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Straight Talk

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Pandemic management is a matter of balancing "health vs. health"

With Dr. Martha Fulford

Canadian policy-makers don't seem to have evolved much in their approach to handing COVID-19 since the early days of the pandemic, when the country was understandably locked down in the face of an unknown threat. To shed light on this issue, this Straight Talk features Martha Fulford, an associate professor of medicine at McMaster University. The publication is based on a transcript of a recent discussion between MLI Munk Senior Fellow Shawn Whatley and Martha Fulford

Dr. Martha Fulford is an associate professor at McMaster University. She is currently the Chief of Medicine at the McMaster University Medical Centre of Hamilton Health Sciences. Dr. Fulford provides infectious disease consultations for both the pediatric and adult patient populations as well as running the McMaster Travel Clinic. She completed her training in internal medicine and in infectious diseases at McMaster University. She is a member of the PIDAC Communicable Diseases Committee with Public Health Ontario.

MLI: We are delighted to be joined today by Dr. Martha Fulford, an associate professor in the division of infectious diseases at McMaster University. Today, we'll be talking about COVID and the pandemic. You've actually lived and worked through other pandemics, so I wanted to ask how has COVID-19 been different from your experience dealing with other infectious diseases, particularly other pandemics?

Dr. Martha Fulford:

We've always had very detailed pandemic management plans. The most recent one for Canada was from 2018. The thought, of course, was that the next big pandemic would be influenza. As it turned out, it was COVID. But, in a lot of ways, it's a very similar respiratory virus. And our plans for influenza, if we had just crossed out the word influenza and added in the word COVID, or replaced it with COVID, these would have been excellent pandemic management plans. But, obviously, there was a lot of uncertainty when this started; people weren't quite sure what was going to happen. And with COVID, we've tossed out what would be a normal pandemic management plan with the local provincial and federal emergency response teams, opting for a much more top-down control than I've ever seen with not as much input in terms of protecting infrastructure, protecting the economy, and other things that you would normally do with a pandemic.

Clearly, when infectious diseases hit the population, one of the most important things is to protect those who are most vulnerable from being affected from it, e.g., protecting people who might become severely ill and who might die. We need to figure out where the virus is being transmitted and focus our attention on the areas of transmission. We then need to build surge capacity because with any pandemic, it's usually recognized there will be a surge in patients. This is what happens with pandemics and we get ready to deal with it by building surge capacity.

Finally, and very important, while doing our best to protect the health and wellbeing of those who are vulnerable to the infection, we need to make sure we don't actually destroy the fabric of our society. A short lockdown, for example, at the beginning of a pandemic, is meant to buy time to get ready. It's not normally the go-to mechanism for ongoing control. The lockdown never makes

a virus go away; the lockdown buys you time. During that time, you get ready with your surge capacity and targeted approaches and that's what we haven't really seen with COVID, with a very few exceptions.

MLI: You mentioned this uncertainty at the start. And people have commented that this is completely different and we have to do whatever we think is reasonable because the threat is so huge, in what is sort of worst-case scenario. Can you comment on that?

Dr. Martha Fulford:

In March of 2020, we had some fairly horrifying images coming out of China with them building mass field hospitals. There was also the pretty devastating impact in Northern Italy and then in New York. At that point, it was not 100 percent clear exactly what the impact of this virus would be and how many people would actually die of it – and this was the context for the initial lockdown.

It rapidly became apparent, and by May of 2020 it was eminently clear, that this virus predominantly targeted our seniors. There's no question that for anybody in long-term care, or for an older member of our society with comorbidities, that getting COVID could be quite devastating. But it was equally evident that young people were not, in fact, particularly affected by COVID or dying of it. That really goes to the infection fatality rate. The number of people who get the infection and who actually die was dramatically lower than what we initially thought.

MLI: When did we find that out?

Dr. Martha Fulford:

It was pretty clear by the end of the first wave. We had data from around the world; children were not dying. This was clear in New York. It was clear in China. It was clear in Italy. It was clear anywhere that COVID was happening. There are always going to be some exceptions in which a younger adult might succumb. But if you looked at the numbers, this was unquestionably a virus that was very devastating to frail elderly in congregate care settings and while younger people could certainly get COVID, in younger people it's essentially an upper respiratory tract infection.

MLI: Would you say that we knew who the vulnerable were within a few months or weeks?

Dr. Martha Fulford:

We certainly did within a few months. I think if you look at the mortality in Canada and in a great many countries, it was the 80-plus and 70-plus age group. We have weekly updates from the Public Health Agency of Canada. If you look at the Canadian data and see the people who died of COVID, the vast majority are in the 80-plus group and then the 70-plus group. Again, this is not to minimize that there are some younger people. But if you just took those numbers, then the threat and the danger is not that different than the threat of a lot of things that we would normally deal with.

In other words, the perception of the risk that we had in March seems to have never altered. There are still some people who seem to feel this is a deadly virus for anybody who might get it, with really no sense of perspective or comparison. Nobody is comparing it to other infectious diseases, to cancer, to heart disease, to car accidents. Again, this is not to minimize anything. There are people who are dying, but there's no sense of perspective. And by the summer, there were enough people saying we should have a targeted approach. We know that it's our seniors and frail members of our society who are at risk. For me, I would have thought we could start to talk about a targeted approach. We didn't do a very good job.

MLI: Were we on the right track?

Dr. Martha Fulford:

That's an interesting question. There was a lot we could have done, for example, in our long-term care facilities. Even though we recognized that fact after the first wave because it was pretty devastating, make no mistake, we didn't do very much to change things when COVID went through long-term care facilities again. A lot of investment probably could have been made and to be fair, many of us have known about the problems in long-term care for a very long time. They've just dramatically come to light with COVID, so it's not to say they're new. Have we done a huge investment to fix these underlying structural staffing and infrastructure problems? I haven't seen a lot of that in Ontario, no.

MLI: Do you think we could have done more in our response? And maybe what would that have been? Should we have been doing daily testing for people who work in long-term care?

Dr. Martha Fulford:

If you look at where the transmission was consistently happening

and where we would have our hot spots, it pretty much has always started in individuals that we refer to as our essential workers. These are people who have to work. You can lock down or have stay-at-home orders as much as you want, but that's for the people who have the luxury of being able to stay at home. For example, I live in a nice house and have a backyard. It's not that difficult for me to have to work from home if that's what I am required to do. I can go on my computer, order a box delivered to me, and have everything sent to my home. But somebody has to pack that box, somebody has to deliver it, somebody has to pack grocery store shelves, etc.

With long-term care, the people who provide care in the long-term care settings are often very tenuous in terms of job security. They are part-time and working at multiple sites. They have no security in terms of benefits or sick pay. They use public transport. They work in very close contact with a frail part of the population, and by close contact, they're feeding them, they're helping them with their toileting, they're helping them with their bathing and going to multiple sites. And they are often (but not exclusively) women, with no job security and no job benefits. A person like that can't suddenly be off work for 14 days because the choice is going to be quietly keep working or have no money, no income, and no food for his or her children for two weeks. And we didn't really fix that. We could have done things like massively train up a cadre of personal support workers. The training could have been provided for free. We eventually did do that but quite late in the game.

MLI: Is that where transmission was happening, e.g., with the essential workers or with people who had to go to work but yet still had close contact with the frail elderly?

Dr. Martha Fulford:

Wave one was a little bit different because we weren't sure. But certainly, with wave two and very definitely with wave three, it was very clear that transmission was taking place in the hot spots. These are the areas from where essential workers are living and working. Even for our third wave, if you look at where it started, it was in the Toronto, Brampton, and Peel areas – those neighbourhoods that were still in lockdown when our third wave started, because the people working in those settings still had to go to work. They still had to provide these essential services.

It's not hard to find a lot of physicians and a lot of people advocating for things like paid leave, isolation facilities, etc. You need to go to those workplaces because that's where the transmission

is happening. And we need to target vaccinations, once the vaccines were available, to those neighbourhoods right away because that's where we were getting a lot of the hot spots. And if you can vaccinate the group that's highest at risk and those around them, you have almost like a ring around that area to try to slow down transmission.

I think it's pretty clear that we didn't do a lot to build surge capacity. Maybe we started to in the last third wave. In Hamilton, where I work, we're putting up one of the mobile health facilities. It'll be up and running by the beginning of June and perhaps in hindsight, that's the kind of thing we should have been planning for last summer.

Again, we need to look at the history of pandemics. Personally I'm not sure that COVID is that different than a bad influenza pandemic in terms of the pattern when it goes through a population. I appreciate it's a different virus, but if you look back to 1918-19 at the Spanish influenza, you'll see it had three curves. There's a lot of history of medicine that one can go back and look at and learn how these things tend to go through a population.

I don't think it should have been a surprise that we had a second wave or even a third wave. In hindsight we really should have been doubling down to build surge capacity and ensure we could cope. I mean you know as well as I do that our hospitals are essentially at over capacity every single winter with a standard respiratory virus season. Being over capacity, having gridlock, and dealing with overflowing intensive care units are nothing new. But, unfortunately, when you've got hospitals that are always at 100 percent capacity or over capacity, you have zero ability to deal with an influx of patients in the event of something like a pandemic.

MLI: I've seen a few historic pictures floating around about notices about lockdowns and quarantine from what I think was the 1918-19 influenza pandemic. Can you comment on that? I bristle at lockdowns, but maybe we've always had lockdowns and we're just out of practice.

Dr. Martha Fulford:

If you go back, it's like the repetition of history with the 1918-19 pandemic. For example, you can see curves showing where different communities put in these so-called non-pharmaceutical interventions early or late. And this was, of course, to try to do what we were doing last year, which is flatten the curve. And the idea of flattening a curve is to slow down the rate at which a virus goes through your community. As I was saying earlier, lockdowns

won't make a virus go away, it slows it down. With lockdowns, the idea is to try to minimize person-to-person contact where the virus might be transmitted.

With lockdowns as a short-term initial intervention, I didn't question it last March. I was not uncomfortable with what we were doing, in order to stop and see what's going on. But once we had a better sense, that's where I feel that we didn't evolve in terms of some of our responses. But yes, you're right. There were lockdowns in 1918-19, and if you go back, people also got fed up with them pretty quickly and we definitely see history repeating itself.

MLI: Were there multiple, serial lockdowns every few weeks or months?

Dr. Martha Fulford:

One of the differences then, I think, is it tended to be much more local. It would be a city or a community. There wasn't a lockdown of the entire country or society, and this is probably a reflection of the difference in communications that are going on right now and our ability to do mass intervention. There's a very good book called *The Great Influenza* by John Barry, which showed that there was a lot more going on at the local or municipal level and much less trying to get an entire state or province to do it. And I suspect that's because of slower communication and nowhere near the same degree of mass transit, so there was probably a little more opportunity for individual responses at different community levels.

MLI: I'd like to circle back to something you said earlier about how decisions are being made and how it feels like a top-down approach when plans are tossed out. I feel like we're being told what to do and what to think by a small group of really smart people. But how does someone like yourself, who is on the cutting edge of this issue and who has raised questions publicly, how do you stickhandle through all that and how do you feel as an expert? Is this a good way to handle an emerging, evolving viral pandemic?

Dr. Martha Fulford:

Whenever we are confronted with something new like COVID, there's going to be a very fast learning curve. And clearly, there was going to be, and continues to be, an awful lot that we don't know. One of the single most important things in a situation like this would be, in fact, to be extremely open-minded about information coming in to ensure we look at all different viewpoints and ask probing questions because it's new and there are a lot of unknowns.

We're doing a lot of things that are very different for our society and for some people we're doing some incredibly destructive things. To ensure that we're doing the right thing, there should be constant questioning, debate, discussion, and trials, even at the community level. What interventions work best? What can we do to ensure that we minimize the impact of COVID, while maximizing all the rest of the really important public health issues that we need to look after? For me, health is defined as a state of physical, social, and mental wellbeing, it's not just the absence of disease. Public health can't just be about COVID. It's a very important public health issue. But, as we learn information, I think it's important to be open-minded, to ask questions, to be critical, to look at what other jurisdictions are doing.

I live in Ontario. What has British Columbia done that's different? How come it's worked there and can we learn from them? Can we learn from European colleagues? Sweden is a much vilified country because they never had any of these hard lockdowns. They certainly had public health interventions, but they didn't have the same degree of harsh lockdown. But, instead of just saying that they're terrible and everybody's dying, maybe we could have asked questions. Is there something that Sweden is doing that we can learn from? I don't know that we were very open-minded in looking at other jurisdictions. We were very quick to condemn any plan or any way of trying to deal with this that was different than what we were doing.

MLI: There have been physicians with voices outside of the mainstream consensus that have been vilified. Let's say we have some physicians who are really insistent on saying things that perhaps even make you and me cringe, and say they're not even talking about the basics of science anymore. If everyone thought the way you did, and hopefully the way I do, then we could have a rational discussion. But are there some docs who maybe go too far? What are your thoughts on that?

Dr. Martha Fulford:

It's a very interesting question. When is something true misinformation? When is it that we just don't know? And when is it that there is more than one correct answer because there's not always only one way to accomplish something. This is not unique to medicine; many situations come with various paths one could take and they're all okay.

Clearly, there's some stuff that's just not right: dunking people in a lake and saying it's going to cure COVID is totally incorrect. There are some really far out ideas. I'm an infectious disease physician, I'm extremely pro-vaccine. I think it's reasonable to ask

questions, but our vaccines are certainly not connecting you to the 5G network and they're not somehow connecting you to Bill Gates as part of some strategy to control people. They are not altering our DNA. This is incorrect information and we've got facts. We can show this is just not true. And we can respond with better information.

But there's a huge area that I would describe as a grey zone. People can be against non-selective lockdowns, meaning the mass shutting down of everything. I believe in COVID. It's very real and I absolutely believe we should have targeted restrictions, but I think those restrictions should be focused on where we know that transmission's happening. We can to the best of our ability control COVID, but simultaneously with controlling COVID, we can ensure that we're maximizing public health and all the other important health parameters of our population.

A person, for example, could be anti-hard-lockdown, but absolutely pro-restriction, pro-vaccine, and pro-masking in the right circumstances. This polarization of viewpoints – where only one perspective is correct and everybody else is wrong – is problematic. I don't think there are very many physicians who think nothing should be done. I think all of us agree that COVID is a medical emergency that requires targeted interventions. That doesn't mean that a group of people who are anti-lockdown – and I'm going to have to be careful with that word – are on the extreme right-wing. It's this polarization that's problematic and with polarization, you end up with these situations where we're not even allowed to talk or debate these issues.

A year ago, for example, we did not know as much about transmission. Today, we know that the risk of outdoor transmission is essentially non-existent. We should be actively encouraging people to go outdoors. It gets them out of their house. It gets people active because we know the value of physical activity and being fit. The two risk factors for severe COVID are obesity and lack of physical activity, which increase the chances of severe disease and poor outcomes. When you encourage people to go outside, they're not inside, which is where transmission occurs.

Another thing we've learnt, for example, is that COVID is not transmitted on a surface. All this business of wiping down everything is really completely unnecessary. No virus jumps from a surface into your nose. You have just to wash your hands if you've touched something dirty. There are things that we know now that we could be applying. It isn't because what happened in March of last year was wrong. It's because we have learnt a lot more about this virus and so our response should be evolving as our knowledge evolves.

MLI: You said you are extremely pro-vaccine. Does that mean that you are unquestioningly pro any kind of vaccine that comes out for any disease? Doesn't matter where it comes from, how fast it was made, etc?

Dr. Martha Fulford:

I believe vaccines are very effective. I think they've been one of the miracles of modern medicine, but I also think that when we apply a vaccine, there should be thought process about how effective is it. Who needs it? What population do we need it for?

An extreme example would be the Ebola vaccine. We're certainly not going to do mass vaccination against Ebola because it's not necessary. That vaccine should be targeted to an area where we've got transmission and that's where you'd do the ring vaccination to try to protect everybody in an area to stop transmission. There are other vaccines, for example, shingles or one of the pneumonia vaccines that we recommend for certain age groups. We know that 50-plus or 65-plus are at much higher risk for these diseases, so we recommend the vaccine at that age.

MLI: You mentioned to me some of the people you've seen who've come to harm from other vaccine-preventable diseases. Could you comment on that?

Dr. Martha Fulford:

I mostly work with children at a pediatric hospital. I see any age group with an infection, but the majority of my inpatient, hospital-based work is with children. I think every single year of my working life, I have been involved with the care of a child who has died of a vaccine-preventable disease: whopping cough, meningitis, bad pneumonias. In children, it's usually because they haven't been vaccinated. And in babies, for example, with whopping cough, it's more likely because their siblings or the family aren't vaccinated because the baby is still too young to be vaccinated.

MLI: What do you say to folks right now who are feeling a bit hesitant about the vaccines? I see two groups of people. One is the elderly, who I'm just begging to get their vaccination. And then there are the very young people who are under 18 years old or under 12 years old. Can you help us unpack those two groups and the different types of vaccines available to us?

Dr. Martha Fulford:

We have two types of [COVID] vaccines that are currently under what emergency use approval (EUA), though I imagine Pfizer will have full approval at some point over the summer. Pfizer and

Moderna are what we call messenger RNA or mRNA vaccines. And then we have AstraZeneca and Johnson & Johnson, which are adenovirus vector vaccines. If you asked me a year ago about having vaccines this quickly, I would not have thought we would. I would have been very wrong in my predictions. I thought it would take at least three or four years. The vaccines have been astonishing in terms of the speed with which we've got them. All of them have been remarkable, essentially close to 100 percent at preventing severe disease, hospitalization ,and death.

Then the question is, who needs them? This is why the vaccine rollout started by age groups because the people who are getting severe disease, are being hospitalized or are dying, the vast majority are seniors. If the goal is to minimize severe disease and death, you vaccinate the group who are at risk of that. Again, anybody can look up the numbers. I'm not talking about who might get COVID. For the vast majority of people, COVID has either no symptoms or extremely mild symptoms, in which case, it's really not that important anymore because they're okay. They're never going to need to see a doctor. They're never going to be in hospital. It'll just be another respiratory tract infection and they'll get better. But the people who do end up in hospital, that's what we're trying to prevent.

By vaccinating the 50-plus age group, we will have accomplished the goal of not having an overwhelmed hospital system.

The whole lockdown and flatten-the-curve effort, it's based on the idea that we don't want our hospitals and intensive care units overwhelmed. By vaccinating the 50-plus age group, we will have accomplished the goal of not having an overwhelmed hospital system. And I'm not worried that the vaccine is dangerous to anybody. I just want to put this in context. But let me put this in context. The need at this point – and where it really becomes a little bit more of a conversation – is about risks and benefits to an individual.

A person who maybe has poorly controlled diabetes, who's obese, who maybe has hypertension, who's an essential worker at very high risk of being exposed to COVID because of his or her work, that person is at higher risk of getting COVID. That person, at higher risk of having severe disease if they get COVID, might want

to get vaccinated.

Another person who is 30 and completely healthy and at very low risk of becoming exposed at any point because they're able to work from home or work mostly outdoors, I have no concerns that the person gets vaccinated. But again, the impact on the health care system is very different.

In terms of young people, children and youth are not among those being admitted to hospitals; they are not part of the problem. We know from other countries who are ahead of us in vaccination – for example, Israel, United Kingdom and the United States – that just vaccinating adults provides extremely good control over community transmission.

MLI: Don't these kids make us all sick?

Dr. Martha Fulford:

I'm going to go off topic here and then I'll come back to children. Nobody should be blamed for getting a respiratory tract infection. One thing that's also happened with COVID, which I find really unfortunate, is this naming and shaming and blaming and penalizing of people for getting a virus. We have never done this before. You would never blame somebody who inadvertently got influenza. We don't blame somebody who gets pneumonia or gets meningitis.

MLI: What if they travelled when they're not supposed to be? Shouldn't we blame them and shame them on TV?

Dr. Martha Fulford:

No. I am dead against naming, shaming and blaming. I think this is criminalizing an infectious disease and it's actually quite shocking to me. We've done it in the past with things like HIV and it doesn't work. It just drives it underground. We should be using harm reduction and risk mitigation. We should be helping people out, but what we don't want to do is make them feel guilty. It is not the youth driving this. Young people are allowed to be young people. If we look at where transmission was happening, it was almost exclusively in terms of the big numbers, in congregate care settings and in our big workplaces with our essential workers. If you look at our schools, this was not where we had high numbers. This is true in Ontario, it's true in British Columbia, and it's true around the world. Study after study has shown COVID is less likely to be transmitted by children than it is by adults. It's not to say that children never will, but again, I personally am not in favour

of penalizing children because there's a pandemic going on. It is not the fault of our children and our youth. And our children and our youth deserve to have normal lives.

MLI: I agree with you entirely. But I also know a lot of people have responded to me by saying these sick kids, if we open schools, they're all going to have runny noses and they're going to infect the teachers and the teachers are going to infect grandma who lives in the granny suite.

Dr. Martha Fulford:

But why isn't grandma vaccinated? That will have protected her. The same for teachers or even for health care workers. I don't want to pick on teachers, but a young otherwise healthy teacher who might get COVID is probably not going to have severe disease. But any adult can get vaccinated, and again, a teacher who may be in an environment where he or she is at high risk of being exposed is somebody who should in fact be vaccinated. Again, this can be contrasted to the person who is predominantly working from home and unlikely to be vaccinated.

I have no concerns with the vaccine rollout as it was, by age group. In fact, when I'm not working at the hospital, I've been working at the vaccine clinics in the city because I think the faster we vaccinate, the better off we are. But neither am I going to think that I need to coerce or force or shame somebody. I would like to hope that if somebody is hesitant that we can have a conversation, we can discuss that individual person's concerns, the risks, the benefits, the timing. There are a lot of things we can do.

For children, I'm surprised we're as gung-ho to vaccinate teenagers in Canada, again, only because it's still emergency use approval. We don't have a problem with kids filling up our hospitals. But my main reason for saying this is that if we really want to control COVID, remember that it is a global problem; it's in every country in the world and by donating the vaccines that are currently being used for our very low risk people, to countries like India – so they can be used in countries that have a lot of transmission – it would probably would do more to control COVID world-wide in the long-term.

I'm not alone in saying this. When you've got a pandemic, it doesn't respect borders. There are quite a few of us who have been asking if this the best way that we should be using vaccines – to vaccinate teenagers. I know there've been a lot of stories in the United States where people are asking the same question. Wouldn't it be better to shut down transmission in countries like

India and save a heck of a lot more lives long-term by doing that? That's a very high-level decision on vaccine allocation.

MLI: So how do we get back to normal? What is normal? Can you describe for me what normal is going to look like? Are we going to need boosters? Are we putting too much faith in vaccines themselves and maybe we're going to have to lock down again in the fall?

Dr. Martha Fulford:

One of the important questions that I haven't seen clearly articulated or at least explored: what are we trying to achieve as a society? I would argue that our original objective from March of last year was to flatten the curve; in other words, to slow down the rate at which people might get severely sick so we don't have an overwhelmed hospital system. That's an appropriate goal. COVID is not going to go away.

I know there are some people who use the term COVID-zero, but this would mean we would never ever, ever open up because COVID's not disappearing anytime soon. I think what will happen is that with vaccines, along with natural infection but predominantly with vaccines, particularly amongst our seniors, we are going to see a significant decrease in hospitalization and severe disease. Not that there will be none, but it will be very controllable. It will become our fifth circulating coronavirus.

Pre-COVID, we had four endemic coronaviruses that circulated every year. They cause a respiratory tract infection, like the common cold. I think once COVID has swept through the population in areas where they do have a lot of vaccines or in countries that are heavily vaccinated, what we will see is when respiratory tract season comes around, COVID will be one of our background viruses in the way that pandemic influenzas become endemic. When we think back to our influenza pandemics, those viruses didn't disappear. We had enough immunity across the population that they became manageable and we could co-exist with them.

In terms of normal, I would hope that we get to a state where we're co-existing [with COVID]. I think we need to accept that there will be some degree of COVID seasonality. We will have these waves, but it won't be devastating anymore because of the vaccines. Our objective is to ensure that we can cope and we've managed to co-exist and the vaccines really are remarkable at that. We should at that point start to think about going back to normal. And we can see that this is happened in Israel. We can see it happening in the United States.

With protection, we won't need a lot of the non-pharmaceutical interventions. In other words, we won't need to constantly fear getting close to people. The role of masks will become unnecessary for most people. There are some people who may choose, for whatever reason, to continue wearing a mask, which is fine. But would they be mandatory? No, because people are protected.

There may be some new normals. One new normal I would really like to see is that if people are sick, they're allowed to stay home. We've had a culture where we don't really encourage people who are sick to stay home. We actually almost penalize them and shame them and make them come to work sick. There are some things I would like to have become normal and one of them is that we don't shame people if they stay home because they're not feeling well.

MLI: Are we going to have to completely rewrite all the infectious disease and public policy textbooks because of COVID? And what final advice could you give?

Dr. Martha Fulford:

COVID has taught us a lot about things like transmission. We used to have this dichotomy between droplet versus airborne. I think we've all realized that it's not quite that simple and there's a spectrum of how things are transmitted. We have normalized in a way that's probably good to not get infections, but I would hope that it doesn't stop anybody from leading normal lives.

One thing we haven't really talked about, which I actually think cannot be underestimated, is COVID has clearly had a devastating impact, but our response to it has been also very devastating. Lives have been ruined because of some of these lockdowns. There are job losses, there are shattered dreams. The impact on our children with school closures is going to be felt for their entire lifetimes. We have children who will no longer meet literacy goals or numeracy goals. We have children who have essentially been lost to the school system now because they've just faded away. Online doesn't work. They have no sports. They have no music. They have no social activities. We're seeing a public health emergency in our children and our youth, which really is going to reverberate for many years.

There are also adults who I think are so anxious and so terrified to go out now that there's a degree of anxiety in adults that's going to take a long time to get over. And it's not really economy versus health, it's health versus health. Because forbidding people from activity, forbidding people from socializing, forbidding

people from taking part in their social structures, whether it be their friends, their church, their knitting group, their yoga group, or the people they play poker with, has been profoundly harmful in what we have done to the fabric of our society and this simply cannot be underestimated.

We can acknowledge that we've had this pandemic and that COVID was bad, but we mustn't forget that there are many other aspects of public health that have been neglected. And because of the vaccines, we should be turning a lot of attention to trying to remember that the basic tenet of public health is not just no COVID, but it's all the other physical illnesses. It's mental wellbeing. It's emotional wellbeing. It's societal wellbeing. We have really lost that balance and I do think we need to find that balance again even as we deal with this. And I hope we learn from this for the future that we never again are in a situation where we skew so much towards one issue facing our society that we lose sight of everything else.

MLI: What a fantastic closing comment. I haven't heard it said so well, so thank you so much for joining us to discuss these issues.

excellent

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- *Hill Times* says **Brian Lee Crowley** is one of the 100 most influential people in Ottawa.
- *Wall Street Journal*, *Economist*, *Foreign Policy*, *Globe and Mail*, *National Post* and many other leading publications have quoted the Institute's work.

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The Right Honourable **Paul Martin**

I want to congratulate the **Macdonald-Laurier Institute** for 10 years of excellent service to Canada. The Institute's commitment to public policy innovation has put them on the cutting edge of many of the country's most pressing policy debates. The Institute works in a persistent and constructive way to present new and insightful ideas about how to best achieve Canada's potential and to produce a better and more just country. Canada is better for the forward-thinking, research-based perspectives that the **Macdonald-Laurier Institute** brings to our most critical issues.

The Honourable **Jody Wilson-Raybould**

The **Macdonald-Laurier Institute** has been active in the field of Indigenous public policy, building a fine tradition of working with Indigenous organizations, promoting Indigenous thinkers and encouraging innovative, Indigenous-led solutions to the challenges of 21st century Canada. I congratulate **MLI** on its 10 productive and constructive years and look forward to continuing to learn more about the Institute's fine work in the field.

The Honourable **Irwin Cotler**

May I congratulate **MLI** for a decade of exemplary leadership on national and international issues. Through high-quality research and analysis, **MLI** has made a significant contribution to Canadian public discourse and policy development. With the global resurgence of authoritarianism and illiberal populism, such work is as timely as it is important. I wish you continued success in the years to come.

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