



AN OVERVIEW THE IMPACT OF HEALTH CRISIS (COVID-19) ON HEALTHCARE ADMINISTRATION

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Abstract:

A public health and economic crisis has been generated in both high and low resource settings as a result of the COVID-19 pandemic, which began in the beginning of the year 2020. Kenya has taken action in response to the discovery of the first case of the disease on March 12, 2020. The country has implemented both health and non-health policies in order to reduce the direct and indirect effects of the disease on its population. In spite of this, the whole health care system in the country has been affected in both positive and negative ways as a result of this. Improved investments throughout the many building blocks of the health system are required for effective pandemic preparedness for future responses. These building blocks include human resources for health, financing, infrastructure, information, leadership, service delivery, and medical products and technologies.

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Introduction:

There have been several million infections and close to five million deaths as a result of the global pandemic caused by the Coronavirus disease 2019 (COVID-19), which has caused Severe Acute Respiratory Syndrome Corona virus -2 (SARS CoV-2). This epidemic has devastated the world until late October 2021[1].

Although the COVID-19 pandemic has had an impact on all sectors, either directly or indirectly, the problem is more severe for the health care systems that are already struggling to cope with the strain in many nations. Due to the consistent spread of the virus across all settings, there was a high level of disruption to the delivery of health services, particularly in the early stages of the outbreak. It presented difficulties in matters pertaining to the management of medical supplies, facility utilization, and human resources in the health sector [2].

There is evidence to suggest that the COVID-19 pandemic has caused major disruptions in the delivery of health services, particularly in nations with little resources. The disruption is not just the result of the direct consequences of the COVID-19 pandemic, but it also resulted in the health systems being put under pressure and was able to stretch others beyond their capabilities for indirect reasons. [4] The COVID-19 pandemic has brought to light the deficiencies that are already present in the health system. The COVID-19 pandemic has caused disruptions in both preventative and curative services for diseases that are communicable and those that are not communicable. Patients were unable to attend follow-up appointments and acute care visits as a result of the fear and anxiety they experienced during the pandemic waves [5]. This is owing to the fact that the healthcare facilities have delayed the delivery of a significant number of vital services. In addition to the direct disease burden, the COVID-19 pandemic posed a considerable risk of indirect morbidity and mortality from other diseases that could have been prevented or treated. This risk was a direct consequence of the interruption of key health services [6]. The most frequently cited reasons for critical gaps or reductions in services during COVID-19 were the following: the relocation of health care workers to support COVID-19 services; the cancellation of planned treatments; the reduction in public transportation; the loss of income to pay for services and limit utilization; and high rates of morbidity and mortality among health care workers. These are just some of the reasons that led to staff shortages. The most significant factors contributing to the disruption of services have been

identified as a lack of medicines, diagnostics, and other technology in a number of nations [6].

Previous studies have revealed that during the early stages of the pandemic, there was a considerable decrease in the consumption of health care services that were not connected to COVID. The research that is now available, on the other hand, is structured around the data collected from individual health care systems, particularly in the early stages of the pandemic. There is a lack of evidence about the utilization of health care and the outcomes among patients who were suffering from chronic illnesses other than cancer during the pandemic [7].

Review:

It is because of the COVID-19 pandemic that health disparity has been brought to the center of public health. This is due to the fact that the pandemic has afflicted different categories of patients disproportionately. Based on the findings of a number of research, it appears that the most significant reductions in consumption of most categories occurred among females, children, and older citizens. These findings are in line with previous research that demonstrated that a greater proportion of women than males did not receive the preventive treatments that were advised, and that children saw a greater reduction in the amount of care they received as a result of the pandemic. For the purpose of ensuring that the COVID-19 pandemic does not result in an increase in health disparities across various patient groups, it is necessary to implement public health policy solutions that are more long-term [8].

Two areas that indicate responses to the pandemic by the health care system to promote safe access to care are the considerable increase in telehealth and the decrease in gaps between prescription fills and their associated refills during the pandemic. Both of these areas are examples of how medical professionals have responded to the pandemic. During the pandemic, insurance companies made changes to their policies in order to encourage the use of telemedicine. These changes included abolishing copays and coinsurance for telehealth services, as well as reimbursing for telehealth sessions at the same rate as in-person visits. Furthermore, during the pandemic, many people saw increased flexibility regarding how to obtain their drugs. This included the ability to acquire their medications through mail orders and door-to-door drop-offs by pharmacies, which may have made it simpler for patients to receive their medications on time [9].

Through our research, we were able to uncover the first detrimental effects that the pandemic had on the continuity of both critical and non-essential to general health services. MCH, tuberculosis, HIV, and assistance for patients who require routine and ongoing care were among of the categories that were emphasized. The reasons for this were attributed to a number of issues, including government mandates to stop these services and the transfer of staff to give COVID-19 relief and support services. The results of these investigations were comparable to those of earlier research that were conducted in both high and low resource settings and that demonstrated a considerable interruption in the provision of health services [10]. It is important to increase governance, coordination, and informed decision making across the health care delivery network as a COVID-19 post recovery plan for safeguarding the public health benefits made for these services. This is for the purpose of protecting the gains made for these services. In the event of a public health emergency, this will be of assistance in promoting the provision of high-quality health services, which are crucial in assuring the achievement of universal health coverage [11].

According to the findings of our research, a decrease in the extent to which persons sought medical attention was also observed in other nations. Because of this, certain health services were stopped, lockdowns were implemented, curfews were implemented, and there was a concern of illnesses spreading. Previous studies that were conducted during pandemics such as the Ebola virus have also revealed changes in the behaviors of individuals who seek medical attention [12]. A key measure to ensure continuity of services in the event of a pandemic is to foster multi-sectorial collaboration and develop a resilient health system that is able to cater to needs from a pandemic while maintaining routine health services [10]. This is something that has been recommended by our key informants and has been seen in other studies.

In addition to the deficiencies in effective pandemic response, our research sheds light on a number of existing problems, including inadequate financing for healthcare, a lack of infrastructure, and restrictions on the ability of human resources, all of which have significant consequences for the achievement of universal health coverage. Particularly in light of the fact that Kenya is currently undertaking a transition away from concessional donor aid and needs to become more self-sufficient in delivering services for its

population, these difficulties have the potential to have a significant influence on the overall resilience of the health system [12]. Increasing the quality of basic health care and implementing the appropriate proportion of Universal Health Coverage (UHC) and Global Health Security (GHS) domains has been proposed as a strategy for addressing the deficiencies in the health system. It is also possible for the country to strengthen its future preparation by including measures to improve public financial management in order to increase budget allocation and accountability [12].

The individuals who participated in one study disclosed the first failures of the government to effectively manage enough provision for testing, isolation, and quarantine services. Nevertheless, these services are considered to be at the core of effective responses to COVID-19 in the field of public health. Respondents pointed out that although the government did take proper public health measures to limit the epidemic, it was not successful in a number of areas due to the fact that health facilities and people were overburdened, there was a shortage of adequate resources, and there were problems with capacity while coordination was lacking. These findings are similar to those that were discovered in an investigation that aimed to comprehend the lessons that the world may learn from the pandemic while also tying it to historical deficiencies in the health system of the country. The lack of resources were ascribed to long-standing inadequacies in the health sector that were caused by weak leadership and governance that had existed prior to the outbreak. One of the most important factors that determines how a nation reacts to public health emergencies is the quality of its leadership and governance [13].

As a result of the fact that congestion in emergency departments (EDs) is a burden on public health, it is of utmost importance for healthcare systems and policy makers to have a knowledge of the characteristics of people who use the EDs frequently. In 1994, Taiwan became the first country in the world to introduce National Health Insurance, which improved public access to medical treatment. Approximately 20.7% of emergency department visits in Taiwan grew between the years 2000 and 2015, which resulted in an increase in the number of patients who visited the ED on a regular basis [13].

Persistent erectile dysfunction (ED) users are older, have a greater number of chronic conditions, more complex mental health problems, or are addicted to drugs, in comparison to occasional ED users.

Through the use of specific intervention techniques, such as case management, personal nurse care planning, strategies for pre-hospital transfer to non-emergency care, and enhanced primary care, it has been demonstrated that it is feasible to minimize the number of trips that are made by individuals who frequently utilize the emergency department. As a result, determining the characteristics of people who visit the emergency department (ED) frequently and developing suitable intervention strategies are essential responsibilities for lowering the number of times people go to the ED and improving the outcomes that are relevant to healthcare [14]. In the year 2020, Taiwan's healthcare system was confronted with the huge challenge posed by the pandemic of the coronavirus illness (COVID-19), and emergency treatment became the primary strategy employed in the fight against this disease. Stay-at-home recommendations were made by the Centers for Disease Control and Prevention (CDC) of the United States of America in an effort to minimize the spread of disease. Additionally, the CDC encouraged local governments or healthcare systems to establish rules or legislation that corresponded to these recommendations [14].

It is possible for patients to avoid going to the hospital owing to concerns about the quick transmission of the disease, which is caused by the infectious nature of COVID-19. Patients are consequently prevented from seeking medical care as a result of this restriction, which may result in a reduction in the utilization of emergency department services. In the United States, a recent study revealed that there was a decrease of 49.3 percent in the number of visits to emergency departments (EDs) following the proclamation of the COVID-19 pandemic [15]. During the COVID-19 pandemic, the overall utilization of emergency medical services for children dropped by 63.8% [15].

Conclusion:

In order to combat COVID-19, the health system provided prompt responses and was generally prepared. During the second wave of the COVID epidemic that was occurring all over the world, the interviews were carried out when reaction measures were still in the process of developing. In spite of the fact that the study focuses on a variety of public health measures and controls that have been implemented to prevent the pandemic from spreading further, it does not concentrate on COVID-19 vaccination tactics, which are essential to putting an end to the epidemic. Health care service recipients who were receiving treatment during the pandemic are not included in the study's

participants. A drop in the majority of nonpharmaceutical health treatment for patients with chronic diseases occurred during the early stages of the COVID pandemic; however, by the summer, this trend began to revert to levels that were closer to those that existed before the epidemic. In addition, the results of this study demonstrate that different member characteristics were shown to have a distinct impact on COVID. In the early months of the pandemic, there was a significant increase in the use of telehealth, but this trend diminished in the summer that followed. Therefore, it will be essential to conduct additional research on the patterns of telehealth visits both while the pandemic is still ongoing and after it has been contained. In conclusion, additional research will be required to evaluate the influence that alterations in health care utilization have on the long-term health outcomes of patients who are afflicted with chronic diseases.

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