Public Health Expert Martin McKee Compares the Europe and US Response to COVID-19 – Hospitals In Focus Transcript

Speaker 1 (00:05):

Welcome to Hospitals In Focus from The Federation of American Hospitals. Here's your host, Chip Kahn.

Chip Kahn (00:14):

Our series on COVID-19 has focused on the impact and response in the United States. Today, we're going to provide another angle. We will view the American experience through the lens of a European public healthcare expert as well as seek lessons from the pandemic's path in other parts of the world. How does the impact and response of other countries compare with the United States? What are the public health takeaways we can glean from the experience of others and where is the light at the end of the tunnel? What are the prospects for a vaccine that might put this conflagration behind us? We will take a deep dive into these questions in just a few moments, but before we get started, I'd like to ask you to take a minute to rate us five stars, and leave a review if you enjoy listening to Hospitals In Focus. Your feedback is so much appreciated.

Now to our guest. We are joined today by Professor Martin McKee of the London School of Hygiene and Tropical Medicine.

Martin McKee (01:21):

Good to be here. Thanks for inviting me.

Chip Kahn (01:23):

Great to have you, Martin. Martin, you have enjoyed an extensive public health career both in the UK as well as around the world. Could you tell us a bit about your leadership and efforts to improve the health of populations and your research as well as your role at the London School of Hygiene and Tropical Medicine?

Martin McKee (01:43):

Well, I started with the substantive post here at the school back in 1989. And the idea then was that the school wanted to extend to its work within Europe. We had a long tradition of working in the tropics, in Africa and Asia in particular. But then in November 1989, suddenly the parts of Europe in which I could work expanded enormously because as you may recall, a wall fell down in Berlin. So I developed a lot of research in the countries initially of central Eastern Europe, then the former Soviet Union, looking at the health impact of the collapse of communism, trying to understand the health impact on people who were undergoing major, social, economic, and political change.

Then in the 2000s, we had the global financial crisis and we had more major economic and social change, and we built up a body of work trying to understand what happened to people when their world was turned upside down. We're having a similar situation with COVID now. In the meantime, I was doing a few other things, we set up an organization called the European Observatory on Health Systems and Policies, unusual because it brought together universities, international agencies like WHO, the European Commission, and national governments, and we've been trying to monitor healthcare reform for 20 years in Europe now. And I should say, in terms of other roles, I've also been precedent of the European Public Health Association.

Chip Kahn (03:08):

Wonderful. I guess now let's turn to, as you said, our latest crisis, which is COVID-19. Parts of the United States have probably seen and may be now experiencing the worst of COVID. Though Europe was an

earlier epicenter, how would you compare the progress and response to the pandemic in the UK and Europe versus the United States?

Martin McKee (03:32):

The first thing to say is of course that the United States is 50 States plus the District of Columbia, and the European region of WHO is 53 countries. The European Union, 27 countries plus the United Kingdom. So there's a tremendous amount of heterogeneity within both, just as there's been very different patterns of the epidemiology of COVID between, say, New York on the one hand and Washington state or somewhere else in the other. We have had big differences within Europe. We have had some countries that have performed remarkably well, in some cases because they were lucky. They were ones that were not seeded with infections early on, but also it wasn't enough to have luck. You needed to have that political leadership and technical capacity to respond.

Countries like Austria, the Czech Republic, Slovakia did very well. Within Europe, Italy was unlucky because it was the first country to be effected with people coming in from China. And in particular to the region, Milan, the Lombardy region, that was really problematic. The health system there was overwhelmed and people were struggling to know what to do. The Italian government did respond. There were problems in the regions, but did respond and it managed to confine the epidemic largely to a small number of Northern regions, but the disease then did spread to other parts of Europe, particularly to Spain and to the United Kingdom, and in fact, more generally.

There we saw countries adopting different approaches. Spain had major problems, and I think we now recognize that was due to failings in its social care system. Very poorly developed and it really struggled with that. The United Kingdom, an example of political failure. United Kingdom has a very strong public health system, but we had a prime minister whose attention was diverted. He had been pursuing a policy of leaving the European union, which the country technically did on the 31st of January, and that had occupied much of his time. And when he wasn't fixated on that, he was going through some very challenging, personal situation with a divorce and a new child coming along. And I think the general view is that his attention was very much diverted. Sweden, on the other hand, another country with a strong health infrastructure, stewed out from its Nordic neighbors in pursuing a policy of allowing the infection to go through the population and to achieve herd immunity. That now, I think, is generally recognized as a mistake, but we've got a tremendous natural laboratory in Europe from which we can learn.

Chip Kahn (06:14):

Martin, you've sort of touched on it, but what role does planning, coordination, and leadership at a national level have on how different countries have responded and maybe how well they do? And do we see any common characteristics or patterns for what we might consider success?

Martin McKee (06:33):

First thing is that a country does need to have the technical capacity, the public health infrastructure in place, but above all, I think we've seen the importance of political leadership. I should say that one of the striking findings from what we have seen is that countries who are led by women have done particularly well. Obviously New Zealand, Germany, Taiwan, Iceland, and Finland stand out. Now the explanation for that, I'm not sure that we fully understand it and I'm sure it will be the subject for many PhDs in the years to come, but leaving that aside, what we also see is that we look at, as we did a few days ago, the countries with the highest number of cases worldwide, the top five, the United States, the United Kingdom, India, Russia, and Brazil all have one thing in common, and that is that they are led by

individuals who've pursued populist policies, who have set themselves up as the voice of the ordinary person against the elite. And by the elite, we mean the scientists as well as other groups in society, and having rejected concepts of evidence. We've seen denialism, a bit like we did in South Africa with AIDS denialism back in the 1990s, and that seems to be a recipe for failure, unfortunately.

So that really, we were relearning the lessons of the political determinants of health, lessons that we shouldn't have to relearn because public health historians would remind us that Rudolf Virchow in 1848, a very famous Prussian pathologist, was sent to investigate an outbreak of typhus in Silesia, now part of Poland, and he concluded that fundamentally the problem was political. It was the keeping the population down, the entrenched power of the aristocracy propped up by the church, and he said that although obviously lots of things needed to be done on a practical level to combat the epidemic, until you dealt with the political factors, you would still be having these problems.

Chip Kahn (08:33):

There's a statue at our archives here and there's a plaque that reads, "Past is prologue, but it's often forgotten." Considering that, Martin, what do you predict are the key takeaways that we will eventually read in medical science and historical literature about these different responses? You've touched on it, but what are the takeaways?

Martin McKee (08:56):

Well, there's a couple. First the importance of leadership, which I've already talked about. I think a second will be the need to look at the nature of scientific advice. Countries have struggled with this, I think. We know that we need to have the highest level of expertise in terms of virology and modeling and so on. But these people, when they come together to give advice, they need to be able to move outside their silos to understand the perspectives that you can get from other disciplines and to recognize that we're dealing with a particularly complex virus causing a complex illness, requiring a complex response. And all of that complexity means that we need an interdisciplinary, complex response with particularly a systems analysis to try to understand how all the bits fit together, and I don't think we've been terribly good at that. So I think a second message will be about the need to look at how we actually synthesize all of that expertise to come together to provide a meaningful set of answers for the people who have to make the decisions.

Chip Kahn (10:05):

Martin, both Europe and the United States are still in their initial wave. I guess parts of Europe are getting somewhat of a respite. Do you think there's a high likelihood, even in those areas, we'll see a resurgence in the fall and winter, and how will the annual flu season come into play later in the year when there's an intersection between COVID and the flu?

Martin McKee (10:30):

There's been a lot of discussion about a second wave drawing on what happened after the 1918 influenza pandemic. It's not immediately clear that we will have that in the same way. Influenza does have a clear seasonal tendency, and that doesn't seem to be the case with coronavirus or particularly with this coronavirus anyway, although of course, in colder climates when people are gathering together indoors, it will increase the risks of transmission. I think what we're more likely to see is that we will get the levels of infection down in many countries. In some countries, I think we're getting to the stage where we're virtually eliminating it, at least in terms of domestic transmission. There will still like in New Zealand be continued cases being imported, but hopefully there will be a mechanism to control that. But

I think we're going to see a smoldering epidemic for a long time until we do get hopefully some vaccine. I think we might be talking about that later.

But we will almost certainly be seeing isolated outbreaks. That is going to be a challenge for some countries. We really should have been using the time that we have had with the lockdowns and so on to make sure that everybody has in place well-functioning find, test, trace, isolate, and support systems, and I stress all of those elements. Here in the UK, for example, we have a testing system, so to speak because it's highly fragmented. We have a contact tracing system, also highly fragmented, [inaudible 00:12:02] communicating with one another, but very little activity in terms of case finding, which is very important with this infection, given transmission is often before people develop symptoms or in people who don't develop symptoms. And we also have done relatively little in England in particular about the isolating and supporting people while they're isolating, because we have to remember that many people are in very precarious jobs, precarious employment, precarious income, and we need to provide that support to help them.

Chip Kahn (12:31):

Along those lines, if we're going to have to live with it, how well are the health systems in the UK and Europe geared for a continuous or at least rolling waves of COVID?

Martin McKee (12:42):

They're much better prepared than they were. Partly that's because we understand the nature of the virus much better and the infection. At the beginning there was a focus on getting large numbers of ventilators. The assumption was that this is a viral pneumonia just like any other viral pneumonia. What happened as a result of that is that we probably ventilated people too early in the disease. Putting people on a ventilator is actually not good for them. You only should do it if you absolutely have to. I mean, I recognize this is a complex multisystem disease with effects particularly in blood clotting, on the linings of the blood vessels, and other organ systems, and so we're developing much more sophisticated treatments for this.

And as a result of that, the outcomes are definitely improving. We've got clinical trials underway, and here is an area where the UK has done very well. Because we do have the national health service, which provides care for everybody, then it has been possible to organize a very large number of clinical trials. The recovery trial in particular has meant that a high proportion of patients hospitalized have gone into trials. And we were able to show, for example, that hydroxychloroquine was ineffective, but equally importantly, we were able to show that dexamethasone was effective in some patients in improving survival. So I think that the health systems are going to be much better at treating people.

But we're also going to have the challenge of a large backlog of people who did not get treatment, people who should have been screened for cancer, who should have been diagnosed early, or who have complex chronic diseases that have deteriorated as a result of the delays in treatment. The health systems will have to pick those up, but they will do so in a new situation where you will have physical distancing, increased personal protection, and that is going to radically reduce the efficiency with which they can do that. So I think we are going to look at how we use our health facilities.

The big advantage in all of the European countries, I think really important, is that with universal coverage and with mechanisms for ensuring the financial stability of the health system, then we're not going to see what we're already seeing in the United States, something that a colleague, [Vichelle Aurora 00:15:01] in Boston and myself wrote on, published on very recently, which is looking at the

economic or the financial failure of many health care providers in the United States with the reduction in office visits a fee for service payment system obviously is much more vulnerable to that. So I think from that point of view, even though we spend much less on health in Europe than you do in the United States, I think our health systems are much better placed to respond to the longer term problems.

Chip Kahn (15:32):

I'd like to add in in terms of comparing the systems, there was a recent study that indicated at least in the hotspot areas around the northeast, around New York City, that during the worst part of the epidemic, there were more deaths than expected, not just from COVID, but from other conditions where I guess people were either weren't going to the hospital or they weren't being treated properly. Do you think you'll see that in the UK and Europe? Excessive deaths above because of the concentration on caring for COVID?

Martin McKee (16:08):

What we are seeing is that increasingly there's a focus on looking at excess all-cause mortality by which we are looking at the total number of deaths from all causes above what you would expect for the time of year. The Financial Times has been publishing data on that. We've written about that on the European Observatory COVID Response Monitor website. When you look at that, you see quite a lot of variation in countries as to what share of that excess mortality is attributed to the deaths that are labeled officially as being COVID.

In Belgium, for example, most of the excess deaths are labeled as COVID. In other countries it's much less. That gets away from some of the problems we have with international comparisons. There is some evidence that myocardial infarctions in particular may have gone down during the crisis, but that's not fully understood yet. But it is certainly the case that there are people who are being denied care or unable to access care, and we may actually see more of that unfolding in the future, particularly as the consequences of deferred or delayed care become more apparent. Particularly with cancer, there has been some interesting modeling work in the UK and elsewhere suggesting there could be quite a large toll of premature avoidable death because of the delays in getting treatment and early diagnosis for cancer.

Chip Kahn (17:30):

Considering that we're in the midst of COVID, when do you think there will be real light at the end of the tunnel and what are your thoughts on the development of a vaccine?

Martin McKee (17:41):

This is a very difficult one because we do not have an effective vaccine against any other coronavirus. There are a number of paths that being pursued. The usual ones, which are of a live attenuated virus, you take them the virus itself and you can reduce it. [inaudible 00:17:59] risk that it poses killed vaccines. New models in particular are looking at putting RNA, one of the basic forms of life, into cells of people so that they actually produce a substance which fools the immune system into thinking that they've got circulating bits of the spike that we have on this virus. Increasing amount of work, looking at genetic modification of other viruses, adenoviruses, putting bits of the coronavirus into them. So there's a lot of new ideas around. The RNA viruses are certainly very exciting theoretically, but they haven't worked so far.

As we look at these different models, it looks like some of them, if they are successful, will prevent the infection taking root and some of them may rather in a different way act by preventing the adverse consequences of the infection. So for example, the Oxford vaccine, one of the ones that's most advanced at the minute certainly in tests in nonhuman primates and animals, has not prevented the animals getting infected, but it has prevented them from getting ill with it. So all of that will take time.

One of the biggest challenges we will face and one of the reasons why we didn't have a vaccine for SARS is that you need to test this in a population in which the virus is circulating. So a lot of the phase three trials, these studies to look at the effectiveness of the vaccine, are being undertaken in particular in countries like Brazil where you still have tragically, unfortunately, a high level of circulating virus. It is going to take time because we also need to be clear about there is always a risk of longer term side effects that we can't anticipate. But on the other hand, the amount of effort that is going into producing the vaccine, I think we have a good chance of getting something that will work.

The challenge, of course, that comes after that, which I think we may talk about later, is how we actually distribute it, but also a worry in some countries, more so I think on your side of the Atlantic and the United States, really not so much of a problem in much of Europe, although there still is a little bit, which is the anti-vaccination movement. And that, I think, will be much more of a problem for you than for us.

Chip Kahn (20:23):

Let's get into that. Even when we get a vaccine, it will be quite some time before we will have enough supply to vaccinate everyone. How should public health officials decide who gets the vaccines first as they're rolled out?

Martin McKee (20:38):

This is a really difficult question. We have been here before. In 2009, the Australian government put an export ban or restricted the export the vaccine against swine flu, and there have been ongoing discussions over the years about access to the viral material for influenza viruses. This is where we really do need some international agreement on this. Now, that is going to be particularly difficult, obviously with the current administration in the White House, but November is not that far away, so I think we're looking ahead to what happens after that.

We will see tremendous international pressure, both from national governments and also from the manufacturers. The last thing that any of them want is to get caught up in the middle of some sort of a bidding war because that will be hugely problematic for them to deal with both in terms of the practical arrangements, but also the public relations aspect of that. Got to be very problematic. I think we will see a lot of pressure for particularly the WHO or some other system, there's Gavi and there are a number of other international initiatives, to play some sort of a role in trying to get some fair system, making sure that the vaccine does go to those who need it most earliest, but ultimately be rolled out much more widely.

Chip Kahn (21:57):

You talked about in terms of the vaccine, actually very different types of mechanisms that they'll use to protect people. Do you expect eventually when one model or the other wins out that we'll have to have an annual coronavirus shot like the flu or will it be a one- or two-time deal and then you'll be taken care of?

Martin McKee (22:20):

We really don't know. In theory, if an RNA virus worked, then you wouldn't need to do it again. With some of the others, it's possible. I think what we're learning is how little we actually know about the immune response to this virus. Much of the focus at the beginning was in antibody testing, which is only one type of immune response to viruses. The B-cell, the B-lymphocytes produce antibodies. But we also know that in the immunity against viruses, the T-cells, another type of lymphocyte, play a very important role. Natural killer cells are important which are non-specific in terms of their response to viruses.

And it may well be that we are perhaps underestimating a little bit the extent of immunity. It may be that a lot will depend on whether the vaccine stimulates the antibodies of the T-cells. I think really far too early to say. Another unknown, of course, is whether the virus will mutate. Fortunately, unlike influenza, it doesn't seem to be anything like the same extent as influenza. That's a very good sign, but of course we cannot eliminate that possibility because clearly this virus mutated to get to the stage that it said already, and that was how it took off

Chip Kahn (23:38):

Let's return to an assessment of the responses. The varied national responses to the pandemic combined with the information from experts and government leaders about how the virus is treated, prevented, and spread seem to fuel misinformation campaigns on social media and elsewhere. Martin, what do you think are the implications of this pandemic on overall trust in government and public health experts?

Martin McKee (24:07):

Some governments have done remarkably well. I mentioned some of the countries that performed very well. Jacinda Ardern in New Zealand, for example, very highly trusted. Angela Merkel, very highly trusted. Those leaders that have been open and honest and accepted their limitations about what they knew and what they didn't know, I think, have done very well. Others, of course, have not, and there has been an erosion of trust. That's hugely problematic because trust is fundamental to the response to the virus. If we are going to get people to isolate themselves, to socially distance, to wear face coverings, to do all of these things, to be vaccinated, then they will only do it if they have trust in leaders.

The role of social media is particularly interesting because it has really put some of the people, I'm thinking in particular of Mark Zuckerberg and Facebook, under real pressure because for a long time, their argument has been, well, we're neutral, we don't decide what people can post or what they can't post. But with COVID, of course, allowing people to publish conspiracy theories really is a matter of life or death. People will die as a result of some of the more bizarre ideas that are in circulation. And I think a combination of that with other areas in which they've been putting out fake news, hate speech, and so on, obviously the Black Lives Matter movement and so on, are coming together and particularly led by the advertisers on Facebook.

The fact that advertisers are pulling back and putting pressure on Zuckerberg in particular. Now, I know he said that this is only temporary, they'll flood back to them again. I'm not so sure. I think people are going to hold these companies to a higher standard and expect that they will do something about some of the particularly more bizarre ideas that are being put a bite. Now that, of course, will have implications not just for COVID, but it will have big consequences for politics, too.

Chip Kahn (26:11):

Unfortunately, and we've been talking about it, the pandemic knows no borders, and for better or worse, the Trump administration has chosen to separate from the World Health Organization. You're very active in international public health. What are the implications of this decision for global population health as well as the COVID response and mitigation itself?

Martin McKee (26:35):

Well, my colleague Richard Horton, the editor of The Lancet, has described the decision as a crime against humanity, and politicians in Europe, many of them have spoken out including countries like the Irish, Foreign Minister Simon Coveney. Ireland is a country that has always enjoyed a special relationship with the United States. Think of the St. Patrick's Day parades and so on. [inaudible 00:26:56] said it's just in comprehensible in the midst of a pandemic.

We need to wait until we see what happens. I've already said that November is not that long away and there are some questions about the ability of the president to withdraw the US from the who without Congressional approval. Also, the other thing to remember is that the United States owes the WHO quite a lot of money in arrears, and that would have to be paid back before it did leave, so that's another interesting point, too.

Leaving that aside, this has been tremendously disruptive for the organization in the midst of a pandemic. It's a little bit like having your house on fire, the fire department comes around, and you go out and cut the hoses. This, it's damaging to the United States because of course, if we don't control cases elsewhere, you will ultimately have continued imports of cases, and we will have to get back to some sort of a globalized world in due course. It will have a particular impact on some of the areas that have been supported by American money, the eradication of polio, for example, and that's a particular tragedy given the role of United States citizens contributing to the March of Dimes and all the work that was done in polio coming out of the US historically. So hugely damaging, but it also is symbolic in a way of a withdrawal of American leadership, not just from WHO. Obviously President Trump pulled the US out of UNESCO. The Iran nuclear deal with the consequences for peace in the Middle East. I know it may be controversial in the United States. It was not controversial in Europe, and from the Paris Climate Accord, which was greeted with shock in many parts of the world overall, so I know there.

Like with the COVID response. Many of the states have actually taken the initiatives themselves, both with COVID and with climate change, so I think you're also seeing a reaction against that both internationally, but we from outside the United States shouldn't forget there also is a domestic response, too, and this is clearly not speaking for all of the American people.

Chip Kahn (29:11):

Martin, this was so helpful and your perspective so meaningful. I think you've provided a lot of food for thought for our listeners, and you really have been and will be an important voice and I know that your message will be heard. I just hope our policymakers here in the United States hear it, too. So thank you so much for spending some time with us on our podcast.

Martin McKee (29:35):

Thank you, Chip. Thank you very much. It was great to talk.

Speaker 1 (29:38):

Thanks for listening to Hospitals In Focus from the Federation of American Hospitals. Learn more at fah.org. Follow the Federation on social media @FAHhospitals and follow Chip @ChipKahn. Join us next time for more in depth conversations with healthcare leaders on Hospitals In Focus.