Commentary: COVID-19 outbreak has overworked some but left more with little to do

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By Tim Hartford

During this coronavirus outbreak, industries must find ways to make better use of idle resources to fight the virus, says the Financial Times' Tim Harford.

LONDON: "It's really quiet," said the proprietor of Oxford's best falafel stall when I popped over to buy lunch on Monday. It is even quieter now.

Meanwhile, my wife emailed friends to ask if we could help. Both of them are doctors and they have three children and a parent undergoing treatment for cancer.

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"Thanks. We will be in touch," came the reply. No time for more. It may be quiet for the falafel man, but not for them.

SOME OVERWORKED, SOME LITTLE TO DO
There, in miniature, is the economic problem that the coronavirus pandemic has caused, even in its early stages. For everyone who is overworked, someone else has little to do but wait.

The supermarkets have struggled to meet a rush of demand for some goods, but that should pass. "We are not going to run out of food, so chill," Yossi Sheffi tells me. He's an MIT professor and an authority on supply chains.

While the pressure on the supermarkets may ease, the strain on the healthcare system will not. It is already intense and will get much worse. Yet while clinicians are overstretched, others wonder when the next job is coming from.

From the falafel seller to the celebrity chef, the hotel porter to the millionaire motivational speaker, many tens of millions of people around the world are fit and eager to work, yet unable to.

This is a test of flexibility and imagination. Gourmet restaurants are shifting to takeaway service; conference speakers are building portable studios.

TURNING DISTILLLERS TO HAND SANITISER PRODUCERS

Best of all is when we find ways to turn idle resources into weapons in the fight against the virus. It is hard not to cheer when reading tales of distillers turning their stills to the task of producing hand sanitiser, or hoteliers offering their empty rooms to doctors and nurses.

But it is a much tougher task, for example, to make more urgently needed ventilators.

In the mid-20th century, William Morris, a man who made his fortune manufacturing British cars, turned his workshops to the task of producing “iron lungs” for people paralysed by polio.

It’s an inspiring precedent for his successors at Meggitt, McLaren and Nissan scrambling to emulate him by building ventilators to use in the current crisis, but it took time.

Prof Sheffi reckons that it would be straightforward for, say, an automobile parts supplier to retool in a matter of months, and having many thousands of extra ventilators by the autumn would certainly be better than nothing.

But to produce complex equipment from scratch in weeks, perhaps using 3D printing, would be a miraculous achievement even if regulations are loosened, as they should be.

HARDER TO RESKILL WORKERS

Yet harder is to find more nurses and doctors; intensive care units do not operate themselves.

And even for less specialist staff, the task is larger than it might seem because of what the late Thomas Schelling, a Nobel laureate economist, called “the acceleration principle”.

Let’s say that Europe has 10 million hospital orderlies, with an annual turnover of 30 per cent. That means 3 million need to be trained each year, 1 million at a time on a four-month training course.

Now let us aim to expand gently to 11 million over the next four months. It doesn’t sound much — just a 10 per cent increase. Yet the training programme must double in scale to accommodate it, because now 2 million rather than 1 million orderlies are enrolled in the same four-month window.

The same logic applies to anything we need more of, from the personal protective equipment that is in desperately short supply in our hospitals, to the Internet bandwidth that we will all be using more of, while working from home.

THE CAPACITY TO ADAPT

The task, then, is immense. But we must try. Under any conceivable scenario, we would not regret trying to expand emergency medical care several times over.

If it is impossible, so be it. But if it is merely expensive and difficult, such costs are trivial compared to the costs of suspending everyday life for weeks or months.

And there is some hope. Efforts are already under way to persuade doctors and nurses who have retired or switched careers to return, and to put medical students to work at once.

We could quickly train new medical support staff to perform focused and limited roles. I can only imagine the breadth of the skills needed to be an intensive care nurse, but if we cannot have more experienced nurses with complex skills, let us at least support them with people who can quickly be trained to change an oxygen tank or turn a patient in bed.

Even those apparently ill-suited to intensive care duty — the 75-year-old retired doctor, the community volunteer with first aid training, or even furloughed airline crews — could indirectly support health systems.

While medical professionals staff the wards, I would gladly pay taxes to fund online advice from a retired doctor, a virus test administered by an air steward, or stitches and bandages from a St John Ambulance volunteer.

Killing two birds with one stone never sounded easy to me. But there is no excuse now not to be radical. This crisis is a test of many things. Not least among them is our capacity to adapt.