

Point of view: it will soon be time to widen our thinking on the COVID-19 pandemic beyond its direct impact on public health



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Summary

It is becoming increasingly clear that the COVID-19 pandemic will impact public health and well-being not only directly but also through its disruption on health care systems and the global economy. The scale of these disruption effects could, based on examples from past health and economic crises, pose a public health risk on a similar scale to the direct effects of COVID-19 itself. As our understanding of COVID-19 improves, and measures to slow its spread begin to be lifted, policy makers should take the opportunity to move beyond a simplistic discourse that depicts a trade-off between protecting the public from the health risks of COVID-19, and the economic costs of doing so, to a more balanced approach that considers how to maximize public health and well-being in the face of several linked risk factors.

Three key considerations for policy makers should be:

- ▶ Identification and prioritization of key health care services that may have been disrupted by COVID-19 and restoring focus on them (for example, vaccination programs and cancer diagnosis)
- ▶ As social distancing measures are relaxed, and economic recovery begins, prioritization of initiatives that reduce long-term unemployment, given the proven relationship between unemployment and poor health (in particular, mental health) outcomes
- ▶ Where austerity measures are required to redress the costs of the COVID-19 pandemic, safeguarding key health care services to avoid excess mortality

At the time of writing, confirmed cases of COVID-19 have exceeded seven million globally, accounting for 412,972 deaths to date.⁽¹⁾

Figure 1: Summary of COVID-19 cases for top 10 countries in the world by number of cases as at 9 June 20⁽¹⁾

Country	Total cases	New cases 9 June 20	New cases (%) 9 June 20	Total deaths	Active cases	Total cases/1m population
World	7,310,832	120,385	1.6%	412,972	3,299,102	938
US	2,045,549	19,056	0.9%	114,148	1,142,539	6,182
Brazil	742,084	31,197	4.2%	38,497	377,985	3,493
Russia	485,253	8,595	1.8%	6,142	236,714	3,325
UK	289,140	1,741	0.6%	40,883	N/A	4,260
Spain	289,046	249	0.1%	27,136	N/A	6,182
India	274,780	8,852	3.2%	7,719	132,896	199
Italy	235,561	283	0.1%	34,043	32,872	3,896
Peru	203,736	4,040	2.0%	5,738	105,069	6,184
Germany	186,516	311	0.2%	8,831	7,485	2,227
Iran	175,927	2,095	1.2%	8,425	29,045	2,096

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To date, the focus of politicians and health systems has, understandably, been on managing the direct threat COVID-19 poses to human life and public health. This discourse often portrays a trade-off between safeguarding health against the economic cost of doing so. However, this is likely to be too simplistic, and secondary effects of the crisis, such as disruption to health care systems and the wider economy, may pose a similar threat to public health and well-being as COVID-19 itself. If so, responding to these new threats

will require a change in discourse to one where we acknowledge that any course of action will have both an economic and humanistic cost, and that any decision may trade off the health and well-being of one group of citizens against that of another.

In this paper, we explore evidence from recent epidemics and economic crises to better understand these potential secondary threats to public health.

The strain COVID-19 is placing on health care systems may endanger the lives of patients with other conditions

The COVID-19 pandemic is likely to severely strain and disrupt health care systems, with significant resources and management capacity focused on caring for patients that have tested positive. The additional strain on intensive care services alone is already unprecedented: for example, the UK is quadrupling its intensive care capacity through the conversion of surgical theaters and other areas of hospitals, as well as relaxing regulations on the number of intensive care staff required per patient and redeploying staff who do not usually work in intensive care. This kind of disruption could affect almost every aspect of health care, from prevention activities in primary care and the treatment of patients with conditions other than COVID-19, to the supply of goods and services that health care systems rely upon.

Previous health crises have disrupted vaccination programs, resulting in significantly reduced rates of vaccination and, as such, the re-emergence of infectious diseases previously close to eradication. For example, the 2014 Ebola crisis led to an outbreak of tuberculosis and measles⁽²⁾⁽³⁾ (both are considered to be more contagious and deadlier than COVID-19).⁽⁴⁾ In the UK, we have seen relatively small outbreaks of diseases such as measles in recent years as vaccination rates have dropped, and the potential situation where a whole cohort of patients miss or delay vaccinations due to disruption from COVID-19 could lead to much larger outbreaks.

In addition to disrupting prevention efforts, COVID-19 could also affect treatment. The Ebola crisis limited the capacity of health systems to diagnose and treat other diseases such as malaria, tuberculosis and HIV/AIDS in countries such as Guinea, Liberia and Sierra Leone. This is estimated to have caused as a similar number of excess fatalities as the death toll from Ebola itself, which stands at 10,623.⁽⁵⁾ In developed economies, disruption of services such as cancer care and monitoring of medication compliance could be key risk areas.

As well as impacting health care services directly, COVID-19 has the potential to also disrupt the supply chains that these services rely on. Meningitis epidemics in Burkina Faso caused supply-demand mismatch issues, including shortages of medical staff, bed capacity and medicine, and heightened risks of error due to fatigue among staff.⁽⁶⁾ The media is already reporting concerns of shortages in personal protective equipment (PPE), intensive care medicine and ventilators for COVID-19 patients, but these shortages could also divert supplies and staff time from other services, placing lives at risk.

Economic crises can directly impact mental and physical health, with being in employment a key driver of health and well-being

The social isolation interventions being implemented by governments across the globe, as well as the public reaction to the COVID-19 pandemic, come at a significant economic cost and the threat of mass unemployment. Chinese gross domestic product (GDP) dropped 6.8%⁽⁷⁾ in Q1 compared with the same quarter the previous year, while in the US, unemployment claims have increased by 9.9 million (6.3% of employment) and, in the UK, there were 950,000 claims for universal credit welfare payments between 16 and 31 March, around 750,000 more than normal.⁽⁸⁾

There is a significant risk that the economic impact of COVID-19 will lead to medium- to long-term increases in unemployment and debt, which could in turn have an impact on the mental health and well-being of citizens. Periods of increased unemployment are associated with increased risk of mental health issues, including depression, suicidal ideation and suicide attempts, with debt being an exacerbating factor for men in particular.⁽⁹⁾⁽¹⁰⁾⁽¹¹⁾⁽¹²⁾⁽¹³⁾ There is also a consistent correlation between mortality due to suicide and unemployment, despite some contention regarding the causality between rates of suicide and economic crises.⁽¹⁴⁾⁽¹⁵⁾⁽¹⁶⁾⁽¹⁷⁾⁽¹⁸⁾⁽¹⁹⁾ This means that, should the economic downturn related to COVID-19 and the measures implemented to slow its spread turn into an extended period of economic crisis, there will be a

significant risk of increased mortality due to suicide.

An economic crisis could also impact physical health through an increase in the prevalence of chronic health conditions. Analysis of the 2008 financial crisis found a link between unemployment rates and the prevalence of respiratory, cardiac and orthopedic conditions, in addition to the impact on mental health.⁽²⁰⁾ A similar effect following the COVID-19 pandemic could lead to not only increased mortality in the short term but also impaired quality of life and additional strain on health care systems in the medium to long term.

There is also a risk that COVID-19, its economic consequences and the effect lockdown has on people's daily lives will negatively impact the determinants of health. Binge-drinking and other health-damaging behaviors tend to increase during economic downturns, particularly in Western societies, and this could have an impact on physical and mental health and, consequently, excess mortality in both the short and long term.⁽²¹⁾⁽²²⁾⁽²³⁾⁽²⁴⁾ However, there is also some limited evidence that recessions, such as Iceland's in 2008, can lead to some reductions in health-compromising behaviors such as smoking and consumption of sugary drinks, due to relative price increases.⁽²⁵⁾

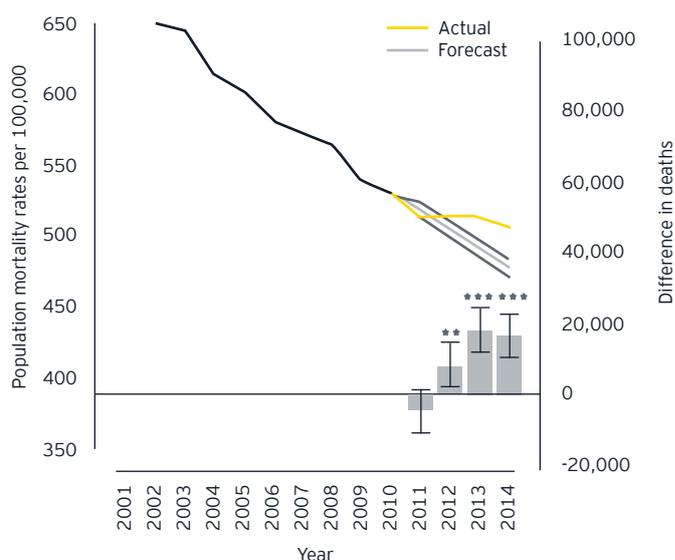
The fallout of an economic crisis could also restrict public and private expenditure on health care, putting further lives at risk

A global economic crisis resulting from the COVID-19 pandemic may necessitate a public finance strategy involving governments returning to a period of austerity; especially where large-scale government spending and borrowing has been required to prop up economies. Austerity can have consequences for public health through the restriction of health and social care budgets, as was the case following the 2008 financial crisis,⁽²⁶⁾⁽²⁷⁾ while rates of private medical insurance (PMI) also tend to drop during periods of economic downturn,⁽²⁸⁾ placing yet more pressure on public sector health care systems.

Approximately 260,000 excess fatalities from treatable cancers are estimated to have occurred across 35 OECD countries following the 2008 financial crisis. These deaths were correlated with increases in unemployment and occurred predominantly in countries that lacked universal health care,⁽²⁸⁾ suggesting loss of access to health insurance or lack of ability to self-pay were key drivers of mortality. This potentially places countries with largely insurance-based models of health care, such as the US, at particular risk of excess mortality from acute health conditions following an economic crisis.

In England, population mortality rates consistently reduced every year from 2001 to 2008; after the 2008 financial crisis, National Health Service (NHS) and social care (local government) budgets were restricted. This led to an increase in mortality rates in 2011 and a less rapid decline in mortality rates between 2011 and 2014 than the historical trend. Comparing the historic trend in mortality rates with the observed actual rates, austerity led to c.45,000 excess fatalities over the period 2009-14. ⁽²⁹⁾ Should a period of austerity be required following the COVID-19 pandemic, and with similar consequences for mortality as those observed in England after the 2008 crisis, excess fatalities resulting from these austerity measures could exceed those of the COVID-19 pandemic itself.

Figure 2: Time trend projections of age-standardized death rate per 100,000 people in England⁽²⁹⁾



Policy decisions on the management of the COVID-19 pandemic are not a simple trade-off between public health and the economy, but a more nuanced balancing of several risks to public health and well-being

It is becoming increasingly clear that the COVID-19 pandemic will impact public health and well-being not only directly but also through its disruption on health care systems and the global economy. The scale of these disruption effects could, based on examples from past health and economic crises, pose a public health risk on a similar scale to the direct effects of COVID-19 itself. As our understanding of COVID-19 improves, and measures to slow its spread begin to be lifted, policy makers should take the opportunity to move beyond a simplistic discourse that depicts a trade-off between protecting the public from the health risks of COVID-19, and the economic costs of doing so, to a more balanced approach that considers how to maximize public health and well-being in the face of several linked risk factors.

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Team

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