PERSPECTIVE

After the coronavirus pandemic changes in the Healthcare

Jennifer Grey

Grey J, After the coronavirus pandemic changes in the Healthcare. J Health Pol Manage. 2022; 5(6):68-70.

ABSTRACT

Globally, the coronavirus disease 2019 (COVID-19) pandemic is having a profound influence on many nations' social, political, economic, and healthcare systems. The cost of this pandemic in terms of human lives and suffering, the psychosocial effects, and the economic slowdown provide compelling reasons to turn experiences into practical lessons, not just to avert similar crises in the future but also to advance population health and healthcare provision as a whole. After the severe acute respiratory syndrome (SARS-CoV) and the Middle-East respiratory syndrome (MERS-CoV), as well as other viral outbreaks like Zika virus and Ebola virus over the past ten years, this is the third coronavirus (CoV) outbreak of international significance. It becomes obvious that infectious diseases should be regarded as one of the most significant health risks that we will need to deal with going forward. As a result, it appears inevitable that many components will change at the individual, societal, and governmental levels.

Key Words: *COVID-19; Pandemic; Economic; Infection; Healthcare*

INTRODUCTION

The COVID-19 pandemic has served as a sobering reminder of many areas of the healthcare systems' preparation, notably overall. Programs for public health surveillance and the existing infrastructures were revealed to not always be at their best. Additionally, especially in acute care settings, healthcare systems looked unable to absorb and handle unexpected and ongoing constraints on their workload. Even though emergency measures were frequently in place, the healthcare systems appeared unprepared to handle the abrupt, significant increase in demand. A potential delay in making important decisions, like lockdown measures, in an "epidemiologically timely approach," could have a substantial effect on the course of future healthcare. The latter is particularly significant since, at least for infectious diseases, healthcare difficulties in one nation should be seen as both an internal and potentially global challenge. Last but not least, it was overestimated how quickly a problem with global public health turned into a financial crisis that affected many other industries.

The COVID-19 pandemic serves as a catalyst for change, hastening the introduction and acceptance of modifications to public health initiatives. As a result, a new approach to providing healthcare that places a strong focus on preventative measures, remote care, and technological dependence arises. The rapid adoption of new technology, mental health issues, ethical worries about the potential rationing of resources, and the preservation of privacy and personal data during emergencies are contrasted with these continuous technological hurdles to meet the surge capacity in laboratory testing. The following elements appear to be most likely to be impacted in the post-COVID-19 era, taking the former into consideration. In the past, routine care, crises, and emergencies have all been treated via remote care or telehealth services. The COVID-19 epidemic has increased the use of these drugs on a wider scale. The usage of telehealth services is increasingly widespread and includes pre-visit screening on a broad scale, triage assessment, routine home monitoring, remote clinical interactions, and oversight of off-site professionals' patient care. As telemedicine offers greater convenience and better patient-centered care, it is anticipated that a sizable fraction of such services will continue to be telehealth-based beyond COVID-19. This will help to solve the flow rate and capacity issues within the healthcare system. This has also been seen in the field of mental healthcare, where the pandemic served as a catalyst for the adoption of online treatment and e-health technologies into standard practice after more than 20 years of numerous brilliant but largely unsuccessful endeavors. The discipline is resolving dominant

Editorial Office, Journal of Health Policy and Management, United Kingdom.

Correspondence: Jennifer Grey, Editorial Office, Journal of Health Policy and Management, United Kingdom, e-mail editor.jhpm@scholarlymed.com

Received: 05-Nov- 2022, Manuscript No. PULHPM-22-5637; Editor assigned: 07-Nov-2022, PreQC No. PULHPM-22-5637 (PQ); Reviewed: 17-Nov-2022, QC No. PULHPM-22-5637; Revised: 22-Nov-2022, Manuscript No. PULHPM-22-5637 (R); Published: 28-Nov- 2022, DOI: 10.37532/ pulhpm.22.5(6).68-70

assumptions, such as the one that "the clinician/patient therapeutic bond can only be developed face-to-face," despite evidence to the contrary. Given the benefits they have seen over an extended period of crisis response, it is likely that mental healthcare institutions won't abandon any of these once they have gained the capacity to serve their patients via various digital technologies post-COVID-19. Future routine services are likely to adopt a "blended approach" in which e-mental health solutions make up a larger portion. Additionally, by leveraging both guided and totally self-directed interventions, like self-help applications or online therapeutic modules, the recently gained expertise can be applied to extending a larger public e-mental health approach. As a beneficial long-term result of COVID-19, the latter could also be investigated and eventually implemented in environments and nations with limited mental health resources, where such need has already been established. The progressive acceptance of more new technologies, such as the use of drones to carry essential supplies, robotics, the ubiquitous 3D printing of medical goods, and smartphone-enabled monitoring of patient adherence to treatments, is likely to be aided by this system evolution. The pace at which SARS-CoV-2 spread internationally serves as yet another reminder of the pressing need for accurate and representative surveillance systems for infectious illnesses. Utilizing reported positive results from sentinel clinical laboratories or laboratory networks, public health surveillance for infectious diseases monitors the existence of particular microorganisms that pose a risk to the public's health in a given community. However, as public health expenses continue to be rationalized, a number of clinical microbiology laboratories have been consolidated, resulting in a move toward laboratory merger. A new operational paradigm was created through this consolidation action, with big, centralized clinical laboratories operating on a single platform and one or more distant laboratories handling local, urgent analyses alone. It would be instructive to determine whether the ability to detect epidemiological changes in the setting of COVID-19 was conditioned or not by the decline in the number of small clinical laboratories and the consolidation of the remaining ones.

DISCUSSION

In order to enhance current structures, it would be necessary to regularly use big data and artificial intelligence approaches to simulate crises as well as to uncover and comprehend the flaws in current systems (almost in real-time). As in the examples of South Korea and Taiwan, mobile-enabled technologies can now be widely used to monitor individuals in quarantine and to quickly and accurately track exposed individuals within regions and/or nations. These are some of the brand-new instruments that are most likely to advance the field of public health and aid comprehension in a hyper connected and complex global setting. The need for swift deployment of specialized teams on the ground and for international collaboration and information sharing among competent healthcare authorities during crises has been emphasized numerous times before, and this is expected to intensify even more following COVID-19. To prevent infectious disease outbreaks, any such improvements would need to be accompanied by a stronger public understanding of the health systems, new and/or improved instruments, and their potential application. As a result, mass communication, education, and health promotion are anticipated to make substantial use of the connection between social media and behavioral science. Although the COVID-19 epidemic sped up many of the aforementioned procedures, difficulties still exist. These include, for instance, issues with certification, licensing, reimbursement, and technology-related security, privacy, and litigation concerns. More specifically, from an ethical standpoint and from the viewpoint of an individual, full data anonymization is ineffective in protecting the identity of the data source due to the collection and availability of vast amounts of information about people (e.g., via geo-tagged social networks), making it only harder but still possible to (re)identify people through the use of cutting-edge systems and triangulation. In light of the risks associated with downstream data linking and unintentional individual identification, it is important to uphold the ethical need of transparency. Systems that are fully dependent on anonymous data to safeguard data providers may not function well from a population-level perspective since accountability for the information and consequent openness are compromised. Anonymous information is currently best practice; however it cannot be seen as the ethical silver bullet, especially in the event of humanitarian situations and most definitely communicable disease outbreaks. It is important to emphasize that public health ethics are distinct from clinical ethics in that they call for giving the common good precedence above preserving individual autonomy. In resource-constrained situations during public health catastrophes, where overburdened healthcare institutions may start to ration staff or medical resources, this ethical disparity becomes even more pronounced, leading to upsetting decisions like who receives life support.

Unprecedented levels of false information, rumors, and conspiracy theories about COVID-19 that were spread by lay and social media were one of the pandemic's defining characteristics; these can only be harmful in the short- and long-term fight against the epidemic. This may be a result of the epidemic occurring in the "social media age." In response to the "info emic," the WHO issued a statement, suppressed a number of measures that were promoted online and on social media but were ineffective in treating COVID-19, and has continued to do so. In terms of reactions, social media sites have taken down or added various warnings to the vast majority of social media posts that fact-checkers have evaluated as fake. However, disinformation has almost probably spread even more quickly because the number of fact-checks in English increased by more than 900% between January and March, exceeding the resources that are available to do so. As a first step, it appears that consistency in public health message and increased funding for fact-checking are both required. After COVID-19, it seems certain that there will be a reassessment of laws, rules, and regulations pertaining to people's rights, the deployment of severe public health measures like protracted quarantines, and the management of innovative technology driven healthcare solutions. Currently, a common legal and ethical standard is used to justify mandatory "public health-triggered" powers, which considers the risk of the pathogen to the individual and the general population, its incidence rate and mode of transmission, the efficacy of available public health interventions, and the availability and type of clinical treatments. The "precautionary principle" should be applied, especially in situations where a crisis is developing and the science is unsure, like in the case of COVID-19. After COVID-19, it's anticipated that a number of these actions would be assessed for their

timing and effectiveness, whether they were proportionate to the risk in terms of both type and implementation, and whether the legal evaluations of the limited scientific evidence were successful. COVID-19 had two opposing effects on laboratory medicine activities at the same time. On the one hand, the influx of COVID-19 suspected patients forced microbiology departments to drastically expand their diagnostic workload. The activities of clinical laboratories that were not directly involved with COVID-19, however, significantly decreased. This included, for example, the cancer services, which had to adjust to a new, remote-based service model. Similar trends were seen at the institutional/hospital level, including a decline in routine activity, as well as an urgent need for staff and service reallocation. In light of these elements, COVID-19 has altered the basic academic health sciences, public health surveillance, and corporate commercial models. A crucial component of the European response to COVID-19 and in addressing urgent clinical and global needs was the effective collaboration among informal networks made up of clinical laboratories providing services to consortia of hospitals, academic institutions, and test manufacturers. These informal networks were formed through prior recent outbreaks and/or operational consolidations (e.g., utilization of the existing COMBACTE Network).

CONCLUSION

The COVID-19 outbreak serves as a reminder that continued commitment to global public health preparation and proactive planning for healthcare emergencies are both essential. Future healthcare should be transformed by taking into account the lessons learnt regarding the shortcomings of existing healthcare systems and their ability to deal with infectious disease epidemics in the twenty-first century. The criteria for a deeper integration of such technologies as part of standard healthcare design and provision should be the awareness that technologically empowered solutions can be put into practice and work successfully. When patients and healthcare professionals participate actively in this process, the best results can be achieved. However, in order to do that, it is necessary to address the ethical, governmental, and legal issues that surfaced during this pandemic. The existing experiences around the world establish the groundwork for a large post-COVID-19 healthcare reform so that systems can be better prepared to deal with the upcoming 21st-century global threats.