A Moral Obligation of Health Care Service for Non-Covid Patients: A Reviews

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Abstract

The spread of coronavirus has turned the world upside down, and has spilled through economies and made the situation unbearable. The largest expense for this war is thus borne by non-COVID-19 sufferers. The non-Covid sufferers are the most overlooked in receiving health treatment, resulting in misery and many died because of lack of medication, where health services were redirected to treat patients with Covid. The study would investigate the implications of the failure of hospitals, governments and other stakeholders to provide the basic health service that, contrary to the Constitution, includes provisions ensuring everyone's right to optimal physical and mental health Article 21 defends everyone's life and liberty. The Supreme Court ruled that Article 21 guarantees human dignity and so demands health security. Furthermore, the basic right to health is a component of the basic right to life, therefore the state must provide health services under the Constitution. The reviews will analyse the pandemic implications.

Keywords: Non-Covid Patients, Health Care, Out-Patient Services, Artificial Intelligence, World Health Organization (WHO).

1. INTRODUCTION

The spread of coronavirus has turned the world upside down, and has spilled through economies and made the situation unbearable. The largest expense for this war is thus borne by non-COVID-19 patients. For more than five months, Outpatient Department (OPD) and non-emergency services have been stopped in most hospitals in order to redirect all money for the battle against COVID-19 and emergency medical treatment during the first lockdown. As noted, decreased access to out-patient and hospital care has been shown to be lethal for many non- coronavirus patients, both communicable and non-communicable. Media reports indicate that Patients with non-COVID-19 disorders who had scheduled surgical procedures and follow-up appointments were confronting an unprecedented epidemic, which is compounded for patients requiring hospitalisation. In a country with 5.5 government beds per 10,000 people, even a

small rise in hospitalization would raise the burden on the system exponentially.

Another study reported that more than 7,000 people died every day in India from cardiovascular disease in 2016. Regular check-ups, doctor consultations, and drug access are limited due to a paucity of healthcare professionals and transportation issues created by the countrywide lock-up. India has the world's highest TB death rate, with over 1,200 deaths every day. The development of COVID in India appears to be unstoppable, with no indication of mass vaccination and worrying daily caseload increases. While the rate of recovery is increasing, it is slower than the pace of new cases.

Adding community transmission, especially in rural regions, will only exacerbate the situation. Is India's healthcare system ready to deal with this historic crisis? Over the last decade, public healthcare expenditures have been around 1% of GDP, substantially lower than comparable emerging countries. In 2018, the OECD estimated 8.8%. India has a doctor for every 1,404 people and a nurse for every 675. The WHO recommends one doctor and three nurses per 1,000 people.

There is also a visible delay in non-COVID patient treatment when entire hospitals are converted into COVID care centres or when private practitioners and nursing homes are temporarily closed. Chronic illnesses include asthma, diabetes, hypertension, and heart disease necessitate ongoing treatment and frequent doctor visits. Cancelling scheduled visits or delaying medical care may worsen their health and raise their chance of mortality. So, the current investigation is to get a scenario overview.

A. Taking advantage of technology to fulfil health needs

Because the traditional healthcare delivery system cannot give pre-pandemic services to the general public, it is now more important than ever to use digital technology to provide remote healthcare services via smart devices and AI-powered applications. Remote patient monitoring utilising sensors such as blood glucose monitors, ECGs, heart rate monitors, pulse oximeters, etc., paired with telemedicine may save patients with comorbidities. Many breakthrough AI-enhanced solutions on the

Indian market currently provide remote patient monitoring at home. The ten3-T wearable patch gathers vital indicators such as ECG, pulse, oxygen saturation, breathing and blood pressure.

The AI-based systems monitor data for symptoms of early deterioration and alert caretakers. App for Mobile The Beat-O smartphone-compatible glucometer can take sugar measurements simply and store past readings to identify sugar level trends. The use of AI-enhanced technologies can assist reduce manual work for overworked workers. Patients with suspected pneumonia, TB, etc. can use AI-based imaging software to scan for chest X-rays. Indian hospitals are now using Google and Microsoft algorithms to detect diabetic retinopathy.

B. Financial pressure on non-COVID patients

Aside from their health, non-COVID patients' costs have skyrocketed due to administrative fees and other cleanliness activities. While private hospital expenditures have risen by 10-25 percent, non-COVID patients are now being reimbursed for PPE and other standard operating procedures. Reduced hospitalizations, hospital stays, and re-admissions, and home therapy reduce healthcare expenses. The COVID-19 problem and rural-urban health disparities are two pressing issues that can be addressed through tele-health and tele-medicine.

C. Government needs to step up technical progress in healthcare

The pandemic has revealed flaws in the country's healthcare system; as the government races to address them, the healthcare industry should see the glass as half full. COVID has opened doors for Indian health startups. Wearables and Android apps with AI-enhanced data creation systems can help produce vaccines and medications utilising data from millions of individuals.

Artificial intelligence in healthcare is not a 'future thing.' Instead, it can solve our world's pandemic-hit health needs. The technology would not solve all healthcare difficulties. Increasing its use, however, is critical in case similar situations arise in the future. It's critical to mainstream technology-based healthcare solutions from temporary to permanent. The

availability and use of technology in health care facilities will improve quality only if it is not restricted to private hospitals. During this crisis, the government must fully utilise technology to make AI-enhanced goods widely available. The greatest method to accomplish 'Healthcare for All' efficiency is to invest in hospitals and people. In addition to expanding hospitals and hiring more employees, a pandemic must be a true game changer in terms of healthcare.

The present study is to review the implications of hospitals, governments, and other stakeholders failing to provide basic health services that, according to the Constitution, guarantees the right of everyone to higher quality health care. the right to life and liberty. The Supreme Court concluded that Article 21 guarantees health security. The right to health is part of the right to life, and the state must provide health care. The current study looks at non-covid patients' access to care during the covid epidemic. The first part of the study gives a brief introduction on the problems of Non-Covid Patients and Second part provide with conceptual framework of the study and third part illustrates the survey of literature and fourth part offers concluding remarks.

II. CONCEPTUAL AND THEORATICAL FRAMEWORK - HEALTH STATUS PERSPECTIVE IN INDIA

Today, there is a clearly discernible change in the way healthcare services are being offered and perceived in India. As the adage goes, hardship has truly brought out the potential that the Indian healthcare system offers. The pandemic has been challenging for even the best and the most organized healthcare systems in the world, and this is where the quality and amount of effort put in by the medical professionals and support staff throughout India has been extraordinary. We might have lost certain battles, but we have been extremely effective in the struggle against the epidemic.

Despite the impact of the second wave – and as the country has crossed the one billion plus vaccine doses barrier – there have been some really optimistic takeaways from the healthcare operations in 2021. These are trends and advancements that will serve as the mainstay of

future of healthcare in India and revolutionize the way things are regarded by patients and caregivers alike.

A. Integrated healthcare delivery

The rise of collaborative and patient-centered healthcare delivery is encouraging. India's healthcare system used to be split up into hospitals, doctors' offices, diagnostic labs, and pharmacies Because each service vertical focused on its own business, there were various coverage and quality gaps. We now know that combining these diverse parts of healthcare is necessary to ensure that patients receive proper care and treatment at the appropriate time. This necessitates substantial usage of technology.

The NDHM has begun out on a mission of establishing such a framework for our healthcare ecosystem and this should provide results in the future years. In the interim, several health tech businesses have moved in to provide solutions that can aid enabling digital access to patients and doctors.

B. Reducing the Challenge of Access

Unlike the past, in 2021 we have seen healthcare access people instead of the one-way route of people trying to contact healthcare. This advent of doorstep delivery of healthcare isn't a novelty, as the services have been available for several years in India. However, appropriate focus was not given to the role that contemporary technology may play in the delivery of medical services across India. It is not only the large 1.35 billion plus population, but also the challenge of different topography and lack of infrastructure has been making access to healthcare uneven across the country. However, tech-based healthcare delivery is now tackling part of this difficulty through telemedicine and doorstep delivery of medicines across the country. In contemporary times, telemedicine has doubled up as not only the most accessible, but also the safest route of care for patients suffering from non-critical or chronic health disorders.

The telemedicine rules that the Government of India had given last year, allowing Indian telemedicine business to come into its own in 2021. Considering the huge lack of doctors, qualified nurses and other medical workers, telemedicine is efficiently bridging the gap between demand and supply.

Home healthcare has been the other main facilitator that has helped overcome 'access' difficulties in 2021. For patients that require in-person medical care such as dialysis, giving fluids, accident or chronic illness management, vaccination and other non-emergency support, home healthcare is a tremendous advantage. It is a well-established truth that patients can heal better and experience a greater quality of life when they are provided appropriate treatment within their home environment. This is what Indian home healthcare industry enterprises have made feasible through their innovative and effective employment of modern technologies. With capabilities of giving more advanced support like as chemotherapy and remote ICUs, a system is being constructed that will considerably expand the healthcare coverage in the country in the years to come.

C. Research and Development

Healthcare R&D didn't receive significant attention in the past despite India being among the countries with the most urgent need for the same. However, we have seen things shift radically in 2021 with numerous healthcare technologies coming into the scene in immunization, diagnosis, and delivery categories. Many governments, both central and state, have fostered the development of 'Made in India' digital technologies. This investment in R&D and skill development in healthcare bodes well for the future.

D. Vaccination

Despite the early concerns about development and delivery of vaccines, India initiated the mass immunization and a few days back, the country crossed the 1 billion doses landmark. This ability to mass-vaccinate the adult population with at least the first dosage has helped the country emerge strongly from the pandemic shadows. There is a vaccination for children in the works that will be disclosed in the months to come, and there is little doubt that a base has been constructed to deliver much improved universal healthcare for all Indians in the years ahead. From a reflective point of view, 2021 has been a year of great learning, capacity building and reorienting the roadmaps towards delivering world-class healthcare coverage across the country in the times to come. May the momentum continue. (Times of India, 2022)

III. SURVEY OF LITERATURE

Anant Kumar et al. (2020) examined that urgent action must be taken to monitor

the spread and its after-effects and that this opportunity must be taken to reinforce and expand its primary health care system in countryside India. The effect of this pandemic, in particular the social locking technique, is multidimensional. What may be significant from the point of view of public health is its effect on the jobs and educational opportunities of lots of people in rustic areas who are migrant workers in many cities.[1] Besides, Arvind Kasthuri (2020) identified unrealistic expectations may be at the root of much of the stress, it is time for the profession to realise that awareness of the issue and its potential underlying causes is the first step forward. Health ethics should be a highly debated topic within the discipline rather than outside it.[2] Moreover, Deo S. V. S. et al (2020) described the Pandemic Guidelines in Cancer Surgery. Cancer treatments generally take a few months to complete and require many visits and hospitalizations. Cancer encompasses a wide range of diseases, clinical appearances, and clinical trajectories. Involve the patient and family in the decision-making process. Minimize new patient hospital visits and only recommend required diagnostic tests. Recommend that cancer patients who have finished their treatments stay at home. These patients can have teleconsultations. Planned treatment should be based on the current and emerging covid condition, allowing for timely completion of oncologically suitable treatment procedures. Operate on patients with onco-surgical emergencies using all surgical emergency precautions during a covid pandemic. Elective cancer surgery decisions should be personalised according on type, stage, biology, non-surgical treatment choices, and treatment centre resources.[3] Apart from that, Dinesh C Sharma (2020) investigated how the statewide lockdown imposed to prevent the virus's spread impacted cancer care, as Mumbai is a significant cancer treatment centre for patients from other states. The author concludes that cancer hospitals must continue to treat cancer patients while also addressing COVID-19, so that unfavourable cancer outcomes owing to withholding or delayed cancer therapy do not become more problematic than pandemic morbidity and death. [4] Simultaneously,

During the COVID-19 pandemic in Paris, Eloi Marijon et al. (2020) studied out-of-hospital cardiac arrest, but not the indirect effects on the population through lockdown, lifestyle modifications, and healthcare system reconfiguration. We intended to compare the incidence and implications of OHCA in a pandemic and non-pandemic location. The study found a transient two-fold increase in OHCA incidence and a reduction in survival during the pandemic compared to similar time periods in years without a pandemic. This may be attributable to COVID-19 infections, but it is also likely due to the pandemic's lockdown and adaption of health-care facilities. Thus, while analysing mortality and public health data, these variables should be addressed. [5] Although Ezekiel J. Emanuel et al. (2020) concluded that governments and policymakers must do everything possible to avoid medical resource scarcity, we believe the six recommendations we outline should be used to develop guidelines that can be applied fairly and consistently across cases if resources become scarce. Thanks to these standards, doctors will never be allowed to determine which patients receive life-saving care and which do not. Not only would this reduce physician stress, but it would also ensure that all patients are treated fairly. The preceding ideas may impact the guidelines' creation. [6] So Higor Leite et al. (2020) studied the COVID-19 outbreak and its impact on healthcare. The authors explain how "flattening the infection curve" might safeguard healthcare, defer rising demand, and realign supply chain activities. Their analysis includes demand and capacity management, quality improvement in healthcare operations and supply chains. A lack of organisational reactivity during uncontrolled occurrences, for example, is discussed as a post-pandemic sustainability of lean, "just in time" practises, inventory trade-offs, and inventory management. [7] In addition, Hummy Song et al (2020) discovered that during the initial Covid-19 pandemic epidemic, hospitals around the world reallocated resources from routine inpatient critical care and outpatient clinics to meet the rise in demand. To alleviate delays in release owing to testing limits, hospitals could implement quick testing more generally, and post-acute care facilities can build quarantine sections for patients to receive treatment while awaiting findings. [8] In addition, Manish Rathi et al. (2020) looked at the impact of the COVID-19 pandemic on patients with systemic lupus erythematosus: Observations from an Indian inception cohort. Our SLE (systemic lupus erythematosus) patients have been severely impacted by the current COVID-19 outbreak. During the epidemic, patients encountered challenges with pharmaceutical supply, skipped doses, faced financial limits, and spent more money on health. [9] As a result, Mathiharan K (2020) argued that the patient's right to life was not being violated due to the lack of prompt medical attention from a government hospital. The Court also maintained the state's obligation to provide health care. Collective applications for compulsory access to health care have been filed in accordance with Article 21. [10] McGuire Amy L. et al. also researched Ethical Challenges Arising in the COVID-19 Pandemic: An Overview from the Association of Bioethics Program Directors (ABPD) (2020). The study concluded that while every attempt has been made to develop fair and equal standards, many of the policies in place are insensitive to the needs of disabled and disadvantaged people. Even the best-intentioned policies fail to identify daily triage and allocation decisions, revealing a typical gap between institutional policy and healthcare practitioners' actual day-to-day work. Bioethicists have traditionally focused on some of the most critical ethical judgements that affect patients' lives. [11] Despite this, Peiffer-Smadja N et al (2020) believe that many health systems will be confronted with an increasing number of COVID-19 patients and will need to plan for the consequences, such as the need for more beds, competent HCWs, and ventilators. [12] Preventive healthcare in India faced "challenges and potential" according to Pragati B Hebbar et al. (2020). The study determined that Covid-19 has harmed India's healthcare systems, raising concerns about the fate of those unable to access care. It outlines initiatives healthcare systems can take to address Covid-related and non-Covid-related needs. Some examples of this include leveraging technology for consultations, enhancing healthcare facility readiness, providing medicines to patients' homes, and expediting travel during lockdowns. [13] In light of this, Raffaele Galiero et al. (2020) claim that telemedicine has grown in importance due to growing use of digital technology. It should be evaluated for updating national and international recommendations. The COVID-19 pandemic's severe social seclusion and lack of viable cures made telemedicine the safest way for patients to engage with doctors. Several evidence-based

telemedicine scenarios have been developed. Telemedicine for diabetes therapy is licenced and regulated. On the other hand, the document outlines the actors and users. However, implementing such gadgets and digital applications must be made easier and less time consuming. The cost-benefit ratio should also be as low as possible. Expanding the use of telehealth technologies to general practitioners and patients would be promising. [14] Snehil Gupta and Swapnajeet Sahoo (2020), on the other hand, investigated Pandemic and mental health of front-line healthcare workers: a review and implications in the Indian setting during COVID-19. The study reveals that mental health issues among HCWs (Health Care Workers) are widespread; some of the most common conditions include burnout, anxiety, depression, stress-related diseases, and so on. Biological, psychological, and socioenvironmental factors all play a role. Some of the key contributory causes for the development of mental health problems among HCWs include a lack of effective communications, concrete support from higher authority, disinformation, unavailability of PPEs (Personal Protective Equipment), stigma, and job-related stress. [15] Syed A K Shifat Ahmed et al. (2020) studied the influence of pre-COVID and COVID-19 lockdown stakeholder discussions on access to healthcare for non-COVID-19 health issues in Bangladesh, Kenya, Nigeria, and Pakistan slum areas. Slums, the report indicates, represent a COVID-19 issue. Controlling slum epidemics is crucial for the local and larger population's welfare, and we can see how governments protect the most vulnerable in society. In addition to mitigating the effects of COVID-19 and future pandemics, strengthening their healthcare system will help them reach their health-related SDGs. [16] So Sylaja P. N. et al. (2020) looked at SARS-CoV-2/COVID-19 and stroke care in India. The COVID-19 epidemic has complicated stroke care. Several areas of stroke care need to be reorganised to provide best services. Both developed and developing countries must increase stroke awareness and adopt appropriate triage, acute treatment, rehabilitation, teleservices, and virtual check-in procedures. This will help maintain stroke care and reduce morbidity and mortality. [17] The COVID-19 pandemic's impact on primary care's basic functions was studied by Veronique Verhoeven et al. (2020). A qualitative interview study of Flemish GPs was conducted. The study

found that the modern era has a big impact on basic primary care skills. Despite the significant growth in people seeking medical treatment and the required separation of covid and non-covid flows, GPs are concerned about the continuance of regular care and the anticovid measures. These could jeopardise the population's health and the provision of primary healthcare in the near and far future.[18] Tuberculosis in the age of COVID-19 in India, as seen by Vijay Kumar Jain (2020). Lockdown, social separation, isolation, and public health recommendations impacted all aspects of Tuberculosis care. The COVID-19 outbreak has hampered various tuberculosis prevention, monitoring, and treatment programmes, the paper says. Rethinking patient assistance practises, including more use of remote consultations, has become necessary due to lockdown and public health norms. [19] Is non-covid patient care a moral duty or a choice, argue Bashar Hassan and Thalia Arawi (2020)? Regular monitoring, screening, prevention, and quality care for non-COVID-19 individuals who were denied care during the epidemic should be resumed as soon as possible. For example, hospitals must keep records of "rejected" or "postponed" patients who may have gotten care elsewhere. Patient groups should include COVID-19 survivors, loved ones who have died, and non-COVID-19 patients whose treatment has been delayed. Everyone has the right to a complete medical evaluation, treatment, and care. Although the new guidelines focus on COVID-19 children, all patients are patients, and we as caregivers are accountable to all. [20] Devi Dayal et al (2020) monitored youngsters with newly diagnosed type 1 diabetes. The coronavirus 2019 (COVID-19) pandemic has unintentionally neglected crucial non-COVID-19 care (1). The COVID-19 strain has imploded already overburdened healthcare systems in LMIC (2). For fear of exposure to SARSCoV-2 in hospital settings, patients with non-COVID-19 illnesses have been forced to stay home and suffer until their illness deteriorates dramatically, and sometimes irrevocably. COVID-19 has had a modest impact on the paediatric population except in comorbid children (3). Children with new non-COVID-19 infections during the pandemic risk deteriorating or dying due to a shortage of hospital care. Delaying insulin administration increases the risk of diabetic ketoacidosis in children with newly diagnosed type 1 diabetes, increasing morbidity and mortality. [21]

Simultaneously, Elham Monaghesh and Alireza Hajizadeh (2020) examined the role of telehealth in the COVID-19 outbreak. Telehealth can help fight the COVID-19 outbreak. An investigation on how telehealth services helped prevent, diagnose, treat, and control sickness during the COVID-19 outbreak. Currently, telemedicine is a great approach for healthcare providers and patients to prevent COVID-19 transmission. This strategy can prevent direct physical contact, provide ongoing community care, and ultimately reduce COVID-19 morbidity and mortality. [22] The COVID-19 pandemic also prompted Dr. Driggin and colleagues (2020) to examine Cardiovascular Considerations for Patients, Workers, and Systems. The coronavirus disease 2019 (COVID-19) is an infectious disease caused by the coronavirus 2. It affects patient cardiovascular care. For starters, patients with COVID-19 and pre-existing cardiovascular disease are more likely to die. Second, infection has been associated to acute myocardial infarction, myocarditis, arrhythmias, and venous thromboembolism. Third, the COVID-19 therapies under test may have cardiovascular consequences. Concerns about fast triage of non-COVID-19 individuals with cardiovascular issues. Finally, giving cardiovascular care exposes health-care providers to danger as viral hosts or vectors. [23] During the COVID-19 epidemic, Ibrahim Jaly et al. (2020) identified considerable interruption in diabetic foot service provision both in primary care and hospitals. Social distancing and protective public health norms have impacted diabetic foot care delivery. As the COVID-19 pandemic spreads globally, healthcare systems are struggling to treat diabetic foot patients. Public health recommendations and the risk of viral transmission have prompted changes in diabetic foot care approaches, including virtual consultations. The Government of India's e-Sanjeevani telemedicine programme will help patients receive remote guidance and monitoring. When surgery is required, local anaesthesia or regional blocks should be used to reduce patient and staff risks while allowing patients to return home sooner. [24] ThenLuca Santi et al. (2021) studied Non-COVID-19 pandemic treatment in Northern Italy, including emergency room visits, hospitalizations, and fatalities. The COVID-19 outbreak forced the organisation to adapt. Not much is known about how this impacts non-COVID-19 patients. The study's purpose was to examine the pandemic's impact on non-COVID-19 patients in a 1 million-person population in Northern Italy (the Bologna BMA), as well as ED visits, hospitalizations, and mortality rates. This study's purpose was to assess the epidemic. Data from BMA healthcare information systems were used for retrospective observational research. All-cause and cause-specific mortality were compared to weekly trends from the previous year. Between December 1, 2019 and May 31, 2020. Non-COVID-19 hospitalizations and ER visits showed a pattern of documenting the first Italian COVID-19 case on February 19, 2020. The number of ED visits decreased across all age, diagnostic, and severity groups. Endocrine, metabolic (79.5%), and cardiovascular (32.7%) disorders increased throughout the lock-down period. Lockouts have also increased. During the lockdown, the pandemic reduced ED visits and non-COVID-19 hospitalizations, while increasing out-of-hospital fatalities from neoplasms, cardiovascular ailments, and endocrine diseases. [25] During the COVID-19 pandemic, Muhammad Abdul Kadir (2021) examined the significance of telemedicine in underdeveloped countries. It helps contain virus propagation, efficiently utilise healthcare specialists' time, and reduce mental health issues, according to the study. Many developing countries have mobile and internet networks. Some countries are using the internet and cellphones to give virtual healthcare services. However, most people in developing nations are ignorant of telemedicine's practical benefits. Telemedicine services must be widely deployed and promoted in poor countries. EKG and electronic stethoscope may be more useful than standalone diagnostic instruments in telemedicine. It can also help doctors detect ailments more accurately and provide better health recommendations. [26] Rakesh Lodha and S K Kabra (2020) explored COVID-19: Pandemic Preparedness. Rapid spread of SARS nCoV 2 pandemic has halted global travel and caused serious concerns in industrialised countries, which are predicted to worsen in countries like India if infection rates grow. Faced with a crippled health system, rapid preparations are essential. Simultaneously, available resources must be used judiciously, with a heavy focus on protecting frontline combatants such as medical workers. In the absence of specific antiviral drugs, supportive care for the sick and many preventive measures

appear to be the best options.27] To illustrate the rapid expansion and implementation of digital health technologies in healthcare over the previous year, starting with the COVID-19 crisis and continuing now, Sailee Bhambere et al. That's why this piece focuses on lawmakers and insurers who are fast implementing more inclusive policies for digital health technology and paying for out-of-network treatments. A look at the key parties' personal developments Previous patient-related difficulties hindered general public acceptance of digital technology. Even while many variables remain, evolving social and physical infrastructure has encouraged consumers to embrace digital health solutions. To help patients who need in-office care re-establish resources and preserve social distance, hospitals and healthcare professionals have turned to digital healthcare technologies. While the digital infrastructure has evolved, it still need continual maintenance. Patient safety continues to be an issue when it comes to technology. In some cases, people and power may return to their old ways of thinking. It's vital to remember the epidemic's lessons and apply them to a more integrated health-care system. [28] After the epidemic, Shankar Prinja and Chandrakant S. Pandav (2021) looked at the problems and solutions for health policy. The onset of the COVID19 pandemic in 2019 offers major health-care concerns. The government must oppose COVID19 control practises while also providing other basic health services. Second, increased infrastructure is needed to combat the possibility for epidemics. Finally, establish financial stability and household income. This has made it challenging for governments to manage health and public policy trade-offs. COVID19 has given us important health and policy insights. To begin with, the government has prioritised health-related investments. Policy entrepreneurs and the public health community should not miss this once-in-a-lifetime opportunity to advocate for proper funding. In addition, essential economic concepts for care procurement and payment should be followed. Finally, the COVID-19 pandemic teaches us how to build public health systems and reduce dependency on commercial healthcare purchases. This is critical given the government's involvement in public health. Finally, COVID-19 management allows all government sectors to contribute to the health-for-all policy cause. Time will tell how much governments and healthcare professionals have

learned about public health and adopting COVID19. [29] So, according to Snehil Gupta and Swapnajeet Sahoo (2020), mental health issues among HCWs are widespread, including burnout, anxiety, depression, and stress-related diseases. Genetic, psychological, and social variables all play a part. Lack of effective communication, concrete support from higher authority, disinformation, lack of PPEs, stigma, and job-related stress are some of the primary contributory factors of mental health issues among HCWs. Taking experiences from previous pandemics and other countries that successfully combatted COVID-19 could considerably decrease the psychological impact of COVID-19 on HCWs. More research is needed, especially from low- and middle-income nations like India, to develop treatments for HCWs. [30] Soumitra S. Datta et al (low and middle-income countries). The COVID-19 pandemic showed us the value of empathy, sensitivity, and responsiveness amid a tragedy. The mental health of cancer centre personnel is critical at all times, but especially in times of crisis. Aside from the usual pandemic issues, cancer care practitioners in LMICs have unique hurdles. Lessons learned from this pandemic can help us and other LMIC institutions prepare for future pandemics, especially in terms of sustaining healthcare professionals' mental health.[31] Surinder K. Jindal (2021) studied COVID-era respiratory disease care in India. Various modelling exercises have employed TB patient treatment, nutritional supplements, and government financial assistance to predict a rise in TB infections and deaths post-COVID. The intense focus on COVID-19 also hurt patients with chronic respiratory disorders including asthma and chronic obstructive pulmonary disease (COPD). After a little respite, the COVID issue has resurfaced. This was due to early anti-pandemic measures, including lockdowns, and public health initiatives. The second wave hit like an earthquake, threatening the entire infrastructure. Controlling non-COVID respiratory infections is challenging when COVID-19 is present. [32] During the 2019 coronavirus (COVID-19) pandemic, Vivek Gopinathan et al. (2021) analysed numerous university emergency departments' preparedness for disasters and plan approaches. A multicentric cross-sectional online survey was conducted over eight weeks in India, containing data from 28 academic departments. Compared to the preceding COVID-19 pandemic, 90% of

centres used a separate triage method, and 70% used individual transit channels. 80% of the institutes used the COVID-19 institutional treatment plan. Airway management and PPE training were provided in 93% and 80% of the centres, respectively. The recommended use of PPE in emergency departments varies widely in India. The study found that during a pandemic, ED preparation varies widely across India. Preparations for distinct EDs in India should be examined and planned independently. [33]

IV. CONCLUSION

Health ethics should be a hot topic within the field, not outside. The impact of public health on the jobs and educational possibilities of millions of rural migrant workers in various cities must also be examined. The patient's right to life was not being abused by a government hospital. It also upheld the State's obligation to provide healthcare. Article 21 collective petitions for compulsory health access have been submitted. The Indian Government's e-Sanjeevani telemedicine gateway will help patients receive remote counselling and monitoring. When surgery is essential, local anaesthesia or regional blocks should be used to minimise patient and staff risks and allow patients to go home faster. COVID-19 patients, survivors, bereaved relatives, and non-COVID-19 patients should receive psychotherapy. A proper medical evaluation, attention, and treatment are rights. Our role as health care providers extends to all patients. Governments must avoid medical resource shortages. The six guidelines should be utilised to create rules that can apply equitably and consistently across circumstances. Doctors would never be allowed to pick who gets life-saving care. This will not only relieve physicians but also assure fair treatment.

Poor communication, inefficient leadership, misinformation, lack of access to PPE, stigma, and job-related stress are all factors that contribute to mental health concerns among HCWs. COVID-19 could be controlled more effectively by learning from previous pandemics and other countries' experiences. More research is a need of the hour, especially from underdeveloped nations like India.

To promote telemedicine, developing countries must widely employ it. More and more doctors are using telemedicine with video and diagnostic tools (e- stethoscope and temperature). The use of AI and CADD can help doctors diagnose and treat patients.

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