

Emergency Management - Role of Public Health



Dr John A Carnie
Chief Health Officer

Presentation to Aged Care Quality Improvement Seminar: Expect the Unexpected!
Emergency Planning and Management in Residential Aged Care, 15 July 2009

DHS & Emergency Management

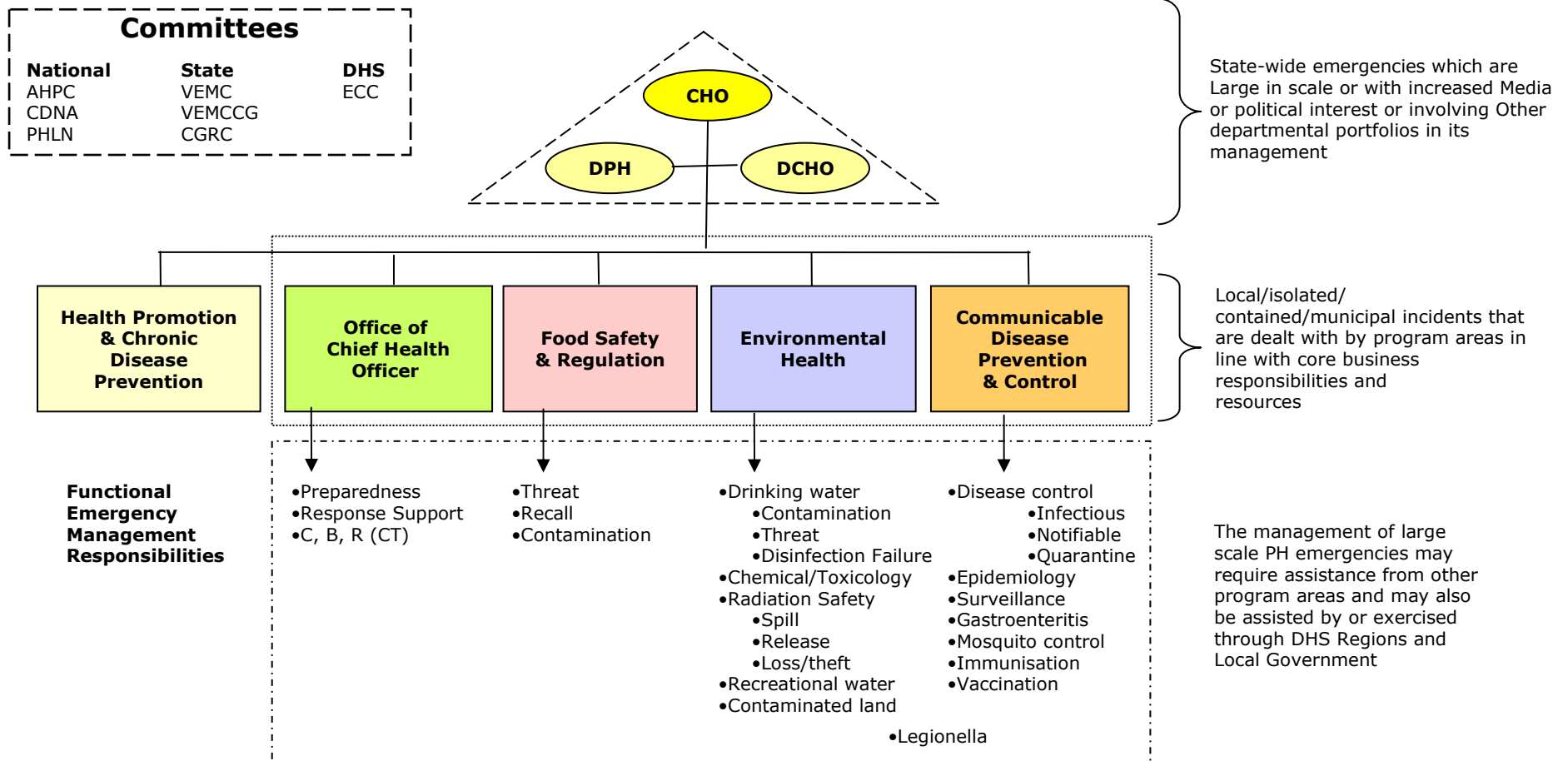
Under the existing State arrangements DHS has responsibility for:

- Public Health Emergency Response
- Pre-hospital Medical Response (State Health Emergency Response Plan, SHERP – i.e. mass casualty incidents)
- Community Support & Recovery (Coordination)

Also has a portfolio interest in ensuring:

- Hospitals Emergency Management preparedness
- DHS State Level Emergency Management Coordination

Public Health – Structural Responsibilities



Legislation

- *Health Act 1958* to be replaced by new *Public Health and Wellbeing Act 2008* on 1 January 2010
- Aspects of this legislation already in force
- *Health (Infectious Diseases) Regulations 2001*
 - require medical practitioners and laboratories to notify certain communicable diseases
- *Health (Immunisation) Regulations 2001*
 - require school entry immunisation certificate

Public Health Emergency Response

Role/functions vested in Chief Health Officer

Aim is to protect affected and surrounding population from health risks generated naturally or by disaster, both immediate and long term...

- Incident Controller for
 - Infectious/biological outbreaks
 - radiological incidents
 - water contamination
 - food contamination
- Support agency for
 - chemical incidents (i.e. effects on human health and safety)
 - Any threat with potential public health implications



Health hit by smoke

By MICK HIGGINS

MORE than 70 per cent of Albany people who responded to a health survey at the height of the bushfire crisis experienced problems as a result of the smoke.

The survey, carried out by the Centre for Public Health, involved 200 people selected randomly.

Of those who had health problems, the most common complaints were eye irritation (55 per cent), coughing (31 per cent), throat irritation (30 per cent), shortness of breath (24 per cent), and headaches (18 per cent).

“Thirty-five people surveyed experienced asthma associated with the bushfire smoke,” Mr Kolbe said.

He said 7.5 per cent of people sought medical attention for symptoms caused by smoke pollution.

“We did look at hospital admissions as well and the data that we have shows that emergency department presentations for asthma were up 23 per cent,” he said.

“They were mostly not acute asthma attacks but people who were known to have asthma but their conditions were made worse by the bushfire smoke.”

The survey also asked people whether they had heard health messages during the days when smoke was thickest.

“Seventy-six per cent of people interviewed can recall hearing the health messages and of those, 55 per cent changed their daily activities to avoid the smoke,” Mr Kolbe said.

A further 103 changed their daily activities because of their concerns about the smoke.

“Overall the smoke resulted in a change of daily activities for 48 per cent of people interviewed.”

Mr Kolbe said on two occasions during days of heavy smoke he wore a mask while outdoors.

He said the effects of smoke on health were not well known.

“There are small amounts of carcinogenic material in bushfire smoke and while we don’t know what the long-term cancer risk is it is thought to be smaller than the risks associated with exposure to vehicle emissions, he said.

Mr Kolbe said the survey results would be more closely examined to see whether there were connections between the effects of the smoke on pre-existing medical conditions.

A complete report will be released in June.

Mr Kolbe said he was pleased with the level of co-operation with the

Common complaints	
Eye irritation	55%
Coughing	31%
Throat irritation	30%
Shortness of breath	24%
Headaches	18%
Asthma	9%

Source: Centre for Public Health



Public Health Emergency Response

Activities:

- Threat assessment with Emergency Services
 - Threat control/management protocols
 - Food and water contamination
- Surveillance/Case management – infectious diseases
- Incident response for Biological & Radiological issues into the field
- Advice to medical/hospital community
- Public 'risk' communication
- Long term follow up

Residential Aged Care Settings

The Residential Aged Care Sector faces a number of potential challenges with public health implications that may create or escalate to emergencies

These include:

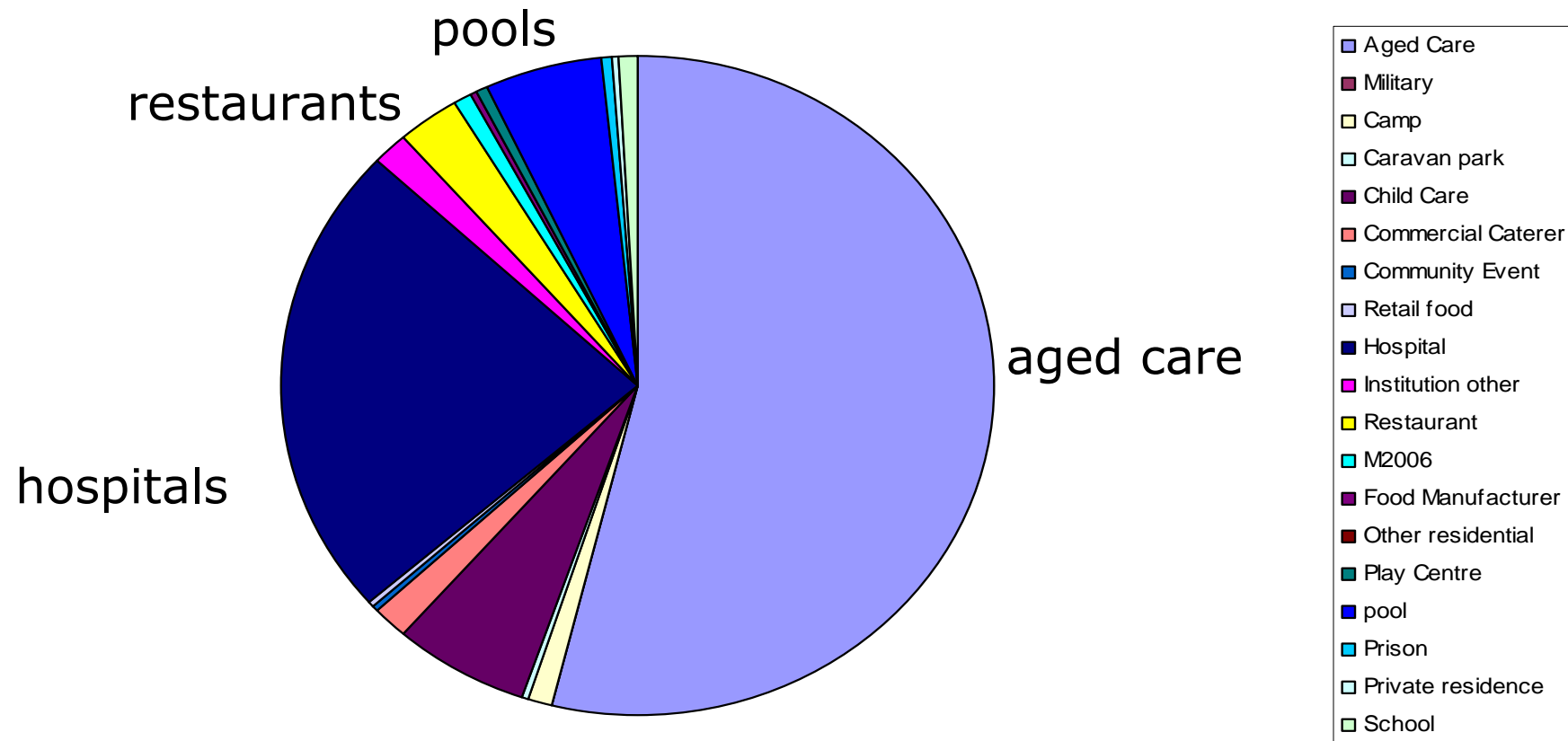
- Gastroenteritis Outbreaks
- Respiratory Outbreaks
- Heatwave
- Business Continuity during natural events i.e. bushfire, flood, power loss

Gastroenteritis

- Legislation requires reporting
- Viral vs. Bacterial - requires investigation
- Food or water safety – is this a contributor?
- Hygiene
- Infection control – isolation, exclusion
- Cleaning
- Manage by delegation through Region/Local Government
- Guidelines - currently under review, will not change substantially but will be clearer and more explicit
 - http://www.health.vic.gov.au/ideas/diseases/gas_ill_index

Outbreak settings (2006)

Outbreaks by setting



Public Health Role

- Prevent further transmission of illness
- Provide information which can be used to control outbreak
- Prevent similar occurrences in the future
- Help identify populations at risk for a disease
- Learn more about the disease including the impact of control measures

Respiratory Outbreaks

- Infectious causes i.e. influenza, other viral
- Hygiene
- Infection control
- Manage by delegation through Region/Local Government
- Commonwealth Guidance
 - <http://www.health.gov.au/internet/main/publishing.nsf/Content/icg-guidelines-index.htm>

Heatwave

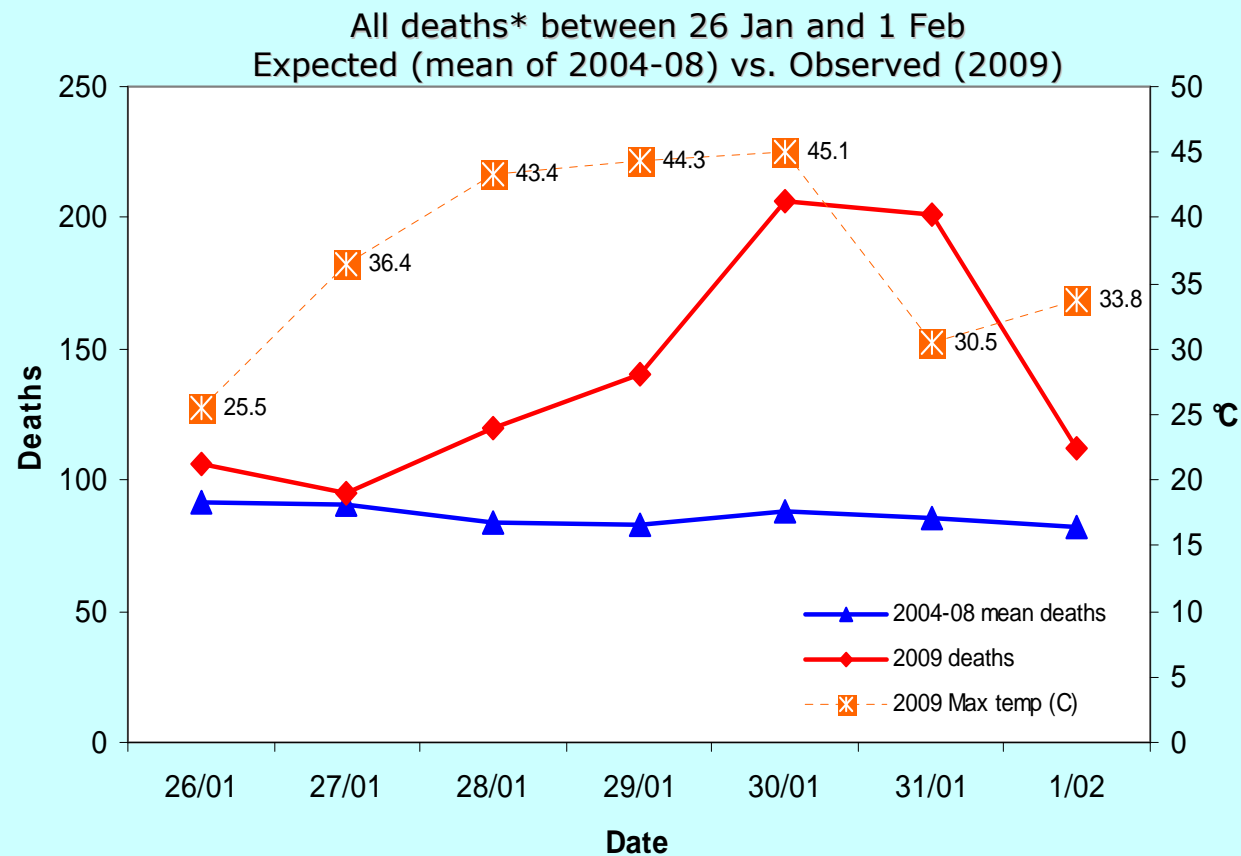
- May be experienced more often (Climate Change)
- Associated with excess morbidity and mortality in aged/vulnerable
 - Reduced ability to physiologically deal with heat
 - Fluid intake requirements
 - Preventable (?)
- Impact on infrastructure
- Concurrent events i.e. bushfire, windstorms

Heatwave Morbidity

During heatwave conditions late January 2009 there was a 25% increase in total Ambulance presentations in Melbourne, with a significant increase in heat-related conditions and cardiac arrests.

- 514 attendances for heat stress and dehydration compared to 15 for the same period in 2008
- Sixty percent of the heat related cases were in those 75 years of age or older.
- 192 attendances for cardiac arrest (from all causes) compared to 69 for the same period in 2008.

Heatwave Mortality



*Deaths data from BDM and reports to SCO

Total all cause mortality is 374 excess deaths (above expected)

Planning

- Pilot projects with councils to develop heatwave plans
- Focus on vulnerable in communities
- Heatwave planning guidance
 - <http://www.health.vic.gov.au/environment/climate/heatwave.htm>

Normal business

- All Hazards, all agencies
- Wherever possible emergency management should be an extension of existing processes within organisations
- Providers maintain responsibility for those in their care
- Scale is the issue

Further assistance

Communicable Disease Prevention & Control Unit

www.health.vic.gov.au/ideas

**Phone: 9096 5354 or
1300 651 160 (24 hours)**

Environmental Health Unit

Phone: 1300 761 874