Submission to the Senate Select Committee on Australia's Disaster Resilience

Contact

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Primary Health Network (PHN) Cooperative

Executive Summary

Despite the demonstrated and potential value of PHNs and primary care (e.g., general practices, allied health, pharmacy, and community health providers) to contribute to disaster resilience, they are systematically neglected components of civil capabilities absent from formal disaster management arrangements and state-led health preparedness, response, and recovery planning. Currently, the capacity of PHNs and primary care to support disaster preparedness, response, and recovery is not adequately recognised, utilised, embedded, or resourced to reach its full potential and deliver maximum value.

This has resulted in uncoordinated, reactive, and under-resourced disaster responses and recovery efforts which add to the already overburdened mental and emotional toll on the health workforce and community members within a disaster impacted region. Despite this, PHNs have demonstrated an ability for agility in the coordination of a primary care response in disasters, which if better integrated into disaster management frameworks, would provide even more benefit.

Solution:

For a disaster resilient Australia, an integrated, nationally consistent (one-system) approach to disaster preparedness, response and recovery efforts is needed. PHNs and primary care must be embedded within a one-system approach, as they play an integral role in supporting people and communities to prepare for, respond to, and recover from a disaster event.

We recommend that:

1. PHNs are formally recognised and included in disaster management arrangements. This includes planning, preparedness, response, and recovery arrangements.
2. PHN are adequately resourced to undertake this formal role and meet the needs for their local communities.

Outcomes:

Implementing these two recommendations will:

- Ensure the role and scope of PHNs and primary care is clearly understood by all relevant stakeholders to ensure an efficient, nationally consistent and coordinated one-system approach to disaster management.
- Ensure the utilisation an effective coordination of a highly skilled primary healthcare workforce, comprising general practitioners, pharmacists, nurses, and allied health professionals, is maximised and workforce burnout is minimised.
- Strengthen communication and coordination between all parties, reducing duplication and confusion during response and recovery.
- Enable continuity of care during times of disaster, reducing pressure on hospitals, and meeting the health needs of people and communities.
- Ensure preparedness and planning is tailored to local needs and that recovery efforts can continue for as long as they are needed, rather than until funding runs out.
- Facilitate opportunities for PHNs to provide targeted support to other sectors, such as aged care as part of disaster management arrangements.

This submission will elaborate on the above themes and provide the rationale for the outcomes listed.

Introduction

Primary Health Networks (PHNs) are independent organisations established in 2015 by the Commonwealth Government of Australia.

Nationally, there are 31 Primary Health Networks (PHNs) working at regional and jurisdictional levels to strengthen primary care, improve person-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes.

The primary care system is made up of a diverse mix of organisations, consisting of a series of mostly small- and medium-sized private practices (often single discipline), alongside not for profit and publicly funded community health services and Aboriginal Community Controlled Health Organisations (ACCHOs). Primary care services aim to provide high quality care when and where people need it.

PHNs are a key component of the primary care system and the health system, valued for their ability to facilitate collaboration, their strong understanding of the needs of their communities and their understanding of the complexities of demand and supply of healthcare. PHNs are also valued for their key role in regional commissioning. Health care commissioning is a continual cycle that involves planning, designing, or procuring, monitoring, and evaluating health services to make sure they are performing well and improving the health of the communities that they work within.

Local knowledge of community need, workforce supply and barriers to access, as well as relationships with local health providers and other stakeholders (particularly Local Health Networks (LHNs) / Local Health Districts (LHDs) / Hospital and Health Services (HHS)), is used by PHNs to facilitate the design and implementation of initiatives to improve the provision of, and access to, primary health care.

PHNs are uniquely positioned to deliver value to the health sector in a range of areas, including:

- System coordination and integration to reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors.
- Collaboration and building relationships with providers and health services within, and external to, the primary health care sector.
- Collation of information and data to inform planning, and to monitor and evaluate sector performance within the local area. This includes engaging with local stakeholders to obtain high quality qualitative data.
- Communication and engagement with the community and primary health care providers, including education and workforce development.
- Bridging the jurisdictional, hospital-community-primary care and cross-sector divides through collaborative commissioning and co-design.

Response

This submission represents the views of all 31 PHNs (the PHN Cooperative). We welcome an opportunity to discuss any aspect of this submission further.

The PHN Cooperative welcomes the opportunity to provide a response to the Senate Select Committee on Australia's Disaster Resilience.

Our response will address the following terms of reference:

(a) Current preparedness, response, and recovery workforce models, including:

ii. the impact of more frequent and more intense natural disasters, due to climate change, on the ongoing capacity and capability of the Australian Defence Force,

iv. The role of Australian civil and volunteer groups, not-for-profit organisations, and state-based services in preparing for, responding to, and recovering from natural disasters, and the impact of more frequent and more intense natural disasters on their ongoing capacity and capability.

(b) Consideration of alternative models, including:

i. Repurposing or adapting existing civil and volunteer groups, not-for-profit organisations, and state-based services.

(c) Consideration of the practical, legislative, and administrative arrangements that would be required to support improving Australia's resilience and response to natural disasters.

(a) Current preparedness, response, and recovery workforce models, including:

ii. the impact of more frequent and more intense natural disasters, due to climate change, on the ongoing capacity and capability of the Australian Defence Force

Key Messages:

- Australia needs a cohesive, proactive, one-system approach to disaster preparation, response, and recovery to effectively respond to cascading disasters.
- The Australian Defence Force (ADF) plays a critical role in disaster management, however, there is a need for a fully integrated and utilised civil health capacity considering the cascading, more frequent and intense nature of disasters.
- Primary healthcare and Primary Health Networks (PHNs) are a crucial component of civil health capacity that have proven experience in facilitating continuity of care and responding to local need in times of disaster.
- Despite this, there is a lack of a nationally consistent, approach to PHN involvement in local disaster preparedness, response, and recovery efforts. This fosters variability in the care delivered in communities, undermining the principle of universal access to quality care.
- To ensure Australia has the best possible disaster preparedness, response, and recovery approach in the face of cascading disasters, formal structures must be created, and funding provided to embed PHNs and primary care within an integrated one-system disaster approach.

Disasters are no longer one-off events. Their increased frequency and intensity can trigger compounding, cascading disaster scenarios, with one disaster exacerbating another. This amplifies the consequences on people's health and wellbeing, with more harmful impacts in the short and long-term, and generates unique challenges that make systematic preparedness, response, and recovery efforts more resource and workforce intensive.

The PHN Cooperative supports the role of the Australian Defence Force (ADF) in supporting Australian communities in response to disasters where civil contingencies are exhausted or are predicted to be exhausted. However, given the ADFs primary mission of national defence and the growing number of domestic and international disasters threatening Australia, all civil capabilities need to be fully integrated and utilised to ensure an effective alternative approach is available in the eventuality that the ADF does not have the capacity to respond to domestic disaster relief. Further, due to the impact of disasters on the mental and physical health of both the defence and primary care workforce, it is crucial that all aspects of a disaster response are systematically integrated and effectively work together within the framework of a 'one-system' approach, to minimise these impacts and reduce undue fatigue on the workforce.

PHNs coordinate primary healthcare, a key component of the civil health capacity. PHNs across the country have been involved in supporting the primary care health workforce to prepare for, respond to, and recover from the impacts of various disasters, including the COVID-19 pandemic, the 2019-2020 bushfires, and multiple flood events in Victoria, Queensland, and New South Wales. These efforts are ongoing, with disaster recovery persisting for prolonged periods, in some cases for many years.

However, there is a high degree of variation in the contribution of PHNs to disaster preparation, response, and recovery efforts with many PHNs operating independently from systematic disaster management arrangements (see case study 1). Even when the important roles of PHNs are recognised, a lack of a nationally consistent, one-system approach to PHN involvement in local disaster resilience fosters variability in the care delivered in communities, undermining the principle of universal access to quality care.

The lack of PHN and primary care involvement in disaster management arrangements means that they are often called upon on short notice and on an ad hoc basis for assistance. This can result in the duplication of service provision by local primary care providers and external agencies (including the ADF), leading to an inefficient allocation of resources and a lack of support where it is most needed. Additionally, it can contribute to services gaps, when a lack of understanding of the role of PHNs and primary care leads to requests that are outside their scope (see case studies 1, 4 and 5).

Where this systematic exclusion and inefficient resource allocation occurs, it contributes to community frustration and can result in workforce fatigue as community primary care providers are required to deal with additional logistical arrangements. This can leave local providers, who must continue to assist the community once the emergency response workforce and the resources they bring depart, disempowered and unsupported, exacerbating the risk of ongoing workforce burnout and retention issues in disaster impacted regions.

National disaster preparation, response, and recovery initiatives must be systematically integrated with the local community responses to ensure local coordination and ongoing support after an event. In a healthcare context, primary care is well-suited to provide this support given its interaction with 85% of the population annually[i]. PHNs, as experts in regional primary care coordination, have essential skills, capabilities, and existing local relationships to support the integration of the primary care into coordinated disaster preparedness, response and recovery efforts (In the handful of localities where PHNs are incorporated into local arrangements, PHNs enable primary care providers to continue delivering primary care to their local communities *and* effectively contribute to the local health response (see case studies 1, 2, 3, 4 and 5). However, PNHs currently face many barriers to delivering their maximum value due to their continued systematic exclusion from formal disaster management processes (see case studies 1, 2, 3 and 4).

Australia needs a cohesive, proactive, one-system approach to disaster preparation, response, and recovery to effectively respond to cascading disasters. To achieve this, primary care must be incorporated. PHNs, despite lack of recognition, have repeatedly demonstrated their capacity to contribute to disaster management efforts. Yet, in many circumstances, a lack of a nationally consistent one-system approach has undermined the delivery of a best practice response. To ensure Australia has the best possible disaster preparedness, response, and recovery approach in the face of cascading disasters, formal structures must be created, and funding provided to embed PHNs and primary care within an integrated one-system disaster approach.

The case studies in this document demonstrate how PHNs can contribute to disaster preparation, response, and recovery and do so in innovative ways. Importantly, challenges and barriers limited the

preparedness, response, and recovery capacity of PHNs in most of these cases, ultimately reducing the potential value they could have provided.

Case Study 1. A need for one-system, Western Australian Primary Health Alliance (WAPHA). In early 2020, the WAPHA responded comprehensively to COVID-19 across its three PHNs (Perth North, Perth South, and Country WA). WAPHA coordinated and distributed information on the vaccine rollout with general practice, residential aged care facilities, and disability accommodation. Additionally, WAPHA supported various programs such as outreach COVID-19 vaccination, COVID positive home visits, and after-hours GP Respiratory Clinics.

However, despite WAPHA's attempts to raise concerns about the lack of primary care involvement in the state's COVID-19 planning and coordination efforts, the state declined to involve them in the development of a whole health system-wide framework for disaster management.

Later, when WA Health approached WAPHA to lead community-based care for mild-moderate COVID-19 symptoms, WAPHA was unable to anticipate and plan for this request due to WA Health's limited understanding of how the primary and community care sector worked. This demonstrated the need for involvement in state planning to ensure seamless coordination across the health system.

Furthermore, the state's differing policies to the Australian Government regarding eligibility for COVID-19 vaccination disrupted the primary health-led rollout. Practitioners were forced to repeatedly inform patients that they were not eligible at their clinics, creating confusion and frustration.

WAPHA's experience in the COVID-19 response in Western Australia highlights the importance of integration and collaboration across health systems to create a unified whole. Collaboration strengthens preparedness for future disasters, promoting efficiency and effectiveness in the response.

Case Study 2. Associate Member of one Local Disaster Management Group, Northern Queensland PHN (NQPHN).

In North Queensland, while Queensland Health is the primary health representative in the Local Disaster Management Group (LDMG), the Northern Qld PHN is an associate member of one LDMG, and is “in the room” during disaster planning and responses. This allows NQPHN to actively participate in disaster management efforts. NQPHN in this instance, is well positioned to hear and anticipate requests for primary health support, which can improve response times and enhance overall effectiveness of disaster response efforts. NQPHN can also provide timely feedback of primary healthcare needs.

NQPHN promotes and advocates for the role of primary care in disaster preparedness, response, and recovery within the LDMG outside of disaster times, enhancing their contribution to the overall disaster management efforts.

By including PHNs as members of LDMGs, a whole-of-system approach can be enabled to support primary care response times during a disaster. This will enhance the primary care providers’ capability and preparedness to respond to disasters and support on going recovery post-disaster.

Case Study 3. Response and innovation in a crisis, Nepean Blue Mountains PHN (NBMPHN).[ii]

The Blue Mountains bushfires in October 2013 highlighted the need for local coordination of primary health resources during disasters. The NBMPHN and local health district recognised the absence of primary healthcare in formal processes and the potential for high demand from displaced residents on an already stretched emergency department for primary care matters.

NBMPHN organised GPs to attend evacuation centres on a 24/7 basis. They also coordinated primary healthcare efforts within practice settings, diverting patients to neighbouring practices where GPs were not open or operational due to the impact of the fires. NBMPHN was the conduit to communicating what was happening on the ground in relation to primary care, back to the emergency operations centre, and seeking support from practices in surrounding towns to extend hours or see patients from other practices over this period.

In the recovery phase, the PHN secured additional funding for counselling services for local residents with payments made to private mental health clinicians by the PHN.

NMBPHN also showed their innovation and preparedness in anticipating the next disaster. They coordinated with other local response members, including the hospital district's Local Health Network, provided training to local GPs and organised a register of GPs willing to be called on in times of disasters. The Medical Incident Management and Support (MIMMS) training for GPs was included in the preparedness efforts, as well as packs developed for doctors in emergencies. These packs included identifying vests with "DOCTOR" printed on them, referral forms, contact numbers, script pads and other supplies.

The Nepean Blue Mountains PHN demonstrated their value in local coordination of primary health resources during disasters and in recovery, and their innovation in preparing for future emergencies. Because of their planning and experience, the NBMPHN was able implement many of their innovative practices during the 2019-2020 bushfires.

However, the role of the PHN and general practice contribution to emergency management is still not formally recognised in plans and this means that involvement relies on relationships which need to be continually re-established when there are staffing changes. The PHN needs to continually educate disaster management personnel on the contribution and value add of primary care. This often means primary care and the PHN are overlooked in preparedness planning and the full potential of involvement is not realised.

The lack of a dedicated resource or funding for disaster preparedness also means that the learnings from the 2013 bushfires and development of the PHN disaster planning response took a significate amount of time as other priorities took precedence. This limits PHNs ability to contribute effectively as funding tends to only be provided for recovery activities and PHNs must scramble in the height of a disaster to develop processes on the run which is poor practice.

Case Study 4. Disaster Management Framework, Healthy North Coast (HNC).[iii]

The Northern NSW floods in 2022 put significant strain on emergency services. It was necessary for primary health care services and the local PHN (HNC) to play an active role in the response effort due to the catastrophic nature of the event, even though this role was not articulated in local or state-wide plans. Some of the requests made to primary health care from response agencies were relevant to the scope and nature of primary health care, some were not. In response Healthy North Coast developed a Disaster Management Framework to define the role that primary health care and the PHN could play in future responses on the North Coast. The Framework has been shared with local response agencies to help prepare for future disasters.

HNC's Disaster Management Framework is structured around the four phases of emergency management: preparedness, response, recovery, and prevention. A severity scale provides guidance to assess the severity of an event and determine the appropriate level of response. The Disaster Action Plan outlines the activities that HNC will undertake during a disaster, depending on the severity, and the key services, such as general practice, community pharmacies and psychologists, the organisation will work with. More than 40 activities sit under the objectives of: 1) Communicate, advocate and network; 2) promote and enhance local planning; 3) communicate and escalate; and 4) commission, debrief, share learnings, and evaluate.

The Disaster Management Framework has provided HNC with a structured approach to prepare, respond, recover, and prevent disasters that have a health impact on communities. The framework has been informed by 2022 Northern NSW floods in 2022 but also learnings from the 2019 bushfires, the 2021 Mid North Coast floods and the COVID-19 pandemic. It has also been tested through scenario planning which has resulted in a more comprehensive and tailored response.

The Disaster Management Framework has enabled HNC to articulate the contribution that primary health care and primary health networks can make during disasters on the North Coast. *Key challenges exist, however, with the incorporation of the Disaster Management Framework into local emergency management plans.*

Case Study 5. Ensuring Coordinated Healthcare During Disasters, COORDINARE (South Eastern NSW PHN).

The South Eastern region of NSW experienced unprecedented, catastrophic bushfire damage in December 2019 and into March 2020, followed closely by the COVID-19 pandemic. In response to these events, PHNs took on new responsibilities, ranging from supporting communities in their recovery from drought and bushfire trauma to helping ensure that primary care is connected into a planned and well-coordinated disaster response.

COORDINARE has developed processes and tools to ensure that GP and Aboriginal Community Controlled Health Organisations (ACCHOs) are supported as an essential service to ensure access to medical care during a disaster or pandemic, therefore helping maintain community health and resilience. COORDINARE is also working to ensure that primary care is represented at the regional and local level in preparation and planning. Our vision for disaster planning and management is: ***One coordinated regional health system*** *that supports resilient communities to prepare and respond to past, present, or future disasters.* Key activities undertaken by COORDINARE include:

- **Disaster response register**
  COORDINARE maintains a register of trained primary health care providers willing to assist during a disaster situation - which could include providing medical care at a residential aged care facility, another general practice, or an evacuation or recovery centre.

- **Audit of primary care providers**
  COORDINARE conducted a baseline audit and consultation with the aim of ensuring that general practices had emergency plans and business continuity plans in the event of a disaster or pandemic. COORDINARE provided training and resources regarding improving emergency plans, scenario planning and implementing specific HealthPathways regarding emergencies (e.g., treatment for burns and smoke inhalation for bushfires, COVID-19 management).

- **Disaster Management Community of Practice**
  COORDINARE established a Community of Practice online hub for GPs to foster peer-to-peer collaboration, enabling them to share information, connect and collaborate and stay informed of important news and events in the region as they happen.

- **Liaising with Emergency Management Agencies**
  A key role for COORDINARE is to strengthen and build local and regional partnerships for planning, communications and effectively responding to disasters. COORDINARE has been campaigning to have primary care representation as a recognised part of the disaster preparedness and planning process. There is now agreement to have GP representatives on the two Regional Emergency Management Committees, and in some of the Local Emergency Management Committees with observer status.

However, financial, and structural barriers (including legislative barriers) exist for our GPs and ACCHOs to participate fully in disaster management processes. Dedicated government funding will be needed if the PHN disaster management coordination and representation roles are to continue in the future, which will be essential in ensuring people are able to access primary care during and after an emergency.

iv. The role of Australian civil and volunteer groups, not-for-profit organisations, and state-based services in preparing for, responding to, and recovering from natural disasters, and the impact of more frequent and more intense natural disasters on their ongoing capacity and capability.

Key Messages:

- PHNs and primary care have an important and unique role to play in disaster and crisis situations and must be better integrated into emergency preparedness, response, and recovery efforts as recognised in several formal government documents and reports (e.g., Royal Commission into Disaster Management Arrangements, Primary Care 10 year plan)
- PHNs, in a disaster context, deliver value in two critical areas:
    - To ensure a continuity of access to primary care resources to meet continuing health care needs and reduce pressure on acute care.
    - To address the immediate impacts of the disaster at-hand.
- PHNs have a proven track record as innovators in the development of locally integrated disaster preparedness, response, and recovery efforts.
- Despite their efforts, PHNs do not have a formal role in Commonwealth or state/territory disaster emergency management arrangements.
- This lack of coordination results in the underutilisation of a highly skilled primary healthcare workforce in disaster situations (general practitioners, pharmacists, nurses, and allied health professionals).

Primary care has an important and unique role to play in disaster and crisis situations.

Primary care providers often share the disaster experience with their local community affording them a deeper understanding of their health care needs and the real-time effects of the disaster on the community. The Royal Australian College of General Practice (RACGP) recognises that general practice is the "linchpin of Australia's health service" in responding to disasters, from the immediate and acute phase through to long-term recovery.[iv]

The Primary Care 10 Year Plan states:

> "Primary health care needs to be better integrated into emergency preparedness and response at local, jurisdictional and national level to prepare for future droughts, floods, bushfires, communicable disease outbreaks and other emergencies" [v]

This statement for the inclusion of primary care in disaster arrangements is further supported by Recommendation 15.2 of the 2020 Royal Commission into Disaster Management Arrangements, which states:

> "Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports"[vi]

PHNs, as the regional coordinating bodies of primary care, have been acknowledged to provide value in preparing for, responding to, and recovering from disasters.

In The Primary Care 10 Year Plan 2022-2032 (The Primary Care 10 Year Plan), PHNs are recognised for their "vital role" in supporting the primary care response to drought, bushfires, floods, and COVID-19 pandemic in recent years. The Commonwealth has recognised this through the important responsibility afforded to PHNs in the implementation of the Primary Health Care 10 Year Plan with an action area to:

> "[i]ntegrate primary care services into local and state emergency preparedness and response arrangements, with facilitation from PHNs"[vii]

The benefits of PHN representation in formal disaster management arrangements are also articulated in the 2020 PHN Cooperative White Paper, 'The role of Primary Health Networks in natural disasters and emergencies'[viii]. The paper notes that while Commonwealth and state/territory agencies hold responsibility for on-the-ground disaster management during disasters or health emergencies, PHNs are well placed to coordinate a strong primary health care response. A one-system approach that incorporates PHNs and primary care can more effectively deliver care where and when it is needed, reducing pressure on the acute sector in a cohesive, organised, and effective way.

PHNs act in two capacities in relation to disasters:

1. Firstly, PHNs enable a continuity of care by supporting primary care to keep delivering for communities. This is important for:
    a. maintaining the health and wellbeing of local communities as community health needs do not cease and give way to the presenting disaster, rather, the effects of chronic disease and mental health continue and are in some cases exacerbated because of the disaster.
    b. reducing pressure on acute care in hospitals during and after a disaster.
2. Secondly, PHNs help to address the immediate impacts of the disaster at-hand.

PHNs have a proven track record as innovators in the development of locally integrated disaster preparedness, response, and recovery efforts.

PHNs streamline healthcare services by coordinating care so that people receive the right care, in the right place, at the right time. PHNs achieve this by leveraging their broad networks (e.g., general practice, allied health, pharmacy, and community health providers like Aboriginal Community Controlled Health Organisations (ACCHOS)) within their local communities to continually identify and assess current and emerging needs and develop responses accordingly (see case study 6). PHNs bring these critical skills to the table in disaster preparedness, response, and recovery efforts, as demonstrated in the case studies included throughout this document.

In previous disaster situations, PHNs have acted to ensure the continuity of primary care by coordinating in real-time with providers and gathering intelligence on changes to practice opening hours and practice closures as well as coordinating the extension of hours where necessary (see case studies 7, 8, 9 and 10). Where practices are closed in a disaster region, PHNs have also been able to utilise their local networks, and overcome issues of provider numbers, credentialling, billing and resourcing of supplies, to coordinate general practitioners to practice from other sites and arrange additional support to be provided from neighbouring regions, including via telehealth (see case studies 11 and 12). This is crucial as it ensures continuity of routine care for the community and ensures additional pressure is not added to already stretched acute emergency hospitals and health services.

PHNs have also demonstrated their capacity to advocate for and implement innovative solutions in response to community need, such as advocating for changes to MBS to enable increased access to telehealth for disaster impacted regions (see case study 11) or coordinating integrated models of multidisciplinary care to support people during the COVID-19 pandemic (see case study 13).

Yet, PHNs do not have a formal role in Commonwealth or state and territory disaster and emergency management arrangements.

Despite their proven capacity to prepare for, respond to, and assist in the recovery from disasters, there has historically been a lack of systematic coordination with primary care providers and PHNs. PHNs across Australia have varying degrees of integration with disaster management systems, with the vast majority not included. This lack of coordination results in an underutilisation of a highly skilled primary healthcare workforce, comprising general practitioners, pharmacists, nurses, and allied health professionals. Given the unique local knowledge and established community relationships held by primary care, this is an inefficient workforce approach and undermines the provision of essential care to the community when it is most needed.

It is essential that PHNs and primary care providers are enabled to function as efficiently as possible during times of crisis. Primary care professionals are trusted community leaders that people look to for guidance and the management of acute injury or illnesses and ongoing management of chronic disease (e.g., asthma and chronic obstructive pulmonary disease (COPD) are exacerbated by bushfire smoke and thunderstorms). If these essential services are not integrated into disaster planning and response activities, in a coordinated way that leverages the existing capability of PHNs as system coordinators, they will be unable to provide the appropriate level of holistic and ongoing support their communities need as a consequence of cascading disasters.

It also presents a missed opportunity to maximise the primary care workforce capacity to relieve pressure on the already stressed acute care sector (refer to Royal Commission report[1]**)[ix].** By enabling continuity of care in primary care (e.g., keeping general practices open to see patients), this can prevent people from presenting at hospital emergency departments. PHNs have meaningful relationships with LHD / LHN / HHS and the state-led health workforce and can support them in times of disaster. However, a lack of PHN integration state-led disaster management arrangements consistent with a one-system approach, prevent PHNs from being able to provide maximum support.

Furthermore, during a disaster, aged care shifts to the jurisdiction of the state government, not the commonwealth; thus, supporting aged care is not within the PHNs scope of work. Despite this, some PHNs have been able to offer support to struggling residential aged care facilities (RACF) during disasters (see case studies 1, 5, 6 and 15). Future PHN support for RACFs during disaster could be better coordinated, enabled, and increased if PHNs were formally involved in state-based disaster management arrangements.

It is worth noting that in the face of a health workforce crisis, health resources are finite. Coordinating care, providing efficiency, and reducing undue stress on healthcare workers is vital to preventing further workforce exodus. PHNs have the skills and experience to assist with this and can play an

[1] The Royal Commission into Natural Disaster Arrangements noted that despite being trusted members of the community that are depended upon in the event of a natural disaster, PHNs and primary care providers remain inconsistently incorporated into natural disaster arrangements. This in turn, impedes the delivery of healthcare. The Commission recommended that PHNs be incorporated at the necessary level of government.

important role in supporting and promoting the well-being of the primary care workforce (see case study 14).

Case Study 6. A Collaborative Flood Response, Murray PHN.

During a recent flood event, Murray PHN worked collaboratively with stakeholders to ensure access to primary care services to displaced people and health services (general practices, pharmacies etc.).

Emergency Primary Care Clinics (EPCCs) were established in flood impacted areas and Murray PHN recruited and maintained a roster of general practitioners and nurses across a 7-day period to provide services for displaced people. Murray PHN also provided necessary equipment to manage conditions and ensured clinical governance oversight through a GP medical advisor. Twice daily stand-up meetings were held on site at emergency evacuation centres and included the clinical staff from the EPPC, Acute Health Services, Ambulance Victoria, Commissioned Health Services and State government.

In addition, Murray PHN helped ACCHOs and pharmacies to access generators and sandbags with the assistance of the State government and State Emergency Service. Murray PHN also provided direct advice on how to protect key equipment (servers, fridges etc.) in the event of flooding.

By maintaining regular contact with primary care providers including pharmacies, the PHN was able to ascertain significant supply chain issues, which resulted in decreasing stock in wound management equipment and medications, specifically antibiotics, insulin, and antidepressants. To address this issue, the PHN coordinated with other providers to share stock and worked with the State Government and the other stakeholders (e.g., The Pharmacy Guild), to liaise with usual transport suppliers to expedite deliveries and find alternate delivery modes.

Murray PHNs also supported Residential Aged Care Homes (RACH) during the floods with many significantly impacted by staff shortages and COVID outbreaks, and with GPs not able to access their patients. The PHN worked with local general practices not impacted by the flood to provide temporary services to RACH and arranged for staff that were part of the roster for the EPCC to provide staffing to the RACH.

Case Study 7. Lismore Health Precinct – Supporting Primary Care Continuity, Healthy North Coast PHN (HNC).[x]

The Lismore Health Precinct was established by Healthy North Coast in response to the 2022 Northern NSW flood recovery efforts. Funded by the Australia Government the Precinct houses over 20 primary health services to provide care for Lismore residents impacted by the floods.

The initiative was coordinated in just three weeks and will be available for clinicians for at least two years after the flood at no cost to providers. The precinct included general practice, pharmacy, pathology, mental health, and a range of allied health services. The initiative ensured local providers could remain viable, continue to generate income, and care for the community.

Case Study 8. We Are Open, Healthy North Coast (HNC).

We Are Open is an initiative that focuses on supporting general practitioners, Aboriginal Medical Services (AMSs), and pharmacies to extend their opening hours during times of emergency. The program was first introduced during the 2019 bushfires and has been used in disasters since. We Are Open is a cost-effective solution to ensuring service continuity of primary health care services during emergencies.

We Are Open can be activated in situations where there have been disruptions to health care facilities, reduced availability of the health workforce, or essential utilities such as electricity, water, and telecommunications have been cut off. The program is funded via the Australian Government PHN program although there is no specific schedule for this initiative. The program ensures access to essential primary care services to assist in preserving local emergency department capacity. It also allows more residents to access timely and appropriate local care and provides an alternate option to providing emergency health care services at evacuation centres.

Communication of extended hours and opening times to evacuation centres, hospitals and health services, and others involved in the emergency and relief response efforts, assists with patient flow management. Participating services agree to see new patients affected by the emergency, charge patients the same bulk billing and fee structure as regular weekday fees and provide information to allow monitoring of patient throughput during the additional sessions. In return, participating primary care providers are supported financially by the PHN to prepare and co-ordinate additional service delivery.

During the catastrophic 2022 Northern NSW floods, We Are Open was activated in affected areas to provide extended primary care services to patients who were impacted by the floods. Participating general practices and AMSs extended their opening hours and provided essential services to their patients at no extra cost. The initiative played a critical role in providing primary care services to the affected communities, as well as assisting in the management of patient flow at local hospitals and emergency departments.

The We Are Open initiative has been a vital part of HNC's disaster management approach. It has allowed communities to continue to access general practices, AMSs, and pharmacies during disasters while also supporting the broader health system's response efforts.

Case Study 9. SMS Emergency Alert System, North Queensland PHN (NQPHN).

NQPHN serves the disaster-prone regions of North Queensland. In preparedness for these events, including cyclones, floods, and bushfires as well as public health emergencies, NQPHN developed its SMS Emergency Alert System to notify GPs and pharmacies in preparation for adverse events.

This program enables NQPHN to communicate to subscribers via direct SMS. Examples of these SMS communications include seeking:

- business operation status, or
- the capacity to provide workforce support in response to a request from Local Disaster Management Groups or Hospital and Health Services (HHSs).

All subscribers are categorised via profession, Local Government Area, and HHS region. This enables targeted SMS communications to be sent as required.

Utilisation of this system during a significant wet weather event resulted in the ability to ascertain the business operation status (open for business) of 55 general practices and pharmacies within 1.5 hours with minimal impact or disruption to subscribers' business operations.

60 per cent of responses were received within 30 minutes of the SMS message being sent.

Prior to the introduction of the SMS Emergency Alert System, NQPHN staff manually gathered information from general practices and pharmacies by phone, which was a burden on healthcare professionals who had to take time away from patient care to provide this information.

Case Study 10. Capacity Tracker Implementation, Gippsland PHN as well as Hunter New England and Central Coast PHN.

Gippsland PHN and Hunter, New England and Central Coast PHN recognised the need for real-time data from the primary care sector to ensure operational readiness in times of disaster, as well as to gauge workforce, vacancies, and PPE supplies. To meet this need, they introduced Capacity Tracker, a software developed by an NHS agency in response to COVID-19.

Capacity Tracker was introduced to general practice, pharmacies, and residential aged care facilities during the COVID-19 pandemic. The software enabled real-time data sharing to identify issues early and assess service capacities, with the information fed into daily regional meetings that included health and emergency services.

In addition to its COVID-19 response, Gippsland PHN also utilised Capacity Tracker to gauge primary care capacity to scale up and respond to other emergencies, such as floods and bushfires. The provision of accurate and real-time information on workforce and resource needs helped coordinate response efforts and ensured that those affected by the disaster received care and support in a targeted and timely manner.

The implementation of Capacity Tracker by Gippsland PHN and Hunter, New England and Central Coast PHN was a success, providing critical real-time data that helped coordinate response efforts during emergencies. The technology has since been adopted by other PHNs across Australia and highlights the importance of real-time data sharing and coordination in ensuring operational readiness and continuity of care during times of disaster.

Whilst the platform was initially resourced through COVID-19 funding, ongoing licencing costs require support from other sources, and its utility is dependent on PHNs being able to share this important information with other emergency response agencies to facilitate co-ordination of local efforts.

Case Study 11. PHNs Advocate for MBS Change in Response to Flooding.

In early 2021, the Hawkesbury region in New South Wales (NSW) experienced severe flooding, causing local GPs to close and patients to be evacuated or left isolated/cut off. This posed a significant primary care access challenge for affected residents, who were unable to see their regular GPs due to the telehealth rule that requires patients to be an existing patient/be seen face-to-face once per year.

To address this challenge, Primary Health Networks (PHN) in the region advocated for an exception to the telehealth rule during disasters. The Department of Health and Aged Care

granted this exception at the PHN's request, enabling patients to access telehealth appointments with GPs who were not their regular providers.

To facilitate this, the PHN created a list of GPs in non-flood areas who were willing to accept telehealth appointments for patients in flood-affected areas that could not see their regular GP. This list was published and made available to affected residents.

When subsequent floods hit the region and other parts of NSW, the PHN's telehealth exception was not only accepted again but was also made a permanent Medicare Benefits Schedule (MBS) item/exception that applies when a region is listed as disaster affected. This means that PHNs Australia-wide no longer need to seek MBS exceptions during each disaster, and affected residents can access primary care through telehealth during disasters without needing to see their regular GPs face-to-face.

This innovative approach by the PHN Cooperative demonstrates the value of their local knowledge and advocacy skills in responding to community needs during disasters. By identifying barriers to access and advocating for solutions, PHNs can ensure that affected residents receive the care they need, even when local resources are stretched.

Case Study 12. Response to the February 2022 Floods, Brisbane North PHN.

In February 2022, Brisbane North PHN was faced with the challenge of supporting 134 of their 340 practices in the region that were affected by floods. Nearly 40% of practices had their service continuity disrupted due to water damage, road flooding, and power outages.

The PHN acted proactively to ensure continuity of primary care provision and rapid issue identification through directly liaising with each practice to confirm their status, impact on service continuity, and provision of targeted support where needed. The PHN provided communications on access to key emergency contacts, disaster support, and mental health services. The PHN also liaised with the local hospital network where electronic communication was not possible to ensure continuity of referrals for acute/outpatient services could continue.

In the long-term, the PHN provided intensive support to five practices that were forced to close due to the flooding including assisting with obtaining new provider numbers, operating out of different practices temporarily, and the set up, and billing for telehealth services. The PHN also assisted practices in obtaining maintain access to the Practice Incentives Program.

Overall, Brisbane North PHNs proactive response ensured that practices could continue the provision of primary care services for their respective communities with minimal disruption. The PHNs response was critical in alleviating pressures on primary care providers in the immediate days following a disaster.

Case Study 13. Integrated COVID-19 Pathways, North Western Melbourne PHN.

During the second wave of COVID-19 in Victoria, North Western Melbourne PHN (NWMPHN) identified the need for early intervention and monitoring of COVID-19 positive patients to minimise community transmission and enable timely and appropriate care transitions for deteriorating patients. The goal was to improve clinical outcomes and strengthen the public health response.

NWMPHN developed and piloted the COVID-19 Pathway as an integrated model of care with primary, community and acute hospital providers to proactively support the health and social care needs of people with COVID-19. Following the pilot, the care pathways was expanded to

include the remaining hospitals in the network and informed Victorian guidelines for state-wide adoption.

As a result of the COVID-19 care pathway, 80 percent of COVID-19 positive patients enrolled in the North Western COVID-19 Care Pathway were able to be cared for in the community by GPs. This meant patients were able to recover more comfortably in their own homes, already burdened hospitals were spared further admissions, and the risk of further transmission was greatly reduced at a time when infections were hitting record highs. Additionally, 89% of respondents to the experience survey rated the healthcare they received as good or very good.

More than 300 GPs and 200 practices received proactive PHN support to implement the pathway and were provided with access to secondary consult support, education, and training and the HealthPathways Melbourne platform, which saw 2,633 page views during the second wave.

Overall, the Integrated COVID-19 Pathways developed by North Western Melbourne PHN proved to be an innovative solution to meet the health and wellbeing needs of people with COVID-19 in the region. The success of the program was due to the collaborative effort of various healthcare providers and the proactive support of the PHN in implementing the pathway.

Case Study 14. Workforce Support and Wellbeing Program, Healthy North Coast (HNC).[xi]

The Workforce Support and Wellbeing Program was designed to support primary care teams in the region during the disaster recovery period after the 2022 Northern Rivers floods, with a focus on retaining the workforce by addressing the impacts of the flooding on the mental health and wellbeing of healthcare professionals.

The program's three key initiatives were developed in consultation with local clinicians and aimed to provide rest and relief for overworked healthcare professionals, promote resilience and debriefing among teams, and build individual capacity to be responsive to patient needs. The first initiative, Debrief and Wellbeing, was tailored to support teams and individuals in looking after themselves following the flood event. The program was delivered by a local psychologist and/or experts in this area and offered flexible content to meet the needs of participants. Importantly, the program was free and easily accessible, providing an opportunity for early intervention when issues arose and aiming to increase individual resilience.

A buddy locum service was also established with practices linking up to provide much needed rest to exhausted health professionals and administration staff. With funding from the Australian Government, the PHN was able to ensure no service was at a loss for sharing their staff with another practice. Out-of-region locums were also engaged when there was no local capacity.

By focusing on the needs of healthcare professionals and supporting their wellbeing, the Workforce Support and Wellbeing Program helped to ensure that the primary care workforce remained in the region to provide essential services to the community during the recovery period. The program's engagement and empowerment approach not only addressed the immediate impacts of the flooding but also aimed to build individual and team resilience to better prepare for future challenges.

(b) Consideration of alternative models, including:

i. Repurposing or adapting existing civil and volunteer groups, not-for-profit organisations, and state-based services.

Key Messages:

- Disaster management arrangements must be dynamic and systematic, incorporating all aspects of disaster preparation, response, and recovery efforts, and be responsive to local community preferences, values, and needs.
- The system intermediatory role, expertise, and existing structures of PHNs makes them ideally placed to contribute to systemic preparation, response, and recovery efforts in disaster situations, coordinating the efforts of primary care providers within wider disaster management arrangements.
- To appropriately utilise Australia's primary care resources and ensure a continuity of care during disasters, PHNs must take on a consistent and defined role in disaster management. PHNs will require systematic formal recognition, authorisation, and resourcing to accomplish this.

Disaster management arrangements must be dynamic and systematically incorporate all aspects of disaster preparation, response, and recovery efforts to effectively utilise the available workforce, especially given the toll that more frequent and intense disasters are likely to have on human resources. These arrangements must also be responsive to local community preferences, values, and needs. Finding creative, flexible solutions to workforce continuity should be a priority, as an external, fly in workforce is not a sustainable option, given the increased frequency of cascading disaster events (see case study 15).

PHNs are ideally placed to effectively contribute to coordinated, systemic resilience efforts in disaster situations, coordinating the efforts of primary care providers within wider disaster management arrangements. This requires PHNs to be formal members of disaster management arrangements, complementary to the LHN / LHD / HHS role within the broader health response. In some regions there are existing arrangements between local PHNs and local disaster management committees (see case study 2); however, this has not been systematically adopted across Australia.

PHNs have systems in place that can be drawn upon immediately, including capabilities in coordinating the primary care workforce and local reporting of system issues and needs. These systems could be better utilised within a disaster management context if PHNs are systematically incorporated into local health planning across Australia. PHN capabilities in coordinating the primary care workforce allows for the quick mobilisation of primary care resources, while reporting structures allow for dynamic assessment to be undertaken to ensure these resources are utilised effectively and where they are most needed. Their utilisation across Australia, however, remains inconsistent with variability in the way PHNs are incorporated into disaster arrangements, and many not included at all. PHNs must take on a consistent and defined role in disaster management arrangements to appropriately utilise Australia's primary care resources, but require systematic formal recognition, authorisation, and resourcing to accomplish this.

PHNs possess valuable knowledge of local communities which will assist decision-making structures to allocate resources based on population circumstances, such as the presence of vulnerable groups, as well as tailor proposed solutions to these communities. This is demonstrated in the case studies throughout this document, however, their incorporation into wider arrangements is essential to ensure Australia's preparation, response, and recovery in the face of more frequent, cascading disasters. The involvement of PHNs can be particularly beneficial in the recovery phase of a disaster as PHNs are able to tailor and deliver ongoing support to where it is most needed (case study 16 and 17).

Case Study 15. Enhancing the Immunisation Workforce, Tasmanian PHN.

The Tasmanian PHN demonstrated its capacity to address disasters through its work enhancing the immunisation workforce.

In March 2021, in response to the increased demand on the immunising workforce, the Tasmanian PHN subsidised access to the Course, 'Immunisation Practice in Primary Healthcare and Tasmanian endorsement unit'. The first intake targeted nurses and Aboriginal health workers working in general practice and Aboriginal Community Controlled Health Organisation (ACCHO), later expanding to those working in residential aged care and disability facilities in 2022.

201 participants registered for the course. This created an opportunity to either enhance professional development in vaccination, or on completion of the course for registered nurses (RNs) to register in Tasmania as an Authorised Immuniser.

Whilst assisting in meeting an immediate need, this initiative also strengthens the vaccination workforce for the longer term.

A funded role in disaster preparedness would have potentially enabled an ongoing training program to build authorised immuniser workforce over time as part of pandemic planning, providing an immediate capability at the time of the pandemic, rather than building this workforce as the pandemic progressed.

Case Study 16. Primary Health Care Infrastructure Support, Healthy North Coast (HNC).[xii]

The Flood Recovery Infrastructure Grants Program 2023 offered financial assistance to eligible primary healthcare services located in the Lismore Local Government Area (LGA) that were impacted by the 2022 floods.

Co-funded by the Australian and NSW Governments through a $5 million flood recovery package, the grants provided up to $150,000 per eligible grant recipient to rebuild flood-damaged infrastructure, repair or replace flood-damaged equipment, or relocate to alternative premises within the Lismore LGA. Using a place-based approach the PHN worked closely with local primary health care professionals to ensure local needs were identified and addressed appropriately via the grant distribution methods. The program was open to primary health care providers.

Case Study 17. Community Wellbeing and Resilience Grants, NSW.[xiii]

Community Wellbeing and Resilience grants have been made available by PHNs in bushfire and flood effected regions via Australian and NSW government recovery funding. The grants support communities to recover from the impacts of natural disasters and build their capacity to face future challenges. The program funds grass-roots community initiatives that address trauma impacts, improve social and emotional wellbeing, build individual and community resilience, strengthen social and cultural connections, and increase preparedness, response, and recovery capabilities.

Activities demonstrate local leadership, respond to identified community needs, mobilise the skills, passion, and experiences of individuals, families, and organisations, foster the development of partnerships and linkages, and focus on long-term sustainability.

Some PHNs offer grant writing support as part of the commissioning method to build capacity of small community organisations. Some PHNs also facilitate a community of practice to ensure learnings are shared between providers.

The limitation of this program is that the grants are short-term and small scale so successful initiatives cannot be funded again unless alternative funding is sourced.

PHNs in other jurisdictions also have had similar programs; however, the role of such programs are not consistently recognised and could be better built into disaster management frameworks.

(c) Consideration of the practical, legislative, and administrative arrangements that would be required to support improving Australia's resilience and response to natural disasters.

Given more frequent, intense, and cascading disasters, considerations need to be made to allow PHNs across Australia to support the capacity of the primary care workforce to prepare for, respond to, and recover from disasters.

The following recommendations outline what practical, legislative, and administrative requirements are needed to support this objective:

1. *It is vital that primary care is integrated within existing disaster arrangement structures and that PHNs have a seat at the decision-making table to enable this integration*. PHNs can embed a primary health focus to disaster planning, preparedness, and response decision-making to complement current processes focused on the acute care setting. To do so:
    a. Current emergency preparedness, response, and recovery legislation at both the Commonwealth and state/territory levels must allow for the representation of PHNs on Emergency Management Committees.
    b. PHNs should be incorporated within the health portfolio on disaster committees consistently across Australia to ensure effective coordination of primary health resources. As highlighted in case studies 1 and 2, incorporating PHNs into local disaster committees results in more cohesive and efficient disaster responses by the primary care sector.
    c. To support this aim, funding of a disaster coordinator role in each PHN across Australia is essential to allow PHNs the resources to participate in disaster preparedness activities.
2. *Adequate resourcing must be provided to enable PHNs and the primary care workforce to adequately prepare for, respond to, and recover from disasters.* Currently, funding is generally distributed on an ad hoc basis where a disaster is declared for the immediate response, leaving PHNs to independently fund preparedness and recovery efforts.
3. *Primary care and PHNs must be adequately prepared to respond to disasters through support for involvement in capability building and training alongside emergency services and tertiary care providers in local disaster arrangements.* These capabilities must also be tested alongside emergency services to ensure effective lines of communication and execution of plans. PHNs must be adequately funded to strengthen the disaster preparedness, response, and recovery capability of the primary care workforce with funding targeted towards communities likely to face disasters.
4. *Regulatory requirements must be changed so that primary care providers are able to practice from different locations, including medical installations and other practices.* Provider numbers are necessary for billing, prescribing, and referral processes. During the 2019-2020 bushfires, short term regulatory changes enabled primary care practitioners to practice from various locations for up to two weeks and apply for a new provider number beyond this point. These arrangements should be in place and nationally approved for them to be immediately available, when necessary, rather than policies that are enacted on an ad hoc basis (see case studies 4 and 11). PHNs are ideally placed to distribute such information to providers, ensuring they are prepared to practice when needed.

5. *Funding must be available to PHNs and primary care providers to continue to serve the community during disasters.* This could be by way of existing funding mechanisms such as MBS items that can be claimed by PHNs and primary care providers alike. Flexible funding options should also be available to PHNs that can be drawn upon immediately in the event of disaster. In the past, PHNs have had to privately fund providers during disasters as they were unable to access Medicare funding. PHNs have also supported primary care providers to stay open for longer (see case study 9).

6. *The Government must invest in the expansion of data sharing capabilities*:

    a. They must provide PHNs with access to relevant data to inform planning and preparedness activities. The sharing of this information will allow for the targeted planning of responses in disaster situations that are specific to individual community needs.

    b. There must also be an expansion of interoperable technology that support the continuity of clinical care through systems such as MyHealth record. Patient notes and prescriptions should be able to be easily recorded and shared to ensure continuity of access to care and maintaining safety and quality.

7. *Clarity must be provided around insurance coverage for primary care providers practicing in a disaster response capacity.* During previous disasters, insurance coverage has been unclear, which creates undue stress and uncertainty for practitioners giving up their time to serve the community in distressing and difficult disaster circumstances.

8. *Credentials must be provided to primary care providers in temporary medical installations to ensure that primary care providers are correctly identifiable when necessary.* They must also be provided with identifying clothing such as high-visibility vests with “DOCTOR” or “REGISTERED NURSE” on them, like the NBMPHN initiative implemented after the 2013 bushfires (see case study 3).

9. *Clinical governance structures must also be implemented for all practitioners in a disaster response setting*. This should be embedded within disaster preparedness structures to avoid clinical risk from breaches of care safety and quality during the response phase. PHNs can develop these frameworks in conjunction with local care providers and local disaster management structures appropriate to workforce and local needs (see case studies 3 and 4).

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A White Paper

The role of Primary Health Networks in natural disasters and emergencies

phn COOPERATIVE

An Australian Government Initiative

The role of Primary Health Networks in natural disasters and emergencies

The extraordinary circumstances of 2020 have highlighted the important role that should be held by primary care providers and Primary Health Networks (PHNs) during times of crisis. Primary health care is an important part of Australia's healthcare system but while there is much goodwill and commitment from primary care providers, they are not able to maximise existing capabilities for response, relief and recovery, without coordination, leadership and support.

Although Commonwealth and state agencies have the overall responsibility for on-the-ground disaster management, during natural disasters or health emergencies, PHNs offer the opportunity to coordinate a strong primary health care response that will deliver care where and when it is needed, reducing pressure on the acute sector and ensuring an organised and effective response. It is essential that disaster management is integrated and coordinated between all key stakeholders and the role of primary care and PHNs is recognised and supported by all levels of government (local, state/territory and Commonwealth). The following recommendations provide a platform for integrated emergency preparedness, response and recovery efforts in the future.

Recommendations

1. **Authorised:** PHNs must be authorised by national, and state and territory governments and recurrently funded to coordinate regional primary healthcare responses before, during and after natural disasters and emergencies, as part of the overall health emergency response.
2. **Recognised:** PHNs should be included as key agencies in national, state and regional health emergency preparedness and response plans with clear, formalised roles and responsibilities. Adequate PHN and primary care representation on relevant planning and preparedness committees is an essential component of disaster management.
3. **Funded:** The Australian Government must fund PHNs and primary healthcare providers to undertake regional emergency planning and preparedness work, including developing primary health preparedness and response plans, and related communication, training and trialling.
4. **Resourced:** The Australian Government must ensure that additional primary healthcare resources and arrangements are available to provide regional surge capacity if, when and where required—for example the funding provided to enable PHNs to manage the distribution of personal protective equipment (PPE) during the COVID-19 pandemic.
5. **Prepared:** Regional emergency plans for effective engagement of PHNs and primary healthcare providers must: be made in advance; include local communication pathways; build on lessons learned during 2020; and be incorporated into existing emergency management structures and protocols.

The Royal Commission into National Natural Disaster Arrangements Report released on 28 October 2020 recommended "*Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports*" **Recommendation 15.2: Inclusion of primary care in disaster management**

Problems with current primary health care emergency response arrangements

A high-performing system—in 'normal' times

Australia is fortunate in having a high-performing health system, based on the strengths of a mixed public–private model, a commitment to universal healthcare, and world-leading clinicians and researchers.

Our health system is at its strongest when all parts work together—namely primary healthcare (GPs, allied health and similar), secondary healthcare (specialists) and acute healthcare (predominantly hospitals).

General practices and other primary health services are critical to ensuring healthy and safe local communities—but sub-optimal coordination and distribution of primary healthcare efforts can bring sub-optimal results and a wasting of resources—for example, presentations at busy hospitals for problems that could have been dealt with at the primary healthcare level.

The need for coordination of primary healthcare in times of emergency

'Heroic' individual efforts by people working above and beyond normal community expectations are of course admirable, but not ideal. Stand-alone, such efforts cannot be relied upon to be either consistent or sustainable.

The need for coordination of primary healthcare services is exacerbated during disasters such as bushfires, floods, cyclones and other major emergencies.

A case in point, the extraordinary scale of the 2019–20 bushfire disasters exposed significant vulnerabilities in provision of emergency as well as ongoing primary healthcare services in communities and regions across Australia.

Some communities had difficulty accessing any first aid or primary health services, including general practice, pharmacy and mental health care. For example, in one area the bushfires and smoke blocked the St John's Ambulance's access to the region (by road or air).

However, there was no backup plan to use local GPs to provide first aid in case the ambulance and helicopter could not get through.

GPs offering their services in fire-ravaged communities faced barriers with evacuation centre access, provider numbers, and other logistical difficulties.

In addition, decision pathways on the need for deployment of AUSMAT (Australian Medical Assistance Teams, usually deployed to international disasters) or Australian Defence Force medical teams, were unclear. The role of GPs and primary care was usually not included at all in disaster planning.

These difficulties have since been magnified by the threat and presence of COVID-19.

A leading example has been the significant weaknesses in the clinical care available and provided to people living in residential aged care—eventually leading to AUSMAT support being provided in several aged are facilities in Victoria.

The Newmarch House inquiry1 specifically included recommendations on how general practice should be engaged and better supported to provide care for aged care residents.

Further, for some major COVID-19 outbreak clusters, acute (hospital) care alone proved unable to cope with the care needs of the community.

In many instances local primary healthcare services may have provided quicker more effective care—but without the systematic inclusion of primary care in regional management responses and protocols, coordination was sub-optimal. Arrangements were devised 'on the run', and were reactive rather than pro-active.

What needs to happen

Mobilise and coordinate a willing primary care workforce

The primary healthcare sector is the cornerstone of Australia's healthcare system, and equal to the hospital sector in terms of total annual health expenditure.

Primary care providers offer a ready-made workforce that can provide appropriate and timely care during an emergency. Ensuring people can access primary care providers to treat primary healthcare issues during disasters and emergencies reduces pressure on acute care services (hospitals), allowing them to focus on acute care needs.

Primary care providers have valuable knowledge of their local communities, and are willing to contribute.

However, for would-be patients, the path to primary care during emergency conditions is not as well-defined as the path to acute care, which can result in a potentially overwhelming and unnecessary burden on the latter sector. Inappropriate diversion to acute care leads to a waste of resources as well as a loss of the continuity of care that is so competently provided by GPs. In the long term this can lead to adverse patient outcomes.

If not well-coordinated during an emergency, primary healthcare risks becoming underutilised, with unnecessary gaps and overlaps.

This can be largely due to the need to make 'on the run' decisions about what is and what isn't primary care, and many other decisions about coordination and incorporation into the total health service mix.

Clear delineation and preparation

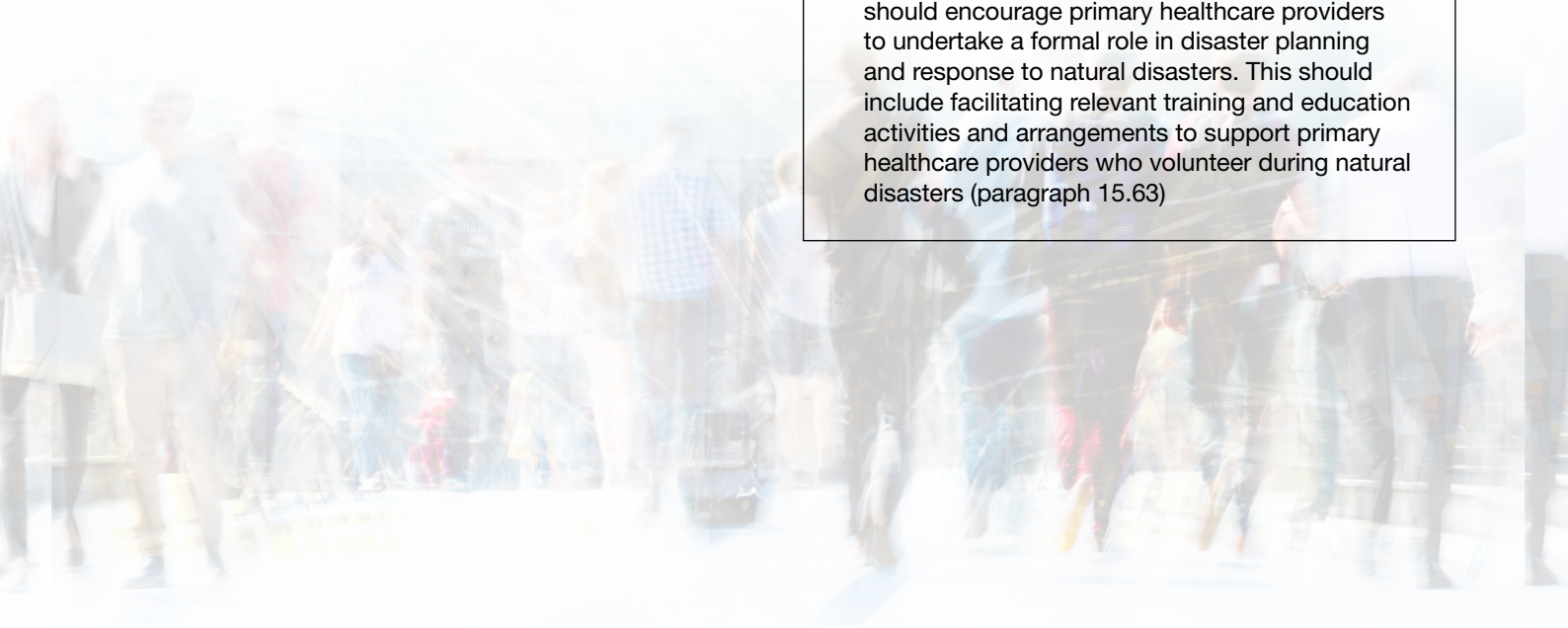
These problems can be alleviated through primary healthcare services having a clearly delineated role that is recognised by all levels of government and stakeholder planning bodies and being better prepared beforehand, with responses ready to be enacted within the total emergency response.

Within its own sphere, primary healthcare should function as a coordinated system built on existing capabilities, with clear chains of command and treatment pathways known beforehand by providers and the community.

For the above to occur, primary care needs to be recognised as an integral part of disaster planning and the emergency response and that all levels of disaster management must seek out and include primary care representatives in the planning process from the outset.

The Royal Commission into National Natural Disaster Arrangements Report released on 28 October 2020 made the following observations:

- The Australian, state and territory governments and health authorities should develop comprehensive strategies to prepare and adapt the health system to the increase in natural disaster risk (paragraph 15.30)
- Primary healthcare providers and PHNs can play an important role in supporting health responses during and following natural disasters. Primary healthcare providers and PHNs should be included in disaster planning processes at the local, state and territory and national levels, as appropriate" (paragraph 15.58)
- Australian, state and territory governments should encourage primary healthcare providers to undertake a formal role in disaster planning and response to natural disasters. This should include facilitating relevant training and education activities and arrangements to support primary healthcare providers who volunteer during natural disasters (paragraph 15.63)



Why PHNs are well-placed to handle the coordination task

National network and mandated functions already established

There are 31 Commonwealth-funded Primary Health Networks already established, covering all of Australia.

They were established in 2015 by the Australian Government as part of the Government's commitment to delivering an efficient and effective primary healthcare system.

PHNs aim to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time.

Three key functions of PHNs in 2020 are to support general practice, commission or purchase locally needed services, and integrate local services and systems.

Local knowledge and coordination expertise already in place

Local knowledge and coordination expertise are essential aspects of an effective emergency response—and key strengths of PHNs.

Since establishment, PHNs have developed unique insights into their communities and healthcare provision at a local level. As part of their integration role, PHNs have developed expertise in working across systems and sectors.

As a result, PHNs can bring together and empower the primary healthcare sector to work alongside and in conjunction with the acute care sector, as well as community, social and emergency services.

PHNs also have expertise and experience in quickly identifying emerging needs and service gaps, and commissioning locally-appropriate services to cover those gaps.

Ability to mobilise quickly

PHNs can mobilise and coordinate primary healthcare services quickly to provide the appropriate type of care that reduces the burden on local hospitals before, during and in the months after a disaster or emergency.

This can be achieved through PHN governance structures such as Clinical Councils and Community Advisory groups, and other well established relationships with general practices and other types of primary care.

Support of the Royal Commission into National Natural Disaster Arrangements

The Royal Commission into National Natural Disaster Arrangements[2] has backed the role of primary healthcare, PHNs and supporting emergency management training and registration arrangements in the following reports:

- Royal Commission into National Natural Disaster Arrangements— Draft Propositions[2] issued 31 August 2020. Draft Postpositions F4 and F4.1-4.7
- The Royal Commission into National Natural Disaster Arrangements Report[3] released on 28 October 2020. Chapter 15, ***Primary healthcare providers and Primary Health Networks*** paragraphs 15.48–15.63

What would change if PHNs were involved?

Federal, state and regional emergency preparedness and response plans

PHN representatives would work with all levels of government (Commonwealth, state/territory, state government health districts and councils) to incorporate the role of primary care into federal, state and regional health emergency preparedness and response plans. This would clearly outline roles in both the preparedness and acute emergency response phase and clearly articulate chain of command for activation of resources.

Support from the Federal Government would enable general practices to be prepared in the event of future disasters. Local information and training sessions would be held for primary care providers likely to be involved in providing emergency/disaster-related services.

Preparedness and response plans would set out the role of PHNs themselves during and following an emergency, e.g. inclusion on emergency management executive committees and participation in emergency management operations meetings.

Coordination of and communication between primary healthcare services before during and after the emergency

Before, during and immediately after an emergency (during the recovery phase) PHNs would coordinate preparedness activities, communication, and mobilisation of services offered by primary care providers at the local level.

Identifying demand and ideal locations for additional primary healthcare services during an emergency, if required, would be triggered by the agreed lead following existing emergency command and control protocols at a regional or state/territory level. For example, during a natural disaster PHNs would coordinate mobilisation or establishment of the required primary healthcare services, as advised by local emergency operations controllers or equivalent, the Commonwealth Department of Health or other authorised body.

PHNs would coordinate two-way sharing of localised information, messages and intelligence between primary care providers and the broader health emergency response team. They would communicate service availability and needs, to address current or expected demand, supporting better overall 'whole of health system' organisation of services. For example, this has worked successfully when establishing GP-led Respiratory Clinics during the COVID-19 pandemic.

Go-to organisation on local primary healthcare

PHNs would act as first points of regional contact on primary healthcare coordination matters and service availability during emergencies, as part of the overall coordinated response.

PHNs would coordinate the contribution of expertise for development of strategies involving primary care (i.e. pandemic preparedness planning and responses for residential aged care facilities where GPs provide care to residents).

Examples of PHN capabilities in emergencies

Many PHNs have been pro-active in demonstrating their capabilities and what could be achieved for regional primary healthcare during an emergency or disaster, as seen in the following examples.

Incorporating primary care into regional health response

Nepean Blue Mountains PHN (NBMPHN) developed local arrangements to incorporate primary care into the regional health response to natural disasters. This was following the 2013 Blue Mountains Bushfires.

NBMPHN documented this approach to share with other PHNs. Its *Planning for disaster management guide for primary care providers and PHNs* can be found here.

The procedures and arrangements outlined in the document were 'tested' during the 2019–20 bushfires resulting in a much more coordinated and collaborative response compared to 2013. Ongoing participation in preparedness work with primary care providers and the LHD during times of no disaster supported the response role.

Care for people experiencing mild coronavirus symptoms during a COVID-19 outbreak

North Western Melbourne PHN worked together with cohealth, the Victorian Department of Health and Human Services, and the Royal Melbourne Hospital to implement a pilot program to care for people experiencing mild coronavirus symptoms during the Melbourne COVID-19 outbreak in August 2020.

The program was designed to reduce pressure on the health system as the state struggled with more than 7,500 active cases.

Rapid establishment of respiratory clinic in Emerald, Queensland

Central Queensland Wide Bay Sunshine Coast PHN supported the development of the first GP-led Respiratory Clinic in Australia, opening within 1 week of the Australian Government's announcement in March 2020 that it would fund 100 private practice respiratory clinics across the country. The clinic was established during a rapidly escalating and changing emergency situation.

Within a few months PHNs across the country had supported the establishment of over 140 GP-led respiratory clinics within their regions, demonstrating the agility of PHNs and their strong on-the-ground relationships with General Practitioners.

Rapid development of HealthPathways to support emergency pandemic management

Hunter New England PHN invested in rapid development of HealthPathways specifically for emergency pandemic management which supported the development of localised HealthPathways in other regions.

Three in every four GPs surveyed in the region named HealthPathways as the most valuable support provided to them in relation to the pandemic.

The PHN also procured and adapted an online Capacity Status Tracker, with which general practices, Aboriginal Medical Services and residential aged care facilities could update real-time information on their capacity status. This was particularly well-received by residential aged care providers.

Patient resource materials on COVID testing, in six languages

South Western Sydney PHN produced patient resources for use by General Practice, using simple text in six community languages, outlining testing options and other information.

These resources were linked to HealthPathways.

Facilitating allied health student support of childhood educators in the Kimberley

The Western Australia Primary Health Alliance (WAPHA) worked with the Marjalin Kimberley Centre for Remote Health, which facilitates clinical placements for students from Australian universities, to support allied health students to use the HealthDirect telehealth system to interact with childhood educators in the Kimberley.

Students from Notre Dame University, University of Newcastle, University of Sydney and Monash University were able to provide a physiotherapist services to two early childhood centres in Broome during the coronavirus pandemic. The rollout of the HealthDirect video system in Western Australia was facilitated by WAPHA, as part of a national program to support primary care during COVID-19.

Western Alliance for Mental Health (WAMH)

Western Queensland Primary Health Network in collaboration with Royal Flying Doctor Services, North Queensland Primary Health Network and state government departments has commissioned low intensity mental health services located within communities with a primary focus on psychological support and services in the wake of the 2019 North, North West and Far North Qld monsoonal event (impacting 39 local council areas). The WAMH hosted a Flood Summit 2019 with key stakeholders nine months post the monsoonal event and developed an action plan for all stakeholders to refer to in relation to planning service responses. The unique position of PHNs provides the ability to respond quickly and commission service responses on the ground to meet the needs of both the general community and high risk population groups.

How best to bring about the change?

It is vital that the role of primary care be well defined and clearly incorporated into current emergency preparedness as one overall system where each party knows the roles and chain of command so that during a natural disaster or emergency, agreed responses are ready to be enacted.

PHNs, as the regional primary health coordinators, must be part of the advance planning and preparation for future disasters and public health challenges.

- Processes need to be developed and implemented and arrangements documented in health preparedness and response plans that support primary care providers to provide health services in the response and recovery phases of emergencies. This should include mechanisms to remunerate them for time delivering care outside of their usual premises and systems to manage aspects such as professional indemnity insurance.
- The Federal Government should recognise the role of PHNs in preparedness and coordinating the primary healthcare response to natural disasters and emergencies (not just recovery) and fund PHNs to undertake this work.While there is much goodwill and commitment from primary care providers, they will not be able to maximise existing capabilities for a strong response, relief and recovery effort, without leadership, coordination and support.
- At a national level, PHNs need to be required and resourced (through the Department of Health PHN Program arrangements), to work with the local Health Emergency Management structures and represent primary care on local regional emergency management committees.
- At a state level, PHNs and state government health districts need to be mandated to work together in emergency preparedness, response and recovery and this needs to be supported at a state and national level.
- PHNs should also be represented on state and national committees where appropriate when decisions and strategies are developed as part of the emergency response impact on primary care e.g. national aged care emergency planning and responses.

Recommendations

Their development has been informed by the draft propositions of the Royal Commission in National Natural Disaster Arrangements[2] and the final report of The Royal Commission into National Natural Disaster Arrangements released on 28 October 2020.

Recommendations (1) and (2) are in line with Draft Proposition B19:

> *B19. Each state should establish a central accountability mechanisms or process to promote continuous improvement and best practice in natural disaster arrangements ... which should include:*
>
> *B.19.3 and B.19.14 regularly reviewing/assessing effectiveness of local groups, local plans, and cooperation between responsible entities..*

Draft Proposition F4 and F4.1–4.7 have also been considered in the development of the 5 recommendations:

> *F4. `There should be a greater inclusion of primary health care providers in disaster planning committees, disaster plans and response, at local, state/territory and national levels. Arrangements to facilitate greater inclusion of primary health care providers should have regard to:*
>
> *F4.1 primary care providers and Primary Health Networks (PHNs) representation at municipal, regional and state planning committees and in incident and regional level Health Incident Management Teams (at the discretion of the local commanders and Regional Health Coordinators);*
>
> *F4.2 participation in emergency management exercises and training;*
>
> *F4.3 the inclusion of arrangements with local primary care providers in local/municipal emergency management plans;*
>
> *F4.4 the presence of pharmacists, as relevant and necessary, in emergency relief settings, including relief and recovery settings or information hubs;*
>
> *F4.5 registration of volunteer primary health care personnel prior to deployment to support participation;*
>
> *F4.6 emergency management training of primary health care personnel to ensure they understand the emergency management command and control structure, such*
>
> *as through the Major Incident Medical Management & Support (MIMMS) standard or Australian Medical Assistance Teams (AUSMAT) training; and*
>
> *F4.7 supporting the inclusion of primary health care providers by providing necessary resourcing and training to primary care providers to facilitate their role during a disaster.*

References

1. Newmarch House COVID-19 Outbreak Independent Review— Final Report, Prof. Lyn Gilbert & Adjunct Prof. Alan Lilly. Canberra: Department of Health 2020. Available at https://www.health.gov. au/resources/publications/newmarch-house-covid-19-outbreak- independent-review.
2. Royal Commission into National Natural Disaster Arrangements— Draft Propositions by Counsel Assisting. Canberra: Royal Commission into National Natural Disaster Arrangements 31 August 2020. Available at https://naturaldisaster.royalcommission. gov.au/publications/draft-propositions.
3. Royal Commission into National Natural Disaster Arrangements Report, Air Chief Marshal Mark Binskin AC (Retd), the Honourable Dr Annabelle Bennett AC SC and Professor Andrew Macintosh. Canberra, Royal Commission into National Natural Disaster Arrangements 28 October 2020. Availble at https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report