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Case Study

Are COVID 19 Pandemic Policies Good for Public Health

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Jean Woo*

Department of Medicine & Therapeutics, The Chinese University of Hong Kong

***Correspondence Author:** Jean Woo, Department of Medicine & Therapeutics, Prince of Wales Hospital, Shatin, N.T. Hong Kong.

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The answer posed by the title of this article may seem obvious: that pandemic policies are formulated as a crucial part of public health. However, a more in-depth exploration show that the situation is complex and one may not simply assume that all pandemic policies equate with good public health. To do so would imply that these policies override all other aspects of public health. Current debates among Western societies on this topic are highlighted, and discussed with respect to current pandemic policies in Hong Kong, where differences in culture and health and social systems exist.

Horton [1] put forward the concept of using the term syndemic instead of pandemic to describe COVID 19. There is a need to consider biological and social interactions between conditions and states, interactions that increase a person's susceptibility to harm or worsen their health outcomes, rather than follow purely biomedical solutions to COVID 19. An integrated approach is advocated and would likely be more successful than simply controlling epidemic diseases or treating individual patients. This theme is further developed by the Lancet Chatham House Commission on improving population health post COVID-19, which highlights that in order to maintain resilience: breaking barriers between clinical, academic, and policy boundaries, involvement of commercial and other non-state actors, public, policy makers, in modifying key behaviours contributing to NCDs are important strategies [2]. Another aspect in the formulation of pandemic policies is the disagreement between scientists on what should be done, which contributes to a breakdown of trust of pandemic policies [3]. Lastly a book has been written attacking pandemic policies as an example of 'biomedical imperialism', ending with a plea to put both health and care back into healthcare [4].

These comments resonate with the situation in Hong Kong. The government has a panel of scientific and medical advisers, who all have different perspectives based on their area of expertise. The media frequently reports on the opinion of various experts, presumably based on which government policies are made. It can be seen that pandemic policies appear to be dominated by infectious disease and public health experts, who would not have the responsibility of considering the impact of such policies for the whole of society. This is not to negate the important scientific contributions that have been made, such as the monitoring of social movements using the Octopus cards, that enables prediction modelling, as well as the screening of drainage system of housing blocks for COVID-19, to identify potential clusters. There is a need for an evidence based COVID-19

pandemic response policy that incorporates risk benefit considerations, that does not accentuate health inequalities, and that are guided by ethical principles. With successive mutations in the virus, policies need to respond in a timely fashion to fulfill such criteria. These principles also apply to policy implementation. The number of letters to the Editor of newspaper and feedback from television and radio talk shows etc show that trust between the public and government could be improved, as well as the extensive areas of hardships consequent to pandemic policies. With the persistence of COVID 19 world-wide, longer term strategies are needed to tackle health inequalities consequent to pandemic policies (such as neglect of non-acute health conditions, rehabilitation, community care of older people, mental health, school children), as well as loss of employment and economic impact. A more in-depth analysis of pandemic policies in terms of the evidence base (epidemiology, vaccination, virus testing method, elimination of the virus from society, quarantine), and the societal costs especially in accentuating health inequalities for vulnerable and those in the lower socioeconomic groups, has been discussed elsewhere [5]. It cannot be assumed that all pandemic policies are ethical because public health considerations justify them: rather formulation of policies should take into account not only scientific evidence, but with input from the public as well as experts in ethics, and communicated to the public on this basis. It would be instructive to consider whether the issue of trust, and the concept of 'biomedical imperialism', may not also be applicable in Hong Kong.

The disadvantaged: focus on older people

While older people are recognized as the most vulnerable group in terms of hospitalization and death, such that pandemic policies place vaccinations of older adults of the highest importance, the adverse health and social consequences of pandemic policies have received little attention. Among Western societies it has been pointed out that COVID-19 has given rise to some of the worst examples of ageism, where the pandemic has been characterized as 'the boomer remover', where age becomes a rationing criteria for use of ventilators in Italy, and unwillingness to adopt social distancing measures by younger people to protect their older relatives [6]. Hong Kong cannot be said to be deficient in its intensive care provisions in normal circumstances, such that age alone will not be used as a criteria for rationing. There are other clinical indicators of likely response to intensive care treatment, such as frailty, that may guide management. However, when the system is overwhelmed, some form of rationing is unavoidable. This is not apparent to the public, and yet public dialogue would be welcomed, as there is increasing interest about choice of treatment in hospitals, and even choice of admission to hospitals, for those in the last years or so of their life [www.ioa.cuhk.edu.hk/end-of-life-care/].

COVID-19 shines a spotlight on how health and social welfare system have been grappling with unmet needs of the aging population for some time already in all sectors: primary care, hospital care, long term care in both community and residential care settings [7]. Fragmentation and lack of communication exist between health and social service providers; policies exist but there are problems with effective implementation and evaluation. Performance targets are constructed for the service providers rather than for care recipients, suggesting that 'care' may not be appropriately included in the phrase health care or social care system.

Needs of older people who are sick requiring health care during COVID

It is well established that older people who fall ill and admitted to hospital often require a period of rehabilitation before they can recover premorbid functioning, even though the acute problem has been resolved. Before the pandemic, non-acute hospitals as well as Geriatric Day hospitals fulfill this function. During the pandemic Day Hospitals were shut down. Non-acute hospital beds are often used to make up the short fall in hospitals beds due to increase demand for covid cases. At the height of the pandemic three nonacute hospitals were told to convert to care for covid patients. A large number of sick patients with COVID admitted to hospitals were older adults. At a time when such rehabilitation services are in high demand, paradoxically such services were cut. The consequent pent up demand has not become apparent, but would likely contribute to an epidemic of frailty and disability in the not too distant future [8]. Furthermore, older adults who survive COVID 19 infection have persistent symptoms and functional impairment, particularly those with multi morbidity and frailty, requiring a period of post acute care [9, 10]. Such services must be regarded as essential and not take a second place to acute care. From a broader perspective, older people are more vulnerable to pandemic measures in addition to the infection. Successful pandemic control must be balanced against adverse consequences of pandemic measures [11]. Community support services must also be regarded as essential, and not left to individual non-governmental orga-

nizations to decide. Withdrawal of services results in functional and cognitive decline, resulting in carer stress [12]. Even for older adults with no functional impairments, physical inactivity consequent to lock downs result in loss of muscle function and gain in body weight [13]. This situation is magnified for mandatory hotel quarantine of 21 days, when combined with poor nutrition [14].

Case study

A 70 year old lady living with her husband and daughter and independent in all functions developed onset of acute back pain which limited all movements. As this occurred at the height of the fifth wave, and no visitors were allowed, her family opted for private care and was admitted to a private hospital. She was found to have para vertebral abcesses requiring drainage. As the problem was recurrent and was accompanied by life threatening septicaemia, she underwent four operations, required intensive care, and consultation with multiple specialists. After three months of stay, she was discharged, but could not walk or transfer or manage toileting without assistance. Appetite was poor and there was weight loss. She also had a foley catheter in situ. The patient required intensive rehabilitation with a holistic review of all her medical and functional needs, which is best carried out within a multidisciplinary geriatric setting only available in the Hospital Authority. However many beds were taken over for COVID 19 patients; geriatric Day Hospitals which normally would undertake a comprehensive assessment were closed. The relatives sought help through friends who were connected with the Public Hospital services. The hospital in their district had no beds for in patients assessment and rehabilitation, because of the COVID 19 situation. Essentially the family had to fend for themselves, with much carer stress, and the patient may become more dependent for self care in future, a scenario which should have been avoided. How should the medical community balance the needs of this patient, against the needs of patients with COVID-19 infections, and the prevention of transmissions? One should argue that all community and day services should be classified into the essential category, just as outpatient clinics, as their needs are even greater. It seems that advocacy for those who are not labelled with a specific disease would receive lower priority service provisions; yet such problems are just as much a public health one as the COVID-19 pandemic.

Conclusion

The above discourse argues for the need to go beyond a biomedical vision for solving this syndemic, and to distinguish the difference between biosecurity and public health [15]. There is an urgent need to develop a resilient health and social care system that work in synergy; with fit for purpose policies to support this.

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