

WEBINAR TRANSCRIPTION:

HOW TO PRIORITIZE HEALTH INTERVENTIONS IN TIMES OF A PANDEMIC? SCARCE RESOURCES AND INFINITE DEMANDS

Presented by Amanda Glassman, Robert Klitzman and Javier Arcos

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PANEL DISCUSSION:

Minute 00:06:22

Bill Savedoff: Amanda, I would like to start by asking you about the broad picture here. CGD (Center for Global Development) has raised a lot of concerns about the tough choices that countries are making during the pandemic, often without explicitly recognizing the trade-offs. If you could just start by talking about how you characterize these choices and trade-offs and why would you say that they matter.

Amanda Glassman: Thank you Bill and it is great to be with all of you again. We are seeing at least three allocation choices and went then into each area of allocation trade-offs, few of which have been clearly articulated by policy makers and their partners and have not really been examined empirically.

The first choice is how we are going to spend between the health sector and the rest. The IMF is showing that low income and emerging markets are spending a little bit more on health but not much more. There is an increase of about 0.2% to 0.3 % of GDP. That hardly represents a surge. The social protection and firm response has been several orders of magnitudes larger and that is fine, given that the effects of recession and wellbeing and the relationship between recessions and health is also important and has important effects. But we have to recognize that without driving down the virus the rest won't work and will just increase the costs associated with those pieces of the response. So I do think we need to rethink the magnitude of resources going into the health sector urgently and I wonder if our countries are even doing the fiscal planning to purchase an eventual vaccine, for example.

Second, there is the critical allocation choice in allocation of money, effort between healthcare and prevention, clinical care and prevention. We are seeing countries scale up oxygen and ventilators but how much money and effort is going into interventions that enable hand washing, distributing and encouraging the use of masks, for example, that might make a larger impact on the spread of the disease?

And finally, there is the question, which I think occupies most of our panel, which is within clinical care what to do? Here too we need to take a "whole-of-health" approach. In other words, we need to look at the net impact of measures taken on health outcomes and excess deaths are a rough way to look at this issue and have been of increasing importance, especially because cause of death data from low-and middle-income countries is very poor and very incomplete. So really we are relying on these totals of deaths to understand what's happening. I would say that at the start of this pandemic we did not have enough data on COVID-19 but we have always had lots of data on other health interventions, their health effects and their costs. So what we need to do is look at (...) you know that letting vaccination rates fall, not providing reproductive health services, not doing early management of some cancers, for example, the health risk of the interruption of these services may be vastly greater than that of COVID-19 itself. We at CDG have posted a tool that enables some self-calculation of the net impact of

COVID-19 restriction policies on other outcomes. And I would say this is a lesson we learned in previous outbreaks and we already know that it causes huge health effects. Why aren't we acting as if we knew that? This is a very important policy issue that is not addressed.

And finally, I think we need to pay better attention to palliative care. There are stories emerging out of the UK and elsewhere that illustrate the extreme hardship that closed or highly restrictive services are creating for people who are terminally ill or for people who would normally be in hospital care or hospice care. And I think for the people themselves and also for their families and caregivers it is quite dramatic. So those are the many allocation choices ahead with huge trade-offs.

Minute 00:10:17

Bill Savedoff: Thanks Amanda. That is a fantastic overview and you packed it into a small period of time with a lot to think about there. I would like to turn to Dr. Klitzman. That sort of the picture we have, these trade-offs that are happening in this broad allocation question - what I would like to ask you about, people talk about health care in terms of equity, fairness and human rights and ethical judgments often sound simple in the abstract but they are really extremely painful in specific circumstances. From the way Amanda was talking about them, we could get some of those pictures. If you could say a little bit about how you see the role of ethics in public health policy. Is it possible for public health policy makers to consider ethics more generally and in responding to an emergency like this?

Minute 00:11:32

Robert Klitzman: Yes, great questions and also thank you so much for inviting me to this panel and this discussion. I think these are very important issues and I am really pleased to see organizations looking at them and hopefully we can all learn from each other going forward.

So going back to what Amanda has said, there are very difficult trade-offs involved and it is important to have fair processes in thinking about them to involve stakeholders and also aim to have good and fair outcomes. In general, in bioethics – as mentioned I have been involved with bioethics at Columbia University and elsewhere for a number of years – there is several basic principles that we try to follow. One is the rights of individuals, including human rights. We have a right, many of us believe, to a certain amount of health care and rights to make decisions for themselves. There are also principles of beneficence. We try to do as much good as we can and converse we try to avoid risks and harms. And we abide by principles of justice. We don't want to unfairly burden one group and unfairly favor another group but we are concerned about issues of equity and social justice. These sound, as you say, very simple but the problem is that they can often conflict. And particularly in a pandemic when there is a public health emergency crisis they can conflict. So, for instance, we believe that individuals have rights. On the other hand, if people go out and don't use a mask, because they don't want to use a mask or don't wash their hands, they are going to spread the virus. And if they have been infected they are going to infect other people.

So there are times that in the name of public health we say that we need to restrict certain individual rights because of the greater social benefit that is involved. And similarly if we only have so many ventilators or so many intensive care unit beds or so many hospital beds. Let's say we have a hospital where we only have a hundred beds and ten ICU beds and we have a thousand patients. We need to decide which patients will get the bed. So obviously, as Amanda was suggesting earlier, the best cure is prevention. So if we can prevent an increasing number of patients and if we prepare in advance. And as Amanda mentioned also, the problem has been that there have been reports in the past following prior public health emergencies such as the H1N1 pandemic a few years ago. A number of countries and states, in the US New York State and other states, come up with guidelines saying that we need to prepare for such emergencies that we are now facing and we need to invest in long term benefits in terms of deciding that we are going to stock pile personal protective equipment or masks and invest in personal education etc.

And a major problem has been that we respect benefits ethically but there are long term and short term benefits. And a major problem has been that policy makers are focused on short-term problems and benefits and have not thought about long-term ones. And yet again this is another illustration of why ethics are crucial in public health and in policy responses to an epidemic because they involve tensions between: we could focus on treating everyone now or we could focus some of our resources to trying to prevent a future pandemic.

And of course COVID is a problem because it is new and so we – as Amanda was saying – don't have as much information as we need. But also we know that the curves start out with few cases and slowly mount and then hit a tipping point and suddenly it takes off. And it is easy when the numbers are low to think: "ok, well it will still go away". And policy makers can be in denial of it because there are only a hundred cases, or a thousand cases in my country, so no need to worry about it. But scientists are saying that if the curve looks like this [slowly rising] it is soon going to look like this [steep increase]. And so you need to begin to plan for the future needs and think about the future benefits that we are going to need even if there were short-term costs in terms of having to switch beds over, having to delay certain treatments for patients today. So benefits and risks are important ethically.

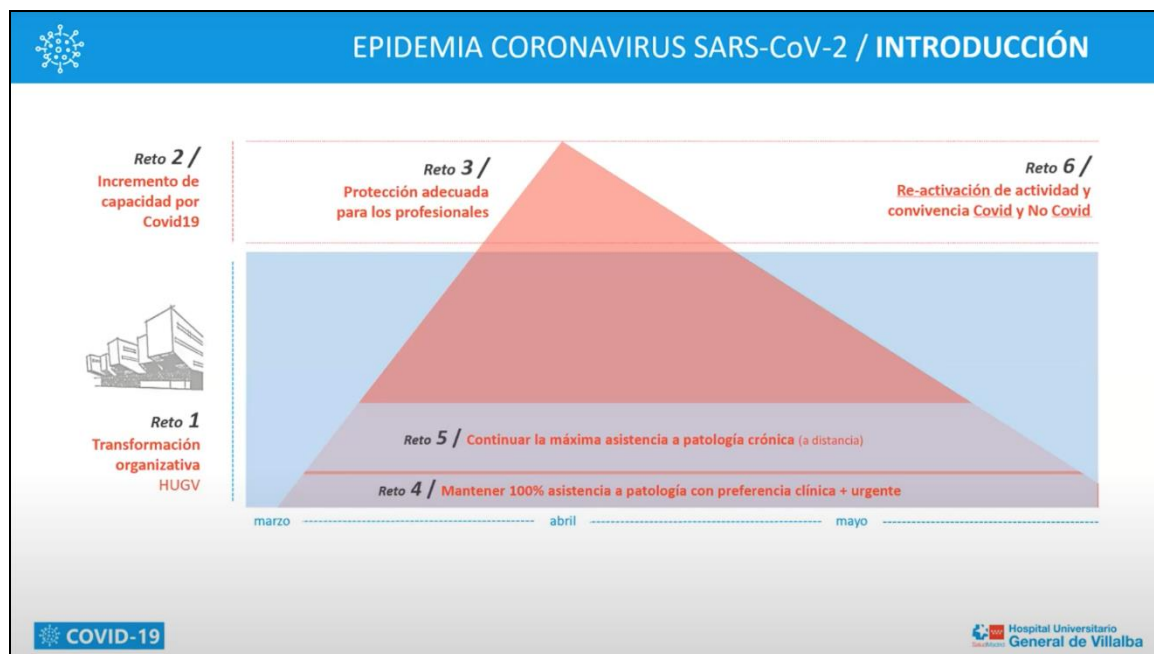
And the last thing is justice. And the major problem has been that we want to make sure that poor people, in whatever country we are in, in the United States, in New York, are not disadvantaged. We know that certain groups are going to be at an increased likelihood of getting COVID and of getting sick and dying, the elderly, the poor, people with prior medical conditions, or in the United States unfortunately, people of African American descent. We know partly because they have had poor access to health care to start, they have more prior conditions and they are more likely to get sick. There are people with disabilities. So we want to make sure that in allocating resources and in making these decisions that we don't increase the gaps between the "haves" and the "have-nots". And these are fundamental ethical issues of making sure that we are not making these gaps worse, that we are not discriminating against people. And I am going to say that this is becoming increasingly important. As we develop

treatments and vaccines there will be questions of whether there is a limited supply initially of the number of vaccines and doses of a treatment we have. Who should get them? And I think as we are talking later in the session we need to come up with a fair process of making these kinds of ethical decisions. So ethics are critical. They seem simple but they are, in fact, often complex given the uncertainty and the newness of the pandemic.

Minute 00:18:08

Bill Savedoff: I wanted to turn to Javier. You have been at the front line of dealing with this disease. And I am sure I speak for many people when I say that we are grateful for the work that you and your colleagues are doing for patients. If you could tell us about the kinds of trade-offs that you have been facing as a clinician and as a health care provider during the pandemic in Madrid.

Javier Arcos: We have faced many trade-offs during the last months and we have to cope with many of them in the next month. If you don't mind I will switch to Spanish.



Translated from Spanish

The two main challenges or dilemmas we had when we started were how to get the best care for all patients. And when we talk about all patients we talk about COVID and non-COVID patients and how to ensure that all professionals have the equipment and personal protection they need. So in this context and under these two premises we begin to work on the epidemic. We worked in a framework where we defined six points, six challenges or six key lines to define the intervention. If you see on the screen some criteria are designed for a regular activity. We know more or less what activity we have each year. We know how much surgical activity we are going to have, how much clinical activity, how many laboratory tests. We can manage hospitals in an orderly way. When the epidemic came, what happened is that suddenly in the month of

March we had a sudden increase in cases of a new disease about which we do not have much information and of which there is also controversy in its clinical aspects. And we had to completely transform a hospital to meet this new challenge. And this overload of disease, such as COVID, had to come accompanied by a reduction in care for other common non-COVID pathologies.

Thus, we defined the axis of our intervention and the challenges we faced in six points. The first was to transform a hospital. A hospital, from the organizational, architectural and human resources point of view prepared for a series of regular pathologies, had to become a monographic hospital for Coronavirus where 95% of all resources were going to be allocated to the new disease. This was the first great challenge.

The second is that, in addition, according to the estimates we had, in the first quarter of March the capacity of the hospital was going to be completely exceeded. In other words, we not only had to transform the hospital, but also increase its capacity in all areas, hospitalization, ICUs, but we always forget the diagnostic capacity of the laboratory, the capacity of the emergency services. So it was not just a transformation, an increase in capacity.

Thirdly, the adequate protection of professionals. And here we are not only talking about the ability to have personal protection material but also about the knowledge, handling and routine use of them. And this was a challenge almost as important as having the material, the training of professionals.

Fourth, we had to be able to maintain 100% activity, at least in the most important clinical areas other than COVID. We are talking about urgent attention to all pathologies and those clinical processes that time prevents you from delaying, such as oncological pathologies and severe pathologies, such as dialysis patients or other similar patients.

The fifth challenge was how to be able to maintain the activity with those chronic patients who were no longer going to come to the hospital since the situation prevented it and what strategy we could put in place to be able to follow these patients at a distance from their homes or from outside the hospital.

And in sixth place is how to reactivate the activity as soon as possible. We have already talked before about the importance of not only treating COVID, but of thinking about the rest of the pathologies. Now we are going to face a situation that may be even more complex than COVID itself, which is all the delay that is taking place in new diagnoses, in beds for cancer patients, falls in vaccination coverage, the erroneous operation of primary care – by wrong I mean intermittent.

That is to say, the sixth and last challenge, in which we are now working above all, is how to reactivate the activity that is not purely COVID and how to try to recover all that time lost in the rest of pathologies that can generate a much greater impact in the health system than the one generated by COVID itself.

Minute 00:23:29

Bill Savedoff: So it is really quite a challenge to handle the whole sequence of activities that you have to deal with in the hospital at that level.

The next question is back to Robert. It seems like the field of ethics was basically built on these kinds of dilemmas. I think the classic one I learned in college was the train going down the track and there is one person here and there are ten people there. And here you have got a limited number of ventilators or ICU beds. Are there specific criteria or processes that you recommend to help people think through to deal with stuff like this? I imagine there are courses for doctors that actually deal with these kind of things.

Robert Klitzman: Yes, these are great questions. We have, as I said, a Master's program in Bioethics at Columbia and individual courses. We have people from all over the world who take our courses online, we have had for several years, and people might find that of interest.

We looked and continue to look at many of these issues. In general, ethically there are important criteria in terms of the processes one uses and the outcomes. So in terms of processes, it is very important that there be transparency. And we are talking about how to decide in a country or a region, or city who is going to get certain treatments and who is not, as well as some of the other decisions and dilemmas that Amanda mentioned, such as how much we should put resources towards prevention versus treatment. And, as Javier was saying, how much we should focus on patients with COVID versus patients with other diseases and where to draw the line. So you want a process that is transparent that involves stakeholders. You want to hear the perspectives of all the different groups that are involved in some way, different groups of patients, providers, population at large, etc. And, as Amanda was saying, given to the fact that we are learning literally every day and certainly every week about COVID as we get more and more data from more countries. So whatever the process is you may set up, and as Javier showed in his graph, you may set up a process in March but you may need to reevaluate that in April and in May as we see more about what is happening or how well social distancing is working in a particular area. So you need an ethical process.

In terms of what the content should be, here too there are ethical considerations. So if we have a shortage of ventilators or masks or ICU beds or staff, you don't want to do first-come-first-served because there may be people who get to the hospital first who are not very sick and could be home or you may get people first who are really sick and who are going to die no matter what you do and having them take up space in a hospital, if there is a limit in the number of spaces you have, when you can give this space instead to someone who will die if they don't get the space and with the space they will survive. You need to make those kinds of trade-offs.

So you want to not have first-come-first-served, you don't want to do it randomly, for the same reason, you don't want to have a lottery where we just flip a coin. You want a process that is logical. And the underlying goal, with this process called triage, which is allocating resources when we don't have enough for everyone, is that you want to give the limited resources to

people who would die if you do not give it to them. So this is going to allow them to survive and they would not survive if you didn't give it to them. So the people who are going to survive anyway they are not going to get the priority because they don't really need the equipment as much as someone else. And the people who are going to die anyway, no matter what you do, they get lower priority.

You then want to have an independent way of deciding. So you don't want me to decide about my patients because you would say: "well I really like this one patient, I really want to help her. And this patient I don't really know them so I don't want to decide." You want an independent group of doctors, two doctors, who are not directly involved with the care of the patient to decide. And you want to make sure that they are following clear criteria.

You want to assess in terms of how we know if someone is likely to survive or not. You want to use objective criteria. And there have been criteria developed based on whether people have other organ systems that have failed. So if people have had bad heart disease or diabetes or they are in coma or they have severe brain disease or they have severe Alzheimer's. We know statistically that people who have multi-system failures like that are less likely to survive. You want to decide looking at their scales, looking at things like: do that person's kidneys work, do their hearts work, do they have dementia?

And you want to be careful you don't discriminate. You want to bend over backwards, as we say, to make sure that you don't exclude groups who do not need to be excluded. So, for instance, we are concerned about people with disabilities. So people with Down syndrome may do well in terms of getting treatment. And the criteria should not be the quality of their life. They may be in a wheelchair, let's say, but we don't want to say: "well they are in a wheelchair so we are not going to help them". It should be based on will they survive to the discharge of the hospital and will they be able to go home alive. That should be the criteria rather than: are they going to be an important person in the world or are they going to be in a wheelchair and that is going to count against them. So there are criteria like that we can use.

Minute 00:29:42

Bill Savedoff: So I am hearing that this kind of putting it in the direction of objectivity and transparency and logic is a way of moving it from that kind of unfairness that you would feel if it was somebody being privileged. So Javier, you deal with this directly. Have you had to face similar decisions and is there something new you have learned in the past few months because of the pandemic?

Javier Arcos: (Translated from Spanish) Yes, we have learned a lot. In fact, in my case, although I now work in the medical management of a hospital, it is true that in the use of limited resources and in that ethical balance of how to use it, I do have a lot of experience because I have worked a lot in different epidemics, both in Latin America as in Africa and Southeast Asia, also in natural disasters, typhoons, Tsunamis, earthquakes. It was not the first time that I had faced such a situation and I think that learning from the previous situations has helped me to

deal with it in a much more objective way. As Robert commented, one must always try to have a criterion of objectivity.

I think it is also very important that this decision-making responsibility does not fall individually on the only doctor responsible for the case. It has to be a shared decision in multi-disciplinary units and with a series of criteria that are based on objectivity and, as Robert said, not on what that person's individual future will be, what his life will be or what its actual quality, but what is the real probability of improvement with that support or that resource.

And in that sense, I believe that our learning has been that what is important is the whole existential process and not just the final resource. There has been a lot of talk about ICUs and respirators but the course of the epidemic, if we look at the history of the three months, has had a first phase where the avalanche of cases was in the emergency services, that avalanche moved to the services hospitalization and later moved to ICUs in the final phase. It is true that the ICU is the most critical resource, but it is necessary to work in the previous phases also to minimize this ethical dilemma and try to provide the necessary resources to all patients. And in that sense I think the key question is not: what can I do to have more ICUs or more ventilators? - which of course has to be done - but what can I do to prevent that patient from reaching the ICU and from reaching that final extreme in which I have to make a critical or conflicting decision?

And in that sense our recommendation or learning has been to try to have all those intermediate units that can facilitate the need for this resource, such as respiratory intermediate care units, which have allowed us to provide less complex ventilator support than an intensive care unit and has managed to prevent some patients from reaching that resource. And, on the other hand, it has allowed us to cut the average stay in the ICU so that this resource can be useful for more people. With the intermediate care units, we have been able to carry out discharges earlier. Therefore, we have shortened the need for ICU time for each patient. And let's say that the ICU resource has been effective for a greater number of people. So perhaps the key to the level of organization in the hospital and the learning has been that, trying to do everything possible before, learning to better manage the disease clinically, increasing and creating new intermediate care units so that the need for this resource is less. And in the event that it arrives - in our case we have had to multiply the capacity of ICUs and respirators by four - that this decision does not fall on a single individual but is agreed with multi-disciplinary teams and based on objective parameters.

Minute 00:33:29

Bill Savedoff: I think it is fascinating. You are pointing out how hard the choices are because we work so hard at loosening the restrictions and the constraint, right? It is not just the number of beds or ventilators but then you try to figure out how to use them in a way that you can serve more people. The more people you can serve the fewer hard choices you have to make.

Javier Arcos: (Translated from Spanish) And also clinical management because in the end, due to clinical experience, we have managed the disease much better in the last two weeks

than in the first two weeks. There is also a lot of focus on clinical learning about disease management because that is directly related to need and the impact of resources.

Bill Savedoff: Fantastic. Those are kind of the trade-offs at the clinical level. I want to step back a bit to allocating the scarce resources more broadly and return to Amanda on this. You mentioned about health services that are not related to the pandemic. They are being postponed and neglected. You mentioned some of the figures about the net impact. I guess the question here is if it is possible to reconcile public policies to slow COVID-19 transmission with the need to maintain the other kinds of health services? And, what role would priority setting play in that?

Minute 00:34:51

Amanda Glassman: I think there is and it is all about (...), you know Javier laid out these five challenges – I think it was five challenges. And one of the challenges was to sustain the provision of essential services by getting them out of the hospital and providing them safely to those who need them. And I would say that, collectively, no country has really figured out how to do this very well yet. And it is obviously an urgent priority. And it is more of a priority in low- and middle-income countries where the prevalence of infectious diseases is much higher. So vaccination is really important in the United States where the measles vaccination rate is so low that if we let our vaccination rate fall any further, which has happened, we are going to be subject to another outbreak that is much more health damaging and to a different group of the population than COVID.

I wanted to respond to your previous question because I think there are two really interesting examples. And I will use the examples of the UK and the US just because they are quite well documented. So in the UK what we are seeing is that people are ventilated that would not be ventilated under normal priority setting protocols. So we will see a 90-year old person with multiple system failure being ventilated, which the NHS would never have done in a pre-COVID world. And that is because of the huge, I mean you might call it hysteria. It seems like the regular structures for deciding who gets what have a bit fallen apart at the clinical level and the system management level. It is just a reflection what we are really seeing in the practical advice that Robert and Javier are giving us at the clinical level.

And then another example is Remdesivir, which is a medicine that shortens the duration of the illness. In the United States the medicine was held by the Federal Government but no one knew what was the criteria for its distribution, which hospitals got it, which states got it and within those hospitals who was going to get it. And it did end up being first-come-first-served. And of course every facility in the United States does its own thing. And that is another great lesson for everyone else, which is try not to do that. Of course there is some facility specific work that must be done. The committees must operate. But there should be some ability in the way that we decide. We use cost-effectiveness criteria and we use public deliberation around evidence of who could benefit most in health terms and equity terms to decide who gets vaccinated, for example. In the US we have a committee, it is called the ACIP – I am going to forget what it

stands for – but it is based at the CDC. The question is: why wouldn't we use those same mechanisms to decide the allocation of these kinds of medical counter measures?

I think a similar point goes to who (...) even if we are talking about prevention we could think about these priority setting committees also thinking about where are the communities that we know are most vulnerable where we need to take action sooner rather than later, for water and sanitation, for those decentralized services, in-city services for example, older persons homes, hospice care, prisons or slums where there is a lot of overcrowding. We know that information already. I am very disappointed in ourselves collectively for, sort of, not being better. We have been giving a lot of clinical advice from the international agencies but what we are not giving is sort of a public health approach. Where are the communities where I need to act quickly in urban areas to be able to make these prevention investments that will make a difference in the spread of the disease?

Maybe the last thing to say is that many countries in Latin America do have processes to evaluate new medicines, for example to look at their costs and benefits from a health perspective and an equity perspective and to make recommendations to policy makers. I am afraid that they have been slow at recognizing the ethical dimensions of those recommendations and to open those processes up to public scrutiny, to transparency and to deliberation around the evidence so that it would be a decision that was considered legitimate. And I think that is an area where the IDB has been working for a long time and I hope that we can use this opportunity to really elevate and make these bodies that set priorities for public spending much more functional, more dynamic and responsive to what is happening now with COVID-19.

Minute 00:39:43

Bill Savedoff: Thank you. That is really good. Robert, Amanda has been talking about the clinical level examples like the ventilators and then broader questions about the allocations. Is there something you can tell us about that kind of ethical choice not at the triage level of the patients but at the public policy level? I mean there are criteria like cost-effectiveness etc.

Robert Klitzman: We didn't do this well enough I would argue, many of us in the United States. We didn't quite think of the fact that if we put all the resources into treating COVID what would happen to other patients who needed services. And a lot of hospitals said that they were only going to treat COVID and there ended up being patients who died at home who would come to the hospital for heart disease, for instance, and we could have treated them. I think there is a tendency among policy makers to go from denying the illness and underestimating the amount of harm to overestimating, like saying: "Oh my god we have to just focus on COVID", rather than, as Javier and Amanda said, what other patients need. And obviously we are not going to be able to meet every patient's needs but there are some people who might die from heart disease if we don't treat them. So I think that these kinds of considerations need to be taken in and I think that that is why, as part of the process of transparency and local stakeholders, you would hopefully hear those kinds of concerns brought on early enough. I think that when we

began to see that there is a problem in the US we still didn't readjust our direction fast enough. And lastly I think just education and messaging to the public is very important here. And I think that is another area where the better we can do that, telling people to social distance, explaining why even if they don't want to, that can also help with these issues.

Minute 00:41:50

Bill Savedoff: Thank you. Javier, you told us what you did in the hospital in terms of dealing with COVID. How did you and your colleagues deal with these other patients and the ongoing needs of treating other kinds of patients? And what kind of advice would you give to your colleagues in Latin America about this?

Javier Arcos: (Translated from Spanish) I think we can answer the two questions together because in the end our recommendations are basically also fruits of experience. I think there are three key ideas here. First of all, I think we have to understand that health systems have to be prepared to coexist with situations of this type for a long time. We cannot focus on responding to epidemics like COVID by forgetting about the rest of healthcare.

Second, if we look at the cycle of prevention, preparedness, and response every time there is a medical emergency, we tend to start with the third step rather than the first. We always start with the answer without being prepared and without having worked a prevention. And I think this is a very serious warning, globally, that we have to invest much more in preparedness. And when I say invest I mean technically, not necessarily financially, but to be prepared to face situations of this type.

And then I would like to leave three general recommendations that are, in a way, the fruits of our experience here. In the first place, the preparation of spaces and logistics is very important. It is very important, for example - and I think it has been one of the successes at least in our response hospital - we have managed to almost double the capacity of the hospital and quadruple that of the ICU without using spaces in such sensitive areas as the surgical block, where all the surgeries are done, the daily clinic where cancer treatment is done or the dialysis unit, where the most sensitive patients are. This has allowed us, for example, to be able to maintain all the oncological activity of the hospital and to be able to receive oncological patients from other hospitals in the health system that do not have this capacity. And so it has allowed us to keep all critical non-COVID activity in a relatively normal situation.

The second idea is to design very well, from the beginning, the clinical processes of other pathologies. This is here to stay. We don't really know when the second wave is going to be, if there is going to be one or not, or how long it will last. My recommendation is that regardless of the situation in each hospital or in each country, they start working together. A scenario in which we only work at COVID is unfeasible. We must define the clinical circuits: who is going to undergo PCR, who is not going to do it? What is the flow of access to the hospital? How are we going to separate and isolate the patients? How are we going to differentiate the area of the

hospital where they will be? It is work that can be done from the first day of the epidemic.

And thirdly, it is to open the door, finally, to remote medicine with the resources or systems that each center has. We here are lucky enough to already work a lot with our own application, the patient portal. We work a lot with tele-medicine on a regular basis. And we have multiplied the remote monitoring of chronic patients during the epidemic by up to ten, which has allowed us, in many cases, about 60% to 70%, to maintain more or less the regular activity of chronic pathology, of course at a distance.

So the big ideas are: to work much more in preparation, aimed at understanding the coexistence between COVID, or future epidemics, and the rest of pathologies, this is going to be more than necessary in a world as globalized as ours. And thirdly, pick up or try to start as many remote medicine initiatives as possible because they are proving effective not only in epidemic environments like this, but for the sustainability of health systems.

Minute 00:45:32

Bill Savedoff: Ok that is quite a range of very useful ideas I guess. It is another case where we have to be resourceful and use every strategy and idea that you have. That is great. Thank you for those responses.

Questions and answers

Bill Savedoff: *A couple of the questions are around the issue of mental hospitals and nursing homes, which are vulnerable both because resources are going to COVID but also because there are concentrations of people who are quite vulnerable. Do you have any advice, either from a policy perspective or from the ethical or clinical side that you would say how we should be dealing with those?*

Robert Klitzman: I would just say that the feeling we had, many of us in the United States, is that we didn't pay attention early enough to harms that were going to happen in nursing homes. And we are now seeing these in prisons, I should say, in the United States. So I think making personal protective equipment available there, encouraging hand washing and things that can be done for prevention, as I said earlier. We often ignore that even though the cases sprouted up in nursing homes. So we should be extra careful there in terms of distributing personal protective equipment and make sure they get there. And I should just say that in health services I am concerned that there is a lot of symptoms of depression, of stress and of anxiety out there and I think these are other issues that we need to address and that countries need to address and consider and dealing with how to encourage people to exercise, to eat properly, to think of ways to structure their day if they are at home or avoid just relying on alcohol, for instance, as a way to deal with stress for instance etc.

Minute 00:47:34

Javier Arcos: (Translated from Spanish) Adding to Robert's comment, especially about nursing homes and residences in general, I think it has happened to all of us the same. We are all a little late. I think the feeling is global. And there I would add, to Robert's comments, the importance that hospitals, as structures usually with more capacity than many primary care systems, are also involved in supporting residences. Not only the distribution of materials, but also clinical advice. Here, as an example, in that part of the hospital's organizational transformation, since we did set up different brigades and clinical teams that we had to form in an accelerated way because they were not specialists in the field. And they were supporting the residences, moving to many of them daily to try to fill part of the assistance deficit that many of them have because they do not have health personnel or do not have specialized health personnel.

Minute 00:48:30

Bill Savedoff: *We have a question from Wendy Gerber saying: One of the silver linings to this pandemic is the necessity for collaboration globally and regionally.” She is asking your thoughts about how we can foster collaboration. My sense is that an emergency like this brings out the best and the worst in people. It is like there are a lot of people coming together around it but there can also be a lot of fighting. Amanda, I don't know if you want to talk a bit about the international or national collaboration in*

this crisis.

Amanda Glassman: Well, it is a mixed bag as you say. You know, certainly there is some very interesting international collaboration around the development of the vaccines, therapeutics and diagnostics led by the World Health Organization and some commitment to make sure that low-income countries at least have access to an eventual COVID-19 vaccine, although it is still underfunded.

The other great thing is the very rapid sharing of the science and the epidemiology studies coming out of China and the rest of the world. They are being posted without peer review, data sets are being posted, code is being posted. That is hugely interesting although it creates an enormous amount of confusion. I think somebody said 20,000 papers a month are being released on the issue, which makes it difficult to keep up on what do we know and how do we know it. And we are seeing some of that reflected in the confusion on (issues like:) “Do masks work or don’t masks work? Just wear the mask!” So it is actually great in terms of knowledge but it is affecting our ability to communicate clearly as public health professionals.

If I can maybe, I will respond to a couple of the questions that I see popping up on the chat. And it illustrates some of the issues that we have talked about earlier. One of them is from Honduras. It is about how they are facing both, the Dengue and COVID outbreak at the same time. And that sort of raises the question of saying: “ok, we have an expensive, slightly efficacious Dengue vaccine, not as efficacious as we would like, but is this the time (...). You know if I were an international agency or a philanthropist and I wanted to make a difference in health maybe now is the time to help Honduras buy the Dengue vaccine, so that at least they would not have to be coping with two massive outbreaks at the same time, or stepping up fumigation against mosquitos or something like that. We need to be aware that decisions that we are taking in real time about how to manage these competing threats that are consuming so much of our health care resources, when we do have things that we could use but they do cost money. So I think there is some role too for the international community in helping countries to look at this strategically and manage some of these other risks.

Another point was made about some of the small countries doing really interesting things that have been very effective. You know, Vietnam comes to mind where they did a huge public health push and then they did the basic “shoe leather epidemiology”, as they say, test, trace, isolate. And they have done it so effectively that they still have just a very low caseload. And that is not an island. It is a low- middle-income country. It is certainly something that we should all be looking at. And in the United States we need to do the same thing. It is just the basics: test, trace, isolate, repeat, repeat and repeat; and to finance that. Does that exist? What is the status of contact tracing in countries like Latin America? What do we know about the spending on that? I sense that it is inadequate.

I mean Suriname is an interesting example. They have had one case after a 45 days streak of no cases recently. But what is happening there? Is it just that the outbreak is slow to develop?

And then finally an initiative like health and the economy; And I hope that seems clear from all of this. But what I am a little discouraged by when I look at the multilateral banks, and I don't want to single out IDB, I am mainly looking at the World Bank, is that I see this massive social protection and firm response and I do not see the surge in health spending at the level that we need to see it to be able to do this massive contact tracing or related.

I will stop there. I have much more to say, but please e-mail me.

Suriname now has 168 cases. Diana is telling me in the chat. So I am completely out of date.

Minute 00:53:15

Bill Savedoff: *What has been striking is that some of the smaller countries have been able to hold it down because they are isolated or have not opened up. And again we are all kind of wondering what is going to happen as countries start opening international travel and so forth.*

I would like to turn a little bit more to that perspective about transparency and objectiveness in these decisions because it is at every level. It is what the government is choosing to do, what the World Bank and the IDB are choosing to do in terms of allocations and at the clinical level. There is a question from Luis Fernando Gomez involving citizenship and what it is about participation. I thought it was striking what Javier and Robert said that you don't ask a single doctor to make these choices but you have a committee doing it. And in a sense that is kind of the same issue for public policy. It is different to have a president making a decision on its own or a Minister of Health than having a public participatory process. Are there specific ways you have seen that done in different places that could be good models for people to think about? Or other issues that come up when you think about participation?

Robert Klitzman: So I think making sure you have key stakeholders so you don't want to have it as open as possible. You don't want a "free-for-all" where it goes on for months and months and everybody says something. But I think to have a period to make it clear and then have a period of public comments and then have the comments evaluated carefully. I think those are important things. I think it is the commitment to transparency and the stakeholders, in other words to hear from (...). I think unfortunately in the US, for instance, in a number of States they developed criteria and did not include disability advocates or include people from the African American community as much as they should have. And so those communities, which are overly burdened by the epidemic, or might be, I think had not been included and so processes had to quickly catch up. So I think thinking through who do we need to have at the table and not just who happens to show up and it is the usual suspects. But I think since COVID affects all of us in all walks of life it is important to have different perspectives. Who are the essential workers? Are they the poor people? Who can represent them? Things like that; So I think it takes a conscious effort.

Minute 00:55:54

Javier Arcos: (Translated from Spanish) I would like to add. In this perspective of resource limitation, I think - and this is a completely personal point of view - the most advanced income countries perhaps have made a strategic mistake in recent years and that is to imply that our resources are unlimited. And that we don't make these kinds of decisions in real life because before the epidemic, decisions like this were made. In ICUs decisions like these are usually made almost with every patient and almost every day because in the end the resources are not unlimited and you always have to make individual decisions. So perhaps here we have been wrong in implying that our systems are unlimited and that resources are not ending and that this exercise of decision-making on resources is something exceptional in COVID when it is not. That obviously in the impact of public opinion has been more negative because it is more difficult to understand. If we had done better before and if it were understood to be a normal situation, I think that part of public opinion and collective perception of the limitation of resources would not have been so complex.

Minute 00:57:11

Bill Savedoff: *I want to take one last question, a question from Vicente (inaudible) about policies to help health professionals deal with these issues. You mentioned the normal stress. What kind of public policy and managerial approaches do we need to do to help people manage these decisions ethically and trade-offs in their work as health professionals?*

Robert Klitzman: Two things come to mind. One, are legal protections for health care workers. So I don't know the state of liability and malpractice in all the countries we represent here today but at least in the United States doctors were told that they have to do things differently and not follow usual standards of care. But if you don't follow usual standards of care you can get sued. And I think that puts extra strain on doctors. I think there is a need to recognize enormous mental health strains on doctors. So hospitals need to be aware of that. At my own institution we had a COVID doctor who killed herself. It was just too stressful etc. I think institutions need to pay attention to avoid burnout, to realize that we are often taking doctors from other fields and having them work in ICUs and try to get as much training and support for them as possible.

Javier Arcos: (Translated from Spanish) I would like to complement Robert's comment. I completely agree with him. And to give some examples, perhaps, that may be useful for some colleagues, in this sense, we learned from other pandemics. From the beginning, for example, we have had mental health support units for all professionals. And as Robert said, not only in critical areas but at the request of all professionals who needed it and in a structured way for those areas that were fighting the disease in a more intense way. Especially since it must be borne in mind that this is a context where fear is very rational and despite being health professionals we lose an objective point of view when this touches us closely. In Spain alone, there were, at least documented, more than seventy deceased health professionals. I think the data in Italy is also similar. And we are also talking about a disease, really, that we still don't know much about. We are all parents, we have children, sick relatives. The collective fear that

has been generated has been enormous and mental health support has to be one of the most important axis. When we talk about personal protection we are not only talking about masks or bats or gloves but we are talking about mental health protection. And you have to put exactly the same intensity into that strategy from day one as having enough gloves or masks in the warehouse.

Minute 00:59:58

Bill Savedoff: *Amanda, do you want to pitch in on that? I guess it is also related to spending. Where is the money for masks, for protective gear, for mental health support or personnel issues that come up?*

Amanda Glassman: Exactly, you just imagine in an ideal world; I mean especially because now that this initial period is over but we do know that the outbreak will last another year or more. And therefore, this is an ongoing problem this situation of fear and challenge and it should be really part of our planning for the sector. We need to bump up our epidemiology enormously and we need to bump up the protection of the health workers in all respects, not just physically but mentally as well



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