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Early look at the future of healthcare during the COVID-19 pandemic

Editor

Amidst the COVID-19 pandemic, all efforts are now focusing on controlling and treating the disease and its far-reaching consequences[1–3]. Several measures have been put in place, including shutdown of social and economic activities, mask protection and self-isolation when needed[3]. Hospitals have been transformed into emergency assessment areas, medical and surgical COVID-19 wards, and busy intensive care units (ICUs)[4]. This has led to a rearrangement of the healthcare system, including suspension of purely elective surgery with the aim of saving ICU beds for COVID-19 patients.

In the current situation, we have all witnessed the flexibilities of the system, especially the hard work and altruism of its healthcare providers. As providers of oncology surgery, it is our duty to focus on what the services will look like following the pandemic. Our aim should be to return to treating these patients, starting with the most urgent and life-threatening medical conditions, with the aim of re-establishing a full service as soon as possible. This planning and reflection should be made as early as possible in a collaborative approach between medical, managerial and logistic expertise based on local realities, available resources and patient needs.

Clinicians and healthcare providers should have an important role in advising both policy-makers and the public on the need for caution before calling for a full return to normal activities. Ideally, this would be based on evidence, accumulated experience and professional wisdom. We would anticipate that if the agreed strategy will be a gradual return to normal activities, healthcare would be one of the first to begin, followed by economic, industrial, agricultural and educational systems. When given the green light, hospitals should start a gradual introduction of their elective activities. This can only take place when they can reduce the number of their committed hospital and ICU beds 'at peak' without affecting the quality of the COVID-19 services offered. At that stage only, a reintroduction can be initiated by prioritizing services with the most important and pressing clinical needs such as oncological care.

At that stage, a careful assessment of COVID-19 status in admitted patients and healthcare providers is essential to ensure a low risk of transmission. As patients will require a wide range of services from radiology, endoscopy, intensive care and surgical services, offering a full range of services in completely COVID-19-free areas may be required. Each hospital's planning committee will need to be imaginative and creative with its reimplementation models. Strategies such as hospitals being divided into a number of wings or buildings, some dedicated to COVID-19 patients, and others to non-COVID-19 patients with separate entries, pathways and services, may be considered. It may be essential to identify separate teams dealing with COVID-19-negative or -positive patients to reduce cross-contamination risk. Establishing other models, such as identifying some hospitals to be dedicated to the chronic management of COVID-19, leaving other tertiary hospitals to deal with COVID-19-negative patients in clean environments, needs strategic solutions at wider levels.

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