



A White Paper

The role of Primary Health Networks in natural disasters and emergencies

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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 care 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 Arrangements² 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 Propositions² issued 31 August 2020. Draft Postpositions F4 and F4.1-4.7
- The Royal Commission into National Natural Disaster Arrangements Report³ 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 Arrangements² 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. Available at <https://naturaldisaster.royalcommission.gov.au/publications/royal-commission-national-natural-disaster-arrangements-report>