

An “Impending Tsunami” in Mortality from Traditional Diseases?

By William Smith

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Introduction

Coronavirus disease, which is caused after people become infected by the coronavirus SARS-CoV-2, has swept the globe. It is certainly one of the great public health crises of recent decades. Although, COVID-19 has not been more lethal than the AIDS pandemic that has caused 35 million deaths worldwide, and COVID is likely far less lethal than the 14th century's "Black Death," which likely caused close to 75 million deaths.¹ The latest data suggest that COVID-19 has caused about four million deaths, although this count could be higher due to significant undercounting and underreporting by certain nations.^{2 3}

This paper addresses future indirect deaths that may be caused by the general climate of fear during COVID, exacerbated by government lockdowns, which deterred people from visiting their physicians or receiving important diagnostic tests that would have allowed chronic conditions to be treated earlier, and therefore more effectively.

This is a huge topic to tackle, as the prevalence of virtually every disease could have been accelerated by the COVID crisis and patients' inability or unwillingness to visit their physicians and get a proper diagnosis. For example, a recent CDC study indicates that breast cancer screenings were down 87 percent during the pandemic.⁴ Early detection screenings for most every disease was likely down during the pandemic. Therefore, we have limited our research in this paper to cardiovascular disease (CVD), which despite significant progress in recent decades, is still the leading killer worldwide,⁵ as well as the leading killer in the United States.⁶

According to a study in *Circulation*: "Age-adjusted death rates from cardiovascular disease (CVD) have declined more than 70% since the 1960s because of advances in prevention and treatment."⁷

Recent trends are more mixed, with death rates from cardiovascular disease levelling off, albeit at a lower level than decades ago. One study argued that declines in mortality from cardiovascular disease had been "decelerating" beginning in 2011.⁸ Because the declines in CVD slowed, CVD did not drop below cancer as the leading cause of death. If the same rate of progress prior to 2011 had continued, CVD deaths would have been second to cancer beginning in 2013.⁹

Therefore, this paper examines whether, after the COVID-19 pandemic subsides, the U.S. will have another looming public health crisis emerging from patients failing to have had their cardiology needs addressed properly during the lockdowns. Moreover, if we surmise that a follow-on public health crisis will emerge, we can also conclude that certain population segments are going to be more impacted by CVD, as there are documented health disparities in this therapeutic area. Finally, there are policy changes that could be taken to mitigate a possible spike in CVD adverse events; the paper will close by recommending certain policy changes.

A Climate of Fear

The difficult question that should be asked is: did public health officials create such a climate of fear around COVID that they neglected to encourage people to visit their physicians and receive regular screenings for serious chronic conditions? While there have been over 375,000 U.S. deaths from COVID in 2020, there were 691,000 deaths from heart disease, 600,000 deaths from cancer, 160,000 deaths from stroke, and over 100,000 deaths from diabetes.¹⁰ Each of these chronic diseases are more successfully treated when they are treated early. While there were regular admonitions to social distance and to "wear a mask," even outdoors where the science was unclear, there were not the same repeated calls to "go to the doctor and get your screenings." By their failure to remind the population that they should still see their physicians for regular screenings, even during COVID, public health authorities may have helped to create another looming public health crisis.

Therefore, we want to first look at the trends in physician visits, cardiologist visits, CVD screenings, and prescriptions to treat CVD. This will give a hint about whether a significant CVD mortality spike looms in the future.

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A recent study¹¹ in *JAMA Network Open* contained some troubling data. Compared with 2018 and 2019, primary care visits declined 21.4 percent in the second quarter of 2020 despite a surge in the use of telemedicine. Telemedicine only comprised 2 percent of primary care visits in 2019 but surged to 35 percent of visits in the April to June 2020 time frame. Another study of the U.S. Veterans Administration indicated that total outpatient office visits, including both telehealth and in-person, were 30 percent lower after March 2020 compared to previous years.¹²

Not surprisingly, the reduction in in-person office visits resulted in substantially fewer cardiovascular screenings. Blood pressure (BP) evaluations dropped 50.1 percent while cholesterol screenings dropped 36.9 percent. The reductions were due not only to the fact that fewer people saw their doctors, whether in person or remotely, but also because fewer screenings tend to take place in telehealth visits.¹³ For in-person office visits, 69.7 percent of people had their BP evaluated, while only 9.6 percent had a BP evaluation during a telehealth visit. For cholesterol screenings, in-person screening rates were 21.6 percent, which dropped to 13.5 percent for telehealth visits.

Another *JAMA* study documented a huge “shift in ambulatory cardiovascular care from in-person to remote visits” during the COVID pandemic.¹⁴ The study results also indicated that “during video and telephone visits, clinicians had lower odds of ordering any medication or tests, such as electrocardiograms or echocardiograms.”

The study also pointed to a health disparity aspect to this shift to remote visits as Asian, Black, and Hispanic patients were more likely to use a remote cardiology visit. Therefore, these populations were also likely to get fewer medications, tests, and screenings. A study published in *Heart, Lung and Circulation* warned that patients should not confine themselves to remote visits: “Whilst telemedicine reviews undoubtedly assist, particularly in triaging patients who require physical review, patients should be encouraged to attend specialist reviews in person to ensure appropriate management and control of chronic conditions.”¹⁵

Fewer tests and screenings seem to be leading to more adverse events. One study pointed “to reports of up to 3-fold increases in out-of-hospital cardiac arrests during the COVID-19 pandemic, compared with previous years. When patients with acute conditions do present, they have been presenting later than usual, and their treatments have also been delayed after arrival, resulting in poorer outcomes.”¹⁶ Perhaps patients’ fear of COVID is the reason they are presenting themselves for treatment later than usual. In many places, public health authorities themselves warned patients to avoid the emergency room for non-COVID conditions.

The study’s author warns that: “As delays in presentation and treatment become more common, we are likely to see increases in CV-related morbidity caused by increased rates of heart failure, physical disabilities, and cardiac structural sequelae in survivors of acute events that some authors have labelled an ‘impending tsunami.’”

Let’s look at the trends in some of the conditions that may lead to cardiovascular disease.

High Blood Pressure

As indicated earlier, screenings for high blood pressure may have dropped by as much as 50 percent during the COVID pandemic. Presumably, substantially fewer patients are being diagnosed with hypertension, and therefore fewer patients with hypertension are being prescribed medications. As one study points out, failure to use anti-hypertensives, or “cessation of antihypertensives, even for a short duration, can result in adverse cardiovascular events unless closely monitored in specialist settings.”¹⁷

This widespread failure to diagnose a huge number of hypertension cases is particularly troubling as numerous studies have indicated that: “Hypertension is a common comorbidity in hospitalized patients with COVID-19 infection.”¹⁸

Many anti-hypertensive medications are inexpensive generics. However, one financial analyst pointed to a large drop in the anti-hypertensive drug market during 2020: “The global anti-hypertensive drugs market is expected to decline from \$26.1 billion in 2019 to \$23.5 billion in 2020 at a compound annual growth rate (CAGR) of -9.7%. The decline is mainly because of the lockdown measures due to the COVID-19 outbreak.”¹⁹

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While the drop in the use of anti-hypertensives is very likely related to the decline in in-person physician visits, it is also the case that, early in the pandemic, there were reports that anti-hypertensive drugs could worsen the symptoms of COVID. Several studies proved these reports wrong, but it is possible that some patients ceased taking their medications.²⁰

Hyperlipidemia

As indicated above, screenings for high cholesterol dropped more than 35 percent during the COVID pandemic. This is troubling because, of course, high risk patients may avoid a heart attack by complying with their regimen of cholesterol-lowering medications. One study found that, "discontinuation of lipid lowering therapy, particularly in high risk patients, can increase the rate of death or acute myocardial infarction within 1 week."²¹

As with antihypertensives, there are some data to suggest that, with fewer in-person physician visits, there were fewer prescriptions dispensed for cholesterol-lowering agents. For example, one study in *JAMA* examined prescription patterns for the top 10 drugs, based upon total claims. The study found that the number of prescriptions filled in 2020 for atorvastatin were down 9.1 percent over 2019.²² Atorvastatin is the leading cholesterol lowering drug in the world and the most dispensed drug in the United States with 118 million prescriptions dispensed in 2019. A 9.1 percent drop in the number of atorvastatin prescriptions translates into 10,738,000 fewer dispensed prescriptions for atorvastatin, raising the risk of cardiovascular disease for hundreds of thousands, if not millions of Americans.

Moreover, atorvastatin is only one in a panoply of cholesterol-lowering agents, the majority being statins. It is estimated that close to 30 percent of American adults over 40 years old are taking a statin.²³ If these other agents also witnessed 9 percent drops in the number of prescriptions filled, the impact upon public health would be quite large.

This drop in atorvastatin prescriptions is more remarkable because there were numerous reports and studies indicating that the use of statins reduced the risk of developing severe COVID.²⁴ Statin prescriptions during the pandemic should have been going up, not down.

Atrial Fibrillation (AFib)

Atrial fibrillation is an irregular heartbeat, where the heart rate typically gets much faster when the heart's two upper chambers receive disordered electrical signals. A patient's heartbeat can rise to hundreds of beats per minute. Untreated atrial fibrillation can lead to blood clots and, in serious cases, to stroke.

The famous decades-long Framingham Heart Study contains data suggesting that the lifetime risk of atrial fibrillation is as high as one in four.²⁵ While there is more to understand about how various underlying conditions can increase the risk of COVID, the evidence is very strong that an AFib patient is at far greater risk for a "catastrophic COVID outcome."²⁶

Yet, as with other cardiac conditions, some patients with atrial fibrillation are reluctant to see their physicians. Two of the most common methods for screening for atrial fibrillation, the traditional electrocardiogram (EKG/ECG) and a Holter monitor, generally require the patient to come into the office for their heartbeat data to be interpreted. One cardiologist in Oklahoma pointed out that many patients with irregular heartbeats are reluctant to come to his office. "Patients are definitely more guarded about going to large medical facilities. COVID has probably reduced office visits by 20 percent. Yet if a patient wearing a traditional Holter monitor does not come into the office, that's a problem."²⁷

Fortunately, a new generation of cardiac monitoring devices, ECG systems where a patient can be monitored remotely, is emerging that would not require patients to come into the doctor's office. Data could be read during a telehealth visit. Again, however, patients have been reluctant to come to the physician's office to be fitted for the new devices. Because of this reluctance, some ECG systems are offering instructional videos so patients can fit their monitors at home, without an office visit.²⁸

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However, some patients have physical limitations that require them to be fitted in the doctor's office, or they do not have the necessary electronics to use a remote monitoring ECG system.

This screening challenge for AFib is compounded by the fact that COVID can damage the heart muscle, and arrhythmias can be associated with viral infections. "Case reports have demonstrated the occurrence of arrhythmias in association with many viral infections including the influenza virus, Epstein-Barr virus (EBV), human immuno-deficiency virus (HIV), and others."²⁹ And one study suggests that AFib is the most common form of arrhythmia in COVID patients.³⁰ Patients who have recovered from COVID, particularly older patients, might benefit from an AFib screening.

Many studies have been done about the association of AFib with COVID, but there are far fewer studies about how patients with AFib failed to get diagnosed because of the pandemic. One worldwide study found a tremendous drop in diagnostic procedures in almost all nations that were studied. In the United States, diagnostic procedures for cardiovascular disease dropped 68 percent between March of 2019 and April of 2020. In all countries studied, stress tests dropped 78 percent over the same time period. That same study found that stress tests with an electrocardiogram, which can be used to diagnose AFib, dropped nearly 80 percent in the United States.³¹

Cardiomyopathy

The term cardiomyopathy captures a diverse set of conditions in which the heart muscle develops a reduced ability to pump blood, weakens and, eventually, may begin to fail. The symptoms of cardiomyopathy are what you might expect: shortness of breath, chest pain, dizziness, arrhythmias, and heart murmurs.³²

Patients experiencing these symptoms, especially if the symptoms were mild, showed a much greater reluctance to get diagnosed during COVID. There are many diagnostic tests to help determine what type of cardiomyopathy a patient may be suffering from and how severe it may be. These tests include blood tests, chest x-rays, ECGs, Holter monitors, stress tests, genetic tests, echocardiograms, and angiography. People familiar with how these tests are conducted will recognize that all of them require the patient to go to the physician's office, a clinic, or a hospital—something patients have been very hesitant to do during COVID. In the worldwide study cited above, the data indicated that, in the nations studied, stress tests were down 78 percent, invasive angiography was down 57 percent and CT coronary angiography was down 54 percent. Data from the United States were similar to the worldwide numbers, with stress echocardiograms down almost 80 percent, coronary angiography down almost 80 percent, and invasive angiography down about 60 percent.

Summary

Diagnostic testing for cardiovascular disease collapsed during COVID, and, not surprisingly, the number of deaths from cardiovascular causes spiked dramatically. Deaths from ischemic heart disease and hypertensive diseases saw the greatest upward spikes beginning in late March of 2020 and peaking in late April.³³ Most of the states studied saw increases in deaths from ischemic heart disease and hypertensive disease, with New York City seeing the most pronounced increases. However, Massachusetts saw no increase in deaths from ischemic heart disease from 2019 to 2020 and only modest increases in deaths from hypertensive diseases.

From January 1, 2020 to June 2, 2020, there were 397,042 cardiovascular deaths. On June 2, 2020, there had been about 106,000 COVID deaths in the US.³⁴ According to the CDC, there were about 375,000 COVID deaths in 2020.³⁵ Yet, during 2020, cardiovascular deaths far outpaced COVID deaths, with 691,000 CV deaths during 2020 and an additional 159,000 deaths from stroke.³⁶

While COVID deaths surged during the early months of 2021, making it briefly the leading cause of death in the United States (surpassing cardiovascular disease and cancer), this trend

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completely reversed itself with the introduction of vaccines and promising therapeutics. By June of 2021, COVID had dropped to the seventh leading cause of death in the U.S., falling below Alzheimer's disease.³⁷ With the rise of the Delta variant, COVID deaths rose to the third leading cause of death but remained behind cardiovascular disease and cancer. If current trends continue, it seems likely that COVID will remain less deadly than cardiovascular disease, even with the huge surge in COVID deaths early in the year.

Despite the looming public health crisis for the two leading causes of death in the United States, the White House recently announced that they would be working with Facebook to censor posts on that platform that are deemed as "misinformation" about COVID.³⁸ In short, the Surgeon General is going to work with a private company to censor the posts of U.S. citizens when they are deemed to be misleading and this extraordinary step is going to be taken on posts that discuss the third leading cause of death in the U.S. This paper takes the position that, while COVID is a dangerous disease and could return as an even greater danger, as it was in early 2021, there are currently far more important public health challenges and concerns that are being neglected.

What also seems clear is that the rapid decline in the number of diagnostic tests performed, especially for the leading cause of death—cardiovascular disease—the United States may be on the verge of a non-COVID related public health crisis. We may be on a brink of a surge in deaths from more traditional diseases due to later and later diagnoses. The Surgeon General's office may wish to consider turning its attention to this impending problem.

Recommendations

1. A Public Health Campaign Urging People to See their Physician

Our public health authorities are in a very odd place. They are spending nearly 100 percent of their time talking about the third leading cause of death in the United States. Discussion of COVID is endless; currently many public health officials are discussing whether young children should return to school and, if so, whether they should wear masks, when the science is clear that a young child's vulnerability to COVID is limited. Meanwhile, millions of older Americans have not had their blood pressure screenings, their mammograms, and their lipid tests. This needs to change.

Public health officials across the nation should conduct a massive public awareness campaign about the dangers of not getting screened for the leading causes of death in the United States. This is the perfect time to conduct such a campaign. While COVID variants may create new dangers, currently Americans over 65 have a vaccination rate of almost 90 percent, and those vaccinations are still proving effective.³⁹ It is quite safe for this population to return to the doctor, and they should be encouraged to do so. Likewise, the media has an obligation to point to the crisis of screenings and make people aware of the public health consequences of avoiding one's physician during COVID.

There have been a few scattered voices urging people to return to the doctor for things besides COVID.⁴⁰ But, in general, the public health establishment and the media cannot stop talking about a disease that is not even in the top two leading causes of death.

- Addressing Health Disparities

Any public relations campaign to increase physician visits diagnostic screenings should find its highest visibility in communities of color. For example, African Americans have higher death rates from cancer and heart disease than any other racial or ethnic group.⁴¹

Moreover, studies indicate that communities of color have far lower diagnosis rates for diseases such as cardiovascular disease,⁴² and a higher percentage of the population in these communities lacks insurance.⁴³ This means they are paying high out-of-pockets costs for their medicines, making it less likely that they would fill a prescription.

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Moreover, we cited evidence earlier in this paper that African Americans, Asians, and Hispanics were more likely to utilize telemedicine during COVID and such patient-physician interactions typically involved fewer diagnostic tests such as blood pressure screenings.

Given all these factors in underserved communities, as part of any public relations campaign, public health authorities should consider tactics that were used to distribute free vaccines: set up large venues in key communities around the nation where diagnostic tests could be performed at no cost to patients. The nation needs to mobilize to catch up on our screenings.

2. Reduce or Eliminate Access Restrictions to Many Vaccines, Therapeutics and Prescription Drugs

One of the most enlightened decisions of the COVID crisis was the elimination of co-pays for COVID vaccines and the elimination of co-insurance for many COVID therapeutics and treatments.⁴⁴ After waiting in a long line to get the vaccine shot, no one wanted long queues of people waiting to pay a \$10 co-pay. For the next year, why not do the same for those therapies that treat diseases in which screenings saw great declines during COVID, such as cardiovascular disease and cancer?

One recent Harvard/Berkeley study found that a 34 percent increase in out-of-pocket costs for prescription drugs led to a significant decline in the number of prescriptions filled and a 33 percent increase in mortality.⁴⁵ From this study, it seems that a significant reduction in out-of-pocket costs for older people would likewise lead to a significant decline in mortality. Policy makers and health plans should consider waiving all co-pays and co-insurance on therapies for the two leading causes of death for one year.

If policymakers choose not to pass on the costs of reduced or eliminated out-of-pocket costs to health plans and employers, Congress should at least pass legislation that would allow drug companies to provide coupons to senior citizens that would offset their out-of-pocket costs.

The growth in out-of-pocket costs has been particularly acute for seniors. In Medicare Part D, drug companies are not allowed to provide seniors with drug coupons or other methods of reducing coinsurance requirements that are common for patients in commercial insurance plans. Moreover, payers and pharmacy benefit managers (PBMA) offering Part D plans have an incentive to dispense drugs with higher list prices because they will bring greater rebates. This bias toward more expensive drugs in Part D means that seniors will pay more out-of-pocket. While only 4 percent of patients in commercial health plans pay more than \$1000 out-of-pocket, 9 percent of seniors in Medicare Part D pay more than \$1000. As the life sciences consulting firm IQVIA describes the problem of seniors and out-of-pocket costs, "Overall, 8% of patients reach annual out-of-pocket costs above \$500 compared to 17% in Medicare, in large part due to benefit design."⁴⁶

Congress should redesign the Part D program to enact a cap on out-of-pocket costs and to allow seniors to spread their out-of-pocket costs over the entire year. This would relieve financial pressures on seniors during the first few months of the year, when coinsurance requirements are steepest. The cap would have a particularly beneficial effect upon seniors with cardiovascular disease who are prescribed expensive specialty medicines. Out-of-pocket costs can be the primary obstacle for patients who are advised to begin a drug therapy. Given the declining number of diagnostic tests and prescriptions that occurred during the pandemic, lessening this obstacle should be a priority.

Finally, the current system of "rebating" created by PBMs can drive up out-of-pocket costs for patients. Under the current system, pharmaceutical manufacturers have an incentive to launch their drugs with high list prices so they can offer generous rebates and obtain a preferred place on health plan formularies. Likewise, with drugs already on the market, manufacturers also have an incentive to take large list price increases in order to offer more generous rebates. Rebates, or what might more appropriately be called "discounts," now average 48 percent off the list price of drugs.⁴⁷ During 2019, total rebates paid to PBMs, and health plans totaled \$175 billion.⁴⁸

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While these rebates certainly help lower health care premiums for patients, as well as drive profits for PBMs and health plans, the rebate system has considerable downsides for patients. For example, when patients pay out-of-pocket for their drugs in order to meet their co-insurance requirements, many do not benefit from the discounts that were negotiated by their health plans, i.e., they are paying the full list price at the pharmacy counter. This means that, on average, they are paying a 48 percent higher price for their drug than their own health plan is.

Some health plans, such as UnitedHealthcare, have announced that they will now pass along their discounts to their patients who are paying out-of-pocket at the drugstore.⁴⁹ However, not all health plans have taken this approach. Given the incredible growth in rebates being paid to PBMs, policy makers may wish to consider requiring that such discounts be passed along to patients in order to lower out-of-pocket costs.

Given the growing public health crisis for more traditional diseases, Congress should act quickly to reduce out-of-pocket costs, especially for seniors, for those therapies that treat the nation’s leading causes of death. The elimination of co-pays, co-insurance, and deductibles for COVID treatments was a major success story for patients and this policy should now be applied in those therapeutic areas where a lack of screening during COVID is likely to cause a spike in disease prevalence in the near future.

Likewise, other bureaucratic impediments that slow access to therapies should be eliminated or reduced for at least one year. Burdensome “step therapy” schemes in which a patient must “fail” on cheaper and older drugs—or on the drug paying the highest rebate—before they receive the drug preferred by their physicians should be eliminated for entire classes of therapies.

Also, complex “prior authorization” forms should be streamlined. For very expensive or complex therapies, prior authorization requests by insurers can be perfectly legitimate; they can help ensure that a patient is receiving the correct drug for their condition. However, some forms are designed to be so complicated that they serve as a deterrent to the physician in prescribing certain therapies. These forms need to be simple, uniform, able to be completed within minutes, and adjudicated quickly by the payers.

3. U.S. Preventive Services Task Force Needs an Emergency Mobilization

An independent body, the U.S. Preventive Services Task Force (USPSTF) works “to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.”⁵⁰ In short, the USPSTF is the most important group of public health officials and physicians involved in making recommendations on the optimal methods of screenings for deadly diseases.

Given the dramatic drop in screenings that took place during COVID, one would think that there would be a heightened sense of urgency emanating from the USPSTF. However, a recent scan of their website indicates the opposite.

For example, on April 20, 2021, the USPSTF issued a “Draft Recommendation Statement on Screening for Atrial Fibrillation.” Estimates of the prevalence of AFib in the U.S. are currently between 2.7 million to 6.1 million with the expectation that cases would rise to 12.1 million in 2030.⁵¹ AFib is a serious condition that is also associated with stroke. Given the drop in screening for AFib that was happening as this press release was being written, one would assume that there would be an important recommendation on screening for this condition, especially for those over 65 where prevalence is considerably higher than for younger people.

However, the USPSTF recommended almost nothing. “The Task Force determined that there is not enough evidence to recommend for or against screening for AFib in adults age 50 and older without signs or symptoms.”⁵² One might ask, why was the study population limited to patients 50 and older? Would a different conclusion be reached if patients 65 and older were studied? Or, the Task Force could have made recommendations about how to counter the drop in screenings for patients who actually do exhibit symptoms.

The USPSTF website is populated with many important recommendations on how patients should be screened for various diseases. There are recommendations on screenings for Vitamin

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D deficiency, colorectal cancer, hypertension, chlamydia, healthy weight, etc. However, there are no statements or recommendations discussing the crisis-level declines in virtually all types of important screenings during COVID. For a body charged with improving “the health of the people nationwide” by offering recommendations on screenings and other preventive measures, this seems quite an omission.

The USPSTF should, in an emergency and timely fashion, report to the nation with recommendations on how to mitigate the public health damage that may have occurred due to the precipitous drop in screenings during COVID.

Conclusion

The COVID pandemic was undoubtedly the most serious public health crisis of recent decades. Thanks to new vaccines and therapeutics, the crisis is ebbing. Public health authorities would be wise to continue carefully monitoring COVID prevalence, COVID-related hospitalizations and COVID deaths. COVID could come back with a vengeance, vaccine effectiveness could wane, and new mutations of COVID could prove more resilient. Vaccine manufacturers and others need to continue studying whether booster shots will be required.

One thing, however, is clear about our current situation. Given current trends, COVID is *now* a less deadly threat than traditional diseases such as cardiovascular diseases and cancer. Public health authorities, politicians, and the media should begin talking more about the most serious public health challenges looming on the horizon and less about COVID.

A perpetual focus on COVID was understandable early this year when it was the leading cause of death. The nation needs to pivot and take more seriously the dangers from more traditional diseases, particularly cardiovascular disease.

Given current trends, COVID is *now* a less deadly threat than traditional diseases such as cardiovascular diseases and cancer.

Endnotes

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Mission

Pioneer Institute develops and communicates dynamic ideas that advance prosperity and a vibrant civic life in Massachusetts and beyond.

Vision

Success for Pioneer is when the citizens of our state and nation prosper and our society thrives because we enjoy world-class options in education, healthcare, transportation and economic opportunity, and when our government is limited, accountable and transparent.

Values

Pioneer believes that America is at its best when our citizenry is well-educated, committed to liberty, personal responsibility, and free enterprise, and both willing and able to test their beliefs based on facts and the free exchange of ideas.

