Assessing the potential impact of COVID-19 on life expectancy

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Demographic Consequences of COVID-19
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Objectives

• To provide first estimates of the potential impact of the COVID-19 pandemic on period life expectancy
  • Range of scenarios of bias-adjusted age-specific case fatality rates
  • Range of scenarios of prevalence rates
  • Applied to different life tables:
    • 1) North America and Europe;
    • 2) Latin America and the Caribbean;
    • 3) South Eastern Asia;
    • 4) Sub-Saharan Africa.

• Not a prediction of what will happen to life expectancy
Method: microsimulation

• Discrete-time microsimulation model that simulates the life of individuals week by week for a period of one year (built in SAS)
  • Parameters:
    • age-specific probabilities of dying ($q_x$): taken from aggregated lifetables (5-year age groups) (UN-World Population Prospects 2019);
    • prevalence rate of COVID-19 infection ($i_x$);
      • No age differential
      • distributed over the year following a normal distribution centered on the middle of the year and with a standard deviation of 10 weeks
    • length of illness ($z$), which is set at 2 weeks
    • age-specific probabilities of dying from COVID-19 among the infected population ($f_x$);
**Schematic representation of the microsimulation model**

- **Start:** Week = t

  **Event 1:** Whether die from another cause other than COVID-19?
  - No
  - Yes
  - **Filter:** Has already recovered from COVID-19

  - No
  - **End of the simulation**

  - Yes
  - **Filter:** Has been infected in week t-1

  - No
  - **Event 2:** Whether get infected by COVID-19?
    - No
    - **End of the simulation**
    - Yes
    - **Event 3:** Whether die from COVID-19?
      - No
      - Go back to event 1 for week t+1 until week t=52
      - Yes
      - **End of the simulation**

- **Discrete time, 52 weeks**
- **3 events:**
  1. Probability of dying of any other causes (qx)
  2. Probability of getting infected by COVID-19 (ix)
    1. Can only happen once
    2. Last for two weeks
  3. Probability of dying of COVID-19 (fx)
- **100,000 simulations for each age group/region**
What are fatality rates?

The official counts have many biases:

- Underreporting of milder cases → Upward bias in the fatality rate
- Time lags between diagnostic and death/recovery → downward bias in the fatality rate
- Methods vary among countries
  - France: 18%
  - Sweden: 10%
  - USA: 5%
  - Russia: 1%
  - Belarus: 0.5%
• Source of data for bias-adjusted age-specific case fatality rates
  The Lancet Infectious Diseases
  • accounting for censoring and ascertainment biases
  • Hubei, China
Age-specific fatality rates of COVID-19
There is no clear pattern in age-specific prevalence rates

We tested 6 scenarios:
- 1% of the population infected over a year, no age differential;
- 5%;
- 10%;
- 25%;
- 50%;
- 70%

Source: Natale et al. 2020

Figure 5 Relative Illness Ratio by 5-year age groups
• In high life expectancy regions (North America and Europe), each percentage increase in the prevalence of COVID-19 infection would reduce life expectancy by about 0.1 year.

• At 10% of prevalence, one year is lost. At 70%, almost 7 years are lost.

### Total fatality rate, North America and Europe

<table>
<thead>
<tr>
<th></th>
<th>fx = central estimate</th>
<th>fx = lower limit 95% CrI</th>
<th>fx = upper limit 95% CrI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1%</td>
<td>0.6%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

![Graph showing loss in life expectancy according to different prevalence rates, error bar=95% credible interval, North America and Europe](image)
Life expectancy, Sweden
• At 70% of prevalence rate, the loss in life expectancy reaches also about 6 years in Latin America and the Caribbean.

• The total fatality rate would however be much smaller than in North American and Europe because of a younger age structure.

### Total fatality rate, Latin America and the Caribbean

<table>
<thead>
<tr>
<th>St.</th>
<th>fx = central estimate</th>
<th>fx = lower limit 95% CrI</th>
<th>fx = upper limit 95% CrI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.5%</td>
<td>0.3%</td>
<td>1.1%</td>
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</table>
• The less there are survivals at older ages in the life table, the lower is the impact of COVID-19 on the life expectancy.

• One year lost in life expectancy corresponds to a prevalence of infection of about 15% in South Eastern Asia.

<table>
<thead>
<tr>
<th>Total fatality rate, South Eastern Asia</th>
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</thead>
<tbody>
<tr>
<td>$f_x = \text{central estimate}$</td>
</tr>
<tr>
<td>$f_x = \text{lower limit 95% CrI}$</td>
</tr>
<tr>
<td>$f_x = \text{upper limit 95% CrI}$</td>
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</table>
• In low life expectancy regions, the impact of COVID-19 would be smaller.
• One year lost in life expectancy would be lost with a prevalence rate of 25%. At 70%, 3 years are lost.
• In Sub-Saharan Africa, assuming the same age-specific fatality rates, the total fatality rate would be 5 times lower than in North America and Europe because of the age structure.

<table>
<thead>
<tr>
<th>Prevalence rate</th>
<th>Loss in LE (nb of year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0.1%</td>
</tr>
<tr>
<td></td>
<td>0.2%</td>
</tr>
<tr>
<td></td>
<td>0.4%</td>
</tr>
</tbody>
</table>

**Total fatality rate, Sub-Saharan Africa**

<table>
<thead>
<tr>
<th>Estimation</th>
<th>Fatality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$f_x = central$</td>
<td>0.2%</td>
</tr>
<tr>
<td>$f_x = lower$</td>
<td>0.1%</td>
</tr>
<tr>
<td>$f_x = upper$</td>
<td>0.4%</td>
</tr>
</tbody>
</table>
Summary

• As long as the prevalence of COVID-19 infection remains low in a region, the pandemic would not affect life expectancy substantially.

• At merely 2% of prevalence of COVID-19 infection, the secular increase in life expectancy (0.2) is likely to be suspended.

• At 10% of prevalence, the loss in life expectancy is likely be above 1 year in high life expectancy countries.

• At 70%, it would translate into the years of life lost between 4 to 11 years in high life expectancy regions, between 3 to 9 years in medium life expectancy regions and between 1 to 5 in low life expectancy regions.
  • A clear break in the historical trend might be observed and would be visible when plotting the age pyramids in the coming few years.

• The evidence from our modelling could be applied to specific areas as well as to countries as a whole at given level of prevalence.
Some limitations

• The results should be interpreted in the context that all other things are kept constant, albeit being rather unrealistic
  • likely the true age-specific case-fatality rates differ among regions given country differentials in policy interventions, health infrastructure and population behaviors

• Mortality rates are not independent of the prevalence of COVID-19 infection
  • health infrastructures are likely to be overloaded and to not be able to provide care for everyone who needs it, resulting in higher mortality rates both from the virus itself and from other causes
Thank you
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