1. **UNEMPLOYMENT CLAIMS FALL BELOW EXPECTATIONS, INCHING CLOSER TO PREPANDEMIC LEVELS**

New weekly unemployment insurance (UI) claims fell by 11 percent for the week ending October 9, the fastest rate of decline since the end of June and falling below the 300,000 mark for the first time since the beginning of the pandemic. The headline seasonally adjusted number fell by 36,000 to 293,000 (and was revised slightly higher for the previous week). New jobless claims are closer than ever to prepandemic levels, which averaged 217,000 in the year before COVID-19 hit. The four-week moving average also fell after two consecutive weeks of increases. Softening UI claims, a proxy for layoffs, reflect that employers are increasingly hesitant to let workers go amid growing demand and difficulties filling open positions.

Continuing claims for regular state benefits fell to a fresh pandemic-era low of 2.6 million (reported with a one-week lag). The total number of individuals receiving benefits under all state and federal programs fell to 3.6 million, compared to nearly 25 million a year earlier. As processing backlogs persist, over a quarter of all UI beneficiaries are still receiving payments under already expired federal programs.

2. **QUIT RATE HITS HISTORIC HIGH AS DEMAND FOR WORKERS EASES SLIGHTLY**

Nearly 3 percent of workers—4.3 million people—quit their jobs in August, the highest on the record that begins in 2000. At the same time, end-of-month job openings fell slightly in August to 10.4 million as companies responded to both continued supply chain problems and the pull-back of consumer demand amid the late summer surge in the Delta variant. Yet the 10.4 million job openings, still near a record high, exceeded the 8.4 million Americans reported as unemployed in August, reflecting a bountiful 1.25 jobs available per unemployed person.
Quits rates (those who quit as a percentage of total industry employment) were highest in hotels and restaurants (6.8 percent) and retail trade (4.7 percent)—reflecting the hypothesis that workers are rejecting jobs that present an outsized health risk and that offer comparatively low pay. Overall, 4 in 10 people who quit were in customer-facing retail or leisure and hospitality jobs. Quit rates were also high among workers in professional and business services (3.4 percent), who (especially mid-career millennials) are increasingly reevaluating how and where they want to work, and may have the most options in the tight labor market. Now at 2.5 percent, manufacturing has seen the largest increase in its quit rate (+1.0 percentage point) compared to prepandemic levels.

Strong worker confidence in available job opportunities is creating a lot of churn in the labor market. In addition, several factors are still holding workers back from taking open jobs, even though they are plentiful, including fear of contracting COVID-19, employer vaccine mandates, and lack of child care. And beneath all of the turbulence on the surface of the job market is the reinforcing undercurrent of the aging, and the retirement, of the baby-boom generation. Taking age 65 as the midpoint of the distribution of retirement ages, we are now nearly dead center in the retirement process of the baby boom. Elevated birth rates extended from 1946 to 1964, and the median-aged member of that enlarged generation, born in 1955, turns 66 years old in 2021. So among the quits that we observe in the labor market likely are a significant number of baby boomers for whom all of the near-term factors reinforce the argument for retirement now.

3. FEDERAL OPEN MARKET COMMITTEE APPEARS CLOSE TO TAPER

The Federal Reserve released the minutes of the latest (September) meeting of the Federal Open Market Committee. The discussion indicates that the members are firm in their conviction that it is time to begin to dial down (or “taper”) the stimulus provided by their purchases of longer-term securities. The Fed has indicated that it will likely remove all of the stimulus of asset purchases before it begins to tighten policy through an increase in the Federal Funds rate, which has long been its conventional policy tool.

4. PANDEMIC NEWS

On average, nationally, progress against the pandemic continues. The seven-day moving average of daily new cases has declined below 90,000, well down from its local peak of more than 160,000 in the Delta surge last month, and its absolute peak of more than 250,000 last winter. The current 90,000 is much better than 160,000. But it is important to put that progress in perspective. The current new case count is still far, far above the pre-Delta lull of about 11,000, and the late summer 2020 count of about 35,000 that preceded the winter surge. There was no vaccine early last winter, of course, but we are very little better vaccinated than we were when Delta surged this past summer. Complacency is hardly warranted.
And that case count is the national average. You have probably heard the sad tale of the six-foot-tall economist who drowned in a stream that was on average three feet deep. To be fair, progress is widespread; for example, Florida, has now seen substantial (relative) relief. But that progress is not universal. The chart below shows that against the progress in Florida, there are substantially elevated (and in a couple of instances, still rising) case rates per 100,000 population in the upper-Midwest and Mountain states. This illustrates the limitations of an apparently borderline-acceptable national average vaccination rate. Having the highest vaccination rates among the elderly is great, because that protects many of the most-vulnerable Americans. But if vaccinations are concentrated geographically, that leaves large unvaccinated regions as the coronavirus’s playground. Surges there inevitably are spread back to even the highly vaccinated regions, to seek out the unvaccinated and the vulnerable there. This is why many experts despair that we are doomed to live with COVID long-term: with so many Americans unvaccinated, the virus will continue to circulate. And because infection yields inconsistent levels of immunity, those who refuse vaccination may be infected again, keeping the virus alive.
Meanwhile, the number of hospitalizations nationwide continues to decline, in line with the national decline in the case count. Hospitalizations are down almost 12 percent from the Delta peak, and are a little less than half the all-time peak during the winter surge.

However, yet again demonstrating that averages can be misleading, the six-foot tall economist was rushed to the hospital after his accident in the three-foot-deep (on average) stream, and because the accident occurred in the upper Mountain states, he could not be seen in time. The upper Mountain states are still beset by a rising load of COVID cases. The chart below does not precisely align with the group of states in the infection-count chart above (this chart includes Montana, the Dakotas, Wyoming,
Utah, and Colorado), but it is evident that hospitalizations there are still on the rise. Facilities in these and other states are stretched thin, and even more importantly, the personnel in those facilities are being worked to exhaustion.

And again, nationally, COVID deaths are down. The current seven-day average of daily deaths is at 1,252, which seems low until you look at the individual coffins. It is down from 1,815 in mid-September.

But again illustrating the incompleteness of averages, the death count in the Mountain region, although a much noisier data series because of the comparatively small population, is virtually as painful as it was
in the winter surge. The chart below shows Utah as an example, but the same pattern holds in the other states.

![Chart showing daily trends in number of COVID-19 deaths in Utah]

5. VACCINE NEWS

The number of vaccine shots that we are pumping into arms continues to disappoint. The recent small bump in vaccinations, which peeked above the one million level for just a few days, has receded again.

![Chart showing daily count of total doses administered and reported to CDC by date administered]


Of those vaccinations, however, a disappointing number are first doses, indicating that comparatively few previously unprotected Americans have even belatedly decided to safeguard themselves and their communities.

And even more troublingly (by exclusion), the number of second vaccinations—and therefore the completion of two-dose regimens—also is tailing off.
The CDC does not provide a daily count of third (“booster”) doses. However, if total injections had a temporary bump, but neither first doses nor second doses had an uptick, it follows that even the small jump in total vaccinations was not so much a reaction either to the shock of the transmissibility of the Delta variant or to employer mandates. Rather, it was a rush by the eligible to receive third doses. For each individual recipient of a “booster” dose, that may be good news; their antibody counts will be temporarily higher, possibly providing more protection. However, Dr. Paul Offit, Director of the Vaccine Education Center at Children’s Hospital of Philadelphia and a member of the Vaccines and Related Biological Products Advisory Committee of the Food and Drug Administration (FDA), who has twice spoken to CED Trustees on COVID issues, has expressed reservations about the push toward boosters. Dr. Offit’s concerns come from several directions. The implied message that two doses do not provide robust protection against moderate-to-serious illness (in fact, they do) is disquieting, and might even lead some unvaccinated people to underestimate the benefit of vaccination. There is some side-effect risk of vaccination (especially for young males), and a third injection may repeat that risk. There is also an ultimate danger—probably remote, but not negligible—that the human system may at some point tire of generating antibodies such that further vaccination will cease to be productive. And there is no question that from a public health standpoint, it would have been better if those injections had gone into the arms of some people—either here in the United States, or even in a third-world country—who were previously unvaccinated. And so if one were to believe that vaccine doses are aging toward their shoot-by date on the figurative shelf in the United States, and that unvaccinated Americans flatly refuse to avail themselves of the opportunity, then those who are eligible should accept booster doses. But in the long term, the authorities should beg, bribe or cajole unvaccinated Americans to go straight, or should ship the vaccines promptly to poor countries to safeguard the entire planet—rather than widening eligibility for boosters beyond the truly vulnerable populations.

And here are the CDC counts of the slow, slow progress towards administration of at least one vaccination...
...full vaccination...

...and a booster dose.
Not to overstate the case, but the eight-plus million booster doses administered to date would take a substantial chunk—well over 10 percent—out of the estimated unvaccinated population if given to them instead.

And in the news, the FDA panel on which Dr. Offit serves has approved emergency-use third injections of the Moderna vaccine according to criteria that appear identical to those that applied to the earlier Pfizer decision. Dr. Offit and others expressed approval with reservations along the same lines that Dr. Offit articulated publicly (see above). The FDA panel today is considering an analogous booster dose of the Johnson & Johnson vaccine, which has shown highly promising results. The panel will also consider potential “mix-and-match” inoculations using different vaccines, which also have been found to be effective in early trials.

In further news, an Ohio Member of the House of Representatives issued a tweet calling for his state to ban all vaccine mandates—for polio, smallpox, measles, mumps, rubella, the lot. Some political observers believe that some vaccine mandates may in fact be repealed in the aftermath of the COVID-19 pandemic that has killed twice as many Americans as World War II.

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6. SPOTLIGHT ON REOPENING: AFRICA, COVAX

COVID-19 Vaccines Global Access, abbreviated COVAX, is a joint venture among the World Health Organization (WHO), the Coalition for Epidemic Preparedness and Innovation (CEPI), Gavi, the Vaccine Alliance, and UNICEF. It works toward equitable global access to COVID-19 vaccines. Set up in October 2020, COVAX intended to pre-purchase large quantities of vaccines from major manufacturers, and distribute them equitably so that every country gets a share based on its population size. Nearly every country, rich and poor alike, has signed up to COVAX with the goal of vaccinating at least 20 percent of the global population.
More than 50 countries have missed the WHO’s target for fully vaccinating 10 percent of their population by the end of September. Most are in Africa, where the WHO’s overall estimate of those fully vaccinated is 4.4 percent. Only 15 out of 54 African countries have achieved the 10 percent target, while half of all African countries have vaccinated less than 2 percent of their populations. Ethiopia and Nigeria have fully vaccinated less than 3 percent of their populations, while two countries on the continent – Burundi and Eritrea – have yet to roll out vaccination programs at all. The highly vaccinated countries on the continent are of higher income and have procured vaccines directly from manufacturers. “The way COVAX was packaged and branded, African countries thought it was going to be their savior,” said Dr. Catherine Kyobutungi, who directs the African Population and Health Research Center; but reality has clearly fallen short of hope. COVAX plans to deliver 470 million doses by the end of 2021 – revised from the previous goal of 620 million. That number will be enough to vaccinate just 17 percent of Africa’s population, with an additional 500 million doses needed to achieve the WHO’s target of vaccinating 40 percent of the world by the year’s end.
Originally, COVAX banked on giant deliveries from the Serum Institute, which manufactures Covishield, the AstraZeneca vaccine manufactured in India. Covishield promised to deliver 200 million doses to the program. But after the Delta variant surged through India in March and April, the Indian government halted vaccine exports. More than 111 million doses were set to be delivered throughout Africa and the Asia-Pacific region between February and May this year. As of the end of May, only about 30 million Serum Institute doses had been distributed. Johnson & Johnson, which also had production struggles, had yet to deliver any doses ordered by COVAX as of August. Several other major vaccine suppliers, including Moderna, recently agreed to supply the program, agreeing to supply up to 500 million doses of its vaccine. On September 22, President Biden announced that the US is doubling its purchases of the Pfizer vaccine to share 1 billion doses with the world. The US is paying approximately $7 per donated dose, a third of Pfizer’s price for Americans. The US purchase allowed COVAX to get more doses, and faster, than the program could acquire on its own. A Pfizer spokeswoman, Sharon Castillo, said the company had “a collaborative relationship” with COVAX. The EU has committed to donating 500 million doses – an increase from its earlier announced plans.
The WHO estimates that six out of seven COVID-19 infections go undetected in Africa, which would suggest that the true severity of the pandemic on the world’s least vaccinated continent is far underestimated. To date, 8.4 million cases have been confirmed in Africa – 3.5 percent of the global total for a continent accounting for a sixth of the world’s population. “With limited testing, we’re still flying blind in far too many communities in Africa,” Matshidiso Moeti, WHO’s regional director for Africa, said in a statement. The COVID-19 pandemic has caused an estimated 200,000 deaths on the continent – which of course may also be an underestimate. Egypt is currently battling its fourth wave and is aggressively working to amp up its vaccination campaign – nearly 270 youth centers are now open for vaccine distribution. As of late September, the country recorded just over 302,000 COVID-19 infections. Health officials claim the real numbers of infections are much higher. Meanwhile, in Uganda, President Yoweri Museveni eased social restrictions in late September as cases ebbed. Museveni had the country under a sweeping lockdown – shuttering nearly all businesses and schools – since Delta sent cases soaring in May.

Moderna announced on October 7 that it would build a vaccine manufacturing facility in Africa. Health experts noted that Senegal, Rwanda, and South Africa could be potential locations because they either have existing vaccine expertise and production, or expressed interest in the industry. This news is welcomed for long-term vaccine availability on the continent, but it will not address the immediate need for COVID-19 vaccines. Completing construction on the plant and then validating it will probably take two to four years, CEO Stephane Bancel said in an interview. Moderna’s facility would eventually produce up to 500 million doses of its mRNA vaccine. The company is in the process of developing other vaccines against Zika, influenza, and cytomegalovirus, meeting Africa’s high demand. Moderna’s plan to build a factory in Africa is part of its broader initiative of expanding its in-house global capacity. The company recently announced plans to build a plant in Canada under a deal with the Canadian government.