

[Transcript] The Daily / A New Covid Shot for a New Covid Era

Mass General Brigham is a leading healthcare system with five nationally ranked hospitals, including two world-renowned academic medical centers, located in Boston, where biotech innovates daily, with doctors who teach at Harvard Medical School, and where the people doing the world-changing research are the ones providing care. When you need some of the brightest minds in medicine, there's only one. Mass General Brigham. Learn more at massgeneralbrigham.org. From The New York Times, I'm Michael Bilbaro. This is A Daily. On Tuesday afternoon, the U.S. government recommended that almost every American begin taking a new annual vaccine for COVID, a milestone in the nation's three-year-long battle against the virus. I spoke with my colleague, Apoorva Mondavili, about why the era of booster shots is now over, and how exactly we're supposed to navigate this latest uptick in infections, in what, to many, feels like a post-COVID world. It's Wednesday, September 13th. Apoorva, we're talking to you just about an hour after the Centers for Disease Control and Prevention did something they don't do all that much of these days, which is to publicly weigh in on COVID all these many months after telling us that COVID is no longer a national emergency. So tell us exactly what the CDC just did. What they did today is they sort of reframed how we think about the coronavirus vaccine. We used to have all these boosters and doses to keep track of, and they recommended a single shot that everyone should get. The idea is that you're going to continue to get COVID vaccines, but you should really think about this like the flu vaccine. You're going to get one dose every fall, and that's going to be for everybody, not this many doses for this group and that many doses for the other group in this very confusing melange they had before. It was a confusing melange. That's not just me thinking that. It was confusing to me too, and I write about this stuff. I think everybody had trouble figuring out how many doses they'd had and what they were due for next and whether they really needed it and what the cost-benefit analysis were. And so today what we have is a much more simple model. Here's this vaccine that we're going to have every year, like we do with the flu vaccine. It'll now be a part of our regular healthcare, and everyone should go get it. Right. It will become part of the ritual of getting a vaccine. And I have to imagine that a big reason why the CDC is pushing this is not just because the previous regime was confusing, but because the previous system wasn't really getting people to take a vaccine. It's a bit of both, I think. Not many people got the last booster.

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Pfizer actually thought something like 100 million doses of the booster would be administered this year, just as an example.

And actually only about 12 million doses were in the first six months of the year.

That's a tiny fraction.

It's a tiny fraction, and it gives you a sense of how few people really were interested in getting the vaccine.

The numbers were the best for people who really needed it.

Older adults really did go out and get it. About half got it.

But if you think about adults as a whole, fewer than one in five Americans got it.

And that's just not a very high number.

Well, so what should we know about this new vaccine, this new annual COVID shot, and how it differs from past shots, the ones that we have talked about, thought of as boosters?

For a while, we were getting the vaccine that was intended to protect us from the original version of the virus that came through in early 2020.

And we got several doses of that.

And then the most recent vaccine that we all got, or at least I got, the FDA tried to sort of hedge their bets by having part of that,

but also part of the Omicron variant.

And so they were trying to sort of protect us against both.

And before we were sort of reactive, we had wave after wave, and we were just rolling out the vaccine as needed.

And this was much more intentional.

In June, the FDA decided, okay, this is what we're going to do.

We are going to pick the variant that is the most dominant,

and we are going to design the vaccine to protect us from that variant.

So it was all a bit less rushed and frantic than it used to be.

Got it.

So it's a little bit more anticipatory?

It is.

And this is a very familiar process for our federal health officials.

They know how to do this because they do this every year for the flu vaccine, except for the flu, they pick that variant.

And in the spring, after they've seen what the flu did in the Southern Hemisphere, sometimes that vaccine ends up being a good match for what we actually see in the fall.

Sometimes it's not, but usually, even when it's not a great match, you end up getting sick for fewer days.

You may not get quite as sick.

And so it's still usually worth getting it.

And that's, I think, the hope for the COVID vaccine, too,

is that even if they pick a variant in June and everything changes by the fall, you'd still get some amount of protection from getting the vaccine,

and it would be better than nothing.

Right. And you kind of just hinted at this,

but I'm assuming nothing changes here with the function of a COVID vaccine.

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The idea is that the vaccine won't necessarily prevent you from getting COVID. It's designed, above all, to make a COVID infection milder.

That's absolutely right.

I think many of the vaccines that we've had in the past few years have not been great at preventing infections.

I think now we should really just expect these vaccines to protect us from ending up in the hospital.

We're getting really seriously sick or dying from it.

Okay. So now I want to better understand what the CDC has said about who should get this vaccine, how broad or narrow their guidance is for age groups, populations, and so on. It's actually really simple now.

They said everybody who's older than six months should get at least one dose of this vaccine.

That's about as broad as a recommendation can possibly be.

I'm curious how that compares with the breadth of the government's recommendation for the flu vaccine.

It's exactly the same as for the flu vaccine.

And I think that's another hope that by keeping it the same as the flu, it will make things very simple for people to remember and understand.

Right. Okay. Given these very broad recommendations,

I want to ask a few logistical questions about this new vaccine.

Now that it's supposed to be an annual shot, when exactly on the calendar are people supposed to get this vaccine?

What's the specific window of time?

You should get it when you're actually likely to get it.

Whenever it's most convenient for you is what I hear from the experts because they're so worried that if you try to give a very specific window, people will just not go.

If you can go multiple times, they recommend that you get the COVID shot.

When COVID is looking like a problem and you get the flu shot sometime in October, because flu usually peaks much later than COVID.

Got it.

But if you don't think you're going to actually get to the clinic multiple times, then you should get both as soon as you can whenever you have time.

I want to talk about the reality that these recommendations from the CDC arrive at a moment in our relationship with COVID that feels worse contextualizing, which is that despite the government telling us that the danger has really passed, cases are actually rising right now.

I just had to deal with an infection in my own family.

Several people on the daily team have recently been infected.

I should say not by me.

And yet our access to hard data on case numbers is very different than it's been in the past. So it's a strange time to try to wrap your head around things.

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So give us the official lay of the land.

It is a confusing time because before it was very clear that COVID was dangerous.

There were rising cases.

There were rising hospitalizations and deaths.

We knew exactly where we stood and where the cases were going up.

Now, as you pointed out, we don't actually have great data.

The CDC is not reporting numbers of infections anymore.

So we don't have a great idea of whether and how much cases are going up.

We kind of have a sense that they're going up because we see it in things like wastewater.

And as you said, you hear about people around you getting sick,

but we don't know the exact numbers.

And when you say wastewater, just to be clear, this is the idea that sewage is tested periodically by municipalities.

And that's how local governments can often determine that COVID seems to have been growing in a particular place.

Right. And it's not a very quantitative way.

It doesn't give you a really clear idea of how much virus there is,

but you get a general sense.

You can see that it's going up.

You can see that maybe it's about the same level as it was last year at some time.

But they're not exact numbers.

And so we just don't really have a clear picture of cases.

We have better data for hospitalizations and deaths.

And we can see from that that those are going up.

They've been going up since July.

But the actual numbers are a lot lower than they were in previous years.

So hospitalizations are about half the number they were at the same period last year and one-fifth the number in 2021.

And deaths also, you know, there are deaths.

There are 600 or so deaths every week, which is not nothing.

But they are lower, a lot lower than they were in August 2022

when there were 3,000 people per week dying

and 14,000 per week in August 2021.

So that is a risk level that is significantly lower than in the past.

I mean, 14,000 deaths a week versus 600 per week is, I think,

something like 23 times less lethality.

That's meaningful.

That is meaningful.

But when you compare it to something like the flu, it's still worse than the flu.

It's just a lot better than it was in the really horrific Delta period.

So we've come a long way, but COVID is still a pretty significant threat

and it's still among the leading causes of death in the country

and it's worse than flu, which we take seriously every year.

Right. What is the annual death rate from the flu

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compared to what, based on the numbers we expect this year, to be the death rate from COVID?

So deaths from flu vary a lot based on how bad the strain is in any given year. But there was just a modeling estimate for COVID that said, even if everybody goes out and gets the vaccine and the variant is really sensitive to the vaccine and we respond very well, we could still see something like 46,000 deaths from COVID and that's a very bad flu year.

And let's not forget, there's also respiratory syncytial virus, which is a third respiratory threat, especially for older people and kids. Right, better known as RSV.

Right, RSV, that's the third virus that we had to deal with last year. Remember, there was the triple-demic and we had people in hospitals for months and months because there was COVID and there was flu and then there was RSV.

There were all these things circulating. And not everybody may worry about those things. A lot of people don't have to worry about RSV. It's really a risk for older people and kids and a lot of young people probably don't think very much about the flu or get the flu vaccine, but COVID is a little bit different. We're just learning that if you get infected with the coronavirus, you don't even have to get very sick, you could still have a lot of long-term health problems, you know, long COVID, long-term damage on the heart, for example. So it's not just like the flu.

And I understand that that's a bit of a confusing paradox. The government is telling us go get the vaccine, but other than that, no, it's not really a problem. There's no data for us to make our decisions. And yet we're somehow supposed to try to figure out how to help ourselves, how to protect ourselves. And so we all have to come up with our own ways of figuring out whether to socialize, whether to go out or not, whether to tell people we're sick or not, all these questions that we have and what we are willing to live with. We'll be right back.

My name is Melitza Marghera, and I'm a glaucoma clinician scientist at Mass General Brigham. At Mass General Brigham, the researchers changing the world

are also the physicians providing care.
My patients are desperate for new glaucoma treatment options.
And as a scientist and a clinician,
being able to tell them I'm working on new therapies,
even if I don't have them available yet,
is so comforting to them.
It also helps keep my research grounded
in the lives and needs of real people.
Learn how research directly affects patients
at [MassGeneralBrigham.org](https://www.massgeneralbrigham.org).
Like, who is most vulnerable to climate change?
Should we redesign our cities?
Should we be eating differently?
What happens to the millions of people
who live by the coast as the oceans rise?
To make sense of this,
I talk to climate scientists and ventures,
activists.
Mostly, I document the impact of global warming.
And that impact is highly, highly unequal.
My colleagues and I are doing our best
to answer complicated questions like these,
but we can't do that.
Without our subscribers,
if you'd like to subscribe,
go to nytimes.com slash subscribe.
And thank you.
So, Uprova, I want to spend some time
now talking about how we are supposed to navigate
this period of COVID,
not just the vaccines,
which we've been talking about,
but all of it.
And I want to start with a pretty simple question
around masks.
In my experience,
very few people are regularly masking right now.
That just seems like a given.
I am going to confess,
I don't carry a mask around with me.
A number of people I know don't either,
but I don't want COVID again.
So, how should I, how should many people like me
think about what may end up being the rare times

that we might want to consider putting a mask back on?
This is a tough one,
because before, we used to be able to look at case numbers
and decide, okay, the numbers are going up,
so I'm going to put on a mask now.
Now we're having to make those decisions
based on what we're hearing around us.
There are a lot of people who seem to be getting sick,
that number of hospitalizations is going up.
And then you start to make decisions
about specific circumstances.
I totally agree.
I don't see the average person
returning to any kind of full-time masking.
But if you know you're going to be in a crowded indoor space,
that's usually a good place to wear a mask,
you know, a subway train or a really crowded bathroom.
You know, when I travel,
I don't really worry so much
about taking my mask off on the plane,
because airplanes are great.
But airport bathrooms, no,
I think I will put a mask there or really any bathroom.
And any, you know, crowded indoor space
where you think people might be sick,
like the pharmacy or the hospital
where you know people are coming in
who are infected, coming to pick up their meds
or to see the doctor.
So it really does have to be this sort of circumstance
by circumstance, case by case basis,
if you're not okay wearing a mask most of the time.
It's interesting, the pharmacy now that you're mentioning,
it seems incredibly obvious.
Sick people go to pharmacies to get drugs
or to get over-the-counter medicine.
And it's a very logical place to wear a mask,
especially if you're going to be standing in line
to get drugs with other people for a long period of time.
And that's the key thing there, standing in line, right?
You're spending a lot of time around those sick people.
And it's the same if you go to an ER
and there are a lot of sick people waiting in the emergency room,
you probably want to put on a mask.

If you're just going in and out quickly,
it may not be as important.
And of course, if you live with somebody
who is immunocompromised,
then you're probably taking more precautions anyway.
Right, that's a different calculation.
Okay, so on to testing in this moment.
As you know, because I know you live in the New York region,
a lot of those pop-up rapid testing sites, they're gone.
In my neighborhood, a bunch of them
seem to have gone out of business, closed shop.
Insurance companies cover less testing now
than they did in the past.
So a lot of us are left with at-home tests
made by various companies.
How good are those at-home tests right now
at correctly identifying an infection?
They're decent.
They all still detect the new variants that are around.
But a lot depends on who's doing the test
and how carefully they do them.
I think the best way to make sure that you are positive or not
is to do more than one test.
If you test on consecutive days
and you try not to be negative,
then it's more trustworthy than if you just did it once.
But you're right that there aren't a lot of ways
to test very easily now.
I mean, New York actually is sending tests to schools
that request them.
So kids may still end up getting tested
or they may send tests home like they used to.
But it's much more difficult to get a sense of who's sick.
And that's why we're struggling to figure out
how big this problem is at the moment.
Finally on testing,
and this is admittedly a bit of a delicate matter,
I have noticed there's a growing reluctance to test
even after an exposure or when you wake up
with a tickle in your throat,
especially if a person isn't really feeling all that sick
because there's a cost to testing positive
that folks just want to avoid.
Missed school for kids, missed work, missed whatever.

And judgments of that aside,
does that just speak to the reality
that in this moment exposure to COVID
is kind of the reality of living in this world?
You know, I can't really endorse not testing
because I think you do need to know if you're sick.
You know, I completely understand the societal cost.
I have two kids.
I know that when your kid tests positive,
the kid has to stay home and then you can't go to work
or you don't get as much work done.
And there are all these sort of ripple effects from that.
But you don't want to send the kid to school
and start a mini cluster in that classroom.
And you don't know who else is in that kid's family.
So I think people should still test
and should still make every effort to not go out
and spread the virus to other people.
But I guess what I'm asking is,
do you need to operate under the assumption
that many people aren't testing?
Isn't that just reality?
That is the reality.
And I think that comes back to masking.
If you want to protect yourself,
you may have to rely on your own self to mask
because chances are pretty good
that other people around you are not testing,
don't know if they're sick,
or not telling you that they're sick.
Right.
So let's say you do test and you test positive.
In the past, that triggered this kind of shutdown of life, right?
That's like everything closed and we quarantined.
That does not seem to be the case for a lot of people anymore.
You know, people who test positive,
they still take flights for all kinds of reasons.
They get on the plane, right?
They still go to parties.
I had the experience of notifying a friend pretty recently,
hey, I'm pretty sure I've been exposed.
Fair warning.
Do you still want to come over this weekend?
And the answer was, yes, I do.

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I want to see you.
I want to see the kids.
So how do you think about the new rituals around all of this?
Knowing that in this current surge,
people's tolerance for risk is pretty high.
But you don't know if the person you're about to meet
has a very high tolerance.
I think what you did,
where you informed your friend
and let your friend make the decision,
that's a great way to deal with it.
You know, I think about it like when my kids were little
and they would have colds,
which was like every day it seemed like.
Right.
And if you had a social engagement,
you'd tell the friend, hey, my kid is sick.
Do you still want me to come over?
And it's, you leave it up to them to decide it's okay with them
rather than you deciding for them that COVID is not a big deal.
Right.
So you're suggesting a kind of sick kid model,
which if you have a kid tends to be kind of automatic.
I have a sick kid, can I bring them over?
Or you're headed over here, you should know I have a sick kid.
Apply that essentially to COVID as a matter of disclosure.
Ideally, you know, people just wouldn't go out at all
if they were sick.
But realistically, as you're saying,
if people aren't going to do that,
then I think you at least are obliged to tell people
and let them make the decision.
Okay, this might be something of a curveball,
but I've heard this kind of story from people in my life.
They test positive for COVID.
They're headed to an outdoor social activity.
And they tell themselves, it's going to be okay.
Outdoor transmission doesn't happen.
This is going to be safe.
This is really important to me.
We are where we are in this pandemic.
I'm going to do this.
So how should we think about that?
You know, I wouldn't go to an outdoor event

if it was going to be very crowded,
like a, I don't know, Taylor Swift concert.
But if it's a picnic with a bunch of friends
and you can maintain some distance,
we know that outdoor activities,
generally safe for COVID,
there's very, very few documented cases
of transmission from outdoors.
So, you know, you could wear a mask if you wanted to,
but really, as long as you weren't too close
to somebody outside, it's probably okay.
Okay, here I want to acknowledge that we have been
trying to inhabit the mind space of those
who have decided that taking a ton of precautions
in this moment doesn't make sense for them.
But there are of course those who don't feel that way.
They want to be very careful
and they want to take a lot of precautions.
Perhaps they are immunocompromised.
Perhaps they live with someone who is immunocompromised.
Or they just want to be careful
because they really don't want to get COVID.
How are they supposed to navigate this moment,
especially as cases rise and as so many people
are not taking these precautions, right?
I mean, that means it's pretty hard to be
a cautious person right now.
There are ways that they can protect themselves.
And we know this from earlier in the pandemic.
You know, you wear a good mask.
You avoid socializing with other people
or you socialize outdoors.
You know, you avoid crowded indoor spaces,
all these things.
But it is a little bit different now
because so few other people are doing these things.
And so, you know, there's a lot of judgment.
I mean, I've heard from people who are severely
immunocompromised who are going to hospitals,
even cancer centers where you'd think
everyone should be masking.
And they're the only ones wearing a mask.
Even the staff aren't wearing a mask.
And so it's terrifying for some people.

In fact, there was a study recently that said that more people with cancer died during Omicron when the cases were mild than during the previous winter's surge. Partly because so many fewer people around them were taking precautions. And so the risks to them were higher. Which presumably might apply to this moment as well. In other words, when people let down their guard, the risk to those at highest risk is just much higher.

It is.

And it's also lonelier for them because everyone around them is doing something entirely different.

Right.

Okay.

So given that this may be our last conversation about COVID on the Daily Four a little while, I want to ask about the future.

Not just the near future, but the distant future.

So much has clearly changed in just the past three years of this virus.

There's no better evidence of that than the fact that we're talking about an annual COVID shot that we're supposed to take along the flu shot.

And the fact that boosters are no longer even part of the conversation.

So I'm curious whether you've given thought to what this all might look like in five years, maybe even 10 years.

And will this continue to be a story of less and less risk, do we think, and looser and looser approaches to it?

Or not?

It's almost impossible to predict what will happen. As you know, we've had that conversation many times, but we've been talking this whole time with the idea that we're going to keep going in this direction where the virus becomes less and less of a threat and we all build up more and more immunity and we have fewer hospitalizations and deaths.

And that's certainly one possibility and one that we all hope for.

But there are other possible scenarios.

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There are possibilities where maybe we see a variant that comes through that doesn't respond to vaccines. Maybe we see a variant that's incredibly contagious, sort of like Omicron was, and threw everything into a tailspin. So really the short answer is we hope that this will become like the flu and something that we only worry about for three months of the year, but we just don't know. Thank you very much.

Thanks for having me.

The new COVID vaccine is expected to be available in pharmacies and clinics by the end of the week.

We'll be right back.

At Mass General Brigham, scientists and physicians are working together to improve patient care.

Here's Oleg Batovsky, a senior neuroscientist at Mass General Brigham.

My lab studies immune cells in the brain.

In rare cases, those cells can cause diseases like Alzheimer's and ALS.

We're working with dozens of other labs and clinics across Mass General Brigham to understand those cells and to create better treatments for patients.

Learn how research directly affects patients at [MassGeneralBrigham.org](https://www.massgeneralbrigham.org).

Here's what else you need to know today.

More than 5,000 people have died and thousands are missing in northern Libya after torrential rains caused two dams in the coastal city of Derna to burst, setting off floods that washed out bridges, buried buildings, and carried entire neighborhoods into the sea.

The flooding is the latest natural disaster to befall the region.

An earthquake over the weekend in another northern African country, Morocco, has killed nearly 3,000 people.

And...

Welcome back, everyone.

House Republicans have uncovered serious and credible allegations into President Biden's conduct.

In Washington, House Speaker Kevin McCarthy

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has opened an impeachment inquiry into President Biden, focused on whether Biden improperly benefited from business dealings involving his son, Hunter, and sought to conceal his knowledge of those dealings.

The American people deserve to know that public offices are not for sale and that the federal government is not being used to cover up the actions of a politically associated family.

The move appears to be an effort to appease far-right lawmakers who have threatened to oust McCarthy unless he meets their demands for deep spending cuts in the budget, something McCarthy has so far struggled to accomplish.

But while impeaching the president is popular among conservatives, there was not enough support among more moderate Republicans to begin an impeachment inquiry with a formal vote, so McCarthy instead opted to start the inquiry on his own.

Today's episode was produced by Claire Tennisgetter, Olivia Knatt, and Sidney Harper.

It was edited by Devin Taylor, contains original music by Dan Powell and Marion Lazano, and was engineered by Alissa Moxley. Our theme music is by Jim Brunberg and Ben Landford of Wonderly.

That's it for the Daily.

I'm Michael Morrell. See you tomorrow.

This is an exciting healthcare system with five nationally ranked hospitals, including two world-renowned academic medical centers, located in Boston, where biotech innovates daily, with doctors who teach at Harvard Medical School, and where the people doing the world-changing research are the ones providing care.

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