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### COVID-19 Vaccines Don't Really Work as Hoped

Posted on [August 5, 2021](#) by [Gail Tverberg](#)

Last week, the CDC announced a [surprising finding](#): “Delta infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people.” Public officials had known from the early days of vaccine development that vaccinated people could catch COVID-19, but *the assumption had been made that they were not going to be spreaders of COVID-19.*

It turns out that the delta variant is sufficiently different from the original Wuhan version of the virus that the **vaccines work much less well**. The CDC performed an [analysis](#) of COVID-19 cases arising from one public gathering in Massachusetts. They found that the gathering led to 469 COVID-19 Delta cases among Massachusetts residents, with 74% of these cases in fully vaccinated attendees. Massachusetts is a highly vaccinated state, with approximately 64% of the population fully vaccinated.

There are other issues coming up as well. How long does the vaccine really last? Is the vaccine itself part of the reason that the virus is mutating as rapidly as it is? Are we making problems for ourselves by creating an army of people with very light cases of COVID-19 who can spread the virus to both the vaccinated and the unvaccinated without realizing that they have more than a cold? Aren't we inadvertently killing off the least able of the virus mutations and allowing the most virulent to multiply?

My training is as an actuary, so I am familiar with modeling. I am also a “systems thinker.” I know that it is important to look at longer term impacts as well as short-term impacts. If a person works in the healthcare field, it is easy to consider only the obvious short-term benefits. It takes some analysis to figure out that today's vaccines may lead to stronger variants (such as Delta) and more overall spread of COVID-19.

In this post, I will explain some of the issues involved.

**[1] Today's vaccines provide only a fraction of the true level of protection required. Their actions are in many ways similar to applying weed killer at half the strength needed to kill the weeds or providing antibiotics at half the dose required to stop the spread of bacteria.**

All of our lives, we have been told, “Be sure to complete the full course of the antibiotics. It is necessary to kill *all* of the bacteria. Otherwise, it will be easier for a few of the stronger bacteria not to be affected. If you stop too early, the bacteria that are least affected by the antibiotic will survive and reproduce, while the others will die. Stopping the drug too soon is a great way to achieve antibiotic resistance, quickly.”

Unfortunately, COVID-19 vaccine makers seem to have overlooked this issue. The respected BMJ published an editorial entitled, [Will covid-19 vaccines save lives? Current trials aren't designed to tell us](#). It makes the point:

*Peter Hotez, dean of the National School of Tropical Medicine at Baylor College of Medicine in Houston, said, “Ideally, you want an antiviral vaccine to do two things . . . first, reduce the likelihood you will get severely ill and go to the hospital, and two, prevent infection and therefore interrupt disease transmission.”*

*Yet the current phase III trials are not actually set up to prove either.*

We were told that the new COVID-19 vaccines are “95% effective in preventing symptomatic disease,” but it turns out that this is far less adequate than what most people would assume. The vaccine is “leaky.” A big issue is that the virus mutates, and the vaccine works much less well against the mutations. The world can never reach herd immunity if immunized people keep catching new variants of COVID-19 and keep passing them on, as the evidence now suggests.

**[2] In a way, getting sick from a virus is helpful. It tells us to stay at home, away from others. It is the fact that humans experience symptoms from viruses that tends to limit their spread.**

If a virus has severe symptoms, those infected with the virus will not feel well enough to continue their usual activities. They will tend to stay at home.

If the symptoms are mild, as is the case with the common cold, people will likely go about their activities as usual. This is especially the case if people need to work to feed their families. Thus, viruses with mild symptoms often spread easily.

But, if citizens feel that they are protected by a vaccine, they will likely continue to go about their activities as usual. Most of them will not realize that they might be spreaders of Delta, and perhaps other new COVID-19 variants. Symptoms are likely to be mild or non-existent.

**[3] It is becoming clear that people immunized with today's vaccines can both catch the delta variant and spread it to others.**

As I mentioned above, the CDC concluded from looking at [its analysis](#) of 469 delta cases that the infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated individuals.

We have independent corroboration of the ability of vaccinated individuals to spread delta COVID-19 in a [new analysis](#) from Singapore. This article reports, “PCR cycle threshold (Ct) values were similar between both vaccinated and unvaccinated groups at diagnosis.” This is precisely the information that the CDC was relying on in Massachusetts when they reported that there were similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people. While this analysis has not yet been peer reviewed, it reaches precisely the same conclusion with respect to early viral load as the Massachusetts analysis.

The data from this same Singapore study indicates that there are about 3 times as many asymptomatic cases in the vaccinated (28.2%) as the unvaccinated (9.2%). The median number of symptoms reported by the vaccinated was 1, compared to 2 in the unvaccinated. Among the vaccinated, the most frequent symptoms were fever (40.9%), runny nose (38%) and cough (38%). One of these symptoms, especially if it occurred only briefly, could easily be overlooked as a sign of COVID-19.

**[4] With nearly all of the current vaccines, the immune system is trained to look for the spike protein from the original Wuhan virus. This narrow focus makes it relatively easy for the virus to mutate in ways that outsmart the vaccine.**

A “History of Vaccines” website indicates that there are several ways vaccines are being made, including weakened (“attenuated”) viruses, killed viruses, and segments of the pathogen. In the new COVID-19 vaccines, a particularly limited part of the virus is used, the spike protein. In fact, in the newer vaccines, only an mRNA code is injected, and the body is instructed to make the spike protein itself.

Using a very narrow target has made it easier for viruses to evade the effects of the vaccine. Delta is one variant of the original virus from Wuhan that is evading vaccines through its mutations. Another such [variant is Lambda](#), which caused serious problems in Chile in the spring of 2021, despite vaccine usage as high as 60%. The virus

underlying all of these variants is called SARS-CoV-2, reflecting the fact that this virus is closely related to the virus which caused the 2003 SARS epidemic.

Since vaccination began about December 15, 2020, we have so far encountered two variants that are poorly controlled by vaccines. This is not a promising sign for the long-term success of COVID-19 vaccines. As more time goes on, we can expect more such variants. These variants do not necessarily stay around for more than a few months, making it difficult to create and distribute new specially targeted vaccines.

**[5] Given the likelihood of mutations away from the narrow target, it seems strange that the governments have set very high expectations for the new vaccines.**

It seems to me that Pfizer and Moderna should have said, "We are producing new vaccines that will somewhat lessen symptoms. In a way, they will be like the annual influenza vaccines that various companies make each year. We will need to update the vaccines regularly, but we will likely miss. Hopefully, our guess regarding what will work will be 'close enough,' so the vaccine will provide some partial benefit for the upcoming variations."

Such a statement would have provided a more realistic set of expectations, compared to what many people have been assuming. No one would expect that herd immunity would ever be reached. The vaccines would be perceived as fairly weak tools that need to be used alongside medications, if they are to be used at all.

**[6] Leaky vaccines, if widely used, can encourage the virus to mutate toward more virulent (severe) forms. Ultimately, the problem becomes viruses that mutate to more virulent forms faster than the vaccine system can keep up.**

If, as we are seeing today, vaccinated people can catch the variant and pass it on to both vaccinated and unvaccinated people, this extra boost can help the variant tremendously in its ability to spread. This extra boost is especially helpful for the variants that are very virulent, since in the normal situation, people who catch a virulent variant would *recognize that they are sick* and stay at home.

There would normally be a limit on how much the variant could spread based on its impact on the unvaccinated. This limit goes away if both the vaccinated and unvaccinated can catch and spread the illness. Without a vaccine, the variants might be either more or less virulent, with the more virulent tending to die out because the people who get them either die or stay at home because they are very ill. I would expect that this is the reason why quite a few viruses tend to become less severe (virulent) over time, when leaky vaccines are not available to artificially boost their virulence.

The article, [Vaccines are Pushing Pathogens to Evolve](#), gives the example of how the vaccines for Marek's disease in chickens have been failing, as the disease gradually evolves to become more virulent under pressure from the vaccines being used to keep this illness away. The first vaccine was introduced in 1970. A decade later, outbreaks of Marek's disease began to be found in vaccinated flocks. A second vaccine was licensed in 1983, but it too began to fail. When the article was written in 2018 the industry was on its third vaccine, but it too was beginning to fail, as the disease became more deadly. But there was no new vaccine yet available.

A 2015 article in *PLOS Biology* is entitled, [Imperfect Vaccination Can Enhance the Transmission of Highly Virulent Pathogens](#). A person would think everyone involved in vaccine technology would be very much aware of this issue.

The chase after new vaccines is precisely the problem we can expect to have with the vaccines for COVID-19. Only, our problem with the vaccine not really working correctly is coming after a few months, not 10 years. Trying to keep up with new vaccines for a virus that evolves away from us, this quickly, is likely to be an impossible task. It is not just the unvaccinated who have a problem; it is everyone, as the vaccines quickly lose their effectiveness.

**[7] Another potential problem with COVID-19 vaccines is [Antibody Dependent Enhancement \(ADE\)](#). When this occurs, it worsens later infections by different variants.**

ADE is a rather strange condition in which the antibodies against one variant gained from a first infection (or immunization) act to make some later infections by a different variant worse, rather than better. Dengue Fever is [an example of an illness](#) for which this is an issue.

Dr. Robert Malone thinks that [ADE may be happening now](#) for COVID-19. He sees the high virus levels in immunized individuals as evidence of possible ADE.

The large number of immunized patients in the hospital with COVID-19 in Israel (which has mostly Delta cases) is also given as possible evidence:

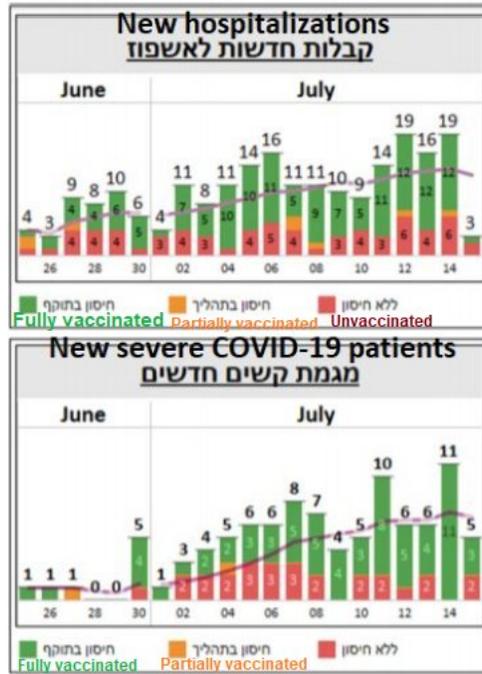


Figure 1. Image from Israel's official COVID-19 website, showing new hospitalizations and new severe patients separately for fully vaccinated, partially vaccinated, and unvaccinated individuals.

The illness SARS is closely related to COVID-19. There is evidence that vaccinations against SARS tend to [produce ADE](#). In fact, the National Institute of Health provided funding for a 2020 [academic paper](#) that reaches the following conclusion:

*The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for trials and future patients after vaccine approval, in order to meet the medical ethics standards for informed consent.*

**[8] Another problem with the current vaccines against COVID-19 is that immunity may not last very long.**

The virus that causes COVID-19 is a coronavirus. The common cold is another illness caused by a coronavirus. We know the immunity of the common cold doesn't last very long, perhaps a year. While we don't have long-term

experience with COVID-19 vaccine immunity, we shouldn't be surprised if its immunity begins to wane within a few months, or in a year or two.

Israel, after analyzing its recent COVID-19 experience (almost all with the Delta variant), is now offering [anyone over 60](#) who was vaccinated more than 5 months ago a booster shot. Third doses are also being given to those with weakened immune systems.

It should be noted that if immunity doesn't last very long, any strategy of "flattening the curve" by stretching out COVID-19 cases becomes counterproductive because it runs the risk of moving the timeframe of the next cycle beyond the time when natural (and vaccine-induced) immunity is still operative.

**[9] The public has been led to believe that vaccines are the only solution to COVID-19 when, in fact, they are at best a very poor and temporary band-aid.**

Vaccines are a tempting solution because the benefits have been oversold and no one has explained how poorly today's leaky vaccines really work.

We are already past the period when these vaccines were well matched with the viruses they were aimed at. Now we are in a situation in which the viruses are constantly mutating, and the vaccines need to be updated. The catch is that the variants stick around for such a short time period that by the time the vaccine is updated, there is likely to be yet another new variant that the new vaccine does not really match up with well.

Requirements that employees be vaccinated against COVID-19 cannot be expected to provide much benefit to employers because workers will still be out sick with COVID-19. This happens because they are likely to catch a variant such as Delta, which does not line up with the original vaccine. Perhaps they will be out for a shorter period, and their hospital bills will be lower. These types of benefits are what people have expected of influenza vaccines. There is no reason for them to expect more of the new COVID-19 vaccines.

Even with 100% vaccination herd immunity can never be reached because the vaccine encourages the virus to mutate into more virulent forms. Each new variant stays around for only a few months, making it hard for vaccine makers to keep up with the changing nature of the problem. Vaccine makers can expect to face a constant battle in having to run to stay even. Someone will have to convince citizens that each new vaccine makes sense, even though [injuries reported](#) to the US Vaccine Adverse Event Reporting System seem to be much more frequent than those reported for vaccines for other diseases.

An erroneous, one-sided story is being told to the general public, in part because the pharmaceutical lobby is incredibly powerful. It has the support of influential people, such as Anthony Fauci and Bill Gates. The pharmaceutical industry can make billions of dollars in income from the sale of vaccines, with little in the way of sales expenses. The industry has managed to convince people that it is OK to sell these vaccines, even though injury rates are very high compared to those for vaccines in general.

Vaccines are being pushed in large part because the pharmaceutical industry needs a money maker. It also wants to be seen as having cutting-edge technology, so young people will be attracted to the field. It cannot admit to anyone that technologies from decades ago would perhaps work better to solve the COVID-19 problem.

**[10] The pharmaceutical industry has been telling the world that inexpensive drugs can't fix our problem. However, there are several low-cost drugs that appear helpful.**

One drug that is being overlooked is [ivermectin](#), which was discovered in the late 1970s. It was originally introduced as a veterinary drug to cure parasitic infections in animals. In the U. S., ivermectin has been used since 1987 for eliminating parasites such as ringworm in humans. Ivermectin seems [to cure COVID-19](#) in humans, but it

needs a higher dosage than has been previously approved. Also, it would not be a money maker for the pharmaceutical industry.

The possible use of ivermectin to cure COVID-19 seems to have been intentionally hidden. At approximately 32:45 in this [linked video](#), Dr. David Martin explains how Moderna announced ivermectin's utility in treating SARS (which is closely related to SARS-CoV-2) in its 2016-2018 patent modification related to the SARS virus. It sounds as though Moderna (and others) have participated both in developing harmful viruses and in developing vaccines to cure very closely related viruses. They then work to prevent the sale of cheap drugs that might reduce their sales of vaccines. This seems unconscionable.

Vitamin D, in high enough doses, taken well before exposure to the virus that causes COVID-19, seems to lead to reduced severity of the disease, and may eliminate some cases completely.

Various steroid drugs are often used in the later stages of COVID-19, when conditions warrant it. The medical community seems to have no difficulty with these.

Monoclonal antibodies are also used in the treatment of COVID-19, but they are much more expensive.

**[11] Conclusion. Governments, businesses, and citizens need to understand that today's vaccines are not really solutions to our COVID-19 problem. At the same time, they need better solutions.**

Current vaccines have been badly oversold. They can be expected to make the mutation problem worse, and they don't stop the spread of variants. Instead, we need to start quickly to make ivermectin and other inexpensive drugs available through healthcare systems. People do need some sort of solution to the problem of COVID-19 illnesses; it just turns out that the current vaccines work so poorly that they probably should not be part of the solution.

The whole idea of vaccine passports is absurd. Even with the vaccine, people will catch the new COVID-19 variants, and they will pass them on to others. Perhaps they may get lighter symptoms, so that they will be off work for a shorter length of time, but there still will be disruption. If those who catch COVID-19 can instead take ivermectin at a high enough dose at the first sign of illness, many (or most) of them can get well in a few days and avoid hospitalization completely. Other medications may be helpful as well.

I am skeptical that masks can do any good with the high level of transmission of Delta. But at least masks aren't very harmful. We probably need to go along with what is requested by officials.

It is becoming clear that today's pharmaceutical industry is far too powerful. Investigations need to be made into the large number of allegations against it and its leaders. Why did members of the pharmaceutical industry find it necessary to patent viruses, and then later sell vaccines for a virus closely related to the viruses it had patented?

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#### About Gail Tverberg

My name is Gail Tverberg. I am an actuary interested in finite world issues - oil depletion, natural gas depletion, water shortages, and climate change. Oil limits look very different from what most expect, with high prices leading to recession, and low prices leading to financial problems for oil producers and for oil exporting countries. We are really dealing with a physics