The Economic Case Against New Mask Mandates

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As soon as the Centers for Disease Control and Prevention (CDC) recommended that vaccinated individuals wear masks indoors in areas of "substantial or high" COVID-19 transmission, you knew the re-introduction of mask mandates in liberal cities was inevitable.

"Progressive" politicians like to "follow the science" put out by the government, after all. So DC Mayor Muriel Bowser ruling that everyone aged over two must wear masks indoors here in Washington, DC was expected. Waiting until after she'd celebrated her birthday and excluding herself from the rules at weddings was more of a surprise.

Other cities and states are now adopting the CDC guidance as law. Los Angeles County reinstated its mask mandate last month. Atlanta and Kansas City, Mo., have reintroduced their own versions, as has San Francisco, and a mandate is under active consideration in Chicago. The CDC and city public health officials remain convinced that government-enforced indoor mask mandates help reduce transmission of COVID-19, and that they are therefore an important tool in curbing the spread of the more highly transmissible delta variant that threatens to rip through the most unvaccinated populations.

Let's presume here that they are right about this: that fact is not sufficient to justify new government mask mandates today. The truth is that the recent context of vaccination availability makes the case for these impositions much weaker on both consequentialist and "rights" grounds than before. And the Delta variant doesn't change that.

The *economic* rationale for *any* COVID-19 government mitigation measures stems from the idea of "externalities." Ordinarily, we engage in activities that affect us personally, implicitly weighing up the risks and benefits of our own actions. Yet sometimes our activities impose costs on third parties for which it is difficult to appropriately compensate them.

As I noted in my book, *Economics In One Virus,* the virus that causes COVID-19 is a thorny and pervasive externality problem. Absent regular, accurate testing, we do not know who is

infectious and who is not, and presymptomatic and asymptomatic spread make it easy to impose infection costs on others unknowingly when going about our day-to-day lives.

Me entering a store not only brings elevated infection risks to other shoppers, but raises risks to other third parties not present at the time, such as my family and work colleagues. The “external costs” or “externalities” of such shopping or socializing ultimately manifest themselves through the elevated risk to other people of suffering the requirement to quarantine, or else symptomatic disease, hospitalization, and, for the most unfortunate, death.

Now when it comes to things like colds, we accept such externalities as part-and-parcel of normal life. We, in effect, entrench a “right” to normality through an absence of a policy intervention, meaning the externality is ignored by governments. But COVID-19 is deadlier than colds, or even flu, for everyone over the age of about ten, and increasingly so as possible get older. For much of last year, there was also uncertainty about other risks associated with infection, and it was believed that an “uncontrolled” spread of COVID-19 risked overwhelming hospital capacity too.

So, given how highly economists’ value avoiding the loss of human life, the costs of ignoring the externality and just letting people adjust to the existence of COVID-19 was thought to be massive — there needed to be some government action beyond a voluntary response to mitigate its effects. Over 611,791 Americans have died of COVID-19 since the pandemic began, *despite* extraordinary amounts of social distancing, both voluntary *and* government mandated. It’s not inconceivable that things could have been a lot worse still without the government measures taken, at least on the COVID-19 front.

Acknowledging a meaningful externality risk like COVID-19, however, doesn’t tell us precisely what to do about it. One of economic Nobel Prize winner Ronald Coase’s famous insights was that all externalities are two-sided. In this case, yes, my entering a store brings additional risks to people I then socialize with at weekends, but them going out and getting close to me at weekends is their choice too. Who should bear the costs associated with this potential transmission risk of the virus isn’t any clearer than considering whether airports or homeowners below a flight path have the “right” to either their activity or quiet time.

Ideally, you’d impose liability for each COVID-risk encounter on those who could avoid it at the lowest cost. The debate around “focused protection,” for example, was really a proxy debate about this — whether it would have been less costly to impose the liability for avoiding risky contact onto vulnerable people themselves, rather than imposing society-wide measures on everyone.

Given the dense interconnectedness of modern society, uncertainty about who was vulnerable, the subsequent difficulties of protecting them in reality, and the perceived benefits of solidarity from collective action, policymakers ultimately decided that society-wide mitigation policies were better here. All of us therefore faced measures being imposed by the state to mitigate the externality risk, including requirements for indoor mask wearing.

The presumptive “right” that underpinned previous mask mandates, then, was essentially that “individuals should have the right to not have you breathing near them unmasked when indoors.” It was a variant of “The right to swing my fist ends where the other man’s nose begins” with droplets or aerosols from your nose or mouth replacing the hand — albeit recognizing that masks reduced, but didn’t *eliminate* the risks of transmission given the virus was airborne.

Now you can disagree at each stage with the assumptions behind this logic, or question the beneficial consequences of mandates. You can argue that the net benefits of a mandate beyond guidance were low. You can claim that a lot of masks don’t work that well, or might bring risk compensation effects, with people then spending more time indoors thinking they are “safe.” But this chain of reasoning, at least, was the most robust *economic* justification for the policy.

One of the crucial insights of my book, however, is that good economic policy is context-dependent. Aside from the delta variant, which can seemingly spread more easily, there’s an obviously huge difference between now and when mask mandates were first introduced: every U.S. adult has had 15 weeks to obtain a high efficacy COVID-19 vaccination, free of charge.

Children 12 years and older, in fact, have been able to get the Pfizer-BioNTech COVID-19 vaccine for weeks too. And we know these vaccines reduce the risk of infection, transmission, hospitalization, and death associated with this virus very significantly, even for the delta variant.

This change of context should have two major effects on thinking about our externality problem. Firstly, as more and more people have been vaccinated, or recovered from COVID-19, the external costs of socializing, shopping, and being around others has fallen substantially.

With 80.1 percent of over-65s having been fully vaccinated nationwide, in fact, the highest cost externalities — the external costs of serious hospitalization or death from social contact — have been slashed dramatically. And this is particularly true in mask-mandated Washington DC — a place where 65 percent of all adults have been vaccinated overall, including 81.4 percent of seniors.

Unfortunately, a panic has developed in the U.S. given the CDC case study of a largescale outbreak in Provincetown, with people emphasizing particularly cases that “breakthrough” vaccines. But data from the UK’s outbreak is more heartening about what’s in store for cities with significant vaccination levels here.

In late June, when their delta wave started taking off, around 60 percent of adult Brits were fully vaccinated. By mid-July, a surge in the virus’s prevalence meant cases topped out not far off the deadly January surge level there (incidentally, they abolished their mask mandate, despite this, at around the same time). And yet, hospitalizations only peaked at just over a fifth of the level of the winter outbreak, while daily deaths are currently at around 6 percent of the level seen back in January.

Yes, it’s clear now that vaccines don’t fully protect you from infection, or fully stop transmission, or even, sadly, the risk of death. What’s more, kids who haven’t had vaccines available to them can still get infected, albeit with similar death risks to flu, and there remains a

smaller number of immunocompromised people who face ongoing risks of serious illness or dying too.

But the British data shows clearly that vaccinations are extremely effective in dampening the strength of the pre-vaccine link between infections and serious cases or death. The obvious implication is that widespread vaccine take-up massively lowers the value of any health benefits resulting from government-imposed measures, such as mask mandates.

In other words, the "benefits" of mask mandates in highly vaccinated areas such as DC have plunged, while the costs are as high or have potentially increased further (both because the imposition of the mandate reduces the perceived benefit of vaccination, potentially deterring further take-up, and because many businesses have engaged in extensive reopening investments that will now be disrupted). Crucially, as more people become vaccinated, the benefit-cost ratio of these mandates falls and the case for them becomes ever weaker.

The obvious retort to this is that, in other areas of the U.S., vaccine take-up has been much lower overall. In Mississippi, just 44 percent of the adult population are fully vaccinated and cases are surging. Does that make mask mandates there more economically justified?

Let's leave aside that 77 percent of seniors (over-65s) are fully vaccinated even in Mississippi, again significantly reducing the value of any health benefits of mandates. There's a second reason in the externality framework that weakens the case for government mask orders today, although it might sit less comfortably with those in the public health world.

As Paul Krugman outlined in his most recent newsletter, the strongest argument for any government measures to mitigate or suppress COVID-19 last year was that vaccines were coming, meaning lives saved now from COVID-19 were potentially deaths averted from it forever. Yet, as stated, vaccines have been freely available now for months for any adult who wants one. In that reality, the "right" re: who should bear the liability for facing the external costs of other's behavior should arguably shift back to our cold/flu normality.

As the vast majority of the population can access something that mitigates their risk of getting and transmitting COVID-19 much more significantly than a mask, it is surely the case that we should now consider the majority of the external costs as "internalized." Each individual now is the "lowest cost avoider" of harm. In non-economic speak: if people still want to roam unvaccinated, they should bear the elevated risk, and not expect others to be coerced into making sacrifices to (primarily) keep them safe.

In other words, after setting aside a period of time to allow people to get the vaccines, we should take the non-vaccinated folks' decision not to be pricked as a willing acceptance to personally front up the infection dangers. Many will self-evidently change their minds if they see delta cases in their area surge. But burdening everyone in a territory with government-enforced mask wearing or even lockdowns again (as Krugman advocates) is unjustifiable when the vast majority of the benefits will go to those actively forgoing the most effective means of alleviating the virus's effects.

Accepting this means acknowledging that this principle may result in more illness and death. In many areas with weak vaccination coverage, hospitalizations are surging. If the public health officials are right, then mask mandates would reduce cases and deaths in these cities. But provided these hospitals are not at risk of having their capacity exceeded, the case for personal vaccine responsibility, and government action instead concentrating on broadening vaccine availability to children while offering resources to protect the immunocompromised, is now much stronger relative to society-wide mandates.

An economic approach to the pandemic made the case for certain government-mandated social distancing and mitigation efforts relatively strong a year ago. With vaccines freely available, those same economic principles bolster the case now for more limited interventions for the most vulnerable groups, while leaving most COVID-19 risk management to individuals. Blanket masking rules that apply to all are now far more difficult to justify on the grounds of "externalities" than before. And the reason for that are the vaccines: our path back to normality.

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