WADEM Primary Healthcare Response

July 2020 Issue 1

Welcome

Welcome to the inaugural WADEM Primary Care SIG newsletter.

The Primary Care SIG has been created to connect WADEM members with an interest and expertise in primary healthcare during disasters at a time when there is poor integration in disaster management systems. This SIG is open to all those who are interested in improving the engagement and integration of primary care practitioners in disaster management.

Healthcare systems consist of primary care in the community, secondary care from specialists, and tertiary care in hospitals.[1] Primary healthcare promotes a broad holistic view of person-centred, rather than disease-focused, healthcare.[2] It improves equity of healthcare access, and emphasizes prevention alongside cure. [2]

Evidence shows strong primary health care creates a robust healthcare system: which saves lives; decreases mortality from heart disease, cancer, or stroke; decreases infant mortality; and increases life expectancy.[3, 4] Despite this evidence, very few countries include primary care in disaster healthcare systems. If it is included, roles and integration tend to be *ad hoc* and variable for each disaster. In a disaster aftermath, lack of access to primary care and the services they provide is a leading cause of mortality.

In 2020, a vast collective world experience of disaster healthcare now exists, accumulated from the increasingly frequent disasters occurring around the world. We have increasing scientific evidence of the epidemiological patterns and impact of mental and physical health consequences because of disasters, demonstrating a high burden of healthcare need over the immediate, short-term, and longer term. Emerging evidence shows effects on social determinants of health within communities, with some documentation of changes in chronobiology of health conditions following disasters. Following the 2019/2020 catastrophic summer bushfires in Australia, growing public expectation of less disruption to healthcare in local communities affected by disasters is creating an opportunity to review how we 'do' disaster healthcare.

It is time to consolidate and translate this extensive information and experience into creating a better, stronger, disaster healthcare system. We need to refresh the way we approach disaster healthcare. We need to change our focus from the acute visible injuries in the immediate days of the response to a holistic person-centred approach coordinating physical, mental, and social effects. We need to consider a broader time frame from disaster risk reduction well before the event, to primary and secondary prevention in the weeks and months and years after the event. This involves primary healthcare becoming central, rather than peripheral, to disaster healthcare.

Primary care clinicians, local family doctors, pharmacists, nurses, physiotherapists, psychologists, occupational therapists, and other allied health professionals, have a responsibility to be prepared when disasters strike their local community, to understand how they can contribute in an effective and useful manner alongside other responders, in order to reduce gaps and duplication in the care of those affected by disasters.

The World Association for Disaster and Emergency Medicine Primary Care Special Interest Group would like to provide a platform to support preparedness for disasters across all primary care groups. We invite you to join us.

- Dr Penny Burns, Co-Chair of the Primary Care SIG of WADEM

References

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0021/714243/5.-Health-system.pdf

[2]https://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/starfield/summary%20PHC%20NOW%20MORE%20THAN%20EVER.pdf

[3]The relationship between primary care and life chances. *Shi L J Health Care Poor Underserved. 1992 Fall; 3(2):321-35.*

[4] Primary care, specialty care, and life chances. *Shi L Int J Health Serv. 1994; 24(3):431-58.*

Australian Bushfires highlight need for Primary Care in Evacuation Centers

Almost every year bushfires ignite the Australian bushland. However, the recent Australian summer of 2019-20 was the hottest and driest year on record and resulted in some of the most devastating bushfires in Australia.

Fires ravaged over 17 million hectares, killing an estimated one billion native animals. Nearly 2,500 homes were destroyed, 33 people lost their lives, including nine fire-fighters, and 444 deaths were considered attributable to bushfire smoke haze. Communities including the major cities of Sydney and Canberra were covered in smoke for weeks at a time. Families on beachside holidays were cut off by fires and smoke, trapped on beaches or on gridlocked roads trying to get home. Support was received internationally from many nations including New Zealand, Canada, Singapore, the USA, Fiji, Papua New Guinea, Indonesia, and France.

As communities were threatened by fire and smoke, many local general practitioners (GPs) and pharmacists were working to assist, providing scripts and medications, visiting evacuation centres and setting up their usual clinics to provide healthcare at a time when they themselves were dealing with their own threats to home and family.

The role of primary care in evacuation centres in Australia is still being defined and established. There are mixed experiences of primary care providers in evacuation centres in Australia. Some are not included or allowed, while others contribute in an *ad-hoc* nature as their roles have not been officially established. In some regions, local GPs are included in the planning and considered valued members of the evacuation centre team. They are trained and supported members of the evacuation team with their own equipment, defined area and roles, and back up support from their local Primary Health Network (PHN) if required. It is important these discussions and collaboration are outlined during non-disaster times, so all responders have the same understanding and expectations of primary care.

Dr Louise McDonnell, a GP who experienced previous Australian bushfire disasters, and subsequently contributed to the establishment of formal roles for GPs in evacuation centres in her PHN region recounted her experience during these catastrophic 2019-20 summer fires and how she contributed to the healthcare in the evacuation centre. She found herself at the Bega evacuation centre, on the far south coast of NSW, where she presented to the registration desk at 6.30 am, with a script pad in hand, offering her services. Realising she needed basic supplies including salbutamol and spacers for asthma management, saline for removal of ash under eyelids, and betadine for minor wounds, she contacted a local GP. The local GPs had opened their surgeries for extended hours, to off load the local hospital which was dealing with several major burns. Dr McDonnell also contacted the local pharmacists to document their opening hours on a small whiteboard in the evacuation centre.

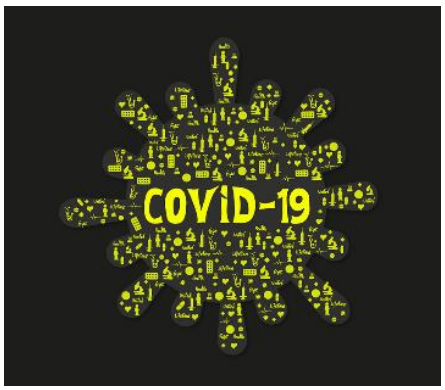
Many evacuees needed basic advice and scripts, along with attendance to minor injuries. Many presented with mild symptoms of difficulty breathing, sore throats, and eye irritation due to the smoke. Dr McDonnell stated that

"Many people just needed information. Having a GP on site gave patients an immediate feeling of confidence and reassurance in an extremely frightening situation. A young pregnant couple were concerned about the effect of smoke on their unborn baby. Others had more complex needs like the 21 year old incontinent man with severe intellectual disability and cerebral palsy whose mother had left home rapidly without adult nappies" They needed additional support to change and safely dispose of nappies in a large open evacuation centre. The mother was also the local wildlife rescue worker and along with her disabled son had evacuated with 3 baby wombats and a cat. The baby wombats needed 4 hourly bottle feeds and this task was a great diversion to the mayhem and orange smoke filled skies outside.

Scripts were in high demand, for the many who had rapidly evacuated from their homes. There were several requests for opiate scripts, and I obliged with limited supplies, now was not the time to address opiate addiction.

Psychological first aid was in high demand, particularly those returning from having narrowly escaped death, from often unsuccessful attempts to save their homes."

It doesn't stop at COVID-19…



"COVID-19 does not make your jurisdiction immune to other disasters"

For the last few months our news, social media, and workplaces have been bombarded with changing information about the COVID-19 pandemic.

The pandemic has seen lockdowns previously unseen in cities all over the world as we fight to contain the virus. Primary care providers have been put in the spotlight during this pandemic as they tackle continuing to provide ongoing patient care whilst tackling COVID-19 challenges (e.g. drug shortages, staff shortages, PPE concerns, selfcare/burnout, etc.). It is encouraging to see the primary healthcare sector get recognition for their contribution during the pandemic.

But, while success with virus containment differs from country to country, there is one truth that remains the same no matter where you live. **COVID-19 does not make your jurisdiction immune to other disasters.**

Severe Tropical Cyclone Harold devastated Solomon Islands, Vanuatu, Fiji, and Tonga. This occurring at the same time as COVID-19 has meant delays in assessment and recovery efforts in the communities affected. Humanitarian supplies that reached affected areas were under strict quarantine rules and could only be accessed three days after arriving.

For Tropical Cyclone Harold, the usual media coverage, and fundraising efforts to assist affected communities was oddly absent from our televisions and newsfeeds in light of COVID-19.

For an area with a developing health system, the double disaster of a pandemic and natural disaster is devastating.

Given that it is unclear when lockdowns and restrictions associated with COVID-19 are expected to end, it is important that while we are preparing and responding to this pandemic that we keep in mind other disasters that might be likely to impact our work during this time.

Mission, Vision and Objectives

About the Primary Healthcare Response SIG

The Primary Care SIG was formed to bring together WADEM members with an interest and expertise in Primary Care during disasters. This SIG is open to all researchers, educators, health practitioners, and management personnel who have an interest in improving the use of and engagement with primary care practitioners during a disaster.

Mission:

To promote local, interdisciplinary integration of primary healthcare into disaster management and to advocate for the primary health needs of the community throughout the different disaster management stages – prevention, preparedness, response, and recovery.

Vision:

Our vision is for future disaster management to better integrate primary care health professionals and for them to work collaboratively together with disaster health professionals, local hospitals, governments, and disaster management sectors to ensure the best health outcomes for patients in all stages of the disaster management cycle.

Objectives:

- Promote consideration and inclusion of **local** primary care health professionals and organizations as integral contributors to disaster management systems
- Develop disaster **health co-operation** globally amongst and between *Primary Care Response SIG* members and the broader WADEM community
- Coordinate linkage and collaboration **between** primary care disaster professionals **and** local hospitals, government, and disaster management sectors to **promote** a holistic approach to disaster PPRR
- Network and integrate *Primary Care Response SIG* into WADEM activities and programs
- Assist members with forming connections with other primary care professionals, local hospitals, government, and disaster management sectors.

Healthcare is the heart of the community and it needs to be prepared to keep beating during emergencies and disasters

SIG Updates

This special interest group was developed to provide a place for community healthcare in disaster prevention, preparedness, response, and recovery.
The idea for this special interest group was discussed at the WADEM Congress in Brisbane 2019.

We wanted a place that allowed for discussion and fostered interest and research for disaster primary healthcare.

We invite you to be a part of this SIG and to contribute with your unique expertise.

Together, we can increase the awareness and recognition of the primary healthcare sector within disaster management.

To join the Primary Care SIG, please complete this form.

Call For Material

Material is requested for any of the sections listed, or under a new category, if it is appropriate. Personal experiences, case and research reports are especially welcome, and we ask that these are limited to no more than 1,000 words. The subject matter can be aspects of a disaster or response that is unusual because of its type, location, or effects. Material is welcome from WADEM members and even non-members internationally.

Any suggestions regarding material for content, or suggestions to improve this Newsletter are welcome. Please forward contributions to Dr Libby McCourt – libby.m.mccourt@gmail.com

Feedback

Thank you for your interest in our special interest group, if you have any suggestions or questions please contact us as below.

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Feedback to Dr Libby McCourt – *libby.m.mccourt@gmail.com*

Disclaimer

The comments, opinions, and material in this Newsletter are those of the respective authors and not necessarily those of WADEM or the WADEM Primary Healthcare Response SIG.

For more information go to the WADEM webpage for the Primary Healthcare Response Special Interest Group