to act using tools that, beyond their health-epidemiological value, will re-establish public trust in the system, which was severely damaged during the crisis. Public-health education should encourage personal responsibility—**"those who are ill—stay at home"** and be tested in these cases, regardless of immune status. **Assistance should be provided in making the vaccine available to at-risk populations who have not yet been vaccinated**, and efforts should be made to develop **safe alternatives for at-risk populations** in order to reduce their exposure to places with high potential for infection. Action should be taken to create "green spaces" in areas where there is a particularly high-risk population or contagion potential, the entry into which will be permitted only following a rapid test (regardless of vaccination status). **Reliable load indices** should be developed that correctly reflect the load on the health system due to COVID. Finally, efforts must be made to **strengthen the healthcare system**, and to promote the development, research and assimilation of new drugs for severe illness due to the virus.

6. A government should never adopt as a working assumption the most severe and extreme scenario (not even in matters of security) **because the cost of the actions taken would exceed the possible risk**. Such a conduct constitutes a deviation from any accepted norm of risk assessment and preparedness, as strongly evidenced by lockdowns, whose harm far outweighs their benefits. "Zero-risk" conduct entails heavy costs of abandoning the other important determinants of physical health, mental health, welfare, economy and society.

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