

Letters

The disaster is in the details: Primary Health Networks are ill-suited to disaster response

This letter is a response to ‘Situation report: Australian general practitioners in disaster health management’ by Burns et al in the January–February 2025 issue of the *Australian Journal of General Practice* (AJGP).

The role of Primary Health Networks (PHNs) in disaster response is often overstated, with the contributions of medical practitioners, particularly rural general practitioners (GPs), often undervalued.

Many GPs possess broad skill sets, being well-equipped to respond to disasters at all stages, from initial roadside care to recovery. Local primary care teams (GPs, primary care nurses and administration) will always exceed PHNs’ local knowledge of real-time statuses, risks, resources and relationships; all while getting on with disaster response with proven abilities to ‘do more, with less’ Despite the aforementioned, primary care’s integration into formal Australian disaster management systems remains limited.

Recent bushfires, floods and the COVID-19 response demonstrated that, despite having specialist preparedness teams, PHNs were often slow to adapt to rapidly evolving disasters.^{1,2}

A key challenge for disaster management is general practices’ independent business structures, resulting in varying approaches and resistance to coordinated responses to top-down decision making. This lack of alignment can lead to delayed and inconsistent responses. A standardised, centralised approach is unlikely to be effective across diverse GP settings, especially given ongoing dissatisfaction with the 31 PHNs’ engagement with the GP

workforce.³ In a disaster’s initial response phase, Burns’ model of GPs having to ‘connect with their PHN to facilitate this [‘chain of command’ emergency systems] connection’ will be a new, separate disaster.

Funding earmarked for PHN disaster management would be more effective reallocated to support GP-led, bottom-up approaches. This could include an opt-in model that integrates GPs with existing disaster response frameworks – such as the SA Ambulance Service’s Rural Emergency Responder Network.

Such a funding approach would leverage GPs capabilities, ensure a more agile and context-specific response, and provide a cost-effective alternative to centralised planning. Importantly both the Australian Medical Association (AMA) and Rural Doctors Association of Australia (RDAA)/ Australian College of Rural and Remote Medicine (ACRRM) have called for such integration into disaster and emergency responses, including the development of state-based rural responder networks that can flex from local incidents to larger disasters.^{3–5}

Authors

Alex Shaw FACRRM, FRNZCGP, MRCP, BMBS, RGA, DTMH, DMCC, Rural Generalist, Visiting Medical Officer; GP Anaesthetist, NSW Health, Retrieval Consultant, Royal Flying Doctor Service Central Operations (SA & NT), Port Augusta, SA; Medical Educator, Australian College of Rural and Remote Medicine

Thomas Quigley BSc, BM, BS, FRACGP, Medical Director, Rural General Coordination Unit, NT Health, Darwin, NT; Consultant, Barossa Hills Fleurieu Local Health Network, SA Health, Victor Harbor, SA

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Reply

Thank you for the opportunity to reply to the letter to the editor regarding ‘Situation report: Australian general practitioners in disaster health management’. The aim of our article is to provide an up-to-date understanding for all interested general practitioners (GPs) on how they can link to the broader disaster health response in a disaster in their community, to keep them safe and supported in providing healthcare to their patients, and to outline the structures and activations that are occurring around them as a disaster unfolds.¹

Disaster health management (DHM) starts at the local level and is supported at state level if needed. It involves a multi-agency All-Hazard (bushfires, cyclones, floods etc) Prevention-Preparedness-Response-Recovery (PPRR) system that provides a unified systematic response to healthcare provision when disaster occurs. To be safely operationally involved and included in up-to-date communications, GPs need to link to the DHM system. For most GPs this will be through a locally based group representing GPs – currently, this is the Primary Health Network (PHN).

It is the local PHNs who will receive communications from the Local Health Districts (LHDs), also known as local health networks, when a disaster response is activated, and updates as the disaster progresses. Past attempts to link to the DHM response through GP professional groups have not aligned with the local response strategy of disaster response. Lack of a united single GP group to connect with has been a key issue.

Linkage through the PHNs is an attempt to address that issue, with the support of strong GP responses seen to the 2013 and 2019 bushfires in the Nepean Blue Mountains Primary Health Network (NBMPHN) region, to the 2022 Northern New South Wales floods and to the recent cyclone in the Healthy Northcoast PHN, region, among many others. Although various PHNs may not have developed their disaster plans, the model exists with willingness among prepared PHNs to share planning.^{2,3}

For optimal inclusion of the broad scope of GP expertise, the ongoing process of GP integration into DHM is likely to include a number of different pathways for GPs with differing specialist skills. All of these contributions will need linkage pathways to the broader response and will vary across the DHM spectrum of PPRR.

Prepared rural emergency response teams, including local rural GPs with emergency/ anaesthetic training linked to the local disaster response, have a valuable role to play as a part of the response phase of DHM. Other roles include GP liaison officers, disaster-trained GPs acting in a liaison role when local or state/Territory Health Emergency Operations Centres are activated. Roles during COVID-19 included GPs working in state- and national-level positions to support preparedness and response.

However, the majority healthcare need in disasters is well-documented in the research across response and recovery phases, and falls within the remit of daily general practice healthcare, particularly deterioration and exacerbations of chronic conditions. Early management of these conditions offers an opportunity to mitigate the significant burden of healthcare conditions that continue into the aftermath of disasters.⁴ This is the key role for GPs in DHM: healthcare, firstly through keeping local general practices functioning and secondly through assisting in evacuation centres through a planned linked response.⁵

Disasters are about all healthcare services working together with one aim – to provide the best healthcare for those affected, and to do this we need methods of inclusion for all GPs. It is important all GPs have the option to contribute during disasters and to do this as part of a supported, planned response.

Author

Penelope Burns BMed, MPHMT, PhD, Co-Chair, World Association Disaster and Emergency Medicine Primary Care Special Interest Group, Madison, Wisconsin, USA; MIMMS (Major Incident Medical Management and Support) Instructor, NSW MIMMS Faculty, Sydney, NSW; Emergo Train System Instructor (emergency and disaster management simulation education and training), NSW Health, Sydney, NSW; Associate Professor, Academic Department of General Practice, The Australian National University, Canberra, ACT; General Practitioner, Northern Beaches Medical Centre, Sydney, NSW

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Australia needs to harness the skills of rural generalists to respond to disasters at local and state level

Burns et al ('Situation report: Australian general practitioners in disaster health management', *AJGP* January-February 2025) describe the need for integration of general practitioners (GPs) into disaster management. Examples included a bus crash and a flood – for the former there is a need for an immediate emergency response. Moreover such an incident will rapidly overwhelm resources in rural and remote communities, where GPs with rural generalist skillset are well-placed to assist.

One-third of major trauma occurs in rural Australia. Even a relatively small incident such as a minivan rollover, farm accident or similar may rapidly overwhelm healthcare capacity. Such 'mini disasters' occur on a weekly basis in rural and remote Australia. Local ambulance may be limited in number and scope; the tyranny of distance means retrieval teams may not be on scene for some hours. This 'trauma gap' causes harm to patients with time-critical needs.¹

The 2007 Kerang rail disaster is illustrative, when rural doctors with advanced skills were prevented from rendering aid on scene. Instead, metrocentric emergency responses relied upon retrieval teams from Melbourne and afield, despite availability and skillset of rural generalists locally.²

Geographically small countries such as the United Kingdom and New Zealand have well-developed systems to integrate local clinicians into emergency response.^{3,4} That Australia does not is puzzling.

For over 15 years, South Australia has utilised a well-developed system (the Rural Emergency Responder Network) of 50 rural doctors who are trained (by ambulance) and equipped (by use of a standardised Sandpiper Bag) to respond to pre-hospital emergencies.⁵

Establishing rural responder networks as the building blocks for state-based emergency and disaster response means nimble help can be tasked to scene to deliver early meaningful clinical interventions for

patients with time-critical needs. Moreover it provides a ready-made locus of expertise to work with public health networks (PHNs) and flex up for state-based disasters, such as bushfire, cyclones, floods, earthquakes, or even integration into national incidents such as pandemic response.

Integration of primary care via PHNs is sensible to address disaster prevention, preparedness and recovery. However, for the initial response phase, there is a need for rural responder networks, in keeping with existing position statements from the Rural Doctors Association of Australia (RDAA)/Australian College of Rural and Remote Medicine (ACRRM), the Australian Medical Association and media demands.

Authors

John Hall BSc (Hons) MBBS, DRANZCOG (Adv), FACRRM, FRACGP, Grad Dip Rural Dip, ACSCM, GAICD, Director of Medical Services and Rural Generalist Obstetrician, Western Cape York, Weipa, Qld; Past President, Rural Doctors Association of Australia, Canberra, ACT; Board Director, Australian College of Rural and Remote Medicine, Brisbane, Qld

Tim Leeuwenburg FACRRM, FRACGP, JCCA (Anaes), Grad Dip Aeromedical Retrieval, Rural Generalist, KI Medical Clinic, Kangaroo Island, SA; Senior Specialist, Central Australian Retrieval Service, Alice Springs, NT; Rural Responder, South Australian Rural Emergency Responder Network (RERN), Adelaide, SA; Chair, Sandpiper Australia, Brisbane, Qld

TL has a keen interest in community-based emergency and disaster response. He lost his house in the 2019-20 Kangaroo Island bushfires and has been significantly underwhelmed with the ability of PHNs to deliver effective and nimble responses to evolving disasters.

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correspondence ajgp@racgp.org.au