



Review

Health Management Crisis of COVID-19

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Abstract: Coronavirus disease 2019 (COVID-19) has a negative effect on the poor, minority populations, and a wide variety of vulnerable communities because of its unequal distribution in populated regions and its limited ability to be mitigated by the rise in chronic conditions or the lack of access to high-quality healthcare (HC). Furthermore, the pandemic's negative consequences, such as social isolation and travel limitations, disproportionately affect persons in the poorest socioeconomic (SE) groups. We prepared seven national case studies from across the world to address the difficulties of improving health and highlight some of the responses used by government agencies and local groups: Afghanistan (AFGN), Albania (ALB), Algeria (ALGR), Australia (AU), Brazil (BR), China (CN), and France (FR). We encourage academics to continue doing rigorous research and establishing a sound evidence foundation for further scientific inquiries into COVID-19 health equity problems throughout the world. HC organisations may improve their agility, resilience, and learning with the support of insights from complexity science in order to better prepare for unexpected occurrences in the future.

Keywords: pandemic, COVID-19, populated region, unequal distribution, health crises

1. Introduction

With the increasing number of coronavirus disease 2019 (COVID-19) deaths worldwide (WW), it is becoming obvious that the severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) viral fatality is evenly distributed among high-risk populations. Older folks, those who live in highly crowded regions, people with poor socioeconomic (SE) status, migrants, and a minority may all be at risk [1]. These people have a higher prevalence of chronic joint problems, which puts them at a higher risk of infection and illness complications [1, 2]. People, who play an important role, often from low-wage jobs such as public transit workers, groceries and pharmacy shopkeepers, are highly exposed to the public and so infected. Young people and migrants also confront linguistic and cultural hurdles, which limit their access to proper prevention and reduction information, leading them to rely on potentially false advice on social media [3]. People who may not have appropriate access to healthcare (HC) and develop symptoms associated with COVID-19 may postpone or even discontinue testing, and as a result, may seek medical help only when symptoms are severe, resulting in inferior results. This puts their families and communities at threat [3].

The recent remarks on COVID-19's response to Iran (IR) [4] are an example of low and middle-income countries

(LMICs) general response, as well as hurdles to testing, supply of personal protective equipment (PPE) for HC professionals, and better medical services. Millions of impoverished individuals in high-income countries (HICs), as well as those in LMICs, suffer major challenges to protection from overcrowding, poor housing conditions, and sanitation. Furthermore, millions of people in LMICs are in danger of food insecurity due to the global economic crisis and insufficient humanitarian assistance. In addition, there is a lack of sufficient control for future epidemics [5]. The World Health Organization (WHO) is required to provide assistance to these countries in order to increase resilience and decrease the health and social implications of upcoming public health crises [6].

The fact that the present number of COVID-19 deaths fails to convey the tragic implications of adherence to health equity is becoming increasingly concerning. Loss of health insurance, jobs, and housing, for example, all raise the chance of mental and physical sickness, as well as mortality. It is important to protect human rights (HR) and create social and political policies that are widely implemented and don't target the most vulnerable people, like refugees, undocumented immigrants, and detainees. Segregation and movement restrictions have the potential to harm health and access to essential services [7, 8]. As a result, systemic measures that take into account the challenges of HR protection, particularly the safety of humanitarian staff, should be adopted [9].

We have included seven national studies that highlight the numerous needs of the most vulnerable people and some of the actions done by each nation to address these needs in order to discuss the effects of the current pandemic on global health equality. The case study provided here gives a transient overview of the hurdles and other developing solutions, which may be broadly distributed as governments recognize the need to treat COVID-19-related health concerns both before and after the illness is prevented. The research of experts and community health workers on the themes they cover is represented by our team of authors. Students should use WHO status and country reports, as well as materials like the WW analysis offered for the implementation of Health System Response Monitoring (HSRM) for a thorough assessment of available national information [10].

The International Journal for Equity in Health has recently published more comments and research that broadens our understanding of COVID-19-related health problems and their local, national, and regional treatments. The authors explore the concerns of stigma towards older individuals in connection to intensive care unit (ICU) hospitalisation and social reduction initiatives in their remarks from Italy [11]. By providing therapies to protect vulnerable families with young children from the negative social effects of COVID-19-related social disruption measures, a study from Mexico provides an alternative to other countries [12]. A recent letter from China (CN) on the use of "pairing aid" to bring people together in COVID-19-affected regions discusses local inequalities [13]. A step-by-step strategy for developing and executing a COVID-19 response in traditional communities is used to remark on the difficulties confronting traditional communities in Latin America. Due to the direct implications and assurances of COVID-19 on global health equality, we encourage authors to continue contributing health equity research papers and comments to expand global knowledge and allow statewide learning about what works for persons in need [14].

2. The health perspectives on COVID-19 by various countries

2.1 Afghanistan (AFGN)

AFGN's HC system has already been devastated by 40 wars and is now threatened by COVID-19. As of February 7, 2021, COVID-19 has been recorded in 106 million occurrences and 2.31 million in more than 180 nations. AFGN's HC system is still not prepared to respond quickly and effectively to the COVID-19 pandemic [15]. On February 24, 2020, the first case of COVID-19 in AFGN was reported from Herat province, which shares borders with the Islamic Republic of IR [16]. COVID-19-confirmed cases have grown in AFGN since then. There were 55,335 confirmed cases and 2,410 fatalities in AFGN as of February 7, 2021 [17].

A Herat state official claims that 1,000 Afghans return from the IR every day, with the initial instances recorded among these returns being followed by public transfers across the nation due to a lack of border crossing safeguards [16]. However, due to a lack of testing resources, the number of cases recorded in AFGN remains low. In a country of 36.6 million people, AFGN has completed 264,791 tests to date, and the number of confirmed cases is directly related to the availability of operating laboratories in the provinces. As laboratory capacity grows, the number of reported cases has grown since February 24, 2020. In all, 73% of cases were recorded from COVID-19 diagnostic sites in six provinces of AFGN [16].

As of January 7, 2021, just 1,200 out of the 200,000 returnees had been tested for COVID-19 prior to compiling the virus's dissemination by regulatory methods, including the closing of borders. In terms of national risks, such as strict borders, normal border movements, a poor health system, high levels of malnutrition, limited water and sanitation facilities, inequalities in access to HC, gender-based violence, limited mobility of women, and a large number of people with special needs, the transmission of the virus to the Afghan population should have been consistently high [18]. Furthermore, continued wars in AFGN, particularly in the first half of 2020, and the attack on the Médecins Sans Frontières maternity facility in Kabul, have wreaked havoc on the country's already precarious HC system [19]. Deep social ties, huge and extended families, large populations, and religious and cultural beliefs make it nearly hard to adjust to social isolation and other types of protection, all of which contributed to the virus's fast spread. Furthermore, due to possible stigma and low levels of anxiety, many patients diagnosed with human immunodeficiency virus (HIV) are unwilling to reveal their status, leading to isolation [16].

The Afghan government is actively collaborating with non-governmental organisations (NGOs) and foreign donors to outline the issues that HC workers face and to propose strategies to reintroduce money as a key source of HC delivery in the country [20]. Furthermore, COVID-19 hospitals are no longer operating owing to a lack of funding. Overcrowding and staff shortages are putting a strain on health professionals. Because of political unrest, many health workers have fled the nation [21-24].

The following are some suggestions for enhancing HC professionals:

- The government should include informal care providers in national health policy as well as quality monitoring and improvement operations. The HC industry is suffering a manpower shortage, and the government should recognize the existence of these informal providers and make steps to improve the care they offer. This could include official and informal education, training, and rewards.
- Locations with extreme poverty, such as AFGN, should be prioritized. The international humanitarian system, multilateral organisations, and NGOs should identify priority areas for evaluating the quality of care provided in these situations, not just to patients but also to HC staff. They should devise measures to enhance it. In such cases, the treatment of conflict-related trauma and mental illness, as well as the protection of HC personnel from conflict-related violence, should be addressed.
- To minimize mental health (MH) and psychological issues, HC personnel's wages should be repaid on time.
- The World Bank should continue to support AFGN and promote HC packages throughout the nation, which would help to revitalize the process by reinforcing locally-led efforts.
- Global powers must exert pressure on the next administration to ensure that female HC workers may work freely.
- Given the history of violence against HC professionals in AFGN, ensuring the safety, health, and well-being of HC workers should be a top global health priority. The Taliban leadership must coordinate with humanitarian organisations to ensure the safety of Afghan citizens and medical personnel.
- The inequitable distribution of COVID-19 vaccinations, as well as the inherent problems of providing HC services in war-like settings, exacerbates the difficulties that HC workers face. It is suggested that HC professionals receive at least one dose of the life-saving SARS-CoV-2 virus vaccination.
- The epidemic has provided HC workers with more work than they have ever had, while simultaneously making their professions more difficult and dangerous. Their health and well-being must be urgently prioritized in global efforts and national programmes.
- There is a need to develop an efficient social health-protection system that offers universal access to low-cost, accessible, and suitable HC standards for employees, as well as financial support during illness, accidents, and maternity leave, the WHO has said.

Finally, the continuous tragedies in AFGN have exacerbated the medical personnel's dissatisfaction. Economic hardship, political insecurity, and a scarcity of HC experts have all hurt the position of HC professionals. Therefore, it is imperative that WW communities should take rapid action to enhance the working environment for HC staff. If not, the issue would worsen for HC employees, and the nation's HC system would be in danger of failing.

2.2 Albania (ALB)

The situation has gotten worse since January 2021, even though the incidence of COVID-19 occurrences in ALB stabilized in the middle of December. Due to limited testing, the number of new cases reduced to less than 185 per day

on January 4. During the holidays, the situation deteriorated drastically, with over 800 cases reported each day. With 971 active COVID-19 cases per 100,000 persons, ALB is ranked 15th in the globe. Of the 1,380 human deaths caused by the virus as of January 31, 46 were caused by wild animals [25].

Since the formal diagnosis of zero patient on Monday, March 9 [26], the United Nations Development Program (UNDP) has been assisting ALB in the battle against the new coronavirus. The UNDP rallied to respond to the immediate response by helping people remain aware of the dangers and protecting against COVID-19 by purchasing 31 life-saving ventilators as the government imposed mandatory incarceration to curb the spread of infection and assist the national health system in dealing with cases; aiding physicians and nurses by providing protective equipment to vulnerable and rural regions and teaching civil employees and other professionals to offer their services online without disrupting people in need. Meanwhile, UNDP ALB supported labour market performance analysis and the impact of the pandemic on the economy as part of its long-term assistance and assisted in the development of efficient labour market policies targeted at promptly converting newly appointed people into employment [26].

On Sunday, ALB reported 28 new cases of coronavirus, citing a lack of social distribution as the cause of the greatest infection rates in the previous three days. According to the Public Health Institute, the COVID-19 virus, which is caused by a coronavirus, has killed 20 individuals, infected 361 people, and forced three people to seek respiratory help. 104 had recovered, he added. In addition to the police-military lockdown and steep fines, some ALBs have been smuggling food out of the country. Outside, two people were arrested for having coffee and drinking. The sickness was also transmitted by mourners attending a funeral in the northern city [27].

On March 26, the number of instances grew from two on March 9 to 28 for most of the day. The next week, it dipped to half, then rose to 27 on Friday, 29 on Saturday, and 28 on Sunday. ALB, one of Europe's poorest countries, was previously devastated by an earthquake in November that killed 51 people and displaced 17,000 more. To keep the health system from growing frustrated, the government is enforcing stringent closures. The government cautioned ALBs not to be misled by comparing their country's statistics to those of the worst-hit countries before implementing its third 40-hour shutdown over the weekend. The rise in cases in Shkoder and Tirana also demonstrates a lack of access to community-based treatments and infection control measures that the Ministry of Health (MoH) has been advising on a daily basis, said Health Institute's Albana Fico. ALBs also stressed the need for observing techniques to avoid illness from our cousins by avoiding visits for whatever reason [28].

2.3 Algeria (ALGR)

COVID-19 affects ALGR, as it does to other countries. With 2,718 cases, it is Africa's third most afflicted country (after South Africa, Egypt, and Morocco), and the ALGR health minister declared the pandemic to be in phase three on March 23. The mortality rate (14.1%) is likewise one of the highest in the world, with 384 deaths [29]. This rate does not seem to be affected by the fact that there are not more than 7,000 tests performed each year and that there are a lot of positive instances [30]. The fact that 23% of all testing methods result in positive instances should also be taken into consideration since it shows that ALGR is no longer as susceptible to the virus [31]. Contrarily, a total of 2,618 radiological cases increased the overall number of cases to 4,720 [32].

Based on the number of flights from airports in impacted areas in CN and targeted in Africa, ALGR was determined to be one of the nation's most at risk of importing COVID-19 from CN, Egypt, and South Africa [33]. Because of its proximity to and capacity for working with CN, it was also designated one of the 13 most important countries by the WHO [34]. Despite the delay of the travel or flying ban to CN (February 3, 2020), the early incidents began in Europe rather than CN. On February 25, 2020, in the southern Italian region of Ouargla, the first COVID-19 case was found. They saw two French-born Algerians who were later discovered to have it on March 1, 2020, a few days after they returned to France (FR). Since that time, COVID-19 has been spreading over this area (Blida) [29].

Concern over the diverse immigrant origins was expressed by other departments, in particular the Nord Center of ALGR. In 47 of the 48 departments, at least one positive case was recorded on April 15. The virus was divided into a genetic component made up of French, Italian, and Spanish species, indicating its imported origin, whereas the genomic sequencing of the Algerian species revealed 95% to 97% similarity with the French strain [34]. Since the outbreak, many cutting-edge strategies for stopping the virus' spread have been created.

In order to clean public spaces, both public and private services have been established. Germs were killed on the highways and streets of popular areas using a truck sprayer, hand spray, and law enforcement trucks. Disinfection,

movement control, monitoring respect for closure and isolation from the community, and aiding needy families are all done by other neighbourhood and village groups [35, 36].

2.4 Australia (AU)

The AU Health Sector Novel Coronavirus Emergency Plan went into effect on February 27, 2020, in response to the rising WW problem. The national reaction to COVID-19 care was then started [37, 38]. In the primary care (PC) sector, this strategy includes general practice, community and integrated HC, MH, geriatric care, disability care, home care, and traditional health professionals. Initiatives to enhance Aboriginal and Torres Strait Islander health services, palliative care services, and services for persons with disabilities are part of the PC response [39-43]. There was also a lot of overlap with established systems for elderly home and in-home care. Recognizing the role of general practitioners and other PC physicians in providing services in nursing homes. The PC response was designed in consultation with representatives from general practice and the larger field of primary HC, and it was enhanced by frequent involvement with over 30 national organisations [44].

The Australian approach to PC in COVID-19 acknowledged the strength of the national primary HC system and offered major roles in general functioning and the larger HC sector in responding to the epidemic based on the first important communication role and lessons gained. Previous outbreaks and diseases [45-47]. Experience in public health, infectious diseases, epidemiology, nursing, and MH are also included in national planning and decision-making procedures [48]. The Australian national COVID-19 PC response is based on a set of principles that serve as a framework for dealing with the current crisis as well as future national and international responses to health emergencies that harness the contributions of general practice and PC [49]:

- Vulnerable individuals are safeguarded.
- Those who have been impacted can receive treatment and assistance.
- Availability of HC services on a consistent basis for the entire population.
- PC providers and services should be safeguarded and encouraged.
- Providing the general public and PC professionals with MH services.

PC doctors and other PC providers might be able to provide continued medicinal therapy because the majority of COVID-19 patients have mild to moderate symptoms and do not need hospitalization. Major elements of epidemic planning should include facilitating testing and proper care for people with symptoms, infection diagnosis, or who have been diagnosed but do not need hospitalization [50].

As part of AU's response, 130 traditional-led respiratory clinics were established around the country to detect, diagnose, and treat people suffering from mild to moderate respiratory infections, as well as rule out any cases of the sickness. Emergency rooms in hospitals and regular clinics [51]. These clinics are outfitted with emergency services provided by public hospital clinics, as well as a national contact center and an online signage checker that gives advice to those experiencing health problems. A nationwide clinic network was built in collaboration with 31 basic health networks [52-55].

Hospital staff members, general practitioners, and other PC providers must all be immune from infection during an outbreak [56]. When the COVID-19 outbreak first started, primary HC practitioners in AU, like others throughout the world, were concerned about the lack of PPE. PPE has been obtained and supplied by the Australian government through conventional methods, neighbourhood pharmacies, and other primary HC providers [57]. In order to maintain the country's operational and commercial procedures, the Australian government has also given infrastructural contributions, particularly to support the ongoing employment of PC group members in regular operations [58].

2.5 Brazil (BR)

The COVID-19 pandemic was announced in BR on February 26, and the first COVID-19-related mortality was recorded on March 17 in the state of São Paulo. On March 20, the Brazilian MoH announced that public transfers are now available nationally. By May 13, the country has accumulated 177,589 COVID-19-certified cases (84.5 per 100,000 patients) and a 7.0% (12,400) COVID-19-related mortality rate. Nearly 60,000 cases were estimated a week later, giving it one of the world's highest transmission rates [59]. The coronavirus entered BR via plane from upper-class Europeans, the bulk of whom were white and educated. When it arrived, it infected domestic employees, many of whom were black

and illiterate, and spread the sickness to their poor neighbours. Given this proclivity, infection and fatality rates in record cases in CN and Italy may be insufficient predictors of COVID-19's trajectory in BR, the world's ninth most unequal country [60].

It is understandable how difficult it is for the great majority of people to adhere to basic advice like hand washing or using alcohol jelly given that 30 million Brazilians lack access to basic sanitation [61]. Similarly, it is practically challenging to avoid traffic and complement home offices that serve the 11.4 million people who live in slums and need to go there to conduct their daily activities. As a result, among the most vulnerable Brazilians who experience social and economic inequality, the risk of COVID-19 may be greater [61]. Furthermore, this economically disadvantaged group has a higher prevalence of chronic disorders including diabetes, hypertension, and cardiovascular disease. According to the National Health Survey from 2013, more elementary school children (54%) than high school students (28%) and seniors (34%) reported having one or more of these ailments. Another significant predictor of COVID-19 complexity is disease [62].

Racial inequality is a significant problem in BR because black people make up the bulk of the impoverished. Additionally, given that blacks have the greatest COVID-19 death rate; it is already a factor in violent times. Despite making up 23.1% of COVID-19 hospital admissions in BR, black people still die at a rate of 32%; however, the situation has improved for white people, who now make up 73.9% of hospital admissions and 64.5% of mortality [63]. The homeless and prisoners are two more vulnerable community groups. The biggest jail population in the world, with 773,000 inmates, is in BR. 80% of inmates are predicted to contract an infection, 20% to need hospitalization, and 10,000 (8%) in an ICU bed [64].

The MoH's preventative measures have only recently included restricting visits and short excursions, as well as making a few HC suggestions. It was not unusual to find a handful of apostates inside the prisons. The Institute for Applied Economic Research (IPEA) estimates that there were 101,854 homeless people in BR in 2015 [65]. These individuals are not covered by social policies, including emergency measures like a minimum grant of \$100 per month for three months, which was approved by the National Congress but was not paid on time by the government. Finally, and probably most crucially, BR may find it difficult to address other sexual health-related issues during the pandemic. Prior research has emphasized the necessity to concentrate on the COVID-19 pandemic's short- and long-term consequences on sexual health [66]. In terms of infection and risk levels, as well as the capacity for isolation and other preventative measures, as well as access to primary HC facilities, BRs' existing SE, racial, and geographic disparities are evident.

2.6 France (FR)

Surprisingly, the criticism leveled at H1N1 flu management coincided with FR's steady retreat from the focus placed on preventing the pandemic a decade earlier. Because numerous emerging coronaviruses and Ebola are situated outside of FR, there has been a decline in mask storage locations and maybe a complete loss of surveillance. Early on in the COVID-19 outbreak, the government's reaction was mostly geared around preventing overcrowding in hospitals, with little emphasis being placed on the need for prevention and a complete plan for screening, monitoring, and separate epidemic management [67]. Other HC needs, particularly those of non-COVID-19 patients, including frail elderly people, have been disregarded as a result of emergency measures [68].

In addition to the critical economic support measures undertaken since the crisis began, the national shutdown in the spring of 2020, followed by the second in November, has escalated income disparities, poverty, and MH difficulties. Anxiety and sorrow are on the rise in FR, according to recent studies, impacting both high-risk and low-risk populations [69]. Managers of health problems have identified several obvious flaws [70]. Strong central government during the first wave allowed for swift national action, particularly to protect the populace from the detrimental economic repercussions of preventative measures, but the speed of decision-making in one area also resulted in a lack of communication and transparency [71]. The main participants' lack of cooperation on both the intermediate and local levels hindered the potential to swiftly adopt integrated measures and discuss local solutions to viral content [71, 72].

The COVID-19 incident, on the other hand, has caused a considerable learning process in the HC industry. In times of crisis, HC personnel have demonstrated amazing tenacity and innovation. Despite ongoing strikes when the epidemic occurred in February, the hospital displayed great resilience, rapid training, and integration of HC professionals. During the sanitation crisis, public-private partnerships were increasingly common, eroding not just the barriers between these

disciplines, but also those between HC professionals [73]. Due to the obvious epidemic, more flexible and accessible care is now available online, in communities, and hospitals. The fast development of telemedicine systems like telephone monitoring and online consultation has aided in improving access to treatment, lowering staff and patient disease exposure, and decreasing the number of patients who need to be admitted to hospitals [74]. These novels, locally developed approaches should be expanded to help sustain and enhance therapy beyond the present outbreak.

2.7 China (CN)

Since its first reported incident in Wuhan, Hubei Province, CN on December 8, 2019 [75], COVID-19 has spread to more than 200 nations and affected more than three million individuals WW (as of 28 April 2020). In contrast, the COVID-19 outbreak has sparked not just a historic WW health catastrophe but also a severe global economic slump, according to a report from 2020 [76]. The inability to manage the virus when it initially appeared in Wuhan and the remainder of Hubei province is one of the main reasons for the present public health crisis [77]. Similar to SARS, COVID-19 can cause respiratory illnesses, but it spreads more quickly. Six months after SARS was discovered in Guangdong province, SARS first appeared in CN on November 16, 2002, and quickly spread to 24 of CN's 34 provinces, municipalities, and autonomous territories [78]. I traveled across the country in just 54 days. Given Gundel's [79] typology of concerns, it is clear that the public health risk brought on by COVID-19 is an unexpected problem, which means that it is challenging to predict but simple to effect.

Despite learning great lessons from the SARS public health disaster and later creating a disease control and prevention programme under the direction of the Centers for Disease Control and Prevention (CDCP) [80], CN has been unable to stop the fast spread of COVID-19. It's important to think about this question. The present research on COVID-19 focuses on the genetic sequence, patient statistics, death rate, and pathological characteristics of the patient [81, 82], as well as COVID-19 [83-85]. This study makes use of social exclusion, social inclusion, general epidemiological research, response techniques (isolation), and clinical diagnosis. The adverse elements that caused the region's quick expansion and a considerable increase in the number of virus-infected individuals are lacking [86]. By examining big data, data that is readily accessible to the public, and other media sources, this study seeks to close this research gap by determining what, in CN's administrative systems and public health policies, is the main source of the issue. The integrated structure and practices of the COVID-19 disaster management system are evaluated in this study using building-institutional theories [87].

Political science, sociology, psychology, and management science are among the disciplines that are involved in disaster risk management [88]. In issue management, analysis techniques for system processes and resilient engineering are frequently used [89]. Rasmussen developed a social-technical catastrophic risk management system with three levels: the government, regulators and organisations, and the enterprise, using rigorous techniques from top to bottom. Additionally, they discuss the operating system's structure, objectives, difficulties, constraints, and pressures [18]. Based on robust engineering, he stated that a disaster response system requires four skills: (1) anticipating a catastrophic event; (2) monitoring its working condition to maintain control of its performance (during disturbances); (3) reacting where disruption is present; and (4) learning from the emergence of disorders [90, 91]. As a result, catastrophe management necessitates multiple research and teamwork to prepare for, handle, and recover from adversity. When dealing with a public health issue, five variables are typically addressed [92]: (1) information disclosure or control; (2) risk and hazard assessments; (3) disaster communication information channels and health education forums; (4) disaster risk management plan formulation and execution; and (5) general resource integration.

Finally, increased government investment in public health is essential. There is a major scarcity of public health personnel, as well as hospitals that lack public health services, according to CN's CDCP. As a result, the Chinese government should increase public health spending on expert professional training and improve the availability of medical resources. To improve training, more investment in relevant education is required. To utilize the resources available for HC, a contingency plan may be developed [93]. Local governments fund the project, which may be adopted in any city, at large infectious disease hospitals and general hospitals. In the event of an infectious disease, each hospital should have enough emergency rooms and medical facilities to assist patients [93]. Despite the significance of these and other quality care duties, obtaining information for these and other courses is not always easy. In mid-2020, the WHO issued a guideline titled *Protecting Critical Health Resources: A Practical Guide to the Context of COVID-19* [93], the majority of which is concerned with delivering quality care in the middle of an epidemic.

The WHO's ten-point approach for COVID-19 essential quality systems:

- Adapt governing and coordinating processes to allow for rapid reaction.
- Emphasize critical HC services and modify them as standards and limitations change.
- Improve the delivering services parameters and systems.
- Always maintain a safe and efficient patient flow.
- Rapidly improve the capabilities of the HC staff.
- Ensure that all required medications, equipment, and supplies are always on hand.
- Invest in public health while lowering entry barriers.
- Enhance initiatives to encourage proper usage of essential public services.
- Improve the administration of essential HC services.
- Utilize digital services to assist in the delivery of critical HC services.

This valuable list is not easily accessible. According to Staines and colleagues [94], the pandemic poses long-term difficulties to HC systems, and there may be a tendency to neglect the contribution quality and safety employees may make to aid efforts. This is especially true when caregivers must be retrained to deal with a growing number of infectious patients. According to Staines et al. [94], it was vital not to neglect patient safety and quality of care staff that had more to give but were underutilized or excluded. Their message was a plea to create technology that empowers and liberates people.

Overall, even in tough times when practically everything is meant to be focused on COVID-19 and everything else is regarded essential, we must not overlook the everyday care and quality of care offered to all patients, whether or not they are infected with the virus. Effective health systems require adaptability, suppleness, and reactivity, as well as the capacity to execute numerous jobs, or resilience [95]. Indeed, rehabilitating injuries and providing excellent care during times of violence is a critical responsibility if we are to follow the global health strategy of providing universal health care at a high enough level for everyone while enhancing continuous care, including in times of crisis. This study is supported by the International Society for Quality in HC, WHO and other significant international organisations. It's also a comprehensive aim that everyone involved in providing high-quality HC should aspire to.

3. Conclusion

The COVID-19 pandemic has highlighted the need for a better HC system in the United States (US). The current system has been deemed dysfunctional, as evidenced by the fact that the virus has been far more dangerous in the US than in other countries. Winston Churchill's quote, "a crisis should never be squandered", is a reminder that this crisis should be used as an opportunity to make changes to the HC system. The US HC system has been criticized for its lack of access to HC, high costs, and disparities in care. These issues have been exacerbated by the pandemic, as the US has had one of the highest death rates from COVID-19. This is in stark contrast to other countries such as AFGN, ALB, ALGR, AU, BR, CN, and FR, which have had much lower death rates. The US HC system has been unable to adequately respond to the pandemic due to its lack of resources and infrastructure. This has resulted in a lack of testing, inadequate contact tracing, and a shortage of medical supplies. These issues have been further compounded by the lack of a coordinated national response.

In order to address the health management crisis of COVID-19 in the US, there needs to be a comprehensive overhaul of the HC system. This should include increased access to HC, improved coordination between state and federal governments, and increased investment in public health infrastructure. Additionally, there needs to be an emphasis on preventive care, such as vaccinations and screenings, as well as increased access to mental health services. The US can learn from the successes of other countries in responding to the pandemic. For example, countries such as AU, CN, and FR have implemented comprehensive testing and contact tracing programs, as well as effective public health measures. These countries have also invested heavily in HC infrastructure and resources, which has enabled them to respond quickly and effectively to the pandemic. The COVID-19 pandemic has highlighted the need for a better HC system in the US. This crisis should be used as an opportunity to make changes to the HC system, in order to ensure that the US is better prepared for future health crises.

Conflict of interest

The authors declare that they have no conflict of interest.

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