Editorial

iMedPub Journals
www.imedpub.com

Journal of Hospital & Medical Management
2471-9781

2020
Vol.6 No.3:259

DOI: 10.36648/2471-9781.6.3.259

Learning from Experience to take Precaution Regarding Covid -19

Med lu V*

Tianjin Medical University, Republic of China

Received: July 01, 2020, **Accepted:** July 15, 2020, **Published:** July 30, 2020

***Corresponding author:**
Med lu V

lukimed@murs.uoa.ca

Tel: 2107014145

Tianjin Medical University, Republic of China

Citation: Med lu V (2020) Learning from Experience to take Precaution Regarding Covid -19. J Hosp Med Manage. Vol.6 No.3:259

Editorial

Regarding the use of personal safety precautions and personal protective equipment, the authors correctly noted in 2007 that education of the public on these topics would likely be delayed and lead to illnesses and deaths that could have been avoided. What the authors did not fully anticipate was the lack of readiness within the healthcare system that we are experiencing today. The availability (or rather the absence) of ventilators, N95 respirator masks, and test kits has gained widespread news coverage; however, the long-term care facilities that serve the most vulnerable populations and in which the first major U.S. round of fatalities occurred have received comparatively little attention [1].

The COVID pandemic has brought to forefront the challenges of the public health system. India needs well-equipped government hospitals and not grand buildings, which will serve no public purpose. In our country there is a gross mismatch between the healthcare resource distribution and the needy clientele. With less than 1 physician per 1000 population, India is well behind its peer countries [2]. It needs an additional 3.6 million hospital beds to reach the recommended capacity. Only about 27% of India's population is covered around any form of health insurance and the out of pocket expenditure on health is 62.4% in India as compared to the world average of 18.2%. Two-thirds of hospital beds in India and almost 80% of available ventilator-equipped ICU beds are in private hospitals. At 3.6% of GDP, India's overall health spending is among the lowest compared with peer and advanced economies. Of this, government spending on health is less than 1%. Alarmingly, out-of-pocket health expenditure for households is extraordinarily high in India [3]. About 65% of all health expenditure in India (approx 2.5% of GDP) is borne privately by households. India could find itself in an acute health crisis over the next few months and the direct cause of it will not be the SARS-CoV-2 virus. Hundreds of thousands of children might already have missed vital immunizations [4]. The shutdown of the economy has inflicted unbearable social and economic costs. An estimated 122 million jobs in the formal and informal sectors have been lost. The informal sector, which employs 90% of the workforce and the MSMEs, are worst hit. In the past 10 years, there is a shift in disease pattern, India's growing noncommunicable disease cardiovascular ailments, cancer, respiratory diseases, diabetes, and mental health conditions are seeking most attention, both resource wise and financially [5].

While containing the surge of COVID-19, we will also have to be on alert for other contagions, which assume menacing proportions during the summer in various states.

Innovation and Standard Based Care Standardized clinical processes, which were not being accepted due to reflex defence of "clinical autonomy", will be the primary basis for excellence. This needs to change. Standard based care is the new norm. Especially useful for handling ethical dilemmas - if and when resources reach their limits, such as rationing ventilators. It should put out standard treatment guidelines for public and private providers, frame a patient's charter of rights, engage with professional associations and civil society, and establish a regular audit system [6]. The government's National Innovation Council, which is mandated to provide a platform for collaboration amongst healthcare domain experts, stakeholders and key participants, should encourage a culture of innovation in India and help develop policy on innovations [7]. Protecting Workforce: Workforce needs to be protected against occupational hazards and they should be properly equipped. Besides short-term motivating events such as clapping, fly-pasts, flower-shower, etc. long-term sustained motivation in terms of improved pay, facilities, etc. should be ensured [8,9]. Redefining Health Architecture: Need to encourage nature integrated and ventilation-based constructions rather completely climate-controlled structures. In Covid-19, even though an infection spreads by contact and air-borne droplets, the same failed to infect individuals in open

spaces and high ventilation areas [10]. Hence the planning and designing of Health facilities may need a fresh look. Brown field project development and retrofitting to suit the existing demand of ventilation and air circulation will be important [11].

References

1. Leonardi Vinci D , Polidori C , Polidori P (2020) The healthcare and pharmaceutical vulnerability emerging from the new coronavirus outbreak. Eur J Hosp Pharm 27: 129-30
2. 2Phelan AL, Katz R, Gostin LO The novel coronavirus originating in Wuhan, China: challenges for global health governance.
3. Maxson PM, Derby KM, Wrobleski DM, Foss DM (2012) Bedside nurse-to-nurse handoff promotes patient safety. Med Surg Nurs 21: 140-145.
4. O'Connell B, Penney W (2001) Challenging the handover ritual: Recommendations for research and practice. Collegian 8: 14.
5. Ofori-Atta J (2015) Bedside shift report. Nursing 45: 1-4.
6. Radtke K (2013) Improving patient satisfaction with nursing communication using bedside shift report. Clin Nurse Spec 27: 19-25.
7. SAGE (2016) Quantitative Research Methods.
8. Saunders M, Lewis P, Thornhill A (2007) Research Methods for Business Students 4th editn Harlow: Prentice Hall.
9. Taylor PC (2010) Transformative educational research for culturally inclusive teaching. Keynote address delivered at the 7th International Conference on Intercultural Competence, Khabarovsk, Far East Russia
10. Tobiano G, Bucknall T, Sladdin I, Whitty JA (2018) Patient participation in nursing bedside handover: A systematic mixed-methods review. International Journal of Nursing Studies 77: 243-258.
11. Wildner J, Ferri P (2012) Patient participation in change-of-shift procedures: the implementation of the bedside handover for the improvement of nursing quality in an Italian hospice. J Hosp Palliat Nurs 14: 216-224.