23 June 2020

The Solicitor Assisting the Commission at
King & Wood Mallesons, Level 61, Governor Phillip Tower,
1 Farrer Place, Sydney NSW
Emailed to: RCNDA.Notices@royalcommission.gov.au

To The Solicitor Assisting the Commission, Royal Commission into National Natural Disaster Arrangements.

This letter is provided in response to the Notice to Give Information (NTG-HB2-428), received 17 June 2020.

1. Provide an overview of the AHHA, include its role, purpose and membership.

The Australian Healthcare and Hospitals Association (AHHA) is Australia's national peak body for public hospitals and healthcare providers.

Our vision is a healthy Australia, supported by the best possible healthcare system. Our activities are guided by the principles of healthcare being effective, accessible, equitable, sustainable and outcomes-focused.

Our membership includes state and territory health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals, and medical colleges and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA represents numerous Australian healthcare services, support agencies, health peak bodies and major universities directly and indirectly impacted by the recent 2019-20 bushfire disaster across the country.

2. Describe any difficulties that the AHHA has identified with coordination and integration of health and mental health services during and immediately after a natural disaster, including in relation to Primary Health Networks and Local Hospital Networks. Describe any improvements that could be made.

GOVERNANCE AND COORDINATION

Each community in Australia is unique with structures and processes formed through diverse histories, cultures and environments. Natural disasters magnify regional diversity as they

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impact communities in distinct ways and to varied degrees of severity, as evidenced by the 2019-20 bushfires. Therefore, when considering the development and implementation of structures that act to strengthen emergency preparedness, response, resilience and recovery, it is vital that sufficient local governance flexibility is prioritised to enable effective regional responses.

Mechanisms that allow national support and resourcing in times of crisis are also integral to the development of effective disaster preparedness and recovery strategies. The 2019-20 bushfire emergency demonstrated the importance of Australian Government support to ensure that state and regional governments were sufficiently resourced to meet local needs. While initially slow to respond, once activated the Australian Government was able to work with the states and territories to support local recovery through funding grants and the distribution of national resources such as the provision of medical equipment from the national medical stockpile.[1]

In planning for future natural disasters, The *National Health Reform Agreement – Addendum 2020-25*[2] provides for the Australian Government and the States 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 natural disasters and emergencies. 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 an emergency, 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.[3]

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.

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[1] Hunt, G. 2020.' Number of P2 masks provided for bushfires almost 3.5 million'. Ministers Department of Health. Available at https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/number-of-p2-masks-provided-for-bushfires-almost-35-million

[2] Addendum to National Health Reform Agreement 2020-2025. Available at http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

[3] Prime Minister, Minister for Health and Chief Medical Officer. 2020. 'Advice on Coronavirus'. Available at https://www.pm.gov.au/media/advice-coronavirus

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 and 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.[4]

REGIONAL RESPONSIVNESS

Specific disaster response and planning mechanisms must be informed by local knowledge and on-the-ground expertise and make effective use of existing local level infrastructure and capability. In the context of health, Australian government-funded PHNs and the state-funded LHNs or equivalent, are currently best placed to coordinate and lead comprehensive integrated health emergency responses at a local level. PHNs and LHNs have local knowledge, skills and capacities in coordination, commissioning and performance monitoring, as well as established local relationships, structures and processes that can be rapidly activated in times of need. To adequately prepare for future natural disaster emergencies, PHNs and LHNs must be empowered to work in partnership to develop collaborative integrated healthcare pathways and services that are patient-centred, outcomes-driven, local context specific, culturally appropriate and cost effective.

In the wake of the 2019-20 bushfires, the role of the existing local PHN structure in disaster financing and coordination was recognised through the allocation of $10.5 million[5] (inclusive of $6.9 in million community wellbeing grants) to allow PHNs to commission local community mental health, wellbeing and recovery activities.[6] The recent COVID-19 response also highlights the activation of PHNs in an emergency, with each PHN provided with $300,000 to facilitate local identification of appropriate primary care facilities to repurpose as dedicated COVID-19 respiratory clinics. PHN local knowledge and processes have also been activated in the control of PPE distribution to ensure equitable allocation, responsive to community need.[7]

However, these arrangements 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.[8] The plan was implemented during the 2019-20 bushfires, and demonstrated a unified and well-coordinated regional response.

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[4] Shoebridge, M. 2020. 'The national cabinet is key to our coronavirus response. Here's how it will need to work'. *The Canberra Times.* March 18. Available at https://www.canberratimes.com.au/story/6684142/the-national-cabinet-is-key-to-our-coronavirus-response-heres-how-it-will-need-to-work/

[5] Community Affairs Legislation Committee 2020, Senate Estimates 4 March. Available at https://www.aph.gov.au/Parliamentary_Business/Senate_estimates/Daily_summaries

[6] The Hon Greg Hunt MP. 2020. 'Immediate mental health services deployed into fire affected communities'. *Media Release,* 12 January. Available at https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/immediate-mental-health-services-deployed-into-fire-affected-communities

[7] Australian Government Department of Health. 2020. Coronavirus (COVID-19) National Health Plan. Available at https://www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-primary-health-respiratory-clinics.pdf

[8] Wentworth Healthcare 2019, Planning for disaster management, https://www.nbmphn.com.au/Resources/About/268_0618-DisasterPlanning_F.aspx, viewed 23/6/2020

- 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.

3. Describe any difficulties that the AHHA identified with access to healthcare services and the supply of, and access to, medications during and immediately after natural disasters in affected communities. Describe any improvements that could be made.

ACCESS TO HEALTHCARE

During natural disasters and national emergencies, health services can be disrupted in various ways. Recently, for example, in Western Australia, flights for attending GPs to outlying communities were cancelled during bushfires and when certain cyclone alerts were issued. Health professionals seeking to volunteer their services to provide emergency care or to relieve local clinicians have also been stymied from doing so through issues relating to Medicare provider numbers, funding and other administrative barriers, identification of credentialed providers, and a lack of a centrally-coordinated register of available and trained personnel. While these matters were addressed to some extent through temporary measures during the recent bushfire period, a more permanent solution is required to ensure the best use of health professionals.

Disaster response planning and coordination must prioritise the timely distribution of funding to models of care that maintain access to care. This will minimise affected Australians being prevented from or delaying accessing essential healthcare services in times of crisis.

Adopting virtual healthcare

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 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,[9] 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.

Accessible health records

The bushfire crisis also demonstrated the importance of up to date medical records maintained through a consistent, accessible, joined up electronic health record system. In the aftermath of the fires many Australian had difficulty accessing their essential medications through traditional prescribing and dispensing methods e.g. individuals trapped in bushfire affected areas without access to their regular prescribing health professional. However individuals who had opted in to My Health Record were more easily able to access their medications throughout the crisis, as pharmacists could dispense based on the medications recorded in an individual's My Health Record, while those who had opted out were forced to navigate cumbersome bureaucratic restrictions.[10] Investment in digital health records systems must therefore continue to be prioritised by governments to support health service linkages and enable the continuity of healthcare in an emergency.

Embedding primary healthcare in responses

There were many reports of GPs being sidelined or restricted from assisting their local bushfire evacuation centres.[11] 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*[12] 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

[9] Barraket, J and Wilson,C 2020, Digital inclusion and COVID-19, https://apo.org.au/sites/default/files/resource-files/2020-04/apo-nid303046.pdf, viewed 4/6/2020

[10] Haggan, M. 2020. 'My Health Record Helps Pharmacists in Bushfire Zones', Available at https://ajp.com.au/news/mhr-helps-pharmacist-in-bushfire-zone/

[11] https://www.abc.net.au/news/2020-01-07/bushfire-emergency-sees-local-doctors-call-for-addition-to-plan/11843974

[12] HealthPathways Community, https://www.healthpathwayscommunity.org/About, viewed 23/6/2020

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.[13]

Such systems, however, must be established in advance of natural disasters and emergencies to allow rapid activation and clear communication when required.[14] 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.

Healthcare workforce

The geographic spread of the health workforce does not reflect the distribution of the population, nor the level of healthcare needed. Workforce shortages exist across many professions, particularly in outer metropolitan, regional and remote areas and in disadvantaged

[13] Hunt, G 2020. Ensuring continued access to affordable PBS medicines for those impacted by bushfires, Available at https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/ensuring-continued-access-to-affordable-pbs-medicines-for-those-impacted-by-bushfires

[14] AMA 2020. Government responds to calls to speed up the pro cess to get doctors to bushfire-affected communities, Available at https://ama.com.au/gp-network-news/government-responds-calls-speed-process-get-doctors-bushfire-affected-communities

populations. This presents a significant challenge when health services come under increased pressure, such as in times of natural disasters and national emergencies.[15]

Allowing greater flexibility within the healthcare workforce is therefore essential to ensure the resilience and preparedness of healthcare services to respond to natural disaster emergencies. Evidence suggests some tasks that fall exclusively under the domain of particular professions could just as effectively, practically and safely be performed by other professions. As the Productivity Commission has recommended, carefully relaxing some specific regulations affecting scopes of practice to allow workers to be better allocated to tasks where they can add the most value, could improve the efficiency and scope of local health systems.[16] Acknowledging this, there are also some professions that are essential and as such consideration could be given to have arrangements to mobilise emergency responses of specific craft groups where required to address local needs.

Flexibility of workforce deployment must also be facilitated. The implementation of protocols and structures that remove or relax bureaucratic and administrative restrictions to providing care in times of health system stress will allow greater workforce adaptability and increase health system capacity in times of emergency e.g. utilisation of the primary care workforce to reduce the burden on tertiary providers. This will ensure access to care remains streamlined for impacted Australians.

The importance of removing workforce restrictions was highlighted in the 2019-20 bushfires response when the removal of mental health GP referral restrictions allowed timely, and streamlined access to mental health services for those impacted by bushfire.[17] COVID-19 provides another example where emergency conditions necessitated workforce flexibility to safeguard healthcare service continuity. Bureaucratic changes such as lifting international student nursing visa work restrictions and MBS amendments facilitating healthcare access via telephone and video consultations, have helped ensure workforce availability and continuity within an overburdened health and aged care system.[18]

The increased prevalence of natural disasters also necessitates investment in the training and development of all health professionals to ensure they are adequately equipped to respond to emergencies. Clinical placements and ongoing professional development opportunities, that are considered and distributed in terms of areas of public need and service models, must be incentivised and supported by government.[19]

Furthermore, an adequate workforce relies on health professional and student learning continuity to ensure service demands remain met. Continuity of education is therefore essential during an emergency to ensure workforce learning requirements are sufficiently maintained. Processes must be embedded that ensure clinical placement requirements remain sufficient and appropriate in services prioritising a crisis response.

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[15] Australian Institute of Health and Welfare 2016. Medical practitioners workforce 2015. Cat. no. WEB 140. Canberra: AIHW. Available at, https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015

[16] Productivity Commission. 2015. 'Efficiency in Health'. Commission Research Paper, Canberra. Available at https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf

[17] Department of Health. 2020. 'Mental health support for Australians affected by the 2019–20 bushfires'. Available at https://www.health.gov.au/resources/publications/mental-health-support-for-australians-affected-by-the-2019-20-bushfires

[18] Prime Minister of Australia. 2020. 'Update on Coronavirus Measures'. Available at https://www.pm.gov.au/media/update-coronavirus-measures

[19] Australian Healthcare and Hospitals Association. 2017. 'Healthy People, Healthy Systems: Blueprint for a Post-2020 National Health Agreement'. Australian Healthcare and Hospitals Association. Available at www.ahha.asn.au/blueprint.

Governments must prioritise building a sustainable, qualified, resilient healthcare workforce that is adequately and appropriately prepared, resourced and sufficient in numbers to meet the excess healthcare requirements essential when responding to natural disasters and emergencies.

MEDICAL SUPPLY CHAINS

In times of emergency it is essential that governments ensure transparency and consistent communication in the governance and coordination of medical supply chains. A more transparent and responsive approach to the management of medicines shortages was introduced in 2019 following amendments to the *Therapeutic Goods Act 1989*, with roles and responsibilities of relevant parties clarified. All medicine shortages are reported to the TGA, with both current and anticipated shortages that are assessed as having critical patient impact being published. The value of this system in natural disasters and national emergencies has been demonstrated. Following localised shortages of specific medicines where there had been increased demand (e.g. salbutamol during the bushfires and smoke), reassurance of adequate stock in Australia could be confirmed to discourage stockpiling or over-ordering.[20]

The network of pharmacies has also been demonstrated to be important in managing an effective and sustainable medicine supply chain during national emergencies, e.g., providing a mechanism for nationally consistent approaches to limiting the dispensing and supply of essential medicines in response to the COVID-19 pandemic.[21] These mechanisms, however, need to be more anticipatory in natural disasters and emergencies to prevent out-of-stocks that can occur at the local level, despite there not being national level shortages.

Clear and consistent governance structures and communication guiding the distribution of medical equipment is also vital in times of emergency. In both the bushfire crisis and COVID-19 pandemic, a disjointed and inconsistent approach to the distribution of Personal Protective Equipment (PPE) has contributed to shortages in some areas, and led to anxiety and uncertainty across health, aged care, disability, allied health and private sector providers in providing patient care.[22]

Assuring the supply chain for medicines and medical supplies during natural disasters and national emergencies must embed and leverage existing mechanisms that have been proven successful in providing public information and response. However, mechanisms need to be more anticipatory and be leveraged in advance of shortages to ensure timely responses. Clear and consistent communication about priority access between and across sectors is critical when there is a finite supply. Rationing decisions and resource pathways must be clearly communicated to providers so they can understand the objectives in place for management of emergencies. Providing credible and consistent information to the public will also contribute to community trust in the way critical resources are used.

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[20] Therapeutic Goods Administration. 2020. 'No shortage of salbutamol asthma inhalers'. *Media Release.* Available at https://www.tga.gov.au/media-release/no-shortage-salbutamol-asthma-inhalers

[21] Pharmacy Guild of Australia. 2020. 'Limits on dispensing and sales of prescription and over-the-counter medicines - 19 March 2020. Available at https://www.psa.org.au/wp-content/uploads/2020/03/Pharmacy_dispensing_limits-joint_statement.pdf

[22] Mahase, E. 2020. 'Novel coronavirus: Australian GPs raise concerns about shortage of face masks'. *British Medical Journal.* Available at https://www.bmj.com/content/bmj/368/bmj.m477.full.pdf

4. Describe any priority areas for research, or improvements to data collection for the purpose of research, identified by the AHHA in relation to the health and mental health impacts of natural disasters.

RESEARCH PRIORITIES

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 Australian's 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.

DATA COLLECTIONS

There is limited use of primary health care data for research and for data linkage between healthcare settings.[23] Data collected by general practices would be an important source for research into the health and mental health impacts of natural disasters. Mechanisms for collecting data through electronic medical records are available. However there is a need for coding and data development related to heat exposure, smoke inhalation and air quality and their contribution to respiratory conditions, for both primary and acute care data.

A model for collecting and sharing such data for research must be progressed, underpinned by transparency and a strong legal, ethical, governance and data security framework.[24]

5. Provide a high level overview of the impact of natural disasters on existing health inequalities in Australia, and how this could be taken into account in natural disaster planning and response strategies.

It is widely recognised that disparities of income, age, race, gender, location, sexual orientation, religion and culture can impact an individual's health and ability to access health services.[25] This can be compounded in times of crisis, as damage and disruption from natural disasters and emergencies create new, or exacerbate existing social and financial hardships.[26]

Many vulnerable Australians face a greater probability of exposure to natural disasters. For example, Aboriginal and Torres Strait Islander people, a population group who experience significantly higher mortality and burden of disease rates than other Australians,[27] live in greater proportions within bushfire predisposed areas and are disproportionately impacted by natural disasters through the loss of cultural resources. People living in rural and remote locations are similarly vulnerable, with a lack of healthcare resources and infrastructure increasing their potential exposure to negative health outcomes when facing natural disasters.

Vulnerable Australians possess a unique view of the operations and structures connecting national, state, territory and community health and social systems, informing an awareness and intricate knowledge of system inefficiencies and structural weaknesses. Governments should seek to capitalise on this information through consultation and feedback mechanisms that

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[23] Canaway, R, et al 2019, Gathering data for decisions: best practice use of primary care electronic records for research, Med J Aust, vol. 210, iss. 6, pp. S12-S16, https://www.mja.com.au/journal/2019/210/6/gathering-data-decisions-best-practice-use-primary-care-electronic-records

[24] ibid

[25] World Health Organization. 2018. 'Health iniquities and their causes', WHO. Available at https://www.who.int/features/factfiles/health_inequities/en/

[26] Australian Government, Department of Home Affairs. 2018. 'Profiling Australia's Vulnerability: the interconnected causes and cascading effects of systemic disaster risk'. Available https://www.aidr.org.au/media/6682/national-resilience-taskforce-profiling-australias-vulnerability.pdf

[27] Australian Institute of Health and Welfare (AIHW). 2020. 'Indigenous Australians'. Available at https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview

enable vulnerable Australians to have their voices heard. A more comprehensive understanding of health and social system challenges will help facilitate targeted, cost effective action to strengthen structures and improve disaster response capabilities.

Embedded cultural and historical knowledge within vulnerable populations should also be explored and embedded within disaster preparedness strategies. For example, Aboriginal and Torres Strait Islander populations possess important knowledge in land management and bushfire prevention practices that could be essential in bushfire disaster prevention. Furthermore, the cultural structures, social links and shared histories ingrained within Aboriginal and Torres Strait Islander communities fosters an adaptability and resilience that communities and health services could model.[28]

If the Australian Government aims to ensure that Australia's national disaster preparedness, response and recovery initiatives are equitable and inclusive then engagement, collaboration and co-design with vulnerable Australians is vital. Such collaboration was evidenced by the highly lauded engagement with peak Aboriginal and Torres Strait Islander organisations to design the new Close the Gap strategy.[29] It has also been demonstrated through the Australian Government and National Cabinet's positive and collaborative response to fund and support measures created and driven by Aboriginal and Torres Strait Islander people, organisations and communities, which have been recognised as crucial to the successful response to the COVID-19 pandemic.[30] It is essential that national natural disaster arrangements are informed by a similar inclusive and consultative process to ensure a thorough and equitable response.

If you have any further questions regarding this response, please do not hesitate to contact us.

Sincerely,

Alison Verhoeven
Chief Executive
Australian Healthcare and Hospitals Association

[28] Williamson, B., Weir J and Cavanagh, V. 2020. 'Strength for perpetual grief: how aboriginal people experience bushfire crisis', *The Conversation*, January 10. Available at https://theconversation.com/strength-from-perpetual-grief-how-aboriginal-people-experience-the-bushfire-crisis-129448

[29] Council of Australian Governments. 2009. '*National Indigenous reform agreement (closing the gap)'*. Canberra: Council of Australian Governments.

[30] Turner, P 2020, Speech opening Reconciliation SA's Reconciliation Week Breakfast May 27, https://nacchocommunique.com/2020/05/27/naccho-aboriginal-health-coronavirus-and-reconciliationweek-news-alert-read-full-speech-from-our-ceo-pat-turner-launching-nrw2020-inthistogether-and-new-coalition_peaks-website-cop-closethega/?utm_content=130240178&utm_medium=social&utm_source=facebook&hss_channel=fbp-216656545108133