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I am responding on behalf of? An organisation or group
Which paper are you responding to? Health Arrangements in Natural Disasters

Your Organisation

What is the name of the organisation? Australian Healthcare and Hospitals Association
What is the nature of the organisation? Peak body
What is the organisation's ABN, ACN, or other registration number? 49008528470
What is the organisation's role in natural disasters? Represents members affected

Your Response

Are the current national health coordination arrangements appropriate to respond to natural disasters in Australia? If not, how should they be improved?

The National Health Reform Agreement – Addendum 2020-25 provides for the federal and state and territory governments to work together on system-wide policy, with regional planning and funding for efficient and effective integration across health services at the local level (Schedule E, clause 38). Joint planning and funding at a local level is a priority in the agreement (Schedule C).

The joint governance arrangements established by Local Hospital Networks (LHNs), Primary Health Networks (PHNs) and other stakeholders at the regional level should be an explicit structure in the national, state and regional frameworks for planning and responding in times of health emergencies and disasters. Needs assessments, planning, service integration, evaluation and funding for the response at a local level should be led through these joint governance arrangements, where the roles and responsibilities of the broad range of service providers can be defined for activation in a timely manner.

As evidenced in the coordinated response to the COVID-19 pandemic, the rapid activation of a National Cabinet, consisting of federal, state and territory representation, offered a mechanism to ensure a strong coordinated multi-level national response to emergencies, reflective of regional diversity. The National Cabinet has allowed state, territory and federal governments to share information and align action to implement a coherent strategy reactive to the emergent demands of the rapidly evolving emergency, yet has maintained mechanisms of regional decision making autonomy.

It is important that the deliberations of the National Cabinet, including evidence used to support decision-making such as modelling and other expert advice, are publicly released or accessible via Freedom of Information provisions wherever feasible. This will assist in promoting transparency and public trust in decision-making, and will allow informed public and scientific debate. Including opposition parties in the National Cabinet during an emergency would assist in ensuring a national consensus at times when there is a critical need for all political leaders to work cohesively.

A National Cabinet emergency coordination structure must ensure the inclusion of mechanisms that allows key stakeholders including national health peak bodies and, where appropriate, the relevant medical and professional bodies, to feed into, provide clinical expertise advice, and be informed by, the National Cabinet process. This will better facilitate consistent decision-making and communication across all jurisdictions and zones of influence to protect the health of Australian communities.

Should primary care providers and primary health networks be better integrated in natural disaster preparedness, response and recovery? If so, how should this be done?

Primary care providers and PHNs should be better integrated in natural disaster preparedness, response and recovery. As noted in response to question 1, this requires joint governance arrangements at the regional level 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.

Examples of joint governance arrangements providing effective responses to emergencies and disasters can be recently observed in:
• The Nepean Blue Mountains region, where the Nepean Blue Mountains PHN and Local Hospital District (LHD) developed a joint regional disaster plan in response to the 2013 Blue Mountains bushfires. The plan was implemented during the 2019-20 bushfires, and demonstrated a unified and well-coordinated regional response.
• The Northern Territory, where an agreed multi-organisation structure, with agreed roles and responsibilities for organisations and individuals, was enacted in response to the COVID-19 pandemic. This demonstrated an effective joint acute, primary and community health sector response.

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 recent 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.

Some PHNs have also developed HealthPathways to support responses during disasters. This is a decision support tool developed in partnership with the acute care sector and other clinicians and services in the local area. GPs can access these through their clinical information systems to support coordination of care between primary, acute and other care providers. Support is required to further develop these across all PHNs.

Community pharmacies also played a critical role in supporting the health of local communities. As the bushfire season peaked, temporary changes were introduced to allow the continued supply of prescription PBS-subsidised medicines when a doctor's prescription was not immediately available. These changes extended the emergency supply of medicines from a 3-day supply to a one-month supply.

Such systems, however, must be established in advance of natural disasters and emergencies to allow rapid activation and clear communication when required.

Primary care providers should be included in disaster planning and responses, through:
• inclusion on committees that inform local and regional plans;
• having access to region-specific disaster response protocols and role descriptions, training, networks and care pathways. These should be coordinated through PHNs and actively communicated in response to natural disasters and emergencies;
• having access to mental health support services, activated according to regional need; and
• the development of dedicated Medicare item numbers that can be used during a natural disaster response to support practitioners delivering services regardless of their usual place of practice.

Support for primary care providers should be coordinated through the PHNs, with them:
• acting as a central repository of information for primary healthcare in responding to disasters and emergencies, including the development of HealthPathways in partnership with LHNs and local health services to support responses during disasters and emergencies;
• coordinating local supply of resources (e.g. as with personal protective equipment during COVID-19 and masks during the bushfires) and services (e.g. access to records);
• coordinating with local general practices to provide extended hours and after hours services, to assist in managing the workload on emergency departments;
• having direct participation in national, state and regional disaster response structures, to inform responses to emerging and evolving operational issues, as well as inform critical infrastructure requirements that need to be assured by national and state governments in their planning and responses; and
• sharing information and experience across the 31 PHNs.

What approaches could be adopted to better support primary care providers to provide health services in the response and recovery phases of a natural disaster?

Refer to response to question 2.

Further, as we have seen in the COVID-19 response, virtual healthcare (including telephone and video consultations) provides a natural option to replace face-to-face services, yet historically criteria for funding services often prove to be a barrier to use by those who need them. Limited funding mechanisms have meant that the costs of providing virtual services have needed to be absorbed by services or borne by patients. Until recently a variety of online GP services existed, but most telephone and video consultations required the full fee to be incurred by the patient and were therefore accessible only to those who could afford it, exacerbating inequities.

Virtual healthcare will be an important mechanism for care delivery through both the response and recovery phases of natural disasters and emergencies. National health funding agreements should continue to support the innovative virtual healthcare models pursued by state health departments, as well as Commonwealth funding through the Medicare Benefits Schedule (MBS). Embedding virtual healthcare in primary care will need to be driven by more than individual practices operating to meet their own practice priorities and desired incentive payments. Care models must be patient-centred, outcomes-focused, coordinated and integrated with the broader health sector to target and be responsive to local community needs. Accountability and responsibility for implementing virtual healthcare models effectively in general practices and primary healthcare requires agreed and supported leadership and governance arrangements (see earlier section on 'Governance and coordination').

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. This includes consideration of digital inclusion. With more than 2.5 million Australians not online, and many of those who are, lacking the skills to benefit fully from this connectivity, strategies must be informed by the complex and multi-dimensional factors influencing digital inclusion. Exposure to out-of-pocket expenses must also be considered.

The Australian Government should not be trying to establish virtual care systems and arrangements in a crisis, but ensure they are established and embedded as part of standard health service arrangements.

Should a standard approach to reporting and categorising air quality across Australia be implemented, and if so, how?

With PM2.5 the harmful fine particle pollutants found in bushfire smoke, real-time and consistent air quality reporting of both PM2.5 and PM10 should be implemented across Australia. This reporting should also be at an appropriate level of spatial resolution to enable individuals to assess the local risk of poor air quality and to respond accordingly.

While PM2.5 impacts healthy people, it can have a life-threatening effect to people with asthma, other respiratory and cardiovascular conditions. With no safe level of PM2.5 and rapid fluctuations observed over a 24-hour period during the bushfires, average concentrations over a 24-hour period are not helpful. Real-time data would provide individuals and health professionals with the information necessary to

minimise the adverse effects as fluctuations in levels are observed.

Such data would also be useful in emergency services planning. 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.

How should public health information about bushfire smoke be improved?

Improvements to the provision of public health information about bushfire smoke can draw from the review of the Victorian State Government response to the thunderstorm asthma event in November 2016. This should include:
• using real-time data of air quality measured at an appropriate level of spatial resolution to inform communications and decision making;
• establishing clear thresholds of air quality that trigger an alert;
• providing timely notifications to primary care providers and emergency response agencies to ensure recognition of deteriorating health in response to bushfire smoke; prioritisation in the supply of critical medications (e.g. salbutamol inhalers) and personal protective equipment (e.g. masks); and rapid identification and assurance of available medicines and equipment and their supply pathways; and
• clear and consistent public information developed, for rapid communication, according to the alert triggered and the responses being advised to primary care providers and emergency response agencies.

What should be the priority areas of research concerning the physical and mental health impacts of natural disasters?

The 2019-20 bushfire season highlighted a lack of robust evidence on the long-term health effects of bushfire smoke. While health professionals have a good understanding of the short-term effects on vulnerable populations and can target services and action accordingly, the long-term population health outcomes have not been properly researched.

In 2016, following significant bushfires in Alberta, Canada, the Canadian Institutes of Health Research (CIHR) immediately responded by providing targeted funding to investigate the impacts of bushfires on people's health. The National Health and Medical Research Council (NHMRC) must now do the same. Coordinated, comprehensive and targeted funding to support research into the health impacts of the recent and ongoing bushfires in Australia is required, with emphasis given to vulnerable population groups.

Research organisations, health networks and government agencies, and those relevant organisations beyond the traditional domains of health, need to be enabled to collaborate for cost-effective, long-term, longitudinal studies on the impacts of climate change on the physical, physiological and social domains that will affect public health.

However, research priority areas need to be extended beyond the physical and mental health impacts of natural disasters. Health system capacity and resilience are a crucial area of research that also need to be made a priority.

To build a robust evidence base that fosters and promotes an adaptable and resilient health system with effective disaster response, coordination and planning capabilities, AHHA recommends that the Australian Government invest in the development and implementation of a health systems evaluation and resilience framework that can be used to:
• identify the direct and indirect effects of natural disaster emergencies on health, health service delivery and health governance, including specific implications for communities returning directly to disaster affected zones;
• evaluate the preparedness of the health system and communities to respond swiftly and appropriately to new disasters; and
• plan for post-event recovery and health system resilience to environment-related crises.

In order to strengthen the capacity of the Australian health system to respond to more frequent climate-related emergencies investment in data collection and development is necessary. Investment must prioritise the development of data that specifically considers the unmet need for:
• real time or more frequent data collections that gather and link data on human health and the environment-related matters that are essential to determining causality, and monitoring trends and projections;
• standardised clinical coding protocols and accurate coding of relevant conditions seen in hospital admissions, emergency department presentations, general practice and other primary care services that will be essential for health care planning, resource allocation and health systems resilience; and
• development of indicators to support national, state and regional performance reporting and service planning.

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