

Importance of Healthcare in Covid Time

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ABSTRACT

Globally, health systems have been challenged by the overwhelming demands of the COVID-19 pandemic. Resources and staff are being diverted to test and provide treatment for people with presumed or diagnosed COVID-19, and supplies are limited. Some healthcare services are being compromised in order to meet the demands of caring for COVID-19 patients, and many people fear accessing healthcare facilities due to fear of acquiring the virus. These fears may be worsened by misinformation. During the Ebola outbreak in West Africa in 2014–2015, increased morbidity and mortality in other diseases (e.g., measles, malaria, HIV/AIDS, and TB) were seen due to reduction in access to and utilization of healthcare services, and deaths from these diseases outnumbered deaths from Ebola. It is important to ensure continuity of essential health services in order to prevent illness and death from non-COVID-19 illnesses. This will likely require adaptations to service delivery models and settings. In addition, infection prevention and control measures to reduce the risk of exposure to COVID-19 among patients and healthcare workers (HCW) should be integrated into all healthcare settings.

KEYWORDS: *healthcare, COVID, patients, prevention, risk, resources, systems, doctors, illness*

INTRODUCTION

National and sub-national public health authorities play a critical role in determining how to mitigate the impact of COVID-19 on persons needing essential non-COVID-19 services in a variety of healthcare settings. Specific areas of focus for national and sub-national authorities could include:

- Prioritizing locations for targeted interventions to reduce the impact of COVID-19 on other diseases. This could be based on COVID-19 prevalence, as well as burden of non-COVID-19 diseases or the need for services (i.e. immunization services), and population size.
- Developing targeted communications and educational materials for use in all healthcare settings on:
 - COVID-19 symptoms, prevention, and transmission among patients and healthcare workers
 - Infection prevention and control (IPC) for both healthcare workers and patients
- Developing methods to facilitate access to facility and community-based healthcare services by service providers, patients, and their supporters during periods of movement restriction.[1]

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- Maintaining adequate supplies and commodities to provide services and reduce risk of exposure of patients and HCWs to COVID-19 at all service delivery points:
 - Ensuring adequate supply and use of personal protective equipment (PPE), hand hygiene supplies (soap and water or hand sanitizer with at least 60% alcohol), as well as cleaning and disinfecting supplies.
 - Forecasting and ordering for multi-month dispensing of medications (e.g., 3- or 6-month dispensing) for chronically ill patients who are stable to reduce length of time between clinic contacts. Use telehealth to monitor and support patients between in-person visits.
 - Establishing, staffing, and supplying community isolation centers for mild-to-moderately ill COVID-19 patients to isolate and recover.
 - Planning for and purchasing supplies needed to move essential non-COVID-19 services into makeshift clinics in areas most heavily affected by COVID-19. Coordinating with

IPC focal persons for IPC considerations and requirements in such settings.

- Ensuring monitoring plans track service delivery occurring outside of healthcare facilities in order to track retention in health programs, including those for chronic disease, antenatal care (ANC), and immunization services.

Modify Service Access

- Determine which essential services will continue and which need to be paused or referred to another clinic due to burden of COVID-19 patients.
- Screen patients for symptoms of or exposure to COVID-19 before they get to the health facility; consider using telehealth platforms to screen patients before they come to the health facility and to make referrals, if needed.[2]
- Triage and test patients for COVID-19, including, where possible, touchless temperature checks.
- Ensure hand hygiene (all people entering and exiting facility should wash hands with soap and water or use hand sanitizer with 60% alcohol), appropriate use of PPE, and regular cleaning, especially of high touch surfaces and objects regularly (daily or as needed).
- Ensure use of a medical mask for all patients with respiratory symptoms or other symptoms suggestive of COVID-19 and encourage the use of masks for other patients.

Modify Clinic Space:

- Separate patients by maintaining at least a distance of about 2 arm lengths (about 2 meters) when possible (e.g., move waiting areas outside) and limiting the number of people in the facility at a time, especially in small spaces such as pharmacies and hallway waiting areas.
- Consider altering and repurposing clinic space or designating certain facilities for COVID-19 care while others are designated for essential non-COVID-19 services.
- Modify underused spaces in facilities that have access to improved water sources (water supplied through a household connection, public standpipe, borehole well, protected dug well, protected spring, or rainwater collection) and good ventilation (e.g., operates properly and increases circulation of outdoor air as much as possible) for use as isolation areas for presumptive or positive COVID-19 patients.[3]
- Ensure separate spaces that allow for physical distancing are available for assessment of acutely

ill persons and delivery of essential non-COVID-19 services.

Discussion

Modify Service Delivery:

- Minimize patient contacts with HCW and other patients to reduce risk of exposure or infection:
 - Lengthen time between appointments for stable, healthy patients.
 - Use telemedicine visits (either video, phone calls, SMS (short message service)) for screening, follow-up, and refilling prescriptions.
 - Implement 3- or 6-month dispensing of medication for healthy, stable patients.
- Provide staggered appointments to reduce the number of people in waiting areas and implement and enforce an appointment scheduling system to decongest clinics.
- Provide fast-track services for acute and chronic patients to reduce contact with multiple providers (e.g., charts pulled, medications ready, patient only sees provider if needed, one provider sees patient through all services).
- Limit number of visitors who may accompany patient to clinic or community-based services.
- Relocate services—each community and healthcare facility will need to determine which of the following options best fits their circumstances and available resources. Decisions may vary based on the number of COVID-19 cases in the community.
 - Health facilities with few presumptive or positive COVID-19 patients may designate an area within the facility where COVID-19 patients can be isolated.
 - In sites where there is a higher burden of COVID-19 cases, the facility may consider:
 - Moving essential non-COVID-19 services outside of the facility into community spaces, (e.g., a vacant school, church, or community center) to reduce risk of exposure at facilities, ensure these patients remain in care and on treatment as some may fear getting sick if they return to the clinic, and reduce crowding at clinics so they are better able to care for COVID-19 patients.
 - Moving services for COVID-19 patients with mild or moderate symptoms to community isolation centers to maintain space in facilities for essential non-COVID-19 services.[4]
 - Promoting home-based care for COVID-19 patients with mild or moderate symptoms who can safely isolate at home.

- Offer multiple “no-contact” drug pick-up options for patients with chronic illnesses:
 - Scheduled medicine pick-up at community or clinic pharmacies, or community pick-up points (e.g. houses of worship or schools). Consider adaptations to minimize in-person contact and exposure risk. Alternative modes of communication may include telemedicine calls, SMS, or social media.
 - Implement 3- or 6-month dispensing of medication for healthy, stable patients.
- Maintain routine contact with stable patients. Provide more frequent contact to new patients and patients at risk for loss to follow-up.
- Shift and share tasks as needed:
 - Re-assign staff from less busy services to assist with essential services.
 - Work with the Ministry of Health (MOH) and local HCW societies to determine how task shifting can best be used to provide essential services.
- Ensure HCWs are appropriately trained in provision of care for patients with COVID-19, and that clear guidance/ operating procedures exist for training on transmission of COVID-19, donning and doffing personal protective equipment, etc.

Results

The COVID-19 pandemic has had a major impact on the capacity of health systems to continue the delivery of essential health services. While health systems around the world are being challenged by increasing demand for care of COVID-19 patients, it is critical to maintain preventive and curative services, especially for the most vulnerable populations, such as children, older persons, people living with chronic conditions, minorities and people living with disabilities.

Countries need to achieve the optimal balance between fighting the COVID-19 pandemic and maintenance of essential health services. WHO has been coordinating efforts across several regions and departments to support country implementation of targeted actions to reorganize and maintain access to safe and high-quality essential health services across the life course. [5]

National trauma can change national psychology and create opportunities for major reform. Whether the novel coronavirus will do so remains uncertain, but even if it does not, the pandemic may open the way to meaningful incremental changes that are normally difficult for our highly divided and partisan political

institutions to accomplish. Major reforms may prove most feasible in the area of public health, where recent events have made deficiencies so obvious.

New federal legislation is necessary to clarify and bolster the ability of the federal government to intervene decisively and rapidly, and especially to require states and localities to implement critical health measures that are currently the responsibility of states but are vital to the health and welfare of persons in other states. This legislation would have several aims. First, it would enable the federal government to establish a national public health information system that provides real-time data on disease prevalence and incidence of illness as well as on the availability of critical resources to treat affected patients. This system should connect state and local health departments with one another and with private health care providers and require the participation of private health care facilities, laboratories, and manufacturers to give a complete picture of available resources. Second, it would allow the federal government to expend federal funds, without prior congressional approval, on emergency responses, including the development and distribution of new diagnostic tests, new therapeutic approaches, and new vaccines and the hiring and training of personnel needed to track and contain epidemics at the local level. Third, it would let the federal government require states to adopt measures needed to contain the spread of infections. In particular, legislation could facilitate the use by the federal government of its constitutional powers to regulate interstate commerce by forcing states that did not comply with critical infection-control measures to cease participation in interstate travel and commercial activities. Fourth, it would allow the federal government to regulate the distribution of new vaccines and antimicrobial agents. Fifth, it would grant the federal government emergency powers to require states to allow licensed health professionals to participate in cross-state telehealth. [6]

The use of some of these authorities could be conditional on a presidential declaration of a public health emergency and could be time limited unless extended .

Conclusions

The epidemic has led to the adoption of new technologies, for example, the dashboard on bed availability and ventilators and various technologies and apps for contact tracing. This may facilitate further adoption of different technologies in the future improving service delivery in the coming years.

The epidemic has also led to a resurgence in demand for health insurance as a significant jump has been

observed in the purchase of health insurance since the outbreak of the epidemic. The epidemic has sensitised people towards the importance of health insurance and the cost of healthcare. This will improve the penetration of health insurance in India, which remains woefully under-insured or financially protected for healthcare.

According to Insurance Regulatory Development Authority's annual report 2018-19, only around 25 per cent of the population has some form of health insurance to protect them from catastrophic healthcare expenditure, which drives millions into poverty in India every year. In years to come, deeper penetration of health insurance is expected.

Finally, the epidemic has led to the adoption of healthy behaviors, including hand-washing, face mask, sanitation, and social distancing. These behaviors are expected to reduce the spread of other infections, such as tuberculosis.

Thus though the epidemic has created extensive disruption across all sectors of the economy and lives of people, at the same time, it has pushed some of the long-pending reforms in India's health sector.[7]

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