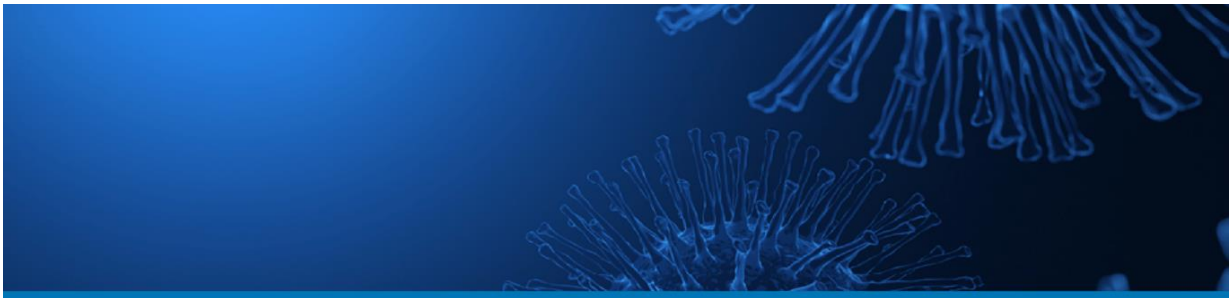

COVID-19
UK Political Analysis

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Lockdown III. Viable timetables, crucial issues and long-term effects.

On the face of it, the third national lockdown in England has much in common in terms of the restrictions that it involves with the first one announced on March 23rd, 2020. Indeed, in some relatively minor regards it is slightly more liberal than the original event, although significantly more of an imposition (not least because of the closure of schools) than the four week set of enhanced national rules brought in for England last November.

In many respects, though, not least psychologically, it is very different. The widespread view last March was that lockdown would be a very strange experience indeed, but one which was highly temporary in nature and would lead in reasonably short order to the restoration of full or very near-full "normality". The inconvenience was softened by that notion and the co-incidence with what would be unusually benign Spring weather. While a vaccine was, at that stage, still obviously some way off, this mattered less because the suppression of the virus through lockdown measures seemed like a strategic end in itself.

None of the above applies in early 2021. No one rational can believe that the latest lockdown will be comparatively short and will end with a swift transition to virtual normality. The inconvenience will be hardened by the likely climate for January and February. The notion that suppression is anything other than a tactic, albeit one with a

sizeable impact, must by now be universally accepted. The vaccination process is the only means to avoid the serious threat of a ceaseless stop-start society and economy.

The key questions now are the credibility of the timetable suggested for the completion of vaccination for the first four (and most vulnerable) sections of the population, other crucial issues to address while this occurs and the longer-term effects of Lockdown III.

EXECUTIVE SUMMARY

- The official target of "offering the vaccine" to everyone in the first four priority categories (over 13 million people) by the middle of February looks extremely challenging. The most awkward issues may not prove to be the numbers of doses manufactured, the apparent shortage of glass vials or the safety checks but more mundane logistical matters relating to the availability of appropriate locations for vaccination, the number of people qualified to conduct vaccinations and the quality of information as to where the individuals sought to vaccinate reside. If the target were to be reached by March 1 that would be a real achievement.
- While lockdown will undoubtedly have a sizeable impact on forthcoming levels of new infections, hospital admissions and fatalies, the effect of the new and much more transmissible variation of the virus will continue to be felt through the end of this month and place massive strain on the NHS. Ambitions for the mass testing programme will have to be scaled back due to other priorities.
- When ministers start to consider easing restrictions they may find it more straightforward to abandon pure regional tiers for an approach based more on spheres of social and economic activity (as was true for May to July last year). Some transitional arrangements relating to social distancing, facemasks and working from home if at all possible are likely to endure for a further period.
- The impact of an additional and extended lockdown on the public finances, the extent to which economic growth in the short and longer-term is sacrificed and on unemployment once official support is phased out (which is destined to be a longer process than presently posited) will be higher than the existing estimates. The Budget that had been scheduled for March 3rd is likely to become an event akin to a "COVID Recovery Spring Plan" with more fundamental decisions about future levels of taxation and borrowing deferred to the Autumn (at the earliest).

- A crucial factor in determining the comparative longer-term effect of the crisis across countries is whether or not the mutated strain of the virus that has so complicated and compounded matters in the UK is replicated elsewhere.

Stung by previous accusations of prevarication in policy, the Government has moved at the earliest practical moment in 2021 to park its preference for operating on the basis of regional tiers once more and resort to a lockdown in England that is closer (but not quite identical) to the one it introduced last March than the lockdown of November. This has required a spectacular reversal of position in terms of keeping schools open, but that was the only means by which the strong upward pressure on the R number which the new variation of the virus creates could be, in part at least, reversed in short order. This in turn will require conventional examinations in England to be abandoned again in 2021.

The probability of a lockdown of both a more demanding nature and longer duration, alongside the revelation of a resurging virus but the prospect of mass vaccination, makes for an especially testing policy cocktail. It also vastly recalibrates personal and business planning for the first half of this year. A number of early observations can be offered.

The mid-February target for vaccinating the key targets looks a very challenging one.

For understandable reasons, ministers, particularly the Prime Minister, want to promote optimism about the future and at not too excessive a distant moment. They also want, for the very best of reasons, to be able to reopen primary schools as soon as they can. They have thus offered a public target, albeit with a few rhetorical caveats, of "offering the vaccine" (a softer commitment than "administering the vaccination") to just over 13 million people situated in the top four priority categories by the middle of February.

Even if this ambition were to be realised, there would be a further delay of two to three weeks while the required level of immunity was reached across this large set of people. It would, though, ensure, assuming the vaccination was as effective as in the trials phase, that 85%-90% of those who would otherwise be thought to be at most danger of death were they to contract COVID-19 would have been vaccinated and be far less likely to die.

That would allow for the first stages of lifting the lockdown to occur, with the restoration of primary schooling before what would have been the end of this term as the priority. The consequence would be that a very cautious lifting process could start in March.

Other decisions to be outlined here later – including the quiet sidelining of some of the notions of mass or "moonshot" testing – will allow ministers to focus on the task in hand. Yet it still looks like a hostage to fortune as a specific target. Much of the commentary to date has related to the vaccine itself, namely the speed at which manufacturing can take place, the apparent global shortage of the glass vials required and the fact that safety checks have to be conducted on each batch that is issued. These factors have indeed meant that while the number of vaccinations conducted to date is very robust by current European standards, it is lower than ministers and senior officials had initially hoped and it has encouraged them to switch approach towards the largest number of initial opening injections with a delay from about three weeks to up to 12 weeks for the second jab.

These are likely to be issues that can be smoothed out before the end of January. What may be the cause of continuing frustration is more mundane. The supply of sufficiently safe and secure vaccination locations is limited. Some 1,000 sites have been identified. To hit the target on time it may be that much more capacity is needed. It is difficult to adapt the typical GP clinic (there are about 6,800 in the UK) or standard pharmacy (some 11,500 in the UK) for vaccination at scale. There are risks with bringing vulnerable people into any hospital setting. Social distancing has to be kept if vaccination centres are not to become vectors for virus transmission. The logistics involved are tricky and troublesome.

There is also the question of the number of qualified people to oversee vaccinations. This has historically been the preserve of GPs, nurses, healthcare assistants and pharmacists, but the supply of them is finite and with the virus still rampant there are other demands on them. The rules were liberalised last year, but bureaucratic blockages are still there. With the best will in the world, this will take more than a few weeks to sort out properly.

Finally, there is an asymetry of information about different categories of priority people. Those who are in care homes, or work there, and frontline NHS staff are comparatively simple to identify and mobilise for vaccination. The NHS has decent records on the 2.2

million people who are considered to be “extremely clinically vulnerable” but has the difficulty that in some cases moving those persons to a vaccination centre will be hard and that will have an unavoidable impact on the speed at which they can be injected.

It is, however, and perhaps ironically, the comparatively old but relatively healthy who may prove to be the headache. The UK is very unusual in Europe in not having a system of national identity cards which include in the public records a date of birth. There is no single national “list” of names, addresses and of age. There is instead a mixture of data (much of it inaccurate or incomplete and invariably decentralised) which includes the electoral register (which has addresses, but not the age of the voter), NHS records (but lots of people do not immediately re-register if they move house), national insurance numbers (some older women do not have them), passports, driving licences etc. This creates a significant complication in attempting to organise mass vaccination quickly.

Putting all the above together, it would be a very great achievement if the first phase of mass vaccination proceeded smoothly and met the current official target. It would also mean other random elements, such as harsh weather, not intervening. If the four priority categories were instead to be reached by March 1 that would also be impressive.

While vaccination is occurring, the NHS has to deal with a clear and present danger.

Planning for mass vaccination in the UK started several months ago and on the basis that the Oxford/AstraZeneca vaccine was the one more likely to be deployed to most people. It was also assumed that it would probably occur in the early part of 2021 and have the health issues associated with the Winter to contend with, notably rising influenza. It was also recognised that there would still be significant levels of COVID-19 circulating.

What was not anticipated was that the virus would have mutated to be more of a threat. This development means that the numbers of new cases, hospital admissions and deaths which are already effectively baked into the system before lockdown has its effect are far higher than any minister, official or adviser could reasonably have expected when they

were considering the blueprint for lifting the second lockdown in England in November. The reproduction number in parts of the country today is far higher than six weeks ago.

The estimates as to how hard the NHS is about to be hit over the rest of this month vary, but they all make for distinctly grim reading. We will be extremely fortunate to avoid a situation in which at least some hospitals in some places have no room for admissions. The Nightingale Hospitals constitute an element of insurance only if they can be staffed. It may be that instead of the original intention for them (that they become overspill and specialist COVID treatment centres), it makes more sense to send non-virus cases there (especially as transmission of the virus within hospitals is still a potential menace). Key medical figures who might otherwise be able to assist with the vaccination campaign will not be able to be spared from the treatment of virus victims and others within hospitals.

Daily new case rates are a useful indicator of a trend but not of precise numbers. A lot of infections are missed because the individuals concerned have no symptoms of the virus, so do not present themselves to be tested for it. The latest stunning ONS survey figures (at 1 in 50 with COVID) offer a clue as to what the peak might look like for the NHS, but it will probably be the data next week that is the better indicator. Those at the top of the Department for Health and Social Care and NHS England are braced for a truly brutal last two weeks of January, not only in terms of the direct deaths from COVID (which could well breach 100,000 in total before the opening vaccination run is over) but possibly tens of thousands more of potentially avoidable deaths from other causes. At best, matters will be as bad as early April 2020. At worst, they will be considerably more traumatic.

The UK will struggle to cope with both conducting a mass vaccination effort at high speed and containing an entirely unexpected tidal wave of new variation virus cases. It cannot fight wars on other fronts. This means that the best use of testing will need rethinking.

Although, in fairness from a very difficult start, testing levels in the UK have increased remarkably, the sort of super-testing witnessed in parts of East Asia does not seem to be possible here (or elsewhere in Europe). Even where it has worked well, the tracing that is needed to follow it up effectively has often been too haphazard. Despite this, at various stages over the past few months, testing has been held up as if a solution in itself. At one

point mass universal or “moonshot” testing was put forward as a means of allowing for a wholesale return to workplaces by early 2021. A few weeks ago, mass testing was to be the method by which areas in Tier Three could put themselves back into Tier Two (with Liverpool highlighted, amid considerable cheering from Downing Street, as a case study). A few days ago, mass testing was to be the device for keeping most English schools open.

Mass testing is likely to become a much more selective tool now and more about the management and measurement of the virus in the next month or so, not its mitigation. For a start, the institution that invariably proved to be the best at organising such tests (the military) is the same one that any logical person would make central to vaccination. Testing will be playing second fiddle to vaccination until the injection drive is done with.

Ministers will face a dilemma when it comes to loosening the lockdown once more.

The public argument as to whether ministers have or have not met their mid-February target (and there surely will be such a dispute) may come down to whether success is measured by the number of vaccinations administered by that date or the numbers that have been booked in (but not necessarily yet delivered) by that moment. Irrespective of whether the first four priority categories have indeed been dealt with in terms of an initial injection by February 15th or, as suggested here, a date more like March 1, there are additional elements to vaccination which have an impact on lifting the lockdown.

The first is that ministers need a high compliance rate (probably at least 70%) of those in the most vulnerable cohorts of the population if the levels of hospital admissions and deaths are to fall back substantially as they should and so ease the pressure on the NHS. If not, then the “light at the end of the tunnel” will fail to be as bright as it should be. The polling evidence is that take-up among these groups will be very substantial but this still has to manifest itself in jabs. There may be a sizeable “mopping up” operation needed.

The second is that although the first wave of vaccinations should have a very big impact on society overall, there will still be a very large number of people (24 million or so) who are in the next five categories of persons for whom vaccination is considered essential.

These include more than eight million people who are aged between 16 and 64 and who have a known health condition of some kind. They are where the remaining set of those most likely to become seriously ill if they contract the virus are concentrated. Lifting the lockdown has to take account of the speed with which these groups can next be injected.

Finally, even before this second wave of initial injections ends, the process of the next injection for those who were closest to the front of the queue will need to begin. It is crucial that this second jab is not somehow forgotten or overlooked as the length of the immunity that a single injection alone lasts is not known but is suspected to be relatively short. The 2021 “vaccination season” is thus destined to be a lengthy one, even more so if the decision is taken that the most effective means of really crushing down on the virus would be to provide vaccinations to all adults. This would add to the effort extensively. It would also entail an unavoidable element of continued social and economic disruption.

When ministers reach the point where they can contemplate lifting the lockdown they will face a policy dilemma. Do they return to the concept of regional tiers which until recently had been held out as an ideal model or, as was the case after the first lockdown, do they engage in a phased reopening through spheres of social and economic activity? The two approaches could be notionally combined by moving the whole of England in stages to Tier Four, then Three and so forth, but allowing a little regional variation at the margins. Some deviation from the old system of tiers does seem highly likely if only to remove the temptation for people to travel out of their own area to others with looser restrictions with adverse implications for the reproduction number. In such a scenario, it is possible to envisage primary schools reopening in advance of what would have been the end of the standard Easter term, with non-essential retail coming on stream in April and the hospitality and indoor leisure sectors the last to return (perhaps not until May). During this transition period, a number of recent features of virus crisis life such as social distancing, the use of facemasks and the edict to work from home if possible will endure.

The impact of a Lockdown III on the public finances and the economy will be immense.

The virus crisis has had institutional as well as individual victims. Her Majesty's Treasury is certainly one of them. Events so far have cost it an enormous, virtually unbelievable, amount of money and knocked the economy sideways. The reality is that that another lockdown of a form similar to that of March to July last year will cost even more. The forecasts on which the Treasury has been operating, largely the work of the Office for Budget Responsibility, set out different predictions for 2021 and beyond based on the effectiveness or not of the vaccination initiative. None of them allowed for the prospect of a second lockdown that would depress growth heavily in Q1 and inhibit it in Q2 too.

The issue is not whether in the short-term the Chancellor can borrow the money. He can. If all else fails the Bank of England can be expected to be very obliging towards his needs. His hand will, nonetheless, be forced in at least three very significant policy regards.

First, the pressure to extend all of the existing schemes which currently have a March or April end date to them will probably be impossible to resist. This includes the business rates holiday, the furlough system and probably the temporary VAT cut and changes to Stamp Duty as well. This means the virus effect on the public finances will last longer.

Second, the Treasury was already prepared for 2021 to be a very unusual year in that it would probably witness, once the current package of support was phased out, both a sharp increase in growth as pent-up consumer expenditure was released and a surge in unemployment as the extent to which certain sectors would never recover from the virus crisis became evident. Lockdown III means that these two (in most ordinary conditions rather contradictory) trends are set to be even more extreme in the later half of 2021.

Finally, the Budget, which has been announced for March 3rd, is far less likely to be the occassion where longer-term questions as to how to restore the public finances start to be addressed. Ministers will still be in the thick of seeking to extract the UK from the virus crisis. It will probably not be the moment to contemplate, for example, the rules around capital gains tax. The March statement is thus more likely to be akin to a "COVID

Spring Recovery Plan" than a classic Budget. Larger strategic thinking about the shape of the public finances is now likely to be deferred to an Autumn Budget (at the earliest).

The rogue element. How wide has and will this mutant strain of virus spread globally?

It might appear a cold, conceivably callous, consideration right now but policymakers will need to ask themselves what the comparative impact of this crisis will prove to be for the UK as a country, economy and society. This has been made more relevant by the arrival of a further and tough national lockdown that is the direct consequence of a new strain of the virus which, at the moment, seems to be far more prevalent here than elsewhere.

As it took the better part of three months for this new variation first to surface in Kent and then become the dominant strain across London, South East and Eastern England, it is probably too soon to tell the extent to which the UK is facing a unique problem or not.

There are, however, three broad possibilities. The first, as asserted by a collection of leading scientific experts before Christmas, is that the mutant virus is already widely established across Europe and largely explains why so many countries are struggling again with the virus and having to reimpose lockdowns of various forms. The UK, due to an unsual academic expertise, was simply the first to spot the new version and the first to have to devise a response to it. The second is that the new strain started in the UK but has moved out via human transmission and will soon become apparent, to varying levels according to international travel patterns, in a large number of nations predominantly in Europe. These countries will therefore face similar difficulties to the UK but later on. The third is that the extent of travel had become so limited by the last quarter of 2020 that any transmission effect will be minor and the new strain will not explode elsewhere and so will not demand a policy response that is more repressive than that for the "old" virus.

This is not comfortable territory to write about. It is still massively important. If the new strain is likely to be the predominant virus force throughout Europe (perhaps beyond) then being "first in and first out" of it, combined with an early and effective vaccination campaign, could put the UK at a comparative advantage when the crisis is over. If the virus emerged here but was then moved abroad in sufficent numbers to have an impact

elsewhere, that suggests a potentially diverse effect and varied policy responses across the continent. If it is a virus strain that exists and spreads in the UK alone, forcing a 2021 lockdown of a length and scale that is not duplicated across Europe where their current lockdowns prove to be enough to suppress the upswing of the original virus, then that is another matter entirely. The impact of the virus crisis overall will ultimately be far harder on the UK in terms of its economy and the public finances. Of all the very many "known unknowns" out there in January 2021, the extent to which the UK is having to respond to a different kind of virus crisis than elsewhere (or not) is probably the most critical one.

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