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ABSTRACT

Recent observations on countries like the UK that have accumulated a large fraction of inoculated individuals suggest that, although initially, vaccines have little effect on new infections they strongly reduce the share of mortality out of a given pool of infections. This paper examines the extent to which this phenomenon is more general by testing the hypothesis that the ratio of current mortality to lagged infections is decreasing in the total number of vaccines per one hundred individuals. This is done in a pooled time-series, cross-section sample with weekly observations for up to 208 countries. The main conclusion from the statistical analysis is that, passed a certain threshold, vaccines moderate the share of mortality from a given pool of lagged infections. This is essentially a favorable shift in the tradeoff between life preservation and economic performance. Controlling for income per capita, stringency of containment measures, and the fraction of recovered and old individuals, estimation is carried out by linear least squares, with standard errors clustered by country and region. The main result is robust to sensitivity analysis with a logarithmic specification. The practical lesson is that, in the presence of a sufficiently high share of inoculated individuals, governments can shade down containment measures, even as infections are still rampant, without significant adverse effects on mortality.

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1. Introduction

Since its outbreak in early 2020 the Covid19 pandemic confronted governments all over the world with a painful tradeoff between containment of its adverse consequences for public health and economic activity. Prior to the appearance of vaccines in early 2021 the main instrument available to policymakers for choosing a point along this tradeoff included various containment measures designed to reduce contagion by limiting individual and business contacts. Along this tradeoff more stringent measures would reduce contagion at the cost of reduced economic activity.

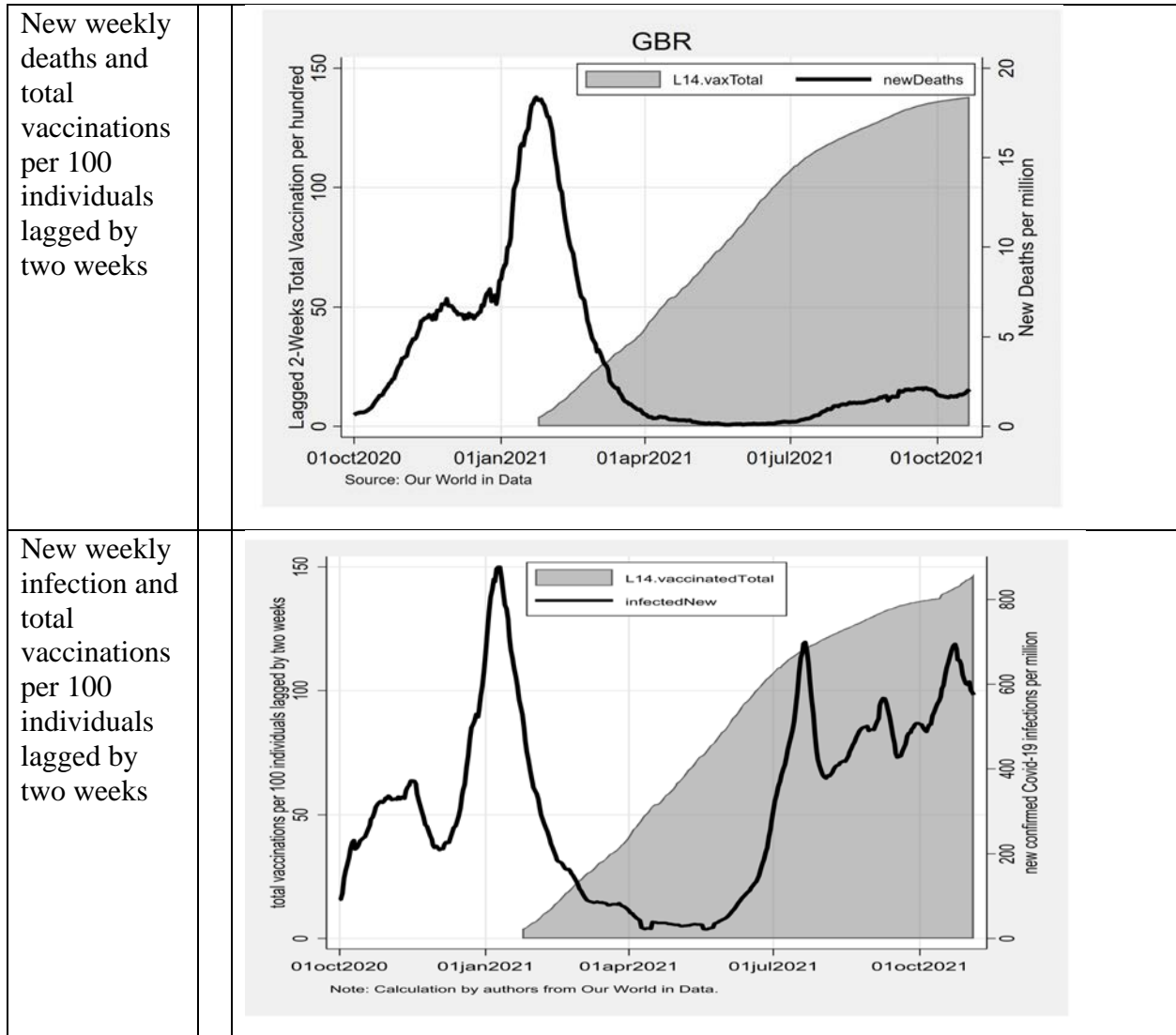
The capacity of medical systems to handle large quantities of Covid19 casualties and serious illness is limited. Two crucial indicators of the ability of the medical system to confront the pandemic from both a practical and social point of view are mortality and serious illness. A third, less stringent, indicator, is the number of infected individuals. An important reason for watching this variable is the fact that a certain fraction of infected individuals induces, with a lag, mortality and serious illness. A fourth variable is the stock of recovered patients that may eventually contribute to herd immunity, on the one hand. However, it may add some pressure on the medical system in the medium to long term due to the 'long Covid.'

Reduction in the adverse consequences of the pandemic due to the gradual administration of vaccines to the population opened the door for experimentation with milder containment measures. This improved the tradeoff and opened the door for more efficient outcomes on both the pandemic and the economy. A natural presumption is that, other things the same, countries with larger fractions of inoculated population should benefit more from this process. Moreover, due to lags in the beneficial effects of vaccines, countries with relatively low shares of vaccinated population may not benefit at all. On the other hand, countries with relatively high shares may be able to reduce or even eliminate stringent containment measures with relatively little risk of renewed infections and Covid19 mortality. Obviously, such considerations figure prominently in the strategies followed by policymakers.

The main objective of this paper is to test the hypothesis that, once the total level of vaccinations has reached a sufficiently high level, the incidence of mortality out of a given pool of infected individuals goes down. This hypothesis was initially motivated by the experience of

Great Britain. After peaking during winter 20/21 both new cases and new deaths shrank dramatically leveling at very low levels around April 21. Since this happened at relatively low levels of

Figure 1: Total vaccinations, mortality and new cases in Great Britain



cumulative vaccinations this descent from the peak was probably due mainly to reasons other than vaccines (Figure 1). Encouraged by those developments prime minister Johnson gradually eased containment measures and finally abolished them completely on July 1 2021. Following those policy changes new cases rebounded but, contrary to the winter 20/21-episode, new deaths remained relatively dormant. A main difference between the two cases is that during February

2021 the vaccination process was just starting whereas on July 1 2021 cumulative vaccinations were above 110 vaccines per 100 individuals.

The British experience suggests that, although the impact of sufficiently high level of cumulated vaccines on new cases is relatively muted its moderating effect on new deaths is substantial leading to the hypothesis that the ratio between new deaths and new cases lagged is negatively related to the cumulative level of vaccines.² A main objective of this paper is to test whether this hypothesis applies more generally when a large number of countries with different characteristics is considered.

To our knowledge this hypothesis has not been tested previously. The closest paper to ours is Karabulut et. al. (2021). They investigate the impact of democracy on Covid19 outcomes. One of their main findings is that the mortality/infections ratio in a cross section of countries is negatively related to the level of democracy. Our focus is on the impact of vaccines on this ratio, and we use a combined time series cross-sectional data.

2. Empirical design and results for the mortality to infection ratio

Our sample consists of weekly observations on a bunch of variables described later starting at various dates during the first quarter of 2020 and ending on November 2021.³ All the data is drawn from the site of “Our World in Data”. A detailed description of the data and its sources appears in the data appendix. The basic estimated regression is

$$MLI_{it} = \beta_0 + \beta_1 MLI_{i,t-1} + \beta_2 V_{i,t-2} + \beta_3 S_{i,t-1} + \beta_4 R_{i,t} + \beta_5 Y_i + \beta_6 OLD_i + \varepsilon_{i,t} \quad (1)$$

where MLI_{it} is the ratio between new deaths in week t and a two weeks lag on bi-weekly new infections in country i . The indices i and t represent respectively the country and week. V is the cumulated number of vaccines per 100 individuals, S is a measure of stringency of containment measures imposed by government, R is a cumulated measure of recovered individuals per million, calculated as the difference between cumulative cases and deaths, Y is income per capita

² A similar, although less dramatic, phenomenon has been observed in Israel. Medical research suggests that there is a lag of about two to three weeks between new cases and their impact on new deaths.

³ The sample includes up to 208 countries. The cross-country variation in starting dates is due to data limitations.

in 2019 and OLD is the fraction of individuals above 65 in 2019.⁴ The variable R is introduced to capture a potentially growing herd immunity effect that might appear after a sufficient fraction of the population recovers from corona infections. The lagged dependent variable accounts for serial correlation in MLI .

Estimation is carried out by least squares, with standard errors clustered by country and region. It is applied to the entire sample, as well as to three bins of observations grouped according to cumulated vaccination rates: Low ($V < 40$), medium ($40 < V < 80$), High ($V > 80$). Table 1 presents three linear regression models; one for the full sample, the second for the high vaccination bin, and the third for the low vaccinations bin. The last column presents a logarithmic version for the entire sample. Except for the low vaccination bin vaccines have a negative and significant impact on the mortality to infections ratio in all regressions shown. In the medium bin vaccines have no significant impact on the mortality/infection ratio (regression not shown). Sensitivity analysis consisting of dropping some of the insignificant regressors in Table 1 reveals that, for high levels of vaccination, the impact of vaccines is always significantly negative but is not uniformly significant for low levels of vaccinations (regressions not shown).

This supports the view that most of moderating impact of vaccines on MLI_{it} materializes at sufficiently high levels of total vaccinations. Although occasionally negative the stringency variable and the fraction of recovered individuals are insignificant in all regressions. The second result is consistent with the view that herd immunity has not been achieved at both the world and the high and low bins vaccines levels. The impact of income per capita is invariably negative and significant while that of the lagged dependent is invariably positive and significant.

⁴ Prior to the appearance of vaccines, the main instrument used by government to moderate the pandemic was the imposition of various restrictions on mobility and mandatory face masks. Hale et. al. (2020) provide a quantitative index for the stringency of those containment measures. Balazs et. al. (2020) investigate the impact of such measures on the reproduction rate of the virus and the economy. Using daily panel data in a cross section of countries along with Hale et. al. (op. cit.) stringency index Deb et. al. (2020) estimate the impact of specific restrictive measures on the incidence of the pandemic. Hubert finds that, during the early stages of the pandemic restrictions on air travel were particularly effective in containing the spread of the virus.

Table 1: Impact of vaccines on the mortality to infections ratio

Regressor	Linear Regressions, Dependent variable: MLI_{it}			Logarithmic Regression, Dependent variable: $\log(MLI_{it})$
	Full Sample	High Vaccinations	Low Vaccinations	Full Sample
$MLI_{i,t-1}$	0.71*** (0.09)	0.37* (0.09)	0.82*** (0.04)	0.86*** (0.02)
$V_{i,t-2}$	-0.02* (0.01)	-0.03* (0.01)	-0.09 (0.04)	-0.02* (0.01)
$S_{i,t-1}$	-0.02 (0.02)	0.01 (0.04)	-0.04 (0.02)	0.02 (0.02)
$R_{i,t}$	-0.04 (0.07)	0.01 (0.06)	0.01 (0.08)	0.02 (0.02)
Y_i	-0.07* (0.02)	-0.10*** (0.01)	-0.06* (0.02)	-0.07* (0.02)
OLD_i	0.01 (0.04)	-0.05 (0.03)	-0.04 (0.03)	0.02 (0.01)
Intercept	8.10** (1.54)	11.56*** (1.39)	8.70* (2.78)	0.47** (0.07)
F-stats.	602.5	64.3	334.8	2242.8
Adj. R-squared	0.51	0.22	0.56	0.81
Number of observations	3496	1348	1570	3087

Standard errors in parenthesis under the coefficients

*P<0.05, **P<0.01, ***P<0.001

3. Impact of vaccines on new infections

This section examines whether vaccines also have a moderating effect on new infections. This is done by replacing MLI_{it} and $MLI_{i,t-1}$ in equation (1) by new infections in country i at time t (NI_{it}) and new infections lagged ($NI_{i,t-1}$). Estimation of linear regressions for dependent variable NI_{it} for the full sample as well as for high and low vaccination bins reveals that NI_{it} is close to being non-stationary (regressions not shown). To address this problem the dependent variable is respecified as ΔNI_{it} rather than NI_{it} .

$$\Delta(NI_{it}) = \beta_0 + \beta_1\Delta(NI_{i,t-1}) + \beta_2V_{i,t-2} + \beta_3S_{i,t-1} + \beta_4R_{i,t} + \beta_5Y_i + \beta_6OLD_i + \varepsilon_{i,t}$$

(2).

Table 2 shows regression results for the full sample and for the high and low vaccination bins for this version. The main finding is that in all cases the impact of vaccines on new infections is insignificant. This is also the case for logarithmic versions of the full sample as well as for all the regressions in which the dependent variable is the level of infections.

Table 2: Impact of vaccines on new infections

Regressor	Linear Regressions, Dependent variable: ΔI_{it}		
	<u>Full Sample</u>	<u>High Vaccinations</u>	<u>Low Vaccinations</u>
$\Delta I_{i,t-1}$	0.32* (0.12)	0.16 (0.18)	0.48*** (0.03)
$V_{i,t-2}$	0.05 (0.05)	-0.05 (0.03)	-0.05 (0.15)
$S_{i,t-1}$	-0.26 (0.15)	-0.49* (0.10)	-0.09 (0.07)
$R_{i,t}$	-1.15** (0.28)	-1.25 (0.89)	-0.95 (0.63)
Y_i	-0.04 (0.07)	0.09 (0.06)	-0.04 (0.05)
OLD_i	0.31 (0.15)	1.14* (0.31)	0.07 (0.26)
Intercept	16.45* (6.15)	24.69* (6.17)	8.93 (6.17)
F-stats	77.3	14.1	89.9
Adj. R-squared	0.12	0.05	0.25
Number of observations	3500	1352	1570

Standard errors in parenthesis under the coefficients

*P<0.05, **P<0.01, ***P<0.001

4. Concluding remarks

The main conclusion from the statistical analysis of the paper is that vaccines, moderate the share of mortality from a given pool of lagged infections. But it does not support the view that vaccines also moderate infections. Cognizance of this regularity by policymakers that are concerned with both mortality prevention and economic performance cannot be overemphasized. Avoiding lockouts and other stringent confinement measures stimulates the economy at the cost of an increase in the pool of infected individuals. But given that, in the presence of vaccines, this increase is associated with lower mortality, governments can provide better performance on both mortality avoidance and economic performance. This is essentially a favorable shift in the tradeoff between life preservation and economic performance.⁵

As far as we know this is a relatively novel regularity and is therefore unlikely to be fully appreciated by many governments including possibly the UK government that lifted most of its Covid19 restrictions on July 19, 2021, even as infection cases were climbing vigorously. Whether this action was based on solid medical knowledge about the impact of vaccines on the mortality/infection ratio or on a response to public corona fatigue is an open question. Be that as it may figure 1 clearly indicates that the lifting of restrictions resulted in a substantially higher increase in new infections than in new mortality.

A similar, although less extreme, route was followed in Israel. The Green Pass and Purple Badge systems, which had set guidelines for who can enter public venues and how those venues can operate, expired starting June 1, meaning that Israelis no longer required proof of vaccination or recovery to enter various venues, and capacity limits at stores, restaurants and other sites were lifted. Although it reinstated some temporary minor restrictions in the face of rising infections in August 2021 the general policy of the Bennett government was to accelerate the vaccination process including booster shots to the entire population rather than re-tighten restrictions.⁶ Between July and mid-September infections shot up from less than 1000 per day to over 10000. During part of this period daily mortality was initially zero, subsequently increasing to a modest peak in mid-September before receding to around 7 daily deaths at the end of October. The

⁵ In a cross states study within the US Hansen and Mano (2021) find that economic activity rebounded by more in states with higher fractions of vaccinated individuals. Furthermore, vaccines were relatively more effective in urban areas.

⁶ The Bennett government was sworn in on June 13 2021.

decrease in new infections since the mid-September peak is probably due to a vigorous booster campaign that raised total vaccinations to 180 per hundred individuals. This countered the decrease in the effectiveness of original vaccinations many of which became older than 5 months by September 21. At a smaller margin, this campaign also encouraged previously non vaccinated individuals 'taking the vaccination plunge,' due to the growing awareness with the faster diffusion of the delta variant, as well as to other reasons related to preferential treatment of vaccinated individuals in public events and international travel.⁷ Be that as it may this opens the door for the hope that following a sufficiently potent accumulation of vaccinations infections are likely to recede as well.

Solid knowledge about the ability of sufficiently high proportion of inoculated population is essential since large pools of infected individuals raises the appearance of new variants and with it the probability that some of them may reduce the effectiveness of vaccines. This is particularly important in view of the fact that the current tendency is to live with the virus implying that air traffic, although lower than in the pre-pandemic era, is maintained at levels that facilitates the spread of new variants across the world.

Unfortunately, since vaccines have been around for less than a year and the fraction of inoculated individuals in many countries is relatively low, there is little statistical information about the ability of high levels of vaccines to also reduce infections.⁸ Such knowledge will most likely accumulate as more countries in the world reach sufficiently high levels of vaccinations. This supports the view that, besides equity considerations, there is a positive externality associated with a more equitable distribution of vaccines across countries (Ghosh (2021)).

Down the road, with new data accumulating in the coming months it may be possible to refine the statistical analysis along two dimensions. The first concerns a potential differential impact of vaccine types and the second regards potential differences in the impact of boosters versus deepening the share of vaccinated individuals on Covid19 outcomes. Precise discrimination between the impacts of different types requires data on immunization for each

⁷ Arce et. al. (2021) report that willingness to get vaccinated in 15 low and middle income countries is higher than in the US and Russia.

⁸ A recent exception is Milman et. al. (2021). Using vaccination records and test results collected during the rapid vaccine rollout in a large population from 177 geographically defined communities in Israel, they find that the rates of vaccination in each community are associated with a substantial later decline in infections among unvaccinated individuals.

type of vaccine in each country -- which is currently unavailable. The second question requires data that would classify Covid19 cases into two bins; One for late joiners into the immunization process and the other with earlier joiners with boosters. Such data is likely to roll out in the not too distant future in Israel that has recently accumulated both types of populations.

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Appendix

Data Description and sources

MLI_t is the ratio between new deaths (ND_t) in week t and a two weeks lag on bi-weekly new infections (NI_{t-2}).

V_t is the total number of vaccines per one hundred individuals up to period t.

S_t is an index of stringency of non-pharmaceutical interventions in period t. It is composed of s a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest).

R_t is the total stock of recovered individuals per million individuals in period t. It is calculated as the difference between total infections per million individuals in period t (TI_t) and total deaths per million individuals in period t (TD_t).

Y_t is GDP per capita in period t

OLD_i is the fraction of individuals above 65.

All the data is drawn from the site of “Our World in Data”. It is available at available at the GitHub repository: <https://github.com/owid/covid-19-data/tree/master/public/data>.

Sample correlations

	MLI	ND	NI	V	S	R	TI	TD	Y	OLD
MLI	1.00									
ND	0.07	1.00								
NI	-0.00	0.40	1.00							
V	-0.06	-0.18	0.08	1.00						
S	-0.01	0.33	0.21	-0.20	1.00					
R	-0.05	0.23	0.41	0.51	-0.10	1.00				
TI	-0.05	0.23	0.41	0.51	-0.10	1.00	1.00			
TD	0.04	0.62	0.20	0.22	0.01	0.65	0.66	1.00		
Y	-0.08	-0.06	0.13	0.37	0.01	0.33	0.32	0.04	1.00	
OLD	-0.05	0.17	0.22	0.23	0.01	0.41	0.41	0.37	0.41	1.00