



Primary care planning during outbreaks
and pandemics: What worked well vs what
needs to change

Dr Rodney Pearce AM

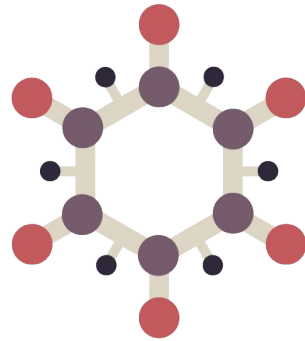
GP MedicalHQ, IC Chair, Medical Officer of Eastern Health
Authority, Adelaide, past member ATAGI and advice to PBAC

9:10

Pandemic Planning

What worked, what didn't

Learnings from
Covid-19?



IMMUNISATION
C O A L I T I O N

Rod Pearce AM

Chair immunisation Coalition. Previous member ATAGI

Director

- Medical Benevolent Association (SA)
- Australian Association of GP
- Australian General Practice Network
- Medic Alert Foundation Australia

Past Director

- Headspace
- Australian GP Accreditation Ltd (AGPAL)
- Royal District Nursing Service (RDNS)
- ACE Division of GP (Medicare Local)

Past Chair

AMA Council of General Practice

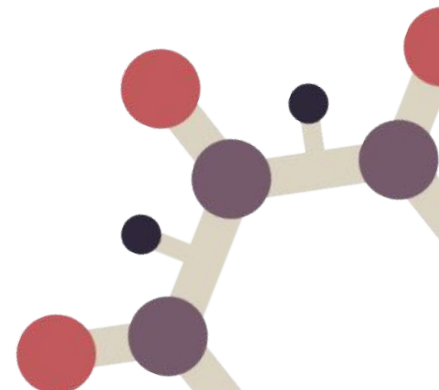
GP Supervisors Association,

LMO Committee (DVA)

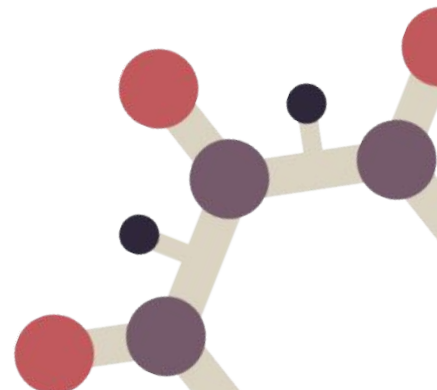
Past President AMA (SA)

General Practitioner (including Rural 25 year Award)

Member of the Order of Australia 2012



**What did it feel like
on the front line...
(like being at war)**



Complex issues...

Patients, clients, customers or community

They look to Primary Care for the translation of "white noise" of information into practical/ pragmatic action

Anger at government and social media issues translated into anger in the consulting room and one on one conversation





EF88 Austeyr Rifle



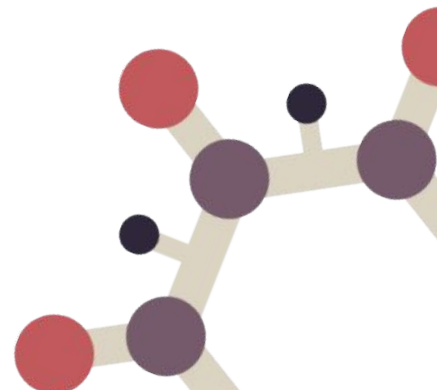
Cyclic rate of fire of
850 RPM

First used by 1st Battalion,
RAR, 2015





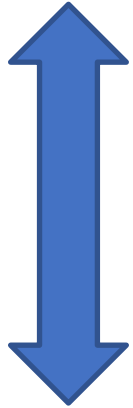
- Properly equipped
- Properly trained
- Know what the enemy looks like
- Adapt to the situation



COVID-19



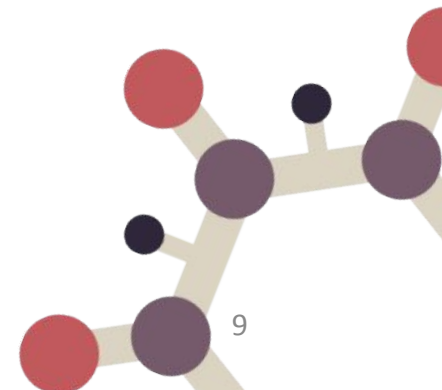
?



PATIENT

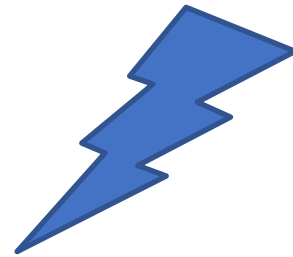
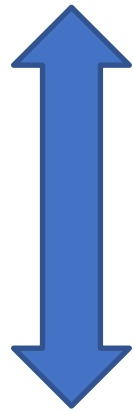
CONSULTATION

Face to face

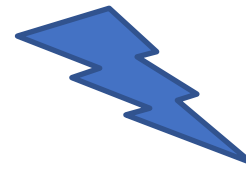


COVID-19

public health communications become “overly adversarial, even toxic”



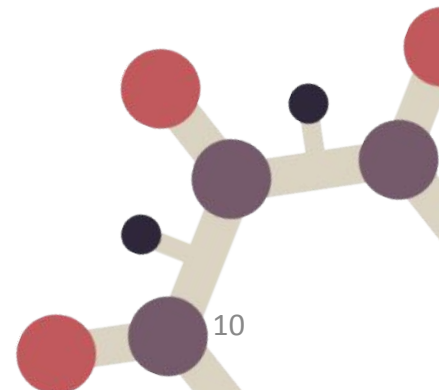
PATIENT



creating a distorted picture of how experts and decision-makers communicate, especially in times of crisis.

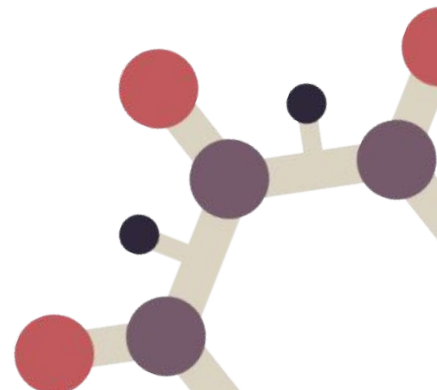
CMAJ 2022 February 22;194:E264-5. doi: 10.1503/cmaj.1095987

CONSULTATION



Overseas messages

- Primary care is adaptable



Covid-19 (Europe)

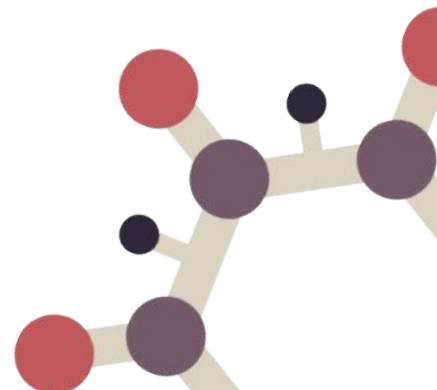
has had a complex impact on primary care,

- with **improved access** and coordination in many settings,
- balanced against **resourcing** and **information flow** issues,
- and a **reduction in the comprehensiveness** of services.



F2Face or remote or both (UK)

- The best features of high quality face-to-face consultations should be incorporated where possible into remote contacts with patients.
- The price of fewer physical examinations and fewer non-verbal cues is currently unknown **but could include a reduction in quality of care**.
- Better (and easier) with a GP the patient knows
- **Need to identify what can and cannot be handled safely and effectively with remote consultation**



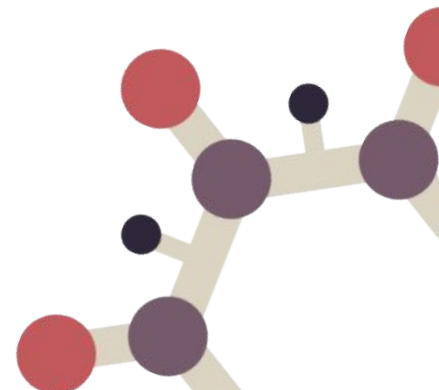
Internationally

Primary care remains the **cornerstone** of pandemic response

Primary Care has shown itself to be **highly adaptable** in meeting the unique demands of the pandemic.

Primary care **needs to be resourced,**

- with sufficient equipment,
- training, and
- financing

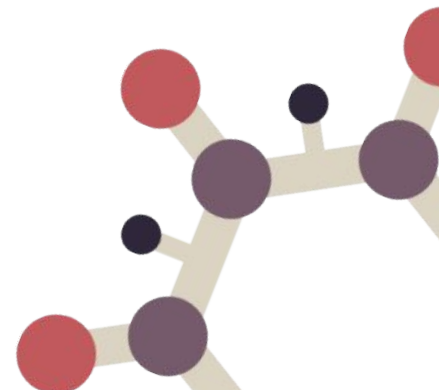


Internationally

Primary care has a key **role to play during and after** the pandemic by using its information infrastructure

- To identify risk groups
- Monitor compliance
- Provide care according to needs
- Detect new cases of Covid-19

Maybe “a unique policy window to convince government to enforce better public health policy”

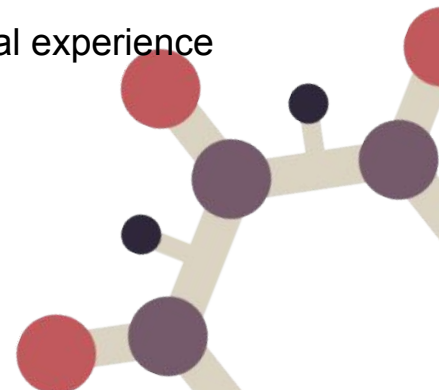


What could have been...

- Advancing telehealth services to support chronic disease management:
- Self-management support:
- Proactive care for at-risk patients:
- Community partnerships:
 - Maintaining and enhancing linkages between acute and community sectors
- Consideration of funding model reform:

The impact of COVID-19 on chronic disease management in primary care: lessons for Australia from the international experience

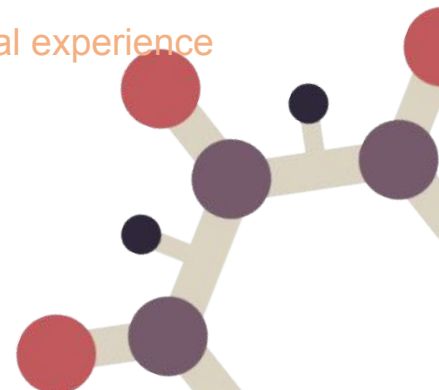
Anne Parkinson et al Med J Aust 2022; 216 (9): 445-448. || doi: 10.5694/mja2.51497



What needs to change...

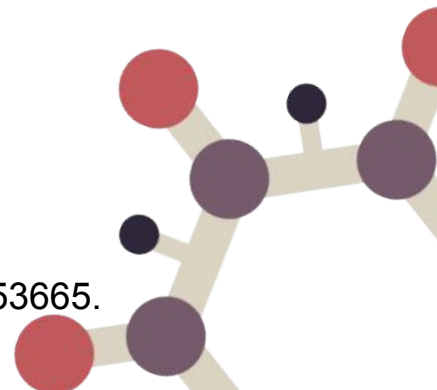
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Future...

- Advancing telehealth services to support chronic disease management:
 - 99.5% clinicians use the telephone alone
 - 66.4% of all consults “virtual”
 - 43.9% say they will continue to use “virtual visits”
- Patients **don't always have access to technology**
- Poor quality or intermittent IT connectivity
- Not fully integrated with electronic health record (EHR)
- Rural (IT doesn't work) urban (overutilised)

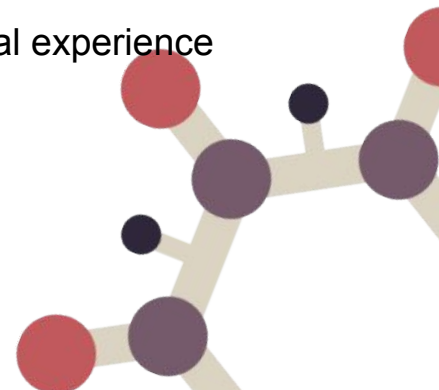


Future patient autonomy....

- Advancing telehealth services to support chronic disease management:
- Self-management support:....**DID NOT HAPPEN!**
- Proactive care for at-risk patients:
- Community partnerships:
 - Maintaining and enhancing linkages between acute and community sectors
- Consideration of funding model reform:

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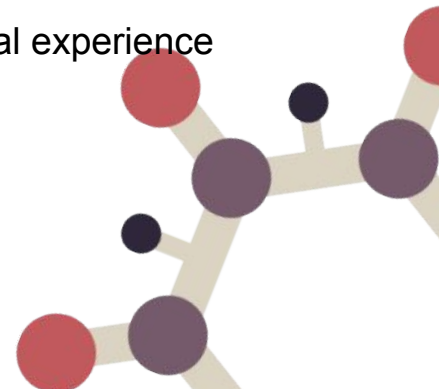


At risk...help to find, help to protect

- Advancing telehealth services to support chronic disease management:
- Self-management support:
- Proactive care for at-risk patients: mixed response
- Community partnerships:
 - Maintaining and enhancing linkages between acute and community sectors
- Consideration of funding model reform:

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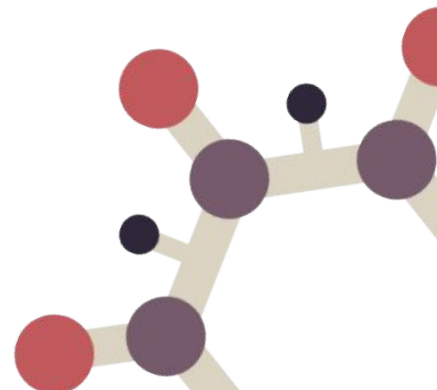
Pandemic disease...existing disease

- Advancing telehealth services to support chronic disease management:
- Self-management support:
- Proactive care for at-risk patients:
 - Delayed health care
 - Avoidance of health care

I am hesitant to visit the doctor unless absolutely necessary. /Ramey Moore et al Medicine 2022 101:32

- Primary care can identify and identify vulnerable patients

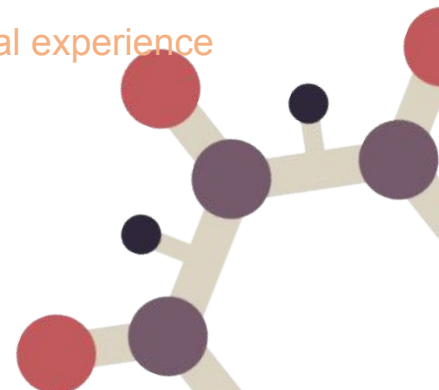
Kumpunen, Webb, Permanand, et al. Health policy 126(2022) 391-397



System as a whole...not parts

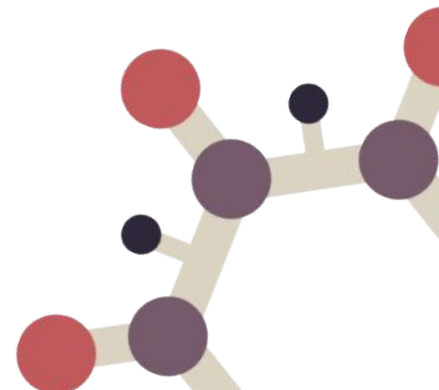
- Advancing telehealth services to support chronic disease management:
- Self-management support:
- Proactive care for at-risk patients:
- Community partnerships: **UNDER THREAT**
 - Maintaining and **enhancing linkages** between acute and community sectors
- Consideration of funding model reform:

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Community partnerships:

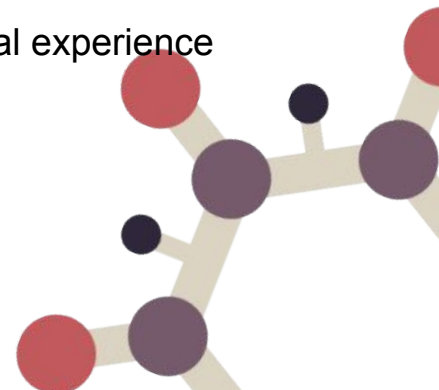
- **Maintaining and enhancing linkages between acute and community sectors**
2. The expectations from young families and individuals now seem to be for rapid access to advice and treatment with any available medical practitioner.
 3. ever growing move towards a short term problem solving model incorporating non face to face acute assessment, triage, and **signposting** to auxiliary primary care practitioners
 4. creates the potential for **poor continuity of care**, reactive medicine, and limited capacity for preventative or holistic care medicine



Don't let telehealth be the only change...

- Advancing telehealth services to support chronic disease management:
- Self-management support:
- Proactive care for at-risk patients:
- Community partnerships:
 - Maintaining and enhancing linkages between acute and community sectors
- Consideration of funding model reform: **Hasn't happened?**

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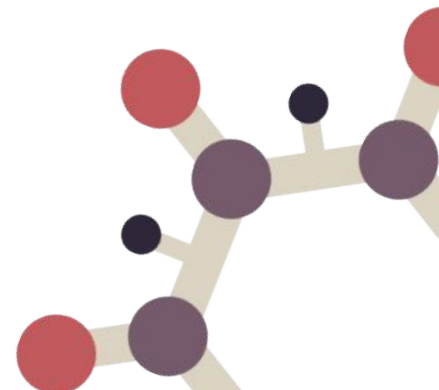


In summary 1/3

Primary care remains the **cornerstone** of pandemic response

and

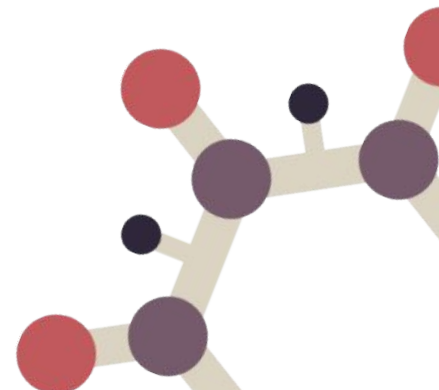
has shown itself to be highly **adaptable** in meeting the unique demands of the pandemic



In summary 2/3

Primary care needs to be resourced

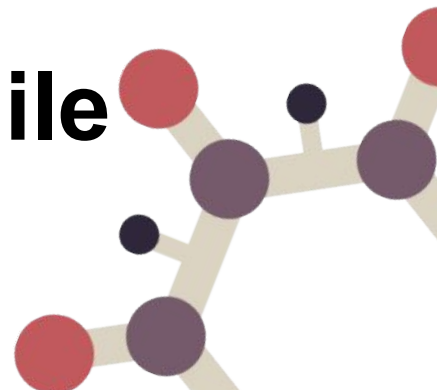
- Sufficient equipment
- Sufficient training
- Sufficient **financing**



In summary 3/3

Primary care needs to be

- Included in the planning
- Integrated into public health and acute care
- Sufficient **status/flexibility to remain agile**



And

