



## What will be the impact of the COVID19 pandemic on healthcare systems?

### Contextualization

For the first time in history, a health crisis has shut down the entire global economy, painfully demonstrating how inseparable healthcare and the economy have become. Is health intrinsically more important now? Or is the overflow of continuous digital information exacerbating fear and influencing political choices? Or is this because so-called 'developed markets' are truly affected this time?

This article will not attempt to answer these questions; however, they are critical to contextualize the future of healthcare systems.

### Introduction

Across the globe, our healthcare systems were not designed to deal with this crisis: an unpredictable, large-scale health challenge that requires urgent mobilization of resources and affects the whole population. Debating these systems' ability

and efficiency to deal with it is therefore not relevant per se.

In many ways, the COVID pandemic is diametrically opposed to the direction that healthcare systems, particularly in developed countries, have been taking over the past years i.e.

### Focus resources on non-communicable, chronic diseases such as diabetes and cardiovascular conditions

- Health issues related to lifestyle changes and an aging population made this type of healthcare burden more relevant for healthcare systems than pandemics. As Zhou Maigeng from the Chinese Center for Disease Control said last year, "going forward, the burden of chronic health problems, especially among the elderly, will far exceed infectious diseases"<sup>i</sup>.
- People aged over 65 will represent more than 11.8% of the total population by

2023, peaking at 29% in Japan and 22% in Western Europe<sup>ii</sup>.

- The number of people living, for example among chronic diseases, with diabetes is projected to increase by 48% to 629 million by 2045, with China (114.4 million), India (72.9 million), and the United States (30.2 million) topping the list<sup>iii</sup>.

### Drive efficiency, shifting care from hospital to outpatient settings

- In France, the number of overnight hospitalization beds decreased by 4.2% while outpatient care beds increased by 7.4% and in-home hospitalization increased by 3.4% from 2013 to 2018<sup>iv</sup>.
- In the United States, aggregate hospital revenue from outpatient services grew from 30 percent in 1995 to 47 percent in 2016<sup>v</sup>, while in England, from 2012 to 2016, the increase in inpatient admissions was 9% and outpatient attendances increased by 21% over the same period<sup>vi</sup>.



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### Incentivize innovation for smaller unmet needs and vulnerable populations primarily, increasing relative focus and spend on Specialty Care

- Rare disease patients make up less than 0.06% of the population in the United States, less than 0.05% in the EU, and less than 0.04% in Japan<sup>vii</sup>. In contrast, worldwide orphan drug sales are expected to have doubled at 12.3% over the 2019–24 period. By 2024, orphan drugs are projected to make up one-fifth of worldwide prescription sales, amounting to US\$242 billion<sup>viii</sup>. In parallel, oncology is expected to have almost a 20% share of the worldwide market by 2024, and an 11.4% in CAGR growth<sup>ix</sup>.

### Limit investment in overall prevention

- In 2015, less than 3% of healthcare spending went to prevention in OECD countries. Most of these countries spent between 2 and 4%, which has remained stable over the long-term. In addition, nearly 50% of prevention spending was on healthy condition monitoring programs, such as check-ups and dental examinations, 25% on health promotion while both immunization and screening programs accounted for less than 10% each. This raises a question on resource allocations; while many immunization and some screening activities have shown to be cost-effective (and some even cost-saving), there is less consensus on the effectiveness of general (including dental) check-ups<sup>x</sup>.

### Immediate and near-term challenge: the COVID emergency and its collateral impact

Leaders around the world are putting in place emergency measures to cope with this health crisis, adjusting in real-time and 'spending each day fixing errors they made yesterday'.

In the near term, healthcare systems will face two major, additional, "collateral" issues. The first will be the physical and mental exhaustion of the healthcare workforce, along with worn-out hospital infrastructure. The second will be the growing "backlog" of healthcare procedures. For example, the inability or fear of high-risk patients to consult a doctor is disrupting chronic disease management and delaying some critical cancer care procedures. In France, consultations have fallen by 40% among general practitioners and by 50% among

specialists since the beginning of the epidemic, even when accounting for the surge of tele-consultations. Concurrently, cancer centers have decided to postpone monitoring consultations and operations considered to be non-urgent<sup>xi</sup>. In addition, containment (and progressive de-confinement) measures, compounded by the economic recession, will undoubtedly affect mental health (e.g., anxiety, depression) and physical health (e.g., weight gain, unbalanced nutrition).

### Long-term view: addressing a new reality while remaining sustainable

The COVID pandemic will have a longer-term impact on healthcare systems, that should be addressed by political and healthcare authorities as soon as possible. Non-communicable diseases will continue to rise – they were projected to account for 75% of all deaths in 2030 — up from 63% in 2013<sup>xii</sup>. Within them, chronic conditions are associated with intensive use of healthcare resources, with for example 70% of total health funding in England spent on 30% of the population that have long-term conditions<sup>xiii</sup>. In addition, mental health is projected to become the leading cause of morbidity and mortality globally by 2030<sup>xiv</sup>. In parallel, the existing management of communicable diseases, including through vaccination, will continue to be a focus.

So, on top of this, how will already resourced-constrained healthcare systems (re)configure to improve their ability to handle unpredictable large-scale health crisis like COVID while remaining sustainable?

The current crisis will inevitably reshape the world we know. In a recent article<sup>xv</sup>, we described scenarios to illustrate the different ways in which our world could unfold after the crisis, across five dimensions:

- **Economy:** will worldwide economies rebound after absorbing a passing storm OR enter an extended recession?
- **Society:** will social cohesion rise with a heightened appreciation for interpersonal and familial relationship OR fall as xenophobia and suspicion of others become the norm?
- **Politics:** will governments around the world gain trust and international organizations such as WHO grow in relevance OR adopt isolationism to protect their constituents?

- **Technology:** will technology advances stay on course OR diverge among different markets, with a focus on advances in surveillance and control measures?
- **Sustainability:** will focus on sustainability, including climate change, be renewed OR decline as countries shift towards energy independence?

### Our top 10 questions for healthcare systems around the world

These dimensions are key to understand the broader environment that healthcare systems will operate in in the future. We believe they will face ten fundamental questions.

1. Will healthcare continue to be managed as a cost, or will it be approached as an investment? Will the global average of 10% of GDP spent on healthcare<sup>xvi</sup> remain the norm, or will we see a significant increase, including to account for a short-term GDP decrease across countries?
2. Will we see a shift towards prevention and communicable diseases? Will the transition of care out of the hospital continue? Will we see an increase in hospital budgets?
3. How will the approach to dependency (e.g., elderly, youth, disabled, mentally ill populations) and to the elderly more broadly evolve, especially given the anticipated rise of mental health issues?
4. Will the mix between universal health coverage pushed by the WHO<sup>xvii</sup> and individual, potentially private, health management evolve?
5. Will the skillset of the healthcare workforce change (e.g., more healthcare professionals able to intubate) and the system become more flexible (e.g., ability to reallocate resources / budgets rapidly)? Will the capacity of the healthcare workforce and infrastructure increase, including through 'safety nets / buffers'?
6. Will we see more centralization or decentralization of healthcare decision-making (e.g., confinement measures decided nationality or by region) and infrastructure (e.g., few large centers of excellence vs. more, smaller local units)?
7. Will governments integrate national technological sovereignty in health policy, force organizations to buy in-country or in-region production, or even nationalize

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- companies to ensure continued supply of vital services / products? How will they balance the need for more sanitary independence while remaining competitive in a global economy?
8. Will intellectual property frameworks and incentives for innovation fundamentally change (e.g., new regulatory and access pathways) to anticipate and respond rapidly to the next crisis?
9. Will public-private partnerships become the norm in the healthcare ecosystem (providers, manufacturers, insurers, etc.)? Will we see an increased role of data-oriented players and GAFAM in tracking / monitoring systems, prevention, and e-health?
10. Will healthcare systems accelerate digitalization, including community and hospital workflows, patient health records, telemedicine, decision support? Will the regulation and management of health data (e.g., integration of datasets) change significantly? Will consumers be more willing to share health data? Will their trust in scientific institutions, health authorities and private healthcare organizations (e.g., pharma) increase?

It is imperative to think about these fundamental questions now to inform near- and long-term decisions. COVID19 might just be a “rehearsal” if we look at the rising evidence of a link between climate change and health issues (including infectious diseases)<sup>xviii</sup>. And if the questions are mainly the same across the globe, a one size-fits-all solution seems unlikely. Each region, each country, each society, each system

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- iv DREES, base statistiques 2013-2017 and SAE 2018 Base administratives
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- x How much do OECD countries spend on prevention? OECD Health Working Papers No. 101, Dec 2017: <https://www.oecd-ilibrary.org/docserver/f19e803c-en.pdf?expires=1587028684&id=id&accname=guest&checksum=F6A64ECB9123788D95FB13903709D073>
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- xii Non-communicable Diseases – European commission : [https://ec.europa.eu/knowledge4policy/foresight/topic/shifting-health-challenges/non-communicable-diseases-ncds\\_en](https://ec.europa.eu/knowledge4policy/foresight/topic/shifting-health-challenges/non-communicable-diseases-ncds_en)
- xiii Karen Taylor, Cosima Pettinicchio, and Maria Arvanitidou, The transition to integrated care: Population health management in England, Deloitte, 2019
- xiv Mental health statistics: global and nationwide costs – The Mental Health Foundation: <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-global-and-nationwide-costs>
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- xvi Worldbank : <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS>
- xvii WHO 2030 Agenda for Sustainable Development Goals 3.8
- xviii The Lancet Countdown on health and climate change

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