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National Recovery and Resilience Agency
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To whom it may concern,

Developing the Second National Action Plan: Discussion Paper

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to inform the development of the Second National Action Plan via a response to this discussion paper.

Who are we?

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality health care to benefit the whole community.

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends Australia reform the healthcare system over the next 10 years by enabling person-centred, outcomes-focused and value-based health care. This requires:

1. A nationally unified and regionally controlled health system that puts people at the centre
2. Performance information and reporting that is fit for purpose
3. A health workforce that exists to serve and meet population health needs
4. Funding that is sustainable and appropriate to support a high-quality health system.

AHHA's *Healthy people, healthy systems*[1] is a blueprint for reform (the Blueprint) with a series of short, medium, and long-term actions to achieve this goal. The actions outlined in the Blueprint closely align with the initiatives mapped out in the Australian Health Minister's *National Health Reform Agreement (NHRA) – Long-term health reforms roadmap*[2]. It is within this context that the following feedback has been provided.

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[1] Australian Healthcare and Hospitals Association. 2021. Healthy people, healthy systems. Available at https://ahha.asn.au/Blueprint

[2] Australian Health Ministers. 2021. National Health Reform Agreement (NHRA) – Long-term health reforms roadmap. Available at https://www.health.gov.au/resources/publications/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap

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Why are we responding?

Disasters and emergencies present both short- and long term mental (e.g., PTSD, anxiety, depression) and physical health (e.g., injuries, respiratory illness, water contamination, air pollution exposure) challenges. As the incidence and severity of emergencies and disasters increase, Australia's health system will increasingly face greater demand for health services and resources.

Therefore, involvement of the heath system in all aspects of prevention, preparation, response, and recovery from emergencies and disasters is crucial to building Australia's disaster resilience.

Our response

Note that as a national peak body for public hospitals and healthcare providers, with membership broadly spanning the health system, we have taken a health system perspective to responding to your questions below.

1. **What do you understand your shared responsibility to be for reducing *systemic* disaster risk (for yourself, your organisation or on behalf of others) and ideally, what should collaboration look like?**

The shared responsibility of health system actors for reducing disaster risk is to be:

- Actively engaged in preventive health promotion and support.
- Prepared to respond to disaster and emergency events and practiced in enacting these responses (with the recognition that planned responses may need to change during real life scenario depending on the circumstances).
- Providing care when and where it is needed, which requires a level of flexibility and adaptability of care delivery.
- Communicating on behalf of, and with, the people and communities to whom care is needed, to ensure that decision-makers and/or appropriate actors can enable and support the delivery of care.

Collaboration with the health sector should entail the primary healthcare sector, acute care sector, and community, social and emergency services all involved and adequately supported in achieving a shared goal, which is to protect and care for people and communities.

2. **What examples can you share about what you are doing to prevent or limit the potential severity of future disruption arising from climate and disaster risks? What is working well, and what isn't?**

The response to the COVID-19 pandemic by health systems actors and institutions over the last few years has given rise to many examples of health system innovation and change. Some key examples include:

- Telehealth and virtual models of care
- The role of PHNs in supporting primary care (for example, the provision of PPE)

- The role of community health services in reaching and supporting disadvantaged groups[3]
- The adaptability and flexibility of the healthcare workforce; from expanding the scope of practice of pharmacists to changes in internal processes and governance structures (see this AHHA perspectives brief for a specific example in the Allied Health Professions' Office of Queensland[4])
- The Healthy Environments And Lives (HEAL) network, which brings together researchers, practitioners, communities and policymakers to address climate change and its impacts on health[5].

However, there are lessons to be learnt from the COVID-19 response to prevent or limit the potential severity of future disruption arising from climate and disaster risks in future. These include:

- The need for efficient, timely and consistent measurement, collection, analysis, and reporting of health data during a disaster to identify gaps and opportunities and facilitate better whole-of-system response, and allow for the evaluation of disaster responses, which can then be tweaked for improvement.
- The impact of the pandemic on the mental and physical health of the healthcare workforce has shown that more support is needed throughout a disaster response to avoid short- and long term consequences on the health system.

3. What is enabling your efforts to reduce disaster risks? Conversely, what is impeding your efforts to reduce disaster risks and why should it be addressed in the second National Action Plan?

Funding, regulation, infrastructure, data, technology, governance, and decision-making structures all enable and impede efforts to reduce disaster risks in the health system. Giving health sector workers the permission and resources to do things differently in order to do things better, is key to success. In addition, a cultural shift is needed to recognise and harness the benefits from involvement of people and communities in care delivery, which is essential to addressing the needs of people whose lives are impacted most.

- **Funding and regulation** – Funding models and regulations currently restrict flexibility and adaptability of care in the health system by restricting what care can be provided and by

[3] Adedoyin S, 'Bridging the gap': Community health a pandemic lifeline. Edited by Coopes A. (2021, August 3). Croakey Health Media. Available at https://www.croakey.org/bridging-the-gap-community-health-a-pandemic-lifeline/

[4] Kuipers P, Finch J, Gavaghan B, Young G and Haddock R. (2022). Deeble Perspectives Brief No 19. What enabled health service innovation during the pandemic? Crisis, staff, system or management? Australian Healthcare and Hospitals Association, Canberra, Australia. Available at https://ahha.asn.au/sites/default/files/docs/policy-issue/perspectives_brief_no_19_health_service_innovation_during_the_pandemic_0.pdf

[5] National Centre for Epidemiology and Population Health. (2022). 'HEAL network to tackle health impacts of climate change'. The Australian National University. Available at https://nceph.anu.edu.au/news-events/news/heal-network-tackle-health-impacts-climate-change

whom. An unintended consequence is that healthcare professionals have been prevented from working to their full scope of practice, which limits or slows down the responsiveness of the health system in times of crisis.

An example of funding and regulation enabling disaster responsiveness is the MBS changes allowing the pharmacists to administer COVID-19 vaccinations; an example of funding and regulation impeding disaster responsiveness was the underutilisation of nurse practitioners in the vaccination rollout.

- **Data, technology, and infrastructure** – Although telehealth and virtual models of care are a success story from the pandemic, the Australian Government must be proactive rather than reactive. There are reports of virtual models of care not being funded for longevity and of a negative wellbeing impact on the health workforce due to inadequate support provided to implement virtual models of care during the pandemic. This emphasises the harm caused because virtual care systems and arrangements had to be established during a crisis. Instead, they should have been established and embedded as part of standard health service arrangements already.

  The same applies for the infrastructure, connectivity, and interoperability that are currently missing from the Australian digital health landscape. This adds to the fragmented and siloed nature of the health system, limiting access to information which can be used for disaster planning, prevention, responsiveness, and recovery.

  For example, as learned with the 2016 thunderstorm asthma event in Victoria, real-time monitoring and forecasting are important components of providing timely, accurate and relevant public information and warnings for health emergencies.

  Equity and affordability must also be assured. While virtual health care has the ability to offer more equitable access to health care, disparities in health care access may be increased for vulnerable populations with limited digital literacy, access to technology and reliable connectivity.

- **Governance structures** - Primary care providers and PHNs should be better integrated in disaster preparedness, response, and recovery. This requires joint governance arrangements at the regional level, that considers community membership, to be an explicit structure within the respective national, state and regional frameworks. These systems must be developed and tested *in advance* of emergencies, at the regional level, so they can be enacted quickly when needed.

  During the 2019-20 bushfire, there were many reports of GPs being sidelined or restricted from assisting their local bushfire evacuation centres. Provider numbers for GPs and allied health professionals required a new system to be implemented. As the bushfire season peaked, the Australian government quickly implemented a protocol where doctors and allied health professionals could work at a new practice for up to two weeks using their existing Medicare provider number; an online service to provide an immediate Medicare provider number for work at a new practice beyond two weeks; and exemptions for restricted doctors to support bushfire affected communities.

There are also reports of effective use of GPs in bushfire affected communities. In the bushfires in Lithgow, for example, demand in the hospital emergency department was increased to provide care for fire fighters who had breathing difficulties, but there was a reduced workforce as staff could not reach the hospital. The PHN worked with the local GPs to provide afterhours services for the community, diverting pressure on the hospital.

Such systems, however, must be established in advance of natural disasters and emergencies to allow rapid activation and clear communication when required. This can occur if primary care is better integrated into disaster risk reduction processes.

- **Community involvement** – A summit held in north-west Queensland in 2019 following a major flood event whereby a diverse range of health and community representatives attended, identified key lessons in disaster management for the rest of Australia. These lessons centred around the importance of local community involvement and leadership before, during and after times of crisis.

  They found that strong community recovery occurred in areas where there was strong local engagement, and a balance was found between local and external aspects of the disaster response. Disaster planning, response and recovery must be community led and there should be recognition of those human and system elements that support preparedness and recovery after events.

4. If the second National Action Plan included ~5 nationally significant strategic initiatives or actions to focus collective efforts over the next 2-5 years, what should they be? What would make the most difference nationally?

The second National Action Plan should include the following strategic initiatives and actions to strengthen the Australian healthcare system and build-in disaster responsiveness capabilities.

1. Greater inclusion of primary health care providers in disaster planning committees, disaster plans and responses at local, state/territory and national levels[6].

2. Greater inclusion of communities and community health services in disaster planning committees, disaster plans and responses at local and state/territory levels.

3. Enhancing health system participation in shared decision-making processes and scenario exercises, across local, state/territory and national levels for capability development and coordinated strategic planning.

[6] For more information on the potential role the PHNs could play in disaster and emergency responses see:PHN Cooperative. (2020). *The role of Primary Health Networks in natural disasters and emergencies* [White paper]. Available at https://www.nbmphn.com.au/Resources/About/The-Role-of-Primary-Health-Networks-in-Natural-Dis#:~:text=Three%20key%20functions%20of%20PHNs,integrate%20local%20services%20and%20systems.&text=Local%20knowledge%20and%20coordination%20expertise%20are%20essential%20aspects%20of%20an,and%20key%20strengths%20of%20PHNs

4. Funding model and regulation reform that allows for timely, flexible, appropriately allocated health funding to enable responsiveness in distribution of the workforce.

5. Harmonised data governance, national data standards and investment in digital health infrastructure, connectivity, and interoperability to enhance health information sharing and support flexible healthcare delivery during disasters and emergencies[7].

5. Anything else you would like to add?

The following outlines the position of AHHA on further points relating to disaster and emergency management:

- Regional governance structures supported by coordinated, comprehensive strategic action across all levels of government, along with timely, flexible, appropriately allocated health funding, must be supported to ensure the Australian health system is adequately prepared, resourced, and agile to protect the health of Australians and respond effectively to disasters and emergencies.

- Existing health inequities and cultural diversity should be recognised and considered in the development of disaster planning and response strategies to protect against further exacerbation of health issues.

- Disaster planning, response and recovery strategies should build capacity through promoting strengths based approaches that recognise the inherent strengths and assets of individuals and communities.

- A strong telecommunications, surveillance and warning system is necessary to communicate real time, nationally consistent public messaging, via a variety of communication channels, on important health and safety issues (e.g. air quality) to communities at risk.

- Australian, state and territory governments should agree on a minimum dataset of metrics and invest in data development, linkages and funding for coordinated research to build an evidence base on the immediate and long-term physical and mental health related impacts of disasters and emergencies. This work should inform future planning and recovery efforts.

- Governance and coordination of medical supply chains must ensure appropriate, timely and efficient allocation of resources during disasters and emergencies.

- The health workforce must be provided with adequate training and resources to respond to disasters and emergencies safely and effectively, with regulation and funding models that enable responsiveness in distribution.

[7] Despite the importance of health information and reporting and the substantial data currently being collected, Australia has not implemented a long-term strategic plan to coordinate and direct national health information interests. A National Health Information Strategy is needed which brings together the information reporting components from various health agreements and initiatives, defines the roles and responsibilities of key stakeholders and identifies future opportunities for development under a single coherent national health information framework.

- The physical and mental health impact on health professionals, first responders and communities must be recognised and comprehensively addressed at all stages of disaster and emergency preparation, planning, response, and recovery.

We would be happy to discuss any aspect of this response further.

Sincerely,

Kylie Woolcock
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Australian Healthcare and Hospitals Association