

The
**Health Policy
Partnership**

[research, people, action]

Balancing risks: adapting
health and social care
in the wake of COVID-19

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Introduction

The past several months, dominated by the COVID-19 pandemic, have demonstrated the centrality of population health to the functioning of our societies.

Those of us working in health have seen the mantras we have been repeating for years become common parlance among politicians and the media worldwide – that health is an investment, not a cost, and that we must take a ‘health in all policies’ approach.

Yet even if health is now top of the agenda, it is hardly a time to celebrate. The human and economic toll of COVID-19 continues to be devastating and its indirect impact on health, wellbeing and the economy is likely to be felt for years to come. While individuals’ health needs have had to be balanced carefully against the risk of infection from COVID-19, the redeployment of services towards the pandemic has interrupted treatment plans and left many people bereft of continuity of care. Experts have warned that we may see a surge of more severe cases of many conditions, due to the postponement or cancellation of tests and interventions, the suspension of prevention programmes such as cancer screening,¹ and delays in people seeking healthcare.

Despite the enormity of the task facing us, we must seize the unique opportunity presented by this crisis. This is the moment to focus political will on building resilience, sustainability, quality control and efficiency across the entire system of care – committing resources to long-term population health gains. We must learn from the negative consequences of austerity measures seen in many countries following the 2008 financial crisis and avoid retrenchment of health and social care services at all costs.²

At The Health Policy Partnership, our aim is to help people think differently about healthcare. With this in mind, we have looked across some of the areas in which we are currently working to identify key strategic issues that will need to be addressed in post-pandemic plans and policies. These issues are likely to linger as we emerge from this pandemic – and will need to be remedied if we are to protect the health and wellbeing of our populations and prepare our systems for any global health emergencies we may face in the future.

Underlying issues exposed by the pandemic

Social inequalities and disparities in health

One of the most striking effects of COVID-19 has been to lift the lid on underlying socioeconomic inequalities in our societies. Across different nations, people who are already marginalised or socioeconomically disadvantaged have suffered disproportionately from COVID-19. Data are still emerging, but what we have seen so far is that in the UK (England and Wales), Black and minority ethnic people admitted to hospital with COVID-19 have suffered death rates two to four times higher than White people,³ while in New York City, death rates from COVID-19 in Black and African Americans have been twice as high as in White Americans.⁴ In Norway, the Somali population has been as much as ten times more likely to contract COVID-19 than White Norwegians.⁵

This pattern of outbreaks disproportionately affecting certain groups has been evidenced before. Historically, overcrowding, poor living conditions, economic instability, malnutrition and lower educational attainment have created the ideal conditions for epidemics to ravage communities – in the 1918 influenza pandemic, for example, higher mortality was observed among the poorest groups in society.⁶ Such communities often face pre-existing barriers in access to quality care, ultimately contributing to compromised health outcomes.⁷ As put by social historian Gwen Robbins: ‘These kinds of crises play out along the pre-existing fault lines of each society.’⁶

Moreover, these same communities will be at greatest risk of suffering financial hardship from lockdown measures and the economic downturn that is projected to follow the pandemic. These worrying trends underline the need to invest in policies that can address social inequalities at their roots.

Protecting our mental health

The pandemic has heightened recognition that mental health issues are not confined to specific populations, but that we are all at risk.

Mental health is an area that often straddles social inequality and health, and experts have warned of a mental health crisis awaiting us after the pandemic.⁸ Measures to contain the spread of COVID-19, imposed on a mass scale by governments around the world, have had a heavy psychological toll. Recognising that this may increase the risk of a surge in poor mental health, the World Health Organization (WHO) has produced guidance on the mental health impact of the pandemic in various sectors of the population, including healthcare professionals, carers and the public.^{9,10} For example, post-traumatic stress disorder is being posed as a possible after-effect of people in critical occupations having to work in life-threatening conditions for a prolonged period.¹¹

The pandemic also risks worsening the situation of people with existing mental health conditions. They are more likely than people with good mental health to experience heightened levels of anxiety, depression and a deterioration in symptoms.¹² With stress a widely recognised trigger for several mental health disorders, including those on the severe spectrum, the many uncertainties surrounding the pandemic can be an additional factor in worsening mental health for people of all ages.^{13,14} In a UK survey, a staggering 83% of young people with existing mental health conditions reported that their mental health has worsened during the pandemic.¹⁵

As with any other condition, disruptions in access to healthcare during the crisis are creating new challenges for people with mental health issues. Reports have emerged of people running low on medications and experiencing difficulties obtaining new prescriptions,¹⁶ and some are suffering because of limited access to their usual support networks as a result of social isolation.¹⁷ There are fears that this isolation, combined with a reduction in services and physical interactions with mental health professionals, may lead to an increase in the number of deaths by suicide.¹⁸

Arguably, however, the pandemic appears to have heightened recognition that mental health issues are not confined to specific populations, but that we are all at risk. This is an opportunity to reverse the chronic underinvestment in mental health services seen in too many countries: mental health must be considered on a par with physical health and resourced accordingly.¹⁹

The complexities of responding to evolving evidence

The pandemic has made evident to everyone that scientific evidence is often a moving target, and that interpretation may differ and evolve over time. It has also highlighted the importance of conveying appropriate information to help people make the best decisions about their health.

In recent months, people across the world have devoured rolling news on COVID-19 and have been forced to react to sometimes contradictory and evolving information. In particular, people with underlying conditions considered to make them more vulnerable to COVID-19 have at times faced unclear advice or gaps in information, which has caused them anguish and uncertainty. They have had to balance the risk of contracting the virus against the need to safeguard the quality of their ongoing care (see *Case study 1*).

Case study 1. Balancing the risks of COVID-19 and multiple sclerosis

Multiple sclerosis (MS) is a neurodegenerative disease that currently has no cure. Care focuses on slowing irreversible disability while managing unpredictable and varying symptoms.²⁰ Disease-modifying therapies (DMTs) are a mainstay of MS management, and any delay to diagnosis or treatment initiation may have life-altering consequences.²¹

As information began to emerge about the COVID-19 pandemic, people with MS on DMTs were considered a high-risk group; DMTs are immunosuppressants which affect the normal function of the body's defences. With a highly infectious virus raging across the world and scarce evidence to inform them,²² people with MS were likely to be anxious. But they and their care teams have also been reluctant to divert from their normal treatment plans: stopping DMTs risks triggering progression of MS, and even so it may take months for normal immune function to return. The 'treatment as usual' approach follows guidance from several professional bodies, which recommended that most people with MS should make no changes to their treatment.²³⁻²⁷

Months later, we are seeing indications for cautious optimism. Data released from Italy at the end of April suggested that not only were most people with MS at no greater risk of contracting COVID-19 than the general population, their DMTs may actually have a protective effect should infection occur.²⁸ One possible explanation is that some DMTs modulate the immune response related to 'cytokine storms', protecting people with MS from massive overreactions by the immune system believed to be responsible for many COVID-19 deaths.²⁹ One common MS medicine is even being trialled as treatment for COVID-19.³⁰

The case of MS illustrates the importance of adapting COVID-19 prevention around best-practice care for people with underlying conditions, not the reverse. It also highlights the importance of shared decision-making between patients and their care teams to discuss relative risks and establish the best course of care for each patient.

The need for multidisciplinary, integrated care in the community

COVID-19 has proven beyond all doubt that the fundamental organisational principle of care must be multidisciplinary – no other model can hope to offer the necessary flexibility to address the complexity of patient needs over time.

For years, governments have recognised the need for healthcare reform. Priority areas for change have been identified as strengthening services across all phases of care, providing person-centred care based on a joint assessment of health and social circumstances, and supporting patient engagement and empowerment. Yet progress has often been lacking, with resources too rarely following declared policy goals.

Insufficient investment in community-based roles and services has been one of the biggest hurdles to progress – and the suspension of many healthcare services during the pandemic has been a reminder of the importance of such roles. Nurses, allied health professionals and social workers form the mainstay of community-based care, ensuring continuity of care for people who are vulnerable or living with chronic conditions (see *Case study 2*). In oncology, for example, there have been repeated calls over the years for greater investment in specialist cancer nurses to provide a single point of contact for individuals once the phase of ‘active treatment’ is over.³¹ Similar calls have been made across many other areas.^{19 32-34}

The pandemic has also exposed significant shortcomings in social services, which are too often de-prioritised compared with healthcare. Across most countries, social care is typically underfunded, under-resourced and poorly coordinated, despite its crucial role in supporting many people to maintain independence. In the UK, the relative disregard for the care home sector at a policy level has been evident in the lack of protection for care home workers, deficit of COVID-19 testing and absence of accurate mortality figures.³⁵ The pandemic has been a stark reminder of the need for investment in this vital sector of care, particularly as populations age. It has also opened up a unique opportunity to recalibrate the organisation of care to truly integrate the health and social care sectors, once and for all.

Case study 2. Managing fragility fractures in older people

Fragility fractures predominately affect older people, who are also at greatest risk of complications if they contract COVID-19. These fractures can be painful, life changing and, in some cases, deadly. A worrying 3.5 million fragility fractures occur in Europe each year³⁶ – and, as most occur in the home, their number is not expected to drop during the current period of confinement. Some countries have issued revised clinical guidelines to manage people with fragility fractures during the pandemic,³⁷ but they tend to cover only the acute surgical phase, with no detail on how patients should be managed beyond this.

Fracture patients discharged from hospital may suffer further due to gaps in the provision of care on which they would otherwise depend. Post-fracture, many people, whether they live at home or in a care facility, rely on daily care from social care providers, friends or family.³⁸ This level of care has faced disruption during the pandemic and may also bring additional risks of COVID-19 infection if carers are not taking adequate precautions.

Fracture liaison services (FLS) are a gold-standard approach to post-fracture care, prioritising the prevention of future fractures. A hallmark of FLS is the coordination of care, often by dedicated FLS nurses in either the community or the hospital setting. Yet in many countries these services have been suspended³⁹ as the workforce has been redeployed to support the COVID-19 response.⁴⁰ While the need to restructure health services in light of the current emergency is understandable, so far there are no assurances that normal service will resume.⁴⁰

The suspension of FLS illustrates the risks to continuity of care for so many vulnerable people during the pandemic – and raises the very real spectre of a ‘second wave’ of avoidable mortality and morbidity hitting our acute system in months to come.

Insufficient support for informal carers

The pandemic has exacerbated the inordinate pressures on informal carers, especially those caring for people whose health condition or age make them particularly vulnerable to COVID-19.⁴¹ A survey undertaken in the UK notes that 70% of unpaid carers are having to provide more care during the pandemic, as access to social care services has become increasingly limited. More than half of respondents reported feeling overwhelmed by their caring responsibilities, unsupported by social care services, and worried about burning out.⁴²

The current situation has intensified risks to informal carers' physical and mental health, exacerbating not only their burden and isolation, but also their stress levels.

In recognition of these issues, several European organisations have called on policymakers to 'recognise the role of informal carers and provide them with adequate support, counselling and training' related to the pandemic.⁴³

Looking ahead

While the pandemic has exposed many existing gaps, it has also opened the door for new ways of working, some of which may prove valuable as we shape our post-pandemic systems of care.

We would like to highlight some of the examples of good practice we have observed in our areas of work.

Maximising the potential of digital health and telemedicine

The pandemic has seen a meteoric rise in the use of digital health, rapidly accelerating uptake and expanding applications well beyond previous levels. With hospitals and clinics no longer able to serve as the epicentre of patient care, clinical teams have embraced digital solutions to facilitate remote interpretation of tests and diagnostics, telephone consultations and remote monitoring of symptoms – allowing them to maintain some level of continuity of care and ongoing communication with their patients.

In some instances, healthcare systems have had to make rapid adaptations to their regulatory frameworks to integrate telemedicine and digital approaches into care.

This has effectively removed some of the pre-existing barriers to their widespread use.⁴⁴ Coverage of telemedicine by health insurance systems has been a hurdle in many countries until now. In Belgium, the National Institute for Health and Disability Insurance has temporarily expanded insurance policies for healthcare professionals to include telemedicine approaches, which means that multidisciplinary oncology teams, among others, can now conduct their meetings virtually.^{45 46} In the US, physicians and providers could previously bill for telemedicine ‘visits’ only in very specific circumstances, but a law has now been passed to allow remote consultations to replace physical appointments; interestingly, changes to reimbursement extend to virtual appointments with many allied health professionals.⁴⁷ This includes social workers, clinical psychologists, physiotherapists and occupational therapists, whose services are often not covered by health insurance.³¹

While recent changes have shown the potential of telemedicine and remote consultations, a note of caution is needed when looking to the future. A blanket replacement of in-person care with remote interactions should be avoided. The appropriateness of remote consultations should be assessed based on the intervention being provided, and the circumstances and preferences of each person. Additionally, the need to provide training to healthcare professionals to adapt to this new way of working should not be overlooked.

Fostering data-sharing and exchange of best practice

The spirit of data-sharing that has emerged from the pandemic has been nothing short of inspiring. Clinicians have created virtual learning communities, often adapting existing data-sharing platforms to gather valuable real-world data on the interface between COVID-19 and different conditions. These data, gathered across multiple centres and locations, may create a sufficient critical mass of experience to help guide colleagues who are facing similar situations in other parts of the world.

Centres of excellence and professional societies have played a leading role in guiding their members and colleagues in the transformed healthcare landscape of COVID-19.

For example, the seven comprehensive cancer centres that form part of Cancer Core Europe have issued a joint publication summarising available guidance and their experiences of trying to make their organisations ‘pandemic proof’.⁴⁸ Such collective insights are likely to prove invaluable in helping professionals learn from the experiences of others, and offer hope that a new set of standards may emerge to drive high-quality care in the future, in cancer and other illnesses. Professional societies across many disease areas have responded to the demands faced by their members throughout the pandemic by adapting their clinical guidelines in record time (see *Case study 3*).

Case study 3. Adapting models of cardiovascular disease care in light of COVID-19

The European Society of Cardiology launched a guidance document in April with recommendations in place while the pandemic status is maintained by the WHO.⁴⁹ The document provides guidance on diagnosis of COVID-19 in cardiovascular disease (CVD) patients and vice versa; protective measures for staff and patients in cardiology departments; the use of telemonitoring and telephone consultations; and provision of psychological support. It also advises home delivery and mailing of standard CVD medication to avoid disruptions to patients’ prescriptions. Virtual communication between professionals is recommended to ensure that cardiac teams remain in contact and are involved in clinical decision-making.

As healthcare services are gradually restored to a ‘new normal’, it will be interesting to see how many of these system changes remain in place, particularly as some of the new models of care born of the pandemic may offer long-term solutions to previous gaps or inefficiencies in the delivery of care. It is also foreseeable that some changes may be preferred by patients, such as being able to avoid trips to hospital for services that they could access remotely.

Strengthening and supporting patient organisations

The COVID-19 crisis has also highlighted the need to ensure the sustainability of patient organisations. Since the beginning of the pandemic, patient organisations have been working tirelessly, and at very short notice, to provide patient communities with accurate, up-to-date information to help them make informed decisions and support them as they navigate through the changes in healthcare delivery.⁵⁰⁻⁵² Many patient organisations are also running surveys to gain a better understanding of the challenges faced by patients during the pandemic,^{53 54} with a view to inform more resilient care pathways in future. Yet there is worrying evidence that the pandemic may be threatening the financial sustainability of the sector.⁵⁵ To address this, the European Patients' Forum issued a direct appeal to the pharmaceutical industry to continue supporting patient organisations despite divestment of budgets towards COVID-19.⁵⁶

Ensuring continuity of procurement and supply of medical resources

The pandemic has raised awareness of the complexity and fragility of provision of medical equipment and technologies. Issues of procurement and convoluted supply chains have hit the headlines in mainstream media, with the term 'PPE' now a household name. The pandemic has exposed risks in countries' procurement policies and the need to adopt contingency planning in case of interruptions in global supply chains. Although the focus of debate has been on personal protective equipment and testing for COVID-19, the supply of almost all medical equipment has been at risk. Undoubtedly, a key focus of future healthcare planning will be health system preparedness – and ensuring adequate supply of essential equipment and technologies must be a key part of this (see *Case study 4*).

Case study 4. Protecting the supply of radioisotopes for use in nuclear medicine

Nuclear medicine is a cornerstone of diagnosis and treatment for many conditions, and there have been widespread concerns about the impact of COVID-19 on the supply of necessary radioisotopes.^{10 57 58} A small number of nuclear reactors across the world produce radioisotopes for medical applications and, under normal circumstances, the supply chain is delicate.^{59 60} Typically, radioisotopes are produced in one country and flown on commercial passenger flights to recipient radiopharmacies, which process them into radiopharmaceuticals to be used for scans and treatment in hospitals. These radiopharmaceuticals have an extremely short shelf-life – usually a matter of hours or days. They must be produced in small quantities and are often administered to the patient the day after production. However, extended border controls, severe reductions in commercial passenger flights and a disrupted supply chain for raw materials have all greatly increased costs and caused delays in obtaining radiopharmaceuticals.⁶¹

Radioisotope processor facilities have adapted, but logistics remain challenging. Production is now scheduled around the few remaining passenger flights and cargo flights are being considered for transportation,⁶¹ as is road travel. Radioisotopes go through multiple connections to reach their destinations, increasing the time to delivery.

The numerous steps and players involved in this situation are not unique to nuclear medicine. In this and many other areas of healthcare, different stakeholders from all sectors have come together in a spirit of crisis management. These collaborative efforts are yielding important information on the potential risks and obstacles in delivering care safely to patients. As the importance of preparedness is becoming apparent to all governments, we may hope that this information will be built into more careful scenario planning and contingency measures to secure procurement of all key facets of patient care in future.

The way forward

As we gradually emerge from the pandemic, a first hurdle will be for our healthcare systems to move from crisis mode to a post-pandemic approach. Policymakers must accept that the wellbeing of our populations is an indication of the state of our health and social care systems at large. To best safeguard both in future, we propose the following:

- **Prioritise equitable, person-centred models of care**, designed to anticipate potential barriers in access to care, including screening and diagnosis, and protect vulnerable populations against public health risks.
- **Recognise that there is no health without mental health** and create greater integration between physical and mental health prevention and care.
- **Integrate the health and social care workforce**, enabling continuity of care and strong community services.
- **Invest in better information for patients**, with close collaboration between governments, patient organisations, professional societies and other stakeholders to provide accurate and consistent information and to avoid risks of misinformation.
- **Accelerate the use of digital health and data exchange**, creating policies enabling their implementation and removing any existing barriers to the exchange of real-world data across settings and locations.

We all have an obligation to learn from this crisis: to find ways to address the underlying issues that it has exposed, and to build on some of the beneficial system changes it has forced and accelerated.

Conclusions

The full impact of the COVID-19 pandemic is yet unknown and, admittedly, the task facing policymakers in the aftermath is immense. There are clear opportunities to develop stronger, more resilient systems of care, and fortifying our health and social care systems will be a core foundation of economically vibrant societies in the future. If we don't take appropriate action, we could find ourselves facing even greater health challenges than when the crisis began – with severe consequences for society as a whole.

When the pandemic abates and we are faced with a fork in the road, we should avoid taking the well-trodden path of cost-containment and dare instead to take the road less travelled, investing in health and social care systems that will allow us to recover, prepare and thrive again.

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This think piece was written by The Health Policy Partnership. We welcome any questions or comments about the issues raised here. Please email Suzanne Wait at suzanne.wait@hpolicy.com

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