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private is so intricate that the divide starts to blur. Both subsystems are rather interdependent. Meeting the public interest while meeting private interests are interrelated dimensions of the contemporary social contract—profit does not, and must not, exist without creating some good to society. Although we disagree with health care being reduced to a mere commodity, the expansion of private services might bring ease to public services for those who need them the most. With services overburdened, care for public patients is sometimes provided by private facilities, as with examinations and medicines when in short supply. Some services benefit society at large, such as by producing and airing televised patient education or giving interviews of general interest. Another overall effect is an influence by analogy on public management, generally aiming at dynamisation and rational spending.

And, conversely, we need not forget the active participation of the public sector itself in privatisation, be it by reinforcing managerial practices or by generating a clientele for external providers. But, the social contract is there regardless.

Claiming that the social contract has been undone inevitably renders the private sector unaccountable for any eventual failure in meeting the public interest. That is not, and must not be, the case.

We declare no competing interests.

*Ricardo Ayala, Bernardo Alarcon
ricardoalexis.ayalavalenzuela@ugent.be

Department of Sociology, Ghent University, Ghent 9000, Belgium (RA); and Faculty of Law, University of Louvain, Louvain-la-Neuve, Belgium (BA)

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Models for mortality require tailoring in the context of the COVID-19 pandemic

Amitava Banerjee and colleagues¹ present the estimated prevalence of serious underlying medical conditions indicative of susceptibility to severe COVID-19 and mortality in England.

Their results are useful for targeting prevention strategies towards people at a higher risk for severe outcomes, to forecast the demand on health systems, to avert the strain on acute care facilities, and for clinicians and their patients who are at a higher risk for severe disease to optimise control of their underlying conditions and adopt precautions for the prevention of COVID-19. Nonetheless, caution is merited in interpreting these results.

The authors assume an identical effect of COVID-19 on mortality, irrespective of the underlying medical conditions, although early data suggest otherwise.² As data emerge on the death rates by underlying conditions and the effect of multiple conditions, it will be important to re-parameterise mortality projections. Moreover, their model does not account for disparities in the prevalence of underlying medical conditions and mortality risk across sociodemographic groups. Data from several countries show that the COVID-19 pandemic is disproportionately affecting minorities and populations with a low income. Barriers related to employment, income, housing, and access to essential services exist, and might impede the adoption of crucial mitigation strategies, such as physical distancing. Mitigation strategies, though essential for controlling an epidemic and with clear benefits for all populations, might have greater collateral negative consequences for some people than others.³

A population health perspective that accounts for the broader determinants of health might help to guide clinical

and public health decisions to not exacerbate existing health and socio-demographic inequities.⁴

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*Arielle Lasry, Roberta Horth
ftn9@cdc.gov

US Centers for Disease Control and Prevention, Atlanta, GA 30333, USA

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Authors' reply

We thank Arielle Lasry and Roberta Horth for their comments on our study¹ and agree that long-term mortality models, applicable to people with different underlying conditions, have an important ongoing role in the COVID-19 response, and that they require further development to include wider determinants of health.

A fundamental question to any patient with a condition would be, we believe: how have my chances of surviving 1 year changed as a result of the COVID-19 emergency? Clinicians and policy makers currently have no consistent way of answering this question; at best, current approaches provide risk estimates for one disease at a time. Lasry and Horth point out the potential benefits of answering this question, and our Article has provided a prototype for development.¹ A strength of our approach is that we estimated absolute risk in 5-year age bands; increasing age has now been established as the most important risk factor for severe or fatal COVID-19. For example, people aged 80 years or older have a 20 times increased risk compared with those aged 50–59 years.² We agree with Lasry and Horth that it is important to consider the health



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