AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

Wednesday, 20 September 2023

AMA submission to the Department of Home Affairs – Alternative Commonwealth Capabilities for Crisis Response

NationalResilience.Consultation@homeaffairs.gov.au

Contents

Introduction

Crises require a well-coordinated, multiagency response involving many different types of responders including medical practitioners who, along with other healthcare workers and emergency personnel, support the health care needs of those directly and indirectly impacted by the crisis, whether at the national, regional or local level.

The AMA's submission addresses crises including natural disasters and pandemics. While the discussion paper does not seek advice on the COVID-19 pandemic, it should be considered as Australia has an All-Hazards approach under its crisis management framework, and especially while the Australian Centre for Disease Control (CDC) is being established. Further, there are several lessons that have been learned from the pandemic that could be applied to natural disasters. Several key themes arise from AMA member experience in crisis responses:

- communication and coordination efforts are not as effective as they could be
- doctors are not adequately supported or consulted to address the health impacts of a crisis or to ensure continuity of care for their patients
- all doctors and health care services need to be considered essential so they have the funding and resources required to provide health care in a crisis.

Health impacts of climate change

Climate change is a health emergency. The health impacts and risks of climate change (including climate-related disasters) are vast, but can include:

- Food and water-borne diseases
- Vector-borne diseases
- Pandemics, epidemics, and outbreaks
- Respiratory illness
- Mental health issues
- Direct injuries from natural disasters
- Nutrition-based illness due to food and water insecurity
- Health, social, and national security issues arising from displacement.

It is important that Australia's crisis response considers these health impacts and has plans in place to control them as they arise. Our current systems are too siloed to achieve the collaboration and action needed to prevent and adapt to the health impacts of climate change. The AMA recently lodged a submission to the Department of Health and Aged Care's consultation on the development of a National Health and Climate Strategy. The AMA has long supported a strategy, however, is concerned that in its current form it does not adequately address protecting Australians from the health impacts of climate change.

As part of crisis response planning, Australia should comprehensively determine the scale of health impacts of climate change in Australia. This includes burden of disease, risk, and costs to health, the economy, and society. Having a better understanding of health impacts in the Australian context will make more effective goals and targets for adaptation and crisis response initiatives.

It is essential there is as much forward-planning as possible before a crisis occurs. As suggested in the National Health and Climate Strategy consultation, the AMA would support the development of a National Health Vulnerability and Adaptation Assessment and National Health Adaptation Plan. The AMA supports the Australian government developing a nationally consistent approach to vulnerability assessment and adaptation planning, however assessments and plans should include expert advice on local risks. Australia has several ecosystems and climates that come with different risks that should be considered. For example, tropical regions will be more at risk of vector-borne disease due to its warm, wet climate.

Climate change-fuelled extreme weather events are already occurring, and we are underprepared. Australia so far has been lacking national leadership and coordination with states and territories when such an event occurs. High priority adaptation actions should include ensuring health care facilities are better prepared to face an extreme weather event, and ensuring there is adequate support and resources for health care facilities facing climate-related events. At a broader level, government needs to focus on community resilience and ensure

social services are adequately prepared for increasing extreme weather events. This includes resourcing for emergency services, transport, housing, and food and water security.

Australia needs to prioritise and resource research into all aspects of health and climate change action to ensure governments and other stakeholders can work under the principle of evidence-informed policy making. Decades of inaction has meant that Australia is behind other countries on climate change action and is lacking investment into researching Australia-specific solutions.

Communication during disasters

Public health messaging

While far from perfect, Australia had one of the most successful responses to COVID-19 of any country, with very few cases by global standards before our vaccination campaign began. Australia then had one of the highest rates of vaccination globally. The great strength of Australia's response was that Governments listened to the advice of the medical and scientific community particularly in the first eighteen months. This is a key lesson and ensuring strong involvement of the medical community in planning and communicating must be built into the plans for future responses.

Over the course of the COVID-19 pandemic, we have also seen the ease with which medical disinformation can be distributed on a large scale. Consistent, succinct, and contemporaneous communication across all media from a single trusted source (the Australian Centre for Disease Control, CDC) must be provided. The public received conflicting and inaccurate information about when they need to be tested for COVID-19, and how they should approach testing, and what comprises effective prevention and mitigation strategies. The messaging improved over time, but this confusion caused undue community distress and system inefficiency. Involvement of the medical profession at all levels in planning and disseminating the public health message is essential.

Messaging must also be appropriate for the diverse needs of communities during a crisis response. This should include all communication being provided in a full range of translated material for those from linguistically diverse backgrounds.

Communication with doctors and the wider healthcare community

The Commonwealth needs to ensure there are clearly understood and implementable planning and protocols in place before an emergency occurs. The Commonwealth must ensure that it utilises the coal-face expertise of health workers at all phases of an emergency. Doctors must be involved in planning and implementation for the emergency response.

During a crisis, doctors must receive timely, consistent, clear, up-to-date and authoritative communications on operational and logistical issues such as accessing power, evacuation procedures and identifying pharmacies with emergency powers to provide medications to patients who have lost theirs.

Where GPs are involved in responding to a disaster situation it is vital that there are communication protocols in place for:

- briefing local GPs of the situation – including nature or emergency and contribution required
- GPs to relay assistance available and any unanticipated or unmet community medical and health care needs in the wake of the disaster and for effective recovery
- identifying local and non-local GPs willing to provide medical services to the affected community
- contacting GPs on any existing Volunteer Registers, if additional assistance is needed
- advising GPs of provisions in place for provision of seamless care under the MBS
- ensuring GPs are provided with the following information:
    - command location
    - assembly points
    - chain of command
    - all necessary contact details for emergency/disaster relief personnel
    - radio communication protocols
    - triage and reporting protocols to be used.

During the COVID-19 pandemic, the AMA was continually frustrated by the poor communication with the medical community on changes to the response. For example, the frequent changes to the vaccine strategy were often communicated to the public at the same time as GPs. The result was a patient would contact their general practice to request a vaccine before the practice was even aware of the change. The CDC should have standardised national communication packages and resources prepared ahead of time to support the health profession. For example, clear messaging on best practice for attending a general practice in the midst of a pandemic would have prevented significant confusion at the early stages of Australia's response, as well as reducing duplication of efforts which occurred in each State and Territory. Resources for clinicians, such as flow charts on the management of patients, were also developed in different jurisdictions in the early stages of the pandemic, creating some confusion.

Health service support

Disaster planning

An effective disaster response requires a coordinated, cooperative and collaborative approach between federal and state governments and relevant agencies. Federal, state and territory governments as well as health care facilities must develop and maintain up-to-date crisis response plans. These should guide the medical and health care workforce in preparing for, and responding to, such an emergency quickly and efficiently to minimise the disaster's impact on the health of the community.

The development and review of disaster plans should be undertaken in consultation with the medical profession and wider health care workforce to ensure plans are evidence-based, practical, workable, adaptive, responsive and supported by the workforce. For example, doctors have expertise on issues of operational efficiency such as addressing surge capacity and the use of emergency provider numbers. In addition to Disaster Medicine experts, consultation should include GPs and other medical specialists in primary and acute care settings in both the private and public health sectors as well as those from rural and remote areas including Aboriginal and Torres Strait Islander communities.

Doctors and local health services are an integral part for local council and regional disaster planning meetings. There should be mandatory committee representation of both hospital and general practice. It is critical to include local doctors during a disaster response as they are best positioned and skilled to advise on local resources and community needs, particularly in rural and regional areas. For example, in regional areas staff shortages will likely be further exacerbated during a disaster, doctors that are already isolated may not be able to safely proceed as quickly as in other places and some clinicians that are sole practitioners in their specialty may require specific protection from harm.

Adaptation actions should include ongoing and effective disaster planning that incorporate measures to ensure healthcare facilities are adequately supported when emergencies occur. For example, it took the AMA almost a year of campaigning for funding to be provided to healthcare providers after the Lismore floods.[1] Crisis responses need to consider and address issues with:

- disruptions to supply chains and energy
- healthcare facility evacuations
- temporary health care access
- financial support
- emergency accommodation
- building resilient communities.

The AMA calls for private health services in rural and regional areas to be declared essential services so they can be offered immediate financial support and resources following climate change-fuelled disasters. Funding is also required to rebuild public and private infrastructure following a crisis. The AMA also calls on government to declare all rural health service providers essential workers, so in future disasters they will not have to bear the stress of funding uncertainty in the aftermath.

When a crisis occurs and a doctor responds to that crisis, their practice continues to have residual costs and cost escalation to cover locum support for a sometimes indeterminant amount of time. Having these costs covered by government makes it easier for doctors to leave their practice respond to crises when needed. This cost

should not be a barrier to doctors making themselves available to provide their services in a crisis. The AMA supports consideration of the National Critical Care and Trauma Response Centre and any lessons learned concerning deploying health professionals.

The development and review of disaster plans should also be undertaken in consultation with the wider public including those from marginalised and vulnerable communities who may already experience health inequities and may be disproportionately affected by a disaster (for example, Aboriginal and Torres Strait Islander populations, the elderly, people with a disability, those from culturally and linguistically diverse backgrounds, LGBTQIA+ individuals, those in prison and immigration detention).

Disaster plans must be promoted and promulgated to the profession, broader health care workforce and the wider community so that they are familiar with them and prepared before a disaster takes place.

The AMA supports the CDC establishing a national public health emergency operations centre (PHEOC) that aligns with World Health Organization Framework for PHEOCs.[2]

The Australian Government and the CDC will need to put measures in place to quickly provide funding and resources to boost capacity of Australia's health system to ensure it can effectively manage the emergency while continuing to meet the usual health care needs of the community. Dedicated funding and resources should be attributed to Aboriginal and Torres Strait Islander communities to ensure they have the capacity to respond to disasters in a culturally safe manner.[3]

Health service infrastructure

Having the facilities and resources with which to provide medical services, be they part of an immediate response, continuing care, or recovery response, is essential. Where the premises of local GPs are impacted in a disaster, such as the 2019/20 Black Summer bushfires or the Lismore floods, this may include the need for temporary premises to be established. State and territory governments should be prepared to secure or make available buildings (or structures) quickly from which medical services can be provided as part of the response, and, where required, on an ongoing basis during the recovery period. Health service infrastructure should be prioritised to ensure the community is not without access to healthcare.

When establishing a temporary premises, consideration should be given to the following factors:

- power availability, including generators and access to fuel supplies
- access to and availability of water
- phone and internet connections
- bathroom facilities
- rooms or cordoned-off areas for consultations and waiting areas
- access to essential equipment such as fridges, computers and printers.

Government funding should be provided to health services, both public and private, to build this infrastructure and to rebuild as required after the crisis. New infrastructure should be built with consideration to local disaster preparedness and planning. For example, avoiding building new infrastructure in areas prone to flooding.

IT infrastructure also requires consideration in crisis planning. In the case of a crisis or disaster, IT networks may become compromised. Having either durable backup mechanisms and/or ensuring the availability of secure communications is critical in the healthcare system.

Primary care

When a disaster occurs, it is essential that affected communities have ongoing access to primary care services. At these times GPs are at the frontline in providing care, treatment, and support to people in their community. They must be supported and equipped to provide crisis care as required while minimising the disruption to normal patient care. Research shows that GPs, even when personally affected by disaster, will do their utmost to respond to the health care needs of their community.[4] Failing to include them in disaster preparedness frameworks ensures under preparedness, confusion and isolation in response resulting in lost opportunities for reducing disaster health risks and health care optimisation in a period of exceptional need and demand.

There are several roles that GPs can play in an emergency or disaster situation. These include but are not limited to:

- participating in medical response teams to assist on-site with triaging, field treatment, and supervising the provision of first aid
- treating the walking wounded either on-site, at evacuation centres, or in rooms (including temporary premises) (including providing vaccinations if needed)
- providing support (i.e. backfill) for hospitals to maintain their capacity function
- ensuring continued community access to primary health care.

The Commonwealth Government can assist access to medical care during a disaster response and recovery by having in place standard protocols (including but not limited to) for enabling:

- GP's flexible use of their Medicare Provider Numbers
- GP's access to Medicare benefits while practising in temporary premises
- access to medical services for people who have lost Medicare/DVA cards
- flexibility in claiming some of the MBS mental health items
- provision of essential medicines and filling of prescriptions outside of standard PBS rules.

GPs in or attending a disaster affected community must have access to international best practice equipment to support and protect them when providing care. This includes:

- personal protection equipment, including P2/N95 facemasks, gloves, antibacterial hand sanitiser; self-contained breathing apparatus (when appropriate)
- clinical equipment such as Thomas Packs, portable ultrasounds, blood pressure monitors; blood glucose monitors, portable ECG and point of care diagnostics
- vaccines for medical staff and for general use in the population as required
- identifying clothing (i.e jackets or vests) marked 'Doctor'.

Ensuring GPs and their healthcare teams can continue to provide services to the community provides relief in the immediate response. It also reduces the long-term health consequences for patients that results where services are disrupted for extended periods, through the deferral of care, and delayed diagnosis and treatment.

Hospitals

The AMA calls for the strategies and funding for climate change mitigation and adaptation of public hospitals to be included in the National Health Reform Agreement Addendum 2025 onwards. Noting that there is great variation in the levels of mitigation and adaptation planning already occurring by hospitals, some of which have undertaken their own climate mitigation and adaptation activities, the AMA suggests that the funding is disbursed either through block funding for specific hospitals/health districts or as part of Activity Based Funding (ABF) National Efficient Price with relevant adjustments according to the needs of individual hospitals. This process must be equitable and not seen as punishing for those hospitals that have already progressed along the climate mitigation and adaptation path.

Aged Care

The care of residents of aged care facilities during crises will require rapid, flexible responses. Planning for all aged care facilities must involve the facility as well as the local hospital and ambulance services, as residents may require evacuation. During the COVID-19 pandemic, the AMA was impressed by the collaboration between the Commonwealth and the Victorian Governments when responding to COVID-19 outbreaks in aged care through the establishment of the Victorian Aged Care Response Centre (VACRC).

The aged care sector is Commonwealth funded, and states and territories usually have minimal engagement with the privately run and owned aged care facilities. However, due to residents requiring medical care, ambulance transfers and hospital care during outbreaks, it became evident that the engagement of the Victorian Government was required.

The Centre coordinated a rapid response to outbreaks and successfully worked with aged care providers to prevent further outbreaks. The key to its success was its quick deployment and the ability to bring all relevant stakeholders together. This should be highlighted as an example of how to respond to crises in aged care.

National Medical Stockpile

The AMA supports the Australian CDC including the National Medical Stockpile into its scope. There should be a key focus on upcoming national health threats to the nation.

The Australian National Audit Office (ANAO) audit of the NMS noted the following in commentary on the distribution of supplies from the NMS:

"In the absence of risk-based planning and systems that sufficiently considered the likely ways in which the NMS would be needed during a pandemic, Health adapted its processes during the COVID-19 emergency to deploy NMS supplies."[5]

The AMA expects that "risk-based planning" would be a core responsibility for the CDC. Future distributions during communicable disease events, or in response to natural disasters like the Black Summer bushfires, would be more effectively coordinated and performed in a consistent manner across jurisdictions.

PPE shortages were a significant issue at the beginning of the pandemic. Doctors were concerned about the lack of access to basic PPE like respirators, gloves, gowns and goggles as well as differing jurisdictional advice as to the appropriate use of PPE. There has been a lack of transparency with respect to the availability of PPE at both national and state/territory level. For parts of the pandemic, the private sector was unable to access PPE.

This had a significant impact on the mental health and wellbeing of health care workers. While the Federal Government aimed to address the shortage of respirators, we know that access to respirators and other PPE remains problematic throughout the pandemic. The distribution of PPE by Primary Health Networks to general practice was inconsistent. The adequacy of the supply of PPE for this and future pandemics needs to be closely examined in relation to available quantities, the type of PPE being stockpiled, as well the performance of available distribution channels.[6]

Medicine Supply

Medicine shortages were a significant challenge during the pandemic and remain so. Australia's supply chain of medicines is vulnerable. Ninety per cent of Australia's medicines come from overseas,[7] primarily from Europe and the United States, who themselves rely on active pharmaceutical ingredients (APIs) manufactured in India and China.[8] Market demand, manufacturing issues, geopolitical interventions, natural disasters, and global crises such as pandemics will all create challenges for our supply.

In addition to these challenges, the Therapeutic Goods Administration (TGA) cannot compel pharmaceutical companies to add their medicines on to the Australian Register of Therapeutic Goods (ARTG), leaving Australia's health in the hands of pharmaceutical business strategies.

There have been a range of initiatives to minimise the impact of medicines shortages in Australia, and the TGA should be commended for how they have managed the ongoing shortages. For example, measures such as the Serious Scarcity Substitution Instrument (SSSI) have worked well and been well communicated with stakeholders. Likewise, the Strategic Agreements with Medicines Australia and the Generic and Biosimilar Medicines Association to ensure stockpiles of essential medicines is likely to limit shortages in future crises, however it is yet to be tested.

While these measures are positive, there is a lack of genuine long-term planning for our medicine supply chains. The Australian CDC could play a stronger role in observing international trends, identifying weaknesses or vulnerabilities in our supply chains, and work with the TGA to coordinate the response to severe shortages.

Support for doctors

Medical practitioners and health care workers, particularly those on a volunteer register, or who will be fundamental to a disaster/emergency response need training on how responses are managed and coordinated. This will reduce confusion during a response, reinforce communication channels, and enable the rapid establishment of triage and clinical services. Disaster preparedness training increases willingness to be part of the response and practitioner response capabilities and effectiveness.[9] Doctors should be provided with financial support for undertaking activities in disaster preparedness, training, and availability to respond to crises.

With GPs key to our healthcare system, greater recognition is required of the unique workplace challenges and mental health stressors they face during events like the COVID-19 pandemic and targeted workplace and psychological support provided.[10]

When considering emergency responses, the Australian CDC and other crisis response authorities must prioritise the health, safety, and wellbeing of all healthcare workers to maintain healthcare delivery capacity during the emergency response. This includes planning for follow-up personal support for all health workers to ensure ongoing psychological wellbeing after the crisis has passed.

Doctors must be provided with immediate and ongoing health care and other support, including financial support and psychological care, to doctors (and their families) who are harmed or die as a result of a disaster. They must also have assurance of appropriate workers' compensation and death/disability insurance arrangements to support their involvement in natural disaster response activities.

Disaster planning should not only address the immediate health effects associated with a disaster but also the associated health effects following on from a disaster, such as increased mental health presentations.

Access to provider numbers

Doctors require a unique provider number for each location they practise in to claim Medicare benefits. Doctors must complete the application process which is administered by Services Australia. This can create problems during crises, with notable recent examples during the COVID-19 pandemic and floods. During the earlier stages of the pandemic when international and state borders were closed or difficult to cross, there are reports that it was taking up to eight weeks for new provider numbers to be issued. While registered doctors are not prevented from providing medical care without a provider number, their patients are unable to make a claim to Medicare. The result is that either the doctor cannot work at a certain location, or the patient must pay the full fee.

This issue was particularly problematic for locum doctors who often provide temporary medical services, particularly in rural and remote communities. It has been a major problem during floods and bushfires as a doctor's provider number is linked to their practice which may have been destroyed or is unserviceable.

The AMA would like practitioners to be provided with a single provider number which could be used at multiple locations. At a minimum, the AMA would like to see a policy or process to quickly recognise and respond to a situation where doctors will need either flexibility with provider location numbers or the issuing of emergency provider numbers for GPs. This should be extant in all emergencies where doctors are unable to work from their usual practice, have to relocate, or who offer their services to disaster affected areas.

Medical indemnity

For doctors to feel confident in providing care during disaster, they must be ensured ongoing and appropriate medical indemnity. In addition, retired or semi-retired doctors (and other healthcare workers) who may be recruited to assist during a disaster, as well as medical students who were used as physician extenders or clinical aides, should receive appropriate medical indemnity protection as well as industrial protections, remuneration, training, supervision.

The temporary pandemic response sub-register established by the Australian Health Practitioners Regulation Agency (Ahpra), the regulatory body for health professionals, in anticipation of workforce shortages caused by the COVID-19 pandemic provides sound framework for future crises. The AMA was supportive of the sub-register, however there were issues identified by the AMA that were readily resolved and can be built into the process for the future. The main issue with establishing the sub-register for recently retired doctors was the implications for run-off cover. Run-off cover provides insurance for incidents which had occurred during a practitioner's career but had not yet been notified to insurers. The Commonwealth Government introduced a Run Off Cover Scheme (ROCS) in 2004 to ensure that eligible doctors get medical indemnity cover that is secure and free and based on their last cover.

The establishment of the pandemic sub-register, which automatically reinstated recently retired doctors to a practising registration status, would have undermined the ability of these doctors to be covered by the ROCS scheme. In conjunction with some medical defence organisations the AMA highlighted this issue with the Commonwealth Department of Health.

To address this issue, the Commonwealth Government ensured that an exemption was included in legislation through the registration of *the Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020* and the *Medical and Midwife Indemnity Legislation Amendment (Eligible Run-off Claims) Rules 2020*. This was a suitable, time limited solution that ensured practitioners were covered.

Community support

Australia's crisis response should adopt an equity lens to recognise that communities require tailored responses. The AMA acknowledges that a person's health is shaped by the social, economic, cultural, and environmental conditions in which they live.[11] Health inequities typically arise because of inequalities within society. Climate disasters compound existing inequities. In disaster prone areas interruptions to ongoing health care for diverse members of the community including Aboriginal and Torres Strait Islander peoples, people living with a disability, disadvantaged socio-economic groups, the elderly and culturally and linguistically diverse groups can have serious health consequences.

Aboriginal and Torres Strait Islander communities

It is essential that Aboriginal and Torres Strait Islander peoples have a leading role in identifying and responding to the nature and challenges of their own health.[12] There is an existing significant gap between Indigenous and non-Indigenous Australians, in terms of health indicators and access to health services. Climate change will only exacerbate these inequities.

There has been inadequate involvement of Aboriginal and Torres Strait Islanders for climate change responses, and a lack of research and data that harness the knowledge of the impact of climate change on local communities, and how to respond to them.[13] Government must ensure that it directly seeks advice from Aboriginal and Torres Strait Islander communities and ensure there is Aboriginal and Torres Strait Islander representation.

Mental health

As mentioned, mental health is impacted by climate change. Mental health challenges are associated in some countries with increasing temperature, trauma from extreme events, loss of income and culture. Climate weather extremes are displacing populations.[14] The impacts of climate change in the Pacific may contribute to an increase in the number of people seeking to move to nearby countries, including Australia, and affect political stability and geopolitical rivalry within the Asia-Pacific region. Together this presents a potential national security and health threat to Australia.

The mental health system in Australia is already failing people with poor mental health, with growing numbers of patients presenting to hospital emergency departments – often the last resort for patients in distress. Mental and behavioural conditions were the most prevalent chronic conditions in Australia, with one in five people (20.1 per cent) experiencing some form of poor mental health.[15]

Australia's crisis response must ensure there are adequate pathways for the community seeking support, with a focus on GP-led collaborative care. This should be developed by the mental health professional community.

Domestic violence

Family, Sexual, and Domestic Violence rate increases are associated with national crises. Women who experienced physical or sexual violence saw this increase over the course of the COVID-19 pandemic. The pandemic resulted in abusers with more access to their victims, who were unable to leave their home or get support. This was combined with additional stress and anxiety, a loss of income, and consumption of alcohol. There was also an increase in calls to domestic violence support services in both the 2019 and 2009 national bushfires. The AMA supports the calls under the *National Plan to End Violence against Women and Children 2022-2032* to include men's violence against women as part of emergency response strategies.[16]

Rural, regional, and remote areas

The flood disaster in Lismore and surrounding Northern Rivers communities damaged the premises of 25 primary care services including medical practices, dental surgeries, and a pharmacy. Many of these businesses

are not insured for floods, as this cover is unavailable or unaffordable. In addition to the 2022 floods, these businesses are suffering from the compounding impact of previous natural disasters and the pandemic.

Recovery for these health care businesses has been slow and difficult. Business owners have not been able to access sufficient or timely grant funding. Many are unable to resume pre-flood activity due to existing damage to their premises, which has affected their ongoing income. Given this financial instability, many health care business owners considered closing their premises and leaving the area.

Closure of these services in these areas would have a significant impact on health care access for residents. Rural and regional populations face worse health care outcomes than those living in metropolitan areas and the closure of these services would exacerbate this health inequity. Some of the impacts of limited health care access include decreased vaccination clinics, decreased chronic condition management, decreased access to chemotherapy and cancer care, decreased screening, and decreased support for vulnerable patient cohorts.

Rural and regional communities have been hardest hit by the current GP shortages with growing workloads and decreasing interest in the specialty among the next generation of doctors. Financial support should be provided to these GPs to ensure that their practices' infrastructure and medical equipment quickly restored and replaced after disasters.

Rural areas struggle to attract and retain GPs, and access to non-GP specialists in many rural areas is limited. GPs are often the only source of access to health services in rural and remote settings. It is crucial for the government to provide all support needed to retain doctors and their practices remain in these areas.

Existing and emerging capabilities

Australian Defence Force

The AMA suggests that the Commonwealth need to consider principles of what is needed in a crisis to determine the capabilities and capacities required to not rely on the ADF. The AMA is not aware of another Australian body that can quickly deploy and coordinate a workforce in times of crisis to the level that the ADF can. If the Commonwealth does not plan on using the ADF in future crises, there needs to be a workforce and coordination in place that can fill in the gap.

For large scale emergencies the use of the ADF should not be disregarded. The ADF can support a disaster response by providing disaster relief supply air drops, all-terrain vehicles and drivers to enhance transport capabilities and by setting up temporary communication networks and capabilities until civilian telecommunication carriers can restore services. It may be that the ADF require upscaling to create new capacity and capability to respond to the compounding and escalating threats of climate-related events.

Australian Centre for Disease Control

The AMA has been calling for a Centre for Disease Control (CDC) since 2017[17] and continuously advocated for a CDC throughout the COVID-19 pandemic. The COVID-19 experience has illustrated the need for a nationally coordinated CDC across all jurisdictions in Australia. The Department of Health and Aged Care have created an interim CDC while the permanent CDC's structure and functions are considered. The AMA's submission to the consultation on the role and functions of an Australian CDC should be considered in this consultation process.

The speed at which pandemic control policies are implemented by a country has been correlated with the effectiveness at preventing fatalities, more so than the level of strictness of those policies.[18] The Australian CDC should play a key role in developing a basic action plan and practical kits and resources for pandemics and other health emergencies such as posters, pathways and tools so that they do not have to be created by individual jurisdictions. In Australia and internationally, the COVID-19 experience has illustrated some of the shortfalls that can arise from poor coordination and inconsistent public health messaging.[19,20,21]

The COVID-19 experience globally, in addition to the growing burden of preventable disease, illustrates the significance of having a central, trusted body to advise on pandemic responses, other disease outbreaks and preventive health. It is fundamental that the Australian CDC is structured to quickly form and release advice in response to public health emergencies as well as a longer-term focus on non-communicable diseases.

In addition to strategy design, the AMA believes that the CDC should have a role in strategy implementation for disease outbreaks. The CDC should employ a range of public health and medical professionals, including public

health physicians and disaster medicine experts who are able to travel to outbreak areas to implement disease infection control activities. This will only be effective if implementation teams are adequately funded, and if they work collaboratively with local health authorities.

The Australian CDC provides a unique opportunity to compliment current public health training pathways in Australia, noting the current gaps and deficiencies in the existing training model for public health doctors in Australia. Currently, training is run through Australasian Faculty of Public Health Medicine, a faculty within the Royal Australasian College of Physicians. However, training opportunities and quality of placements varies significantly between jurisdictions. There are useful training opportunities for public health registrars in the CDC and these should be incorporated into the scope.

Governance structures

It is essential that after a crisis occurs, there is adequate processes in place to review Australia's response to the crisis to find areas for improvement. Reviews should be constructive and have a system-learning focus. It is also important that crisis response plans clearly outline responsibilities of the Commonwealth, jurisdictions, and the crisis workforce to reduce confusion when a crisis hits.

Conclusion

The AMA supports this consultation into alternative Commonwealth capabilities for crisis response. The AMA believes that the health impacts of crises such as natural disasters and pandemics would be better handled if there was improved collaboration and communication with medical professionals at all stages of crisis prevention, planning, and response. The AMA welcomes further input into this consultation, particularly when a draft proposal is available.

Relevant AMA position statements

- Ethical Considerations for Medical Practitioners in Disaster Response in Australia 2023
- Climate Change and Human Health 2015
- Australian National Centre for Disease Control 2017

[redacted]

[redacted]

References

[1] Australian Medical Association (2023) *AMA welcomes landmark funding agreement for Lismore health service providers.* Retrieved 14/07/23 from https://www.ama.com.au/media/ama-welcomes-landmark-funding-agreement-lismore-health-service-providers

[2] World Health Organization (2015) *Framework for a public health emergency operations centre.* https://www.who.int/publications/i/item/framework-for-a-public-health-emergency-operations-centre.

[3] Australian Medical Association (2020) AMA submission to the Senate Select Committee on COVID-19. https://www.ama.com.au/submission/ama-submission-senate-select-committee-covid-19

[4] Burns P, Douglas K, Hu W, Aitken P, Raphael B. General practitioners in the field: A qualitative study of general practitioners' experiences in disaster healthcare. Australian Journal of General Practice, Volume 49, Issue 3, March 2020: doi: 10.31128/AJGP-08-19-5054

[5] Australian National Audit Office (2021) *COVID-19 Procurements and Deployments of the National Medical Stockpile.* Retrieved 6/09/2023 from https://www.anao.gov.au/work/performance-audit/covid-19-procurements-and-deployments-the-national-medical-stockpile

[6] Australian Medical Association (2020) *AMA submission to the Senate Select Committee on COVID-19.* Retrieved 6/09/2023 from https://www.ama.com.au/submission/ama-submission-senate-select-committee-covid-19

[7] Therapeutic Goods Administration (2019) *Reforms to the generic medicine market authorisation process*. Retrieved 6/09/2023 from https://www.tga.gov.au/sites/default/files/consultation-reforms-generic-medicine-market-authorisation-process.pdf

[8] Productivity Commission (2021) *Vulnerable supply chains – Productivity Commission interim report.* Retrieved 6/09/2023 from https://www.pc.gov.au/inquiries/completed/supply-chains/interim/supply-chains-interim.pdf

[9] Balut MD, Der-Martirosian C, Dobalian A. Disaster Preparedness Training Needs of Healthcare Workers at the US Department of Veterans Affairs. South Med J. 2022 Feb;115(2):158-163. doi: 10.14423/SMJ.0000000000001358. PMID: 35118507; PMCID: PMC8785770.

[10] Ng I et al. (2022) Australian Journal of Primary Health, 28(5), 387–398. doi:10.1071/PY21308

[11] Australian Medical Association (2020) *Social Determinants of Health.* Retrieved 09/08/23 from: https://www.ama.com.au/articles/social-determinants-health-2020-1

[12] Australian Medical Association (2015) *Aboriginal and Torres Strait Islander Health revised 2015*. Retrieved 13/07/23 from https://www.ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-revised-2015

[13] Matthews, V et al (2021) *Climate change and Aboriginal and Torres Strait Islander Health*. Discussion paper. Retrieved 13/07/23 from https://www.lowitja.org.au/content/Image/Lowitja_ClimateChangeHealth_1021_D10.pdf

[14] Intergovernmental panel on climate change (2023) *Climate change 2023 synthesis report: summary for policymakers.* Retrieved 5/09/2023 from https://www.ipcc.ch/report/ar6/syr/downloads/report/IPCC_AR6_SYR_SPM.pdf

[15] Australian Medical Association (2022) *Public Hospital Report Card – Mental Health edition.* Retrieved 5/09/2023 from https://www.ama.com.au/clear-the-hospital-logjam/mhrc

[16] Department of Social Services (2022) *National plan to end violence against women and children.* Retrieved 5/09/2023 from https://www.dss.gov.au/sites/default/files/documents/11_2022/national_plan_to_end_violence_against_women_and_children_2022-2032.pdf

[17] Australian Medical Association (2017) *Australian Centre for Disease Control.* Retrieved 6/09/2023 from https://www.ama.com.au/position-statement/australian-national-centre-disease-control-cdc-2017

[18] Stockenhuber, R (2020) *Did we respond quickly enough? How policy implementation speed in response to COVID-19 affects the number of fatal cases in Europe.* World Medical and Health Policy.Retrieved 6/09/2023 from https://onlinelibrary.wiley.com/doi/full/10.1002/wmh3.374

[19] Public Health Agency of Canada (2022) *List of Acts and Regulations.* Retrieved 6/09/2023 from https://www.canada.ca/en/public-health/corporate/mandate/about-agency/acts-regulations/list-acts-regulations.html

[20] Canadian Public Health Association (2021) *Review of Canada's initial response to the COVID-19 pandemic.* Retrieved 6/09/2023 from https://www.cpha.ca/review-canadas-initial-response-covid-19-pandemic

[21] Canadian Public Health Association (2021) *Review of Canada's initial response to the COVID-19 pandemic.* Retrieved 6/09/2023 from https://www.cpha.ca/review-canadas-initial-response-covid-19-pandemic