



## COVID-19 and Health Systems

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*Are certain national level healthcare systems better prepared to cope with the COVID-19 pandemic? What makes them more effective than others?*

In general, no health system can ever be prepared for the tremendous surge in need for hospitalizations stemming from an outbreak such as this. The goal is to have an emergency response plan and protocols in place that allows a health system to scale up its capacity rapidly in response to the threat. Health system “resilience” is the buzzword that everyone is trying to measure these days with several recent systematic reviews on the subject (e.g., Nuzzo et al, 2019; Turenne et al, 2019; Fridell et al, 2019), though the consensus seems to be that there is still no consensus on how to actually measure this construct.

That said, some health systems may have had better existing capacity both in terms of available hospital beds and coordination as well as emergency preparedness protocols. It is likely too soon for accurate lesson-drawing, but Korea stands out, for instance, for having a response plan in place to rapidly scale-up testing, tracing and treatment, at least in part due to its recent experience with MERs and investments in developing a unit specifically devoted to co-

ordinating the response to future outbreaks. It also has a higher existing hospital bed capacity at [11.5 hospital beds per 1,000 people](#) (as of 2015), which is relatively high compared with the OECD average of 3.81 in 2013 and the US’s 2.90 beds per 1,000 in 2013. However, with an estimated 10% of COVID-19 cases requiring hospitalization, even this relatively higher bed capacity would quickly become overwhelmed without measures to control the spread of the disease and flatten the curve. Also, during an infectious disease pandemic where the disease is highly communicable, it is critical to separate parts of the health system designated for patients with the infectious disease while protecting the ordinary capacity. This was a [lesson from the West African Ebola outbreak](#) where mortality from “endemic” health conditions, including maternal mortality, ultimately exceeded mortality from Ebola since people were unable to access more routine health services (Powell & Faulkner, 2019).

However, health systems around the world have started shifting away from expensive, hospital-based in-patient care towards building more outpatient care with the result often being hospital closings and a reduction in hospital beds. Thus, being nimble (e.g., China’s ability to construct 3 massive emergency hospitals



over a week), rather than having excess hospital capacity per se, is probably more important in terms of reducing the case-fatality rate.

The United States faces distinct challenges stemming from the particularities of both our fragmented public-private health system and our decentralized local public health infrastructure in terms of our ability to coordinate an effective response. Testing, surveillance and contact tracing is an integral part of the public health response and is critical for disease containment whereas health system capacity is critical to reducing disease-related mortality and mitigation efforts. The U.S. appears ineffective on both fronts, with difficulties sharing information and supplies in ways compatible with either containment or mitigation. The U.S. also stands out among high-income countries for the compounding effect of lack of universal health coverage with nearly 27 million people completely uninsured and reliance on employer-sponsored health coverage in the midst of a combined health and economic crisis. While the \$2.2 trillion dollar stimulus package covers the cost of co-pays/deductibles associated with Coronavirus testing, out-of-pocket spending on treatment for complications from the Coronavirus may not be covered. For people without insurance, [Kaiser Family Foundation](#) estimates that the costs for a hospital stay for complications stemming from Coronavirus could be as much as \$20,000. Even for people with insurance, treatment could add up to \$1,300 in out-of-pocket costs. How this cost structure affects people's behaviors in seeking care, and feedback loops in attitudes towards government as health care bills roll in, remains to be seen.

Thus, emergency preparedness, [organizational resilience](#) and the ability to rapidly coordinate efforts are likely more important to how effective a pandemic response will be than existing health system capacity or type of health system/health system financing (e.g., National Health Service, National Health Insurance, Social Health Insurance, etc.).

*Are our current conceptual tools for analyzing and explaining healthcare systems and policies adequate for understanding responses to and coping with the COVID-19 pandemic?*

With many notable exceptions (e.g., Nathanson, 2009; Balwin, 2005), there is probably a dearth of comparative politics literature that focusses on explaining differences in *public health* systems and responses across countries as opposed to health care systems. Also, IR scholars have perhaps been more engaged in the literature on pandemics, owing to the notion that “diseases do not respect borders” and in their study of international institutions like the WHO. Yet, the study of comparative responses to other pandemics have revealed the critical importance of national political responses to epidemic control (e.g., Lieberman, 2009; Patterson, 2006; Price-Smith, 2009).

I think there is more room to better integrate the comparative political economy literature focused on economic policy differences across states with health responses as this pandemic has revealed the critical importance of safety-nets of all stripes in supporting an effective public health response. We cannot effectively socially distance without aligning systems that promote economic security with our health and public health systems. Past pandemics have shown the social, economic and political



effects of pandemics to be as profound as the health impacts themselves.

But in terms of conceptual tools, we have many in comparative politics to help us to understand state responses to disease pandemics. The literature on governance/state capacity/state strength, boundary institutions/ethnic fractionalization, federalism/ decentralization, electoral incentives and policy responsiveness seem promising as a first cut.

### *Which political factors affect health policy responses to the COVID-19 pandemic?*

There is already some good emerging scholarship starting to try to answer this question. [Sofia Fenner](#) has identified several factors in a [Duck of Minerva](#) blog post that appear useful in explaining some of the different national responses and how successful they have been in curbing the epidemic so far- regime type, leadership, state capacity, public buy-in. She argues that regime type on its own is too crude to predict the effectiveness of the response, but when combined with a proactive leadership response, state capacity and the degree of public buy-in, can explain some of the observed differences.

“Political commitment” is a loose term associated with leadership that is frequently invoked in the public health literature but that is under-theorized in comparative politics, that would likely benefit from greater conceptual attention (Fox et al, 2011). Fenner describes the reason for this inattention to leadership in the comparative politics literature as follows “[leadership] poses a problem for comparativists, who generally prefer to theorize the structural features of societies, states, and economies rather than the choices of individual leaders.” Yet, idiosyncratic leadership choices have proven important in

explaining disease responses- for instance former President Mbeki’s AIDS doubting policies- although these can possibly also be explained by electoral incentives as appealing to science doubting may resonate with certain constituencies (Fox, 2014).

### *Healthcare policies at which level—national or subnational—are more important for understanding responding to and coping with the pandemic?*

I think this likely depends on the country, but certainly in the US context, our decentralized federal structure has not been an asset in this pandemic. In containing a pandemic, coordinated action is key and porous inter-state borders allows the virus to continue spreading. The differential timing of lock-downs and re-opening of the economy will allow the virus to continue to spread even when it has been contained in one locale, especially with the failure to bring testing to scale. Much of the pandemic response is being carried out by the 2,800 local health departments that implement public health policy across the country, many of which are underfunded and understaffed. More theorizing and research on the role of local public health departments in ensuring the public’s health is likely warranted.

On the other hand, decentralized decision-making and implementation could mitigate the impacts of a poorly planned centralized response. More effective responses appear to have occurred in more centralized regimes with proactive leadership, though federalist Germany also stands out for its effective response to date.

Perhaps equally important, though separate, might be to consider how “hollowed out” the state is- both in terms of the outsourcing of





domestic production as well as contracting out to the private sector as a dimension of state strength/weakness. Countries that are captured by private interests (i.e., the US) seem less supple in being able to respond quickly to emerging threats compared with countries that can quickly mobilize the state apparatus.

*How the COVID-19 pandemic is likely to affect healthcare policies and politics in the US and elsewhere in the short- and medium-terms?*

This is the big question. Will we learn from this pandemic or will we be doomed to repeat the past neglect of pandemic preparedness? Following the 2014 West African Ebola outbreak, a bevy of articles came out calling for reform of the WHO and setting out a series of concrete recommendations that governments and the international community could implement, and yet the global community was unprepared and repeated many of the same mistakes. Certainly, the fate of WHO once again hangs in the balance.

One conceptual framework that I find particularly useful for thinking through this question is Price-Smith & Porreca's (2014) Fear-Apathy cycle, which describes the oscillation we seem to regularly observe between moments of panic in the midst of an outbreak, leading potentially to excessively draconian and undemocratic reactions, followed by long periods of total inaction thereby hampering preventive actions. This cycle repeats with frightening accuracy due to

cognitive biases that affect decision-making processes. Re-reading this and related articles written in the aftermath of the West African Ebola outbreak has proven the almost prophetic prescience of this literature as well as the many unheeded warnings.

However, in contrast with previous pandemics, Coronavirus has not remained confined to low- and middle-income countries, nor to low- and middle-income people, at least initially. By affecting centers of power and infecting powerful leaders, pandemics are no longer something that political elites can easily ignore. Most importantly, the potent and far reaching economic effects of this pandemic, which are not isolated to a particular world region gives me some hope that further investments in pandemic preparedness will be forthcoming. However, the exact nature of those investments and whether they will be adequate is an open question as well as whether this pandemic will elicit a retreat from globalization both in terms of production and travel.

In terms of healthcare politics in the US, many are asking whether the millions of people losing their jobs and their employer-sponsored health insurance coverage in the midst of a pandemic, will impact the political calculus over Medicare for All. I am presently designing a survey experiment to be fielded shortly to try answer this question. As of yet, it is hard to say. ●

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