Sheridan’s update: April/May 2025

Hello!

This newsletter covers two months as I have been exceptionally busy on multiple fronts. The most notable experience was attending a networking event at the Gherkin, which I exploited as a great opportunity to take my message out to IFoA members who I have not had the pleasure of working with previously – my thanks to everyone who took a business card with my campaign details on it!

I’ve also been using LinkedIn to boost awareness of my campaign. The attached thoughtpiece was the most impactful post I’ve made so far – I’m very grateful to everyone who engaged with it.

Voting opens at the start of June, so expect further LinkedIn posts in the coming weeks…

With very best wishes

Sheridan

Five years on: five reasons we need to talk about the Covid era

I previously published a LinkedIn post (see https://bit.ly/4kEGsOl) which lamented the lack of meaningful evaluation of the unprecedented response to Covid in 2020: were the interventions justified?

This is not an academic question: pandemics are thankfully an infrequent occurrence but nonetheless a recurring threat. Therefore it is likely decision-makers may face a similar crisis at some stage and there is every risk the same measures will be implemented, especially if the accepted wisdom post-Covid is that State interventions were a good policy.

This situation is very troubling to me because I do not believe that this accepted wisdom has been subjected to appropriate scrutiny and challenge. Indeed, I can see five clear reasons why this viewpoint is very much open to debate:

1. There was no exceptional excess mortality observed in Sweden, South Dakota or Florida, three territories that shunned restrictions. If restrictions are beneficial, why don't these regions stand out?

2. Whilst it is true that some territories enjoyed exceptionally low mortality in 2020 and 2021, there are good reasons to think this experience was attributable to reasons other than the restrictions.

3. Even if it were possible to replicate such exceptionally low mortality via State interventions, the fact most countries with restrictions failed to achieve this suggests the outcome is unlikely. Consequently interventions look like a bad bet, incurring high costs with certainty in exchange for an unlikely reward.

4. The measures carried a massive opportunity cost: was it wise to commit such gargantuan resources/effort to mitigate a transient threat and ignore other priorities?

5. There is a strong case that, given the chance to decide, those most at risk from Covid would have elected to "take their chances" rather than actively damage the prospects of their children and grandchildren with the harms inflicted by the State interventions. These vulnerable people have agency, so why should their wishes not be respected?

These are not the only objections, but they form a succinct coherent challenge to the accepted wisdom on the Covid response. I elaborate on each one in a follow-up post. Before doing so, I wish to highlight that I feel passionately about ensuring that the Covid response is subjected to appropriate evaluation and this has motivated me to stand for election to IFoA Council at the summer 2025 elections. You can find out about my campaign at this dedicated website:

https://rssfitzgibbon.co.uk/

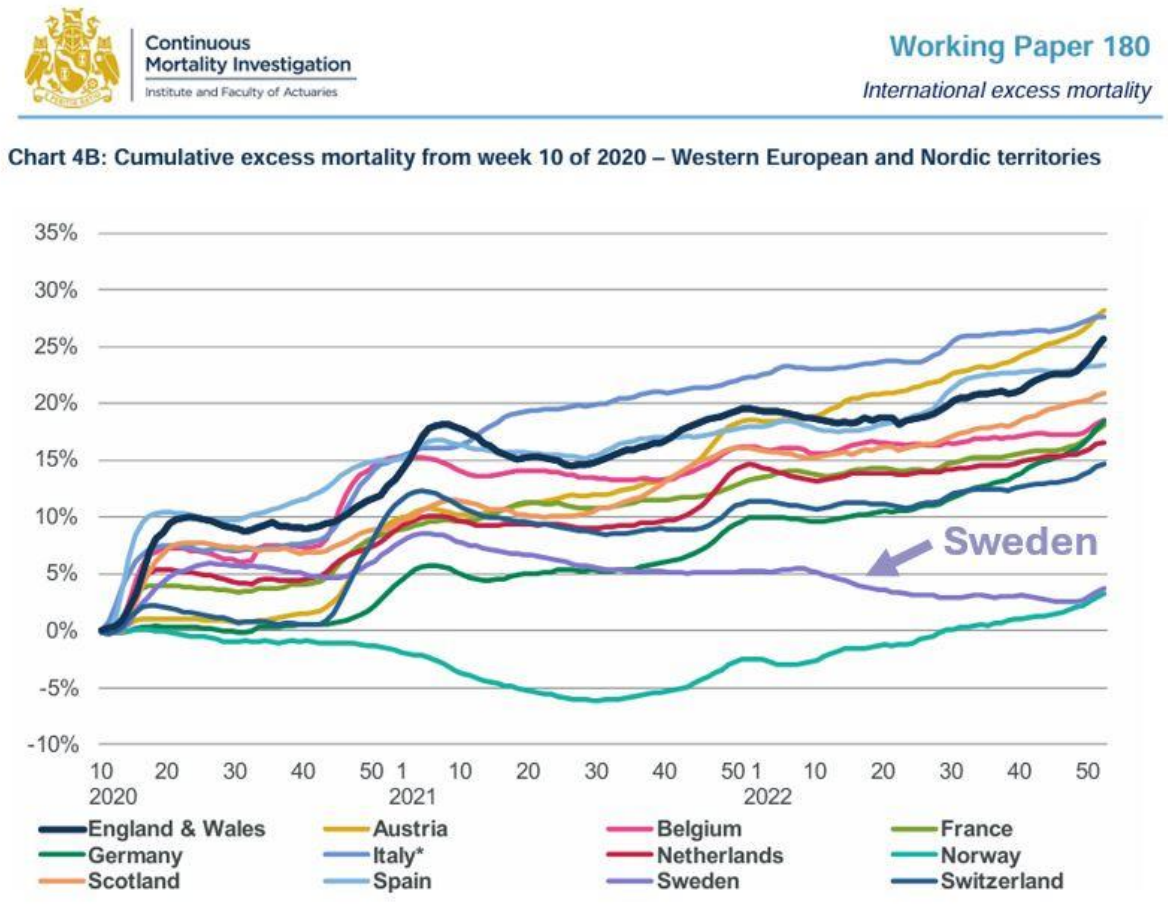
Implications of the lack of exceptional excess mortality in Sweden, South Dakota and Florda (1)

The motivation for curtailing civil liberties in 2020 was simple: authoritarian restrictions were needed to safeguard the population and healthcare systems, otherwise a significant number of unnecessary premature deaths would occur.

If this assertion were true, then it logically follows that territories which neglected to bring in significant restrictions should have experienced this bad outcome: their mortality experience should clearly stand out as exceptionally heavy as a result of their inaction.

Therefore we should be able to test the assertion by looking at the mortality experience of territories which opted against restrictions and comparing them with their peers. Three such territories would be Sweden, South Dakota and Florida (the latter introduced measures during Spring 2020, but dropped these thereafter).

We can use age-standardised mortality rates to compare the mortality experience of these territories with other areas. CMI working paper 180 shows how Sweden performed against a number of European peers during the period from 1 Jan 2020 to 31 Dec 2022:



Implications of the lack of exceptional excess mortality in Sweden, South Dakota and Florda (2)

It is clear that Sweden experienced heavy mortality but there was no exceptional level of deaths (and the country ultimately enjoyed a relatively light rate of excess mortality, although we might hope this was in part due to the Covid vaccines).

Alas the same source does not allow us to review the performance of South Dakota and Florida (CMIWP180 looks at the USA as a single territory), but fortunately the website Mortality Watch offers a table ranking the experience of the different 50 US States:

Rank	Country	Excess age-standardised mortality rate			
		2020	*2021*	*2022*	*Total average excess mortality*
1	USA - Hawaii	-0.4%	3.6%	4.9%	2.7%
2	USA - New Hampshire	4.5%	4.4%	4.0%	4.3%
3	USA - Massachusetts	13.8%	3.3%	1.5%	6.2%
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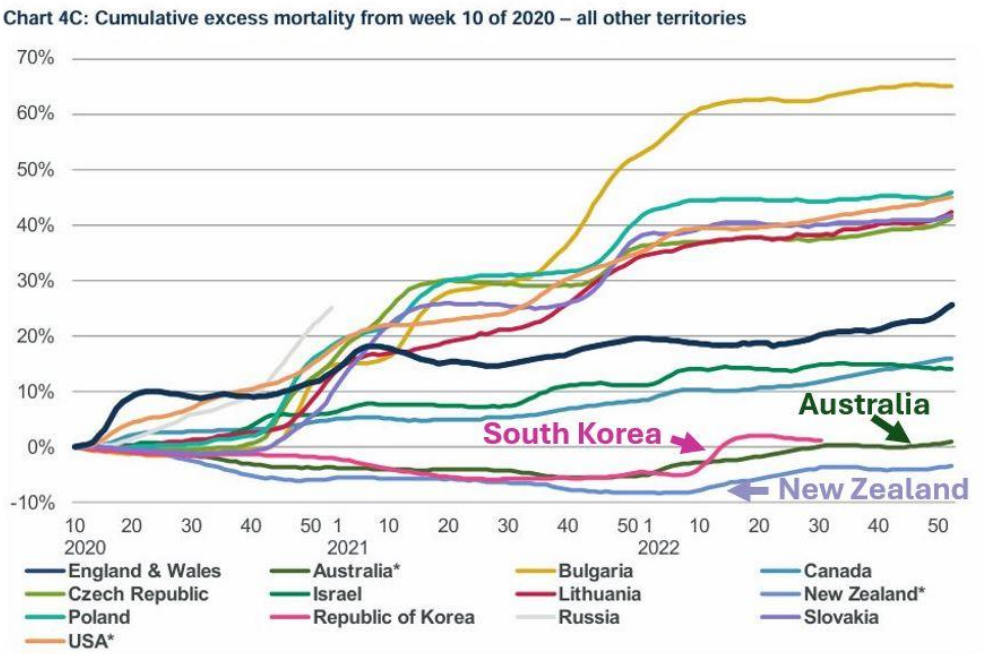
20	USA - Virginia	10.2%	14.4%	8.2%	10.9%
21	USA - North Dakota	21.1%	8.7%	3.6%	11.1%
22	USA - North Carolina	10.3%	15.4%	7.9%	11.2%
23	USA - South Dakota	19.2%	9.2%	5.6%	11.3%
24	USA - New Jersey	24.8%	7.1%	2.2%	11.4%
25	USA - Florida	11.3%	18.6%	5.0%	11.6%

Again, Florida and South Dakota clearly experienced heavy mortality during the period but it was not exceptionally high: they do not appear to have suffered a clear penalty for avoiding restrictions.

It is conceivable that restrictions might have resulted in lighter mortality experience in these territories during this period (though please note this is a hypothesis: it is debatable whether interventionist measures achieve the results which some claim). However the absence of restrictions has not triggered anomalously high mortality. This real world, objectively verifiable data certainly casts doubts on the claim that restrictions were necessary to avoid disaster.

Judiciously assessing the regions with exceptionally low mortality

Whilst the territories of Sweden, South Dakota and Florida did not suffer exceptional levels of excess mortality, it should be noted that there were regions which stand out. Fortunately these anomalous territories are noteworthy for their lack of excess mortality. The most obvious examples are South Korea, New Zealand and Australia, with their light mortality experience well-illustrated in CMI working paper 180:



Apologists for the response measures argue that the experience of these territories provides proof that the restrictions can work, as long as they are implemented correctly.

However this is far from the only conclusion that can be drawn. It is conceivable that there may be natural forces at work here, which may have driven much of the mortality benefit being observed. For example, it is noticeable that the areas which experienced light mortality come from the same geographic region (i.e. Asia Pacific); perhaps there was some environmental condition which helped to hinder the spread of the disease? It is also notable that Australia and New Zealand are remote islands (and the demilitarised zone which marks the single land border of the South Korean peninsular is hardly “normal”). This means there is a crucial difference in approach: these territories can pursue a “lock-out” strategy rather than “lock-down” and it is possible that the former is responsible for the outperformance of these nations.

At this point it’s worth referring back to the Mortality Watch table in Point 1. Which US State performed best? Does anything about the table-topper stand out to you?

This distinction between lock-out vs lock-down is a nuance that does not get much attention, but it is something we should take seriously. There are significantly fewer ethical qualms over a lock-out strategy (= close the borders) than a “lock-down” approach (= place whole population under house arrest).

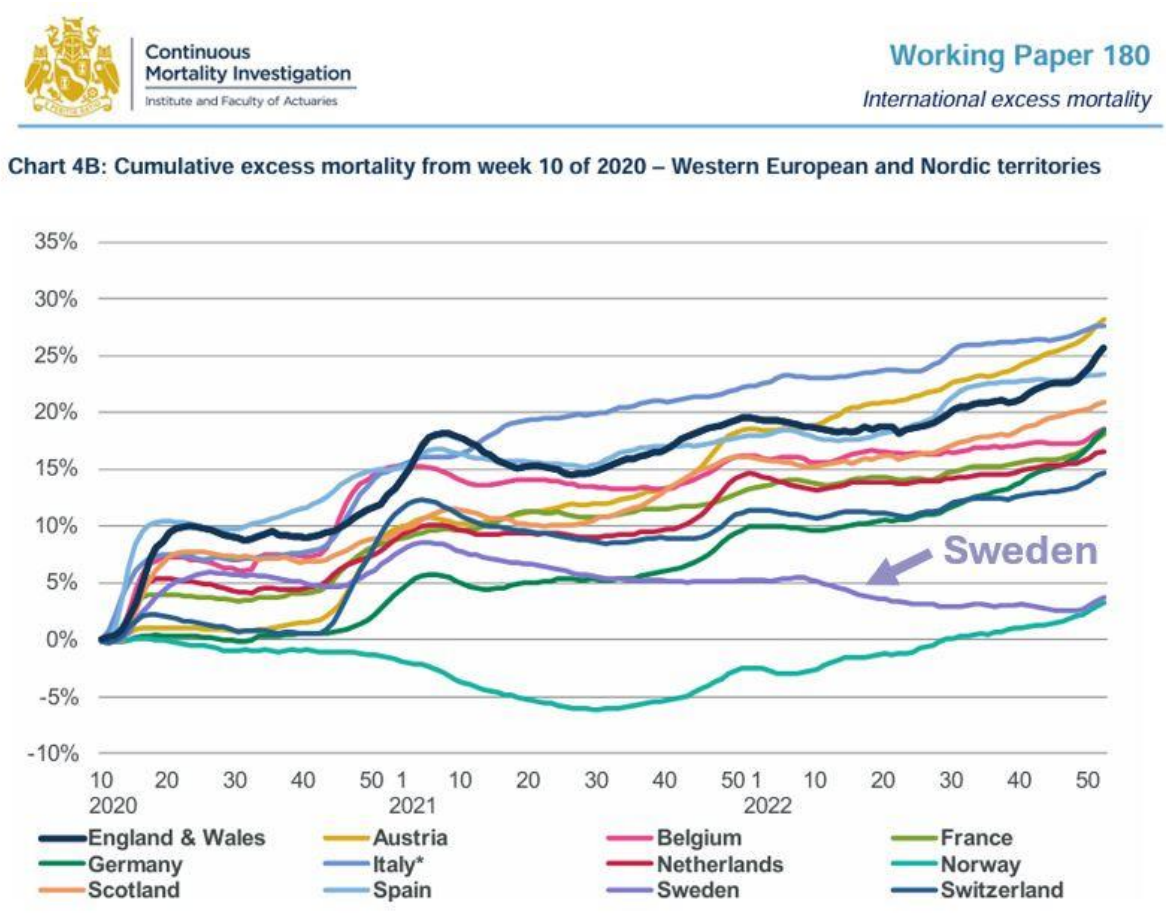
Regardless, it should be evident that we cannot take the exceptional performance of Australia, New Zealand and South Korea as definitive proof that interventions work.

Recognising that restrictions represent a reckless gamble (1)

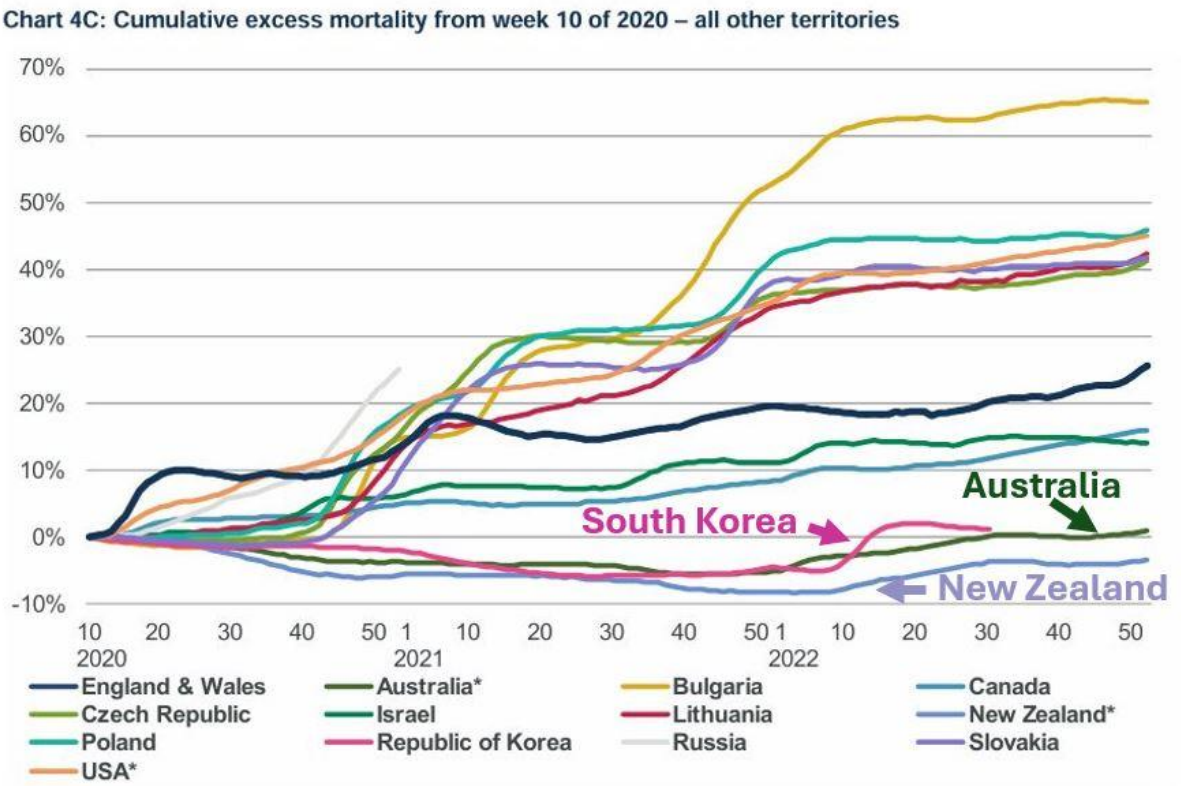
As a quick recap, Point 1 showed that territories which shunned restrictions did not suffer exceptionally heavy mortality as a consequence and Point 2 questioned whether the interventions were responsible for the exceptionally light mortality experience observed in some nations. However, for the sake of argument, let us assume that the light mortality experience of Australia, New Zealand and South Korea was achievable in other countries via State intervention: does it necessarily follow that this would be the correct strategy?

A sober assessment indicates the answer is “no”: just because an outcome is possible, does not make it probable and the likelihood of success is an important consideration when determining the correct course of action. Referring back to the graphs of CMI working paper 180, we see that the vast majority of the countries which tried to tackle the disease failed badly. We can infer that there is a high probability of failure, notwithstanding the success of a few lucky territories.

Moreover, we must emphasise that attempts to tackle the disease require enormous costs/effort which are incurred with certainty. Therefore any intervention activity represents a gamble: the strategy offers rewards with low chances of success whilst substantial costs occur no matter what. How is this not a bad bet?



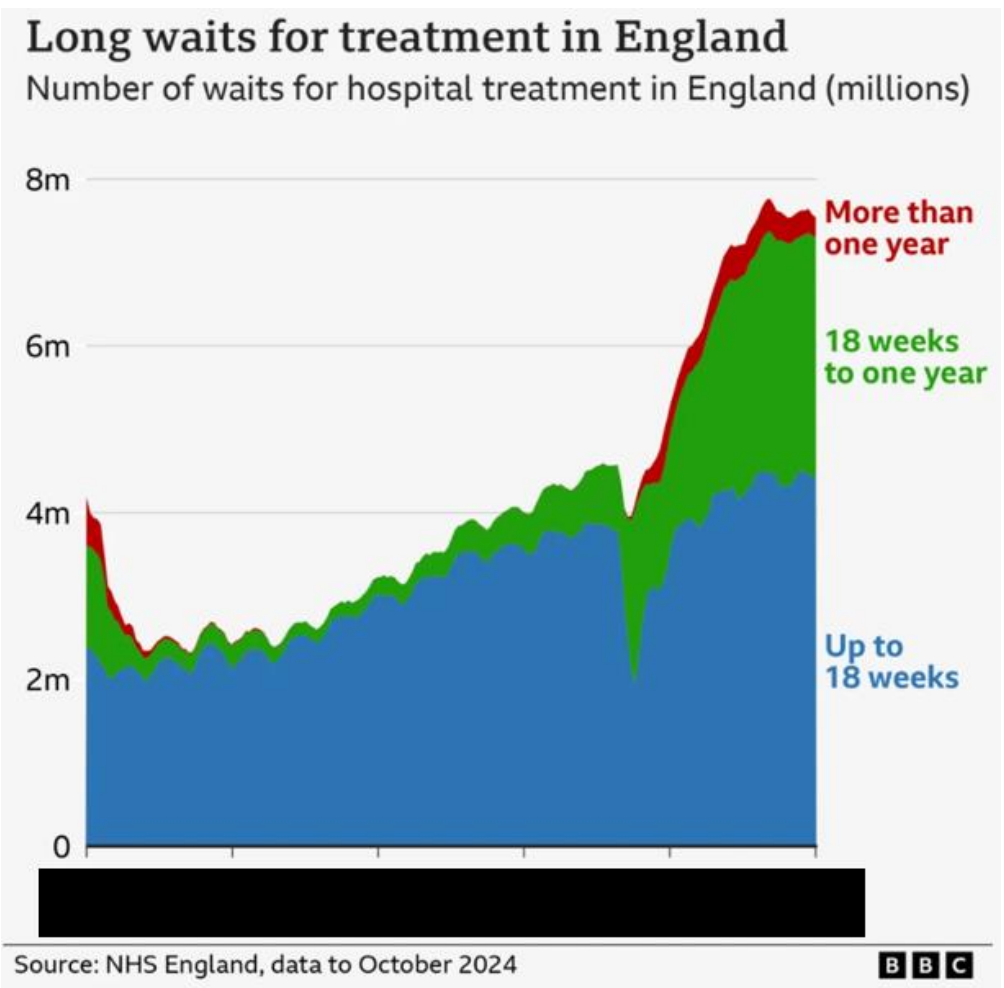
Recognising that restrictions represent a reckless gamble (2)



A rational review of the opportunity cost associated with the interventions (1)

The preceding points focused on mortality during the Covid era to argue that the case in favour of restrictions is weak. Time for a deeper challenge: why does a pandemic justify a mono-focus on resisting the disease? What is so special about premature deaths during the period 2020 to 2022 that we should prioritise them above everything else?

Even if we restrict our attention to healthcare, it is clear that the Covid response had significant adverse repercussions for the treatment of other conditions. Here is a recent graph of NHS waiting times with the timescale redacted: can you pinpoint the moment when the choice was made to prioritise Covid at the expense of all other health matters?



A rational review of the opportunity cost associated with the interventions (2)

Why does tackling Covid trump these other health concerns?

Rational actors pay heed to opportunity costs. Even if interventions could alleviate the impact of a pandemic, we should weigh these benefits against alternative courses of action. Official estimates place UK government spending on the pandemic response at £310 billion to £410 billion. Let's call it £350 billion, just below the mid-point.

This is an enormous sum to spend fighting a one-off, transient threat like Covid. Remember this is a virus which primarily threatened the elderly and we would normally expect the strength of an infectious disease to dissipate in a couple of years (which is exactly what happened with the arrival of the Omicron variant in December 2021). To place the £350 billion financial commitment in context, it corresponds to 1,000 times the Brexit Bus aspiration of sending £350 million to the NHS each week: to put it another way, the UK government’s pandemic spending equated to 20 years’ worth of that promise.

From a rational perspective, what's the better decision: mitigating the short-term impact of a pandemic (assuming this is actually possible!) versus 20 years of infrastructure investment with all the long-lasting benefits that would bring?

The at-risk elderly would rather take their chances than hurt their descendants' prospects (1)

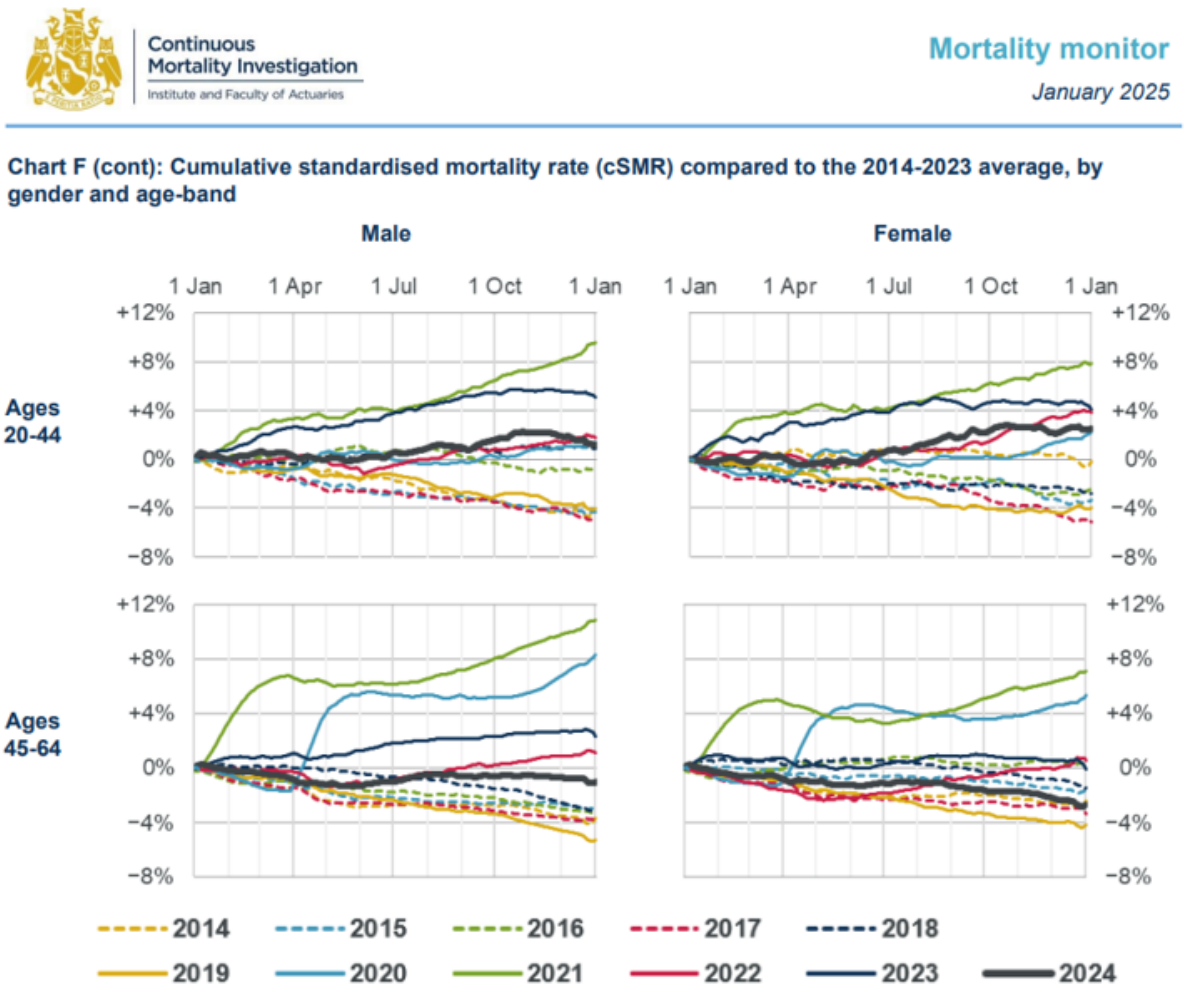
Proponents of government restrictions should not overlook the fact that the people they are seeking to help have agency: those vulnerable to infectious diseases like Covid are capable of articulating their preferences and we should not jump to the conclusion that they wish to be "saved".

We do a disservice to the vulnerable by automatically assuming they want special protection. Undoubtedly they will be concerned by the news that a life-threatening disease is circulating, but we should not thoughtlessly stereotype them as helpless victims characterised by their frailty. These people are the heroes of their own story: many would prefer that the Covid chapter recounted a tale of bravery in the face of grave personal peril.

Yet this area touches on a deeper point: our decision-makers have lost sight of what makes a civilisation thrive. In particular there is a lot of talk these days about the importance of "equality" and the UK actuarial profession has done its part, producing research around the area of "intergenerational fairness". However I take issue with the framing of this research, because I advocate for intergenerational unfairness: specifically I want my son to enjoy a more prosperous life than mine and I hope he will pay this forward to his children in the same vein. This attitude is how nations flourish over time: by focusing on how best to improve the lot of the upcoming generations and prioritising policy towards this.

The Covid response was the antithesis of this attitude. On a particularly sombre note, the UK has suffered consistently heavy mortality in its working age population in the aftermath of the Covid response measures. The picture is particularly stark for the 20-44 age band. The drivers responsible for these excess deaths are not well-understood, but due to the wide-ranging scope of the Covid response measures (together with the ever-present issue of unintended and unforeseen consequences) there is a real possibility that the interventions may have played a material role in the elevated mortality levels being experienced by the younger generations.

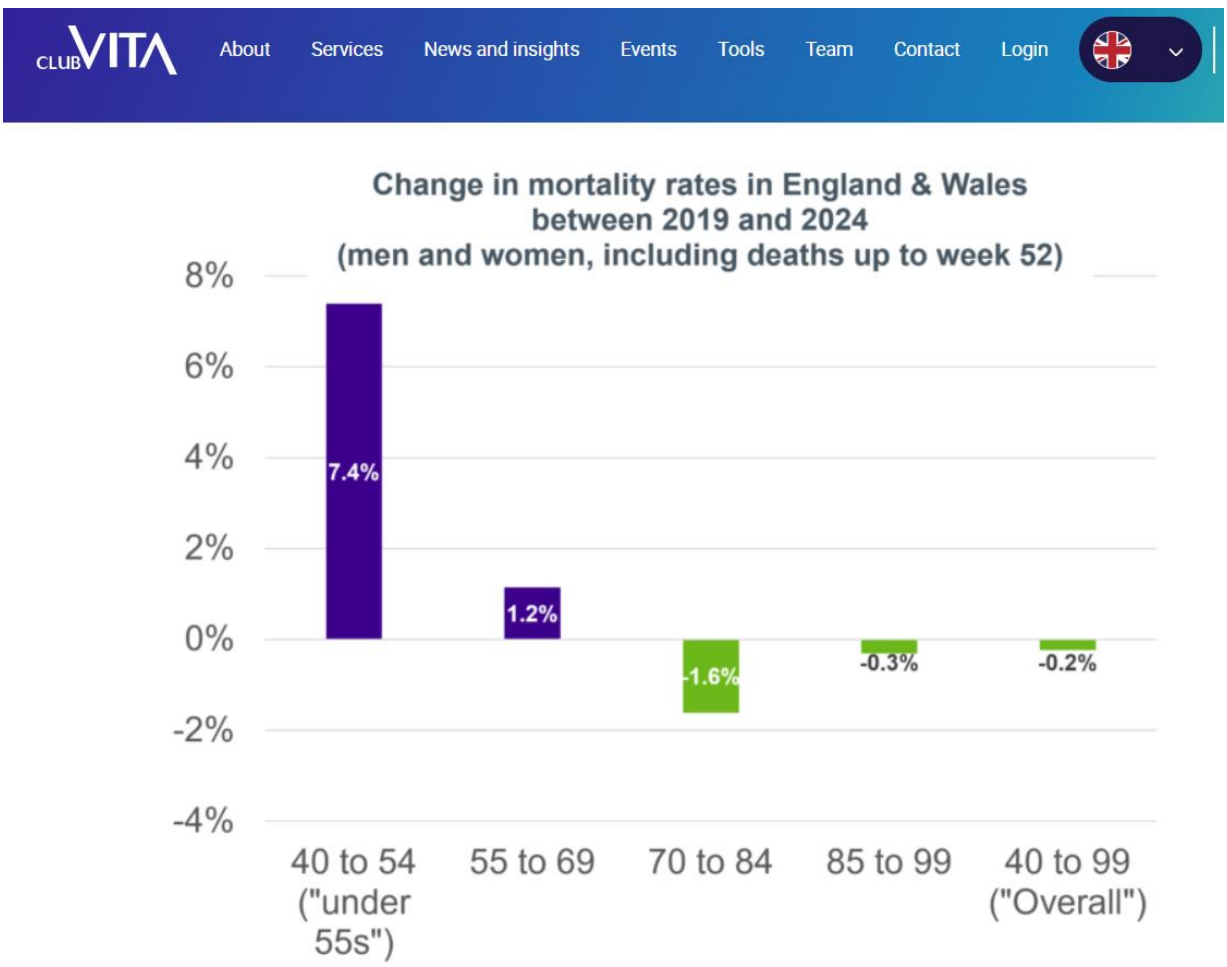
The at-risk elderly would rather take their chances than hurt their descendants' prospects (2)



Aside from older females, all working age people have suffered markedly heavier mortality since the Covid response measures were introduced

For readers unfamiliar with the age standardised mortality rate curves published in the CMI Mortality Monitor, this comparison of 2024 vs 2019 mortality rates for England and Wales published by Club Vita UK provides an alternative illustration of how mortality within the working age bracket has deteriorated in the wake of the Covid response:

The at-risk elderly would rather take their chances than hurt their descendants' prospects (3)



I believe that most people share my perspective on intergenerational (un)fairness, including the at-risk elderly during the Covid era: they would understand the importance of weighing up their own needs against the interests of their children and grandchildren.

We cannot be certain what people want without consulting them and this is obviously unfeasible in an emergency. However I don't think it is reasonable to assume that the default decision of these pensioners would be to prioritise their own protection. I consider it far more likely that they would volunteer to "take their chances" rather than undermine the future prosperity of their offspring and extended family. Why would we not honour these noble wishes?

Conclusion

The five points I have presented are by no means a complete list of the criticisms levelled at the Covid response measures. There are plenty of others, such as:

- The disruption to education
- The backlog created in other important areas (e.g. the courts)
- The mental health strain which was caused by the unnatural conditions

There is also a more fundamental challenge: does the State have the right to impose such restrictions upon the freedom of its citizens?

Nonetheless I believe the five points are sufficient for demonstrating that the accepted wisdom in this area is questionable.

As I said at the outset, I am determined to secure an appropriate evaluation of the Covid response. I am standing for IFoA Council in the summer 2025 elections as a way of driving discussion about the merits of what occurred and my platform seeks a democratic mandate for three specific investigations which I believe could catalyse a more meaningful debate.

Please visit this dedicated website for full details of my activity:

https://rssfitzgibbon.co.uk/

My thanks to all those who took the time to engage with this thoughtpiece.

Sheridan