An Australian Government Initiative

Covid-19 Response Inquiry: PHN Cooperative Submission

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Primary Health Network (PHN) Cooperative

Primary Health Networks (PHNs) are independent organisations established in 2015 by the Commonwealth Government of Australia. Nationally, there are 31 Primary Health Networks (PHNs) working at regional and jurisdictional levels to strengthen primary care, improve person-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes. While the Australian Government helped fund this document, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Introduction

Summary and Recommendations

This submission has been prepared by the PHN Cooperative to provide coordinated input from Primary Health Networks (PHNs) across Australia to the Commonwealth Government COVID-19 Response Inquiry. The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs. It is a joint initiative of the PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

This submission focuses on lessons learned from COVID-19 on the vital contribution of primary health care in preparing for and effectively responding to future pandemics. It highlights the role PHNs played in coordinating, commissioning and capacity building to support an integrated primary care response at a regional level, informed and supported by local knowledge, networks and partnerships. It identifies opportunities to anticipate and more effectively respond to future public health challenges through ***integrating, including, authorising and resourcing*** the role of PHNs in governance, planning, coordinating and commissioning arrangements as part of a 'one-system' approach. A separate addendum to this submission (Evidence 1) provides case studies highlighting the valuable role played by PHNs in response to COVID-19. A second addendum (Evidence 2) provides evidence of the role of PHNs in natural disasters and emergencies.

In a national health emergency such as COVID, GPs and other primary health care services must be supported to ensure optimal continuity of health care for the population, as well as providing an essential component of the health system's response to the emergency and reducing pressure on the acute care system. PHNs facilitated the primary care response to COVID through their core functions of coordinating, commissioning, and capacity building, including:

- **Regional coordination** – PHNs enabled the rapid mobilisation of a coordinated primary care response at a local level, integrated with state funded services, including vaccination, PPE package distribution, public health messaging. They also provided advice and data at a regional and national level on the local impact of COVID and place-based needs.
- **Commissioning** – PHNs established local GP led respiratory clinics, provided outreach services and vaccination for vulnerable groups, and co-commissioned mental health hubs to assess and respond to mental health needs.
- **Capacity building** – PHNs facilitated regular communication with GPs and provided practical support to the primary care workforce to build care pathways and enable them to work to full scope of practice.

The experience of individual PHNs in the COVID-19 response varied across and within jurisdictions, depending in part on the extent of recognition and partnership in place before the pandemic. However all PHNs demonstrated the agility and local knowledge needed to navigate complex needs of diverse communities in a volatile and changing landscape.

This submission recommends that:

1. **PHNs must be formally recognised and integrated as key partners in jurisdictional and local responses** to pandemics and other public health emergencies to ensure that primary care is embedded in the response and to recognise the role of PHNs in primary health care coordination and service capacity issues.
2. **PHNs and primary care expertise must be included in governance arrangements** to prepare for and/or respond to a pandemic to embed the important role of GPs and the broader primary care sector in providing first point of contact and in caring for those who are most vulnerable to the impact of a pandemic in our communities.
3. **Regional public health emergency planning and responses must authorise the role of PHNs in coordinating** the local primary health care response and must be clear in the roles and responsibilities of different stakeholders. This will enable preparedness activities, and communication and mobilisation of services offered by primary care providers at the local level, whilst also ensuring continuity of regular healthcare to the community.
4. **PHNs must be resourced to prepare for and respond to future public health emergencies at a regional level** with local primary care and other stakeholders to ensure roles and responsibilities are clear and address logistical needs such as service mapping, distribution and communication networks and specific place-based requirements.

Response to Terms of Reference of Review

Governance – the role of the Commonwealth Government, state/territory governments, national governance mechanisms and advisory bodies

There was limited inclusion of PHNs in governance associated with preparing for or responding to the pandemic at a national, and state/territory level and advisory bodies did not routinely harness the potential of their unique local knowledge and role. This highlighted a critical lack of understanding and recognition of the role of PHNs in coordinating and advising on primary care response issues and failure to plan for the role of primary care in disaster preparedness.

At a national level, PHNs were engaged by the Commonwealth as key partners in delivering a range of services and supports, as need arose, and received information as it was available, but were not systematically engaged in key governance structures. PHNs initiated and resourced the establishment of a national COVID-19 PHN Advisory Group to share information and facilitate availability of advice and local 'on the ground' knowledge to inform national governance and decision making. However there was no formal recognition or harnessing by the Department of Health and Aged Care of the expertise of this Group to inform or advise bodies such as the Australian Health Protection Principal Committee.

At a state and territory level, those jurisdictions who recognised and brought PHNs to the table early in governance and planning for their response activities enabled a more coordinated regional response and enabled full utilisation of PHN expertise and capabilities in local coordination working with Local Health Districts. However, jurisdictions did not routinely engage with PHNs as key players, or in whole of system emergency response planning. This subsequently contributed to delays or deficits of primary care involvement in the planning and coordination efforts.

Governance arrangements also failed at times to be clear in relation to the roles and responsibilities of various stakeholders involved in the response delivery. This resulted in duplication of effort and some confusion. For example Residential Aged Care Facilities (RACFs) were at some points in the rollout being contacted by the Department of Health, PHNs, the Aged Care Quality Commission and Local Hospital Networks (LNS), seeking information and providing support.

The Commonwealth should ensure that states and territories and its own agencies recognise and understand the important role of PHNs in coordinating the regional primary mental health response to pandemics and other public health emergencies. Primary care expertise is as vital as public health, infectious diseases, epidemiology and acute care expertise.

Key Health Response Measures – vaccinations, treatments, key medical supplies, public health messaging

PHNs facilitated and coordinated the vital role of primary care at a regional level in reducing the impact of COVID-19. In addition to critical coordination activities, PHNs also commissioned a range of preventive measures, logistical support, treatment and messaging, in partnership with GPs and other primary care providers. This included a range of innovative and locally targeted activities which harnessed the agility and local collaborative networks of PHNs, such as:

- Communicating regularly with GPs and other stakeholders. For example in WA, daily COVID-19 bulletins were issued as the single source of truth to GPs by the West Australian Primary Health Alliance in partnership with state Health and Colleges. A multi-stakeholder Community of Practice was established by Western Victoria PHN (Case Study 1);
- Developing on-line care pathways to assist GPs and other service providers to access and refer patients to needed clinical services, referral pathways or resources to address COVID-19 and broader needs (See Case Studies 2 & 3);
- Promoting access to vaccinations for particular vulnerable groups within the community (See Case Studies 4 & 5);
- The rapid establishment of over 100 GP led respiratory clinics across Australia, the first of which was up and running within a week after the Government announcement (See Case Study 6);
- Logistical responsibility for distribution of personal protective equipment to general practice and other service providers in rural and remote locations;
- Promoting and supporting uptake of digital health services within primary care;
- The development of new federally funded, integrated mental health HeadtoHelp hubs in Victoria, ACT and NSW;
- Data on the capability of 6,000 GPs to vaccinate patients to inform vaccine distribution – Primary Health Insights.

PHNs witnessed logistical issues which collaborative emergency planning could have averted. For example, the distribution of PPE and vaccines to remote communities in the larger states required warehouse capacity to be urgently sourced, and knowledge of all local services through which distribution could occur, including state health and disability services.

Better acknowledgement and resourcing of the role of PHNs in coordinating specific local health responses and addressing gaps in some regions may also have averted 'parachuting in' external providers to assume responsibility for coordination of activities such as vaccination and clinical services in residential aged care facilities. In some regions this was costly, not informed by local knowledge and resulted in duplication of function. In general PHNs found that the system was not prepared for management of vaccination and outbreaks in various institutional settings.

Public health emergency planning should recognise and authorise the role of PHNs and engage with them to ensure roles and responsibilities are clear and that logistical needs such as service mapping, distribution networks and particular population reguirements are identified ahead of the emergency including those of people living in institutions.

Broader health supports for people impacted by COVID-19 and or lockdowns.

The Australian COVID-19 health response appropriately included a priority focus on the impact on the mental health and wellbeing of the community of the pandemic, particularly through disruption to services and isolation caused by lockdowns. This is an area where the pandemic drove innovation through PHN activity that informed longer term services.

PHNs have a substantial track record in coordinating, planning, and commissioning primary mental health care and suicide prevention initiatives at a regional level in partnerships with Local Health Districts, including at times of emergency and disaster. Victorian PHNs collaborated in the development of HeadtoHelp mental health hubs in partnership with Victorian Local Health Districts, offering integrated assessment, pathways to care and optimal use of digital service provision to respond to the spectrum of mental health needs associated with the public health emergency. NSW and the ACT also subsequently implemented HeadtoHelp hubs. The model has informed ongoing Commonwealth Head to Health services.

The role of PHNs in coordinating regional primary mental health care and supporting a swift and integrated system response to distress, service disruption, and isolation should be recognised in future planning for public health emergencies.

Support for industry and business

PHNs are concerned that GPs and other essential primary care providers in private practice were not specifically recognised in the business support available through the response. Given the significant pressure on their services, the demand from the community for information, pressure on staff, and the rapidly changing service delivery environment, more targeted support and time-limited incentives to private providers could have been made available. For instance, those GPs who put their normal practice on hold to vaccinate entire RACFs were not always financially rewarded, and staff absences associated with COVID-19 were costly and difficult to backfill. Private GPs also lacked access to capital grants to support COVID safe practice (outdoor facilities, air purifiers, mask fit testing) that were available in public services. Similarly, pharmacies were under significant pressure and dealt with medication shortages and high demand, however they had little business support and also limited PPE to keep them safe. Pharmacies were only allowed 1 box of 50 masks.

Additional resources for both GPs and other primary care stakeholders are needed to anticipate the business challenges associated with responding to a pandemic and to build workforce capacity to respond to a future public health emergency.

Mechanisms to better target responses to needs of particular populations.

PHNs built on local partnerships with local communities and leaders representing vulnerable populations to support tailored public health messaging, targeted vaccination initiatives, and to commission place-based solutions to care needs during the pandemic, with modest additional Commonwealth funding. This included groups such as people from CALD or refugee communities, First Nations people, homeless people, and people in rural and remote areas. However PHN local knowledge and collaborative networks were not always harnessed in efforts to coordinate and target vulnerable groups.

'Parachuting' in high cost external contracted services to provide services may not have been necessary if there had been earlier engagement and resourcing of PHNs to coordinate and optimally utilise local workforce capacity to meet the place-based needs of particular groups. For example, mobilisation of AUSMAT support for clinical care available in RACFs may have been averted. Similarly importing the services of independent contractors to undertake vaccination for some groups resulted in valued nursing staff being diverted from local general practice, hence reducing routine capacity in order to build expensive short term capacity with the same workforce. The Addendum of case studies provides evidence of the agility and effectiveness with which PHNs were able to tailor place based solutions to meet needs of vulnerable groups.

The role of PHNs and primary care in targeting the needs of vulnerable populations through place-based solutions should be recognised in planning for and responding to public health emergencies.

Other issues – appropriately resourcing PHN involvement in preparing and responding to public health emergencies or other disasters.

Modelling undertaken in the White Paper prepared by PHNs on the Role of PHNs in Natural Disasters and Emergencies in 2020 suggested that approximately $21m would be required over a three year period to enable all 31 PHNs to be adequately resourced to participate in regional disaster planning, management and recovery. These costings included the appointment of a regional Emergency Primary Healthcare Planner in each PHN and undertaking logistical preparations, including training, education and communication needs. These costings could be updated, drawing on knowledge from COVID-19 to provide an estimate of the resources needed in future for responding to public health emergencies as well as natural disasters and to factor in the need for surge funding to address unanticipated needs at a regional level. As explained above, mobilisation of workforce resources at a local level through PHN coordination and networks is likely to be a more effective strategy than bringing in external providers who do not understand local workforce issues or place-based needs. PHNs know their communities and, if resourced, can work over the longer term to coordinate an adequate local public health response long after the disaster is over, but the impact is not.

PHNs should be resourced to coordinate and mobilise the capacity of the local workforce to respond early to emerging primary health care needs associated with a pandemic, but also to prepare for the needs of their own region in the event of a pandemic.

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Covid-19 Response Inquiry:

Addendum to PHN Cooperative Joint Submission

Evidence 1: Case Studies on the Role of PHNs in the COVID-19 Response

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List of Case Studies

Communities of Practice
Case Study 1 Integrated COVID-19 Community of Practice - Western Victoria PHN

HealthPathways for COVID
Case Study 2 Hunter New England HealthPathways – Hunter New England and Central Coast PHN
Case Study 3 Integrated COVID-19 Pathways, North Western Melbourne PHN.

Reducing the impact of COVID on vulnerable groups
Case Study 4 Responding to the need of Aboriginal communities – Northern Territory PHN
Case Study 5 More than translation: COVID-19 videos and community activation – North Western Melbourne PHN

PHN Respiratory Clinics
Case Study 6 Rapid establishment of respiratory clinic in Emerald, Queensland - Central Queensland Wide Bay Sunshine Coast PHN

Case Study 1. Integrated COVID-19 Community of Practice, Western Victoria PHN

Identified need

From the beginning of the COVID-19 pandemic, Western Victoria PHN (WVPN) identified the need for a community of practice within primary care to translate the ever-changing advice into local priorities and to understand and overcome implementation barriers.

Approach/Activity undertaken

WVPN developed a COVID-19 ECHO Community of Practice that developed into a Learning Health System. An ECHO network (Extension of Community Health Outcomes) is a virtual information-sharing model that aims to bring clinicians together to develop collective knowledge (University of New Mexico, 2023). The COVID ECHO held over 100 weekly sessions throughout the pandemic with 50 or more participants each week, comprising GPs, nurses, practice managers, pharmacists, Local Public Health Units, deputy state CHO, Healthpathways editors, infectious diseases specialists, PHN implementation staff and local health services. As each new variation in knowledge arose, WVPN interrogated the local data, discussed with primary care context experts (GPs, nurses, pharmacists, practice managers) to find solutions. Over the pandemic WVPN conducted over 5,000 hours of engagement across COVID ECHO sessions and virtual town hall meetings.

Outcomes

In total, 100 unique COVID ECHO sessions were run between March 2020 and September 2022 with 3192 attendances. In a region of around 700 GPs, there were on average 50 participants per session with 38 participants identified as ‘core’ CoP members: members who attended most sessions. Over half of the 220 primary care practices were represented in sessions and six larger webinar events were run to communicate key policy decisions or new technologies, or to share new practice models. A total of 932 participants attended these larger events, with an average of 180 at each. Podcasts generated 927 listens and the Health Pathways pages received 1851 views each month. A brief survey followed each session and education was rated as being of high quality and highly relevant to practice. Participants in COVID ECHO informally reported that they were regarded as knowledgeable by peers, and that colleagues would ask them for information or advice about policy and practice. Key GP stakeholders in COVID ECHO served as primary care representatives to health service leaders and policy makers at times. Participants frequently expressed the timely and relevant nature of the CoP and felt supported by peers through this forum. In addition to building infrastructure for knowledge transfer (COVID ECHO), establishing cross-sectoral networks, developing integrated care pathways and creating durable guidance (Health Pathways for COVID), WVPN achieved very high second dose COVID-19 vaccination rates and anti-viral prescribing rates by GPs, reflected in relatively lower hospitalisation rates. WVPN has continued to build on the COVID ECHO success by broadening the focus to create a Regional Primary Care Learning Health System into Communicable Disease; Women’s Health; Paediatrics.

Case Study 2. Hunter New England HealthPathways – Hunter New England and Central Coast PHN

Identified Need
Hunter New England (HNE) HealthPathways was established as the single source of truth for primary care clinicians within the Hunter New England and Central Coast (HNECC) PHN region from the onset of the COVID-19 pandemic. HNE HealthPathways developed a suite of 17 COVID-19 clinical, referral and resource pathways to assist primary care clinicians and RACFs in assessing, managing, and referring patients during the current COVID-19 climate.

Approach/Activity undertaken
The initial clinical pathway was launched on 24 January 2020 and the remaining pathways were developed over the following 5 months as a result of clinician need, pandemic progress and release of new evidence. The timing of the development and maintenance of these pathways during the first COVID-19 wave was crucial in ensuring that clinicians were prepared to support patients and their practices during the initial 5 months of positive cases. At a national level, collaboration between COVID clinical editors for HealthPathways allowed sharing of learnings on how regions had managed COVID outbreaks, given timeframes for the pandemic varied from state to state.

Outcomes
Three primary pathways were transferred to state-based pathways, developed and maintained by the HNE team and shared with the NSW and ACT community (12 NSW HealthPathways teams). COVID-19 has provided the first opportunity for NSW and ACT to develop and maintain state based pathways to support clinicians with up to date information across the entire state. This has ensured efficiencies with the clinical resource capacity and equity in the dissemination of information. During the COVID-19 period HNE HealthPathways have demonstrated a significant increase in utilisation of the HNE HealthPathways site. 1 January 2020 to 30 June 2020 (6 month period) has seen a 44.93% increase in users, 56.11% increase in new users and 66.76% increase in sessions when compared to the previous 6 months (1 July 2019 to 31 December 2019).

Case Study 3. Integrated COVID-19 Pathways, North Western Melbourne PHN

Identified need
During the second wave of COVID-19 in Victoria, North Western Melbourne PHN (NWMPHN) identified the need for early intervention and monitoring of COVID-19 positive patients to minimise community transmission and enable timely and appropriate care transitions for deteriorating patients. The goal was to improve clinical outcomes and strengthen the public health response.

Approach/Activity undertaken
NWMPHN developed and piloted the COVID-19 Pathway as an integrated model of care with primary, community and acute hospital providers to proactively support the health and social care needs of people with COVID-19. Following the pilot, the care pathways was expanded to include the remaining hospitals in the network and informed Victorian guidelines for state-wide adoption.

Outcomes
As a result of the COVID-19 care pathway, 80 percent of COVID-19 positive patients enrolled in the North Western COVID-19 Care Pathway were able to be cared for in the community by GPs. This meant patients were able to recover more comfortably in their own homes, already burdened hospitals were spared further admissions, and the risk of further transmission was greatly reduced at a time when infections were hitting record highs. Additionally, 89% of respondents to the experience survey rated the healthcare they received as good or very good. More than 300 GPs and 200 practices received proactive PHN support to implement the pathway and were provided with access to secondary consult support, education, and training and the HealthPathways Melbourne platform, which saw 2,633 page views during the second wave. Overall, the Integrated COVID-19 Pathways developed by North Western Melbourne PHN proved to be an innovative solution to meet the health and wellbeing needs of people with COVID-19 in the region. The success of the program was due to the collaborative effort of various healthcare providers and the proactive support of the PHN in implementing the pathway.

Case Study 4. Responding to the need of Aboriginal communities – Northern Territory PHN

Identified Need
Respond to COVID-19 pandemic in remote Aboriginal Communities.

Approach/Activity undertaken
Northern Territory PHN (NTPHN) formed strong collaborative networks with key partners to respond as effectively as possible and support local health services to combat the COVID-19 pandemic. Working closely with ACCHS, NT Government, DoHAC COVID operations team, RACFs and contracted vaccine providers Aspen Medical, NTPHN helped coordinate the delivery of PPE, vaccines and workforce to some of the most remote parts of Australia. NTPHN was often required to work with DHL to redirect vaccines, support cold chain management and find suitable storage. It required an agile team of people who were able to pivot at no notice in order to support the priority at the time. Direct and regular engagement with all services in particular RACFs and Disability services was ongoing. Weekly meetings and daily engagement with Aspen Medical were also essential to ensuring a coordinated response.

Outcome (Please include metrics or explain how the outcome was measured)
Remote communities with the most vulnerable Aboriginal population groups were able to receive education through NTPHN supporting health promotion activities which resulted in many receiving COVID vaccinations despite high rates of vaccine hesitancy.

Case Study 5. More than translation: COVID-19 videos and community activation – North Western Melbourne PHN

Identified need
In the early months of the COVID-19 pandemic in 2020, North Western Melbourne Primary Health Network (NWMPHN) identified a need for culturally appropriate video messaging in languages other than English. Official communications from government to culturally and linguistically diverse (CALD) communities had mostly been in written form.

Approach/Activity undertaken
NWMPHN swiftly engaged video company Jasper Pictures, translation company Language Loop, the Centre for Culture Ethnicity and Health, Ethnic Communities' Council of Victoria, MyCentre Multicultural Youth Centre, Foundation House and the Victorian Aboriginal Health Service to produce videos encouraging people to follow COVID safe behaviour and look after their mental health during lockdowns. The project then expanded to produce videos encouraging people to get vaccinated against COVID-19. This series was very successful and featured on ABC News in Melbourne. Videos were produced in 20 languages, featuring more than 60 local community leaders. NWMPHN's positive relationships with these people were crucial to the project's success. Participants included various faith leaders, doctors and other health professionals, Aboriginal youth leaders, a Deaflympian, leaders from the local South Sudanese community and many others.

Outcomes
Videos reached more than 1.1 million people online across the NWMPHN region – more than half the population. They no doubt contributed to Victoria's COVID-19 vaccination rates, which remain among the world's highest. The project also proved successful in deepening NWMPHN's relationships and communications networks with local community leaders, who were encouraged to share messages with closed networks and through their preferred channels, such as WhatsApp and WeChat. This authentic messaging helped ensure high CALD representation at COVID-19 vaccination clinics and encouraged people to seek support for their mental health.

For example, [redacted] a MyCentre volunteer who was instrumental in managing the Arabic, Turkish, Somali and Urdu resources, said "What we're seeing is an increasing number of people calling MyCentre for mental health support ... the doctor who appeared in some of the videos has told us he's had an increased number of mental health care plan referrals."

Case Study 6. Rapid establishment of respiratory clinic in Emerald, Queensland - Central Queensland Wide Bay Sunshine Coast PHN

Identified Need
The Australian Government identified the need for local private practice respiratory clinics to respond to the need in the community for clinical assessment and support.

Approach/Activity undertaken
Central Queensland Wide Bay and 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 to respond to the COVID-19 outbreak. The clinic was established during a rapidly escalating and changing emergency situation.

Outcomes
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.