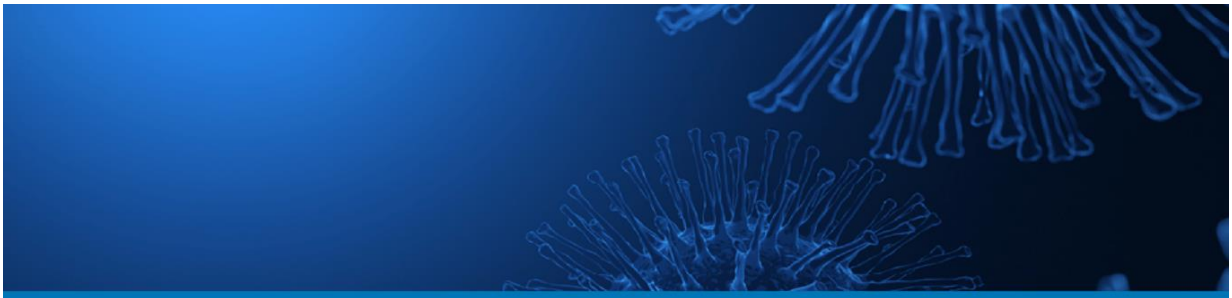

COVID-19
UK Political Analysis

By Tim Hames, Senior Adviser | 17th April 2020

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Road to Re-entry. Why lifting the lockdown in the UK will be harder than elsewhere in Europe.

Fifty years ago today, the crew of Apollo 13 returned to the Earth after an epic rescue mission. An explosion onboard had forced the astronauts to abandon that section of their craft that had been designed to take them back home (the command module) and employ that smaller part which was supposed to land on the Moon (the lunar module) as a lifeboat. Ingenuity and improvisation enabled them to conserve enough oxygen to attempt a re-entry and by swinging the crew behind the back of the moon (in so doing, becoming, as they still are, the three humans to have travelled furthest from Earth), to exploit its gravitational force, hurled themselves back to their planet on less power than a digital watch. The calculations made for the angle at which re-entry could be achieved were made via a slide rule. It remains arguably the most astonishing episode of its kind that has been witnessed.

For NASA then, read COBRA, SAGE and the Cabinet now. The announcement yesterday that the form of lockdown imposed on March 23rd would continue until at least the start of May (and in many key respects probably on until the end of next month) was completely unsurprising. If you are not yet sure that you have passed the peak of the pandemic then lifting the lockdown will only lead to many more infections, hospital admissions and deaths. There is, nonetheless, and despite the best efforts of ministers

and officials, an increasing expectation of an “exit strategy” (or, to put it differently, a “re-entry strategy”). What there is insufficient appreciation of is how difficult this will be to execute.

The issues faced in the UK come in three forms which will be set out in this assessment. They mean that lifting the lockdown is probably even harder today than was thought two weeks ago and noted in an FTI UK Political Analysis on April 3rd which floated a tentative timetable for the restoration of relative social and economic normality. The first set of factors are those faced by every nation that is considering how it can ease restrictions while avoiding a second wave of coronavirus deaths. The second set of factors involve unusual aspects of the UK as a country, as an economy and a society which have a distinct impact on policy options facing our politicians, different from elsewhere in Europe. Two of these features are very unhelpful to devising an effective lifting of the lockdown. The other one works to make matters more manageable. Finally, a few basic conclusions will be flagged.

THE COMMON CHALLENGES.

There are numerous common challenges facing the framing of a re-entry strategy around the world but three are probably the most consequential. They apply largely equally across national borders.

The first is that the most critical single statistic, the reproduction rate, the average number of other people whom a person with coronavirus will typically infect, is hard to estimate with precision and all but impossible to do so in anything close to “real time”. The aim of the suppression measures is to force that reproduction number below one and then secure it below that number until the virus dies out. It is reasonable to assume, and to a degree can be modelled, that the reproduction number is now below one, but how far below one is extremely hard to quantify with absolute confidence.

Yet as it has to be anticipated that even a gradual and a phased re-entry strategy invites the chance of transmissions that would not have occurred if the harder version of the lockdown had continued, scientists have to allow themselves an element of headroom below a reproduction number of one before easing the restrictions at all. They also know that they are dealing with a lagging indicator. It is not the case that SAGE will be in a situation where it can spot a rise in the reproduction number and then have a window of opportunity to introduce new measures to reverse this before there is an impact on infection levels. Instead, what would happen is that the infection levels would increase first, coming through thereafter as an adverse change in the reproduction number, and any action in response would be damage limitation. These complexities are a solid argument for caution in policy.

The second common challenge is that we do not know what the infection rate is with certainty, but it seems to be low compared with the population as a whole. Sir Patrick Vallance, the UK's Chief Scientific Adviser, mused publicly last week that it could still only be in single figures. His thinking is the result of evidence drawn from tests done on those who have volunteered to be part of regular medical clinical trials, the percentage of those who have been tested for the virus who have proved positive (as such individuals are largely those who think they have the symptoms or those who have been in close contact with known victims in the course of their work, the percentage found positive would be expected to be far higher than the national average) and overseas data (notably Iceland).

The passage of time means the infection rate may well be higher as of this moment (10% to 15%) but this is far too low to trigger herd immunity of any consequence. Optimists believe that this low rate is due to a surprisingly high number of infected people not passing the virus on to anyone else and/or an unexpectedly large number of people who have such strong resistance to the virus that it does not take hold in them at any moment. Pessimists conclude that there are an awful lot of people still left who have not had the virus but are capable of contracting it if and when a lockdown is lifted.

The two points above would matter far less if antibody testing, ideally done by oneself in the home, and on a massive scale were available. It would allow us to know who has had the virus in the past, not just right now (antigen testing). The UK put in an order for 17.5 million of these tests from a wide variety of suppliers, contingent on them having a high enough success rate. For the past three weeks now, these tests have been tested and it is reasonable to suppose that silence on the results means the findings have not been as encouraging as was not merely hoped but expected. This could change but even if a suitable anti-body test were found tomorrow, the process of starting the lifting of the lockdown will almost certainly have to take place on the basis of antigen testing (and not antibody testing) which, as outlined in the FTI UK Political Analysis cited earlier, makes the whole process far more complicated and increases the cost in terms of time as those who have tested negative the first time will have to carry on being checked (worse still, they might have had the virus earlier on).

At one stage, the prospect of mass antibody testing emerging swiftly was being hailed, rightly, as a potential “game-changer”. If it does not arrive soon, then, logically, the “game” will not be changed. We may have to skip the antibody test entirely and rely on mitigating drugs before a vaccine comes.

THE UK FACTORS.

Last Sunday, Sir Jeremy Farrar, Director of the Wellcome Trust, stated bluntly that “the UK is likely to be one of the worst, if not the worst, affected country in Europe”. As he is also a member of the Scientific Advisory Group on Emergencies, this was taken, in some quarters, as an implicit criticism of the government to which he offers counsel. It was not. It was a statement of demographic fact. It will be a considerable achievement (or extraordinary fortune) if the UK is not at the top of the grim European table for the overall number of deaths recorded. It will probably not have that status in terms of the proportionate death rate (other than micro-states, Belgium is destined for that tally).

To appreciate this involves analysing the two very large forces which make the UK open to a far higher reproduction number than elsewhere (and hence more transmission of infection) and countering this with another national feature which is of sizeable assistance. These are critical to devising policy. They will also make lifting the lockdown (bar antibody tests suddenly arriving at the scene on a huge scale) extremely complicated and much more challenging than in other nations.

A deep, dense and distinctive population distribution.

If you include Russia up to the Urals, then the UK is the eleventh largest country in Europe by size but the third largest in terms of population (after Russia and Germany). It is also comparatively flat, has few very wide rivers that are hard to bridge or cross and a mild climate which makes travel a feasible option in the vast majority of places the vast majority of the time. It has hence seen a larger amount of internal geographical mobility than its continental neighbours for literally many centuries.

It has, in short, a high population density. There are but three countries in Europe that have a higher one (Belgium, Malta and The Netherlands) and they all have much smaller overall populations. There are only five countries in the world with a higher population and a higher population density and all of them are in Asia (Bangladesh, India, Japan, The Philippines and Vietnam). The overall population density for the UK is 279 people per square kilometre. The equivalent figures for France, Germany, Italy, Spain and Poland are 119, 234, 206, 91 and 124. This, though, understates the matter because Scotland (at 84 people per square kilometre) is quite sparsely populated. If you take England (53% of the land mass of the UK, but 84% of the population), the number is 424 people per square kilometre. In Greater London it is 5,590 per square kilometre. In the borough of Islington (from which I write), it is about 16,000 people per square kilometre. If that were the norm globally then one could fit the whole of the world's population (all 7.8 billion) in Spain and leave the rest of the planet deserted. I should look on the bright side. The population density of Dhaka is three times higher than Islington.

We are also very urban. Using an international index that starts with small towns and then moves upwards some 91.1% of us live in an urban setting. That is the highest in the G8 and there are only two countries in Europe with a bigger proportion (Belgium and Malta). There are (as a percentage) more people who live rurally in Australia (despite its landscape) than the UK. This is starker still when it comes to the bigger cities. Around 55% of British citizens live in cities of 150,000 people or more. The number is about half that (27%-28%) in Germany, Spain and Poland, smaller still (22%) in Italy and much smaller in France (14%). We pack ourselves together. Coronavirus must love the UK.

To top it off we have London. The third largest city in Europe (after Istanbul and Moscow), it now has an estimated population of 9,125,000, which is almost as many as that of Berlin (3,750,000), Madrid (3,225,000) and Rome (2,140,526) combined. It is more than four times the size of Paris (2,140,000). London dominates the UK in a manner which has no equal in Europe (bar very small countries). It is 7.5 times the size of the second city, Birmingham. By contrast, Paris is just 2.7 times the size of Lyon, Warsaw is 2.3 times the size of Krakow, Berlin, Madrid and Rome are all about double the sizes of Hamburg, Barcelona and Milan respectively. London is larger than the next 18 cities in the UK put together. Across the world, there are only three nations with populations over 50 million people with a wider gap in ratio between their largest city and the next one. These are Ethiopia, Thailand and The Philippines. We have, to use a discarded term, a Third World population distribution. This means that the "natural" reproduction number for this virus is notably higher within the UK than in almost the entirety of continental Europe (bar poor old Belgium) and, therefore, that the risk of transmission is peculiarly acute and the degree of social distancing needed to control the virus is exceptionally robust. There is nothing that any minister or official can do about this demography.

An economic structure that reinforces the challenge.

The British do not do things by halves. We have managed to double down on disease through the economic structure that has evolved over the last fifty years, especially the past thirty years or so.

For a start, we have an extremely high labour participation rate (about 79.5%). This compares with 71.8% in France, 65.6% in Italy, 62% in Germany, 58.7% in Spain and 56.7% in Poland. People who leave the home to go to work come into more contact with people than those who do not do so. This alone has implications for the reproduction number of a virus and hence transmission figures.

We also have an extremely large service sector (more than 80 per cent of all employees, up from 47% in 1950) and a fairly large construction sector (almost 7%), a quite small manufacturing sector (around 9.5%, less than half that of Poland, Germany and Italy and two-thirds of that of France and Spain) and a truly tiny agriculture sector (a shade over 1 per cent). This has a major impact on the means by which the British make their way to their place of employment. Not many people take the train for an hour or hop on to the Central Line to work in a field. They tend to live near that farm.

The same basically holds to a lesser extent for manufacturing and factories. People do not tend to commute for sizeable distances to be on an assembly line. They are more likely to drive in cars and hence not be exposed to many other people in the course of that transit. The service sector is very different. It is entirely typical to travel to work in a service economy by train, bus or underground and less common to walk, cycle or drive. The London factor also plays its part here again. Services now constitute 91 per cent of the employment of all of those who live and work in the capital city. Commuting means more contact with other people, a higher “natural” reproduction number for a virus than in an economy which had a different sort of structure and a larger risk of mass infection.

The saving grace (possibly), age profile.

By now it should be evident that the British have conspired to roll out the red carpet to disease. Indeed, it is a rare year when the rate of flu is not higher here than in other European countries. There is, however, one saving grace which will probably serve to push back on virus fatalities.

The British are comparatively young by European standards (although Europe is an old continent). This is partly because of relatively high immigration over the past three decades. Only 17.7% of our residents are aged 65 and over. This compares with 21.7% in Italy, 21.0% in Germany, 18.5% in Spain and 18.4% in France. Of sizeable European states by population, only Poland is lower (at 15.4%).

So, for the purposes of seeking a strategy to counter the virus we at least start with a smaller share of highly vulnerable individuals. This advantage is compounded by the fact that (unlike in southern Europe), it is comparatively unusual for older people to live on a permanent basis with their younger relatives (and in the current crisis be at risk of catching the virus from them). Nor, in relative terms, do many older people here live in institutions alongside other older people where they might be at severe risk if the virus strikes within that building. The number of care home beds that exist in the UK is strikingly lower in absolute terms that France and Germany and in relative terms is less than that of Italy and Spain. Most older people in the UK live alone or as a couple. The consequence of that, in present circumstances, is that they are comparatively straightforward to isolate because they are (by European norms) somewhat isolated already. This may not reflect very well on us as a society but right now it is a convenience. Realistically, keeping death rates as low as practical has to mean sealing off older and more vulnerable people at least until they can be antibody tested (and released if they have had the virus and recovered) or, as is, alas, very likely, until a vaccine arrives. This might not be a joyous undertaking for the old or the young but in the UK it is a practical option.

CONCLUSION.

Lifting the lockdown is not going to be at all simple anywhere but is more awkward in this country because of the character of our population and our economy than almost anywhere else. Just how significant a counteracting force our age profile and the nature of where our older people live is hard to judge with precision, but it is almost certainly worth something. One early indicator is how much lower the proportion of deaths in care homes is in the UK than in France. It probably helps in this regard that by the standards of a notoriously fragmented sector internationally, the care home market in the UK is the most consolidated in Europe by far with five main players responsible for more than fifty per cent of all beds. This

probably makes securing these sites against the disease somewhat more manageable. If so, then private equity is an unsung hero for its role in doing this.

The core point remains that absent antibody tests at scale, the re-entry strategy in the UK will be long, slow and hard and our media (comfortably the most feral in Europe) will moan a lot about it and take little interest in the social and economic factors that ministers and officials must cope with. As we get closer to the next assessment of the lockdown, editions of the FTI UK Political Analysis will explore what the options are and what is likely to be the approach selected and with what impact.

For now, I will leave you with the sober, perhaps sombre, prediction that any firm which ordinarily employs around 1,000 mostly young people in a service industry in an office in central London is not likely to see them all reassembled there under what was deemed normal conditions this side of July. The re-entry strategy for the UK, especially, will not be an on-off switch but akin to volume control.

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