INSIGHTS
PAPER

THE IMPACT OF THE COVID-19 PANDEMIC ON INTEGRATED COMMUNITY CARE

Research commissioned by the Transnational Forum for Integrated Community Care (TransForm)

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1 INTRODUCTION

1.1 INTEGRATED COMMUNITY CARE

Integrated Community Care (ICC) is both a set of principles, and a movement towards better health and care systems. And 'better' means not only being more efficient in delivery, but also more effective in addressing the root causes of health deficits, and ultimately being more equitable and humane.

The approach goes beyond a community-flavoured version of 'integrated care'. It takes a person's and community's strengths, goals and needs as a start point and focuses on tackling inequities in health. ICC has a firm ambition to *reach underserved and marginalised groups,* to help overcome problems related to discrimination, stigma, and violence.

Integrated Community Care is not a prescriptive model, or a managerial toolbox, but a systemic approach to enhancing *the quality of life, social cohesion and resilience of a territorially defined community.* The systemic nature of ICC embodies several elements:

- ICC envisions a paradigm shift in the way health and care systems are organised. The key difference is the move beyond 'delivery' to genuine 'co-creation' with the individuals and communities that are traditionally seen as recipients.
- ICC emphatically addresses the broader determinants of health through evidence-informed policies and actions across all sectors.
- ICC encapsulates a set of generative principles that wholly or partially manifest themselves in a relatively wide range of models and practices. These practices may reflect an ambition to improve health, to enhance community resilience, to improve the quality of life in neighborhoods, or any combination thereof.
- ICC pivots on greater integration between primary care, specialised care, public health functions, social work and neighbourhood development within a given territory. Network governance is a crucial competence to continuously form new constellations of service providers that can respond to changing and spatially differentiated needs.
- ICC comes down to a *continuous process of 'whole system innovation'*. Distributed power and collective learning are the cornerstones of this comprehensive perspective on health and care.

The seven effectiveness principles developed by TransForm, the Transnational Forum on Integrated Community Care[1], provide guidance for innovators and reflect the scope of the approach[2]:

Co-develop health and wellbeing, enable participation

1. Value and foster the capacities of all actors, including citizens, in the community to become change agents and to coproduce health and wellbeing. This requires the active involvement of all actors, with an extra sensitivity to the most vulnerable ones.
2. Foster the creation of local alliances among all actors which are involved in the production of health and wellbeing in the community. Develop a shared vision and common goals. Actively strive for balanced power relations and mutual trust within these alliances.
3. Strengthen community-oriented primary care[3] that stimulates people's capabilities to maintain health and/or to live in the community with complex chronic conditions. Take people's life goals as the starting point to define the desired outcomes of care and support.

Build resilient communities

4. Improve the health of the population and reduce health disparities by addressing the social, economic and environmental determinants of health in the community, and investing in prevention, and health promotion.
5. Support healthy and inclusive communities by providing opportunities to bring people together, and by investing in both social care and social infrastructure.
6. Develop the legal and financial conditions to enable the co-creation of care and support at community level.

Monitor, evaluate and adapt

7. Evaluate continuously the quality of care and support, and the status of health and wellbeing in the community, by using methods and indicators which are grounded within the foregoing principles, and documented by participatory 'community diagnosis' involving all stakeholders. Provide opportunities for joint learning. Adapt policies, services, and activities in accordance with the evaluation outcomes.

1 TransForm, the Transnational Forum on Integrated Community Care. TransForm is a joint initiative of Foundations in Europe and Canada. The overarching aim of the Forum is to mobilize change at policy and practice levels by engaging policymakers, practitioners, and key stakeholders, in knowledge generation, and the sharing of promising and best practices. The TransForm partnership is hosted by the Network of European Foundations and comprises: Compagnia di San Paolo (IT); Robert Bosch Stiftung (DE); Fondation de France (FR); Fund Dr. Daniël De Coninck and the King Baudouin Foundation (BE); Graham Boeckh Foundation, and the Conconi Foundation (Canada). The International Foundation for Integrated Care provides content and management support to the project.

2 Transnational Forum on Integrated Community Care, Strategy Paper. Integrated Community Care 4All. New Principles for Care, March 2020: https://transform-integratedcommunitycare.com/integrated-community-care/

3 Art B, Deroo L, De Maeseneer J. Towards Unity for Health utilising Community-Oriented Primary Care in Education and Practice. Education for Heath 2007 Available from: http://www.educationforhealth.net/

1.2 AIM OF THIS PAPER

This paper explores the potential impact of the COVID-19 pandemic on the Integrated Community Care agenda. The emergence of the SARS-CoV-2 virus early in 2020 has presented itself as a global challenge. Its impact on societies worldwide is enormous. The effects — economic, social, technological, political — are bound to continue to ripple far into the future. However, we are dealing with a challenge specifically in the domain of public health, and it is to be expected that the impact on health and care systems will be particularly pronounced. Exactly how this is going to pan out is far from clear, given the systemic nature of the shock.

This paper does not provide a final assessment of the impact of COVID-19 on Integrated Community Care. Rather it wants to provide food for strategic thinking by members of the ICC community.

We start by summarising findings from desktop research on the impact of COVID-19. This section encompasses contextual developments until the end of October 2020. Then the focus shifts to an ICC-internal perspective. We report insights from interviews — held in June 2020 — with experts and members of the TransForm steering committee. In section 4 we follow up with a set of future scenarios that envision very different settings for the diffusion of ICC-inspired practices. The final section of this paper extends an invitation to practitioners and decision-makers to look beyond COVID-19 and to start developing future-robust strategies to turn the promise of ICC into reality.

In preparing this paper we wish to acknowledge the contribution of experts and TransForm Steering Committee members to this reflection. Participants to two interim workshops are listed in an appendix at the back of this paper.

2 PATTERNS IN A DELUGE OF DATA: INSIGHTS FROM DESKTOP RESEARCH

COVID-19 has unleashed an overwhelming flow of news reports and analyses. It is a challenge to find meaningful patterns in this deluge of data. Moreover, the pandemic has been framed in different, sometimes conflicting ways. We start with a bird's eye perspective on the COVID-19 crisis. In a following section the main implications for health and care systems are discussed.

2.1 MAIN CHARACTERISTICS OF THE COVID-19 CRISIS

It is worth reminding ourselves of the very particular challenge that this pandemic confronts us with.

Multiplicative: The SARS-CoV-2 virus is the carrier of an infectious, potentially lethal respiratory disease. The basic reproduction number R_0 of the virus has been estimated to be between 1.4 and 3.9. This means each infection from the virus is expected to result in 1.4 to 3.9 new infections when no members of the community are immune, and no preventive measures are taken. In other words, it is similarly infectious to a common cold, but much less infectious than, say, measles (R_0 = 12-18).

Global: The pandemic is a global phenomenon. As of 27 October 2020, there have been 45,3 million total confirmed cases of SARS-CoV-2 infection in the ongoing pandemic. The total number of deaths attributed to the virus is 1,16 million. Many recoveries from confirmed infections go unreported, but at least 29,2 million people have recovered from confirmed infections.[4] The five most affected countries are the United States, Brazil, India, Russia and Argentina, which reflects the global reach of the virus[5].

Uncertain: We are dealing with a poorly-understood biological agent. The source of the pandemic has not been ascertained. Its epidemiology still raises a lot of questions. In interaction with the unpredictabilities of human behaviour, the dynamics of the pandemic and its wider implications are impossible to predict.

4 https://en.wikipedia.org/wiki/Severe_acute_respiratory_syndrome_coronavirus_2#Epidemiology
5 https://www.worldometers.info/coronavirus/?

Non-negotiable: There is a considerable human toll associated to the spread of the pandemic. As a result there is significant, but by no means general, buy-in from the general public for stringent containment measures imposed by governments[6,7].

Short-term disruptive: Containment measures essentially require people to maintain physical ('social') distance and respect elementary hygiene measures. This is an obvious impediment to many production and service delivery processes. As a result, the short-term economic impact of the COVID-19-crisis has been significant. There has been a contraction of global economic activity by an estimated 5% in 2020[8]. This constitutes the most severe economic downturn in 70 years, possibly a century[9]. In addition, mental wellbeing has been negatively affected by the general atmosphere of crisis, the confrontation with death and life-threatening illness, the insecurity associated the economic fallout, and the reduction of social contacts through quarantines and distancing measures.

Long-term transformative: The long-term effects of COVID-19 are shrouded in uncertainty, but the pandemic carries the potential for important transformations in key aspects of life in advanced and emerging economies.

— It is not unlikely that the unavoidable economic contraction will increase already considerable socio-economic inequalities. Austerity policies, macro-economic effects (inflation, unemployment) and weakened redistribution mechanisms may reinforce these effects. These developments may have significant knock-on effects in terms of popular discontent, social strife, and unpredictable voting patterns.

— The fabric of economies will transform, as winners (technology, life sciences) and losers (corporate real estate) become clearer. The demonstrated risk of reliance on one single global production hub — China — may also lead companies and countries to diversify their production base to other countries. Supply chains may be rewired for 'just in case' resilience rather than 'just in time' efficiency. Economic fabric may be reformatted to result in more market share

6 Consider https://viruswaanzin.nl/ as an example of activist opposition to government-imposed containment measures.
7 Note that this was different in the case of the 1918 Spanish flu. In the US the war economy demanded a sustained effort which even the pandemic was not able to call into question. Hence, the economic impact of the Spanish Flu pandemic was much less severe compared to C19: https://voxeu.org/article/1918-influenza-did-not-kill-us-economy
8 https://www.weforum.org/agenda/2020/06/imf-lockdown-recession-covid19-coronavirus-economics-recession/
9 ibidem

for large companies with deep pockets and significant resources to dedicate to digitisation and innovation. A number of sectors, such as travel, entertainment, hospitality, possibly also energy industries, may need to go through a phase of creative destruction to develop novel post-COVID operational and revenue models. At a local level it remains to be seen what the long-term impact of COVID-19 will be on main street retail and entertainment outlets.

— It is almost certain that we will have to rethink how we will move and live together. Density is a risk factor in the case of a pandemic. On the other hand, from a sustainability point of view it is a desirable quality in built environments. Urbanists and architects will have to find new solutions to enhance built environment resilience in the face of a wider range of risks. The concept of the 15-minute city is on the agenda[10].

— Government spending to cushion the economic impact of the COVID-19 crisis may siphon off resources from other societal challenges, such as climate change. On the other hand, stimulus packages could also be designed to help societies reach ambitious climate goals[11]. There are now signs of both directions being pursued, with strong regional variations.

— Even more difficult to assess are the longer-term impacts of COVID-19 on culture and collective psychology. Will anxiety ebb, or will it shape public life? Will we become more accepting of risk, or will we trade our freedom, and accept more surveillance in exchange for more safety?

2.2 EMERGING TRENDS AND CHALLENGES IN HEALTH AND CARE SYSTEMS

Among the many impacts of COVID-19 one has been a significantly increased focus on health and healthcare. In connection with the global pandemic, health services have become the focus of everyone's attention. This has created a unique situation that promotes debate about the different health care systems in different countries[12,13]; inequalities in health and in access to healthcare services; and the effectiveness of such systems in terms of how they approach primary health

10 https://www.ft.com/content/c1a53744-90d5-4560-9e3f-17ce06aba69a
11 On 21 July 2020, EU leaders agreed on a comprehensive package of €1 824.3 billion which combines the multiannual financial framework (MFF) and an extraordinary recovery effort, Next Generation EU (NGEU). The package will help the EU to rebuild after the COVID-19 pandemic and will support investment in the green and digital transitions: https://www.consilium.europa.eu/en/policies/eu-recovery-plan/
12 https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3323-3
13 https://blogs.lse.ac.uk/politicsandpolicy/european-health-systems-and-covid-19/

care as well as hospital and intensive care units[14]. This comparison is extremely difficult as health systems differ in terms of financing, functioning, wealth, etc., and concerning COVID-19 there are both data compatibility problems[15] and very diverse ways of dealing with the pandemic.[16] However, there have been some trends and problems that have emerged in virtually all countries.

2.2.1 The rise of 'virtual care'

One of the key modernizations that have been adopted at an unprecedented speed is the growth of remote and digital care (telemedicine, telehealth, etc.), particularly in primary care. Telemedicine has been quickly and widely adopted in various countries. In particular, video consultations are being used as a quick response to reduce the risk of transmission[17]. This has led to a conclusion that implementing telehealth proactively, rather than reactively, is more likely to generate greater benefits in the long-term, and help with every-day challenges in healthcare, including the handling of emergencies[18]. At the same time, when redesigning the healthcare system and introducing virtual care, it seems critical to consider the large differences in new technology adoption success by different age groups. With this new way of providing services, questions arise concerning the funding systems and mechanisms to monitor new technology adoption levels. With the growth of digital services, it is predicted that they will spread beyond primary care, into applications such as telesurgery[19]. Remote services may not only build new ways of connecting people with healthcare professionals, but also it can foster collaboration between primary care and specialists,[20] making it possible to help patients without putting them at risk. Online instruments create an opportunity also for different healthcare professionals, enabling them to share data, tools, and resources across the communities and/or countries.

14 https://www.lse.ac.uk/PBS/assets/documents/Estimating-the-monetary-value-of-the-deaths-prevented-from-the-UK-Covid-19-lockdown-when-it-was-decided-upon-and-the-value-of-flattening-the-curve-June-2020.pdf
15 https://ourworldindata.org/covid-sources-comparison
16 https://www.cfr.org/backgrounder/comparing-six-health-care-systems-pandemic
17 global Telemedicine Implementation and Integration Within Health Systems to Fight the COVID-19 Pandemic: A Call to Action https://publichealth.jmir.org/2020/2/e18810/?utm_source=TrendMD
18 Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19) https://journals.sagepub.com/doi/full/10.1177/1357633X20916567
19 https://www.bosch-stiftung.de/en/story/post-corona-revolution
20 COVID emergency: an opportunity to increase the interaction between hepatologist and primary care physician https://www.minervamedica.it/en/journals/gastroenterologica-dietologica/article.php?cod=R08Y9999N00A20060202

The rapid increase of innovation in cyberspace requires close monitoring of key digital rights concerns, such as data protection, surveillance, identity, and access to mobile services and the internet.[21] More advanced technology is also creating new risks in certain areas, including biased data affecting treatment decisions, and blurred liability in cases involving AI-based diagnoses.[22] Therefore different policy adjustments in this sphere will be needed in order to provide safe and accessible virtual services for all.[23]

2.2.2 The fragility of residential care

It has become clear that centres for residential and long-term care[24] are potential hot spots for the spread of COVID-19. This has involved not only elderly homes[25], but also rehabilitation centres, mental health institutions[26], and any places where people stay in large groups. The World Health Organisation has indicated that half of the deaths related to COVID-19 in Europe have so far occurred in residential care and support services,[27] and this also that residential care became very ineffective in fulfilling its primary role of taking care of people in a safe way[28]. The pandemic has raised concerns not only about the health and safety of residents, but also of the healthcare workers[29]. It has therefore become debatable whether large-scale, continuous growth in this sector is the future. It seems that staying small-scale, keeping people at home, or in a small home-like[30] communities, might be a more promising and safer option — particularly for elderly care. At the same time, some caregivers looking after relatives at home have faced serious problems. Many have had to deal simultaneously with other burdens including job loss. For home-care recipients and familial care givers who do not reside jointly, lockdowns have posed especially dire dilemmas between compliance with lockdown measures, and the provision of necessary help and care.[31] This has led

21 https://www.accessnow.org/protect-digital-rights-promote-public-health-towards-a-better-coronavirus-response/
22 https://www.beuc.eu/blog/covid-19-and-digital-health-five-risks/
23 https://cdt.org/insights/telehealth-policy-and-covid-19-expanding-access-without-compromising-privacy/
24 https://ltccovid.org/wp-content/uploads/2020/04/LTC-COVID19-situation-in-Canada-22-April-2020-1.pdf
25 https://www.euronews.com/2020/05/08/the-deadly-impact-of-covid-19-on-europe-s-care-home
26 COVID-19 Pandemic: Impact on psychiatric care in the United States https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7200362/
27 http://edf-feph.org/eu-parliament-use-all-its-powers-investigate-tragic-impact-covid-19-pandemic-long-term-care-across
28 https://ltccovid.org/wp-content/uploads/2020/05/COVID19-Long-Term-Care-situation-in-the-Netherlands-25-May-2020.pdf
29 https://www.kit.nl/unprotected-unheard-home-care-workers-fall-victim-to-covid-19/
30 https://www.dewereldmorgen.be/artikel/2020/06/19/op-naar-een-nieuwe-en-betere-inrichting-van-de-woonzorgcentra/
31 https://blogs.worldbank.org/voices/3-ways-improve-covid-19-response-elderly-care-and-persons-disabilities

to discussion about redesigning and rethinking care services, to make them more suitable to be provided at resident's homes.[32] This might be much more effective than removing the resident, and placing them in institutionalized care. The future potential policy considerations in this area may include: strengthening the linkage between the elderly care response and the overall response; issuing clear guidelines and operating procedures for all residential facilities; mobilizing resources for prevention and control; implementing consistent measures with government support for both licensed and unlicensed residential facilities; strengthening coordination between the social sector and the health sector on the one hand, and between residential facilities, health agencies and hospitals; and building capacities on the other[33].

2.2.3 Pressures on mental health

Social activities have been restricted in most countries. Almost all non-essential individual movements were prohibited due to quarantine, while the local hospitals suddenly received thousands of critically ill COVID-19 patients and were forced to implement their emergency protocols. In this context, the general population as well as most front-line healthcare workers became vulnerable to the emotional impact of COVID-19 infection, stemming from both the pandemic and its consequences worldwide.

During the COVID-19 outbreak, many psychological problems with important consequences in terms of mental health emerged progressively, including stress, anxiety, depression, frustration, and uncertainty.[34] Multiple studies have reported a higher prevalence of patients with psychological symptoms, such as emotional disturbance, depression, stress, mood alterations, irritability, insomnia, post-traumatic stress symptoms, anger and emotional exhaustion. The quarantine period seems to have had important dysfunctional psychological consequences on individual mental health, not only in the short-term, but even in the long-term period.

The situation was even more difficult for people with severe mental illness (SMI). For people living with SMI in the community, it appears that the burden of psychological symptoms, including stress, anxiety, depression, and insomnia might have been greater than for the general population during the pandemic. Such data has come from Italy and China. Review of routinely collected clinical notes

32 https://www.weforum.org/agenda/2020/04/hospital-at-home-covid19-coronavirus-pandemic-nursing-care/

33 The Elderly Care Response to COVID-19 : A Review of International Measures to Protect the Elderly Living in Residential Facilities and Implications for Malaysia https://openknowledge.worldbank.org/handle/10986/33861

34 The psychological impact of COVID-19 on the mental health in the general population https://academic.oup.com/qjmed/article/113/8/531/5860841

in Denmark has revealed pandemic-related psychopathology in people with pre-existing mental health problems ranging from non-specific stress, to delusions, obsessive-compulsive symptoms, and suicidality. A single psychiatric study also reported that people suspected of COVID-19 infection and transferred to an isolation unit were associated with higher psychological distress and benzodiazepine use in the short term for people with schizophrenia.[35]

Psychosocial services, which are increasingly delivered in primary care settings, are currently mostly being offered by means of telemedicine. Apart from the primary impact of COVID-19 on mental health, the related secondary stressors were also determined, such as exposures to infected sources, infected family members, loss of loved ones, physical distancing, secondary adversities (economic loss, for example), psychosocial effects (such as depression, anxiety, psychosomatic preoccupations, insomnia, increased substance use, and domestic violence), and indicators of vulnerability (such as pre-existing physical or psychological conditions). Some patients may need referral for formal mental health evaluation and care, while others may benefit from supportive interventions designed to promote wellness, and enhance coping (such as psychoeducation or cognitive behavioural techniques). In light of the widening economic crisis and numerous uncertainties surrounding this pandemic, suicidal ideation may emerge and necessitate immediate consultation with a mental health professional, or referral for possible emergency psychiatric hospitalization.

Overall, the Covid-19 pandemic has alarming implications for individual and collective health and emotional and social functioning. Accessible and inclusive mental health support become a critical issue during any crisis, and particularly in a crisis which has required widespread confinement and isolation. This is consequential for healthcare providers, who in addition to providing medical care, which is already made difficult by the pandemic, have an important additional role in monitoring psychosocial needs, and delivering psychosocial support to their patients, health care providers, and the public.[36]

Mental health among healthcare workers has therefore also become an alarming issue. They have suffered a lot during the pandemic, facing challenges regarding access to adequate personal protective equipment (PPE), or adequate rest, and stressful and often complicated family situations — for example involving an inability to see and take care of children and relatives[37]. Data from previous

35 https://www.cebm.net/covid-19/severe-mental-illness-and-risks-from-covid-19/
36 Mental Health and the Covid-19 Pandemic https://www.nejm.org/doi/full/10.1056/NEJMp2008017
37 https://www.inquirer.com/health/coronavirus/coronavirus-covid19-mental-health-doctors-20200327.html

pandemics, particularly after quarantine, suggest that healthcare workers might develop symptoms of post-traumatic stress disorder, depression, and substance use disorders. Preliminary data from China and Italy during the covid-19 pandemic offer further evidence; healthcare workers in China reported depression (in 50.3%), anxiety (44.6%), and insomnia (34.0%).[38]

The direct effect of the pandemic, such as psychiatric complications due to COVID-19 infection, had to be dealt with during the pandemic, in the medical environment. The indirect effect of the pandemic upon mental health among psychiatric patients and the general public will most likely continue into the longer term. This means there is an urgent need to improve treatments and mental healthcare planning, and develop preventive measures[39,40].

2.2.4 Effective communication and decision making

The scale of the crisis and the government responses to it have been matched by a colossal flow of information about COVID-19 including 24/7 news coverage[41]. Verified, transparent and understandable information became the most effective prevention against the disease of panic.

Political leaders and health experts have become responsible for providing accurate information and to implement measures that require behaviour change in order to fight the pandemic. At the same time, clinicians had to work with new communication channels (mostly digital and over the phone/video), and adjust their communications style to be understood, and to help patients make the right decisions, even when they cannot see their interlocutors face to face, and such communications must often be done under high levels of stress and pressure.

Experienced public health experts are currently advising and serving many authorities, influencing decision making processes and communication[42]. Governments faced with the pandemic have to make high-stake speedy decisions and, thus, gather an incredible amount of power in times of fast-moving crises such as the COVID-19. The unchecked powers during crisis situations can disarticulate and

38 Covid-19: adverse mental health outcomes for healthcare workers https://www.bmj.com/content/369/bmj.m1815
39 COVID-19 pandemic and mental health consequences: Systematic review of the current evidence https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7260522/
40 The outbreak of COVID-19 coronavirus and its impact on global mental heal http://pu.edu.pk/MHH-COVID-19/Articles/Article46.pdf
41 Effective health communication – a key factor in fighting the COVID-19 pandemic, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7180027/
42 https://www.mercatus.org/bridge/commentary/fighting-coronavirus-shift-decision-making-away-politicians-experts

blur the boundaries between traditionally opposed concepts such as legal/illegal and public/private. They can also create a "principal-agent problem" whereby a person or organization (agent) motivated to act in its own best interest takes actions on behalf of another person or entity (principals) such as citizens and residents of a city, region, or country. In governments' attempts to contain and/or stay ahead of the pandemics and their planetary health and economic consequences, democratic deficits thus emerge. For example, when elected politicians rely on expert knowledge in a pandemic, they take away the elected political authority from the sovereign people and instead place it on allegedly objective but unelected experts.[43] This points to a debate over a maximized democratic participation in the times of crisis, resulting in more inclusive forms of democracy which allow contributions from both experts and citizens.[44]

2.2.5 Experiences from less well-equipped countries

Some countries with less developed and less well-equipped healthcare systems were forced to look for different ways of responding to the pandemic. For African nations, COVID-19 is not a unique problem. It is being managed alongside Lassa fever, yellow fever, cholera, measles and many others. This expertise makes these countries more alert and willing to deploy scarce resources to stop outbreaks before they become widespread. Their mantra might best be summarised as: act decisively, act together and act now. When resources are limited, containment and prevention are the best strategies.[45] This approach is particularly noteworthy in these times of financial crisis and austerity.

Cuba

In Cuba's case[46], what the Cuban health system lacks in materials, it makes up for in workforce — it has the highest doctor-per-patient ratio in the world, 8.19 per 1000. By comparison, Brazil has 2.15, and the US 2.6. Before the first reported case, Cuba's government dispatched teams of doctors, nurses and medical students door-to-door asking about respiratory symptoms and educating the public on the disease. It sent suspected covid-19 cases to state-run isolation centres and traced all their recent contacts.

43 COVID-19 Science Policy, Experts, and Publics: Why Epistemic Democracy Matters in Ecological Crises https://www.liebertpub.com/doi/full/10.1089/omi.2020.0083
44 Deliberation, Citizen Science and Covid-19 https://onlinelibrary.wiley.com/doi/full/10.1111/1467-923X.12869
45 https://theconversation.com/what-developing-countries-can-teach-rich-countries-about-how-to-respond-to-a-pandemic-146784
46 https://www.newscientist.com/article/2247740-how-cuba-and-uruguay-are-quashing-coronavirus-as-neighbours-struggle/#ixzz6UnlptLJv

Uruguay

Uruguay never enforced a mandatory quarantine. At the same time, the Uruguayan government undertook aggressive testing measures and rolled out a contact-tracing app from which home visits and tests can be requested. Uruguay had conducted 162 tests per new case of covid-19 as of 26 June, the highest number for any country in South America. Various lessons should be learned from Uruguay's response, not least is the importance of clear messaging which raised the compliance.

Syria[47]

Several factors make Syria, a conflict affected country, highly vulnerable to a severe outbreak, such as an exhausted health system[48], protracted violence, and an extremely high poverty rate which helps cause a high average number of individuals per household, and many cross-generational households. There is also a large internally-displaced population in Syria, living either in high-density residential areas, or in IDP camps with little access to water and no possibility to isolate. Just as civil society across the world is playing a vital role in the response to COVID-19, organizing community support groups and campaigns to raise awareness, Syrian civil society has the potential to play a vital role in responding to this crisis. It requires additional support for organisations active in this area. This is particularly the case in the northwest of the country, where Syrian medical NGOs are leading the fight against the virus.

2.2.6 Community resilience

Strengthening the bond between people and communities has become critical for building a resilient society. It is now advocated that "just in time" supply chains should be balanced by "just in case" resilience. Healthcare experts have started to advocate designing care around the community-centred system. Community health workers, citizens and volunteers can play a critical role during a pandemic. This has been demonstrated by their important roles in integrated community care. Collaboration among local networks turned out to be critical, and it showed the need for trust in society. Community-oriented care enabled the redistribution of resources[49], although an argument was made that there needs to be a critical mass of resources that can be redistributed. The COVID-19 pandemic made it clear that health outcomes are heavily impacted by social determinants.

47 COVID-19 Pandemic: Syria's Response and Healthcare Capacity, Mazen Gharibah and Zaki Mehchy, LSE https://eprints.lse.ac.uk/103841/1/CRP_covid_19_in_Syria_policy_memo_published.pdf

48 https://www.theguardian.com/commentisfree/2020/aug/24/medic-syria-covid-19-crisis-health-pandemic

49 https://sociaal.net/boek/zorgzame-buurt-kwetsbare-bewoners/

2.2.7 Recovering and dealing with the financial impact

Financial pressure on the healthcare system is a factor adding to the pressure for change[50]. Government actions are particularly critical in determining whether the system's recovery will accelerate, or do the opposite[51]. By focusing on the most vulnerable and local communities, central policies can help to deal with inequalities and to reduce them. After-COVID recovery means also dealing with patients that were not able to access health care regularly[52]. As health is at the centre of attention nowadays everywhere, different actors are gaining more power — in particular, in industries that are profiting from tackling the crisis. To accelerate the recovery of the healthcare systems, this shift in power needs to be under careful observation. Financial incentives may encourage the industry to further growth in power[53]. The race for an effective vaccine against COVID-19 has already created a heated political debate[54] and spurred much controversy over the cost, and the appropriate procedure and safety measures[55]. When facing inequalities among communities, it is also worth considering the inequalities between countries — particularly within the European Union — and how those inequalities will affect the population in Europe. A new paradigm seems to be emerging, that moves towards a community-centred health and social care ecosystem.

50 https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due
51 https://time.com/5876606/economic-depression-coronavirus/
52 https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-early-april-2020/
53 https://www.nytimes.com/2020/03/18/opinion/coronavirus-vaccine-cost.html
54 https://www.hhs.gov/about/news/2020/07/22/us-government-engages-pfizer-produce-millions-doses-covid-19-vaccine.html
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3 VOICES FROM THE ICC COMMUNITY: INSIGHTS FROM INTERVIEWS

Another part of our research was gathering perspectives and reflections from different experts, familiar with the topic of ICC and its agenda. Members of the TransForm Steering Committee were invited to voice their views in two group interviews. In addition, the following experts were interviewed:

- **Anna Coote,** Principal Fellow at the New Economics Foundation (NEF) (UK),
- **Elke Plovie,** Researcher and lecturer at UC Leuven-Limburg (Belgium),
- **Erik Leviten-Reid,** Facilitator, Community Engagement and Collaboration at New Dawn Enterprises (Canada),
- **Giuseppe Costa,** Professor of public health at the Department of Clinical and Biological Sciences of the University of Turin, Epidemiologist and head of the Regional Unit of Epidemiology and Health Promotion in the Piedmont Region (Italy),
- **Maria van den Muijsenbergh,** Professor of Health disparities and person centred integrated Primary Care at UMC (The Netherlands),
- **Marie Aline Bloch,** Professor at EHESP School of Public Health (France),
- **Philipp Dickel,** GP and Project Coordinator at Poliklinik Veddel (Germany)

During the conversations we explored the impact of COVID-19 on their personal life, professional life, communities around them, their field of expertise, healthcare, and finally the ICC agenda. Even though each one of our experts has provided a different perspective, we found common themes emerging, and consensus around many aspects. Below, the main themes from the conversations are synthesised under three headings.

3.1 UNPRECEDENTED OPPORTUNITY

Many of our interlocutors shared the feeling that COVID has created an unprecedented chance to move forward with the agenda of ICC. The pandemic has allowed several things to resurface in public discourse, such as the need for cooperation and inclusion, and how heavily social inequalities are influencing health outcomes, thus demonstrating a clear need for a strong collaboration between social and healthcare workers.

Another aspect of this opportune public discussion is that it is health-centric. During the pandemic, public health, and prevention (such as washing hands, keeping distance) became the centre of the public attention. It created an occasion to discuss healthcare systems and their efficiency. In this context, the concern was raised by our respondents over a tension between being pushed by external circumstances, and pulling towards control and influence. The aim should be to consciously participate in a major transformation, involving fundamental change in how to approach communities, their wellbeing, and healthcare systems.

With a large number of emerging creative solutions (such as telehealth, mobile units, etc.), our respondents shared their concern over lack of more fundamental, systemic changes in approach and mindset. They agreed that the introduction of new, often digital tools may change things superficially, without solving the underlying issues. Moreover, it was emphasized that if the tools are not designed in an inclusive way, they may worsen exclusion and lack of access to services, instead of solving it. It was stressed that the inequalities that are and were observed before and during the pandemic, are, according to our respondents, of a systemic nature, therefore they require a systemic approach.

It was also voiced how evident the need for collaboration has become, whether on the level of a community, or between different professionals, or between experts from different countries. For many people it became apparent that different perspectives are enriching the picture of the situation, and helping to create a better understanding, and to prepare the best response to it.

3.2 WE ARE IN THE SAME STORM, BUT NOT IN THE SAME BOAT

According to our respondents, for the first time it had been obvious that the housing conditions, work conditions, health literacy, and other social factors played a major role in the risk of COVID-19 infection, but also any other health-related risks and outcomes. It became easy to see inequalities and differences among communities, for example between groups that are a part of a network, and have access to different resources, vs. people being isolated, and being stripped of any form of support and left alone.

The disparity between so-called “haves” and “haves not” became even more apparent, also regarding access to effective home-schooling, nature, financial resources, online tools, etc. Some people became extremely busy and overloaded with tasks, and needed to redefine their jobs, becoming occupied with extra safety procedures, etc. Others had the opportunity to slow down, had less or even no work, and for some it turned into a relaxing and almost enjoyable time.

3.3 A TIME OF PARADOX

Many of our interlocutors shared observations of acts of solidarity and caring, while at the same time they shared their concern about countries closing their borders, international flights being stopped, and some parts of society (such as the homeless, immigrants, refugees etc) being almost abandoned.

Another paradox that was shared was the emergence of small, local, creative and agile initiatives, at the same time when the central response was often slow, siloed, and inadequate. Some of our respondents and the people around them suffered from mental health issues, while others enjoyed the feeling of togetherness, connections, and used online tools to connect and bond with people.

Another interesting contradiction observed and shared was concerning the inability to meet physically and connect personally, and yet seeing each other in their own homes, in an almost intimate environment, via online video tools. Even though meetings and conferences were cancelled, many global sharing platforms emerged quickly, and allowed people to collaborate and connect efficiently, exchanging information and experience.

Although many governments made efforts to provide safety for their citizens, they often tried to achieve compliance by spreading fear. In a society dealing with conflicting messages and uncertainty, panic and anxiety was used as a powerful tool for building immediate compliance and obedience. Our respondents raised a concern that such actions could potentially have very long-term consequences, saying that social fear was created in many communities.

As the economic crisis loomed, our interlocutors observed the paradox of austerity vs sustainability — raising a question about acting responsively, while designing a more resilient society, which should be able to react better in the face of any crisis. They shared a concern about the difficulties which society was having to draw lessons from the past, or to introduce fundamental change, while at the same time, they had experienced the fast adoption of tools that had previously been thought impossible to introduce quickly. This observation was shared with a feeling of hope: that change is possible, at least at some level.

4 FUTURE SCENARIOS

It is clear that the post-C19 future is riddled with uncertainty. It is impossible to predict even the short-term future. This is why it is now becomes crucial to think in terms of future scenarios. The leading question is: "How might a post-COVID world look like?"

4.1 SCENARIOS FOR STRATEGIZING

When there is confusion it is unwise to bet on one single possible outcome. Rather than extrapolating from quasi-certainties to one single 'official future', scenarios are constructed by investigating how uncertainties may interact, in order to generate alternative, plausible futures.

Hence, scenarios are always presented as a set (a minimum of two, a maximum of four). The idea is not to choose the 'most likely' scenario to build a strategy on. The point is to use all the scenarios to assess the robustness of a strategy. If a given strategy turns out to be associated with significant risks in one or more of the scenarios, then this is an important input into the decision-making process.

Scenarios have to be plausible and internally coherent. However, it cannot be proven that they are 'true' or 'correct'. The relevant question to ask is how we would react, what strategies we would develop, if one of these plausible alternative futures would materialize.

In this context we are interested in how ICC may flourish in a post-COVID world. Some scenarios will be more receptive to ICC, and some less. Given the very different contexts and boundary conditions outlined by the scenarios, we should ask ourselves how the principles behind ICC would be operationalised in each of these worlds. The invitation extended by these scenarios is to discover how ICC might look, and what that means for the ICC agenda and strategy today.

4.2 HOW THESE SCENARIOS CAME INTO BEING

Here we propose a set of thumbnail scenarios based on desktop research. The research and the interviews presented in the earlier sections of this paper already give us a good sense of the scope of possible futures we might want to contemplate. In addition, we have studied a range of published post-C19 scenarios. The scenario framework was validated with a group of experts who are familiar with the ICC agenda. The group also helped to develop seed narratives.

4.3 THE SCENARIO SPACE

We propose to construct the scenarios around two critical uncertainties:

— The impact of the pandemic.
— Our ability to respond to the pandemic.

This opens a scenario space in which the contours of four easily graspable scenarios emerge:

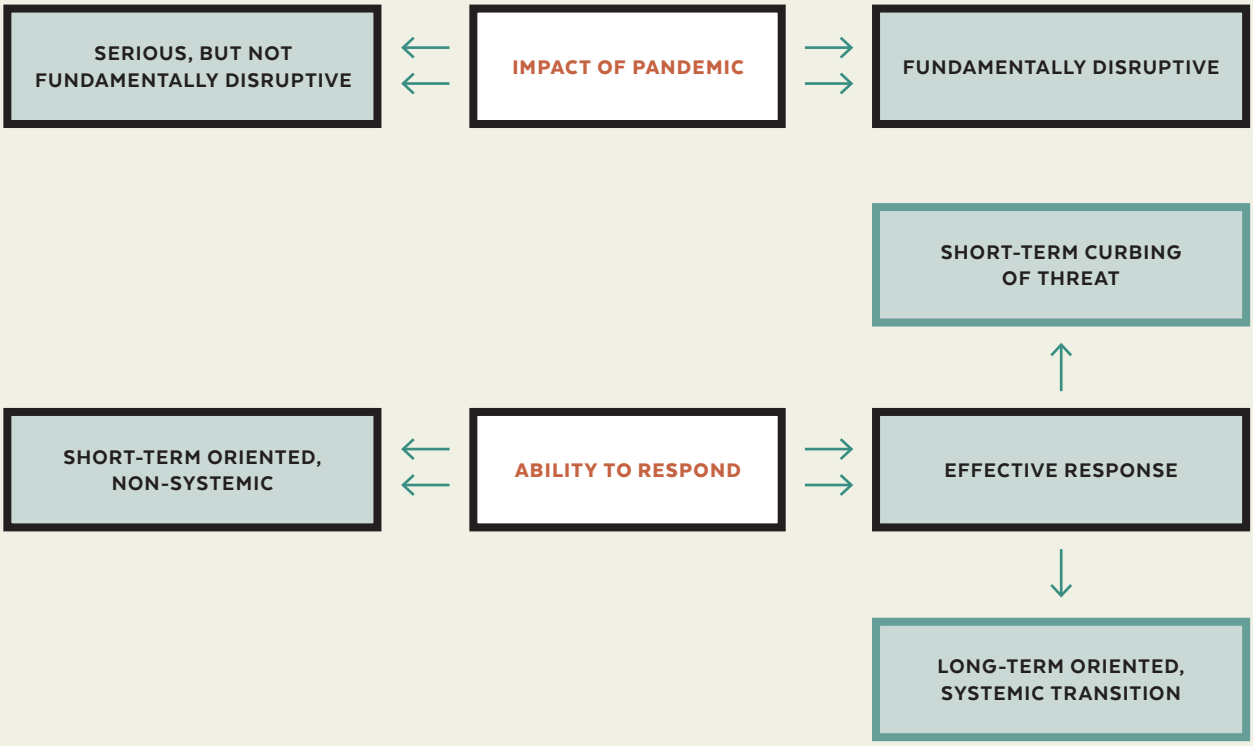
— A high impact, low responsiveness scenario which offers great challenges for humanity and significantly affects the quality of life.
— A high impact, high responsiveness scenario which stretches-out a canvas for rapid, systemic innovation, and societal transformation.
— A low impact, low responsiveness scenario which pivots around a dynamic of 'muddling through'.
— A low impact, high responsiveness scenario in which the impact of COVID-19 can be neutralised through approaches that fit within the accepted way of conducting human affairs.

In order to allow us to imagine how these scenarios play out, we propose a 2030 time horizon, i.e. a 10-year time interval.

4.4 CRITICAL UNCERTAINTIES

We are proposing two generic critical uncertainties here, as a scaffolding for the four scenarios:

— The impact of the pandemic, which can vary from 'serious but not fundamentally disruptive' to 'fundamentally disruptive'.
— Society's ability to respond, which can vary from 'short-term oriented, non-systemic' to 'able to respond effectively'. Associated with the latter we envisage two modes of effective response: either successful short-term curbing of the pandemic threat, or a long-term systemic solution.



One might point out that there is a correlation between these two uncertainties. That is true, up to a certain point. For example, an inadequate response may exacerbate the impact of the pandemic. And vice versa, a high impact may galvanise a strong and systemic response. But it is quite possible to imagine how impact and ability to respond work at variance.

These are very generic uncertainties, conceptualised at a fairly high abstraction level. The advantage is that only two uncertainties open-up a very rich scenario space. The drawback is that it is not easy to define these uncertainties in a very rigorous and unambiguous way. We propose to 'define' these uncertainties inductively, meaning that we bound their scope by listing a range of secondary uncertainties encompassed by them.

Factors contributing to the impact of the pandemic:

- The number of infections
- The number of casualties
- The length of the pandemic
- The severity of successive infection waves
- The capacity of the virus to mutate
- The financial cost of containment measures
- The collateral impact of containment measures on health
- The degree to which societal infrastructures and services adapt
- The change in societal values and behavioural patterns
- The change in the balance of power and social equality
- The degree to which efforts to contain the pandemic siphon off resources which would otherwise go towards other societal challenges
- The degree to which the pandemic affects cohesion within the EU
- The degree to which the pandemic affects geopolitical relations and balances
- ...

This list of secondary uncertainties is not exhaustive. But it shows that impacts may vary over a wide range of systemic levels, from a quantifiable number of casualties, to qualitative shifts in values. A future in which the impact of the pandemic would turn out not to be fundamentally disruptive could, for instance, be characterised by a relatively short-lived pandemic, relatively mild impacts on societal infrastructures, values, power balances and social cohesion. And vice versa for a more disruptive impact.

Similarly, we can list secondary uncertainties encompassed by the primary critical uncertainty, 'ability to respond':

- The relative degree of success in developing a vaccine
- The efficacy of a vaccine
- The speed and efficacy of vaccination campaigns
- The degree to which there is a societal consensus about the containment measures taken
- The level of collaboration between policy domains, administrative levels, providers of public services
- Financial resources available to governments

- The willingness of governments to suspend or revise regulations to enable ad hoc responses
- The ability of civil society actors to fill gaps in the government response
- The level of solidarity and volunteerism
- The level of skills available to citizens to provide mutual help

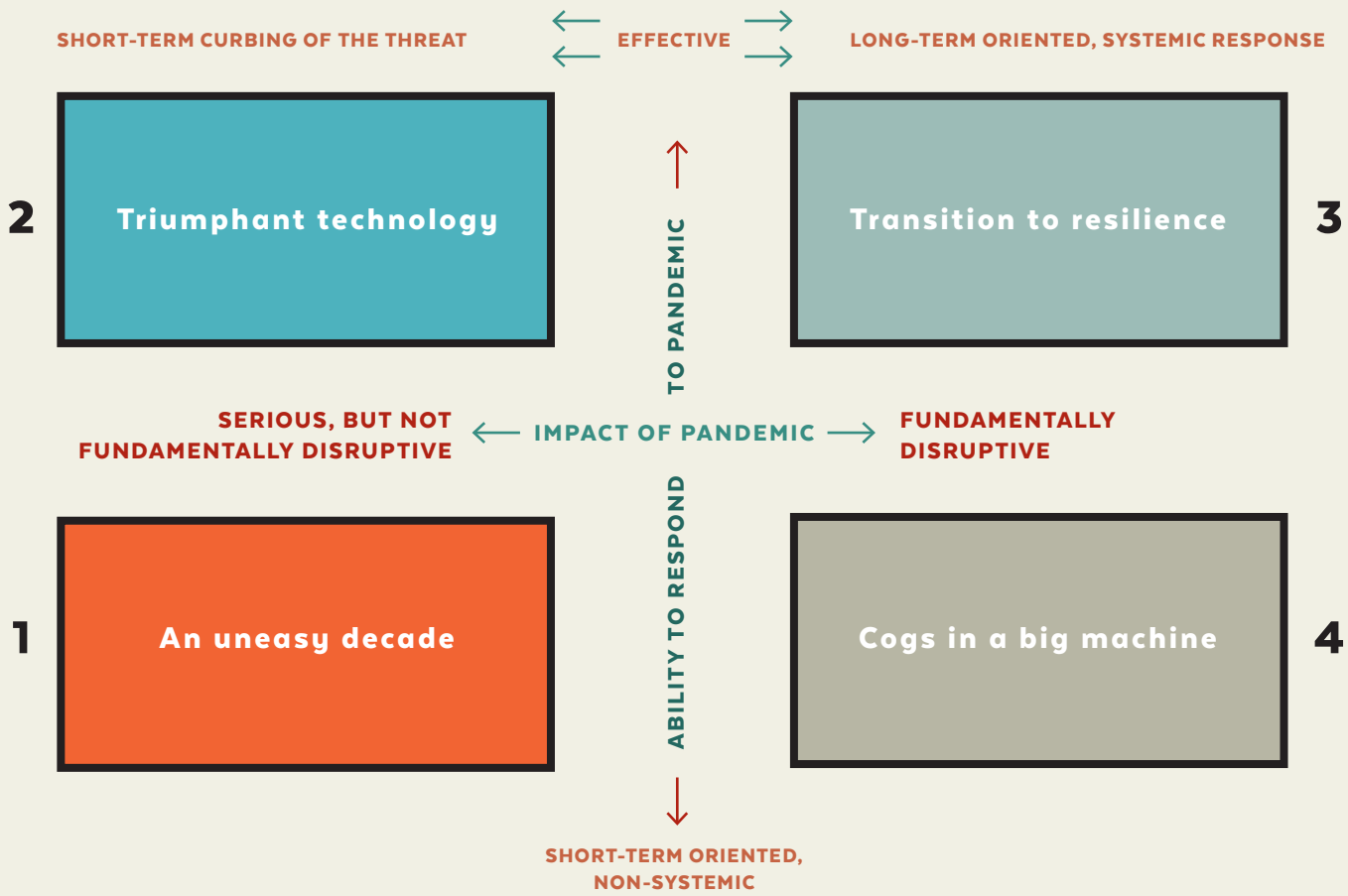
The 'negative' end of the spectrum can be characterised as 'short-term oriented, non-systemic' response. Depending upon the impact of the pandemic, the cost associated with this limited capacity to deal with the threat will be higher or lower. At the positive end, we may want to distinguish between two 'effective' modes of quelling the pandemic: one that hinges on the short-term development of an effective vaccine, and another which orients towards long-term, systemic reform of our societies.

The four futures defined above carry an obvious normative loading. Intuitively we recoil from a future where the pandemic is fundamentally disruptive, and we are unable to respond effectively. The idea is, however, that we contemplate this future as possible and plausible, and take it as a starting point to reflect on how ICC might take shape in this, arguably challenging context.

As already indicated, it is vital to understand that ICC will emerge in each of these future scenarios. Given the very different contexts and boundary conditions, the principles behind ICC will be operationalised in different ways in each of these worlds. The invitation extended by these scenarios is to discover how ICC might look, and what that means for the ICC agenda and strategy today. Perhaps there are a number of no-regret measures that contribute to a more effective ICC in all or most scenarios. If so, those can form the backbone for a robust ICC strategy, able to adapt itself to very different future challenges.

4.5 THUMBNAIL SCENARIOS

Combining these two critical uncertainties in a classic 2x2 scenario matrix results in the four scenario seeds.



Below we present compact scenario narratives to give a feel for what it means to live in these worlds.

4.6 SCENARIO NARRATIVES

Scenario 1 — An uneasy decade

The COVID-crisis was just another nail in the coffin of the Western development model. When the Berlin Wall fell, pundits announced the 'End of History'. Western-style liberal democracies seemed to have proven their moral and economic superiority for once and for all. But in the ensuing three decades serious cracks appeared in the facade: 9/11, the failed military campaigns in Iraq and Afghanistan, the 2008 financial crisis, the increasing frequency of climate change-driven natural disasters, widening inequalities, and a continued structural inability to

provide equal opportunities to people with a migration background. The populace started to lose confidence in their leadership.

And then came the C19 crisis. An unknown, very unpredictable biological agent. Experts didn't seem to understand it. After the 'hammer' of the 2020 spring lockdown followed a sequence of confusing 'dances' as successive infection waves followed each other. A vaccine did materialise, in the autumn of 2021, but it wasn't nearly as effective as people had hoped, and there were some safety issues with it for the elderly, the most vulnerable group. So only by the end of 2023 was there a feeling that the virus was more or less under control. The 'new normal' still included many Corona-triggered hygiene and social distancing routines. Working from home was the norm now. And using mass transport remained a hassle, and fraught with perceived risks. So those three years of experimentation balancing on a fine line between containment, and respect for citizenship rights and psychological resilience, took a significant toll. There was a widespread feeling of resignation, but nobody seemed to be able to pinpoint the root cause of this malaise. People were frazzled and confused, and also wary of one another. The comfort of being in the presence of others was replaced by a greater comfort with absence. Tensions across generations and societal groups sharpened.

The economic fallout of the crisis added to the effect, and it appeared to be rather unequally distributed. Many small, high street businesses had been unable to weather the prolonged period of uncertainty, depressed revenues, and intense competition of online retailers. Hotels, cafés and restaurants suffered quite a bit. As a result, inner city cores looked hollowed out. Bigger industrial sectors also got into trouble. Building and real estate development shrunk. The airline industry was on its knees, and by 2025 had let go of 35% of its workforce (compared to 2020 levels), and thinned out its offerings to travellers. Governments had no levers to soften the knock-on effects of these economic setbacks — growing unemployment, more precarious labour conditions, sharpening inequalities. On the contrary, the austerity policies that were almost universally imposed added to the sense of fragility.

It was an uneasy decade, dominated by feelings of foreboding and frustration. At the margins things loosened up, however. It was a sobering, but also cleansing experience for the younger generation. Many of them acknowledged the emptiness of the consumerist dreams that had egged-on their parents. They showed dry-eyed pragmatism and necessity-driven creativity in the face of the many challenges befalling our societies.

'An uneasy decade' in a nutshell:

- Pervasive feelings of insecurity and friction.
- Increasing inequalities and sharpening tensions.
- Economic pressure on communities.
- Austerity, dwindling public resources.
- Burgeoning mental and physical health needs.
- Erosion of social capital.
- Younger generation willing to change mindset, take risks and get down to work.

Scenario 2 — Triumphant technology

Six months into the COVID-crisis researchers were testing 42 clinical trials on humans and nearly a hundred more in preclinical trials on animals. It was a tremendous effort on a vast scale — mobilising almost 10.000 researchers and tens of billions of euros — never before seen in the history of humanity. One and half years later, three vaccines had been allowed on the market. Each of these vaccines operated on a different biological principle, which increased coverage, facilitated rapid ramping up of production, and discouraged the monopolistic reflexes of manufacturers. It felt like a narrow escape, and the sense of relief was palpable.

Still, it took until well into 2024 until a large section of the global population had been vaccinated. The access campaigns revealed entrenched privileges, and triggered vocal protests among disenfranchised sections of the population. Also, the anti-vaccine movement did not miss any opportunity to stir up the debate and attract followers.

There was no doubt, however, who came out as the winners of this troubled episode. From now on pharmaceutical companies held sway over regulators. The hesitant impulses to move towards a genuine public health-guided drug development and pricing model were quashed. More generally, attempts to soften the rigour of a purely curative, biomedical conception of healthcare lost ground. Vested interests in institutionalised and specialised care were reinforced. And remote, technologically-mediated care was another big winner, of course. This was bad news for those campaigning for a more preventative, cross-sectoral approach that leveraged the diversified potential of communities.

When the dust of the crisis had settled, there was a huge task ahead, of clearing the economic wreckage of the crisis. Government debts had mushroomed, and economic orthodoxy dictated austerity policies, combined with targeted investments in hi-tech growth industries. Gratitude for the technological prowess of the life scientists was quickly forgotten and replaced by a disgruntlement, caused by the realization that the long, grey years that followed the crisis were there to stay. The latter half of the decade was characterised by a reluctant societal consensus. We got a vaccine, but seemed to be on the losing end in many other respects.

'Triumphant technology' in a nutshell:

- Successful rush to a vaccine, but complications arise in relation to the access campaigns.
- Pharma/life sciences companies strengthen their influence and solidify their licence to operate.
- Specialised, institutionalised, medicalised and hi-tech care manages attract more resources. Primary care and broader wellbeing services suffer in the general climate of austerity.
- Dissatisfaction with the generalised reduction in quality of life prevails in the latter half of the decade. Reluctant societal consensus.

Scenario 3 — Transition to resilience

COVID was a curse, but turned out to be a blessing. The blow snapped us out of our lethargy. By mid-decade the full impact of the Corona crisis had become evident, and it was not a pretty picture. The vaccine emerged, eventually, but it was not a single-dose solution, and hence access was marred by limited production capacity. Moreover, protectionist moves by vaccine-producing nation states triggered animosity. Meanwhile, economies continued to slump, quality of life suffered, and there was massive discontent.

And the problems didn't stop with COVID. Global warming had turned into an established, palpable reality for citizens all over the world. Clearly, we were not equipped, and not resilient enough, to handle the uncertainties of the 21st century. By 2025 it was quite clear: either we tipped into a 1930s scenario, or we got our act together and collectively put our shoulders under a new moonshot project. It was the latter that happened. The European Green Deal ballooned into a spending package of 1,250 billion euro in a frantic attempt to put the foundation in place

for a more sustainable, agile and inclusive Union. The private sector had to follow suit. Corporate Social Responsibility was out; Shared Value became the new norm. In the latter half of the decade, green job creation started to get traction.

Public authorities and civil society developed alliances in designing and implementing innovative and context-sensitive policy responses to the challenges posed by the transition to carbon neutral and inclusive communities. The small-scale experiments from early in the 21st century started to bear fruit. In the mix: social impact bonds, complementary currencies, 'new' public goods (such as free and universal access to broadband internet), tax shift away from labour to consumption and wealth, universal public services, universal basic income, citizen-owned personal data platforms. The health equity emphasis proved to be essential as a common metric to compare the relative relevance and impact of different policy options. As such, it facilitated local alliances between sectors.

The effort to push our societies onto a more viable development curve would have to be supported for decades. This was not a game of 'silver bullets' and quick-fire solutions. Patience was needed while the challenges were piling up and climate change continued to create havoc. It helped that boomers, with their sense of entitlement and consumerist mindset, had to pass on the reins to a more sober and realistic upcoming generation who acknowledged the challenges, but also saw the once-in-a-millennium opportunity of transition.

'Transition to resilience' in a nutshell:

- First half of the decade full of tensions and growing inequalities.
- Centralised governments eventually respond with massive investments in a greener, more agile, inclusive economy.
- Latter half of the decade characterised by openness to policy innovation.
- Acknowledgment of 'one size does not fit all'. Local experimentation.
- Health equity lens as common metric to evaluate policy responses.
- Younger generation willing to change mindset, take risks and get down to work.

Scenario 4 — Cogs in a big machine

COVID did not only infect our bodies, it also ate away at the social fabric that kept our societies together. It stirred up a toxic cocktail of resentment that drove a widening rift between the haves and have nots, the young and the elderly, those who believed in science and those who resisted expert advice, risk avoiders and risk takers. The mishaps surrounding the vaunted vaccine solution from a well-known biotech company proved to be a tipping point. Political meddling had cleared the way for a solution that was eventually found to carry considerable safety risks. After that fiasco governments shifted massively to a stringent contact tracing policy with the aid of sophisticated monitoring technology. Fierce resistance from a determined minority triggered a war of nerves that affected the marrow of social life. Suspicion threw people back on themselves, and on their bubbles. Online social networks were torn apart by flame wars. The world was full of very lonely and stressed-out people. Politicians capitalised on these sentiments and acted out a populist soap opera of scapegoating and false promises. Tech companies, however, did brilliantly in providing virtual entertainment and surrogate, conflict-free relationships.

Meanwhile bills had to be paid, and children raised. There was intense competition in a shrinking labour market. Only lean companies with sufficient critical mass to weather setbacks kept afloat. It was not easy to thrive in these super-efficient corporate machines. And humans had to share the shopfloor and management offices increasingly with robots. Public services adopted similar practices. One just had to ask any nurse. They would tell you how breathless and brainless their working day had become. “We’re just cogs in a big machine. All the intelligence seems to be located now in these AI devices that are prowling the ward.”

Many workers escaped into a precarious gig economy, building ‘portfolio careers’, teaching themselves the finer points of ‘jobcrafting’, with very mixed success. And a shrinking social security blanket made an increasing section of the populace dependent upon informal circuits of mutual aid, barter and the black economy.

One acrimonious societal debate was resolved in this decade. Climate naysayers were finally silenced. This was because our earthly habitat quietly continued to spin out of control, and the effects of global warming manifested themselves at all latitudes, adding to the sense of doom and fragility. The default response was: more technology. In 2030 Jeff Bezos signed off on the launch of a mind-boggling solar geo-engineering experiment: a giant, nuclear-powered, LED-lit, hydroponically nourished, carbon fiber–skeletoned space farm that would be positioned in such a way that it would reduce US West Coast incident solar radiation by 30%. Never would the sky above California look the same.

'Cogs in a big machine' in a nutshell:

- Disintegration of social fabric. Social atomisation.
- Increasing precariousness. Shrinking and very competitive labour market. Growth of gig economy and informal circuits of mutual aid.
- Economic competitiveness driven by economies of scale and efficiency. Public services, including healthcare, follow 'lean' corporate templates.
- Erosion of redistribution mechanisms. Social security is pared down to bare essentials.
- Technology is key for automation, information management, surveillance, entertainment and vicarious living, disaster response and climate mitigation.

5 THE FUTURE OF ICC IN A POST-COVID WORLD

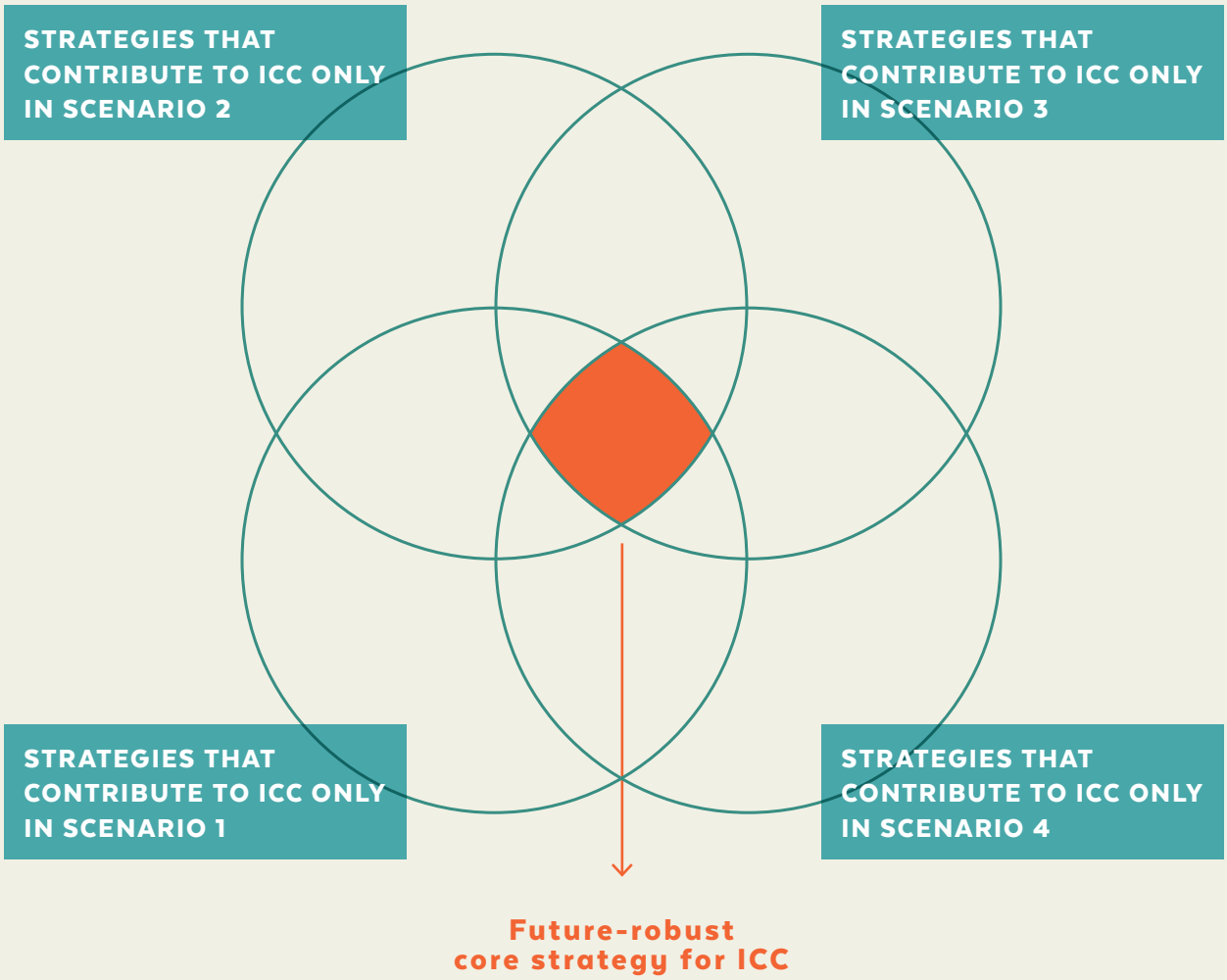
By now we have been living almost ten months under the spectre of the COVID-19 pandemic. At the time of writing, Europe is battling a second wave that threatens to be even more disruptive than the spring. Governments are desperately seeking strategies to reduce the number of infections and casualties while dealing with the constraints of their healthcare systems (number of IC beds, testing capacity) and trying to minimise the impact on economy and social life. One thing is clear: there is as yet no silver bullet solution to the challenge posed by the pandemic, hence we don't know how long this will last, and what impact it will eventually have on our societies.

This paper presents an initial survey of the impact of the COVID-19 pandemic on Integrated Community Care. The provisional conclusion is that the crisis presents challenges and opportunities for ICC. Obvious challenges are linked to the fact that stringent containment measures keep citizens and carers from meeting, maintaining social contact and providing mutual support. Also the agenda of policy makers has been very much focused on strengthening residential health care facilities and emergency response capacities. However, despite the enormous strain that the pandemic is putting on our communities and on health and care systems, it also offers opportunities for the ICC agenda. Beyond the short-term wins — the relaxation of rules, pay rises for health care workers — the disruption has also galvanised volunteers and incentivised professionals to build new coalitions across sectors. The response to COVID-19 has created a level of social capital and trust between governments, civil society, and local communities that might be leveraged for positive change. Moreover, the pandemic has confirmed that community health and resilience, anchored in efficacious and accessible primary care, must remain an absolute priority in a volatile world.

What needs to be done in order to make sure that Integrated Community Care is able to strengthen its presence, and become the guiding philosophy in health and care systems? Inevitably, that reflection unfolds against the background of uncertainty. Therefore we are presenting a set of future scenarios. Each scenario presents a believable image of the future. Altogether they provide us with a feeling for the 'future possibility space' associated with the presence and aftermath of the SARS-CoV-2 virus.

ICC funders, strategists and practitioners might take the effectiveness principles recaptured in section 1.1 of this paper as a starting point for long range planning. Clearly, the way in which these principles will give shape to actual ICC practices will vary from scenario to scenario. How does the specific constellation of social, economic, technological and political driving forces, encapsulated by each scenario, affect our ability to turn the effectiveness principles into reality? What policies and programmes are needed to do so? This reflection leads to scenario-specific strategies to strengthen ICC.

A second step then seeks to understand what the overlap is between these scenario-specific approaches. Actions that are contributing to the strength and efficacy of ICC in every scenario constitute the core of a future-robust strategy. Whatever future unfolds, we can be sure that these measures will benefit ICC.



An initial reflection within TransForm suggests the contours of a future-robust strategy for ICC built around four major imperatives:

- to **consolidate the gains** that have been made over the past years in developing and spreading ICC models and practices.
- to **sustain local actors** in putting in place ICC-inspired practices and to strengthen community and solidarity.
- to **invest in the development of novel**, alternative, community-driven, integrated health & care **practices**.
- to **seek synergies with other societal transitions** that aim to revitalise democracy, build community resilience, increase quality of life, create opportunities for young people and empower vulnerable sections of the population in response to the impact of major political, technological and environmental trends.

The case for integrated community care is clear. This paper is an invitation to practitioners and decision makers to look beyond the COVID-19 crisis and to start preparing for an uncertain future. It will take agility and persistence to turn the promise of ICC into reality.

ANNEX

List of participants to the expert workshops on The impact of covid-19 pandemic on integrated community care 8 September & 18 november 2020

Name	Organisation	Country
Sibyl Anthierens	University of Antwerp Research in Primary Care	Belgium
Giulia Barnhisel	Network of European Foundations (NEF)	Belgium
Marie-Aline Bloch	Ecole des Hautes Etudes en Santé Publique	France
Ian Boeckh	Graham Boeckh Foundation	Canada
Giuseppe Costa	University of Torino and Regional Unit of Epidemiology and Health Promotion in the Piedmont Region	Italy
Nereide Curreri	International Foundation for Integrated Care	UK
Yves Dario	King Baudouin Foundation	Belgium
Jan De Maeseneer	Department of Family Medicine and Primary Health Care Ghent University and EU Expert Panel on effective ways of investing in health	Belgium
Philipp Dickel	Poliklinik Veddel	Germany
Bénédicte Gombault	King Baudouin Foundation	Belgium

Name	Organisation	Country
Stephanie Häfele	Robert Bosch Stiftung	Germany
Cordula Hoffmans	Robert Bosch Stiftung	Germany
Danielle Kemmer	Graham Boeckh Foundation	Canada
Eric Leviten-Reid	Community Engagement and Collaboration, New Dawn Enterprises	Canada
Leo Lewis	International Foundation for Integrated Care	UK
Jean Macq	Université Catholique de Louvain	Belgium
Luisa Marino	Network of European Foundations	Belgium
Cecily Marston	London School of Hygiene & Tropical Medicine, Dept Public Health, Environments and Society	UK
Elke Plovie	University College of Leuven-Limburg	Belgium
Karine Pouchain-Grepinet	Fondation de France	France
Gerrit Rauws	King Baudouin Foundation	Belgium
Anita Reboldi	Compagnia di San Paolo	Italy
Peggy Saïller	Network of European Foundations	Belgium
Nathalie Senecal	Fondation de France	France
Marzia Sica	Compagnia di San Paolo	Italy
Sanja Simic	Conconi Family Foundation	Canada

Name	Organisation	Country
Marta Szulc	shiftN	Netherlands
Maria van den Muijsenbergh	Department of Primary and Community Care, Radboud University Medical Centre Nijmegen	Netherlands
Tinne Vandensande	King Baudouin Foundation	Belgium
Philippe Vandenbroeck	shiftN	Belgium