THE COSTS OF INOCULATING CHILDREN AGAINST COVID-19 FAR OUTWEIGH THE BENEFITS

Ronald Kostoff
November 19, 2021

13 Comments

Note that views expressed in this opinion article are the writer's personal views and not necessarily those of TrialSite.

Free to Read and Share without paying

In our Toxicology Reports (TR) paper on COVID-19 that examined myriad issues associated with the ongoing mass inoculations (hereafter called the TR paper), we also evaluated the ratio of costs to benefits (relative to deaths) for what we termed a best-case scenario. In response to reader requests, I then performed a brief real-world cost-benefit analysis, and found the ratio of costs to benefits increased substantially compared to the best-case scenario. In this OpEd, I will start from fundamentals to show step-by-step why the ratios of costs to benefits for COVID-19 inoculations are

so high in a real-world analysis, relate them to the underlying biological mechanisms that are taking place post-inoculation, and place these results in the larger context of what is being played out on a global scale.

1. WHY ARE THE RATIOS OF COSTS TO BENEFITS SO HIGH FOR COVID-19 INOCULATIONS?

First, some definitions. "Costs" are the deaths induced by the COVID-19 inoculations and "benefits" are the true COVID-19 deaths that only a "vaccine" could have prevented. Since the inoculations were given ostensibly as a preventive measure, the cost:benefit (c:b) ratio should be very low, on the order of a fraction of a percent. Also, in the remainder of this OpEd, I use the term "inoculation" mainly rather than "vaccine", since the COVID-19 inoculants do not meet the legal definition of a vaccine (as we showed in the TR paper) or even the Patent Office definition (as we also showed in the TR paper).

This analysis focuses on the most vulnerable 65+ demographic. Because of the high COVID-19 death rates in this demographic, the analysis would be expected to show the lowest c:b ratio for any demographic. In June/July, when we did the best-case scenario analysis for the TR paper, there were ~467,000 CDC-reported COVID-19-tagged deaths and ~2,600 VAERS-reported deaths post-inoculation (VAERS is the Vaccine Adverse Event Reporting System, and is operated jointly by the CDC and FDA). These official CDC numbers are the starting point for the present analysis.

a) Number of true COVID-19 deaths that required an inoculation for prevention

The first step in developing an actual c:b ratio is to adjust the CDC-reported COVID-19 deaths and VAERS-reported deaths to conform to real-world results.

A1) False Positives

The main diagnostic test with which patients were tagged as having COVID-19 is the real-time reverse transcription polymerase chain reaction (RT-PCR) test, hereafter called PCR test. A number of studies have shown that the false positive PCR rate is significant for COVID-19, and increases with increasing values of cycle threshold (Ct). A comprehensive assessment of the data concluded that at

Ct of forty, where most of the USA testing occurred (some cases even higher), the false positives ranged from 90% to 97%. Selecting the lower part of the range (90%) reduces the number of true COVID-19 deaths that required a "vaccine" for prevention to 0.1 x 467,000, or ~47,000.

A2) Early Treatment

A number of frontline doctors have testified (and published treatment protocols as well) that ~85->95% of COVID-19-tagged cases could have been saved from hospitalization or death had their protocols been implemented at an early stage, They have testified that, instead, patients were provided treatments known to be ineffective/harmful and denied treatments known to be harmless/safe. Selecting the median of the range (90%) reduces the number of true COVID-19 deaths that required a "vaccine" for prevention to 0.1 x ~47,000, or ~4,700.

A3) Deaths attributable to COVID-19 only

For patients diagnosed with COVID-19, approximately 94% had clinically-defined comorbidities, according to the CDC. In that case, approximately 94 % of the COVID-19 deaths could have been attributed to any of the comorbidities these patients had, and only 6% of the deaths could actually be attributed to COVID-19. If pre-clinical comorbidities had been included, this number of 6% would probably be decreased further. If only 6% of the deaths could be truly attributed to COVID-19 because of absence of comorbidities, the number of true COVID-19 deaths that required a "vaccine" for prevention drops to 0.06 x ~4,700, or ~280.

As a side note, the Italian Higher Institute of Health showed "only 2.9% of the deaths registered since the end of February 2020 would be due to Covid 19"...."of the 130,468 deaths registered by official statistics at the time of preparation of the new report only 3,783 would be due to the power of the virus itself", which is even stricter than our 6% CDC-based number.

A4) Deaths preventable by inoculation

Many studies have been performed modeling the number of COVID-19 deaths prevented by the inoculations. The most conservative of these studies showed that for Sao Paolo, Brazil "almost 170 thousand deaths.....will occur by the end of 2021 for Sao Paulo.....If in contrast, Sao Paulo.....had enough vaccine supply and so started a vaccination campaign in January with the maximum

vaccination rate, compliance and efficacy, they could have averted more than 112 thousand deaths". This ***extremely conservative*** estimate reduces the number of true COVID-19 deaths that required a "vaccine" for prevention to 2/3 x ~280, or ~190!

Thus, the number of true COVID-19 deaths that required a "vaccine" for prevention was about 0.04 percent of the number of COVID-19 deaths reported by the CDC! Except for A4, the first three issues (A1-A3) were known in 2020, well before the rollout of the mass inoculations. In other words, the benefit possible from mass inoculation was exceedingly small, and did not justify mass inoculation of hundreds of millions of people in the USA with an inadequately tested new technology "vaccine". This small potential benefit almost ensures that any c:b ratio will be relatively large, given even a moderate number of deaths resulting from the inoculation.

b) Number of actual deaths resulting from the mass inoculations

This section focuses on adjusting the numerator of the c:b ratio, the number of inoculation-induced deaths. The ***most conservative*** approach is to use the results of post-inoculation autopsies. "German Chief Pathologist Peter Schirmacher has recently announced that 30 to 40 percent of people he examined not long ago were found to have died from COVID-19 vaccine-related issues.". Multiplying the VAERS reported deaths by 1/3 reduces the official number of post-inoculation deaths for the 65+ demographic from ~2,600 to ~870.

c) Real-World Cost/Benefit Ratios

At this point in the analysis, ***with no scale-up from deaths reported to VAERS***, the actual c:b ratio is ~870/190, or ~4.6. However, many studies have shown that the VAERS deaths are under-reported substantially. The Harvard Pilgrim Health Care tracking study showed "fewer than 1% of vaccine adverse events are reported", similar to some of our results in the TR paper. Jessica Rose showed that the number of deaths is underreported by a factor of 31, and Steve Kirsch showed that the deaths are underreported by a factor of 41. Using the lowest of these estimates (31), the c:b ratio skyrockets to ~143, while the number of deaths is relatively modest at 870 x 31, or ~27,000. The c:b ratio for this case is about ***five orders of magnitude*** above the desired target for a "vaccine" or vaccine-proxy, as was stated at the beginning of this OpEd. Even if some of the selected parameters could be relaxed downwards, it is difficult to see where much more than perhaps an order of magnitude reduction in c:b ratio could be obtained.

While c:b ratios on the order of hundreds have not been shown by previous c:b analyses (especially for the most vulnerable 65+ demographic), and may seem extreme at first glance, they reflect the underlying reality. The only reason they do seem extreme is that the political and biomedical media have framed the narrative that these inoculations are safe and effective, with the implication that their c:b ratios are extremely low. As I have shown above, only a very small cadre of individuals could have benefited potentially from these inoculations. Mass inoculations of hundreds of millions of people in the USA with an unproven technology produced damage that overwhelmed any small potential benefits.

It should be re-emphasized that this ***conservative*** analysis was for the most vulnerable 65+ demographic. As we proceed to lower age demographics, we can expect the c:b ratios to go substantially higher, since deaths of COVID-19-tagged individuals decrease drastically with decreasing age. Also, these numbers reflect very-short-term results only, and the hands-on results of Drs. Hoffe, Cole, and others showing alarming values of Early Warning Indicators do not bode well for increased "vaccine-induced" deaths even in the mid-term, with the attendant increase in c:b ratios.

2. WHAT ARE THE BIOLOGICAL MECHANISMS THAT UNDERLIE THESE HIGH COST/BENEFIT RATIOS?

The results of a realistic cost-benefit analysis should reflect the underlying technical performance of the technology being evaluated. What are the features of the inoculant being analyzed that account for its extraordinary high c:b ratios?

First, there are at least three types of toxicities associated with the inoculant. The spike protein resulting from the inoculant is extremely toxic, as shown in detail in the TR paper. The LNP encapsulating shell has some extremely toxic components, such as polyethylene glycol, to which many people are sensitive (also as shown in the TR paper) and cationic lipids. The desired product of the inoculations, anti-spike protein antibodies, can react with tissues and cause myriad types of damage.

Second, it evades the immune system in two ways. It is injected, thereby entering the bloodstream directly and indirectly, and by-passing that part of the innate immune system that inhaled viruses encounter initially. The LNP-encapsulating shell, which provides mRNA stability, was developed initially for drug delivery and similar applications, where the target is to deliver drugs to any tissue or

organ in the body. In this case, increased time spent in the circulatory system is the goal. For the present application, long residence time in the circulatory system means that the vascular damage and clotting associated with the spike protein endocytic merging with the endothelial cells can occur throughout the body. This impact is seen in the types of damage listed in VAERS, and in post-inoculation autopsies. Third, while it boosts the antibody titers for a few months, it affects the immune system adversely.

Are there any positive benefits from the inoculations? Obviously, increasing antibody titers against the relevant viral strain will offer some protection before waning immunity commences. For some elderly who are concerned with short-term survival there could be benefits. The inoculation also reduces the severity of symptoms for some people. Because appropriate treatments were withheld from numerous patients, the inoculations saved lives that would have been saved had the proper treatments been administered. But the benefits under the condition that appropriate treatments were administered were small relative to the adverse effects from mass inoculation.

3. HOW DO THESE RESULTS FIT WITHIN THE LARGER PICTURE OF GLOBAL MASS INOCULATIONS AND MANDATES?

The following appears to be the larger picture encompassing the details presented above. In December 2019, a viral outbreak appeared to occur initially in Wuhan, China. There is not consensus on its origins, but it appears the virus was engineered in a lab and released either deliberately or accidentally. It also appears that the outbreak transitioned rapidly into a pandemic. In order for the latter to occur, at least two conditions were required: rapid growth of infections globally, and substantial numbers of deaths from the infection.

A PCR test conducted at high Ct values giving very high numbers of false positives satisfied the rapid growth of infections requirement. COVID-19-tagged patients denied appropriate treatments and given ineffective treatments satisfied the requirement of substantial numbers of deaths from the infection. According to Drs. Zelenko and Ardis, and many others who developed successful treatment protocols for COVID-19-tagged patients, most of the COVID-19-tagged patients could have been saved had the protocols been applied early. Most people who were COVID-19-tagged and died had their deaths attributed to COVID-19. The withholding of appropriate treatments had a double benefit to enforce pandemic measures; it also meant that an EUA could be issued for a "vaccine", since no alternative treatments were available.

After a few short months of clinical trials, the EUA was granted, and mass inoculations were started in mid-December 2020, about one year after the outbreak occurred. This meant that the inoculants were developed and tested within one year, a process that ordinarily takes 12-15 years. As shown in the TR paper, the clinical trials were questionable, and no long-term testing was done.

The mass inoculations in the USA have been ongoing for about ten months, and almost 200 million people have been fully vaccinated. VAERS reports a fraction of the very-near-term adverse effects, but actual scaled-up numbers are mainly estimated. While the elderly, especially with comorbidities, seem to experience the most deaths, children who previously showed no signs of illness are experiencing large numbers of serious effects such as myocarditis. Early warning indicators, such as high D-dimer and troponin levels after inoculation, are an ominous sign of future problems. Steve Kirsch has summarized many of these demonstrated and future adverse effects in an excellent slide presentation.

Dr. Ryan Cole, CEO of a large independent diagnostics lab in Idaho, states in many videos that he has been seeing a twenty-fold increase in uterine cancer since inoculations began. Dr. Byram Bridle states the following cancer prediction succinctly: "What I have seen way too much of and it does cause me very serious concern is that we are seeing people who had cancers that were in remission or that were being well controlled and their cancers have gone completely out of control after getting the vaccine. We do know that the vaccine causes at least a temporary drop in T-Cell numbers. T-Cells are part of our immune system and they are the critical weapons that our immune system has to fight off cancer cells." Numerous doctors are starting to report anecdotes of increased cancer, although these effects have not yet been documented in the biomedical literature.

Studies from the UK and Sweden, among many others, seem to indicate that the second mRNA dose confers immunity for about six months, after which a booster is required to maintain immunity. This could mean that boosters would be required every six months (or sooner) indefinitely, and each booster would be accompanied by adverse effects (such as the micro-clotting that Dr. Hoffe has reported in his patients). If these effects are cumulative and irreversible, that would spell disaster for those on the endless treadmill of booster—short-term immunity—waning immunity—possible negative effectiveness—booster.....

Beneficiaries from the lockdowns, restrictions, and mass inoculations appear to be 1) the governments worldwide who increased control over their people and implemented vaccine passports to different degrees; 2) the companies who manufacture the inoculants and drugs that will be

needed to address the many adverse health effects resulting from the inoculations and boosters; and 3) the organizations who specialize in online and remote business operations, such as the Big Tech companies. Whether any of these beneficiaries played a major role in the events remains to be seen (and decided in courts of law).

It is unclear why the five major stakeholders (healthcare industry, government at all levels, mainstream media, medical profession, academia) involved in promoting the restrictions and mass inoculations are reading from the same sheet of music. While the government is "captured" by industry and does its bidding, and the other three stakeholders are effectively "captured" by industry (and its proxy the government) because of the funding they receive from industry and government, it is unclear why all these stakeholders would have the same attitude when it comes to harming segments of the American population through e.g., mass inoculation with unproven safety.

In particular, why would the Presidents of Universities and Principals of secondary schools, who have "in loco parentis" responsibilities for the students in their charge, be willing to sacrifice the health of their students just to maintain their research funding or salaries? These "leaders" know full well that their charges are not at risk from COVID-19, but are at substantial risks from the demonstrated adverse effects of the inoculants, and potential future adverse effects. Yet, except for a few isolated instances, there is no action taken to refuse these mandates and protect their charges; rather, action is taken to double-down on the mandates!

The five major stakeholders' actions to inoculate the full population of the USA in particular have resulted/are resulting/will result in physically, economically, strategically destroying the USA as a sovereign power and world leader. They are producing a populace that is becoming physically addicted to the inoculations and requisite boosters, and is becoming more subservient to a government that mandates these inoculations as a condition to access all that a civilized society has to offer. By the end of 2021, all those who operate the critical USA infrastructure (e.g., police, firefighters, military, healthcare professionals, teachers, pilots, etc.) will have been inoculated by mandate, and the non-compliers will be terminated from their jobs. If our projections of future adverse effects are correct, those who have been inoculated will be at higher risk for damage, and when the symptoms emerge after a lag period, the USA will be functionally paralyzed.

In stark contrast, our research group has been producing monographs and journal papers showing that severe reactions to the viral exposure are the result of a dysfunctional immune system, that this dysfunction is mainly caused by exposure to toxic stimuli and adoption of toxic behaviors, and these

severe reactions can be prevented by identifying and removing these toxic contributing factors as broadly, deeply, and rapidly as possible. One bonus of the latter is that many of the comorbidities that accompany COVID-19 serious effects will be eliminated as well.

In summary, the COVID-19 inoculations are not justified from any cost-benefit perspective. The potential benefits are too small to justify mass inoculations with their demonstrated large numbers of very-short-term adverse effects, and potential ADE, autoimmune, neurological, cancer, etc. adverse effects in the mid-and long-terms. The above holds true even for the most vulnerable (elderly with many comorbidities) and is especially true for the least vulnerable from COVID-19, the children who may have to bear the brunt of adverse effects potentially for the rest of their lives.

If those at high/medium risk from COVID-19 want to take the inoculation, that should be a decision between them and their doctor. It should not be mandated, and restrictions should be lifted immediately.

Related

Serious Group of Scientists Declare COVID-19 Vaccine Risks Too High to Ignore

Side Effects and More: COVID-19 Vaccines Unlikely Cause of Reported Deaths

Scottish Government Shares Links of Deaths to Vaccine But Probability Still Extremely Low: Vaccines Safe While TrialSite Opens Investigation

Taiwan Temporarily Stops Administration of Second Dose Pfizer-BioNTech Vaccine in 12 to 17-year-old Cohort to Evaluate Safety Situation

Explore Further