NSW Rural Doctors Network Submission to the Inquiry into Australia's Disaster Resilience

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NSW Rural Doctors Network

NSW Rural Doctors Network (RDN) is a not-for-profit, non-government, charitable organisation that works to create and sustain access to quality multidisciplinary healthcare and social services for remote, regional and disadvantaged communities.

To achieve our vision, we seek to support communities with tailored health workforce solutions, grow and strengthen a capable primary health workforce, support the capacity of health service organisations, and contribute to policy.

We work collaboratively with communities, health professionals**,** service agencies, industry and federal and state governments. We are privileged to function as the Australian Government's designated Rural Workforce Agency for health in NSW and the NSW fundholder for health outreach and associated service programs. 2023 sees **RDN celebrate 35 years of service** to rural communities.

Introduction

RDN welcomes the opportunity to provide this submission based on the evidence, experience and data RDN has from its expertise and participation in supporting rural areas in recent natural disasters and emergencies, including drought, bushfires and floods. RDN has been preparing for and responding to such events since 2019, when we mobilised a drought response entitled #ruralhealthtogether.

The RDN submission will focus on Primary Health Care (PHC) [1] and its integration into secondary health care during an emergency. While our experiences and focus will be on rural Australia, many of our insights and recommendations could be transferable to outer metro areas.

In recent years, there has been a growing recognition of the critical role that Primary Health Care plays in rural disaster management, particularly in maintaining community health in times of crisis (Royal Commission 2020). The Covid-19 emergency, along with recent fire and flood disasters in NSW, has reinforced the crucial role played by PHC in disaster management; these events have also exposed gaps in the sector's preparedness strategies and, in turn, its ability to coordinate information resources and decision-making efficiently.

Based on current trajectories, the CSIRO forecasts that climate change will continue to influence Australia's frequency and severity of natural events (fire/floods) for the foreseeable future (CSIRO 2020). While climate change continues to impact all regions of Australia, non-metropolitan areas face more significant challenges around managing vulnerability and building resilience, with almost 50% of rural and remote areas having a 'low' capacity for resilience (Natural Hazards Research Australia 2023, Royal Commission 2020).

Further compounding these natural risks are ongoing systemic challenges associated with managing the interconnectedness and interdependence of delivering essential services in disaster management. The challenges associated with governance, ownership and responsibility were identified as a priority area in the Royal Commission into National Natural Disaster Arrangements, which noted that Australia's current national arrangements for coordinating disaster management are complicated- comprising a plethora of frameworks, plans, bodies, committees, and stakeholders (pg. 74). While recognising that rural and remote resilience is complex with a shared challenge, our submission focuses on the critical role that a coordinated PHC response can play in disaster management and ensuring the continuity of health services in affected communities.

[1] Primary Health Care (PHC) is the entry-level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention to treatment and management of acute and chronic conditions.

Terms of Reference:

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

i. the role of the Australian Defence Force in responding to domestic natural disasters,

The Australian Defence Force (ADF) currently provides Primary Health Care during Natural Disasters across Australia. RDN understands that ADF's health operations in Natural Disasters rely on civilian doctors and enrolled nurses under the supervision of an ADF nurse or a doctor. Like the whole health sector, ADF is also impacted by the significant amount of clinician burnout due to the increase in natural disasters and the operational tempo of ADF units requiring sustainment and medical support. Also, several ADF reservist medical units are staffed with the same personnel already engaged in a civilian capacity in times of domestic natural disaster.

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

RDN is not an expert in defence policy. When preparing and thinking of future ways of delivering Primary Health Care during a Natural Disaster, we have noted the ongoing concerns from defence policy experts questioning ADF's role versus the need for combat readiness. As summarised by Professor John Blaxland from the Australian National University, *"Over-reliance on the ADF in domestic crisis situations is problematic for both crisis management and long-term combat readiness and is inappropriate given the current threat environment and the frequency of environmental challenges. To avoid stretching the ADF too thin at a time when it might be needed most internationally."* [2]

RDN has evidence and research[3] that whether it is the ADF or civilian health teams, the frequency and intensity of natural disasters in Australia will heighten burnout and place more pressure on full-time nurses and doctors. RDN believes that relying on ADF health reservists decreases the ability of civil society to respond not only to natural disasters but also impacts civilian health access as the ADF reserve force comes from civil society. RDN suggests alternative options are investigated.

iii. the impact on the Australian Defence Force in responding to domestic natural disasters, and

ADF also provides a health response in supporting Australian humanitarian efforts abroad. Personnel and equipment must be ready at short "notice to move". The ongoing use of the ADF to support domestic natural disasters decreases the response time. It potentially limits the capability to respond due to burnout, refurbishment of stores and equipment and personnel preparation. This could impact Australia's ability to act in the local region (Asia-Pacific) and other international environments. Some have argued that this could encourage other nations to respond, damaging Australia's position as a regional leader, especially in the Pacific.

As the ADF Health reserves work in the civil environment, using ADF reservists is likely to deplete the ability of civil health to respond during a domestic natural disaster.

[2] https://www.policyforum.net/its-time-for-an-australian-national-and-community-service-scheme/

[3] https://www.publish.csiro.au/wf/Fulltext/WF20083

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

Australia should be able to respond to domestic natural disasters without the need to rely on ADF for Primary Health Care. Access to Primary Health Care in regional areas during a natural disaster is limited. Currently, coordination between civil, volunteer GPs, not-for-profit organisations and state-based services is limited nationally and can vary between jurisdictions and within local regions.

A coordinated approach allowing access, training, and support of regional and other civilian doctors, nurses & allied health staff to be active and available during a natural disaster will:

a. **ADF:** Removing the need to search for civilian doctors/nurses in domestic natural disaster areas will allow ADF to respond to concurrent regional natural disasters and other defence priorities.

b. **Ambulance Services:** Enable the treating of illness/injury & quick support for scripts (many chronically ill need replacement medication) will ensure lower severity of cases requiring ambulance services.

c. **Health Planning:** A state/national-based response plan (including training for all key persons) allowing access to doctors and nurses the community trusts will be imperative in any domestic natural disaster. It also enables continuity of care in local communities.

d. **Working Together:** Civil society organisations need to be engaged and included (but not limited to – St Johns ambulance, College of GPs, AMA etc.). Ensure a comprehensive and appropriate response to all types of domestic natural disasters.

(b) consideration of alternative models, including:

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

RDN has considerable experience and expertise in natural disaster health responses and, if tasked, could help design and implement alternative health delivery models.

RDN believes Australia needs to change its dependence on the ADF to deliver PHC during a natural disaster. Primary Health Care providers are predominately small businesses. Efforts must be made to see these providers at the front of the disaster response and recovery effort. Where emergency support comes in over the top, we have seen a negative flow on short and long-term consequences for PHC providers regarding patient care continuity and business sustainability.

A lead organisation from civil society could be identified to facilitate PHC coordination during a natural disaster. State Governments are responsible for most health responses; however, coordination of health teams, a common health picture and buy-in on models to which a separate organisation could deliver clear responsibilities, interactions, and communications by key health stakeholders from the State Government and the ADF.

Identifying and developing initial responses to PHC challenges in a natural disaster and creating joint coordination have proven effective in recent NSW natural disasters.

A lead organisation other than the ADF could also enable long-term integration and support. RDN has found it has continued to be involved with the Lismore community a year after their devastating floods.

From RDN's experience, we have classified four stages of disaster planning and response from a health perspective:

1. The emergency period.
2. The short-term response.
3. Medium-term recovery.
4. Long-term recovery.

Each period has specific needs and being able to provide continuity of relationships and engagement through these periods, including resource allocation and liaison especially utilising locally based resources and infrastructure, would add value to the community.

In response to the 2020 NSW bushfires, RDN and AMA (NSW) facilitated the **NSW Rural Health Natural Disaster and Emergency Stakeholder Group (NDE Stakeholder Group)**, which brings together 35+ intersectoral organisations/agencies to share, discuss and build PHC disaster knowledge, processes and governance frameworks. The NDE Stakeholder Group demonstrates the value and potential for a well-coordinated, planned approach. It helps the emergency response and improves health access for the community. The community must be at the centre of all involvement. This group was also reconvened for COVID and the floods.[4]

One of the key outcomes from the NDE Stakeholder Group was the NDE Communique, which acted as the aggregation point for on-the-ground intel from all the partners involved from service access, infrastructure and workforce perspectives. This regular communique was shared with national and state emergency centres and all health and social care stakeholder groups to inform and enable coordinated resource allocation and activation into the community.

RDN also established the **Surge Workforce Attract Register and Matching Service (SWARM),** which registers capable and confident healthcare workers to volunteer in rural disaster situations. By promoting a matching service that aligns health professionals to the primary healthcare needs of communities and local practices, the project ensures that health responses reduce risk, harm and severity and the recovery burden on various stakeholders.

Through RDN's work and experience, we also think there is an opportunity to set up a register for **Surge Premises for Onsite Teams (SPOT)**. Aside from the communication and coordination issues, another major issue for PHC during bushfires and floods was setting up fallback clinics that were safe, staffed and credentialed for surge care, with locations that were known by the health workforce so that they could travel to and that ambulances would bring patients to. If we have pre-determined disaster-proof locations, community and clinicians can convene confidently, deliver a meaningful service, and enable secondary health care to prioritise the neediest.

From these activities, the following outcomes are achieved:

- Improved capability, capacity, well-being and retention in the rural PHC workforce.
- Enable year-round training and skills advancement in natural disaster response.
- Primary healthcare professionals feel supported and equipped to stay in or close to the community during disaster events.
- Workforce responses are more effective and efficient because they are tailored to the needs of communities and the workforce's strengths.
- PHC and health workforce have more significant and coordinated involvement in mitigating and preparing for fire and flood hazards.
- Higher levels of preparedness and communication during the disaster process.

[4] See appendix 2

Several recurrent issues have been identified from these activities as impacting the PHC system's ability to respond to recent Natural Disasters; these include.

- Duplicated or mixed messaging into and by the sector during times of crisis.
- A lack of locally and regionally coordinated support responses.
- An unwillingness or unsureness on how to share resources.
- Limited localised data to inform, coordinate and plan.

To help mitigate and prepare for these challenges and ensure future PHC responses are strategic, collaborative and community-centred, the **NDE Stakeholder Group** has identified several strategic directions, focusing particularly on governance frameworks that can help facilitate:

- The sharing of local, regional, state and national intel to inform strategies.
- Developing and implementing strategies to support healthcare responses in impacted communities and regions.
- Minimising duplication and maximising available resources in the provision of these strategies.
- Improving consistency in messaging, education and coordination between agencies and their member networks in the community.
- Sharing resources and data between agencies.
- Support decision-making around PHC workforce resourcing.

Online resources proved crucial in enabling updated messages and services to be widely available. RDN's Rural Health Pro was an essential information-sharing and coordination source. It also enabled a "one-stop" shop of all current information from Government and industry sources. Rural Health Pro continued to provide training opportunities across rural Australia as part of further preparation and skills advancement.

By applying these learnings to our disaster strategies, future responses will be more robust and evidence-based, promote integrated and collaborative decision making and foster capacity and capability building in the rural health workforce and communities.

The work undertaken by the **NSW Rural Health Natural Disaster and Emergency Stakeholder Group** demonstrates a way forward to transition away from dependence on the ADF for PHC in a natural disaster and the ability of the health sector to work together to deliver the proper response. It also enables a more community and localised focus approach. It also allows the ADF to concentrate on its primary aims and its regional and international responsibilities.

Based on recent experiences, RDN believes there is an ability to set a transitional arrangement that enables an orderly transfer from ADF to another coordination body or organisation to undertake a reduced reliance on ADF for PHC.

From RDN's experience as the coordinator of the Rural Health Natural Disaster and Emergency Stakeholder Group in NSW, we see the following as essential elements to enabling the possibility of a civil organisation to implement PHC in a natural disaster situation.

1. **State or National based coordination organisation:** One coordination body responsible for implementing teams, including localised health plans, training health professionals, resourcing, and identifying teams.

2. **Workforce Engagement:** Construct skilled set-up teams responding to all possible domestic natural disasters. Ensure proper accreditation of all health personnel with specific NDE orientation when preparing to practice rurally. Provide training and education opportunities and resources, workforce registers and credentialing.

3. **Logistics:** Life support for all, including accommodation, transport etc.

i. overseas models and best practices.

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

(d) any related matters.

- The United States uses the National Guard for Allstate responses. Australia cannot do this due to different legislation, i.e., no state-based reservists forces.

- A memorandum of understanding between all organisations outlining definitive responsibilities and links between organisations.

- Look for state-based or national-based organisation/s to coordinate and facilitate discussions between the Federal, State, and Local Governments delivering PHC in a disaster situation. The organisation will need proven experience as an intermediary between government (all levels), industry and professional health bodies to enable them to identify responsibilities and links to provide the best results for communities affected by natural disasters.

- Adhere to The World Health Organisation (WHO) principles[5] ensuring less confusion, waste of resources and parallel planning. All health organisations must work together, however, coordinated by one organisation, ensuring consistency and clear direction. Training for all rural health organisations is fundamental.

[5] https://www.preventionweb.net/files/10464_NPmeetingAstanaWHOPPT.pdf

Appendices: one

RDN has a record of helping deliver PHC and community-centred fire and flood mitigation, preparedness, response and recovery management.

RDN with AMA (NSW) produced the learnings report **Natural Disaster and Emergency Learnings and Recommendations Report (2021)**

This Report outlines our understanding of primary health care (PHC) and the challenges and opportunities associated with delivering PHC in rural areas in a natural disaster and emergency context. It brings together what we have learnt from two surveys, the current literature and the learnings from work undertaken by the NSW General Practice and PHC Natural Disaster and Emergency Partnership Group (the NDE Group) and the Rural NSW General Practice and PHC Natural Disaster and Emergency Committee (the NDE Committee).

Also included are examples of good practice provided by the members of the NDE Group that underscore the need for a register of programs and services to identify what is provided at the local, regional and state levels and to highlight the gaps and areas of overlap.

REPORT: https://www.nswrdn.com.au/client_images/2244880.pdf

December 2019 / January 2020: Bushfires Southeast NSW.

Activities:

- NDE Stakeholder Group
- Natural Disaster and Emergency Situational Awareness Report
- Natural Disaster and Emergency Primary Health Workforce Response
- Mental health well-being information and resources
- Recovery Hotline
- Natural Disaster and Emergency Grants
- GP Locum Respite Program
- Targeted support: Batlow Medical Service, Resilience, Recharge and Recovery Program.

March 2022: North Coast NSW Floods.

Activities:

- NDE Stakeholder Group
- Natural Disaster and Emergency Situational Awareness Report
- Aboriginal Communities and Sector Support
- Intel coordination and gathering for PHC services
- Wellbeing Supports
- Grant advocacy.

Appendices: two

Rural NSW General Practice and PHC Natural Disaster and Emergency Committee

Project Committee

Australian Medical Association (NSW).
Department of Rural Health, University of Newcastle.
Medical Benevolent Association of NSW (MBANSW).
NSW & ACT General Practice Disaster Management Committee (Representative).
NSW Rural Doctors Network (RDN).
Royal Australian College of General Practitioners (RACGP).
Sydney North Health Network.
University of Notre Dame.
Western NSW Primary Health Network.

Rural NSW General Practice and PHC Natural Disaster and Emergency Partnership Group

Participating organisations

Aboriginal Health and Medical Research Council of NSW (AH&MRC)
Pharmaceutical Society of Australia
Australian Association of Practice Management (AAPM)
Primary Health Networks (PHNs of NSW)
Australian College of Rural and Remote Medicine (ACRRM)
NSW Rural Doctors Network (RDN)
Australian Doctors Federation
Australian Medical Association (AMA NSW)
Remote Vocational Training Scheme (RVTS)
Australian PHC Nurses Association (APNA)
Royal Australian College of General Practitioners (RACGP)
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
Royal Australasian College of Physicians (RACP)
CRANAplus, Rural Doctors Association (RDA NSW)
GP Synergy
Rural Doctors Association of Australia (RDAA)
Indigenous Allied Health Australia (IAHA)
Rural Training Hubs of NSW,
Medical Benevolent Association of NSW (MBANSW)
Services for Australian Rural and Remote Allied Health (SARRAH)
Murrumbidgee LHD
Southern NSW LHD
The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP),
WayAhead
NSW Health
Western NSW LHD

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