



ASPHER Statement:
**Invest in primary health care and public health
for the pandemic and beyond**

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Henrique Lopes^{1,2,*}, Alison McCallum^{1,3}, Jose M Martin-Moreno^{1,4}, John Middleton^{1,5,6,7}

¹ ASPHER COVID-19 Task Force

² Public Health Unit, Health Sciences Institute, Catholic University of Portugal, Portugal

³ Centre for Population Health Sciences, Usher Institute, University of Edinburgh, United Kingdom

⁴ Dep. of Preventive Medicine and Public Health, Medical School & INCLIVA, University of Valencia, Spain

⁵ Honorary Professor of Public Health Wolverhampton University, United Kingdom

⁶ Visiting Professor of Public Health Chester University, United Kingdom

⁷ President, Association of Schools of Public Health in the European Region (ASPHER), Belgium

*Corresponding author: henrique.lobes@ucp.pt

Introduction

Decision-making and actions by governments through the COVID-19 pandemic have usually been reactive, determined by the characteristics of each SARS-CoV-2 variant and the structural or circumstantial weaknesses of health systems. Western governments and health services were unprepared for the pandemic (1). Preparedness was further weakened by the chronic under-funding of prevention, primary health care and community services which predated the pandemic. The first wave triggered a disorderly race for Personal Protective Equipment (PPE), materials and ventilators (2). In the peak of the first wave, many health services closed non-emergency diagnostic and rehabilitation services (3).

In the second and third waves, elements of immediate response seemed to be under control, at least in high-income countries, but elective surgery and other non-emergency clinical activities were restricted. Space, facilities, and staff were freed up to provide COVID-19 related care. There were ruptures in responsiveness and difficult choices that impacted adversely on patients and their families. Alongside spikes in COVID-19 mortality, excess mortality in all countries increased due to fewer timely presentations, diagnoses, treatment, and follow-ups of patients with multimorbidity. This phase also saw an increase in mental health concerns: anxiety, depression (4), and what has been called pandemic fatigue (5) in adults and children (6).

The developing recognition of primary care through the pandemic

Mass vaccination in 2021 in many countries (7) encouraged proactive involvement of all sectors, especially primary care, community services and the third sector. This led to the decrease in mortality seen by mid 2021. The gap in access to vaccines became massive between high- and low-income countries (8). Within rich countries, there were inequalities between and within communities, between vaccinated and unvaccinated. Serious illness and hospitalisation became predominantly the outcomes for the unvaccinated (9). There were structural and practical barriers to vaccination, but also differences in beliefs, gaps in health literacy and suspicion of authority. These problems could only be addressed and overcome by community organisations sensitive to local needs and beliefs, alongside trusted primary care professionals.

The central role of primary care in vaccination programmes

The advent of vaccines brought a reduction in acute work for hospitals and emergency services, and an opportunity to increase elective cases again (10), but with substantial waiting lists and times for many routine procedures (11). COVID vaccination required huge commitment from primary care and reduced capacity to provide other services in many countries (12).

The relative protection provided by the vaccines led Governments to relax restrictions on people's behaviour, generating increased social interactions that increased the likelihood of contagion, so that the number of cases, and even deaths, did not fall as quickly as anticipated. Governments have failed to follow 'Vaccine-plus' (13) or 'Do-it-All' (14) approaches using all the preventive measures available.

Omicron requires strengthened primary and community services

The Omicron variant has caused huge social and workplace disruption through its increased transmissibility. Omicron also shows reduced risk of severe illness in fully vaccinated individuals (15, 16). These manifestations have prompted many scientific voices to advise rethinking the hospital-centric model that has predominated until now. However, many health systems remain focussed on reactive, primarily specialised, hospital-centred responses, with the daily announcement of new cases, hospitalisation rates, COVID-19 patient beds in hospital and specifically intensive care units and, once again, the planned postponement of potentially elective clinical procedures.

The appropriate response to this phase of the pandemic should be significant investment in primary care, practical interventions in local communities and upstream, preventive action. The hospital response is the third line of defence, not the first. The first line of defence should be addressing the inequities in health, education, income and working conditions that are the main drivers of exposure to COVID-19 and the source of the barriers to immunisation. Coupled with enhanced personal support to address specific concerns it would be possible to lower vaccination hesitancy and obtain

better coverage, reducing infections. People who are fully vaccinated tend to have milder infections, and with appropriate support can remain at home as they recover.

The avalanche of patients with less severe COVID-19 disease, is shifting care progressively from hospitals to primary health care (PHC), without the plans being put in place to strengthen investment and reallocate staffing that happened in hospitals during the first wave. There has been some improved effort and investment in PHC in virtually all European countries, for example in digitization of services, telephone advice lines, video consultation, COVID primary care hubs, and community testing, among others (12,17-20). It is essential that PHC is strengthened. As society opens up again while case rates remain high, primary care and community services remain fragile. The immense number of daily cases that Omicron causes require assessment, advice, and intervention from primary care, not hospital services. The Delta and Omicron waves have seen increasing exposure of children and younger adults. The under-developed services of school nursing (21) and occupational health (22) in many countries, need to be reviewed and invested in. Primary care provides upwards of 90% of all health care and is the main source of assessment and support for people with multimorbidity. Primary health care has the potential to mitigate health inequalities (20).

Failing to invest in primary health care – Learning from history?

It is essential to learn from the experiences in countries such as Canada after the huge shock of the original SARS in 2003, which identified the need for better coordination and integration of public health services with health care structures, particularly primary health care (23). Primary care services have also recognised the opportunities for more permanent and beneficial change brought about by the pandemic.

Unsustainable and unequal pandemic health care

The current pandemic response has produced significant amounts of non-recyclable waste (24). We have taken our eye off anti-microbial resistance, a major killer (25). We fail to protect the world with equitable vaccine delivery (26). As we strengthen primary care, public and community health, we must build approaches that are more sustainable, less wasteful and give due attention to the protection of local and global eco-system and environment, in accordance with the 'One Health' philosophy (27).

The Association of Schools of Public Health in the European Region (ASPHER) believes therefore, that local and national governments and health administrations should:

1. Understand and act on the principle that preparedness and response begins with communities, public health, and primary care services.
2. Assume a multi-disciplinary approach in the creation and dissemination of new knowledge and understanding to responding to the challenges posed by the pandemic: prevention, awareness, diagnosis, treatment, and recovery. Health and science literacy, modern tools and forms of communication must be within reach of all.

3. Ensure that the core of COVID-19's approach is coordinated by pivoting investment towards primary care, interconnected with public health services, making it clear that this does not imply that hospitals withdraw from providing the care that is needed.
4. Sustainably strengthen primary health care with the necessary human, financial and technological means, with the level of investment reflecting the level of community need.
5. Invest in universal community and homecare services to reduce the workload in hospitals and in primary care centres themselves.
6. Address the need for support for children's health in the community, including school nursing and assure health services are complementary to other primary care.
7. Review the availability of occupational health services and seek to grow these to meet health care needs of the workforce.
8. Invest in community development and community voluntary services which can support preventive efforts to tackle inequalities, support vulnerable people and address needs caused by the pandemic
9. Create new plans for strengthening primary care, to safeguard support for the chronically ill, ensure their better longitudinal and coordinated care and minimise the likelihood of them receiving unconnected or non-integrated hospital services.
In addition, primary and community services should be established and funded to manage the increase in multimorbidity arising as a direct consequence of long-covid and the worsening of pre-existing conditions as an indirect consequence of the pandemic.
10. Build approaches that are more sustainable, less wasteful and give due attention to animal health and the protection of the eco-system and environment, in accordance with the 'One Health' approach.

Conclusion

The end of the pandemic is not determined by the pronouncements of politicians or journalists. We will not be free of the virus, until everyone is free (28). All the interventions we have against the SARS-CoV-2 virus still need to be applied. Careless relaxations of public health measures in rich countries, inadequate support for local public health and primary care and the communities they serve, and failure to support the global delivery of vaccines will keep us all in a state of perpetual Covid. We must invest in local public health and primary care and their communities to get us out of this pandemic and give us better health for the future.

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