

# Elaborating Prioritization in Healthcare amidst a Global COVID-19 Pandemic

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**Abstract:-** Healthcare is rife with trade-offs, but depending on one's location is in a pandemic's several stages, one's options it could be more or less limited. During the initial stages of COVID19, there was when ambiguity, Systems of health care were under more pressure and concentrated on a single "Flattening the curve" is a criterion. As COVID19 continued, the 1<sup>st</sup> wave's impact diminished, more options for distinguishing COVID and non-COVID patients became available. After that, as the 2<sup>nd</sup> wave soared once more, and decision-makers were in a frenzy. under more difficulty, even as greater understanding and additional information were established. Transitioning from epidemic to get back on track, decisions becomes critical, as There were no established rules for reverting to prior resource allocation practices. In fact, when specific techniques for prioritization founded on ethical and economic grounds are used, the possibility available is substantial.

**Keywords:-** COVID-19; Healthcare; Management; Prioritization; Global Pandemic.

## I. INTRODUCTION

Allocating restricted resources and setting priorities and has always been a challenge for healthcare decision-makers., both locally and globally[1]. Budget constraints force the inevitability of making decisions, usually on the periphery, on what should be funded and what should not be funded[2]. Prioritization is the term used to describe the process of making these decisions. After examining possibilities and weighing the Decision-makers are concerned about the relative worth of both clinical and non-clinical options entrusted with determining where resources should be allocated should be finest deployed.

During a pandemic, such decisions must be made quickly scrutinized even more closely because the need for emergency services skyrockets. Over the course of COVID-19, it was it is obvious to the general public that healthcare organizations were making trade-offs in terms of which patients would receive services and how They'd be treated quickly.[2]This, in and of itself, should not be surprising. Stated as previously, decision-making in healthcare is a worldwide phenomenon. This might be argued to be the *raison d'être* of healthcare executives. This reality is highlighted by the pandemic and its recovery.

Having said that, we would be the first to confess that there was less flexibility in making judgments during the COVID-19 pandemic, initially due to a lack of knowledge, in the second wave, knowledge about the virus, and finally, in the third wave, due to the virus's rapid spread. However,

looking beyond the current pandemic to recovery, increased attention to the decision-making process, particularly the evaluation of relative value and the trade-offs that must be made follow, may be given, in part due to the need to catch up on the backlog treatments.

The major goal of this brief review is to highlight some of the difficult challenges surrounding trade-offs, followed by an examination of pertinent information strategies. It can be used to create priorities and allocate resources used to manage recovery after a pandemic.

## II. TRADE-OFFS EVERYWHERE

There was a lot of uncertainty throughout the initial in the spring of 2020, there will be a COVID wave. It was unclear what the R value was (the average the number of individuals infected with the virus will pass it on to). There was also no agreement on the underlying issues. biological mechanisms, transmission patterns, the most effective treatment choices, or expected consequences. This state's decision-makers took a preventative approach, and numerous jurisdictions were put on lockdown. Hundreds of thousands of elective surgical operations are performed every year around the country. were cancelled, to begin with considerations of safety, freeing up capacity in the health system. As the first wave faded and additional information became available, other public health options might be made. Physical separation, minimizing travel, and mask wearing were all stressed as "choices" for individuals and communities. From the standpoint of the health-care system, there was also potential for more choice at times. During the summer and early fall, for example, of 2020, there may be a greater emphasis on repurposing capacity that would otherwise be freed up and devoting resources to non-COVID patients rather than "flattening the curve."

As part of the second round, arrived as well as the healthcare system was put under more strain, capacity issues arose once more, and decision-makers' ability to make decisions was hampered. However, because There was more to come information available during the second wave, decisions that are more sophisticated. When a decision is made based on evidence, it is said to be evidence-based using broad policy tools like lockdowns. Vaccines were also made to varying degrees of success in lowering symptoms, but for the most part, substantial levels of productivity (Longer-term proof of their transmission impact mitigation is still in use needed)[3]. This allowed decision-makers to tackle decision-making head-on and be specific about how limited resources should be dispersed. In doing so, one can critically consider the unintended repercussions at various stages of the epidemic, as these can inform future decision-making. Domestic abuse is on the rise, as is isolation, which

can contribute to mental health issues. issues, greater overdosage rates owing to illicit substance toxicity, and happiness in social situations concerns for youngsters unable to visit their friends, to name a few examples, should all be considered.

Almost every choice made in the health-care system is based on this principle. is based on the fundamental economic notion of opportunity cost. Because resources because funds are limited, only one group will be funded results in some benefit being lost by not putting money into another. Despite the claim that healthcare executives have the capacity to make decisions, this was limited When the economics and in the early days of the epidemic, health and non-COVID care went hand in hand limited[4]. Systems with more capacity built in proved to perform better, capacity on the other hand has to be considered. sourced from "somewhere" elsewhere[4]. Health-care systems have begun to plan for recovery and long-term viability. as our understanding of the disease has grown and effective vaccines have been created. Explicit questions about trade-offs should be addressed in the future. The good news is that priority-setting tools are readily available to help decision-makers navigate these frequently complicated and politically fraught seas.

### III.PRIORITY SETTING TOOLS

High-quality evidences have a place in this type of paradigm. High-quality evidence has a place in this type of paradigm, such as that found There are numerous chances for participation in health technology evaluations meaningful participation of the general public[5].Accountability for Reasonability (AR) and Program Budgeting and Marginal Analysis (PBMA) these have been two frameworks utilized. in tandem for many years to help decision makers choose the optimal way to spend constrained resources[6,7].

Multi-Criteria Decision Analysis can be used to assess the relative value of options as part of an explicit method to prioritization, allowing for limited resources, decision-makers must determine the benefit gain of competing choices[7].Clear and weighted criteria to demonstrate relative relevance, are a good method to reflect the views of diverse stakeholder groups in terms of healthcare management. Identifying those criteria can help inform decisions about who gets the limited resources, and what the costs and benefits are by providing a clear picture of the compromises and equitable implications[8,9].

Decision makers can establish not only what the quantitative trade-offs are, but also how resources should be distributed on an ongoing basis, using a prioritizing framework. There are no "set" outcomes from the use of these instruments, and it's very clear that different jurisdictions will reach different conclusions, based on population makeup, resource availability, and societal preferences[5,10]. In the literature on health policy and management, there are multiple examples of this strategy, including our own work with over 100 organizations.

A large metropolitan hospital in Ontario recently conducted a case study to alleviate some budgetary pressures while also optimizing existing spending by reallocating resources. This was done prior to the epidemic, but the challenges were similar to those that will face pandemic recovery, with the exception that the financial demands will be significantly greater due to the additional investment required. The PBMA procedure was followed exactly as stated. A multidisciplinary steering-committee was formed, decision-criteria were chosen, disinvestment and investment proposals were prepared and appraised, and judgments were made-based-on explicit examination of the proposals against-criteria. Access, equity, health gain, innovation, and client experience, to name a few, were among the twelve criteria specified for this procedure. In addition, the steering group used a formal rating tool while making resource distribution recommendations. The entire process took around 08 months, with decisions made as part of the annual budgeting process.

As health-care systems "recover their footing," after a pandemic, it's vital to be specific in the measurement because there will be large opportunity costs resource reallocation. Reallocations in the health-care system necessitates investment in continuous health of the general public Track-and-trace programs and vaccinations, improving Supply networks for personal protective equipment, key to handle endemic illnesses, capacity for vaccine production and health professional resources are required for COVID-19. These investments will have to be weighed against other factors. possible systemic disinvestments, such as lengthier elective surgical wait times. Every organization in the country will have to weigh in on the tradeoffs and determine whether or not certain reallocations are feasible. Long-term care is one sector that has been significantly impacted by the pandemic. Within their restricted finances, these institutions will have to weigh trade-offs. The approach and this article's recommendations can be put to use. to lead a management team through the process of reallocation while keeping important factors in mind. criteria including Patient safety, caregiver safety, patient comfort, and well-being are all factors to consider and care access, to mention a few. In this area having such a structure in place can lead to more responsibility.

The level of public participation in determining healthcare priorities is a significant corollary. There is strong evidence that a greater range of stakeholders can be considered while making healthcare decisions [11,12]. In fact, it's possible that public consultation is even more important during the recovery phase of a pandemic. Furthermore, based on this concept of public engagement, values for future pandemic preparedness might be determined. How important should the potential of the next pandemic be in comparison to non-pandemic purposes that are short-term or even longer-term? In this vein, considering portfolio investment options may well aid in choosing how much to set aside in if there be any future pandemics[13]. The public has a high level of having faith in the health-care system is important, and it is critical that this trust be established, maintained through meaningful and frequent public participation.

Despite the fact that the focus here is on using an evidence-based method to define priorities in healthcare, the repercussions of public policy, including constraints imposed on individuals and groups of people, extend far beyond healthcare and throughout the "whole of government." The most evident of these implications is the economic impact, as localGDP and abroad has decreased since the commencement of the COVID-19 pandemic. Workers who have been laid off as a result of COVID-19 are eligible for income assistance. limits, financing for sick leave for persons who must self-isolate, and child care costs for parents during school closures are all examples of economic trade-offs. As a result, we feel that the mindset that supports the proposed approach to priority setting is likewise sound. very useful in determining cross-sectoral implications. Research from the United Kingdom has recently been published demonstrates to how this way of thinking help you make better decisions[14].

#### IV.CONCLUSION

In conclusion, we are strong supporters of making use of explicit, evidence-based strategies to determine priorities and allocate resources in the field of healthcare. Others in the healthcare management business have taken a similar stance, more transparency in decision-making is being called for[15].Despite the fact that such technologies are always useful, their use During a pandemic, it's possible to be severely constrained due to the high Decision-making constraints. However, as we proceed Such technologies are becoming increasingly important in the aftermath of a pandemic. increasingly important because the variety of options is expanded and there is no need to return to previous patterns of resource allocation. We advise government agencies to take these tools seriously because they can help identify the importance of trade-offs and make the best use of a moment when there are few resources important decisions must be made.

#### REFERENCES

- [1.] Kapiriri L, Razavi D. How have systematic priority setting approaches influenced policy making? A synthesis of the current literature. *Health Policy*. 2017;121(9):937-946.
- [2.] Mitton C, Donaldson C. *Priority setting toolkit: guide to the use of economics in healthcare decision making*. John Wiley & Sons; 2009.
- [3.] Medicine TLR. Realising the potential of SARS-CoV-2 vaccines—a long shot? *The Lancet Respiratory Medicine*. 2021;9(2):117.
- [4.] Donaldson C, Mitton C. Coronavirus: where has all the health economics gone? *International Journal of Health Policy and Management*. 2020;9(11):466.
- [5.] Mitton C, Dionne F, Donaldson C. Managing healthcare budgets in times of austerity: the role of program budgeting and marginal analysis. *Applied health economics and health policy*. 2014;12(2):95-102.
- [6.] Gibson J, Mitton C, Martin D, et al. Ethics and economics: does programme budgeting and marginal analysis contribute to fair priority setting? *Journal of Health Services Research & Policy*. 2006;11(1):32-37.
- [7.] Baltussen R, Marsh K, Thokala P, et al. Multicriteria decision analysis to support health technology assessment agencies: benefits, limitations, and the way forward. *Value in Health*. 2019;22(11):1283-1288.
- [8.] Frolic A, Kata A, Kraus P. Development of a critical care triage protocol for pandemic influenza: integrating ethics, evidence and effectiveness. *Healthc Q*. 2009;12(4):54-62.
- [9.] Williams I, Essue B, Nouvet E, et al. Priority setting during the COVID-19 pandemic: going beyond vaccines. *BMJ Global Health*. 2021;6(1):e004686.
- [10.] Smith N, Mitton C, Hall W, et al. High performance in healthcare priority setting and resource allocation: A literature-and case study-based framework in the Canadian context. *Social science & medicine*. 2016;162:185-192.
- [11.] McKie J, Shrimpton B, Hurworth R, et al. Who should be involved in health care decision making? A qualitative study. *Health Care Analysis*. 2008;16(2):114-126.
- [12.] Litva A, Coast J, Donovan J, et al. 'The public is too subjective': public involvement at different levels of health-care decision making. *Social Science & Medicine*. 2002;54(12):1825-1837.
- [13.] Shiell A, Hawe P, Perry R, et al. How health managers think about risk and the implications for portfolio theory in health systems. *Health, Risk & Society*. 2009;11(1):71-85.
- [14.] Donaldson C, Mitton C. Health economics and emergence from COVID-19 lockdown: the great big marginal analysis. *Health Economics, Policy and Law*. 2022;17(2):227-231.
- [15.] Menon DU, Belcher HM. COVID-19 pandemic health disparities and pediatric health care—The promise of telehealth. *JAMA pediatrics*. 2021;175(4):345-346.