



## COMMENTARY ARTICLE

## Primary Health Care: A Strategic Weapon in the Fight against the Coronavirus

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### Introduction

Primary Care (PHC) is the gateway to the National Health Service in Spain and waiting lists and hospital collapses, such as those currently seen in the different affected countries, will greatly depend on its operation.

The main elements that characterize the comprehensive care model based on PHC (and that make them different from the other care models) are three [1,2]:

1. Centrality in people, family and communities,
2. Integrality of care,
3. Continuity of care.

These elements must be considered as inalienable in the process of construction and implementation of the comprehensive health care model based on PHC.

In a situation of health and social crisis such as the one we are experiencing due to the coronavirus pandemic, the health systems of all the countries where it affects are being tested, and in Spain with a consolidated PHC we are having the challenge, which was not present in the other affected countries previously (China, Italy, South Korea) who did not have a system like ours, as they did not have a structured primary care network.

For this reason, we should face it differently in order to have a better management of the situation. The first level of care assumes health responsibility, which implies:

1. Resolution capacity: Interdisciplinary teams that

guarantee access to quality services.

2. Knowledge of the population: Health priorities and singularities (socio-economic characterization, cultural relevance, particular risks and protective factors).

3. Knowledge of the territory: Community dynamics, risks and resources.

4. Early identification and risk classification (individual, family and community) and care strategies: Care plans, case management, self-help, among others.

At the present time, the main entry point for possible cases of COVID-19 should be Primary Care centers (health centers, rural offices and points of continuous care) [3,4], although unfortunately there are autonomies that have chosen to hospitalocentrism saturating and collapsing hospital emergency doors.

It is estimated that more than 80% of COVID-19 patients develop a mild or uncomplicated illness, approximately 14% a serious illness requiring hospitalization, and 5% require admission to an intensive care unit. In severe cases, it can be complicated by acute respiratory distress syndrome (SARS), sepsis and septic shock, kidney failure, and heart involvement. Advanced age and comorbidity (especially cardiovascular disease, diabetes and COPD) are risk factors for severity and death [2-5].

Our priority function, therefore, is to contain attending to intermediate risk cases, 80%, so that they do not go to the hospital, but care, with face-to-face care when necessary.



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In the rest of the countries where the pandemic has developed, the crisis has centered on the fact that everyone went to hospitals because there was no primary care, as in Spain. This has meant, in countries such as China, the construction of the famous patient hospitals where they were bedridden and had their temperature and constants periodically taken and given the corresponding treatment, these patients can stay at home with family support and with the control of primary care.

In addition, in these wards and hospitals, the viral load is high and therefore professionals are more likely to get infected (in our case this situation is not so important, because if not all of us would be infected already, much of it, as we have seen in consultation quite COVID-19 without having knowledge).

In these places, they are alone in a bed without more attention than the doctor or nurse who occasionally comes to assist them, since relatives are not allowed to pass, due to the great danger of contagion, but with the primary care available in Spain all these patients (80%) can and should be kept at home and only transferred to the serious.

So, we must try to get everyone to stay at home and telephone to manage the situation, sometimes even these patients must be screened, because if they cannot feel abandoned and try to go to the hospital. Above all, patients with risk factors that must be auscultated due to the danger of complications. In addition, being at home all day long makes many people think about it, and after a week of confinement, we will begin to have complex emotional and relational situations to manage.

To do this, the centers must be reorganized:

- Trousers at the door of the Center with an infirmary that classify respiratory symptoms and send those patients,

- A respiratory triage consultation (with doctors with stricter protection measures, PPE that are conspicuous by their absence)

- Other consultations with your family doctor and/or nurse are assisted with a surgical mask, examination gloves, frequent hand washing and cleaning with 1:10 sodium hypochlorite on the table and keyboard several times in consultation with window opening every 3 or 4 patients. For chronic patients with some emergency due to decompensation of their pathology and/or habitual treatment.

- And others at home, knowing that they are controlled by their doctor and/or nurse who will attend to them by telephone.

Their risks are evaluated, and after anamnesis and exploration it is decided: Send them home with telephone control or to the hospital for chest X-rays with

a circuit previously established with a public or private hospital in the area, also an urgent analysis circuit to assess important parameters in infection COVID-19 (CBC, PCR, Ferritin, LDH, Dimero D and liver enzymes) and of course a rapid diagnosis test for coronavirus, one of the keys to success in countries such as Korea or Germany.

Also, in some regions, electronic prescriptions for chronic patients have been extended for three months and for 1 month the confirmation parts of the losses.

Patients with mild or moderate involvement can be treated at home with the usual treatments for coronaviruses: Acetylcysteine, Azithromycin, hydroxychloroquine, and even retrovirals if necessary. Patients with low oxygen saturation below 92% may have home oxygen included.

The most serious cases or those with major comorbidities are sent to the hospital.

All this well planned allows efficient resource management and not saturating urgent ambulances, hospital emergencies etc... [6-8].

In all centers, it is necessary to set up a respiratory consultation with adequate personal protection, have PPE for domiciles with respiratory suspicion (very important in Primary Care given that the most health workers are affected and deceased is at this level), and improve day by day the management of telephone demand, a telephone channel has already been set up by the Health Service Management that filters a nurse and is referring her doctor and/or nurse to solve the rest of the urgent face-to-face pathologies that are usually resolved in primary care.

Fortunately, the medical staff is exceptional and more in emergency cases that outdo themselves, despite the adversities of seeing colleagues who are falling with COVID-19 positive and even symptomatic, but still the teams walk in the same direction. Who have good internal communication, when the work leaves, informative meetings are held to assess what has been done and to continue advancing?

Therefore, the APS must assess its patients with respiratory pathology and decide according to the situation that treatment should be given, it must clarify any doubts that may arise in addition to trying to mitigate the psychological effects of confinement and, in addition to all this, continue to monitor the chronic pathologies of patients and acute pathologies due to other non-respiratory processes.

Well protected we can face and contain, the most important thing is that in this pandemic, primary care has to be reinforced.

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