COVID-19 Crisis-Are Administrative Issues Usurping Health Concerns

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Sir,

A large part of disease burden with COVID is handled by containment strategies technically, an administrative exercise of mammoth proportions. Lately in many countries, this pandemic struggle is turning to be an administrative quagmire slowly veering the disease out of control.

Till recently administrative issues pertaining to health were within a set and clearly defined framework and was managed as per a structured protocol. This pandemic waves have led to breakdown of most organized health care systems. The boundaries that defined health, administration, policies, and practices have been blurred by chaos that has been unleashed.

India as a prototype, is easier to understand the gravity of this thorny issue. In India health is a state subject but crucial aspects of policy drafting vests with the center. India did fairly well in the first 10 weeks when the national lockdown was imposed, in identifying, reshoring, resource creation and controlling death and recovery rates.1 However, since the national lockdowns were relaxed and the onus of implementation was passed to the states. This transition came when India was experiencing its deadliest surge

Needless to say health is best managed when in the hands of health administrators. In the setting of pandemic all major decisions were taken by civil servants (who are political appointees), bureaucrats, health officials with verifiable credentials and vetoed by politicians.

Quarantine measures imposed, were scaled down at alarming regularity ranging from needlessly stringent to lax. The concerns being, the highhandedness, inconsistencies and irrationality in policy implementation without justification or scientific
An area for improvisation projected was to develop infrastructure to reduce the burden on health care by large numbered mildly symptomatic COVID patients. Mismatches in planning and implementation led to unnecessary hospitalization of asymptomatic cases for long periods stretching healthcare resources.

Bed shortages were addressed myopically by creating temporary care facilities in stadiums and auditoriums even as 30-40% of beds lay unoccupied in major hospitals. The shortages, mainly in high dependency unit's beds still persists. Disparity in rapid resource allocation, lack of coordinated policies on patient triaging, administrative gaffes and inaction led to avoidable treatment delays and higher mortality.

Added reason for alarm was due to interstate disparity in terms of emergency readiness, resilience capabilities, political differences, center-state incordination coupled with lack of homogeneity and policy thrust of policies between different states adding to the confusion.

Peculiar to pandemic has been lack of precedence and dearth of quality evidence backed data on measures like lockdowns, quarantines, home care versus institutional care and many other contentious questions. The arbitrariness, lack of hindsight wisdom in handling these delicate issues have mired the decision making process. To usher in much needed uniformity, accountability, scientific credence and administrative justification it is imperative we bring in a draft policy on lockdown and travel restrictions.

The broad guidelines should be formed by a broad expert committee panel of epidemiologists, health administrators, physicians, politicians and bureaucrats. As no single strategy is likely to work, the cornerstone of any implementation hinges on having policies that best fit a country, state and regions.

Setting up a robust surveillance cell will be the key to our future successes and failures against this pandemic. The COVID-19 surveillance within the community should be headed by an epidemiological unit teethered with support from physicians, infectious disease specialists, public health specialists, microbiological cells, health workers, paramedical staff, local administrators, non-governmental organizations and health volunteers. This epidemiological cell based on the inputs from various nodal centers can initiate the triaging of the availability, needs and dynamics involved in triaging patients to home care, COVID surveillance centres or institutions. This model can work only with political commitment backed by strong administrative and community participation.

Surveillance cells are already in place in most places, but they have been hastily constituted and lack in framework, modelling and intent.

There is a need for constituting and reinforcing a central task force with uniform representation from various concerned sectors by eminent panels to oversee and direct the functioning of each independent unit. A government response stringency index is already in place internationally wherein policies of countries across the globe are compared. This should be reinforced for better international co-ordination and similar models can be implemented at state level too for comparison of different state government policies. This should ensure the best practices being pursued with accountability driven by thrust, consistency, innovations and credibility in policy making with an in-built mechanism for redressal and reviews.

In rising to the challenge posed by this pandemic it’s critical for us to realize the pivot of administrative arm in this health battle. It also is imperative that we formulate a structured administrative set-up backed by health, scientific and civil credentials for rationale, decisive and objective decision making.

References