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Global Health Security:
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Pandemic Fatigue: Re-Examining Re-Opening's Logic

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SYNOPSIS

Many economies have already started to re-open in spite of growing COVID-19 active cases, but it may be for the wrong reasons, and some may be premature. Analysing the healthcare and fiscal capacity of countries provides insights on framing the logic of re-opening.

COMMENTARY

MAJORITY OF the world's economies have been on countrywide lockdown since March 2020, when the COVID-19 virus was declared a global pandemic. After months of economic standstill and strict restrictions on movements of people, some economies have started to re-open.

In some countries in Europe, malls, restaurants, cafes and schools are slowly getting back to business. In East Asia, we also see relaxation in countries like South Korea, Japan, and Vietnam, albeit calibrated in some like Malaysia and Singapore. The decision to re-open is often a matter of weighing the costs and benefits of doing so. But how decisions are arrived at, drawing on the kinds of costs and benefits involved, can be contentious.

Lives vs Livelihoods?

A recent article published in the Straits Times, provides an interesting perspective on the so-called "lives vs livelihoods" debate. The writers argued that while lives are by

virtue “infinitely priced”, one can actually put a “price” on life depending on certain situations.

The writers posit that lockdowns help save lives but cost livelihoods/incomes; therefore, countries should re-open when the value of the lives saved, falls below the cost of livelihoods lost.

Such line of thinking, however, is flawed and simplistic. We argue that it may not be so much a matter of trading lives for livelihoods, as it is about protecting lives and ensuring safety through effective and adequate public healthcare capacity. By putting more efforts in strengthening public healthcare systems, one prevents the binary of having to choose one over the other.

Infection Not a Death Knell

One would do well to note that a COVID-19 infection does not automatically result in death. In the absence of vaccines, much depends on the capacity of hospitals to support those who suffer from its symptoms, and government’s fiscal capacity to subsidise hospitalisation expenses.

In this sense, what spells death is not the number of infections per se. Rather, it is the number of active cases relative to the maximum capacity of the health care system. The case of Singapore is instructive.

It expanded its healthcare capacity partly by creating new venues (“community facilities”) to house active COVID-19 patients, while freeing up hospital beds and intensive care for critical patients. For instance, several halls of the Singapore Expo convention/exhibition centre were converted into wards.

Each patient was provided with self-help kits to monitor and log vital indicators like oxygen levels, blood pressure and temperature three times a day. Concurrently, the government has supported total in-patient hospitalisation expenses in public hospitals.

As a result, Singapore suffered only 26 fatalities out of 46,283 infections as of 13 July 2020, representing a death rate of 5.6 for every 10,000 infected cases. This is very low in contrast to other countries which have reported non-zero fatalities, such as the United States (416.6 deaths for every 10,000) and China (543 deaths for every 10,000 infected), based on Worldometer data the same day. The worst countries included the United Kingdom, Belgium, and France, ranging from 1,500 to 1,900 deaths for every 10,000 infected.

Healthcare Capacity as Benchmark

What is remarkable about Singapore’s approach to achieving its low COVID-19 death rate, is its cautious and graduated approach to re-opening. It can be observed that its timing of re-opening has consistently been preceded by *a declining number of active cases relative to its healthcare system’s maximum physical and fiscal capacity*.

Daily government updates show Singapore’s active COVID-19 cases (excluding discharged cases and fatalities) peaked at 20,799 on 12 May 2020, providing an

indication of the historical maximum number of cases that Singapore's health care system can accommodate. When Singapore announced its phased re-opening on 28 May, there were 14,932 active cases (71.8% of maximum capacity).

On 2 June, when Phase One of re-opening began (e.g., some businesses permitted, primary and secondary graduating cohorts returning to school, and household visits limited to two children/grandchildren), there were 12,637 active cases (60.8% of maximum capacity). On 19 June when Singapore proceeded with Phase Two (e.g., restaurant dine-ins, retail outlets, gyms and schools following safe management measures permitted; social gatherings up to five people allowed), there were 8,130 active cases (40% of maximum capacity).

And on 2 July, as more relaxation measures were introduced in the extended Phase Two (some entertainment centres and places of worship permitted), there were only 5,035 active cases or 24.3% of maximum capacity. Steady progress could be observed 11 days after (13 July) with only 3,716 active cases (17.9% of maximum capacity).

Key Takeaway: Strengthening Healthcare Systems

Relative to Singapore and other countries, the Philippines appears to be a moderate case, with 280.5 deaths for every 10,000 infected, so far (1,599 deaths out of a total of 57,007 infections as of 13 July, based on the Philippines' Department of Health).

It can be argued, however, that the Philippines' current state of re-opening, is premature. The country was among the earliest to lockdown on 16 March (island-wide strict movement control across Luzon island). At that time, World Health Organisation data reflected less than 150 confirmed active cases, countrywide.

Active cases ballooned to 7,109 cases on 1 May. By 2 June, a day after the government began lifting some sanctions, there were 13,968 active cases, practically double that in May. By end-June, this figure nearly doubled again to 26,015 active cases.

The extent of government support has also been limited: compared to a Php1.3 million (S$36,600) bill for 15-day confinement of a "level 3 (severe pneumonia)" patient, the Philippine government had since mid-April capped its support to patients with identical conditions to Php333,000 (S$9,640).

The key takeaway from these examples of bringing economies back to life after lockdowns is the importance of strong health care systems. Deciding when to re-open should be contingent on the ability and capacity of a country's hospitals and other healthcare facilities. It should also depend on its government's fiscal capacity ─ to accommodate, manage and support the numbers of infection cases in their communities.

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