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## BMJ INTERVIEW

# “We weren’t that great at treating flu—it should not be our model for covid”: America’s covid-19 tsar speaks

Former US covid-19 response coordinator Ashish Jha tells *The BMJ* about antivirals, long covid, his worries for the winter season—and why the “partisanisation” of vaccination worries him

Mun-Keat Looi

Taking office in November 2021, US President Joe Biden was immediately confronted by the chaotic nature of his country’s reaction to covid-19. One of his first actions was to appoint a “covid-19 tsar”—someone who would oversee the response in a joined up manner, from testing and surveillance to access to vaccines and treatments to on-the-ground responses from doctors.

Jeff Zients was first appointed and when he moved to become Biden’s chief of staff the president chose Ashish Jha, a long time public health expert and one of the loudest voices during the pandemic, to fill the role.

Jha was in the post for 15 months, until the duties were absorbed into other parts of government. His tenure saw the US exit the state of emergency for covid-19 and face an mpox epidemic that has affected over 30 000 Americans to date, as well as the crucial organisation of medium and long term plans for the US to continue living with covid.

### Biography

Ashish K Jha is dean of the Brown School of public health and previously professor of global health at Harvard TH Chan School of Public Health.

Jha received his MD from Harvard Medical School and then trained in internal medicine at the University of California, San Francisco. He completed his general medicine fellowship at Brigham & Women’s Hospital at Harvard Medical School and received his masters from Harvard TH Chan School of Public Health.

In March 2022, Jha was appointed White House covid-19 response coordinator by President Joe Biden, a position he held until June 2023.

### What was it like being US covid-19 coordinator?

“I didn’t really know what the job would entail. People can have misconceptions about what the White House can and cannot do. They often describe [the role] as a ‘tsar’—I think of tsars as having immense amounts of power, and this was not a job that came with a whole lot of power.

“People think that you can just make things happen. But in our form of government in the US, Congress has a lot to say about what will and will not get done. They can certainly decide what’s going to get funded and what’s not. Then you have our courts, which are also independent. And there are policies put in by the administration that the court basically blocked.

So it’s not like you’re at the head of government and all the branches are aligned. Not at all. So much is about navigating and then figuring out where you can really drive policy, and how you drive it in a way that brings a lot of people along.”

### Do you have any regrets?

“It’s obviously very political in every country, but covid-19 has become strangely partisan in the US. The ‘partisanisation’ of vaccines, for instance, was very harmful—what began as partisan views of covid vaccines I worried would spill over into partisan views of every other vaccine. One of my goals has been to try to de-partisanise or make vaccines and treatments much more bipartisan, something that didn’t feel like it had a political angle to it. And while I certainly tried—doing a lot of work in the background, meeting with groups, meeting with political leaders from across the political spectrum, for instance—I don’t feel like I made as much progress as I wanted. I have real regrets about that because if vaccines become something that gets tied to political identity, that’s very harmful for public health. And I worry a lot about that for our country.”

**Video 1** [If vaccines become something that gets tied to political identity, that’s very harmful for public health.](#)

### What’s your view on the covid vaccine situation now?

“I think it’s reasonable to think about covid vaccines the way we think about flu vaccines. Obviously, the virus, SARS-CoV-2, is evolving much more rapidly than flu and it’s not quite as seasonal as flu. But the new XBB variant targeted monovalent vaccine that’s now available clearly gives a big bump in antibodies that helps reduce infections for a period. That’s not a very long lasting protection and it’s not perfect protection, but it does reduce your risk of getting infected. And for a lot of people—particularly people at high risk—avoiding infection is a really good idea. If you’re 75 and have chronic lung disease, getting vaccinated may make the difference between life and death.

“Does a 20 year old need an annual booster? My view is no. But are they better off getting it? I believe they are, because if you get vaccinated, you’re going to have a period of time when you’re less likely to be infected. That’s good. You’re less likely to disrupt your work, you’re going to have lower levels of

transmission even if you do get infected, you're less likely to get long covid.

**Video 2** Does a 20 year old need an annual booster? My view is no. But are they better off getting it? I believe they are.

“For me, the critical thing is that people over 65, people over 70, people over 60, really, really need to get that vaccine because those are people who are going to benefit in a much more meaningful way.”

### What about treatments? Are we putting too much stock in antivirals?

“As a physician, whenever I ask myself if I should prescribe treatment X, I have two sets of questions. One is, what do I understand about this disease where I think this treatment should be helpful? What's the clinical evidence? And then what are the costs of these treatments? And I don't just mean a financial cost, there are also side effects—what's the harm of giving somebody a treatment?”

“So let's take a look at antivirals for covid. These tend to be short courses, 5-10 days, there are some drug-drug interactions, which are very manageable. But no one I know says that these drugs are incredibly toxic and somehow will cause long term damage. They will not. We have a lot of experience with drugs like this. We use them for long periods of time for people with HIV and literally tens of millions of people around the world, certainly many millions of people in the US. And we have good evidence that they're a very safe drug for people to take for a short period of time.

“What's the benefit? Well, we have some really good clinical data and some decent clinical data. I remember [former CDC director] Antony Fauci<sup>1</sup> saying to me, ‘If you have an antiretroviral that's effective, why would you not use it? The less virus you have the less likely it is to do damage.’

“Now we can talk about whether it's financially worth it. How strong is the clinical data? It is good but not great. We have some randomised trial data, but a lot of observational data. I put the whole package together and I think some of the observational data suggest it might reduce risk of long covid. There's a theoretical basis for that.

“The data are not overwhelming, but if you start with deep scepticism of treatments then, yes, you may not be persuaded. I look at it as a risk-benefit and I think the risk of using antivirals is relatively low and I think the benefit is clear for some people and likely for a lot more. And that's why I tend to lean towards doing it, because the risk of these treatments is so incredibly low because they're short courses.

“There are other things that are in the works: phase 3 trials of oral antivirals are happening. And other treatments outside of antivirals. One of the treatments that was used early in the pandemic, before they stopped working, was monoclonal antibodies.<sup>2</sup> I have pushed for more investment in developing monoclonals. For two reasons—firstly there is a proportion of people who just can't get oral antivirals and for them it remains an important option. More broadly, our national ability to build monoclonals against viruses is a really important capability against future viruses and against future pandemics.”

### What about long covid?

“There are several factors underlying covid that we need to separate.

“Firstly, there is clearly a percentage of the population that is suffering from long covid. And what they need is two sets of things. One, they need a system that is supportive of their challenges: we need to make sure that our disability systems and our healthcare systems are designed to take care of those people. Two, they need research for new therapeutics and new approaches to treating covid and long covid. That part we've made some progress with, but it's not gone as fast as we need to.

“But there is a second wider matter: what is the risk of developing long covid today? If you do not have long covid right now, if you feel well and then you go out and you get covid tomorrow, what is the risk that you can develop long covid? And how do we minimise that risk?”

“I often talk about how I think the risk of long covid now is relatively low and people say you're minimising the experience of people who have long covid. No, no, no, no. Those are separate things. There are people with long covid—we have got to take care of them. But the risk of developing new long covid at this moment is reasonably low and we've got to figure out how to continue to drive that risk lower.”

### Covid testing and surveillance has been dropped in many countries since the acute phase of the pandemic passed. What level do we need today?

“There are three sets of things that I wanted to disentangle. Firstly, there is passive surveillance through things like wastewater surveillance, which I feel reasonably good about because it doesn't require behaviour change, it doesn't require any kind of new investment. It's a steady state investment that lets us track covid and that's where we've used it. But I would like it to be expanded to other types of infections.

“Secondly, there is the question of testing surveillance of a population through regular mass sampling—sending kits to people's homes, getting them to swab and send it back—the kind of things that the UK did that the US actually never did. I think there's a lot of value in that, because while wastewater surveillance tells you at a community level how much infection there is, it doesn't tell you anything about who's getting infected, who's not, who's being most affected. Having a baseline level of surveillance that lets you understand which communities, which populations, is valuable. And my sense is most countries are pulling back from that and not doing that.

“That gets us to the third part, which is just general availability of testing for people who have respiratory symptoms. There are a lot of people who say, well, why even bother? What's the point, we never used to test for flu before. Well, for one thing, we have treatments. So if you get flu, especially if you're a high risk, you can get treated for it if you get tested early. Certainly that is true for covid. So there is a good reason to test. Another thing is if you have the flu and you have symptoms, you should probably stay home for a bit. We could talk about how long, but even if you just stayed home during your most symptomatic period, it would dramatically reduce the amount of spread that happens in a population.”

### An often repeated phrase is treating covid “like the flu” but globally hundreds of thousands of people die of the flu each year. Should we accept that level of mortality—for flu or covid?

“We weren't that great at treating flu. I don't think that should be our model. We have a lot of flu—in the US some 10% of the population gets infected with flu every year, 30 000-40 000 people

die every year. Now, that number is hard for people to wrap their brains around. I remind people that 30 000-40 000 deaths means 30 000-40 000 families that will not have a grandparent around. Why do we think that's okay, especially when the interventions are things that we can do to dramatically cut that down and are not super expensive?

**Video 3** *We weren't that great at treating flu. I don't think that should be our model.*

“Now often this gets framed as, ‘Well, we didn't lockdown society for flu.’ No one's talking about locking down societies or shutting down schools. That's a very high level thing that you do under very rare circumstances. But making sure that everybody who's at elevated risk is up to date on their vaccines, that feels like something we should invest in. Making treatments widely available—it could be expensive, some of these treatments can be expensive, but for lots of other diseases when we have an effective treatment, we try to make it as available as possible. We should absolutely do that. And we've already talked about testing and making testing more widely available and trying to reduce spread.”

#### Ashish Jha on choosing medicine

“I went into medicine for, in some ways, all the wrong reasons, which is because my parents really wanted me to become a doctor—and I'm now old enough to just admit it.

“I got to medical school very unsure but just fell in love with it. The demystification of disease, of the human body and how it works: I thought it was all super fascinating and then pretty quickly came to realise I love practising, I love taking care of people, I love being a witness to people and in very difficult moments in their lives.

“Sometimes in medicine you can help people get better, sometimes you can't. But even when you can't, you can play a really critical role in helping them navigate difficult moments. And I still practise largely for that privilege.”

**CORRECTION:** On 30 November we corrected Ashish Jha's biography.

Commissioned, not externally peer reviewed.

Competing interests: None.

<sup>1</sup> The BMJ interview: Anthony Fauci on covid-19. *BMJ* 2020;370.

<sup>2</sup> Mahase E. Covid-19: Has the spread of omicron BA.2 made antibody treatments redundant? *BMJ* 2022;377:doi: 10.1136/bmj.o1009 .