Royal Australasian
College of Surgeons

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Dear Commissioners,

**Re: SUPPLEMENTARY SUBMISSION TO THE ROYAL COMMISSION INTO NATURAL DISASTER ARRANGEMENTS**

Thank you once again for the opportunity to provide feedback to this review. In preparing this submission, we request that it be read in conjunction with the initial response that we provided to this Commission on 28 April 2020.

## RESPONSE TO QUESTIONS RAISED IN THE ISSUES PAPER

**Are the current national health coordination arrangements appropriate to respond to natural disasters in Australia? If not, how should they be improved?**

Please refer to the following statement in our initial submission:

> *Surgeons have demonstrated their capacity to work collaboratively. Examples are the Bali bombing referred to above as well as the New Zealand Whakaari/White Island volcano disaster where Australian and New Zealand Surgeons of the Australian and New Zealand Burns Association (ANZBA) worked collaboratively together. Now with the COVID 19 pandemic, surgeons via the Royal Australasian College of Surgeons and Specialty Societies and Associations have rapidly adapted in preparing for treating COVID 19 patients (guidelines for treatment/PPE, elective surgery prioritization, training, equipment, skills). The collaborative network with all Specialist Colleges has assisted this. However, as was raised in the Letters Patent establishing this Royal Commission, what would support this collaboration is "an overall nationally consistent accountability and reporting framework with national standards."*

**Should primary care providers and primary health networks be better integrated in natural disaster preparedness, response, and recovery? If so, how should this be done?**

RACS supports calls by the Royal Australian College of General Practitioners (RACGP) and other organisations representing primary health care providers, that they be better integrated in natural disaster preparedness, response, and recovery. We defer to their expertise on how this can best be achieved.

**Should a standard approach to reporting and categorising air quality across Australia be implemented, and if so, how?**

According to the World Health Organization ambient air pollution is a major environmental risk to health. The WHO states that the lower the levels of air pollution the better the cardiovascular and respiratory health of the population will be both long and short term.[1]

While the categorisation of air quality falls outside of RACS' direct areas of expertise, given the risks identified, it would seem logical from a public communications perspective, that a consistent national approach is adopted.

**What should be the priority areas of research concerning the physical and mental health impacts of natural disasters?**

*Physical health*

In Australia we know that surgical outcomes are consistently poorer for smokers than non-smokers, with patients who smoke experiencing longer recovery times, increased risk of wound infection, and significantly increased risk for myocardial infarction and stroke. Smokers also have a higher post-surgery mortality rate than non-smokers. [2] Our understanding of these risks has allowed governments to develop strategies aimed at reducing the smoking rates amongst the general population and relieving the pressures this place upon on our health systems.

It is imperative that we develop a similar understanding of the long-term risks associated with bushfire smoke inhalation. A rigorous epidemiological analysis will allow us to predict future service demand and resourcing requirements, as well as influence education and awareness campaigns aimed at educating the public on measures and strategies (if any) that they can take to reduce risk.

In our initial submission the College made the following statement:

> *One response to the maldistribution of surgical services has been to encourage the use of video telecommunication in rural and regional areas. However, last summer there were numerous reports of telecommunications infrastructure being damaged and becoming inactive due to the fires. With climate change and the bushfire season predicted to be more frequent and longer, infrastructure needs to be made more robust e.g. NBN, satellite to allow highly specialized urban surgeons to communicate with local rural service at the injury scene.*

The expansion of telehealth services across Australia as a strategic response to the COVID-19 pandemic has emphasised the importance of ongoing investment into and maintenance of our infrastructure. It also presents an opportunity to analyse the use of telehealth during the pandemic, to guide how we can most effectively integrate telehealth into future service delivery models. It is important that this research considers both the broader impacts of telehealth on our health system, as well as the benefits and limitations of the technology in the specific context of natural disaster situations.

*Mental Health*

psychiatrists report that the incidence of post-traumatic stress disorder is usually greatly underreported in natural disaster situations.[3] RACS encourages that research and funding into the long-term mental health impacts of natural disaster victims be prioritised. This includes the impacts on first respondents and medical professionals.

**How should public health information about bushfire smoke be improved?**

The 2019/2020 bushfire season demonstrated the ability of bushfire smoke to travel vast distances well beyond its origins. As such, many residents who may have previously not considered themselves as living in areas prone to the risks associated with bushfires, became increasingly reliant on the media and public authorities for advice.

In the short-term immediate information about bushfire smoke will mostly consist of mobile phone alerts and media broadcasting to ensure public safety, as well as safety of first responders. This will also rely on robust communications infrastructure to allow rapid dissemination of alerts.

In the longer term, one of the key elements of any public information campaign is the availability of a rigorous evidence base to help guide timely and accurate advice and guide decision-making. This will require ongoing investment and resourcing.

**RECCOMENDATIONS**

RACS has already made the following recommendations to this Commission:

1. **Establish a framework of medical emergency systems, which are integrated, benchmarked for performance, based on national standards/guidelines including triage and regularly tested for capacity. Better use needs to be made of AUSMAT and its approved standards.**
2. **Commonwealth and State jurisdictions to be able to collaborate in declaring an emergency and overseeing the response.**
3. **Commonwealth funding to support the regular conduct of state trauma reviews via the Australasian Trauma Verification program**
4. **Material support for the maturation of the Australian Trauma Registry to benefit the timely provision of accurate detailed injury data**
5. **For the benefit of both emergency and medical teams, fire and flood proof rural video telecommunication systems.**
6. **To enhance surge capacity, utilise the skills/lessons learnt by the rapid deployment of AUSMAT surgical teams not only in the international environment but encourage an increasing role in the domestic environment.**
7. **Commonwealth and State Governments to work collaboratively with the Royal Australasian College of Surgeons to improve access to appropriately trained and resourced surgical services in rural/fire-prone areas. This will improve resilience.**
8. **Ensure first responders are trained to support accurate pre-hospital triage/provide immediate management and ensure systems exist for them to communicate with a network of surgeons and other medical specialists. All medical Practitioners in fire prone areas should attend the Emergency Management of Severe Burns course.**
9. **Workforce training in family violence recognition and referral to enable surgeons to act as the key bridge for a domestic violence survivor to access support services**
10. **Ensure adequate stockpiles of allograft and BTM (biodegradable temporary matrix) for mass burn casualty events.**
11. **Increase the number of rehabilitation beds dedicated to burns patients.**

The College would like to take this opportunity to reaffirm these recommendations, and to make the following additional recommendations:

12. **Governments fund and prioritise research into the long-term effects of bushfire smoke, including the likely short-term and long-term impacts on health service delivery.**
13. **Telehealth is prioritised as an area of research, particularly regarding the benefits and limitations of the technology, the resourcing requirements, and how it can best be utilised to provide optimal service delivery in natural disaster situations.**
14. **Governments fund and prioritise research into the long-term mental health effects of bushfire survivors, including reviewing the adequacy of current support services and providing additional resources as required.**
15. **Consideration is given to a single national measurement scale of air quality to ensure consistent messaging and information flow across jurisdictions**
16. **RACS endorses the position of RACGP and other likeminded organisations that primary health care providers be better integrated in natural disaster preparedness, response, and recovery**

Yours sincerely,

**Professor David Fletcher**

Chair, Environmental Sustainability in Surgical Practice Working Group

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[1] World Health Organization. Ambient (outdoor) Air Pollution [Internet]. May 2018 [cited June 23 2020]. Available from https://www.who.int/airpollution/ambient/health-impacts/en/

[2] Turan, A et al. Smoking and perioperative outcomes. Anaesthesiology. 2011; 114 (4): 837.

[3] Royal Australian and New Zealand College of Psychiatrists. Addressing the mental health impacts of natural disasters and climate change-related weather events [Internet]. January 2020 [cited June 23 2020]. Available at https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/addressing-the-mental-health-impacts-of-natural-di