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CHANGE

Living With Covid Doesn't Mean Ignoring It

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Introduction

Covid-19, the war in Ukraine and the cost-of-living crisis have together created a volatile environment of widespread economic anxiety; people are rightly worried about the future. This, combined with a lack of appetite to bolster investment in our world-class testing and sequencing systems, has seen Covid move from a health to an economic problem.

The government has put in place many of the right measures in its response to Covid, most notably the world-leading vaccination programme that has saved over 100,000 lives. However, over the past two years the overall response to the pandemic has been dogged by a repeated lack of clear, quick strategic planning, and is again in limbo without a comprehensive plan to manage the next phase safely.

Management of Covid now relies largely on repeat vaccinations, while the main tools at our disposal – tests and treatments – are being scaled back. This is a *vaccines-only* rather than *vaccines-plus* approach.

The UK is now managing the virus like other respiratory infections such as the flu, but Covid is not the flu. In the third year of the pandemic – even with effective vaccines – the NHS remains under extreme pressure. There are close to 200,000 NHS staff absences each week and 1.7 million people are suffering from Long Covid. Nearly 20,000 patients are currently in hospital with the virus, resulting in more than 1,000 deaths per week, while A&E waiting times are over four hours and, in some cases, up to 12 hours or more. Covid is less predictable than the flu and spreads at lightning speed – for example, Omicron was reported by South African scientists in November 2021 and within 30 days it had dominated Europe and North America. Within 100 days it was displaced by its BA.2 sub-lineage. The seasonal nature of the virus is not yet understood, and we are unable to predict what variant will be around in just a few weeks' time, let alone far enough ahead to adapt vaccines, something we're accustomed to doing when dealing with different strains of influenza. We also need to acknowledge that flu vaccines have far less uptake than Covid vaccines: in 2021/2022, flu-vaccine uptake was around 54 per cent among those entitled to a jab, while around 79 per cent of eligible people have received at least one Covid vaccine.

Alongside the illnesses and deaths caused by Covid, unencumbered spread will lead directly to an increase in Long Covid – currently growing by 200,000 cases month-on-month in the UK – and a sustained economic contraction. Already, the pandemic is estimated to reduce the size of the economy by 0.6 per cent by 2026/2027, equivalent to around 15 per cent of the long-term impact of Brexit on the economy. While this cannot be wholly attributed to Long Covid, there are 322,000 people currently reporting that their daily activities have been limited “a lot” by Long Covid and this is having a notable impact on people's lives and the economy. In the event of another Covid wave, there are estimates that the economy could contract by around 1 per cent due to long-term sickness and lower productivity as a consequence of a smaller labour force. Currently, it is estimated that around half the population of England has been infected with Covid; if the remaining half were also to be infected it is plausible that a

further 0.25 per cent of the population – 170,000 people – could see their daily activities severely curtailed by Long Covid. People are more likely to get Long Covid than to die from Covid and it is clear that this is not a short-term issue that will go away: its pervasive effects will continue long after Covid has been deemed endemic.

Zero Covid has never been a realistic long-term strategy, especially now that Omicron is the dominant variant. Unmitigated spread is also not a strategy. The government's published "Living With Covid-19" plan has removed almost all testing, undermined access to antiviral treatments and left us one step behind new variants, and asks only the vulnerable to take personal responsibility. The jettisoning of these systems and behaviours hinders our short- and long-term readiness to respond and save lives and livelihoods, but it also makes it slower and more expensive to put these systems back in place in the future. We must plan for prevention and response at the pace of the possible threat, rather than simply aiming to respond more quickly than usual.

We have the tools to do this – vaccines, tests and treatments – and we have refined and invested in them over the past two years. The only realistic way to live with Covid without recurrent disruption to our lives – and to respond to new waves and variants at the speed required – is to apply these tools in targeted and strategic ways. Unfortunately, the Living With Covid plan fails to adequately address this.

There is no easy fix, artificial finishing line or predictable roadmap to this pandemic. Covid is not a passing feature of the health landscape and requires a strategic approach that coordinates the key pillars of the response: vaccines, testing and treatments. These pillars in turn need to be underpinned by sound and sustainable mechanisms for coordination and for risk communication, without which neither responders nor the public can play their part to mitigate the effects of this disease.

It should be clear by now that protecting public health also protects the economy, reinforcing that this is the only responsible path forward as we contemplate the next phase of the pandemic.

Context: Omicron Is Deadly Without Vaccination

Omicron has surged around the world in two separate waves driven by the sub-variants BA.1 and BA.2. These sub-variants have breached the defences of some of the most ardently zero-Covid countries, many of which quickly pivoted to put in place strict but reasonable measures to control the virus. At the same time, many developed countries, including the UK, are embracing the idea that the pandemic is over and removing all measures.

For the vaccinated, it is true that Omicron is relatively mild and generally produces better health outcomes than previous variants. However, it is deadly for the unvaccinated – who face the same risk as in 2020. Because of Omicron’s measles-like transmissibility, it is both able to evade protection of vaccines and efficiently find and infect people. In the UK, there are around 230,000 recorded cases per week and more than 2,000 deaths. In France this number is 532,000 confirmed recorded cases and 900 deaths, and in Germany there are 760,000 recorded cases and 1,200 deaths. In New Zealand, where more than 95 per cent of the elderly population is double or triple vaccinated, there are an average of 58,000 cases and 80 deaths per week, and Australia is experiencing an average of 300,000 cases per week and 219 deaths. Israel – the first country in the world to authorise a fourth dose to everyone aged 60 and over – is seeing an average of 26,000 cases per week, with 40 deaths per week, one of the lowest death-to-cases ratios in the world.

In places with low vaccination rates among the elderly such as China and Hong Kong, there have been spikes in hospitalisations, extended lockdowns, economic stagnation and, in Hong Kong at least, soaring death rates. Just a few weeks ago, Hong Kong was experiencing the highest Covid death rate in the world with 400,000 cases per week and 2,000 deaths. Only 15 per cent of Hong Kong care-home residents are reported to have been vaccinated, while official figures show that for those aged 80 and above, only 58 per cent are double vaccinated.

As Figure 1 shows, without the protection guaranteed by vaccines, Omicron is deadly.

Figure 1 – Daily new confirmed Covid-19 deaths per million people, seven-day rolling average

Source: <https://ourworldindata.org/covid-deaths>

Vaccinations Are Losing Their Effectiveness

Vaccines are an important part of the fight against Covid, but are at their most effective when used alongside other measures. They have been extremely effective against Delta and other variants, cutting severe disease and death by a huge margin and significantly reducing transmission. The arrival of Omicron has rendered the vaccines far less effective at reducing transmission, although in most vaccinated people the vaccines still do their job imperfectly but effectively. However, this protection wanes over time.

Against infection, effectiveness after a third dose ranges from around 60 to 75 per cent, dropping to between 25 and 40 per cent five months after vaccination. Against hospitalisation, effectiveness sits at around 88 per cent two months post-booster. However, further follow-up is needed to evaluate how much protection decreases over longer periods. Against death, in people 50 years and older six months after the second dose, vaccine effectiveness was 59 per cent, while a booster increased this to 95 per cent.

Evidence from Israel on fourth shots of the Pfizer vaccine shows a significant curtailing of deaths in the older population during the Omicron wave. Israelis who received a fourth shot reduced their chances of death by 78 per cent; those who did not receive a fourth shot were five times as likely to die as those who did. Clearly, several deaths were directly averted as a result of the fourth-dose rollout. Immunity after infection also plays an important role: after three vaccines and infection, protection against infection is around 77 per cent. However, this protection – like all protection against Covid – wanes over time.

Vaccination in the UK

Nearly 53 million people – close to 92 per cent of people aged 12 or over – have received a first dose, while 86 per cent have received a second dose, the equivalent of 49.5 million people. A total of 38.8 million people have received a third shot, close to 68 per cent of the population. Additional booster shots are available to people aged 75 and over, as well as people aged 12 and over who have a weakened immune system.

There are 5.5 million people in the UK who remain unvaccinated, almost 3.5 million who have had just one vaccine and nearly 11 million who have had only two. This adds up to nearly 20 million people who are either totally unvaccinated or have less-than-optimum protection. This is especially concerning for the 550,000 unvaccinated over-50s in the UK who, because of their age, are particularly vulnerable.

These data tell us that there are extremely high rates of vaccination in the UK but pockets of highly vulnerable unvaccinated or undervaccinated people at higher risk. Moreover, and despite vaccination

rates, the economic and social disruption that Covid causes is hindering the effective delivery of public services, disrupting social and working life, and exacerbating the economic outlook.

Living With Covid in the UK

The NHS and Our Health System

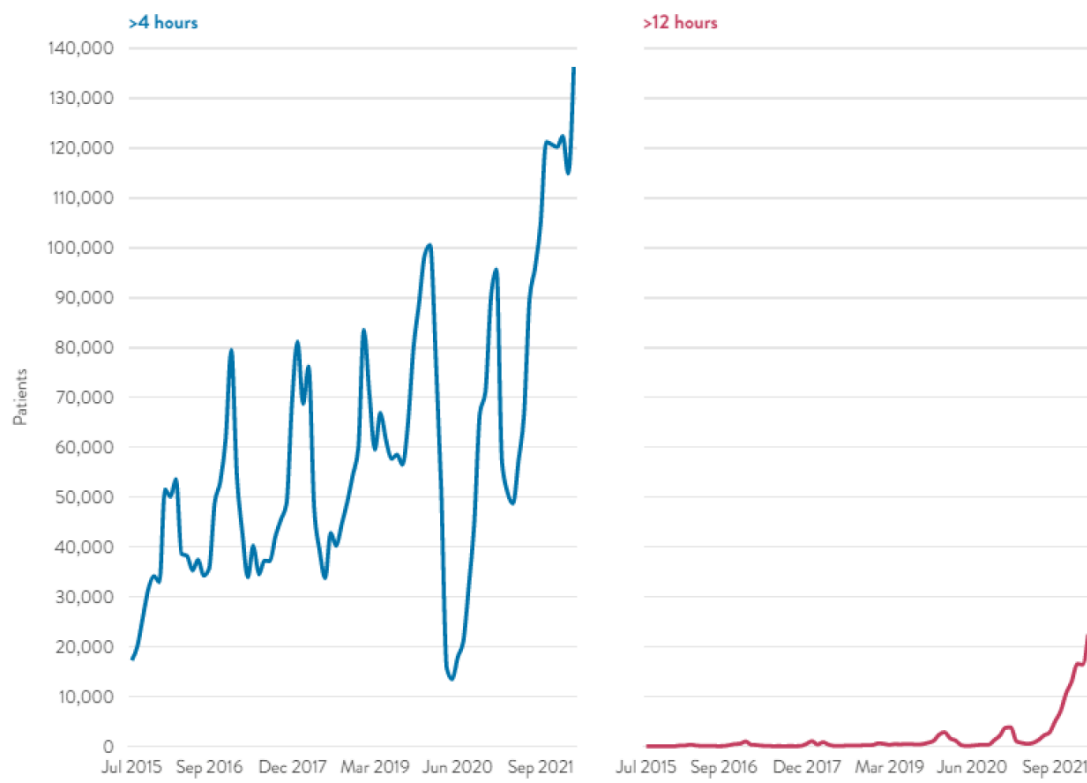
Covid infections are at record levels and while recent experience tells us that we will face another surge of infections in 2022, the truth is we don't know; but we should exercise caution given the history of Covid-19. While we cannot be sure of the virulence or the transmissibility of a new variant, Covid has behaved in such a way that it should be acknowledged that a new variant will have the ability – at some point – to evade protection from vaccines.

It is reasonable to assume, based on this information, that as we learn to live with Covid, millions more people will be infected and many of the 20 million unvaccinated or undervaccinated will face an even higher risk of hospitalisation and possibly death. This will stretch the health system and public services to their limits, regardless of whether people are hospitalised incidentally with Covid rather than because of Covid. Under the government's plan, responsibility will rest with individuals, many of whom are vulnerable and lack the tools they need to protect themselves.

The combined impact of this will continue to push the NHS to the brink, where business-as-usual will mean operating at full capacity and with skeleton staff. Social care and education are also being significantly affected as incidences of Long Covid are higher among teachers and social workers. The NHS plan to tackle the Covid-19 backlog estimates that NHS waiting lists could balloon from 4.4 million before the pandemic up to 14 million. This will result in more deferred surgeries, fewer treatments for deadly diseases, including cancer, and the worst health outcomes in decades. Already, 2.1 million people attended A&E in March 2022 – the highest ever for March, with delays growing on the four-hour target. The backlog in elective care is currently sitting at 6.1 million people in England – the highest since records began. In addition, there is reduced capacity because of staff sickness (200,000 NHS staff absences just this past week), the continued prevalence of Covid and the ongoing need for infection prevention control (IPC) measures. In some cases, 20 per cent of elective theatre capacity was closed due to workforce challenges, including absence. Some of these absences can be directly attributed to Long Covid which around 3 per cent of NHS staff are estimated to have and, even prior to Omicron, NHS staff had lost more than 2 million days due to Long Covid-related absences.

As we can see from Figure 2, A&E departments in England are under huge strain with more and more people waiting more than four hours, and several thousand more than 12 hours, from the decision to admit to actual admission. This is unsustainable in the long term.

Figure 2 – Number of patients waiting more than four hours and more than 12 hours between decision to admit to admission in England’s A&E departments



Source: NHS England

These impacts will be magnified among people living in disadvantaged areas who already experience poorer health outcomes, have far lower vaccination rates than the rest of the population, and who are battling both the Covid pandemic and the cost-of-living crisis.

In addition to the direct impact on the NHS, secondary health impacts such as Long Covid from infection and re-infection will lead to increases in morbidity and mortality. Some countries such as the United States are launching Long Covid action plans, and the UK has invested £19.6 million in 15 projects to examine its causes, trial drugs to tackle it and investigate symptoms. In the European Union, Belgium, France, Germany and Spain are operating specialist Long Covid clinics, but these cater for only a small proportion of the population. The UK is a step ahead of the EU when it comes to funding Long Covid research and addressing it.

As of April 2022, an estimated 1.7 million people (2.4 per cent of the UK population) were experiencing Long Covid symptoms – a month-on-month growth of 200,000 people. Of people with Long Covid, 45 per cent suspected they had been infected at least one year prior. The sheer number of recent infections – and likely future infections – will drive these numbers up even higher.

Vaccination has been shown to reduce the incidence of Long Covid. However, we are seeing that protection from vaccination is waning, and that repeat booster jabs are less effective at “boosting” the immune system with each new dose. In 2022, we will begin to see the real-world implications of this: vaccinated people, who are seemingly protected, will be more susceptible to hospitalisation and death, and we will also likely see a widespread increase in Long Covid cases as protection decreases. We will be less protected as we move into the next phase of the pandemic.

Societal Impacts of Living With Covid

Many of the health impacts of living with Covid may not become apparent for many years, and the impact on society as a whole will also be prolonged. While the lifting of Covid-related restrictions and an attempted return to pre-pandemic ways of living have been welcome in many respects, this is also just one of many “we think it’s all over” moments experienced over the past two years.

Besides the national trauma that we have collectively experienced, Covid’s disruptive nature is now being magnified as this is the first time since the pandemic began that the virus has been allowed to spread without various mitigating measures in place.

We have recently seen [British Airways and EasyJet cancel hundreds of flights](#), affecting more than 20,000 passengers a day. This was directly attributable to staff absence because of Covid infection, and the cost of this will be in the tens of millions of pounds. Impacts on other critical parts of the nation’s infrastructure, such as the NHS, are beginning to play out, with staff absence because of Covid rising for the third consecutive week, accounting for 36.2 per cent of all absences. In some parts of the country, the figure was as high as 48 per cent. This unprecedented level of staff absence adds further pressure to the health service.

In addition, for those organisations that continue to maintain Covid protocols, the question of who bears the cost will surface. Staff absences and regular Covid testing will be costly and are a direct consequence of the policy to simply “live with Covid”. Further, access to disability allowances is [beginning to prove extremely difficult](#) for those suffering from severe Long Covid.

Economic Drag

The economic benefits of living with Covid are outweighed by the combined economic impact of squandering human and financial investments in testing, the impact of Long Covid, loss of workforce from death and sickness, and the regular disruption to critical services such as the NHS and aviation.

The clearest consequence of Covid on the economy is that workers will continue to fall ill and require time off work while they recover. The Office for National Statistics (ONS) estimates that around 14 per cent of sickness absences from work in 2020 were the result of Covid, accounting for approximately 0.25 per cent of total working days. If this trend were to continue in subsequent years, and given that labour contributes around 60 per cent to total output, this could reduce GDP by about 0.15 per cent each year. Indeed, with Covid being permitted to spread unabated, this cost could be larger. (Note: Using a standard Cobb-Douglas production function with the labour (L) share parameter equal to 0.6 and the capital (K) share 0.4, total output $Y = AK^{0.4}L^{0.6}$. Thus reducing total labour input by 0.25 per cent reduces total output by 60 per cent of 0.25 per cent, or 0.15 per cent.)

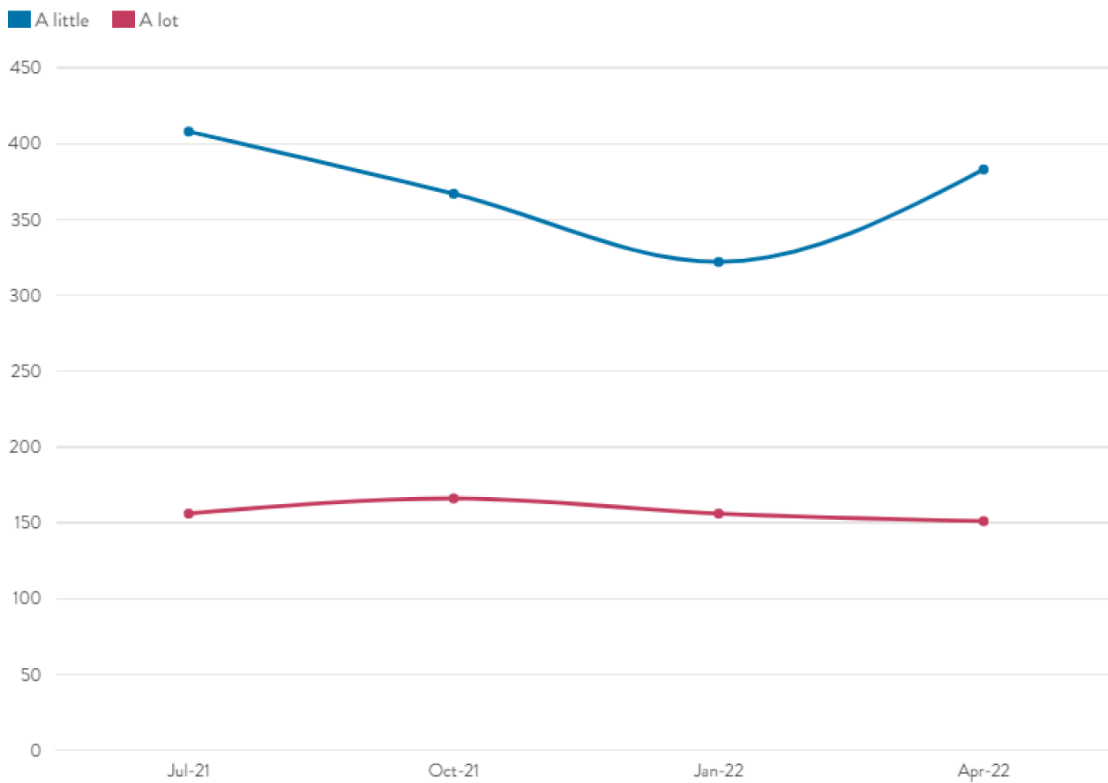
Long Covid has forced many workers out of the labour force, reducing the capacity of the economy. In its latest Economic and Fiscal Outlook, the Office for Budget Responsibility (OBR) estimates that lower labour-force participation as the UK emerges from the pandemic will reduce the size of the economy by 0.6 per cent by the end of the 2026/2027 fiscal year. For comparison, this is equivalent to around 15 per cent of their estimate of the long-term impact of Brexit. They expect that the labour force will comprise 210,000 fewer workers than their pre-pandemic estimates as a result of this lower participation rate, and because older age groups have been hardest hit by the virus, it is anticipated that many will never return to work. Not all of this impact can necessarily be attributed to Long Covid – although the OBR attributes all of the decrease in economic activity to increases in the number of people who are long-term sick or disabled, or inactive for “other” reasons, such as there being fewer opportunities for disabled people to return to work during the pandemic. Nevertheless, with the latest ONS survey showing 281,000 people reporting that their daily activities have been limited “a lot” by Long Covid, it is clear that the condition is having a major impact on people’s lives, which will also inevitably have an impact on the economy.

This raises another important question: how much long-term damage to the economy could result from Long Covid caused by future waves of the virus?

Given current levels of immunity from vaccination and past infection, it is likely that the impact of future Covid waves will be less severe than that seen so far. The ONS has shown that vaccination reduces the likelihood of Long Covid by 41 per cent among those who catch the disease, and it may also reduce its severity. Nevertheless, a future wave could have a significant impact. In its latest Economic and Fiscal Outlook, the OBR also examines a scenario where there is another wave of Covid and assesses that it could reduce the size of the economy by around 1 per cent through a combination of lower productivity and a shortage of workers resulting from more long-term sickness. It is estimated that around half the population of England has been infected with Covid; if the remaining half were also to be infected it is plausible that a further 0.25 per cent of the population – 170,000 people – could see their daily activities severely limited by Long Covid. This in itself could lower national income by 0.15 per cent.

Of course, there is still much we don't know about Long Covid, not least whether full recovery is possible and how long it takes, let alone what future treatments may arise and whether future variants will be more or less likely to cause the condition. But the data we have are not encouraging: the number of people who are still affected by a Covid infection that occurred before April 2021 is not declining (Figure 3). Given these risks, the government should be prepared to spend a significant amount to limit this damage, even if it can't be stopped altogether.

Figure 3 – The number of people who caught Covid-19 prior to April 2021 and whose activity remains limited today



Source: ONS Long Covid Survey

What Is the Best Strategy to Manage Covid-19?

Covid infections in the UK are estimated to be at their highest since the beginning of the pandemic.

The ONS estimates that around 7.5 per cent of the population tested positive during the week ending 2 April 2022 – close to 4.7 million people. This is more than double those testing positive at the start of March, and 40 per cent higher than during the Omicron peak in January 2022. With less systematic testing, these estimates will be less accurate in future.

Vaccines have temporarily buffered the impact of what would have otherwise been a destructive wave on the health system but, as the virus continues to evolve, vaccines alone cannot protect public health and the economy from Covid.

The government's Living With Covid plan – a vaccines-*only* rather than vaccines-*plus* approach – has three key pillars that need to be improved upon if we are to stay on top of the virus:

1. **Vaccination:** People aged 75 and over and immunosuppressed people are eligible for a booster (fourth shot).
2. **Testing:** Tests are restricted to 1.3 million people in high-risk groups, people going into hospital for surgery or a procedure and those who work in the NHS or social care.
3. **Treatments:** Antivirals are available to only 1.3 million people in high-risk groups.

Pillar One: Vaccination

Situation

People aged 75 and over and those who are immunosuppressed are eligible for a second booster (fourth shot). Everyone else aged 5 and over can get a first, second and, for people aged 16 and over and some children aged 12 to 15, a booster (third) jab.

Most people aged 50 and over, and NHS and social-care staff, are not eligible for a second booster.

Assessment

As the effectiveness of the vaccine gradually wanes, many people who received their boosters more than six months ago will be underprotected. This group includes NHS and social-care staff, and most people aged 50 or over. They will face a higher risk of infection, hospitalisation and death. At the same time, the

UK – and almost every other country – has seen a diminishing proportion of people willing to be boosted each time an additional dose is rolled out, posing a short- and long-term challenge to the government around uptake. Vaccines are only effective if people get vaccinated. Despite this, a fourth shot provides significant protection, and this can be rolled out immediately; there are tens of millions of vaccines in stock. In the United States, everyone aged 50 and over is eligible for a fourth dose, while in France everyone aged 60 or over as well as immunocompromised people are eligible. In Germany, those particularly at risk – such as people who live in nursing homes, those aged 70 or over, people with immunodeficiency and health workers – are eligible for a fourth dose.

The UK – with only those aged 75 and over eligible – is out of step with comparable countries. All those aged 50 and over, as well as NHS and social-care staff who want one, should be offered a second booster.

There is a consensus that repetitive boosters are not sustainable. Before next-generation vaccines are available, a strategic approach to the administration of vaccines and a plan to guide decision-making is needed. For example, at what point do we decide that the vaccine is not working well enough and that we should change it? If we are to eventually treat Covid like the flu, this type of approach will be needed to inform whom to vaccinate, with what vaccine, and when. These are processes that need to be proactively integrated for the long-term, safe management of Covid.

Recommendations

- **Extend the “spring booster” rollout** to people who received their third vaccine more than six months ago, prioritising NHS and social-care staff and adults aged 50 or over, like in the United States.
- **Be transparent** in the approach to the administration of vaccines and the plan that guides decision-making on when to change vaccines and whom to vaccinate. This includes doubling down on mechanisms for community engagement that help citizens to understand what is happening and what part they can play, helping to diffuse rumours or misinformation and supporting people to adopt recommended behaviours.
- **Develop a strategic vaccine programme.** There is no consensus on a short- or long-term plan for returning to normal life. How much severe disease and death is acceptable? How much do we want to slow down the spread? The government should be clear on what outcomes it is trying to achieve, and why. This will dictate a strategic vaccination plan: what vaccines, when and how often. The vaccination programme is not yet in a place where it is ahead of the next variant so that maximum protection can be provided to the population at large.
- **Invest in next-generation vaccines.** The current vaccines have filled our short-term needs, but we now need long-term solutions. Access to vaccines that protect against multiple variants, a pan-vaccine that protects against all coronaviruses – including SARS, MERS and the common cold – or

vaccines that inhibit transmission will avoid us being in a firefighting situation when new variants emerge.

Pillar Two: Testing

Situation

Testing is vitally important as asymptomatic infections have been observed to represent more than 40 per cent of cases. Without testing, many people who have Covid-19 will not be able to be identified and isolated, so the rate of community transmission could rise unabated with less understanding of its circulation.

There are currently two types of testing for Covid-19 used in the UK: polymerase chain reaction (PCR) tests and lateral-flow tests (LFTs). PCR tests are more sensitive and allow for greater granularity of information on the evolution of the virus as they can be genomically sequenced to understand the virus's "fingerprint". They provide insight into the evolution of the virus, an ability to spot new variants as they emerge and an understanding of the effectiveness of vaccines. LFTs are less accurate but enable people to test regularly at home and get quick results. This allows citizens to make informed decisions about how they protect their community through their subsequent actions and to seek support as necessary.

Free PCR and LFT testing was available across the UK from mid-2020 until the end of March 2022. Free PCR testing has since ended for everyone in England and Wales, with Scotland and Northern Ireland retaining limited access. Free LFT testing has ended for most people in the UK and people are no longer advised to take a test if they have Covid symptoms. Recent media reports also suggest that testing in hospitals and care homes will be suspended in a bid to save money. If people wish to test and are not eligible for a free LFT, they can purchase them from pharmacies and supermarkets.

Free LFTs can be accessed only if:

- you have a health condition that means you are eligible for Covid treatments.
- you are going into hospital for surgery or a procedure.
- your GP or health-care professional asked you to take a test.
- you operate a care home.
- you work for the NHS and have one of the three main Covid-19 symptoms, or have recently tested positive and need to take a test to return to work.

Most elderly people are excluded from this list, but at the same time they have been prioritised for fourth doses because of the higher risk they face from Covid.

Assessment

The UK is out of step with comparable countries such as Australia, France, New Zealand, South Africa and the United States when it comes to testing. These countries take a coordinated strategic and targeted approach. The UK is also out of step with advice from [the Independent Scientific Advisory Group for Emergencies \(Independent SAGE\)](#), which recommends universal free availability of LFTs.

In Australia, testing remains a [key pillar in the control of Covid-19](#) and is a critical component of the test, trace, isolate and quarantine framework. All tests are provided free of charge. In France, [PCR tests and LFTs are free to those who are fully vaccinated against Covid](#), minors and to people who have been in contact with an infected person. Unvaccinated people are required to pay for tests. In [New Zealand](#), PCR tests and LFTs are provided free to the entire population. South Africa – the first country to detect and report Omicron – runs a lean and sustainable PCR-testing programme that randomly picks out test results from every province across the country to sequence. Since early 2020, this programme has cost only [\\$2.1 million](#). In the [United States](#), no-cost LFT and PCR tests are available to everyone, including the uninsured, at more than 20,000 sites nationwide. The US Centres for Disease Control and Prevention last month announced a [\\$185 million initiative](#) to support sequencing centres at universities.

Testing remains integral to understanding the evolution of the virus and to enabling society to collectively manage the risk. Removing PCR and lateral-flow testing will hinder the management of Covid; over recent months, the coordination mechanisms for testing (as well as other components of the response) at national, regional and local levels have been reduced beyond a point where they can be quickly re-established.

PCR Testing

Removing all free PCR tests will hinder our understanding of changes in the virus (such as how transmissible and deadly it is), our ability to see new variants as they emerge, and the effectiveness of the vaccine against these variants, leaving us reliant on countries such as South Africa to track any changes. Up until now, the world has largely relied on the UK as the “Covid policeman” due to the world-leading genomic-sequencing capabilities that have allowed it to monitor the virus, but this responsibility has been abdicated.

Lateral-Flow Testing

Previously, access to vaccines, tests and treatments was prioritised for the [3.7 million people in England](#) who had been identified as being clinically extremely vulnerable. This list is no longer in use, and instead a new list has been agreed which includes only 1.3 million people in high-risk groups. The list of people classified as high risk now excludes most elderly people, those aged 50 and over (who have a [higher risk](#)

of mortality from Covid) and likely many other vulnerable people, including those exhibiting symptoms of Long Covid.

Withdrawing testing as a key Covid-management component not only hinders our view of the virus and limits our understanding for vaccination strategies, but also dampens investment in new, innovative ways of testing – for example, Covid-19 diagnostic testing using breathalyzers such as that recently granted emergency-use authorisation in the United States.

Testing: Strategic and Targeted

Testing should be both strategic and targeted. Strategic testing will allow policymakers to make important decisions about vaccine rollout, hospital planning and other public-health measures such as masking. Targeted testing will allow individuals to know their Covid status and take appropriate measures to reduce the risk to others, such as isolating or seeking antiviral treatments.

Strategic Testing

Public-health objectives can still be achieved – even with less testing availability – but this testing must be driven by clearly stated objectives and strategic sampling at the population level.

Targeted Testing

Testing of individuals in specific categories that could range from those clinically vulnerable to Covid-19 to the entire population. This enables people to determine their infection status and seek medical treatment.

Recommendations

- Expand eligibility for free LFTs to those with the highest risk of hospitalisation, such as unvaccinated, older or immunosuppressed patients (to match with eligibility for antiviral treatments) as well as their household members.
- Government to proactively send LFTs to all eligible people with instructions on how to obtain more of them if required. The government already has these tests in stock.
- Implement a strategic testing approach using PCR tests at the population level to track evolution of the virus.
- Ensure that policies and the communications around them are rooted in applied social science, not only to help citizens understand what they can do but also to demonstrate that their voices are being listened to by government.

- Build back the national, regional and local mechanisms for coordinating the response to a resurgence of Covid and other hazards to public health, ensuring a legacy from Covid that can deliver the lessons learned from the pandemic.

Pillar Three: Treatments

Situation

Upon testing positive, antibody and antiviral treatments are available to people who are at the highest risk of becoming seriously ill. These treatments need to be administered as soon as possible following the onset of symptoms. The longer the wait between diagnosis and treatment, the worse the outcome. In the UK, people are eligible for Covid treatments when they:

- are aged 12 or over
- are at highest risk¹ of getting seriously ill from Covid-19
- have symptoms of Covid-19
- have tested positive for Covid-19

A doctor or specialist will confirm eligibility. Further, the [PANORAMIC trial](#) is underway to determine which people benefit the most from antiviral treatments. This trial is open to people aged 50 and over or to those who are aged 18 and over with a health condition that puts them at high risk of getting seriously ill from Covid-19.

Assessment

The UK already has nearly 5 million antiviral-treatment doses, of which 2.75 million are Paxlovid – the most effective antiviral treatment that exists. Paxlovid has a shelf life of 12 months.

The high-risk group is identical to those eligible for free LFTs, and the testing and treatment systems are designed to complement each other. The high-risk group is narrowly defined and excludes everyone aged 60 and over, and many other immunocompromised people who are likely to be high risk, unless they qualify for a test for the reasons detailed above.

Most countries have struggled to get an end-to-end “test, trace and treat” system working well, and the UK is no exception. The limitations of the government’s current model are that:

1. Many people who are most vulnerable to Covid-19 (for example, the elderly) do not fall into the high-risk group, so cannot access NHS-issued LFTs and are not eligible for antiviral treatments.
2. Only NHS-issued LFTs are accepted as proof of a positive test, following which one can access

antivirals; for the deployment of treatments to work more effectively, pharmacy- or supermarket-purchased tests should be sufficient proof of infection.

3. The process to obtain antiviral treatments – especially for the most vulnerable, who often face issues in accessing health care – is not straightforward.

The limitations of the PANORAMIC trial are that:

1. People are accepted on to the trial only if they have had symptoms within five days.
2. LFTs are not readily available to many of the people who need access to antiviral treatments, so they will not be able to confirm that their symptoms are caused by Covid-19.
3. Only 450 people can be registered on to the trial each day.

The existence of antivirals, alongside vaccines, is used to justify the plan to live with Covid. However, as demonstrated above, access to these treatments is limited to such narrow and exclusive groups that a reliance on them to mitigate the impact of mass infection and reinfection is of limited value, particularly when there are more than 230,000 cases and 2,300 deaths per week.

Recommendations

- Expand the eligibility for treatments such as Paxlovid in line with World Health Organisation recommendations, specifically for those with non-severe Covid-19 who are at the highest risk of developing severe disease and hospitalisation, such as unvaccinated, older (the definitions of "older person" vary by health system but we recommend Paxlovid eligibility in the UK for those over 60) or immunosuppressed patients.
- Accept LFTs purchased from pharmacies or supermarkets as valid proof of infection for official health-care purposes alongside NHS-issued tests.
- Government should proactively contact all people in the highest-risk groups to inform them that they are eligible for treatment. Communications should convey to the public not only what behaviours are being encouraged and how they can adopt them, but also that the government is listening to citizens' concerns.

Other Health Measures

Masks

Strategic application of mask mandates should be considered. For example, at times of high Covid transmission or where there is higher risk of transmission (such as when a new variant emerges) or severe outcomes (when an outbreak coincides with the flu season), the government should reinstate the mask requirements that were in place in December 2021 under Plan B.

Covid Passes

In the context of a global pandemic, Covid Passes can be a proportionate tool that governments can use to mitigate spread and ensure that reasonable steps have been taken by each citizen to protect those with whom they come into contact. Covid Passes are not infallible and will not eliminate transmission, but they are a useful risk-management tool. Prior investment in Covid Passes should not fall by the wayside and the government should prioritise building the capability to roll out a Covid pass at speed in the event it is needed, while defining the triggers for its implementation.

Conclusion

The view that Covid is too expensive to manage in the “emergency state” that existed throughout 2020 and 2021 is understandable. Covid has placed a major burden on economies worldwide and this burden is being shared by everyone. But removing all restrictions and defunding tools that help people – especially the vulnerable – manage their risk is a mistake.

At the same time, the public disagreement over health measures has been unhelpful. Health measures such as mask-wearing and physical distancing are low-cost tools that are sensible in certain situations and incrementally help us to manage the virus safely. The more we ignore it and relieve ourselves of a combination of light-touch measures, the more likely it is that lockdowns cannot be ruled out as we lose control over the virus.

Business as usual now means higher Covid admissions, NHS staff absence due to Covid, expanding waiting lists, regular disruption of domestic and international travel, and an acceptance that millions will be infected every few months. The potential mass-disabling effect of Long Covid is an example of this that will play out far into the future in its hampering of our economic recovery and disruption to our lives and livelihoods. The risks are being ignored and there are no clear instructions for what people need to do to avert or minimise danger. Without a well-coordinated mechanism to enable us to respond to the pandemic as it continues to change shape (and indeed to enable us to respond to other hazards to public health), or a better approach to helping citizens understand and adopt recommended behaviours to keep society safe, the more likely it will be that the government will lose what control it has over the fragile situation.

We are still in the middle of a virulent pandemic and cannot afford to artificially declare it over, especially with the looming threat of a new and more deadly variant. This is not to say that we must revert to heavy-handed restrictions but, rather, recalibrate to find a sensible middle ground that prevents infections and doesn’t rely solely on the vaccination programme. There is value in shared health security, collective action and the role of government. Now is the time to seek this value by approaching vaccines, testing, treatments and masks in a sensible way to carefully manage the pandemic.

Figure 4 – The current Covid-19 response vs our proposed way forward

Current course

Proposed way forward

Vaccination

People aged 75 and over and immunosuppressed people are eligible for a “spring booster”

Expand eligibility to everyone aged 50 and over and NHS and social-care staff

High-risk group eligibility

1.3 million people who have pre-existing conditions such as HIV/AIDS, certain types of cancer, Down’s syndrome etc.

Expand eligibility to unvaccinated, elderly, and immunosuppressed patients.

Free PCR tests

Restricted to the high-risk group, people going into hospital for surgery or a procedure and those who work in the NHS or social care

In addition, implement strategic testing approach using PCR tests at population level to track evolution of the virus.

Free LFTs

Restricted to the high-risk group	Expand the eligibility for free NHS LFTs to those with the highest risk of hospitalisation, such as unvaccinated, older or immunosuppressed patients (to match with eligibility for antiviral treatments), as well their household members.
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High-risk group must go online to order NHS LFTs	Government to proactively send LFTs to all eligible people with instructions on how to obtain further LFTs. The government already has these tests in stock.
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Treatments

Antivirals are restricted to the high-risk group	Expand the eligibility for treatments such as Paxlovid in line with World Health Organisation recommendations, specifically for those with non-severe Covid-19 who are at the highest risk of developing severe disease and hospitalisation, such as unvaccinated, older (the definitions of “older person” vary by health system but we recommend Paxlovid eligibility in the UK for those over 60) or immunosuppressed patients.
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NHS LFTs are the only form of LFTs eligible to obtain antivirals (pharmacy and supermarket tests are not eligible)	Accept LFTs purchased from pharmacies or supermarkets as valid proof of infection for official health-care purposes alongside NHS-issued tests.
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Source: TBI analysis

Footnotes

1. ^ Down's syndrome; sickle cell disease; HIV/AIDS; chronic kidney disease (CKD) stage 4 or 5; certain types of cancer; had certain types of chemotherapy in the last 12 months; had radiotherapy in the last 6 months; had an organ transplant; a severe liver condition (such as cirrhosis); a rare condition affecting the brain or nerves (multiple sclerosis, motor neurone disease, Huntington's disease or myasthenia gravis); certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease); a condition or treatment that makes you more likely to get infections
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