

The
**Health Policy
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[research, people, action]

Out of the ashes:
why prioritising
non-communicable
diseases is central to
post-COVID-19 recovery

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Preface

Controlling the spread of COVID-19 and caring for people who are ill with the virus has, understandably, dominated the European political landscape since early 2020. But are we neglecting the ‘syndemic’, a concurrent epidemic of underlying conditions that has made our populations and health systems so vulnerable to severe infections in the first place? High prevalence and poor management of non-communicable diseases (NCDs) are closely linked to worse COVID-19 outcomes, and still cause the majority of overall mortality and disability in Europe. They are also intertwined with the inequalities that permeate our societies.

NCDs remain the most pressing threat to the sustainability of European health systems and their resilience to future shocks. It is essential that governments recognise this in their efforts to rebuild their economies, health systems and wider social fabric in the wake of the pandemic.

This think piece explores whether European governments are giving sufficient attention to NCDs in their post-pandemic recovery plans, and proposes key areas to focus on.

Managing NCDs in a pandemic – two years on

Reducing the burden of NCDs on our societies is well-recognised as a core pillar of economic and social sustainability. NCDs, which include cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and mental illnesses, are the leading cause of death and disability worldwide.¹ In Europe, NCDs account for 86% of premature deaths.² NCDs are also responsible for significant economic challenges – it was estimated that between 2010 and 2030 the five types of NCD mentioned above would make up USD \$47 trillion in direct and indirect healthcare costs globally.³

The impact of NCDs across our communities is also starkly unequal, justifying concerns about our prospects of building a fairer society. In Europeans above the age of 50, the prevalence of multiple NCDs is significantly associated with education, marital status, working status, income and wealth.⁴ The urgent need to reduce the burden of NCDs has been recognised by the United Nations (UN), with Sustainable Development Goal 3.4 focused on reducing premature mortality from NCDs by a third by 2030,⁵ a goal to which the European Commission has also committed.⁶

Unfortunately, progress in reducing premature deaths due to NCDs had already begun to slow over the past decade – and the COVID-19 pandemic has hampered it further. At present, many countries are unlikely to achieve Sustainable Development Goal 3.4.⁷⁻⁹ The pandemic has contributed to the slowing of momentum seen in previous years¹⁰ and to significantly worsened outcomes for many NCDs. A World Health Organization (WHO) survey found that three quarters of European countries reported some disruption to NCD services as a result of the pandemic.⁸ The impact of these disruptions is already manifesting itself in increased morbidity and deaths from many NCDs, compounded by the fact that people with pre-existing NCDs are at higher risk of negative outcomes and death from COVID-19 (see *Appendix*).^{10 11}

Governments and institutions recognise that we must place a renewed focus on addressing the growing needs of people with NCDs as we respond to the immediate crisis of the pandemic. The European Union (EU) has made available substantial funds and grants to support post-pandemic recovery in Member States,¹² but when it comes to NCDs, national governments' actions appear somewhat disjointed and lacking in long-term vision. Unless governments seize this opportunity to overhaul their health systems, we risk failing

to curb the impact of NCDs on our societies. We also risk finding ourselves in the same situation again: were a highly infectious disease to strike in the future, there is a real danger it would wreak further havoc on our health systems and compound the vulnerability of socioeconomically disadvantaged groups who are most likely to live with multiple NCDs.

The risk of and outcomes from NCDs are shaped by multiple factors, and tackling them will require an integrated approach across all policies. Broad action is needed to truly tackle underlying inequalities that result in poor health outcomes in socially disadvantaged groups: legislative and fiscal measures must address the social, economic, commercial, environmental and behavioural determinants of NCDs and health.¹³ Action in other sectors, including social care and education, will be needed as part of a broader societal effort towards sustainable prevention and control of NCDs.

To understand the extent to which the challenge posed by NCDs is being addressed as part of post-pandemic plans across Europe, we have reviewed the international literature and recovery plans of five European countries: France, Germany, Italy, Spain and the UK. Based on this analysis, we have highlighted specific opportunities and examples that offer lessons to policymakers in their quest to curtail the threat of NCDs once and for all, as part of sustainable, equitable and resilient health systems.

Health system sustainability

A **sustainable health system** is one that is able to continually deliver its key health system functions (stewardship, generating resources and providing services) and in doing so improve population health, even in the presence of unforeseen crises.¹⁴

Health system sustainability encompasses the notion of achieving health equity, seen as a state of absence of unfair and avoidable systematic differences in health between population groups which differ with regard to their social, economic, demographic, ethnic or geographical background.¹⁵

Resilient health systems are able to absorb, adapt, learn and recover from crises born either of short-term shocks or of accumulated stresses. Resilience allows systems to minimise the disruption such shocks can cause to health services and their negative impact on population health. Resilience is thus a core component of sustainability.

Planning for health system recovery: the response in European and national health policies

The global health policy community has recognised the urgency of reforming health systems and acting on NCDs post-pandemic, but concrete actions from governments are needed to implement meaningful change.

Some of the world's leading multilateral organisations have voiced frustration about the lack of action globally on addressing NCDs as part of post-COVID-19 recovery.

The WHO, UN Development Programme and the UN Inter-Agency Task Force on the Prevention and Control of NCDs have pointed out the long-standing lack of investment in tackling NCDs and set out immediate priorities for countries as they look beyond the pandemic. Among these priorities are: increasing funding for NCD prevention and control, better access to care, and addressing NCD risk factors holistically, including economic and environmental determinants.¹³ Both the WHO and the European Chronic Disease Alliance have also emphasised the need for better data collection on chronic diseases and associated risk factors.^{13 16}

These organisations have further demanded that health be prioritised alongside fiscal, economic and environmental policies – and this will be crucial to formulating an effective response to NCDs in a post-COVID-19 world. The WHO's newly established Pan-European Commission on Health and Sustainable Development is pushing for overall policymaking to consider the importance of health. It calls for the establishment of a G20 Global Health Board of national health and finance ministers to facilitate coordination of health, economic and financial policies. It also demands clear commitment from governments to increase funding for primary, social and mental health care, and invest in prevention of both communicable and non-communicable diseases.¹⁷

At the EU level, despite dedicated multi-year programmes and funding for national post-pandemic recovery plans, concrete asks to Member States to address long-standing health system issues, such as NCDs, appear to be lacking.

The EU policy response to post-pandemic recovery rests on a vision of building fairer and more resilient health systems and providing quality healthcare, with a strong focus on digitalisation. The European Commission uses pan-European programmes and recovery funds as an instrument to hold Member States accountable for measures they are taking towards social and economic recovery from COVID-19. To be eligible for funds, national governments were required to present plans for a green and digital transition, reducing inequalities, and creating resilient health systems and social protection.¹⁸ Various long-term programmes such as EU4Health, Digital Europe and Horizon Europe have been adapted in light of the pandemic,¹⁹ and a stronger EU mandate through the creation of a European Health Union aims to foster greater collaboration and create shared disease management strategies across Member States.²⁰ EU4Health will provide significant funding for initiatives centred on disease prevention, digitalisation, the healthcare workforce, crisis preparedness and cancer.

Despite the central role that addressing NCDs should play in strengthening health systems, plans on NCDs are not positioned as a key element of EU-wide recovery. Cancer is a specific priority in EU health policy, but other NCDs are rarely mentioned.¹⁹ While a dedicated steering group exists for NCDs, there is little specific action included in the EU programmes mentioned above.

In line with EU priorities, national strategies to rebuild after the COVID-19 pandemic do not appear to fully recognise the challenges posed by NCDs.

In the five countries we have analysed, national action plans for post-pandemic health system recovery tend to focus on the short-term response to the crisis, with little recognition that improving the organisation and delivery of care for NCDs is essential to building sustainable health systems. Many national recovery plans, for instance those in France²¹ and Germany,²² focus on investment in the hospital sector and preparedness for infectious diseases. Commitments to strengthening primary care and chronic disease management appear to be largely absent from the recovery plans. Italy is an exception, with its commitment to scale up best-practice ‘community homes’ (see *Case study 4* on p. 11).²³ In these homes, teams of general practitioners, specialists, nurses and social workers are the main point of access to care, and provide monitoring and support for people with NCDs.

Investment in the digital transition is a central element in all national recovery plans and could be an opportunity to make delivery of NCD care more efficient. Following the clear ask of the European Commission, European countries have made the digital transition a flagship area in their recovery plans.¹⁸ Germany, Spain and the UK are among countries that have already made such commitments, promoting the use of eHealth.²⁴⁻²⁶ This could prove beneficial in expediting the roll-out of digital health technologies for the prevention and management of NCDs. However, the links between digitalisation and better NCD control are not explicitly mentioned in recovery plans.

Existing long-term health strategies may support action on NCDs, but in some countries implementation risks being delayed because of the pandemic. France, for example, launched a comprehensive national health strategy, *Ma santé 2022*, promising to advance care for NCDs via means including structural and workforce reforms and promoting integrated care.²⁷ The French government appears to have maintained this focus despite the pandemic, as it launched the French cancer control strategy 2021–2030 with a 20% increase in funding.²⁸ By contrast, in England the implementation of the ambitious NHS Long Term Plan has already been delayed owing to the pandemic (*Case study 1*).

Case study 1. UK: Delays to the implementation of the NHS Long Term Plan

The NHS Long Term Plan, published in 2019 as a long-term vision for reform, covers areas such as ensuring a healthy start to life, addressing major health problems (e.g. heart disease and cancer) and ageing well. A range of promising programmes and interventions support these aims, but the pandemic meant that many, including programmes addressing non-communicable diseases, have been sidelined. A report by the Health Foundation found that more than half of service specifications that were due to start in April 2021 were delayed, including action on prevention, cardiovascular disease diagnosis and health inequalities.²⁹

Opportunities to strengthen health systems and tackle NCD prevention and care

As health systems adapt after the pandemic, we will need a ‘new normal’ for dealing with NCDs. What could this look like and what should we prioritise?

Recognise that care delivery should not prioritise one condition at the expense of another

Health system sustainability cannot be achieved without recognition of – and action against – the dual threat of communicable and non-communicable diseases.

The pandemic has made it strikingly clear that there are important linkages between NCDs and infectious disease. Health systems must be better equipped to cope with people presenting with multiple conditions – and this was certainly true before the pandemic as well. Known and tested components for addressing multimorbidity, including integrated care, multidisciplinary teams and person-centredness, need to become a reality for all. This is essential to break down silos in health system delivery and in people’s experience of care. What it requires is addressing shared risk factors and the interplay of conditions based on each person’s health needs and preferences (*Case study 2*).

Case study 2. US: Integrated care at the Cleveland Clinic

As part of a transformation towards a model of integrated care, with a patient-centred approach at its core, the Cleveland Clinic in Cleveland, Ohio, has implemented a range of innovative practices and a focus on continually improving outcomes:

- Abandoning the traditional hospital structure of siloed specialist care units, the clinic set up ‘multidisciplinary institutes’, where healthcare professionals address all the conditions affecting a particular organ, such as the heart or brain.
- To ensure continuity of care, the clinic launched a certification for patient-centred medical homes to create a standard for comprehensive, collaborative care in primary care practices.
- The clinic established shared medical appointments, where groups of patients with the same condition attend a doctor’s appointment together, benefiting from more face-to-face time and peer support.
- Delivery of care is rigorously evaluated in terms of clinical outcomes, costs and patient satisfaction.^{30 31}

Make dual care pathways practicable within the architecture of the health system

It is crucial to ensure that healthcare services continue for people living with NCDs as part of a resilient response to crises like the COVID-19 pandemic. Implementing flexible models such as dual care pathways can help guarantee that existing healthcare services keep running in parallel with pandemic response efforts³² (*Case study 3*). Such strategies need to be comprehensive and recognise the equal importance of addressing mental, physical and social health needs. They also need to make the most of innovative approaches, including evidence-based digital technologies, to ensure that people living with NCDs receive continuous care and follow-up while minimising their exposure to any potential infectious threats.¹⁶

Case study 3. UK: A dual care pathway for the provision of elective and emergency care during a pandemic

To minimise disruptions to non-COVID-19 care, Croydon Health Services NHS Trust set up an elective care centre which ringfenced beds solely for elective care. The trust repurposed existing theatres and wards to expand capacity for emergency care.

The separation of clinical pathways and the redeployment of staff allowed the trust to provide care for non-COVID-19 patients, including many with non-communicable diseases. This included providing emergency care in dedicated theatres and delivering high-volume, low-complexity elective surgery throughout the pandemic. People who had tested positive for COVID-19 were treated in a separate area of the hospital. The changes to how surgical care was delivered minimised disruptions to training of theatre staff, and prompted a new way of thinking about how hospital staff could be redeployed and their scope of work expanded.³³

As a result of the redesign of care pathways, up to 60% of patients were still able to receive planned care at the height of the second wave of the COVID-19 pandemic in winter 2020/21. The hospital was also one of the few NHS trusts that, in summer 2020 after the first wave of COVID-19, got back to meeting waiting time targets for cancer care and started treating the backlog of patients waiting for surgery.³³ By August 2021, the waiting times for neurology and cardiology services were above the NHS operational standard.³⁴ It also allowed the trust to take in patients from other trusts in south London.³³

Strengthen primary and community care to enable a better response to NCDs and future crises

Greater investment in primary and community healthcare workforce capacity will be essential to manage the growing burden of NCDs. Ensuring continuity of care for people with NCDs during a pandemic and beyond is vital.³⁵ Policymakers must ensure that policies are put in place to help expand services and build greater workforce capacity within primary care, including community pharmacists, nurses, physiotherapists and community paramedics (*Case study 4*).³⁶ These professionals play a central role in improving care for people living with NCDs and other chronic conditions.³⁷

Capitalising on expanding skill sets and the remit of primary and community care is also important. During the pandemic, the remit of pharmacists was expanded in many European countries to cover activities such as renewing medications for chronic disease.³⁸ This could pave the way towards pharmacists playing a greater role in the long-term management of NCDs. Investing in training the broader primary care workforce will be important to enable them to manage patients with complex chronic conditions and refer to specialist care as needed (*Case study 5*).³⁶ This will ease some of the pressure on specialist and hospital care, streamlining resources more effectively, and may also help address the growing shortage of general practitioners seen in the UK and elsewhere.

Case study 4. Italy: Community homes for multidisciplinary provision of care in the community

As part of its effort to strengthen the health system post-COVID-19, Italy has committed to boosting the roll-out of 1,300 community homes (case della comunità), first implemented in the region of Emilia-Romagna as 'health homes' (case della salute) around a decade ago.³⁹

Health homes are community health centres staffed with multidisciplinary teams that include general practitioners, specialist doctors, nurses, psychiatrists and social workers. They serve as a first point of contact for patients. During the pandemic, some of the health homes were kept COVID-19-free to enable regular care without disruptions for people with chronic diseases.

A 2019 evaluation found that health homes contributed to a 16% reduction in avoidable admissions to emergency rooms, a reduction in non-essential hospitalisations, an increase in integrated medical and nursing care provided in people's homes, and high patient satisfaction.⁴⁰

Case study 5. US: Connecting healthcare providers with specialist doctors for telementoring and continuous learning

ECHO (Extension for Community Healthcare Outcomes) is a telehealth model that aims to address widespread issues in disease management: shortage of specialist workforce; difficulties in providing ongoing education, especially in remote areas; and gaps in disease-specific knowledge and confidence among primary care professionals.⁴¹

Following the principle of ‘moving knowledge, not people’, the model links primary care professionals and community health workers with specialist healthcare professionals, such as endocrinologists or dermatologists. They provide telementoring and ongoing education, thus amplifying specialist knowledge and enabling primary care to confidently treat patients with sometimes complex conditions.

ECHO has been applied in 44 countries and various disease areas, including cancer prevention and diabetes management.^{41,42} It has consistently proven beneficial for participants’ learning. An outstanding example is Endo ECHO, a programme in New Mexico, which improved community health workers’ confidence in managing people with complex diabetes by 130%.⁴¹

During COVID-19, the model was applied in New Mexico to support and educate healthcare workers. The First Responders ECHO helped more than 9,700 participants improve their psychological health and self-care during the pandemic.⁴³

Fully integrate digital health into healthcare

Enhanced use of digital technologies could contribute to better management of NCDs, but their implementation must be evidence based and equitable. Many existing technologies have seen a leap in uptake during the pandemic, moving from the periphery to mainstream provision of care. There has been increased interest in digital technologies such as remote monitoring (*Case study 6*) and an acceleration in use of virtual consultations with multidisciplinary teams for several NCDs, playing a key role in increasing access to high-quality care.^{44,45} However, it is vital that the roll-out of promising technologies and remote consultations be supported by further research into best-practice implementation. We must also guard against a one-size-fits-all approach by ensuring that digital literacy and personal preferences are taken into account when offering remote care to patients.⁴⁶

Case study 6. UK: Home-based cardiac rehabilitation for people with heart failure

To improve access to affordable cardiac rehabilitation for people with heart failure, a UK-wide research collaboration introduced the Rehabilitation Enablement in Chronic Heart Failure (REACH-HF) programme in 2019, co-developed by patient representatives and healthcare professionals.

REACH-HF is a 12-week home-based rehabilitation programme that provides participants with guidance on chair-based exercise, an interactive booklet to track symptoms, and resources for loved ones. All participants are supported by a physiotherapist or cardiac nurse.⁴⁷ The programme has proven cost-effective^{48,49} and been shown to yield better health-related quality of life than usual care.⁴⁷

COVID-19 led to a surge in demand for REACH-HF, with a large number of healthcare professionals requesting facilitator training. Overall, 89 additional healthcare professionals were trained in the UK and are now able to deliver REACH-HF in their area. The programme was also adapted to replace face-to-face visits with telephone support. It was well received by both healthcare professionals and participants.⁴⁹

Effective management of co-existing NCDs will require better interoperability between different data sets and digital platforms. People living with NCDs often present with a range of interconnected conditions. IT systems should be able to combine data from across a person's care pathway, including information on risk factors, wellbeing and quality of life, and how different conditions affect one another. At present, patient data are often stored across different IT systems, such as primary care, community care, hospital databases, clinical registries and insurance systems. Interoperability could be improved by countries investing in, and scaling up, existing data linkage initiatives to develop common data standards and processes. This in turn can promote exchange of information and best practices between healthcare institutions and countries,⁵⁰ ensuring that appropriate regulation around data protection and privacy is in place.

Foster self-management and patient empowerment

A major proportion of disease management falls on the people who are living with NCDs – supporting them in their self-care will foster patient empowerment and reduce pressure on primary care. It will be vital to increase efforts to promote self-management and patient activation, and to strengthen the role of primary care in delivering long-term support for people with chronic disease. In diabetes care, for example, long-standing pressures on health services intensified over the course of the pandemic, but also gave a clear nudge towards emphasising self-management, such as continuous glucose monitoring and access to regular remote reviews.⁵¹ The use of remote consultations and digital monitoring may prove beneficial beyond the pandemic for long-term support and monitoring in many NCDs; however, it will need to be accompanied by targeted education and support so that patients are empowered to make full use of these technologies.

Comprehensive collection of patient-reported outcomes data can help guide clinical decision-making and ensure ‘real-time’ actions to improve care for people through digital monitoring. The integration of data on a person’s quality of life, patient-reported outcome measures, and other patient perspectives on their wellbeing and care is integral to optimising NCD care. Remote monitoring of these data can help ensure continuity of care and facilitate targeted intervention by clinical teams without patients having to go to hospital (*Case study 7*).

Case study 7. Mexico: Using remote collection of patient data to improve cancer care

Patient-reported data on symptoms and physical activity have the potential to improve remote monitoring and disease management. A pilot study in Mexico used data from smartphone accelerometers to measure step count remotely in people undergoing chemotherapy. Measuring step count can give insights into changes in patients’ physical activity levels, which can indicate symptoms such as pain and fatigue. A drop in a participant’s step count of greater than 15% alerted the care team to get in touch with the person and investigate whether they were experiencing toxicity from their treatment.

Study participants were highly satisfied with the programme. Of those flagged by the system as possibly experiencing treatment-related toxicities, 60% could be managed over the phone and 28% received urgent medical interventions.^{52 53}

What next for NCDs in post-COVID-19 healthcare?

The COVID-19 pandemic must act as a catalyst, motivating policymakers and decision-makers to improve the management of NCDs and thus ensure the future sustainability of our health systems. This would enable the continual delivery of high-quality care to all and create a buffer to absorb and respond to any future crises.⁵⁴ In all efforts, we must never forget to take a person-centred approach, ensuring that the needs of disadvantaged groups who are at risk of or already living with NCDs are proactively addressed.

As countries take steps towards recovery, governments must recognise the interconnectedness of non-communicable and communicable diseases. This means thinking about synergies across services, rather than focusing on single diseases, and taking coordinated actions. Investment in increased primary care capacity should be prioritised to allow for better disease management and continuity of care.

We also need to widen the lens on health, acknowledging the complexity of and interdependence between NCDs, the wider determinants of health and overall socioeconomic prosperity. Tackling NCDs will require broader action, addressing environmental, social and economic factors, and thus engagement from all public services. Prevention, early detection and tackling deep-rooted causes of disparities in health outcomes must be priorities shared by all.

For the past two years, our view of health systems has been narrowed to focusing on their ability to respond to pandemics. Yet the threat of NCDs cannot be forgotten. Addressing it through proactive system change, targeted investment and proper integration of care is essential to ensure the future sustainability of our health systems, for the benefit of all.

Appendix. The impact of COVID-19 on selected NCDs

Spotlight on cardiovascular disease

The COVID-19 pandemic has disrupted vital cardiovascular care services across Europe. The number of cardiac imaging procedures, an essential diagnostic tool for both acute and chronic cardiac conditions, fell by 69% in April 2020.⁵⁵ In-hospital and follow-up care for people with cardiovascular disease was also significantly reduced.⁵⁶ In England this meant that around 131,000 fewer cardiac procedures and surgeries were performed during the first year of the pandemic than in the previous year.⁵⁷ Globally, 76% of cardiac rehabilitation programmes – which are crucial for recovery and secondary prevention – were temporarily or completely suspended.⁵⁸

As a result of pandemic disruptions, mortality in cardiovascular disease appears to have increased. More cardiac events (such as heart attacks and strokes) are happening outside of hospital, which is associated with worse outcomes.^{56 59 60} Evidence points to a rise in major complications related to cardiovascular disease, and in many European countries death rates for both heart attack and stroke have significantly increased

compared with previous years.⁶⁰⁻⁶² In Paris, for example, there was a twofold increase of out-of-hospital cardiac arrests during March–April 2020 compared with the same period the year before.⁵⁹

Spotlight on diabetes

COVID-19 has affected people with diabetes particularly severely.⁶³ International studies show that diabetes is associated with higher rates of severe infection and mortality from COVID-19. Risk of severe disability and death has been found to be up to 250% higher among people with diabetes than those without.⁶³

National measures in response to the pandemic have significantly affected diabetes care across Europe.^{51 63-66} A European survey found that more than 40% of people with diabetes had their appointments cancelled or rescheduled during the first wave of the pandemic.⁶⁷ In Italy and the UK, gaps in care meant that more people were presenting with uncontrolled glucose levels than before the pandemic.⁶⁸⁻⁷⁰

Spotlight on cancer

People with cancer are at increased risk of contracting COVID-19 and developing severe complications, as they are often immunosuppressed.⁷¹⁻⁷³ They face a greater risk of death due to COVID-19, especially if they have comorbidities.⁷⁴

People with cancer have also faced significant disruptions to diagnosis and care. The European Cancer Organisation estimates that one million Europeans missed out on a cancer diagnosis because of COVID-19.⁷⁵ In the Netherlands, cancer diagnoses were almost 30% lower in April 2020 than in the month before the pandemic.⁷⁶ Rates of treatment also decreased: according to a survey of oncologists in France, Germany, Italy, Spain and the UK, there was a 52% drop in the number of patients seen per week and a 63% reduction in the number of people starting cancer treatment in April 2020, when many countries faced national lockdowns, compared with before the COVID-19 outbreak. These figures did not bounce back to pre-pandemic levels once restrictions were eased in June 2020, when 36% fewer patients were seen by oncologists.⁷⁷

Spotlight on mental illness

COVID-19 has exacerbated symptoms for many people with long-term mental illness, and triggered stress and anxiety for many more.^{78 79} Globally, it is estimated that the pandemic has led to an additional 53.2 million diagnoses of major depressive disorder and 76.2 million diagnoses of anxiety disorder.⁸⁰

In the UK, the number of adults experiencing depression has doubled since the onset of the pandemic.⁸¹ In Germany, more than half of people with mental illness reported a worsening of symptoms between March and December 2020.⁸² And in Italy and Spain, healthcare workers experienced an increase in depression, anxiety and stress.^{83 84}

European mental health services were already under pressure before the pandemic, and COVID-19 has compounded this. Mental health services were reduced to 'emergency only' or adapted to remote care, with up to 75% of consultations being delivered remotely.⁸⁵⁻⁸⁷ In France, mental health units were closed and transformed into COVID-19 wards.⁸⁸

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