

# Covid-19: From pandemic to global economic crisis

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## Part 1: The impending collapse of the health care system

From an economic point of view, the current crisis is initially an enormous stress wave of that is rolling over national health systems globally at very short intervals and at an enormous speed. Any healthcare system, in any social system, would face major challenges from an explosive spread with so little warning. In the current economic system, the pandemic is hitting structures that are already over-stretched overstretched. It affects both centres and peripheries, albeit in different ways. At the same time, the capitalist order is proving incapable of the necessary international response - with deadly consequences for probably millions of people.

### Challenge and possible responses

The dramatic nature of the pandemic is evident from the exponential curve of new infections. At the beginning of the infection explosion, with a core of around 100 infected people, rates were doubling every 2-3 days. With a doubling every 2 days, 100 infected persons become more than 12,000 after just 14 days. The problem is, on the one hand, the inconspicuous symptoms in the early phases of incubation (for about a week), during which time another 2-3 people can already be infected. This makes containment difficult, especially in the early stages of infection, and promotes the rapid spread of the virus.

On the other hand, the resulting disease, Covid-19, which is similar to a severe pneumonia, is itself a major challenge. About 5-10 percent of patients require intensive medical treatment if they are to be saved from suffocation. The need for intensive care units (ICU) increases at the same rate as the exponential curve of new infections. With the doubling rate mentioned above, it is therefore easy to calculate when the capacity of ICUs in a health system will be overtaken by the number of seriously ill patients. What happens then can be seen in the most horrible way from the reports of the intensive care units in Northern Italy. Totally overworked personnel, without sufficient equipment, had to undertake a selection process with new admissions to see who was ?worth? allocating the last free ICUs.

In Germany, for example, there were 28,000 ICUs before the crisis, and up to 80 percent were in use. Even after vacancies were freed up, for example, by postponing operations, a capacity of only around 8,000 ICUs was reached. With a doubling rate of 3 days and a starting point of 115 infected patients on March 1, the capacity limit of the ventilator places would have been reached by the end of March. The decision that therefore had to be made in all countries, with more or less delay, was to choose between the following infection control models:

1. The "herd immunity" model, in which the virus spreads without countermeasures. The aim is to create a natural immunity to the virus in those infected, while isolating the ?at risk? groups. Since these groups

cannot be so clearly delineated and their targeted isolation is not practicable, this model essentially means that a large wave of intensive care patients would flood the health care system. Consequently, the "herd immunity" method means risking the death of all those above the ICU capacity limit.

2. The response adopted by most governments, starting with the Chinese, has been a more or less consistent reduction of contact between their populations in order to minimise the risk of infection and thus slow down the growth rate of new infections. Various forms of restrictions on public life up to the strict quarantine of critical areas or risk groups were applied. It is hoped that the number of patients admitted to intensive care units at any one time can be kept below that of ICUs and personnel - especially since time has been gained to expand this capacity. This is because the "moderate contact reduction" model slows down the growth of new infections, but at the same time extends the wave of infection to a longer period of at least one year.

This may prevent a collapse of the healthcare system (such as we have seen in Italy), but there will still be a high number of deaths, far in excess of normal flu outbreaks. In this model, almost everywhere attempts have been made to prevent the closure of non-essential businesses. Efforts are also being made to get the closed plants back into production as quickly as possible. With the expected premature lifting of most measures to restrict production or non-essential services, the crisis will return after a certain pause.

To prevent this, a third model would be needed: a restrictive quarantine policy that would also immediately end all non-essential work processes, combined with a sufficient number of tests to quickly isolate the infected for the duration of their illness. This was implemented to some extent in China and South Korea, where the new infection curve was kept much flatter compared to the population.

#### Pandemics and the pharmaceutical industry

The other side of fighting Covid-19 is the medical-pharmaceutical one. Although corona-like viruses have been known for quite some time and the virus type now in circulation has already been identified in animals, far too little has been invested in preventive research into vaccines and therapeutic options in view of the known danger. This field of research was not profitable enough for the pharmaceutical industry to invest the necessary funds. Without the pharmaceutical companies' millions, the state laboratories that had worked on these topics were too underfunded to come up with practicable solutions. With the outbreak of the pandemic, an unworthy spectacle has now begun, involving the securing of patents and research facilities by governments and corporations. To the extent they are successful, this is likely to further hinder the necessary, concentrated international research because of commercial secrecy in the interests of profit or state interests. Even though a great race for first place in vaccines and therapies has begun, it will hardly be possible to accelerate the usual development cycle - of at least one year - since the requirements for trials and independent tests must not be shortened here either, especially in view of this greed for profit on the part of the corporations.

In fact, the SARS-COV-2 virus now in action belongs to a family of 40 corona-like viruses, most of which have been discovered in animals. At the latest since the SARS-COV virus spread to humans and caused SARS (Severe Acute Respiratory Syndrome), further such transitions, so-called zoonoses, were to be expected. This points to a deeper-lying problem: Livestock farming and the civilisation-induced coexistence with animals have always been a source of devastating epidemics. For example, plague bacteria were transmitted to humans via fleas from rats, which concentrated in the cities under unhygienic conditions. Some known zoonoses have considerable epidemic potential (e.g. smallpox, tuberculosis, Ebola), others are chronic mass diseases (e.g. malaria). With industrial livestock breeding and its massive use of pharmaceutical products, the fight against such microorganisms has been taken to a new level.

It is well known that the massive use of antibiotics in meat production is a source of antibiotic resistance in

bacteria. However, chemical culls against viral diseases in livestock also contribute to the rapid mutation of the corresponding viruses and the tendency to change hosts. What exactly was the source of the zoonosis in the current SARS-COV-2 virus is still controversial. It is clear that, after the experience of this pandemic, both the issue of animal welfare (livestock farming, exotic animal markets, animals in our mountains of rubbish, etc.) and concentrated research to prevent zoonoses, not only corona viruses, must be high on the international agenda.

### Limits of capitalism revealed

Furthermore, medical technology production under capitalist conditions is also an obstacle to solving the current challenges of the health care system. It is obvious both in the imperialist countries and in the semi-colonies that there is not enough ventilator equipment and protective materials available to cope with the increase in intensive care patients. In the imperialist countries this is one consequence of cuts and privatised medicine, in the semi-colonies it is the lack of financial resources to build enough hospitals from the outset. One might think that, with modern global production systems, the capacities for producing protective clothing, masks or ICUs would be quickly available. Far from it! On the one hand, the production chains proved to be interrupted by the breakdowns in China and other Asian countries, and storage capacities were very limited in an era of just-in-time production.

The production of the vital ICU units is also concentrated in a few companies worldwide, whose products were first used to fulfil the needs of their own countries. The German Federal Government has now ordered a total of over 20,000 units from German producers, who were previously the only significant suppliers to the EU area apart from a Swedish one - which means that their capacity will be fully utilised for the next few months! In fact, various governments have effectively begun to nationalise medical technology production. State-planned or coordinated production clusters are being formed, which now have to produce for the needs of "their" health care facilities, from protective clothing, disinfectants, respirators to test equipment.

Finally, there are the limitations of the hospital facilities themselves.

Not only is there a lack of material and equipment, but of course there is a particular lack of trained personnel. All struggles for an increase of key personnel, for adequate working conditions and payment have been thwarted in Germany in recent years due to cost capping by the financing side (the health insurance companies) and the profit interests of the private owners of the hospital groups. As a consequence, the acute crisis of exponentially increasing patient numbers is now facing hospitals with an already thinned out and overstretched workforce. The emergency plans that have now been developed must fill extreme gaps in areas that are "not so important" in order to be able to increase the number of intensive care staff as the number of cases increases. Desperately, all kinds of personnel are now being brought back from retirement and trainees and students are being sent "to the front" prematurely.

In Germany, while the hospitals are practically quasi-nationalised during the crisis via state-coordinated emergency plans, their private capitalist form is not touched. Nothing expresses this more clearly than the fact that out of the rescue billions for the German economy, the part earmarked for the health sector in the supplementary budget of the Federal Government, will be used primarily to compensate for the "lost business" of the private hospital groups - not to substantially improve the situation of those who are now fighting for all our lives!

One thing is clear: the current overloading of the health and nursing care system is not a short-term exceptional situation that will be over again in a few weeks' time. The "flatten the curve" strategy is one way to avoid the collapse of the system, but it also means that the epidemic will drag on for a long time and the system will be under heavy load for several months.

It is also likely that interests in the industrial and service sectors will push for a rapid return to "normality". This will involve partial quarantines (for "risk groups"), extensive systems of mass testing and other repressively monitored "contact avoidance" regulations. However, all this will not prevent further increases in infection until the much-cited 70 percent or so "contagion" of the population has been reached, that is, a level of immunity that prevents further spread of the virus in its present form - although this does not rule out the possibility that a new variant will overcome this immunity at a later date.

In any case, the health system will certainly have to cope with this particular overload until the end of this year, in addition to its other problems. For example, the German government has not only earmarked billions for acute costs in its "emergency budget", for example, €50,000 per newly equipped intensive care bed, but has also effectively transferred responsibility for the guaranteed operation of the hospitals to the public sector until the end of the year. Financing is provided by billions of euros in subsidies to the statutory health insurance funds, but control is exercised through state coordination, to whom the hospitals must provide premises, staff and equipment for emergency operations.

Further costs are, of course, incurred by the need to re-establish the health authorities, which were greatly reduced before the crisis, but now, as the central organisation for disease control, have to be ramped up again in a short time at high cost. Finally, the expansion of the mass testing infrastructure will also lead to high government investment, both in laboratory and medical care. If we calculate that in the rich nations health expenditure already accounts for 10 percent of national income in normal times, despite the cuts of recent years, it is clear that even a 20-30 percent increase in costs in the health system, as is now likely, will cost some percent of growth in GDP. You don't have to be a prophet to see that those in power will try to finance the additional costs "in solidarity", primarily through mass taxes and health insurance contributions.

It is also clear that the healthcare systems in the semi-colonies will be overwhelmed by the crisis many times over. On average, not even 5 percent of national income has been invested in the health systems there as a result of the imperialist non-development or the priorities demanded by the conditions on the world market. Behind this, there are huge differences in the degree of neo-colonial neglect. In terms of ICUs, for example, Brazil has about as many devices as Germany, with a population almost three times as large - and of course not the capacity to expand that number. Pakistan, on the other hand, with a population of well over 200 million but just 10 percent of German capacity, is helpless in the face of the epidemic that is about to break out.

In African countries, such as Uganda, only 1 percent of German capacity is available. Of course, the demography of these countries speaks for a faster "herd immunity". But the densely packed living conditions in the conurbations makes the rapid rise in infection rates very likely. The low capacity of the health care systems will therefore shift the curve of the epidemic development strongly into the area of the "herd immunity strategy" - with probably millions of deaths. Due to the much more severe economic crisis that is expected to follow, this health problem will be further exacerbated by malnutrition and other epidemics (e.g. tuberculosis).

The corona danger, therefore, threatens millions of lives. At the same time, the capitalist system is proving unable to cope with the pandemic. On the contrary, it itself acts as a catalyst for the crisis-ridden development of the world economy, which we will deal with in part 2 of this article.