



Newsletter Objectives

Sustaining change by keeping disaster management on the agenda

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Keeping Disaster Management on the Agenda

The last few years, we have been bombarded with media coverage of disasters and pandemics. In Australia, there wasn't a break between our 2019-2020 devastating bushfire season and the start of COVID-19. It seems that everyone is growing more and more fatigued with disasters and COVID, but we need to make sure disaster management stays on the agenda.

I recall several years ago when I was telling a colleague about my newly started PhD on the topic of the disaster preparedness of the pharmacy workforce. *'It's interesting'*, they replied *'but not really relevant to practice'*. Several years later I was submitting grant applications which would help health systems respond to disasters. *'Not relevant to us'*, was some of the feedback received at the time. However, several months later and in the wake of the devastating bushfire crisis in Australia and the build-up of the COVID-19 pandemic I received further verbal feedback from a grant coordinator *'if we'd have known this would happen, this project would have been perfect'*.

That is the thing with disasters, you don't often see them coming. We can anticipate when we might be at a higher risk of some disasters (for example during typhoon or bushfire season), however we don't know exactly when we might be affected. That is why the health system, health facilities, and health professionals must be prepared all the time.

Disasters undermine our health system and the health of the community. They stop progress on innovative work and projects, and they speed up development of others to act as a 'knee jerk' response to stimuli. Knee-jerk funding of disaster projects or research when disasters are topical is not the best way to allocate resources or prepare a workforce. Because of the rapid way they are implemented, these works can be poorly considered, not address the actual needs, and can involve personnel who were 'just there' not necessarily the person with the right expertise or experience required to deliver outcomes.

More troubling still is in the aftermath of a disaster

our attention and interest in the work wanes, the work loses momentum, and ultimately fails to gain interest or support from key decision makers as more pressing everyday issues arise. Funding and resources might be allocated to something that has become more topical than the disaster we just saw and previous work falls to the wayside.

We need to be allocating funds, projects, and research resources to disasters regularly, not just during an event, and should incorporate disaster management into everyday practice. The more ready we are for disasters, the better we will be able to respond when they happen.

Dr Elizabeth McCourt

Secretariat of the WADEM Primary Care SIG

Preparedness is Key

While none of us are clairvoyant, the COVID-19 pandemic should not have taken us by surprise. Since 2018, the World Health Organization (WHO) has listed 'Disease X' among the potential epidemics from potential pathogens. WHO states that Disease X represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease. So, while we couldn't predict the specifics of the COVID-19 pandemic, we should have been prepared for an unknown pandemic or epidemic, especially after the recent SARS, Ebola, and Zika outbreaks.

More recently, looking at the major flooding events happening in Australia. Flooding is a known hazard and with the increased rain forecasted with the La Niña weather event, perhaps could have been anticipated. So, what preparation steps did we take as a society and community to prepare?

The challenge lies in the competition for our time and things that are not immediately present before us are often overlooked or not prioritized in our busy schedules. So, preparing or planning for

an emergency or disaster is not completed until we are thrust into responding and recovering from a disaster that has impacted our community and patients. But this does a disservice to our patients and society and does not fulfill our professional obligations. We need to build resilient workforces and communities to withstand the impacts from small scale and large-scale events. Ultimately, because it is expected of us that we will be prepared and capable of helping others to respond to a crisis.

We don't know what, when, or how the next crisis will impact us but we can be prepared and develop a resilient primary care workforce that is capable and prepared to meet any known or unknown disaster or emergency event.

Dr Kaitlyn Watson
Co-chair of the WADEM Primary Care SIG

“Without proper preparedness and planning, the response will be inappropriate..”

Committee members

Co-chairs

Penny Burns

Kaitlyn Watson

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Elizabeth McCourt



As health care providers on the north coast of New South Wales Australia struggled to manage acute healthcare needs during an unprecedented flood, the Bureau of Meteorology warned of days of heavy rain heading towards them, and of a high risk of further flooding, with the ground saturated, rivers and dams full. The town had already flooded, with businesses built in areas unable to qualify for insurance, now suffering huge financial and viability issues. Temporary rental premises were unobtainable. This town **was** prepared for floods. Floods are regular incursions into the lives of locals, occurring annually. In the past, individuals and communities have pulled together and managed. However, this time, thousands of homes have been deemed uninhabitable, and buildings housing General Practices that had previously survived the flooding over the last one hundred years, have experienced a new level of destruction. Temporary residential accommodation is unavailable, and residents are returning to flood-damaged homes. This event highlights gaps in our current planning, particularly the poor inclusion of the primary level of healthcare.

Unfortunately, “disaster”, a word previously describing a rare event has now become part of Australian vernacular as several decades of disasters have been rolled into several years. The incessant unremitting occurrence of recent disaster events arrived with a prolonged drought across vast stretches of inland Australia, then the ‘unprecedented’ 2019/2020 Black Summer bushfires along the eastern coast of Australia burning for months and layering communities and cities with thick

Here comes another disaster... more deadly, more damaging, the worst yet...

smoke particulate matter. Then the SARS-CoV-2 pandemic still present today. Within these a record heatwave, a violent hailstorm, and various floods, landslides, and storms have all occurred until the arrival of the current extreme east coast of Australia flooding resulting in one of the largest evacuations in Australian history since Cyclone Tracey hit Darwin in 1974.

Despite the increasing awareness of the risk of disasters, this does not readily translate into planning and preparedness for future events. The best time for promoting change and improving disaster healthcare systems is when the memory of the disaster and its risk is high. During the Response phase this is usually impossible due to the paucity of available resources and capacity to actually manage the event. If however we wait as we usually do, until the community has recovered and a sense of safety has been restored, the interest in change is significantly diminished particularly amongst directly ‘unaffected’ public, authorities, and media. How do we accommodate this?

Perhaps one solution is to overlap preparedness with recovery. The standard four phases of the PPRR framework of disaster planning Prevention-Preparedness-Response-Recovery are useful but create a rigidity to our thinking and strategies in each phase. Greater flexibility in mixing and overlapping of strategies through different time phases may improve the uptake of planning and readiness for the next event. Recovery is facilitated by agency and useful activities. This may create opportunities to create

plans for future events amongst highly motivated engaged local groups.

Choosing activities that are discrete, clearly defined and achievable might improve and assist the recovery through providing this sense of agency, and through providing tangible achievements for communities and individuals who have felt powerless and threatened. One example of these are just-in-time resources. In disasters just-in-time resources are developed before any hazard and are adjusted for context with a few changes when the disaster strikes. All the hard work and formatting has been done beforehand with clear thinking and an ability to focus on just the task at hand. It should be possible to plan to plan in recovery. By undertaking the planning in advance, while the broader engagement is still high, it may be easier to define the need, clearly articulate the change proposed and provide the wording and the detail so that any policy or planning officers are provided with highly relevant, ready-to-go, easy to understand and implement resources that can support strategy for changes to planning and preparedness activities at a time when motivation and public engagement are greatest.

Planning and Preparedness should begin in Recovery.

Dr Penny Burns

Co-chair of the WADEM Primary Care SIG



How you can get involved

We have a number of objectives that we wish to achieve in our section and underpin this with an operational plan. We would like to gain your support and input in achievement of these, and furthermore, would like to know how we can assist you in your endeavors.

To express your interest to join the Primary Care SIG, please complete this Google Form ([click here](#) to access the form)

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

Feedback

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

Material is welcome for any of the sections listed in the Newsletter, or under a new category, if that is appropriate. Personal experiences, case and research reports are especially welcome; material is welcome from WADEM members and even non-members internationally.

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](#)
