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MIPP COVID-19 RESEARCH BRIEFING

Lessons Learned from the First Wave or Lessons Merely Identified? Improving Nova Scotia and New Brunswick's health system for the second wave of COVID-19 and beyond

Purpose of the Note

On December 11, 2020, Dalhousie's Faculty of Medicine and the MacEachen Institute for Public Policy and Governance (MIPP) hosted a roundtable at which 28 people met online to discuss lessons from the health sector's response to COVID- 19. We chose to distinguish between 'lessons identified' and 'lessons learned' because we felt that many issues have been recognized as important, but it is less clear that in all, or even some cases, institutional and systems learning have taken place. Some of the challenges are considerable; sustained effort will be required.

Participants included senior representatives from both the public health and healthcare systems of New Brunswick and Nova Scotia, as well as academics. Most of the participants were from Nova Scotia, which was the focus of much of the discussion.

For information about the Catalyzing Systems Change Initiative, please visit the FOM's website. For more information about upcoming events, please see the MI website.

About the MacEachen Institute

The MacEachen Institute for Public Policy and Governance at Dalhousie University is a nationally focused, non-partisan, interdisciplinary institute designed to support the development of progressive public policy and to encourage greater citizen engagement.

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This briefing note starts by highlighting selected recommendations that were drawn from the roundtable on December 11. The subsequent pages summarize our goals and methods and the discussions that took place at the session.

This is the second in a series of roundtables hosted by the MIPP in partnership with the Faculty of Medicine at Dalhousie University. These events are focused in particular on supporting the Faculty of Medicine's strategic initiative of catalyzing systems change for better health outcomes. This session expanded on the roundtable that took place on October 2 (see the briefing note that summarizes the discussion) and panel presentation on October 1 (see "First Wave: Atlantic Canada's Chief Medical Officers Discuss Lessons from COVID-19").

Lessons from the first wave that we still need to learn in Atlantic Canada

- We often chose compliance over collaboration and, in some cases, compliance over effectiveness. We need to identify when compliance or collaboration will be more effective.
- We need to define "effectiveness" and create metrics to measure our ability to be effective, and commit ourselves to learning and improving as we proceed. (See endnote for discussion about effectiveness and efficiency.)
- We need infrastructure to collect and manage equity-based data; we also need to make a deliberate and conscious effort to collect it.
- We need to understand and balance the independence of Chief Medical Officers of Health with democratic accountability.
- As the vaccine becomes available, we need to manage the risk that the public will become too complacent in the face of the ongoing threat of COVID-19.

Lessons regarding internal transformations to the healthcare system, including the importance of effective integration of long-term care (LTC)

- We need to fund and institutionalize multi-organizational partnerships that emerged and proved effective during the pandemic.
- We need to continue to integrate long-term and acute care systems better without over-medicalizing LTC facilities.
- Transforming LTC and developing national standards will require us to revisit how federal funding is allocated to provinces for LTC.
- Engaging front-line health care providers and labour union leaders (e.g., NSGEU). will help address fatigue and employee morale.

Lessons regarding cross-sectoral collaboration and reimagined roles for the private and community-based sector

- Formal structures should be established to enable better collaboration between the health sector and community-based organizations, particularly those representing equity-deserving groups; to date, these relationships have been too ad-hoc and informal.
- Out of necessity, public-private processes and agreements became more efficient (e.g., RFP processes). We need to continue these more efficient processes.

Lessons regarding pandemic planning, including establishing a recovery plan

- We need to increase focus on long-term planning; we have been too focused on the short-term challenges and response.
- Rather than go back to "business as usual", we should pursue "business as needed". COVID-19 has been a catalyst in adapting and innovating operations that might be more effective than they were pre-pandemic.
- There are several areas that we need to address: surge capacity of hospital beds; necessary redundancy in staffing; various care and clinical pathway options to ensure value of care and patient-centred care; sufficient number of trained healthcare providers; (over)reliance on single-source and just-in-time supply chains.
- Prioritizing COVID-19 has created a backlog of other work that needs to be addressed.
- As we focus on the road to recovery, there should be emphasis on resilience and equity to build better systems than before, sometimes referred to as *Just Recovery*.
- The role of the government in allocating research funding should continue.

How We Did It

We invited leaders and decision-makers from the public health and healthcare systems as well as academics who research aspects of healthcare and policy. We distributed questions to participants in advance of the session. We started the event with a presentation by Dr. Anne Snowdon, a professor of Strategy and Entrepreneurship at the University of Windsor. Dr. Snowdon is also the academic chair of the World Health Innovation Network (WIN) and scientific director and CEO of SCAN Health. Dr. Snowdon presented findings of recent research about supply chain issues experienced in the healthcare sector during the pandemic. Following her presentation, we started the discussion.

A note-taker summarized the discussion and produced this briefing note. Aside from summarizing the comments of Dr. Snowdon, this note does not attribute comments to individuals; it merely summarizes the comments. We also recorded the session to ensure we described the discussion accurately. Participants shared their observations and experiences; we did not confirm the accuracy of their comments.

Participants were asked to discuss the following questions:

1. Name some 'lessons identified' and discuss whether these became 'lessons learned', and if so, then why, and if not, why not?
    a. What/who were the enablers?
    b. How were the forces of elasticity resisted?
    c. How can we institutionalize learning and maintain momentum?
2. Has any progress been made to integrate equity considerations further into decision-making processes? Are there any concrete examples of this?
3. Balancing competing needs: how do we get on with ‘business as usual’ while dealing with the pressing need of COVID-19?
4. Looking forward through the next six months, what issues are on your mind that concern you? What are the critical vulnerabilities? How do we address them?

For additional information about the method used, please see Appendix I

Why We Did It

COVID-19 continues to cause significant challenges for Nova Scotia’s health system. The current conditions create pressures to prioritize, adapt and integrate health services; these pressures raise questions about fairness, access, and transparency. We have been here before: the first wave of COVID-19 created similar challenges. Did we learn and implement the lessons from wave one?

This event represents a partnership between the MacEachen Institute for Public Policy and Governance and the Faculty of Medicine. The MIPP serves as a forum for vibrant public policy discussion and analysis. Health Systems and Governance is a research priority for the Institute.

The Dalhousie Faculty of Medicine has a strategic goal to catalyze systems change to improve health outcomes. The aim is to work with key community partners to influence health and societal systems for change, with the overall goal of being a valuable agent of socially responsible change for Atlantic Canada’s health systems. This roundtable session was an opportunity for system partners and academics to discuss lessons identified during the first wave of COVID-19 as we prepared for a second wave, particularly with the healthcare system already under enormous stress.

How We Framed the Discussion

Opening Comments from Professor Anne Snowdon – Professor of Strategy and Entrepreneurship at the University of Windsor

Dr. Snowdon presented the findings of her COVID-19 Rapid Response–funded research that investigates and compares supply chain issues in the healthcare system throughout the pandemic. To view the full presentation, please see *Impact of COVID-19 on Canadian Health Systems (Roundtable Presentation).*

Key issues from the presentation include:

- The degree of centralization and integration of a province's governance arrangement to manage supply chains (e.g., the role of a central agency) influenced how effectively Personal Protective Equipment (PPE) was procured and distributed across provincial health systems. Provinces that used a central agency and had integrated governance arrangements had better outcomes, especially regarding LTC.
- How supply chains are managed impacts data collection, including the type of data collected, who it is collected from, and how it is managed. Digital infrastructure to collect and manage data was not consistently in place or used effectively in every jurisdiction.
- Significant problems were caused by hospital-first policies for PPE during the first wave. These policies did not prioritize providing PPE to LTC facilities. PPE was provided to LTC facilities only after outbreaks in facilities had occurred rather than in advance. Working conditions for staff were not safe and outbreaks in LTC facilities were more devastating in jurisdictions using hospital-first policies for PPE.
- There is a need to increase domestic supply of PPE, as well as to establish national standards for certifying PPE products. Reliance on international markets for procuring PPE and the United States for certification (e.g., NIOSH) to validate new products caused significant supply chain issues in the first wave because new products could not be approved quickly.
- We did not learn key lessons from SARS on how to manage PPE stockpiles properly. Processes and infrastructure to track products and rotate out expired products varied province to province. This meant that some provincial stockpiles of PPE at the beginning of the pandemic were not viable. Provinces that had the processes and infrastructure to manage the PPE effectively had better outcomes.
- Transparency and meaningful engagement have been effective in building workforce confidence. Tensions between building a culture of compliance as opposed to a culture of collaboration have risen throughout the first wave. Transparency and meaningful engagement are effective in establishing a culture of collaboration, which is especially important in LTC.
- Tensions between the public health and political spheres have caused communication issues, particularly when political expediency has motivated communications to the public.

Dr. Anne Snowdon is a Professor of Strategy and Entrepreneurship at the University of Windsor. She is the Academic Chair of the World Health Innovation Network (WIN) and Scientific Director and CEO of SCAN Health.

What We Discussed

What We Are Learning

We learned from SARS and H1N1 to procure vaccines from multiple sources and plan for distribution well in advance. We have also learned about the need for rapid distribution of financial resources.

We recognize the effectiveness of digital infrastructure during this pandemic. Nova Scotia, for example, has expanded digital health system infrastructure to allow online bookings for COVID-19 test appointments; we plan to use this infrastructure to book vaccine appointments and continue online bookings for other medical appointments (e.g., X-ray exams and blood tests). Some processes were made more effective by adaptations and innovations in response to the pandemic. For example, changes were made to expedite processes that used to take weeks and can now happen in days (e.g., RFP processes). Decision-makers will need to look closely at the system to understand where money can be saved, but also where additional investment and safe redundancies may be necessary.

The unprecedented rate of the Federal Government's response has been recognized as a benefit throughout the pandemic, including the mobilization of resources to sectors, citizens, businesses, and research.

There are important lessons to learn from the policy decision to establish the "Atlantic Bubble".[1] Although this policy is presently on hold[2] to address the second wave, some key lessons have been identified. For example, the collaboration between Chief Medical Officers of Health of the Atlantic Provinces was highly effective and they worked to provide consistent advice to their respective political leaders.

Equity considerations in health systems continue to be a focus. The National Collaborating Centre for Infectious Diseases and National Collaborating Centre for Determinants of Health have released a report on equity indicators for public health.[3] Equity-based approaches in an organization are influenced by establishing a culture of collaboration rather than a culture of compliance. Local engagement is key. Ensuring that people feel they are contributing to solutions instead of taking orders can be effective, although such an approach can be slower and more resource-intensive. Public Health Agency of Canada (PHAC) Atlantic currently is researching the severe impacts that community organizations and the people they serve are facing (e.g., single mothers living in poverty, people who have drug addictions, HIV-positive persons), including their ideas for solutions and equity-driven emergency management.

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[1] The "Atlantic Bubble" was a policy decision among the Atlantic Provinces to eliminate the need for residents of Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador to quarantine when travelling between these provinces. It came into effect July 3 but has been suspended as of November 23.

[2] PEI, New Brunswick, and Newfoundland and Labrador require 14 days of self-isolation for anyone returning to the province, including other provinces in Atlantic Canada. Nova Scotia, at this time, does not require 14-day self-isolation for anyone returning from provinces in Atlantic Canada.

[3] Haworth-Brockman, Margaret and Betker, Claire. (September 2020). Measuring What Counts in the Midst of the COVID-19 Pandemic: Equity Indicators for Public Health. National Collaborating Centre for Infectious Diseases and National Collaborating Centre for Determinants of Health. Retrieved from: https://nccdh.ca/images/uploads/comments/NCCDH-Measuring-what-counts-equity-indicators_EN.pdf

Collecting equity-based data is also important. If the digital infrastructure to collect data about who is the most impacted and most vulnerable is not in place, then these equity issues cannot be addressed. Data is necessary to gain knowledge about an issue and mobilize resources to implement solutions. Equity considerations have received more attention during the COVID-19 pandemic than past pandemics. Even between the first and second waves, there has been further progress to integrate the Nova Scotia Mi'kmaw Health and Wellness Authority into decision-making. Equity-based decision-making will especially be important in vaccine distribution; this has been recognized at the national level.

The Ontario COVID-19 Health System Response – Bioethics Table could be a model to bring together a variety of different voices. The Bioethics Table is an advisory body that provides ethics input and guidance to support decision-making at, for example, the Ministry of Health COVID-19 Command Table. The Bioethics Table is led by the University of Toronto and comprises independent bioethics experts from health institutions, universities, and non-governmental organizations. It serves an advisory function only, however; the decision to follow the advice is ultimately left to elected officials.

The first wave demonstrated the importance of maintaining the healthcare system alongside managing the pandemic. In the first wave, sections of the healthcare sector were shut down. During the second wave, there has been an effort to maintain operations of the healthcare system to ensure units can stay open and the public can access services.

Where we need to improve

There has been a decrease in willingness and motivation to bring organizations together to respond to the second wave. There is a noticeable concern and loss of confidence that lessons identified in the first wave have indeed been learned, as many innovations made during the first wave have not been sustained. This highlights that the governance and response structure from the first wave did not hold together.

There is recognizable erosion in relationships between the healthcare sector and community organizations. Much of that collaboration has been through ad-hoc relationships; more deliberate effort to formalize these relationships is necessary. The first wave highlighted the separation between acute care systems and community-based systems and resources to support equity-deserving groups. For example, many workers in acute care are not aware of the supports and resources in the community for homeless populations. There is a need to create formal information-sharing structures to fill this knowledge gap, and this should be continued outside the context of the pandemic. Using language that resonates with specific communities and identities (e.g., genders, races, languages, ethnicities, abilities, sexual orientations, ages, education levels, income levels) is especially important in communications approaches, particularly regarding public health directives and vaccine distribution.

In addition to external engagement with community organizations, internal engagement with healthcare workers is important to address fatigue and ensure staff feel that they are contributing towards solutions. Addressing fatigue and supporting the physical and mental wellbeing of workers in the healthcare sector is a priority for the sector. Effectively navigating union relationships will be important to facilitate this.

Evidence from the first wave suggests that leaders often chose compliance over collaboration and, in some cases, chose compliance over effectiveness. Effectiveness will need to be more of a driver going forward, but it is hard to define and measure. Throughout the pandemic, we have seen a variety of approaches and degrees of collaboration within these approaches. For example, some provinces have both the Premier and Chief Medical Officer as spokespeople for the crisis whereas others have the Premier as sole spokesperson. Changes in provincial public health directives have resulted in public confusion and, at times, frustration.

The importance of effective communications, including information to the healthcare workforce and the general public, has been identified as a lesson from the first wave. We have faced challenges when political expediency has driven some communications. The Atlantic region benefitted from cohesion among the provinces, particularly in the advice public health officials provided political decision-makers. A national approach to address this consistently across the provinces and territories may be beneficial to address this.

Stockpiling PPE is an area where we have struggled to learn from past pandemics. At the outset of COVID-19, we learned that many stockpiles of PPE had not been maintained properly (e.g., tracked and expired products rotated out). Due to the intense demand for PPE in COVID-19, we run the risk of not managing the new stockpiles of goods appropriately.

The federal and provincial governments need to collaborate more effectively. The Federal government could be more effective in collaborating with other countries that face similar issues with COVID-19 (e.g., Indigenous populations, geographical size, population density). During this pandemic, the mobilization of federal funding, especially for research, has expanded from what we have seen in the past. The role of the government in mobilizing research funding should continue in the future.

The first wave has demonstrated the importance of integrating long-term-care systems into acute healthcare systems. In jurisdictions with a higher degree of integration between the two systems, there were fewer and less devastating outbreaks in LTC facilities. There is a need to strengthen relationships between acute and LTC systems to ensure appropriate integration without over-medicalizing long-term care. Recognizing and respecting the differences between acute care and LTC will be important, as the relationship between the resident and their LTC facility is more domestic. In addition, the roles of family members as part of the care team for a resident of a LTC facility can be different from acute-care, and this was not always considered when restrictions on visitors to long-term care facilities were implemented in the first wave. As a result of COVID-19, more attention has been focused on national standards and, therefore, this may an opportunity to make national transformations in LTC.

Looking Forward – The Next Six Months

While progress has been made in responding to equity issues during the pandemic, we have not paid enough attention to some key issues or sustained enough momentum to address them over the long term. Homelessness and housing, for example, are facing difficulty in engaging partners; some funding partners have stepped back. It has been challenging not only to sustain the necessary momentum to respond to COVID-19, but also to address serious equity issues. Equity will need to be a core principle in our long-term planning and road to recovery and will require increased effort across systems that are already strained.

We will need to increase our focus on long-term planning, as focusing too much on the short term is a vulnerability in our response. Much of our effort and attention so far has been on resolving the immediate issues regarding COVID-19, but we will need to plan farther ahead to outline our plans for recovery.

There is also a risk in Atlantic Canada that because we have done comparatively well throughout the pandemic, residents may take for granted how well the region has done and forget that the risks are still there. The public may also become more complacent about the pandemic as the vaccine is introduced.

COVID-19 has highlighted issues in democratic accountability. How we hold decision-makers to account, particularly in the long-term, will be a key issue going forward. Command and control systems without democratic accountability should not become the norm. At the same time, there is a need for the Chief Medical Officers of Health to be scientifically independent. This was made especially apparent in the Ontario Auditor General's Special Report on COVID-19 expenditures. Standards should be established at the national level.

As the provincial election approaches in Nova Scotia, this could be a window of opportunity for advocacy groups and non-governmental agencies to advance their positions with political candidates. There will be new provincial leadership, including a new Cabinet, and a new political agenda will be set in place. Organizations and interest groups will need to ensure they are a part of the political agenda to advance their issues. The degree to which these groups are organized will impact their effectiveness to engage political leadership.

COVID-19 could initiate positive long-term changes to LTC and community care; however, this will require transforming systems. Transformation of LTC to include national standards will require us to revisit how federal funding is allocated to provinces for continuing care. Cooperation and relationships developed in the crisis can be mobilized to make progress on other issues.

The role of the private sector in the healthcare system has changed during the pandemic and there may be opportunities to leverage these relationships going forward. The urgency and scope of the COVID-19 pandemic have initiated new ways of thinking about these relationships. The healthcare system should look for opportunities to transfer burden to the private sector in a controlled, manageable, and accountable way.

Rather than go back to "business as usual", we should pursue "business as needed". The work that will need to be done going forward might not be the same as it was pre-pandemic. Physical spaces and flow of care will need to change, and virtual delivery of healthcare services will likely increase. COVID-19 has been a catalyst to adapt to online health services and the virtual

and remote approaches might be more effective than how operations were pre-pandemic. Innovations such as this should be integrated to improve the system overall. It will be a for decision-makers to find the time to reflect on what we have learned and what should become regular practice amidst the pandemic response. As we focus on the road to recovery, there should be emphasis on resilience and equity to build better systems than before, or a "just recovery". Going forward, the value of a healthy population will also become increasingly important as this pandemic has demonstrated the value of having a healthy general population more than ever before.

References

Haworth-Brockman, Margaret and Betker, Claire. (September 2020). *Measuring What Counts in the Midst of the COVID-19 Pandemic: Equity Indicators for Public Health.* National Collaborating Centre for Infectious Diseases and National Collaborating Centre for Determinants of Health. Retrieved from: https://nccdh.ca/images/uploads/comments/NCCDH-Measuring-what-counts-equity-indicators_EN.pdf

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Endnote Discussion on Defining Efficiency and Effectiveness

Generally speaking, effectiveness refers to having a desired outcome (or effect) whereas efficiency refers to producing an outcome effectively without or with limited waste. According to Hood and Jackson's (1991)[4] administrative argument, efficiency claims are founded on assumptions about how to best match resources to tasks for defined circumstances.

The National Health Service in England has recently tried to define these terms in the healthcare context.[5] Efficiency refers to the system's ability to measure and manage activities – or performance management. Effectiveness, however, relates to the system's ability to innovate, adapt, and plan for the future.

[4] Hood, Christopher and Jackson, Michael. (1991). Administrative Argument. Dartmouth, UK: Dartmouth Publishing Co.

[5] Sustainable Improvement Team and the Horizons Team. (April 2018). Leading Large Scale Change: A practical guide. National Health Service (NHS) England. Retrieved from: https://www.england.nhs.uk/sustainableimprovement/leading-large-scale-change/, p. 33

Appendix I: Additional Information About Method

Having a conversation is not the same as writing a summary. We edited the document to make it as succinct as possible. We tried to position comments in the most appropriate places. For example, some comments made early in the session appear towards the end of the note. We did not intentionally omit any substantive comments. Members of the Catalyzing Systems Change Committee reviewed early drafts to contribute to its accuracy. We underscore that this is a summary of a brief, far-reaching discussion on a very complex situation that continues to evolve. This was not an exhaustive discussion; many of the terms and ideas require further elaboration and reflection. In sum, our intention was to flag and document – however imperfectly – some important issues at a key point in the pandemic response in the Atlantic region.

Participants were asked to discuss the following questions:

1. Name some 'lessons identified' and discuss whether these became 'lessons learned', and if so, then why, and if not, why not?
    a. What/who were the enablers?
    b. How were the forces of elasticity resisted?
    c. How can we institutionalize learning and maintain momentum?
2. Has any progress been made to integrate equity considerations further into decision-making processes? Are there any concrete examples of this?
3. Balancing competing needs: how do we get on with 'business as usual' while dealing with the pressing need of COVID-19?
4. Looking forward through the next six months, what issues are on your mind that concern you? What are the critical vulnerabilities? How do we address them?

The discussion lasted about 75 minutes with 15 to 20 minutes allocated for each question.

More from the MacEachen Institute

The Institute is working to create resources and policy discussion around the COVID-19 crisis. These include briefing notes like this one as well as panel discussions, videos and media commentary. You can find all resources related to COVID-19 on our website.

Other briefing notes in this series

- COVID-19: Leaders from the Health Community Identify Lessons from the First Wave and Concerns for the Second
- Halifax Tourism and COVID-19: Scenario Planning Exercises for Summer 2021
- COVID-19 Media Coverage
- Labour Issues and COVID-19
- Quarantine and COVID-19
- People with Disabilities and COVID-19
- Observations from Toronto's Tourism Recovery Post SARS in 2003