

# The Washington Post

## Complacency Bolsters A Pandemic

By Jorge R. Mancillas  
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GENEVA -- The influenza A (H1N1) pandemic is now unstoppable. The world missed its chance, and containment is no longer a possibility. Efforts to contain the outbreak were impeded by the consistent downplaying of the extent and immediacy of the threat. Those influential "voices of reason" that restrained the World Health Organization from issuing stronger, earlier warnings also lulled governments into complacency.

Yet even as the virus spreads to every corner of the world and the realization of its seriousness sinks in, those same voices are dampening the sense of urgency necessary to mount an effective response.

Most of all, the threat is being obscured by the misleading statement that only a few will develop serious symptoms and die. It is true that only a small fraction of those infected are likely to die; the global fatality rate is currently 0.45 percent, or four or five in a thousand. But what happens once the number of those infected rises into the millions? The fatality rate may remain low, but the number of fatalities will no longer be few.

Just how severe is the threat? Recently, Britain's chief medical officer [reported](#) that modeling studies indicated that up to 65,000 people in that country could die. Projected globally, this worst-case estimate suggests the potential for 6.5 million deaths. Except that Britain's current fatality rate, as well as the higher rate that yielded the 65,000 figure, are both lower than the average global rate right now.

To calculate the potential fatalities worldwide, one must estimate the number of people likely to become infected (the clinical attack rate) and the percentage among them likely to die (the fatality rate). So far, the observed attack rate has been 30 percent, meaning one in three who are exposed to the virus becomes infected. This suggests that more than 2 billion people are likely to be infected through successive waves of the pandemic over the next few months. Based on the observed global fatality rate of 0.45 to 0.5 percent, between 9 million and 10 million could die.

This global fatality rate, however, reflects current conditions. Some favorable factors may have kept the numbers down to date.

First, the virus initially appeared in mostly developed, Northern Hemisphere countries experiencing summer conditions. As the pandemic has spread to the Southern Hemisphere, we are seeing cases such as Argentina, where the fatality rate is five times higher, around 2.5 percent.

Second, at this stage, health systems have had to cope with relatively low numbers of patients, though in many cases they have still been overwhelmed. As the trickle turns into a flood, the capacity of these systems to identify those most at risk and to provide the best treatments may diminish. Again, the experience in the countries most affected so far shows that not only the number of fatalities but also the fatality rate increases with the number of cases.

No doubt the development of a vaccine will greatly help to reduce infections. While it will not reduce the fatality rate -- a vaccine is a preventive measure, not a treatment -- it should reduce fatalities. A vaccine is expected to be ready by September, after accelerated clinical trials. Given current production capacities, it will take a few more months before it is available in sufficient quantities.

But one must also remember that we will be engaged in a race to produce and distribute a vaccine before the virus mutates into a more virulent form (with a higher fatality rate) or a subtype that the vaccine is ineffective against. Influenza's high rate of mutation is the reason the vaccine against the seasonal flu has to be produced annually. By the time the second wave of the influenza A pandemic hits next year, the vaccine developed this year may be ineffective. This is why it is crucial to monitor the virus by taking regular samples in different regions.

In all these considerations, we have not even touched on the impact of medical costs, absenteeism and the disruption of economic activities in the midst of a global downturn.

To mitigate the effects of the pandemic, we must understand that influenza's threat does not necessarily result from its severity but its ease of contagion, its rapid spread and its high rate of mutation. It is crucial to accurately measure the threat. While the likely severity of the pandemic may continue to be debated, this flu strain has spread further in six weeks than previous ones have in six months.

The velocity of the spread is a measure of the quality of the containment measures that were or, more often, were not put in place. Even with the low virulence of the pandemic strain, the severity of the outbreak has varied significantly in affected countries, with the determining factor being the level of medical preparedness and the strength of those countries' health systems.

Efforts to play down the threat are predicated on the idea that one must avoid creating panic. That reveals a condescending view of the public as a mindless mob prone to irrational behavior. A well-explained, sober and objective assessment does not generate panic, especially if it lays the groundwork for preparedness and is accompanied by clear guidelines for the public, medical authorities, front-line responders, health personnel and employers. What creates panic is watching unexpected developments -- like the sudden appearance and rapid spread of the virus in a community, accompanied by a spike in fatalities -- when all the public had experienced previously were attempts to lull it into complacency.

As World Health Organization Director General Margaret Chan [said](#) in a speech on July 2 in Mexico, "Between the extremes of panic and complacency lies the solid ground of vigilance." Too many in government insist on lingering on the ground of complacency until they are pushed into panic by their lack of preparedness. How many deaths will it take to shake them into timely, thoughtful, targeted and coordinated action?

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