



Victorian Healthcare Association

Submissions
2009 Victorian Bushfires Royal Commission
GPO Box 4358
Melbourne VIC 3001
Australia

“Relief, recovery and resilience”

The Victorian Healthcare Association Submission to: The 2009 Victorian Bushfires Royal Commission

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. The VHA promotes improvement of health outcomes for all Victorians from the perspective of its members that include public hospitals, rural and regional health services, community health services and aged care facilities.

In preparing this submission, the VHA has consulted its members on their experiences. This submission remains the position of the VHA and does not supersede any submission or position stated by any member agency.

1. Opening Remarks

The VHA wishes to express our appreciation for the dedication and commitment of those who fought Victoria’s bushfires in February 2009 and express our condolences to the communities that have suffered great loss. In particular, the VHA would like to recognise the important role health services play in both the initial response to the bushfires and their ongoing relief and recovery response to the aftermath.

On behalf of the Victorian health sector, the VHA would also like to convey its gratitude to the Minister for Health, Daniel Andrews MP, for his compassionate visits to fire affected health services. These visits provided a welcome boost to the morale of those on the ground.

1.1 Context

It is evident that a volatile climate has, and will continue to have, a significant effect on the frequency, severity and gravity of environmental emergencies into the future. Whilst this is difficult to quantify, or predict, it is evident that emergency planning and strategies need to be reviewed and adapted to suit contemporary need. Reducing the risks of a dangerous climate will require well-informed, co-ordinated and decisive action at global, national, regional, local and individual levels.

Victoria’s health services have a number of roles to play in the management of emergencies. This includes the implementation of preventative strategies, local risk management and planning, acute and emergency care, local leadership, case management and organisation of recovery strategies. The VHA submission to the Bushfires Royal Commission provides an important representation of some crucial issues faced by Victoria’s health services.

Terms of Reference

Matter 2: The preparation and planning by governments, emergency services, other entities, the community and householders for bushfires in Victoria, including current laws, policies, practices, resources and strategies for the prevention, identification, evaluation, management and communication of bushfire threats and risks.

2.1 Safer infrastructure for health

The VHA believes there is a need for design guidelines in health services to maximize safety, minimize ember entry into health service facilities and to protect staff, clients, patients and community members from radiant heat and smoke inhalation. In addition, all existing and new health facilities in fire prone areas should incorporate a ‘safe haven’ from radiant heat. This is required to protect those that do not

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have time or means to flee, as these services did provide refuge for many people throughout the fire period. Into the future, the VHA recommend that this function goes beyond just hospitals and looks at the role that schools and community hubs can play in a coordinated response.

One problem identified by health services is the issue of generators. Despite regular testing, some generators in health services were unable to tolerate the high temperatures, nor able to cope with high usage of air-conditioning during the February heatwave and bushfires. Some health services are now investigating either upgrading existing generators to operate in temperatures of up to 55 degrees Celsius or investing in higher capacity generators suitable for very high ambient temperatures.

Smoke entering health facilities was another problem raised by health services. Many automatic doors default to open in the case of power outage, requiring manual overriding processes and many services are built with evaporative air conditioners that are designed to bring in air, and therefore admit smoke.

Recommendation 1: All health services be definitively classified as Priority 1 assets for both power companies and the CFA to ensure optimal safety.

Recommendation 2: The State Government and Royal Commission further investigate the feasibility, cost and benefit of modernising health service utilities and equipment such as generators and air conditioners. These measures are costly, yet require the significant investment to ensure Victoria's health services are modernised and able to provide safe havens in times of emergency. Into the future, the VHA recommend that this function goes beyond just hospitals and looks at the role that schools and community hubs can play in a coordinated response.

2.2 Incident control system training

Many health service staff have undertaken the Incident Control System (ICS) two day training program designed to 'prepare health and human services sector staff to undertake control, logistics, planning or operations functions in a single or multi-agency emergency context'. The VHA believes this is a good framework that since its implementation by health services has received positive feedback. This training is currently general in its intent with the existing training framework based on the example of a whale rescue.

Recommendation 3: That the Incident Control System training be significantly expanded to senior management of health services and that the training becomes more health-specific to equip the sector for emergencies such as Black Saturday. In the future, the Black Saturday bushfires may be a more useful case study around which to model training packages.

Matter 3: All aspects of the response to the 2009 Bushfires, particularly measures taken to control the spread of the fires and measures taken to protect life and private and public property, including but not limited to:

a) immediate management, response and recovery

3.1 Co-ordination of response

Despite some role delineation, question marks remain over who is in charge in both relief and recovery phases with the Australian Red Cross, Department of Human Services (DHS), DHS Regions, Victorian Bushfire Reconstruction and Recovery Authority (VBRRA) and lead agencies all possessing some form of control.

The health sector feels that the initial component of emergency management response worked effectively and was clearly structured with appropriate leadership from Victoria Police and the Country Fire Authority. This is due to existing legislation articulating operations and logistics (under the *Health Services Act 1988*, health services are required to plan for the prevention/mitigation, preparedness, response and recovery of services from a mass-casualty incident or natural disaster and provide medical assistance to the incident site if requested via the State Health Emergency Response Plan (SHERP)).



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Despite some VHA member organisations being nominated by the Department of Human Services to lead the response coordination in their region in the recovery period, this has not run smoothly in practice. Some VHA member agencies reported other stakeholder agencies assuming some of their designated responsibilities, resulting in conflict and confusion at a time when maximum cooperation was required.

In addition, instances of organisations intrusively delineating what they perceived to be their responsibility in the relief/recovery zones has added to the complexity of the process. The importance of trust and open communication with other individuals and organisations, both up and down the command chain, has many implications for successful relief and recovery in bushfire affected regions.

The *Hospital resilience code brown policy framework* articulates that hospitals should identify the location of a room that can be used as an emergency operations centre (EOC). This was difficult for services to achieve due to workforce constraints and the severity of the bushfires. For example, many staff were needed on the ground for three weeks without additional resourcing by the State Government. However, many services did note that in any future incident, they would set up an emergency control centre within the hospital.

Services said it was difficult to manage people's expectations between what was needed, what they thought might be needed and who had responsibility for meeting that need. During this period, services struggled to meet their normal service delivery obligations – in effect, health services were running two service systems concurrently. For some services, this manifested in increased waiting lists, an inability to meet targets and other consequential actions that impact on normal service delivery.

Health services reported that the merger of the Metropolitan Ambulance Service, Rural Ambulance Victoria and the Alexandra District Ambulance Service proved extremely useful during Black Saturday. This was especially the case for services located on the urban/rural fringe. Having one fluid coordination/communication channel for all Ambulance services in Victoria ensured communication regarding the nature of the incident, road closures, traffic congestion and lack of ambulance. Ambulance Victoria also assisted in the prioritisation of need for transfers and provided on-site expertise in accident and emergency on issues such as intravenous tubing, eye cleansing and oxygen provision.

Recommendation 4: To avoid delineation disputes in post bushfire recovery in the future, it is necessary to strengthen the command and control structures in emergency management and disaster relief and specifically define WHAT a recovery/relief centre must entail. This should define roles and responsibilities and provide a robust structure, framework of agencies, coordination and credentialing capacity and an increased level of formalisation of inter-agency relationships.

There were issues of individuals and groups attempting to provide counselling and support services that could be considered alternative and non mainstream. These individuals and groups had, prior to the bushfire, no connection with the affected communities. As a result the quality of services to bushfire affected community members was not as effectively managed as it should have been. This is extremely damaging to reconciling trauma and grief. Many of these services counter the evidence of the psycho-social model and caused negative consequences to community members most in need.

Recommendation 5: The impact of non-authorized services during this period has the potential to be extremely damaging to the wellbeing of communities and as a result there must be operative processes in place to protect Victorian communities when they are most vulnerable. Due to the existing processes, service staff were required to conduct police checks, working with children checks, and accreditation checks daily. To ease this, the relief process requires coordination and authority frameworks.

3.2 Deficit model vs asset model

There is concern amongst the VHA membership that a **deficit based model** has been favoured in the relief and recovery and rebuilding of communities following the bushfires. These **deficit models** focus on people outside affected communities identifying problems to be 'fixed'. This results in high levels of dependence and misdirected services. Such actions clash with the essence of the dynamic communities in question and threaten the healing aspect of the recovery processes within a community.



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The VHA purports the benefits of an **asset model** that accentuates the positive abilities, capabilities and capacities of Victorian communities to activate solutions that promote the autonomy of communities. This approach, if adopted, would result in a more inclusive approach and generate local solutions for local needs, with the appropriate support and assistance from authorities.

In the VHA's view, resilience is a protective factor for community wellbeing. We also recognise that social capital may act as a protective factor especially for those most disadvantaged. However, even in times of emergency response, it is important to balance the more dominant 'deficit model' and the less well understood 'assets model' to rebuild communities by mobilising the capacities and assets of those communities.

Recommendation 6: The VHA believes all relief and recovery interventions need to rebuild social fabric as they simultaneously provide for needs before, during & after emergencies. This includes empowering community members by giving them control, assistance, support and resources to make decisions to support their own community's recovery.

b) resourcing, overall coordination and deployment

3.3 Workforce Issues

Staff from health services played a role in supporting communities with counselling, acute healthcare, post-event relief services, information provision and general assistance.

There is concern amongst the VHA membership about the added pressures placed on these staff. Anecdotal evidence reveals staff:

1. Felt guilty for not being affected whilst others in their community were (survivor guilt)
2. Did not want to leave work because they felt duty-bound to help others
3. Were concerned about their capacity to cope and function as normal
4. Suffered high levels of stress from looking after others and ignored looking after themselves
5. Suffered trauma, particularly in small rural areas as a result of the majority of emergency admissions being known to them
6. Were torn about their own property being under threat and their duty to the health service

Health services were concerned about affected staff continuing to work in high risk environments, with potential impacts on patient care and the possible onset of mental health issues. Considerable counselling was provided to reduce staff stress, to help staff understand their reactions to the event, and to link them to social support networks.

However, there is concern about how staff will handle next summer, due to a feeling of 'what if it happens again?' This has the potential to be a significant impact on service provision, with chronic job stress increasingly recognised as a major barrier to effective organisational functioning which has far reaching consequences for the worker and workplace¹.

In addition, there is concern around who provides support over the following months **to** those psychosocial support staff providing front line intervention and support throughout the crisis period. Many health services are improving their arrangements for clinical supervision and professional development however there is more work needed to ensure the staff are appropriately cared for.

3.4 VMAT Teams

Health services were pleased with the efforts of the Victorian Medical Assistance Teams (VMAT) implemented under the *Health Displan Victoria*. These teams are made up of experienced doctors and nurses, usually sent from a metropolitan hospital, who provide on-site assessment and emergency treatment of casualties prior to transfer.

In particular, health services noted:

1. The best way to support local staff in emergencies is to remove pressure via accomplished VMAT teams. This allows service staff to focus on inpatients.

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2. VMAT transportation was often used to bring in supplies from metropolitan health services.
3. The members of these teams often knew each other well through their work in Melbourne. Therefore, there was a valuable element of synergy to their work.
4. In rural areas, many people know each other. Therefore, it was good to have VMAT teams in accident and emergency without a connection to the area. This prevents staff being exposed to distressing incidents regarding people they may know.
5. The arrival of VMAT teams was a boost for staff morale.

Recommendation 7: Support is imperative for small rural health services in times of emergency. These services are not funded to have doctors on staff or have a registered accident and emergency service and rely on contracted shared rosters with other services. VMAT teams proved important to the immediate relief efforts of health services and should be recognised through further investment in future emergency and disaster recovery plans.

3.5 Coordination of volunteer medical/nursing staff

The allocation of volunteer medical staff throughout the bushfire recovery was problematic. Additional resources were not provided to manage this and as a consequence the end result was a list of several hundred doctors' names and phone numbers, but limited information on their skill sets or capabilities.

This created a significant problem when services required particular assistance. Some health service CEOs requested a copy of the list to see if there were any doctors that had the right skills for particular situations, however this request was denied on the grounds of "privacy".

Services were unaware of whether there was a single agency responsible for the management of volunteer nursing staff, however they believe this would have been helpful. In the midst of this disaster, management services were fielding multiple calls from nurses wanting to lend their assistance, but did not have the time or resources to assess if their skills sets were suitable to meet the need.

Recommendation 8: Further coordination and investment is required in future emergency situations to coordinate the availability of medical, nursing and community support volunteers. This process should provide imperative details such as the skills, capabilities, availability and capacity of particular staff. A speedier, clearer process will have benefits for utilising staff in emergency situations.

3.6 Capacity constraints

Assumptions were made throughout the recovery and response process that spare capacity in the system existed to accommodate unexpected and unpredictable need. This was an unrealistic assumption. For example, the case management framework, whilst well intended, was announced prior to determining the workforce capacity with services having four days to meet framework requirement. Many services were required to provide staff for the Bushfire Case Management Service at short notice. The demand on case managers remains significant. As an example, the most experienced managers often could not be released as the support needs of consumers already case managed (and their carers) increased dramatically during the first few weeks.

The methodology that underpins the way in which Victoria's health services are funded allow little flexibility or adaptability for services to meet needs that arise unexpectedly. In the case of Victoria's independent community health centres, there are issues of cash flow and potential insolvency that have the capacity to impact on the business viability of these services.

Recommendation 9: The VHA recommend both an increase in capacity of the existing service system and more flexible structures to allow a service to meet specific community needs. In addition, health services need to be consulted earlier in the planning processes for things such as the case management service and other immediate to medium term priorities of relief and recovery.

3.7 Medication and supplies

The VHA believes there is a need for a specific state response to the complex issue of medication needs in times of emergency. Many people presented to health services without scripts, wallets, dentures and medicines as a result of the bushfires. For example, some people with type 1 diabetes fled the fires

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without their blood glucose monitor or insulin. During stress, increased levels of the hormones adrenaline and cortisol raise the level of glucose in the blood resulting in fluctuating blood sugar levels.

In addition, the dispensation rules that state the need for a GP to prescribe and a pharmacist to dispense medications provided a distressing context for workers trying to administer medications to those in need, who may only have known their medication by colour or shape, rather than name.

Medical supplies ran short in many health services. The DHS process to acquire supplies from metropolitan health services was complex and time consuming in the context of the disaster. In many cases, the usual route was circumvented through personal relationships with metropolitan health services. For example, many services relied on relationships within the community for transportation of supplies such as tetanus injections, burn dressings, saline and ventolin to meet high need in an efficient manner.

The *Hospital resilience code brown policy framework* describes the role of a dedicated 'disaster' UR number; however given the scale of the Black Saturday fires, this approach was limited. Some relief and recovery centres implemented a coloured armband approach to visually demonstrate what roles the support staff had (e.g. Social worker, Nurse). This approach proved successful, however the inherent chaos meant controlling these groups proved problematic and most services articulated the need for controlled 'welcome intake' processes.

Recommendation 10: The VHA believes the fast tracking of the Individual Electronic Health Record at a Federal level would allow for medications and script details to be contained electronically on a common database. This would remove the likelihood of medication errors and enable more cohesive care to those who require medications to treat conditions such as diabetes, asthma or cardiovascular ailments.

Recommendation 11: The VHA recommends a feasibility analysis of how the process of medical supply acquisition can be more expeditious through strengthened sister relationships between health services, whilst retaining appropriate levels of government involvement.

c) equipment and communication systems

3.8 Communications

Hickey (Bushfire Cooperative Research Centre) identifies the importance of agencies involved in responding to bushfires to inter-operate their technical and non-technical systems². This means that relief and recovery efforts require optimal and modern communication between multiple agencies to enable the best outcomes to occur.

It is imperative that Victoria's health services have access to the latest bushfire warnings and information. On Black Saturday, health services reported information on 774 ABC failed the 'real time' test, so they relied on direct communication with their local CFA and the CFA Website. Similarly, a lack of up-to-date contact lists resulted in delayed communication from authorities. Furthermore, communication from DHS varied across regions and mobile phone coverage was problematic. Some services lost mobile phone coverage due to the melting of towers, land line phone coverage was limited and UHF radios were only of limited use. People were also unable to charge their phones due to the loss of power over days. Whilst temporary towers were erected following the bushfires in some areas, there is a need for alternative forms of communication.

In 2000, the SMR (StateNet Mobile Radio) system was implemented across many of Victoria's health services. This is a land-based radio service that provides one-to-many and many-to-one communications. However, this service incurs a \$30 a month fee and is very rarely used. As a result, many services have let this service lapse.

Any investment in an automated messaging service should feature a triage cascading function to enable services to obtain the necessary details of the emergency that articulates. This must articulate how services in regions should be utilised as a component of state-wide and local disaster planning.



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Once the immediate threat of the fires had lessened and people had accounted for their loved ones, the immediate need for people was information regarding grants, property clean up, government actions and where people could acquire necessary goods. The abundance of communication from government departments was commended, however this was not coordinated through one voice. Therefore, services received information from a range of government departments that they had to distil down.

Recommendation 12: The VHA believes there is an urgent need to harmonise and operationalise interoperability between communication systems in times of emergency. The VHA believes we must now look at opportunities to build smarter and safer communities that incorporate all of the more robust fire safety communication networks. With the investments in broadband infrastructure expected to occur, the VHA recommends the development of contingency emergency communication systems utilising broadband networks.

3.9 Media

The research literature, encompassing interviews with emergency personnel, indicates that there is concern about the media sensationalising bushfires, as the effects of media reporting are both immediate and long lasting³. Ill-informed, intrusive and sensationalised misreporting by some media further exacerbates the massive impact on both the local economy and community resilience.

Whilst the majority of the media focussed on the emergency recovery sites, health services experienced variable encounters with the media. Stories were often sensationalised or factually incorrect regarding the experiences of particular services, or the service provision during the bushfire period. The VHA believes that sensationalising stories and taking 'staged' photos is not conducive to a healthy recovery for communities. It is certain that bushfires will continue to generate media interest and that we may find more and more media organisations dedicating time and resources to cover such stories⁴.

Recommendation 13: Whilst the VHA appreciates the role of the media in communicating the stories of the bushfires and the work of the health sector to the public, we recommend stronger protocols to restrict the sensationalisation and misrepresentation of health services to the public. In addition, educative processes are required to ensure journalists are aware of the social and psychological consequences of trauma and grief and how their actions can support or hinder recovery.

3.10 Post-event issues

The VHA is concerned about the ongoing impact of the bushfires. For example, anecdotal evidence has reported sharp rises in referrals to family violence programs and a rising incidence of family breakdown due to the pressures of the bushfires. A well-developed mental health system is vital to be readily mobilized during a disaster. In addition, services have provided anecdotal evidence that there has been an increase in counselling appointments three months on, following an initial delay - a natural consequence of the bushfires. Rising rates of alcohol abuse are also noted.

In rural areas, services are concerned about the potential for rising rates of suicide and attempted suicide which may be partially attributed to the bushfires. The bushfires' impact was compounded by the lingering impacts of drought and environmental degradation, insufficient prices for stock and grain (due to the environmental and financial climate) and the ongoing decline of rural communities. These factors undermine capacity for autonomous recovery, and therefore the integration of new services is needed in the existing service system, specifically relevant to the disaster.

The post-bushfire health needs of volunteers involved in relief and recovery has also received negligible attention. Due to limited tracking and problematic coordination, it is now difficult to track the wellbeing of volunteers and support workers. Services are unaware of who they were and where they are now. These volunteers have also experienced traumatic events and there is an issue of duty of care to tend to these needs.

Recommendation 14: The State Government must invest in building the capacity of rural populations through further investment in 'mental health first-aid' training to help respond to the stress on rural



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communities. The VHA recommends this training becomes compulsory practice for those in occupations such as teaching and the police who have high contact with people. It is also important to utilise the "natural information providers" within towns such as hairdressers, supermarket staff and organisations such as the Victorian Farmers Federation.

Recommendation 15: More attention should be placed on the recruitment, training and recognition of volunteers. It is also essential to find ways to provide support for disaster volunteers experiencing stress and mental health needs - we recommend tracking processes of these volunteers to ensure services can conduct follow up work, caring for the mental health and wellbeing of these volunteers.

4. Conclusion

There is a strong reciprocal relationship between Victoria's health services and sustainable, effective and responsive communities. We face future ecological disasters that "have the potential to affect many aspects of human life in ways that are complex and involved interactions between many systems"⁵. As a result, the VHA recommend the Royal Commission ensure Victoria's health services are provided with the appropriate infrastructure, funding and support structures to meet the needs of their communities in crisis.

The Black Saturday bushfires have brought about considerable physical damage to property, people and community infrastructure and will result in both short and long term psychological damage. Victoria's health services continue to play a substantial role in assisting people with the issues arising as a result of the fires. Victoria's health services are vital cogs of the emergency response system and continue to play a crucial role in rebuilding affected communities.

The VHA welcomes the opportunity to represent the Victorian public healthcare sector throughout this or future inquiries. Please contact me on (03) 9094 7777 or trevor.carr@vha.org.au for any further information.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Trevor Carr'.

Trevor Carr
Chief Executive

¹ Noblet A (2003) *Building health promoting work settings: identifying the relationship between work characteristics and occupational stress in Australia*. Oxford University Press

² Hickey G (2008) The role of multi agency approaches to emergency management in enabling and contraining efficacious outcomes, *Poster Presentation: Program D*, Bushfire CRC.

³ Cohen E, Hughes P, White P (2006) Reporting bushfires: What motivates the media? *A Bushfire Cooperative Research Centre project*, Media Studies Program, La Trobe University

⁴ Cohen E, Hughes P, White P (2006) Reporting bushfires: What motivates the media? *A Bushfire Cooperative Research Centre project*, Media Studies Program, La Trobe University

⁵ Baum F (2008) *The new public health*. Oxford University Press Oxford, UK