

The Economic Effect of the CoVid-19 Lockdown in the United States:

Was the Cure Worse than the Disease?

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Abstract

CoVid-19 is an ongoing global outbreak of coronavirus disease 2019, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern on January 30, 2020; and a pandemic on March 11, 2020.

Several mitigation measures have been used in attempts to limit the spread of the virus, including mandatory wearing of masks in public; bans on unnecessary travel; and the closure of non-essential businesses. This paper defines a lockdown as the closure of non-essential businesses combined with requirements that all citizens stay at home except for grocery shopping, trips to a pharmacy, and medical appointments.

The effectiveness of lockdowns is controversial. Proponents tend to argue that lockdowns would have been more effective if enforcement had been increased and if lockdowns had been extended for a longer period of time. Opponents have argued that lockdowns hurt the economy, hurt children, and have had little positive effect on public health.

The paper addresses the economic effect of CoVid-19 lockdowns in the United States using a Benefit/Cost Analysis (BCA) framework. Two separate analyses are provided: a traditional BCA analysis, which assumes that the value of life is constant regardless of age; and a Preferred Analysis, which adjusts the number of deaths, and values the economic cost of the deaths based on the age of the deceased.

Keywords: Benefit/Cost Analysis, CoVid-19, GDP, Lockdowns, Unemployment

1. INTRODUCTION

On March 11, 2020, the World Health Organization declared CoVid-19 a pandemic.¹ At a media briefing, WHO director-general Dr. Tedros Adhanom Ghebreyesus stated that “This is not just a public health crisis, it is a crisis that will touch every sector.” (Ducharme J. 2020)

The first lockdown in the United States (U.S.) occurred in the territory of Puerto Rico on March 15, 2020. By the time of that first lockdown, only 102 people had died of CoVid-19 in the United States. Lockdowns were fully implemented in most U.S. states by April 7, 2020. The number of deaths rose to a total of 167,558 by August 22, 2020. (National Center for Health Statistics 2020)²

This paper performs two Benefit/Cost Analyses in order to estimate whether the economic cost of the lockdowns exceeded the economic benefits. The results indicate that the economic cost of the lockdowns was up to ten times greater than the economic benefits of the lockdowns.

2. HYPOTHESIS

The paper hypothesizes that the economic cost of the lockdowns exceeded the economic benefits. The paper addresses the economic effect of CoVid-19 lockdowns in the United States using a Benefit/Cost Analysis (BCA) framework. Two separate analyses are provided: a traditional BCA analysis, which assumes that the value of life is constant regardless of age; and a Preferred Analysis, which adjusts the number of lives saved, and values the economic cost of the lives saved based on the expected ages of the number of lives saved.

The goal of the lockdowns was to reduce the number of CoVid-19 deaths and to ensure that Intensive Care Unit (ICU) capacity was sufficient to treat patients in critical condition. The paper finds that the lockdowns saved lives, but that the economic cost of the lockdowns was up to ten times greater than the economic benefits of the lockdowns.

3. LITERATURE REVIEW

The literature review explored the eight subjects discussed below. These subject areas were chosen because, taken together, they help explain much of the successes and failures of the economic lockdowns during the period of the study. The eight subjects are:

1. Coronaviruses
2. CoVid-19 Cases and Deaths
3. Health-Care Spending
4. Macroeconomic Effects
5. Stimulus Programs
6. Benefit/Cost Analyses
7. Value of Life
8. Decline in Student Deaths

¹ The WHO defines a pandemic as the global spread of a new disease.

² The National Center for Health Statistics (NCHS) is a division of the Centers for Disease Control and Prevention (CDC), which is a division of the United States Department of Health and Human Services (HHS).

3.1 Coronaviruses

Coronaviruses are a class of ribonucleic acid (RNA) viruses that cause diseases in mammals and birds. In humans and birds, they cause respiratory-tract infections that can range from mild to lethal. Mild coronavirus illnesses in humans include some cases of the common cold (which is also caused by rhinoviruses). More lethal illnesses include Influenza, Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), and CoVid-19. (CDC 2019)

According to the Centers for Disease Control and Prevention (CDC), influenza, commonly called “the flu,” is an infectious disease caused by influenza viruses, which are a subset of coronaviruses. Influenza may progress to pneumonia, which can be caused by the primary viral infection or by a secondary bacterial infection. Other complications of influenza infection include acute respiratory distress syndrome, meningitis, encephalitis, and worsening of pre-existing health problems such as asthma and cardiovascular disease. In healthy individuals, influenza is rarely fatal, but it can be deadly in high-risk groups. (CDC 2019)

Influenza deaths most commonly occur in high-risk groups, including young children, the elderly, and people with chronic health conditions. Since the late 1800s, worldwide outbreaks (pandemics) of novel influenza strains have occurred every 10-40 years. Five flu pandemics have occurred since 1900: the Spanish flu in 1918–1920, which was the most severe flu pandemic; the Asian flu in 1957; the Hong Kong flu in 1968; the Russian flu in 1977; and the 2009 swine flu pandemic. (CDC 2019) Worldwide mortalities were 20-50 million from the Spanish flu; 1.1 million from the Asian flu; 700,000 from the Russian flu; and 284,000 from the swine flu.

There have been 3.3 million deaths worldwide from CoVid-19 since October, 2019.

3.1.1 Cases and Deaths

The CDC has explained that “While seasonal influenza (flu) viruses are detected year-round in the United States, flu viruses are most common during the fall and winter. The exact timing and duration of flu seasons can vary, but influenza activity often begins to increase in October. Most of the time, flu activity peaks between December and February, although activity can last as late as May.” (CDC 2018)

For the period 2010-2011 through 2019-2020, annual estimates of death from influenza in the United States have ranged from a low of 12,000 in 2011-2012 to a high of 61,000 in 2017-2018. In the last full influenza season (2018-2019) before the pandemic, 34,157 people died of influenza. (CDC 2021a) For the period January 4, 2020 through May 1, 2021, 493,985 people died of pneumonia; 276,282 people died of CoVid-19 and pneumonia; and 9,273 people died of influenza. (CDC 2021b) Thus, deaths from influenza declined by 24,884 ($34,157 - 9,273 = 24,884$), or 4.40% of the total number of official CoVid-19 deaths.

The paper assumes that the change in official influenza deaths indicates that at least 24,884 influenza deaths were misclassified as CoVid-19. Therefore, I have reduced the number of lives saved by 4.40% in the Preferred Analysis.

At the date of this writing, CoVid-19 cases from 2020-2021 have exhibited the same seasonal pattern as the historic data of influenza in the United States. On March 7, 2021, the CoVid Tracking Project (2021) found that the seven-day average of CoVid-19 cases peaked on January 13, 2021 at 244,551 cases. The number of cases declined to 54,762 on March 7, 2021. (CoVid Tracking Project 2021) This suggests that CoVid-19 is a seasonal virus.

In an interview with NPR, Chris Murray of IHME said: “When you look at the huge [CoVid-19] epidemics that unfolded in Argentina … in Chile … in Southern Brazil, South Africa, and … the Northern hemisphere, . . . — . . . in the statistical analysis, we see a very strong correlation with seasonality.” (Aizenman N. 2020)

The CDC has reported that weekly provisional death counts for patients with CoVid-19 rose from zero on January 4, 2020 to a high of 24,942 on January 9, 2021, and then fell to a low of 1,729 on May 1, 2021. The CDC has noted that: “COVID-19 death counts shown here may differ from other published sources, as data currently are lagged by an average of 1–2 weeks.” (CDC 2021b)

Science, Public Health Policy and the Law published a paper which found that “Data from the CDC shows that only 6% of 161,392 COVID fatalities had no mention of any comorbidity. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death.” (Ealy H. et. al. 2020)

On March 24, 2020, the CDC changed the guidelines for how cause of death from CoVid-19 is recorded and reported. The new reporting guidelines substantially increased the number of deaths from CoVid-19. (Ealy H. et. al. 2020, p. 2)

Accurate reporting of deaths from CoVid-19 is dependent upon test reliability. S. Lee (2020) examined the reliability of the PCR (polymerase chain reaction) test for detecting CoVid-19 infection. (A PCR test is performed to detect genetic material from a specific organism, such as a virus or a bacterium.) Dr. Lee evaluated 20 test results from the Connecticut State Department of Health using a nested PCR amplification method. Dr. Lee found that the standard PCR test produced a false positive of 30% and a false negative of 20%.

Although Lee’s study does not contain enough observations to definitively find that PCR test kits produce biased results, it does suggest that the number of CoVid-19 cases (and therefore deaths) might have been overestimated by 10%. As mentioned previously, influenza deaths declined by 24,946 (over 4% of official CoVid-19 deaths). The decline in influenza deaths adds credibility to Lee’s finding that CoVid-19 deaths might have been overcounted by 10%.

As of April 14, 2021, a total of 563,440 individuals have died from CoVid-19 in the United States. (Yahoo News 2021) The CDC has reported that 4,270,407 people have died from all causes during the same period. (CDC 2021b) Thus, over 13% of U.S. deaths during that period were caused by CoVid-19.

The Associated Press has reported that: (Marchione M. 2021)

Life expectancy in the United States dropped a staggering one year during the first half of 2020 as the coronavirus pandemic caused its first wave of deaths, health officials are reporting.

Minorities suffered the biggest impact, with Black Americans losing nearly three years and Hispanics, nearly two years, according to preliminary estimates [on February 11, 2021] from the Centers for Disease Control and Prevention.

The number of CoVid-19 deaths was affected by the fact that the virus was not taken seriously by government or public opinion leaders early enough after its discovery. Government officials and public opinion leaders underestimated the extent of the virus and how long it would take to get the virus under control.

For example, from February 2, 2020 until March 2, 2020, New York state public health officials, U.S. House of Representatives speaker Nancy Pelosi, and New York City mayor Bill DeBlasio urged citizens to participate in large public events despite knowledge of the CoVid-19 pandemic.

On March 16, 2020, Forbes Magazine reported: (Kelleher S. 2020)

In a news conference today, President Trump announced more aggressive guidelines to blunt the spread of coronavirus, including avoiding all discretionary travel, shopping trips and social visits.

Asked how long he anticipated it would take to get the coronavirus pandemic under control, President Trump said, “They think August, it could be July, it could be longer than that.”

“It isn’t that these guidelines are going to be in effect until July,” clarified Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases. “What the President was saying is that the trajectory of the outbreak may go until then. We’re not saying the guidelines will be solid in stone until July.”

On March 23, 2020, the Los Angeles Times reported that: (Mozingo J. 2020)

Michael Levitt, a Nobel laureate and Stanford biophysicist, began analyzing the number of COVID-19 cases worldwide in January and correctly calculated that China would get through the worst of its coronavirus outbreak long before many health experts had predicted. Now he foresees a similar outcome in the United States and the rest of the world.

While many epidemiologists are warning of months, or even years, of massive social disruption and millions of deaths, Levitt says the data simply don’t support such a dire scenario — especially in areas where reasonable social distancing measures are in place. “What we need is to control the panic,” he said. In the grand scheme, “we’re going to be fine.”

3.2 *Forecasts of CoVid-19 Deaths*

On June 15, 2020, Reuters reported that “A new forecast projects 201,129 deaths due to COVID-19 in the United States through the beginning of October mainly due to reopening measures under way, the Institute for Health Metrics and Evaluation (IHME) at the University of Washington said on Monday.” (Reuters 2020)

On June 21, 2020, ABC News Australia reported that “The US Centers for Disease Control (CDC) has released a forecast suggesting there will be between 129,000 and 145,000 total COVID-19 deaths in the US by July 11 [2020].” (ABC News Australia 2020)

In September 2020, the University of Washington's Institute for Health Metrics and Evaluation (IHME), headed by Chris Murray, forecast that 410,000 people would die of CoVid-19 by January 1, 2021. Ashish Jha, dean of Brown University's School of Public Health, said that IHME's forecast is highly implausible — particularly when it comes to the projected 410,000 death toll in the U.S. by Jan. 1. "I think that's completely unrealistic. I see no basis for that," says Jha. (Aizenman N. 2020) The CDC reported that 389,371 people had died with CoVid-19 by January 1, 2021. (CDC 2021b)

The September 2019 IHME forecast was much more optimistic than their forecast released in March 2021. In the March forecast, the IHME predicted that 598,521 Americans would die of CoVid-19 by July 1, 2021. IHME also forecast that 655,566 people would die if the mobility of the U.S. population returns to 2019 levels. (McIntyre D. 2021)

On April 21, 2021, the CDC reported the CoVid-19 death forecasts of 36 modelers for the period April 19 to May 15, 2021. The average estimate of the models was that total deaths would rise to 595,522 by May 15, 2021. (CDC 2021c)

Table 1 compares the four mortality forecasts discussed above to the actual number of deaths in the time period predicted by the studies. The forecasts constitute a trend analysis in which the biggest driver of forecasted deaths is the number of deaths at the time the forecast was released.

Table 1: CoVid-19 Mortality Forecasts

Source	Forecast Date	Ending Time Period	Mortality Forecast	Actual Deaths	Forecast Error (%)
IHME	June 2020	October 1, 2020	201,129	210,190	4.51%
CDC	June 2020	July 11, 2020	145,000	137,049	5.80%
IHME	September 2020	January 1, 2021	410,000	389,371	5.30%
CDC	April 2021	May 15, 2021	595,522	570,003*	4.29%*

* As of May 8, 2021

3.3 Lockdowns

On March 15, 2020, Puerto Rico governor Wanda Vázquez Garced signed an executive order ordering all citizens to stay at home starting at 9:00 p.m., with exceptions in limited circumstances between 5:00 a.m. and 9:00 p.m. Governmental operations and non-essential businesses were to be closed until March 30, 2020. On March 16, 2020, U.S. President Trump recommended that residents avoid discretionary travel, shopping trips, and social visits. (Kelleher S. 2020)

On March 19, 2020, California governor Gavin Newsom issued a statewide lockdown order. By April 7, 2020, 43 of the 50 U.S. states had issued lockdown orders. The lockdown orders ("stay-at-home orders") affected approximately 320 million people, about 96% of all U.S. residents.

Stay-at-home orders in the United States were issued by most states, some Native American tribes, and a large number of local jurisdictions. These overlapping orders sometimes led to conflict between different levels of government, and to a patchwork of inconsistent dates and rules. (Bosman J. 2020, Ramsey R. 2020, and Sparber S. 2020)

On March 17, 2020, the first lockdown order from within a state was imposed simultaneously by health authorities in the San Francisco Bay Area (Alameda, Contra Costa, Marin, San Mateo, and Santa Clara counties and the cities of San Francisco and Berkeley), affecting nearly 6.7 million people. (Ravani S. 2020) Other cities and counties across the state followed suit over the next two days, until Gavin Newsom, the governor of California, issued the first statewide order, effective on March 19, 2020. (Wired 2020)

The National Review argued: (Richards J, Briggs W., and Axe D. 2020)

To judge from the evidence, the answer is clear: Mandated lockdowns had little effect on the spread of the coronavirus. The charts below show the daily case curves for the United States as a whole and for thirteen U.S. states. As in almost every country, we consistently see a steep climb as the virus spreads, followed by a transition (marked by the gray circles) to a flatter curve. At some point, the curves always slope downward, though this wasn't obvious for all states until the summer.

3.4 Health Care Spending

Business Economics reported that “The HSEI [Health Sector Economic Indicators] spending brief data provide an initial look at health care spending during the COVID-19 pandemic. They show that the year-over-year change in national health spending began to decline in March of 2020, fell to more than 20% below the previous year’s level in April, and then began to recover. By August 2020, health spending had regained essentially all its losses compared with August 2019.” (Rhyam C., Turner A., and Miller G. 2020)

While health care spending was falling, the price of health care was rising. The St. Louis Federal Reserve Board (FRED) has reported that the health care price index rose by 3.4% from August, 2019 to August, 2020. (FRED 2021a)

The paper did not include health care spending losses in its cost calculations because these losses are subsumed in the loss of nominal Gross Domestic Product (GDP) described in Section 4.3 below.

3.5 Macroeconomic Effects

The official unemployment rate (U-3) as reported by the Bureau of Labor Statistics (BLS) rose from 3.5% in February, 2020 to a high of 14.8% in April, 2020 and then fell to 6.1% in April, 2021. (FRED 2021b) Cohen has found that 1.1 million workers had been misclassified by the BLS. Cohen adjusted the official unemployment rate and found that accounting for the misclassification “yields an adjusted unemployment rate of 9.1% in August [2020], which is meaningfully lower than 11.0% reading in July [2020] and a peak of 19.5% in April [2020].” (Cohen G.D. 2020)

Moutray found that “And, while the unemployment rate peaked at 14.7% in April [2020], the reality was even starker, with the “real” unemployment rate—which adds in those “marginally attached to the labor force and those employed part time for economic reasons”—at 22.8% that month.” (Moutray C. 2020)

3.6 Stimulus Programs

The United States Congress passed three separate stimulus bills: the CARES Act, the Consolidated Appropriations Act 2021, and the American Rescue Plan Act. Additionally, California Governor Gavin Newsom signed the Golden State Stimulus bill. These four bills are described below.

3.6.1 The CARES Act

The CARES Act was a \$2.2 trillion economic stimulus bill signed into law by President Donald Trump on March 27, 2020. The bill included \$300 billion in one-time cash payments to individuals and dependent children, \$260 billion in increased unemployment benefits, \$350 billion (later increased to \$669 billion) in funding for the Paycheck Protection Program that provided forgivable loans to small businesses for payroll expenses, \$500 billion in loans for corporations, and \$339.8 billion to state and local governments. (Snell K. 2020)

Some of the benefits (such as federal unemployment and the eviction moratorium) of the CARES Act expired in July 2020. As a result, the number of Americans living in poverty increased dramatically. On October 15, 2020, the New York Times reported that “The number of poor people has grown by 8 million since May, according to researchers at Columbia University, after falling by 4 million at the pandemic’s start as a result of a \$2 trillion emergency package known as the Cares Act.” (DeParle J. 2020)

Yahoo News reported that “Without the additional \$600 per week under the CARES Act — which expired at the end of July — local consumer spending will drop by an estimated 44%, according to a new paper from the National Bureau of Economic Research that examined how the cut in benefits will affect spending in 18 counties in Illinois.” (Tsekova D. 2020)

3.6.2 The Consolidated Appropriations Act 2021

The Consolidated Appropriations Act 2021 (CAA) was a \$2.3 trillion spending bill that combines \$900 billion in stimulus relief with a \$1.4 trillion omnibus spending bill for the 2021 federal fiscal year. The bill was signed into law by President Trump on December 27, 2020, thereby preventing a government shutdown. (Taylor A. 2020)

According to the Congressional Budget Office (CBO), the CAA provided \$325 billion for small businesses; \$15 billion for economically endangered live venues, movie theaters, and museums; \$166 billion for stimulus checks to individuals; \$120 billion for an extension of federal unemployment benefits; \$82 billion for public schools and universities; \$69 billion for vaccines, testing, and health providers; \$25 billion to state and local governments for rental assistance programs; \$13 billion to increase the monthly Supplemental Nutrition Assistance Program (SNAP/food stamp) benefit by 15%; \$13 billion in direct payments to the farming and ranching industries; \$60 million for small meat and poultry processors; \$10 billion for child care, \$10 billion for the U.S. Postal Service; and an extension of the CDC’s eviction moratorium. (CBO 2020a and CBO 2020b)

3.6.3 The American Rescue Plan Act of 2021

The American Rescue Plan Act of 2021 (ARPA) was a \$1.9 trillion economic stimulus bill signed into law by President Biden on March 11, 2021. ARPA provided extended federal unemployment benefits, \$1,400 direct payments to individuals, emergency paid leave for over 100 million Americans, a tax credit to employers who offer paid sick leave and paid family leave benefits, extended food stamp benefits, expanded the child tax credit, expanded the earned income tax credit, made forgiven student loan debt tax-free, grants to small businesses, \$350 billion to state, local, and tribal governments, \$130 billion for K-12 schools, \$40 billion for public colleges and universities, \$48.8 billion for housing assistance, \$164.3 billion for healthcare programs and services, \$86 billion to pension funds that are close to insolvency, \$55.5 billion for transportation, \$10.4 billion for agricultural programs and services, and \$1.85 billion for cybersecurity funding. (Zhou L. and Stewart E. 2021)

ARPA also subsidized 100% of premiums for Consolidated Omnibus Budget Reconciliation Act (COBRA)³ recipients from April 1, 2021 to September 30, 2021, removed the income limit on premium subsidies for the ACA, increased subsidies to low-income individuals, protected Affordable Care Act (ACA) subsidy recipients from clawbacks due to income fluctuations in 2020, required private insurance companies to cover CoVid-19 vaccines and treatment, allowed states to give 12 months of postpartum coverage for new mothers, and provided new incentives for states to expand Medicaid coverage. (Keith. K. 2021)

3.6.4 Golden State Stimulus Bill

The Valley Post has reported that “Governor Gavin Newsom signed the \$9.6 billion “Golden State Stimulus” bill into law Tuesday, [February 23, 2021] which includes a \$600 check for low-income Californians.” (Miller D. 2021) The bill provides a \$1,200 direct payment to up to 5.7 million tax return filers, and a \$600 payment to individuals who receive an earned income tax credit.

3.7 Benefit/Cost Analyses

Benefit/Cost Analysis, also known as Cost/Benefit Analysis, is commonly used in the development of public policy, such as the choice of whether to build a new highway or to impose environmental restrictions in a transportation corridor.

3.7.1 Value of Life

In public policy, the most important assumption in a Benefit/Cost Analysis is the value of life chosen by the analyst. In the case of CoVid-19 lockdowns, a high value of life will tend to increase aggregate benefits and show that lockdowns were a good policy. A lower value of life will do the opposite.

³ For individuals who experience a job loss or other qualifying event, COBRA provides the option to continue their current health insurance coverage for a limited amount of time. Employers outside the federal government with more than 20 employees are required to offer COBRA coverage to those who qualify.

Sumner et. al have pointed out that “Most of the publicized cost-benefit analyses of COVID-19 lockdowns have used coarse measures like lives as units rather than life-years, which misleads politicians and the public. COVID-19 deaths disproportionately impact the oldest members of the population, whereas the economic impacts of lockdowns disproportionately harm the youngest of the working population, who have far greater life expectancies at the time of impact.” (Sumner A., Jackson J., and Cage J. 2020)

Sumner et. al. conducted a study commissioned by Revolver News and found that CoVid-19 lockdowns are ten times more deadly than the actual COVID-19 virus in terms of years of life lost by American citizens. This paper uses a modified form of the analytical method used by Sumner et. al. (See Section 6 below) An earlier study commissioned by Just Facts found that the lockdowns caused a loss of seven times more years of life than were saved by the lockdowns. (Miller A. 2020)

Forbes Magazine has published an article by Chris Conover of The Apothecary Group. Conover provides a listing of the Value of Life (VOL) used by different researchers. The fixed-rate VOL ranges from \$5 million by Aldy and Viscucchi to \$10 million by Alex Nowrasteh of the Cato Institute. (Conover C. 2020) I use the average value of these studies (\$7.8 million) in my Traditional Analysis given in Section 5 below.

3.7.2 Benefit/Cost Analyses

Anna Scherbina of the American Enterprise Institute estimated “a lockdown would be indeed optimal and, depending on the assumptions, it should last between two and four weeks and will generate a net benefit of up to \$1.2 trillion.” Scherbina employs a Quality-of-Life Year (QALY) method and assumes a value of \$150,000/QALY. She estimates that a maximum of 406,000 lives would be saved. Thus, she implicitly assumes an average of 39.6 QALYs/person. (Scherbina A. 2021)

Broughel and Kotrous found that the benefits of CoVid suppression policies would be from \$605.9 billion to \$841.1 billion and the costs would range from \$214.2 billion to \$331.5 billion. (Broughel J. and Kotrous M. 2021, p. 156) Broughel and Kotrous’ study is for the period March 1 - August 1, 2020. 160,766 people died of CoVid-19 during the time period of their study, which is about 30% of total CoVid-19 deaths for the period January 1, 2020 to May 8, 2021. They assume 1.04 million lives saved and \$351.5 billion in benefits, which is an average value of life of \$337,980.77/person. Their work implies a Benefit/Cost (B/C) ratio of from 2.52 to 2.83, which indicates that lockdown policies had significant net benefits.

Dr. Ari Joffe used a Wellbeing Years (WELLBY) analysis and found that the costs of lockdowns were 5.2 times greater than the benefits of lockdowns in the United States. On average, Joffe assumes a VOL of \$500,000 per life. (Joffe A. 2020, Table 8)

Hanson R. (2020) estimates that 3% of CoVid-19 cases result in a loss of income for three weeks for those with severe cases. On October 12, 2020, Dr. David Cutler and Dr. Lawrence Summers published their estimate of the effects of lockdowns. They estimated that lockdowns would result in mental health impairment costs of \$1.581 trillion. (Cutler D. and Summers L. 2020, Table)

Dr. Allen, an economics professor at Simon Fraser University in Canada, states:
(Allen D. 2021)

The term “lockdown” is used to generically refer to state actions that imposed various forms of non-pharmaceutical interventions. That is, the term will be used to include mandatory state-enforced closing of non-essential business, education, recreation, and spiritual facilities; mask and social distancing orders; stay-in-place orders; and restrictions on private social gatherings.

I adopt Dr. Allen’s definition of the term “lockdown.”

Dr. Allen reviewed over 80 different academic studies and related Covid-19 data sites. He found that “All estimates of costs and benefits depend on various assumptions of parameters and structural model forms, and many of the studies examined (especially the early ones) relied on assumptions that were false, and which tended to over-estimate the benefits and under-estimate the costs of lockdown.” (Allen D. 2021)

Allen issued a report and provided an alternative Cost/Benefit methodology. (Allen D. 2021, Section III) I adopt some of his suggestions in my Preferred Analysis given below.

3.8 School Shootings

The vast majority of schools were closed in 2020 due to CoVid-19. This resulted in a decline in the number of student deaths in school shootings. In 2019, eight students were killed and 43 were injured in 25 shooting incidents that occurred on school grounds or during school-sponsored events, according to Education Week’s school shooting tracker. (Education Week 2020) The paper includes the decline in student deaths as a Benefit in both the Traditional and the Preferred Analyses.

4. METHODOLOGY

The paper calculates a B/C ratio using the following steps for the Traditional Model:

1. Econometrically estimate the time lag between infection and death.
2. Sum the benefits of the lockdowns and the cost of the lockdowns.
3. Divide the lockdown benefits by the lockdown costs and calculate a B/C ratio.
4. If the B/C ratio is greater than 1, then the lockdown was an optimal public policy.

The paper calculates a Benefit/Cost ratio using the following additional steps for the Preferred Model:

1. Calculates an economic value of life (EVOL) for each age group.
2. Sums the individual EVOLs and includes these values as benefits in lives saved; and costs in lives lost due to suicides and to the unavailability of medical treatment for other illnesses such as heart attacks, cancer, and strokes.
3. Estimates the costs of losses in GDP due to the lockdowns.
4. Performs a sensitivity analysis incorporating the findings of S. Lee. (2020) and D. Cutler and L. Simons. (2020) and reports the modified B/C ratio.

I discuss each of these steps below.

4.1 Time Lag Regression

In order to estimate a B/C ratio, more information is required. It is necessary to estimate the time lag between CoVid-19 infection and death from CoVid-19. For example, CoVid-19 deaths rose from 58 in the last week before the lockdown (week ending March 14, 2020) to 24,942 in the week ending on January 9, 2021. Some individuals who died after the lockdown began had CoVid-19 before the lockdown. If the study did not account for the time lag between infections and deaths, one might intuitively reason that the lockdowns caused additional deaths from CoVid-19. The paper estimates that the maximum lag between infection and death is two weeks and uses a two-week time lag in estimating the number of lives saved by the lockdowns.

The following methodology was used to estimate the time period between infection and death. Weekly data was collected from the CDC on CoVid-19 infections and deaths for the period January 19, 2020 through May 1, 2021.

A regression equation was performed on infections and deaths, and coefficients were estimated using a first order Auto Regressive Moving Average (ARMA) regression model for the variables mentioned above.

The regression equation⁴ is $D = \alpha + \beta_1 C + \beta_2 C(-1) + \beta_3 C(-2) + \beta_4 C(-3) + \beta_5 A + \beta_6 M$

where:

A is an AR(1) term.

C is the number of infections at time t

C(-1), C(-2), and C(-3) are the number of cases at time t-1, t-2, and t-3, respectively.

D is the number of deaths in a given week.

M is an MA(1) term.

α is the constant term.

β_1, \dots, β_6 are the estimated coefficients.

The regression output is given below.

⁴ The AR(1) and MA(1) terms are used to adjust for serially correlated residuals.

Dependent Variable: DEATHS
 Method: ARMA Maximum Likelihood (OPG - BHHH)
 Date: 05/04/21 Time: 04:22
 Sample: 4 66
 Included observations: 63
 Convergence achieved after 22 iterations
 Coefficient covariance computed using outer product of gradients

Variable	Coefficient	Std. Error	t-Statistic	Prob.
C	-367.3282	5839.264	-0.062907	0.9501
CASES	0.005191	0.001617	3.209260	0.0022
CASES(-1)	0.004927	0.001942	2.536575	0.0141
CASES(-2)	0.004052	0.002650	1.529123	0.1320
CASES(-3)	0.002345	0.001756	1.335314	0.1873
AR(1)	0.927199	0.053703	17.26520	0.0000
MA(1)	0.792760	0.120098	6.600917	0.0000
SIGMASQ	718352.2	79940.09	8.986132	0.0000
R-squared	0.984676	Mean dependent var	8878.540	
Adjusted R-squared	0.982725	S.D. dependent var	6901.649	
S.E. of regression	907.1052	Akaike info criterion	16.64094	
Sum squared resid	45256190	Schwarz criterion	16.91309	
Log likelihood	-516.1897	Hannan-Quinn criter.	16.74798	
F-statistic	504.8674	Durbin-Watson stat	1.244990	
Prob(F-statistic)	0.000000			

The model results show that only the number of cases in the current week and the number of cases in a previous week had a significant effect on the number of CoVid-19 deaths. Because the paper uses weekly data, an infection could have occurred at any time during a previous week. Thus, a maximum lag of two weeks is used in calculating a B/C ratio.

4.2 Number of Lives Saved

It is not possible to accurately estimate the number of lives saved by the lockdowns because we do not know how people would have reacted to ever-increasing CoVid-19 cases and deaths. People could have decreased deaths by locking themselves down, or they could have increased deaths by moving from one state to another in an attempt to escape the virus. D. Allen. (2021) has pointed out that “Goolsbee, A., and C. Syverson (June 2020), using cellular phone location records, find that voluntary ‘self-lockdown’ explains most of the enormous change in behavior in the spring, and that they do not find evidence of large temporal or spatial shifting in response to shelter-in-place policies (p. 12).”

Nevertheless, lives saved is too important a factor to be ignored in the analysis. As explained below, the paper uses the estimate for lives saved calculated by Yakusheva et. al. Yakusheva et. al. estimated that the 2020 CoVid-19-mitigating public health measures “will save between 913,762 and 2,046,322 lives in the US; however, the economic downturn from shelter-in-place measures and other restrictions on economic activity could create an indirect collateral loss of 84,000 to 514,800 lives over the following years.” (Yakusheva O., van den Broek-Atenburg E., Brekke G., and Atherly A. 2020)

There is a two-week lag between cases and deaths, and lockdowns were not fully implemented until April 7, 2021. Thus, the mortality savings associated with the lockdown orders would not have become evident until the week ending April 18, 2020. The growth in CoVid-19 mortality rates is given in Table 2 below.

Table 2: CoVid-19 Mortality Growth Rates by Week

Week Ending	CoVid-19 Deaths	Weekly Mortality Growth Rate
February 22, 2020	5	N/A
February 29, 2020	9	80%
March 7, 2020	37	311.11%
March 14, 2020	57	54.05%
March 21, 2020	577	912.28%
March 28, 2020	3,186	452.17%
April 4, 2020	10,096	216.89%
April 11, 2020	16,270	61.15%
April 18, 2020	17,136	5.32%
Average	5,264	261.62%

As shown in Table 2, the weekly mortality rate had declined from 912.28% in the week ending March 21, 2020 to 5.32% in the week ending April 18, 2020. It is reasonable to assume that the death rate would have continued to decline in the following weeks.

The Traditional Analysis adopts the high estimate of lives saved (2,046,322) and the high estimate of “indirect collateral losses” (514,800) in the “following years” as estimated by Yakusheva et. al. (Yakusheva O., van den Broek-Atenburg E., Brekke G., and Atherly A. 2020) Their estimate is reasonable given the weekly mortality growth rates calculated above.

If we assume that the weekly mortality growth rate would decline to 3.4% for the weeks after April 18, 2020, a total of 2,544,634 persons would have died of CoVid-19 during this time period. This would constitute a mortality reduction of 2,032,659 over the time period given above, or 13,643 less than the estimate of Yakusheva et. al.

4.3 Nominal GDP Losses

The paper calculates the effect on GDP by subtracting the expected change in nominal GDP from the actual change in nominal GDP for the period 2020 Q2 to 2021 Q1. The first quarter of 2020 is omitted from the calculation because it occurred prior to the first lockdown. The expected change in GDP is the annual growth rate of GDP for the first three years (2017-2019) that President Trump was in office multiplied by the 2019 Q4 GDP. For example, if the growth rate was 6% and 2019 GDP was \$20 trillion, then expected GDP is $1.06(20) = \$21.2$ trillion.

GDP rose from \$19.03258 trillion in 2016 to \$21.74739 trillion in 2019, an annual growth rate of 4.54%. Thus, expected GDP for the period 2020 Q2 through 2021 Q1 is $1.0454(21.74739) = \$22.734726$ trillion. The nominal GDP in 2021 Q1 was \$22.048894 trillion, for a loss of slightly over \$685 billion (\$685,831,687,600).

4.4 Traffic Fatalities

Traffic fatalities rose from 36,096 in 2019 to 42,060 in 2020. The National Safety Council has explained that “[this] marks an 8% increase over 2019 in a year where people drove significantly less frequently because of the pandemic. The preliminary estimated rate of death on the roads last year spiked 24% over the previous 12-month period, despite miles driven dropping 13.” (National Safety Council 2021)

For the Traditional Analysis, the paper calculates the increase in traffic fatalities as a cost of 5,964 lives multiplied by \$7.8 million per life for a total cost of \$46.5192 billion. For the Preferred Analysis, the paper multiplies the increase in traffic fatalities by \$12.55 million for a total cost of \$74.85 billion.

4.5 Stimulus Programs

A total of \$6.4 trillion was spent on stimulus programs by federal and state governments.⁵ Of this amount, \$122.4 billion was spent on non-lockdown related programs. Thus, the cost of the lockdown-related portion of the stimulus programs was \$6,177.6 billion.

4.6 Value of Life

4.6.1 Traditional Analysis

For the Traditional Analysis, the total VOL is the number of lives saved multiplied by each person’s value of life. Thus, the lives saved benefit in the Traditional Analysis is \$7.8 million multiplied by $2,046,322 = \$15,961,311,600$ (approximately \$16 trillion).

4.6.2 Preferred Analysis

The Preferred Analysis uses an Economic Value of Life (EVOL). CDC data was available for the following age groups: under 1 year, 1-4 years, 5-14 years, 15-24 years, 18-29 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49 years, 50-54 years, 55-64 years, 65-74 years, 75-84 years, and 85 years and over. Because life expectancy is dependent on the age of the person, the paper uses a different life expectancy for each age group.

⁵ California is the only state that used its own funds to provide an economic stimulus to its residents.

EVOL was calculated using an average of the age of each group. For example, the group of 30-34-year-olds was calculated using an age of 32. The formula for calculation of the EVOL is $EVOL = (Life\ Expectancy - Age)(Economic\ Value)$. Economic Value is calculated as the sum of GDP/Per Capita for each year of expected life. Expected GDP and GDP Per Capita are updated for each year of expected life.

Let us suppose that a 75-year-old died of CoVid-19 whose life expectancy was 85 years. That person's EVOL would be calculated by the formula $(GDP\ Per\ Capita)_t + (Expected\ GDP\ Per\ Capita)_{t+1} + (Expected\ GDP\ Per\ Capita)_{t+2} + \dots + (Expected\ GDP\ Per\ Capita)_{t+10}$. The EVOL for different age groups is given in Table 5 below.

5. TRADITIONAL ANALYSIS

The Traditional Analysis yields a B/C ratio of 1.28. As shown in Table 3, there were approximately \$16 trillion in benefits and \$12.5 trillion in costs. Sensitivity Analyses (see Table 4) are used to show the effect on the B/C ratio if different assumptions are used. The B/C ratios in the Sensitivity Analysis range from 0.57 to 1.64. The paper notes that three out of four sensitivities yield a B/C ratio of less than 1.00.

Table 3: Benefit/Cost Analysis Using a VOL of \$7.8 million/person.

Item	Benefit (\$ billion)	Cost (\$ billion)
Lives Saved (assumes 2,046,322 lives)	15,961.3	
GDP Loss		685.8
Cost of Federal Stimulus Programs		6,177.6
Cost of California Stimulus Program		9.6
Mental Health Impairment Costs		1,581
Increase in Traffic Fatalities		46.5
Lives lost from economic restrictions		4,015.4
Decline in student shootings	.0624	
Total	15,961.4	12,515.9

Table 4: Sensitivity Analyses Using Different Assumptions

Item	Total Benefits (\$ billion)	Total Costs (\$ billion)	Benefit/Cost Ratio
Sensitivity 1: Assumes the low estimate of lives saved	7,127.3	12,515.9	0.57
Sensitivity 2: Assumes the mean estimate of lives saved (1,023,618).	7,984.2	12,515.9	0.64
Sensitivity 3: Assumes a value of life of \$5 million/person and the high-cost estimate for lives saved.	10,231.6	12,515.9	0.82
Sensitivity 4: Assumes a value of life of \$10 million/person and the high-cost estimate for lives saved.	20,463.2	12,515.9	1.64
Average Sensitivity	11,451.6	12,515.9	0.92

6. PREFERRED ANALYSIS

The Preferred Analysis yields a B/C ratio of 0.22. As shown in Table 3, there were approximately \$2.7 trillion in benefits and \$12.5 trillion in costs. Sensitivity Analyses (see Table 7) are used to show the effect on the B/C ratio if different assumptions are used. The B/C ratios in the Sensitivity Analysis range from 0.10 to 0.19. The results indicate that the cost of the lockdowns was up to ten times higher than the benefits of the lockdowns.

The Preferred Analysis uses an Economic Value of Life based on the estimated ages of the deceased (See Section 4.5.2). The Preferred Analysis uses the following assumptions.

1. Annual GDP per capita will increase at a rate of 3.01% per annum, which is the average annual increase in GDP per capita for the period 2011 Q1 to 2021 Q1.
2. The percent of lives saved in each age group will be identical to the percent of CoVid-19 deaths in each age group.
3. The remaining life expectancy for each age group will be identical to the 2018 life expectancy as published by the National Vital Statistic Reports of the CDC. (Arias E. and Xu J. 2020)
4. The average age of students killed in 2019 was from 5-14 years at an EVOL of \$15,969,563.09/student.
5. An EVOL of \$12.55 million/fatality was used to value the increase in traffic fatalities.

The economic value of life for each age group is given in Table 5.

Table 5: The Economic Value of Life Assuming 1,955,465 Lives Saved

Age Group	EVOL/ Person (\$)	Lives Saved	Age Group EVOL (\$ million)
Under 1 year	24,507,719	233	5,710.30
1-4 years	19,498,632	122	2,378.83
5-14 years	15,959,563	345	5,506.05
15-17 years	12,552,921	282	3,539.92
18-24 years	10,901,237	2,702	29,455.14
25-29 years	8,763,573	4,697	41,162.50
30-34 years	7,250,894	8,527	61,828.38
35-39 years	6,192,284	12,939	80,121.96
40-44 years	5,033,954	21,265	107,047.05
45-49 years	4,035,254	36,864	148,755.62
50-54 years	3,336,338	58,828	196,270.14
55-64 years	2,431,779	241,981	588.44
65-74 years	1,450,787	432,902	628.05
75-84 years	853,578	540,569	461.42
85 years and over	592,537	593,209	351.50
Total (\$ billion)			2,711.19

As shown in Table 5, EVOL decreases as a person ages. The reason is that older people have fewer expected years of life remaining than do younger people. The Preferred BCA estimates a total value of lives saved in Table 6 below.

Table 6: Benefit/Cost Analysis Using a Total Value of Lives Saved of \$2,711 billion.

Item	Benefit (\$ billion)	Cost (\$ billion)
Lives Saved	2,711.19	
GDP Loss		685.8
Cost of Federal Stimulus Programs		6,177.6
Cost of California Stimulus Program		9.6
Mental Health Impairment Costs		1,581
Increase in Traffic Fatalities		74.9
Lives lost from economic restrictions		4,015.4
Decline in student shooting fatalities	0.12	
Total	2,711.3	12,544.3

Table 7: Sensitivity Analyses Using Different Assumptions

Item	Total Benefits (\$ billion)	Total Costs (\$ billion)	Benefit/Cost Ratio
Sensitivity 1: Assumes the low estimate of lives saved decreased by 4.44%.	1,220.9	12,544.3	0.10
Sensitivity 2: Assumes the mean estimate of lives saved.	1,966.1	12,544.3	0.16
Sensitivity 3: Reduces the number of lives saved by 10% due to testing errors.	2,440.1	12,544.3	0.19
Average Sensitivity	1,542.4	12,544.3	0.15

7. CONCLUSION

The paper analyzed the economic effect of the CoVid-19-related lockdowns in the United States from March 15, 2020 to May 8, 2021. The author relied heavily on official CDC estimates of CoVid-19 deaths. Additionally, the author reviewed news stories, academic literature, and independent reports for the period January 4, 2020 to May 8, 2021 and makes conclusions concerning the success or failure of the lockdown policies. The paper concludes that:

1. The cost of the lockdowns was up to ten times greater than the benefits of the lockdowns.
2. The economic value of life per person ranges from \$592 thousand to \$24.5 million, depending on the age of the individual.
3. The lockdowns have saved between 913,762 and 2,046,322 lives in the U.S.; however, the economic downturn from shelter-in-place measures and other restrictions on economic activity could create an indirect collateral loss of 84,000 to 514,800 lives in the future.
4. The lockdowns caused a loss of nominal GDP of over \$685 billion.
5. At least 24,884 influenza deaths were misclassified as CoVid-19 deaths.
6. The average mortality rate for CoVid-19 is approximately 1.75%. There is a maximum lag of two weeks between CoVid-19 infection and death.
7. The number of CoVid-19 cases (and therefore deaths) might have been overestimated by 10%.
8. Government officials and public opinion leaders underestimated the extent of the virus' spread and how long it would take to get the virus under control.
9. CoVid-19 is a seasonal virus.

The paper hypothesized that the economic costs of the lockdowns exceeded their economic benefits. This hypothesis is tested empirically by analyzing the effect of the lockdowns using a Benefit/Cost framework. The paper found that the economic cost of the lockdowns exceeded the economic benefits.

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