Emergency care systems and a pandemic

The current global pandemic of SARS-CoV-2 has dramatically altered how we live our lives, how we conceptualise the risks and benefits of globalisation, and how we understand the fragility of health systems. The constant stream of news is filled with reports of health systems overwhelmed, flares of the virus in locations where it was previously thought contained and projections of worsening resource limitations that may have dire consequences for patients’ survival. Emergency centres have been highlighted as mission critical locations in response to this pandemic. In fact, emergency centres have become de facto intensive care units in the Americas, Europe and Asia, as they are often the only other safe location where critical care can be provided outside of overburdened intensive care units.

As this crisis has starkly revealed, emergency care systems are the essential foundation to provide an effective response to any type of mass casualty event. During infectious disease outbreaks emergency care systems serve multiple critical roles, including immediate syndromic recognition of disease, isolation to protect patients and health care workers, and care for emergency conditions associated with the outbreak, such as respiratory failure and shock. Emergency care systems must also scale efforts to respond to further health crises that may arise as a result of the epidemic, including acute exacerbations of chronic disease.

Stretching emergency care

During crises associated with surge, weak emergency care systems can become overwhelmed by increased demand or, in cases or armed conflict or outbreaks, directly compromised by the impact of such events. Any interruption in timely delivery of emergency care often causes excess mortality, both from the surge event itself (e.g. epidemic) or preventable mortality from everyday conditions. During the Ebola outbreak of 2014 strains on the overall health system (e.g. closure of health facilities, health care worker deaths and illness, and decreasing health seeking behaviour due to fear and disruption of routine preventable health care) led to excess mortality from non-Ebola related conditions, including malaria and emergency obstetric conditions [1]. Emerging data now suggests that there is likely excess mortality from non-COVID-19 related emergencies such as myocardial infarction, stroke and hyperglycaemic crisis, in locations hardest hit by the pandemic (United States) [2,3]. Early data showing excess mortality for African countries suggests a similar significant increase [4].

Emergency care systems are the lynchpin of a successful health system response, yet they remain inadequately supported across the globe, particularly in low- and middle-income countries. This special issue highlights the critical role that emergency care serves in health systems responding effectively to both the ordinary and extraordinary events affecting human health. In this issue, we include review articles to anchor the reader in an up to date exposition of the key health system building blocks through the perspective of emergency care. We include relevant research that highlights successes and expounds on the challenges of implementing crucial emergency care programs in a variety of African contexts. Lastly, we include detailed reports from regional or country wide efforts covering emergency care education, quality care delivery and a deepened understanding of the contextual reality of practitioners and our patients.

Now or never

Investment in robust, resilient emergency care systems is needed now more than ever. The global SARS-CoV-2 pandemic has heightened disparities for the socioeconomically vulnerable that emergency centres have always served, revealed blatant access blocks to emergency care and exposed fatal weaknesses in health systems. Emergency care has vital, pragmatic and human rights driven answers to these critical issues in this time of global crisis and for everyday emergency conditions. I hope this journal issue equips you with powerful examples and information to advocate with policy makers and funders to invest in building emergency care systems worldwide and use this crisis as the moment for change.

References

[1] Sochas L, Channon A, Nam S. Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone. Health Policy Plan 2017;32(supp 3):i022-i9.

[2] Lange SJ, Ritchey MD, Goodman AB, et al. Potential indirect effects of the COVID-19 pandemic on use of emergency departments for acute life-threatening conditions — United States, January–May 2020. MMWR Morb Mortal Wkly Rep 2020;69:795–800. https://doi.org/10.15585/mmwr.mm6925e6

[3] Gogia S, Newton-Dame R, Boudourakis L, Uppal A, Tatem K, Gupta R, et al. Covid-19 X-curves: illness hidden, illness deferred. NEJM Catal Innov Care Deliv 2020 May 29. https://doi.org/10.1056/NEJMcat2002311.

4. Weekly deaths suggests higher numbers of COVID-19 deaths. From: https://www.samarce.ac.za/media-release/weekly-deaths-suggests-higher-numbers-covid-19-deaths. [Accessed 10 August 2020].

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