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House of Representatives Standing Committee on Health, Aged Care and Sport
PO BOX 6021
Parliament House
CANBERRA
Canberra ACT 2600

**Inquiry into Long COVID and Repeated COVID Infections**

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide input to the Inquiry into long COVID and repeated COVID infections.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

**Summary of recommendations**

- A national long COVID strategy should be developed and adequately resourced that encompasses a nationally consistent definition of long COVID.
- A national long COVID strategy must be person centred, value driven, evidence based, and support place-based innovation and diffusion.
- Long COVID primary care service models and referral pathways must be established.
- Funding mechanisms must be embedded that facilitate early multidisciplinary team-based interventions for people experiencing long COVID.
- PHNs should be funded to support the development and implementation of integrated team-based models of care, responsive to addressing long COVID local needs.
- Specialist long COVID clinics must be adequately resourced and equitably distributed to support Australians in metro, regional, rural and remote locations.
- Mechanisms should be embedded to upskill the health workforce though establishing a long COVID learning community that facilitates the rapid dissemination of long COVID research, innovation and education.
- Robust and reliable long COVID data collection mechanisms must be embedded that inform:
    - long COVID priorities, actions, and resource allocation decisions at the population level
    - real time clinical care decisions at the patient level, focused on improving the outcomes that matter

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**Background**

In May 2021, the AHHA published a Deeble Institute for Health Policy Research Issues Brief 'Managing the long-term health consequences of COVID-19 in Australia' (the long COVID brief) calling for the Australian Government to develop an effective and proportionate value-based response to COVID-19, long COVID and its other longer-term consequences, that considered both patient health outcomes and costs. The long COVID brief outlined recommendations to support health policy makers to address the impact of long COVID on people, communities and the health system. To avoid duplication, we have endeavoured not to repeat the findings of the long COVID brief within this submission however we urge the committee to read and consider the evidence outlined as it continues to remain highly relevant.

Since its publication, 18 months ago, AHHA and its members have been left disappointed with the subsequent lack of coordinated government leadership to address the concerns about the impact of long COVID raised in the long COVID brief (and directly with government representatives). This lack of sector coordination has led to a fragmented, under resourced and inequitable response to addressing long COVID, which is now undermining the fundamental principles on which Australia's health system is built: universality of services, equity in service provision, and choice (Commonwealth of Australia 2016) and leading to poor health outcomes.

We continue to urge policy makers to consider and embed the recommendations outlined in AHHA's long COVID brief to deliver a person centred, outcome focused, value-driven, response to the impacts of long COVID and repeated COVID infections.

Informed by broad consultation with AHHA's membership and the recommendations made in the long COVID brief, this submission addresses the following Terms of Reference as identified by the House of Representatives Standing Committee on Health, Aged Care and Sport:

- The experience of healthcare services providers supporting patients with long COVID and/or repeated COVID infections
- The impact of long COVID and/or repeated COVID infections on Australia's overall health system

**A nationally consistent approach**

1. A national long COVID strategy should be developed and adequately resourced that encompasses a nationally consistent definition of long COVID.
2. A national long COVID strategy must be person-centred, value-driven, evidence-based, and support place-based innovation and the diffusion of ideas.

The current experience of service providers supporting patients with long COVID or repeated COVID infections is fragmented and confusing. A key difficulty undermining the development and diffusion of effective management and treatment approaches is a lack of diagnostic criteria or consensus on the definition of long COVID (Australian Government 2022). For example:

The NSW government defines long COVID as:

> "*An illness that occurs in people who have a history of probable or confirmed SARS-CoV-2 (COVID-19) infection; usually within 3 months from the onset of COVID-19, with symptoms and effects that last for at least 2 months (NSW Government 2022)"*

The Victorian government defined long COVID as:

> *"Long COVID is a condition where people continue to experience COVID-19 symptoms usually for at least 3 months from the onset of COVID-19. (State Government of Victoria 2022)"*

With the federal government highlighting that long Covid usually refers to both (Australian Government 2022):

- *'Ongoing symptomatic COVID-19' if their symptoms have persisted for more than 4 weeks after initial infection.*
- *'Post-COVID-19 syndrome' if their symptoms continue after 12 weeks.*

This nationally inconsistent approach to disease definition is impacting the design and delivery of long COVID care, and creating roadblocks for service providers and health professionals seeking to develop specialised models of care (Biddle & Korda 2022). In addition, design and diffusion of learning and innovation for improvements in long COVID treatment and management is negatively impacted, and unnecessary bureaucratic and administrative burden for health services working across the various healthcare jurisdictions is increased.

The UK provides an example for a nationally consistent strategic approach to long COVID and repeated COVID infections. NHS England, with the support of a long COVID taskforce (including people with a lived experience of long COVID, NHS staff and researchers), have developed a national long COVID plan which articulates a nationally consistent definition for long COVID and outlines a coordinated place-based approach that considers care across the whole care pathway (NHS England). The Australian Government should seek to learn from the NHS experience and create a nationally consistent person-centred approach to long COVID care in Australia.

AHHA's *Healthy people, healthy systems* (AHHA 2021) is a blueprint for reform (the Blueprint) with a series of short, medium, and long-term actions to achieve this goal. The actions outlined in the Blueprint closely align with the initiatives mapped out in the Australian Health Minister's *National Health Reform Agreement (NHRA) – Long-term health reforms roadmap* (Australian Health Ministers 2021). The Blueprint is a useful template to inform the development of a long COVID national strategy that is person-centred and evidence-based, supports place-based innovation and encompasses a nationally consistent definition of long COVID.

Implementation of the strategy must be adequately resourced, and mechanisms of evaluation embedded to ensure accountability and continuous improvement.

**Integrated, multidisciplinary, place-based care**

3. Long COVID primary care service models and referral pathways must be established.
4. Funding mechanisms must be embedded that facilitate early multidisciplinary team-based interventions for people experiencing long COVID.
5. PHNs should be funded to support the development and implementation of integrated team-based models of care, responsive to local need.
6. Specialist long COVID clinics must be adequately resourced and equitably distributed across metro, regional, rural and remote locations.

In Australia, service models for long COVID in primary care are not well (if at all) established, with GPs in many areas highlighting the absence of referral pathways from general practice to specialised long COVID supports for patients presenting with long COVID symptoms. This is problematic given that Australian Government advice recommends seeing your GP if you are experiencing long COVID symptoms (Australian Government 2022).

GPs are therefore referring to specific allied health professionals (e.g., local physiotherapists) to treat patients with long COVID. While the contribution of allied health professionals to the management of long COVID symptoms is critical, international evidence suggests that good health outcomes requires joined up, integrated, holistic care provided by a multidisciplinary team that includes general practice, allied health, nursing, and specialist health professionals (NHS 2021).

Chronic disease GP Management Plans (GPMP) and Team Care Arrangements (TCA) present a mechanism though which GPs are seeking to provide more coordinated joined up care for those experiencing long COVID. However, to be eligible for these MBS items patients must have a chronic medical condition which has been, or as the case is more likely to be, the condition must be present for at least six months (Services Australia 2022). Together with nationally inconsistent definition of long COVID and a limited evidence base, health professionals face considerable difficulty determining if the experience of long COVID symptoms actually persist past 6 months. As such, many people are left to experience debilitating symptoms for 6 months before they are able to access subsidised coordinated support for long COVID. Additionally, chronic care management plans only allow for 5 subsidised allied health sessions within 12 months (Services Australia 2022). This is insufficient to address the significant and diverse care needs of people suffering from long COVID.

To date, Primary Heath Networks (PHNs) have not received dedicated funding to support the development and implementation of place-based models of long COVID primary care that are responsive to local need; and would require allocating resources for other purposes to support long COVID care. Furthermore, modelling has predicted that long COVID cases will likely cause a significant burden to the healthcare system, with upper estimates predicting measurable adverse economic impacts due to reduced workforce participation and increased need for healthcare and economic support (Hensher & Angeles 2022). Appropriate funding for PHNs to coordinate the development of place-based models of primary care for long COVID (to keep people out of hospital and provide care closer to home) will be essential.

A number of states and territories have set up multidisciplinary long COVID clinics. However, finding information on where and how to access or refer to these clinics, from both a service provider and

consumer perspective, is difficult. These clinics are primarily being set up in large metropolitan areas in acute settings, creating access inequity for already disadvantaged rural and remote communities (Mannix 2022). There are also reports of clinics being inadequately funded and unable to keep pace with demand, with some clinics reporting an 11-month wait for people to access condition specific (long COVID) care (Mannix 2022).

**A supported and learning health workforce**

7. Mechanisms should be embedded to upskill the health workforce though establishing a long COVID learning community that facilitates the rapid dissemination of long COVID research, innovation, and education.

8. Robust and reliable long COVID data collection mechanisms must be embedded that inform:
    - long COVID priorities, actions, and resource allocation decisions at the population level
    - real time clinical care decisions at the patient level, focused on improving the outcomes that matter.

Workforce recruitment is a major issue impacting the sustainability of state and territory based long COVID clinics (Mannix 2022). Anecdotal reports from AHHA members suggest that the lack of consistent diagnostic, referral and treatment pathways for people with long COVID has resulted in some primary care and allied health service providers (private businesses) actively choosing not to treat people suffering from long COVID.

With the rate of health care worker burnout soaring and reports of a 'great resignation' it is not surprising some healthcare professionals are opting out of providing care to long COVID patients, who present complex care needs (Smallwood at al 2021; Duckett & Meehan 2022). When healthcare professionals are no longer able to provide the care they would like for their patients (e.g., integrated multidisciplinary care for long COVID) they become disenfranchised, burnt-out and disengaged, and either leave the workforce all together or choose not to participate in parts of the system where they are unable to deliver the care that aligns with their values (Sutherland 2022; Trutner, Teisberg, & Bozic 2022).

In the context of long COVID, this could be mitigated though the provision of nationally consistent education, advice and training to enable health professionals to upskill on long COVID diagnostic and treatment approaches and deliver care that better aligns with their values as healers (Trutner, Teisberg, & Bozic 2022).

AHHA recognises the infancy of understanding of the impacts that long COVID will have on both the population and the healthcare sector and therefore the ability of comprehensive evidence-based education and guidance to be developed. However, this should not be an excuse for inaction. Again, we can learn from the NHS, who have implemented a long COVID learning network for health professionals via a digital platform to enable data driven learning and information sharing across acute, community and primary care (NHS England 2021). Membership of the network doubled in a 12-month period reaching 1,400 as of July 2022 (NHS 2022).

Policy makers in Australia should seek to embed mechanisms that will support the development of a long COVID learning community, enabling rapid diffusion of new evidence and treatment approaches as they are developed and tested, fostering a culture of shared learning and continuous improvement. Harnessing technology and embedding effective long COVID data collection mechanism (refer long COVID brief) will be critical elements of this (Hardie, et al. 2022).

Given their novelty and uncertainty, long COVID is particularly well-suited to the application of the WHO's "3D" approach to priority setting for value-based health services: Data, Dialogue and Decisions. This approach requires health planning and funding authorities to search for reliable data for robust, evidence-based analysis. Data are then used to inform a deliberative dialogue process with key stakeholders (COVID survivors and people living with long COVID), allowing decisions on priorities, actions, and resource allocation (WHO 2021).

An effective nationwide registry that combines patient-level data on COVID-19 and subsequent health and healthcare utilisation history is an essential requirement for effective population-level management of long COVID in Australia. The Australian Institute of Health and Welfare's COVID-19 linked data initiative is a great fist step and must continue to be resourced and used to inform population level health planning. Long COVID data collection mechanisms must also support clinicians at the patient level to deliver real time improvements to the outcomes that matter.

In summary, our recommendations are:

1. A national long COVID strategy should be developed and adequately resourced that encompasses a nationally consistent definition of long COVID.
2. A national long COVID strategy must be person centred, value driven, evidence based, and support place-based innovation and diffusion.
3. Long COVID primary care service models and referral pathways must be established.
4. Funding mechanisms must be embedded that facilitate early multidisciplinary team-based interventions for people experiencing long COVID.
5. PHNs should be funded to support the development and implementation of integrated team-based models of care, responsive to local need.
6. Specialist long COVID clinics must be adequately resourced and equitably distributed to support Australians in metro, regional, rural and remote locations.
7. Mechanisms should be embedded to upskill the health workforce though establishing a long COVID learning community that facilitates the rapid dissemination of long COVID research, innovation and education.
8. Robust and reliable long COVID data collection mechanisms must be embedded that inform:
    - long COVID priorities, actions, and resource allocation decisions at the population level
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We would be happy to discuss any aspect of this response further.

Sincerely,

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Chief Executive

Australian Healthcare and Hospitals Association (AHHA)

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