Exercise & Sports Science Australia Submission

Inquiry into the Queensland Government's Health Response to COVID-19

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1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing over 8,000 members, including university qualified Accredited Exercise Physiologists (AEPs), Accredited Sports Scientists (ASpSs), Accredited High-Performance Managers (AHPMs) and Accredited Exercise Scientists (AESs).

AEPs are recognised allied health professionals (AHPs) who provide clinical exercise interventions aimed at primary and secondary prevention; managing acute, sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness. Exercise physiology is a recognised and funded profession under compensable schemes such as Medicare Benefit Services (MBS), Department of Veteran Affairs (DVA), the National Disability Insurance Scheme (NDIS), private health insurance, and state and territory-based workers' compensation schemes.

Accredited Sports Scientists (ASpSs) and Accredited High-Performance Managers (AHPMs) work predominately in high performance/elite sport specialising in applying scientific principles and techniques to assist coaches and athletes to improve their performance, either at an individual level or within the context of a team environment. Exercise & Sport Science Australia (ESSA) is recognised by the Australian Institute of Sport and Sport Australia as the peak accrediting body for physiology/recovery, biomechanics, performance analysis and skill acquisition athlete support personnel working in Australian sports science.

Accredited Exercise Scientists (AESs) are exercise professionals who assess, design and deliver exercise and physical activity programs to improve health and fitness, wellbeing or performance, or focus on the prevention of chronic conditions. They work in fitness businesses, for sporting bodies, in corporate health and as allied health assistants (AHAs).

ESSA welcomes the opportunity to respond to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee on this Submission and appear before the Committee if invited.

2.0 Summary of Issues

The Coronavirus (COVID-19) pandemic has been a rapidly evolving health crisis that has required all levels of government, particularly the Australian Government and state and territory governments to lead a fast and coordinated response.

A significant health milestone in the pandemic was the introduction of a swathe of additional temporary allied health items into Medicare Benefit Services on 20 April, 2020, a change that healthcare experts predicted would take anywhere from three years to a decade to achieve.

ESSA concurs with the Australian Minister for Health, the Hon. Greg Hunt MP's comments in his Media Release[i] that

> **"This is an extraordinary feat and a reflection of our doctors' and allied health professionals' commitment to delivering accessible, best-practice care for all patients, during this difficult time."**

Whilst the National Cabinet has functioned effectively in coordinating a national response, decisions have not been binding and **the interpretation, enactment, and communication of public health orders across state and territory jurisdictions has at times lacked coordination and consistency.** With each jurisdiction focusing on its own public health messaging to suit local conditions, it has been exceedingly difficult for a national association such as ESSA to communicate clear and consistent messages to members across Australia.

A comment made in **2016** by a former CEO of the National Rural Health Alliance, Gordon Gregory that **"Allied health is still the forgotten professional grouping in health policy matters, particularly at the national level[ii]"** has held true during COVID-19 and **the structural weaknesses and inequities within the health system that were evident prior to COVID-19 were magnified even more during COVID-19**.

The first critical weakness relates to legislation. Two legislative issues impeded the delivery of high quality clinical care, specifically exercise therapy delivered by Accredited Exercise Physiologists:

- the lack of a nationally consistent legislative framework for essential services which includes the comprehensive recognition of allied health services and
- the default in Queensland legislation and Queensland exemptions to other legislation that excludes self-regulated health professions.

The need to support non-COVID-19 patients with an information campaign on essential health services that were allowed to remain open for their ongoing care was not managed particularly well by either the Australian Government or state and territory governments. Public health messaging focused more on what needed to close rather than what was allowed to stay open and subsequently the health, wellbeing and quality of life of many Queenslanders was compromised.

Another notable weakness was the absence of an Australian Government Chief Allied Health Officer (CAHO) to provide leadership and coordination; and support clinical decision-making. The quality and timeliness of clinical advice provided by the Australian Government to allied health professional associations and allied health professionals more broadly during COVID-19 has been found lacking. State and territory Allied Health Officers and their staff worked incredibly hard to fill this void. On several occasions, ESSA relied on the interventions of the Ms Liza-Jane McBride, the Chief Allied Health Officer for Queensland and her other state and territory counterparts to support exemptions to allow clinical exercise therapy to continue.

Professional associations had to interpret the limited government guidance available to them and advocate strongly for their professions to be included initiatives such as telehealth and have access to protective personal equipment (PPE). The Australian Government eventually responded to various calls for a CAHO position when an acting CAHO was appointed on 3 June, 2020.

The underinvestment in peak allied health bodies impacted on allied health being able to fully participate in COVID-19 decision making. The Australian Allied Health Leadership Forum (AAHLF), recognised by the Australian Government as the peak allied health mechanism for providing coordinated allied health advice to Government, has no secretariat equivalent to the funded secretariats for the national medical and nursing networks. In addition, Allied Health Professions Australia (AHPA), the peak body for the allied health professions, receives substantially less funding than the other peak health advocacy groups.

The lack of a rehabilitation strategy or national framework for COVID-19 patients of all ages requiring rehabilitation is a weakness. There was a lack of understanding of the critical role that role exercise physiologists and other allied health professionals will play in managing the COVID-19 rehabilitation surge alongside the interrupted care needs of non-COVID-19 patients whose care was suspended or scaled down during COVID-19.

3.0 Summary of Recommendations

Recommendation 1: That the Queensland Government through the National Cabinet and/or the National Federation Reform Council (NFRC) prioritises harmonising definitions of essential services in existing legislation or in any new essential services legislation, including a consistent definition for essential health and allied health services.

Recommendation 2: That the Queensland Government ceases defaulting to the *Health Practitioner Regulation National Law* as the default definition of health practitioners in any COVID-19 exemptions and public health orders.

Recommendation 3: That the Queensland Government reviews all its health legislation to

- **ensure that the default definition of health practitioners reflects COAG policy and recognises health professions not registered with Ahpra and**
- **consider defaulting to the *Private Health Insurance (Accreditation) Rules 2011 (Cwlth).***

Recommendation 4: That the Queensland Government considers establishing an emergency healthcare services fund for vulnerable target populations unable to afford healthcare or unable to access additional Australian Government funding in times of pandemics and other disasters.

Recommendation 5: That the Queensland Government collaborates with the Australian Government to produce resources for service providers to educate staff (including plan managers and personal care workers) about the need to maintain the continuity of care for vulnerable target populations in times of pandemics and other disasters.

Recommendation 6: That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC develops a public information campaign reassuring vulnerable target populations including older people (both in the community and in residential care), people with a disability and people with chronic conditions that health and allied health care is essential and should continue to be accessed; and that they be supported to stay active and remain mobile during COVID-19.

Recommendation 7: That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC asks the Australian Government develop consistent, co-ordinated and clear messaging to educate law enforcement agencies about the range of essential health and allied health services.

Recommendation 8: That the Queensland Government via the National Cabinet and/or the NFRC asks the Australian Government to expedite the appointment a permanent Australian Chief Allied Health Officer as a matter of urgency.

Recommendation 9: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government implement a rehabilitation strategy for patients of all ages requiring rehabilitation with strategic priorities for allied health and exercise physiologists to manage the COVID-19 rehabilitation surge and the interrupted care needs of non-COVID-19 patients.

Recommendation 10: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government task and resource Australian Allied Health Leadership Forum to facilitate the collection and dissemination of allied health service improvements made during COVID-19.

Recommendation 11: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government fund an incorporated entity (possibly Allied Health Professions Australia) to support a Secretariat for the Australian Allied Health Leadership Forum to the same levels as the equivalent medical and nursing national networks and consider increasing funding to Allied Health Professions Australia.

Recommendation 12: That Queensland Health maps COVID-19 related hospital activities against the scope of practice of allied health professionals (both Aphra and self-regulated professions) to determine the highest value use of qualified allied health staff.

Recommendation 13: That the Queensland Health considers utilising Accredited Exercise Scientists to work as allied health assistants in any future surge workforces.

Recommendation 14: That the Queensland Government through the National Cabinet and/or the NFRC reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 15: That the Queensland Government via the National Cabinet and/or the NFRC supports the retention of all temporary telehealth items for allied health and other health care and re-investigate funding models that focus on a long-term, whole person and population health perspective.

Recommendation 16: That the Queensland Government, the Australian Government and other state and territory jurisdiction works to harmonise requirements for COVID-19 Plans.

Recommendation 17: That the Queensland Government via the National Cabinet and/or the NFRC ensures the Australian Government continues to maintain adequate supplies of PPE in the National Stockpile to ensure all health and allied health professionals have access to PPE in the event of another pandemic.

Recommendation 18: That the Queensland Government provides health professionals with pathways and processes to support referrals to the Care Army.

Recommendation 19: That the Queensland Government includes information on the value of exercise during a pandemic on the Healthier Queensland website.

Recommendation 20: That the Queensland Government provides Care Army volunteers with information to pass onto vulnerable Queenslanders about the need to exercise to maintain their mobility, independence, confidence.

4.0 Inconsistencies in Essential Services Legislation

A major issue which has impacted on the ability of national professional bodies to provide standardised advice in a timely manner to members is the lack of a consistent definition of what is deemed an "essential service" within each jurisdiction's legislative framework. In a Fact Sheet[iii] produced by HopgoodGanim Lawyers, the legislative framework on what constitutes an essential service for each jurisdiction is summarised along with specific examples of which services are deemed essential.

This analysis highlights the inconsistencies around what health services are deemed "essential" within some jurisdictions' legislative frameworks:

- **Queensland - securing the essentials of life**
  - New South Wales (NSW) - the provision of public health services (including hospital or medical services); - the provision of ambulance services

- Northern Territory (NT) - hospitals administered under the *Medical Services Act 1982 (NT)* and any other service or facility concerned with the maintenance of public health
- South Australia - a service without which the safety, health or welfare of the community or a section of the community would be endangered or seriously prejudiced
- Victoria - no specific mention of health services other than a broad catch all of any other industry prescribed for the purpose of this definition

Western Australia, Tasmania, and the Commonwealth have no definitions of essential services in their relevant legislation; and the ACT has no current legislation which defines essential services.

An article in The Conversation[iv] on 31 March, 2020 highlighted the inconsistencies in information for the public on essential services information:

> "When it comes to dealing with the COVID-19 pandemic, there are no recent precedents for governments. **There is no pre-determined list in place on what is an essential service.** Instead, 'essential' appears a moving beast that is constantly evolving and that can be confusing"

but there was

> "broad agreement supermarkets, service stations, allied health (pharmacy, chiropractic, physiotherapy, psychology, dental) and banks are essential business and services".

Recommendation 1: That the Queensland Government through the National Cabinet and/or the National Federation Reform Council (NFRC) prioritises harmonising definitions of essential services in existing legislation or in any new essential services legislation, including a consistent definition for essential health and allied health services.

5.0 Intersection of Essential Services and Non-Essential Services

To respond to the rapidly changing COVID-19 environment, the Queensland Government introduced the *Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020 (Qld)*[v] to amend the *Public Health Act 2005 (Qld)*[vi] to enable the Chief Health Officer to issue public health directions. These directions included the opening and closing of non-essential facilities and the limiting of access to these facilities.

Whilst the issuing of public health directions in Queensland has worked relatively well, **there is a lack of understanding that some businesses operate both non-essential and essential services in the same facilities**. The decision to close gyms and fitness studios as non-essential services on 22 March, 2020[vii] had unintended consequences, restricting access for patients to clinical healthcare delivered by Accredited Exercise Physiologists (AEPs) using gym spaces for rehabilitation and exercise therapy.

On 23 March, 2020 (the day after the announcement closing of gyms), ESSA wrote to the

- Ms. Lara Musgrave, A/g First Assistant Secretary, Office of Sport within the Australian Government Department of Health and
- Ms. Catherine Turnbull, the Chair of National Allied Health Advisors and Chief Officers (NAHAC), the Chair Australian Allied Health Leadership Forum and the Chief Allied & Scientific Health Officer for South Australia

to seek an exemption for AEPs working in gyms to be allowed to continue to provide clinical exercise therapy.

Fortunately for some AEPs working in gyms, an exemption was provided a few days later in a letter dated 26 March, 2020 from Dr Lisa Studdert, Deputy Secretary for Population Health, Sport and Cancer, Australian Government Department of Health (Appendix A) to all allied health professionals:

> "**Gyms used for clinical treatment**
> While there has been a decision taken by National Cabinet to close gyms catering to the general public, **small gyms used for clinical treatment can remain open as long as they meet the general social distancing requirements**, namely, space for social distancing of four square metres per person and not more than 10 people attending at the same time."

ESSA advised its exercise physiology members using small gym spaces for clinical care to print out this letter and have it available to show law enforcement officers visiting business premises. With no guidance on what constituted a small gym, ESSA subsequently defined and provided guidance to its members that small gyms were 140 square metres or less.

AEPs working out of large gyms were unable to work prior to and during Stage 1 restrictions due to their workplaces being closed because these workplaces were deemed non-essential.

The exemption provided by the Australian Government Department of Health subsequently become redundant on 15 May, 2020 with the Queensland Government's first release of the *Return to Play Guide for Queensland sport, recreation and fitness industries*[viii]. **An exemption was provided in Stage 1 in the first and second (5 June, 2020) versions of the *Guide* for indoor gyms, studios and health clubs to allow some health professionals but not all to work in gyms**:

> "*Note there may be exceptions where health services are provided by health practitioners registered under the *Health Practitioner Regulation National Law* as outlined in health directives."

The nationally consistent *Health Practitioner Regulation National Law*[ix] passed by each state and territory parliament governs the National Registration and Accreditation Scheme (NRAS) which is administered by Australian Health Practitioner Regulation Agency (Ahpra).

Realistically, the only Ahpra professions that might benefit from the *Return to Play Guide* exemption are physiotherapists and possibly occupational therapists. The health professionals (i.e. Accredited Exercise Physiologists) that use gyms the most as part of their clinical practices to provide exercise therapy are worse off than they were when the Australian Government exemption was provided.

AEPs would be operating illegally in both small and large gyms if Queensland wound back relaxations and moved to Stage 1 restrictions as AEPs are not registered under the *Health Practitioner Regulation National Law*[x].

Queensland's default to a narrow and incomplete definition of health practitioners in the *Return to Play Guide* is in breach of the 2018 COAG Health Council Communique[xi] on the purpose of the National Registration and Accreditation Scheme:

> "It (NRAS) is not intended as a means to protect the interests of health professions or to confer standing or credibility on individual professions. **Inclusion of a profession in the NRAS is not indicative of that profession's value or its contribution to health service delivery**."

The Communique acknowledges that NRAS is not the only form of health practitioner regulation as below:

> "**The NRAS is one of a number of forms of health practitioner regulation**. Other forms of regulation include: professional codes and standards; membership of professional organisations and associations; consumer protection legislation; and statutory codes of conduct administered by governments (including the National Code of Conduct for health care workers)."

Exercise physiology is a self-regulated allied health profession that has met the benchmark standards set by the National Alliance of Self Regulating Health Professions (NASRHP) for the regulation and accreditation of practitioners within that profession. Other recognised allied health professions like dietetics, audiology and speech pathology are also self-regulated health professions meeting NASRHP standards.

On another matter, the Queensland Government defaulted to a different piece of legislation to exempt a different group of health professionals because massage therapists are also not recognised under *Health Practitioner Regulation National Law.*

The latest *Queensland Restrictions on Businesses, Activities and Undertakings Direction (No. 2)*[xii] includes an exemption for massage therapists which defaults to a piece of Commonwealth legislation as below:

> "Qualified massage therapist means a massage therapist who:
> holds a relevant qualification (minimum AQF level 4 (Certificate IV)) under the Australian Qualifications Framework; and
> Example – Certificate IV in Massage Therapy, Diploma of Remedial Massage or Bachelor of Health Science (Myotherapy)
> is a member of a professional organisation within the meaning of section 10 of the ***Private Health Insurance (Accreditation) Rules 2011 (Cwlth)***; and holds approved provider status with one or more private health funds."

The Commonwealth legislation used to provide the exemption for massage therapists is more comprehensive as it recognises three different forms of health practitioner regulation: professions registered with Ahpra, self-regulated professions meeting the benchmark standards set by NASRHP and professions which independently self-regulate like massage therapy.

Exercise physiology is listed with the following Ahpra and non-Aphra registered professions in the following section of the *Private Health Insurance (Accreditation) Rules 2011 (Cwlth)* which incorporates amendments up to the *Private Health Insurance (Accreditation) Amendment Rules 2019 (Cwlth)*:

> "12 Health service not specified in an item—meaning of health service
> For the purposes of paragraph (b) of the definition of health service in subsection 3C(8) of the Act, the following classes of services are prescribed:
> (a) Aboriginal or Torres Strait Islander health services;
> (b) audiology;
> (c) chiropractic services;
> (d) diabetes education;
> (e) dietetics;
> (f) **exercise physiology**;
> (g) focussed psychological strategies;
> (h) mental health services;
> (i) midwifery;
> (j) non-directive pregnancy support counselling;
> (k) nurse practitioner services;
> (l) occupational therapy;
> (m) orthoptics;
> (n) osteopathy;
> (o) physiotherapy;
> (p) podiatry;
> (q) psychological therapy;
> (r) psychology;
> (s) speech pathology.

An example of **current Queensland health legislation with incomplete definitions of health practitioners in breach of COAG policy are the definitions of a clinician, a prescribed health practitioner and a relevant health practitioner in the *Hospital and Health Boards Act 2011 Act (Qld)*** which defaults to the *Health Practitioner Regulation National Law (Cwlth)* as below:

> "Subdivision 2 Membership
> 23 Membership of boards
> (4) In this section—
> clinician means a person who—
> (a) is a health professional registered under the **Health Practitioner Regulation National Law**, other than as a student; and
> (b) is currently directly or indirectly providing care or treatment to persons; and
> (c) is in a profession that provides care or treatment to persons in public sector health services."

> "Part 7 Confidentiality
> Division 1 Interpretation and application
> 139 Definitions for pt 7
> In this part—
> ……
> prescribed health practitioner means—
> (a) a relevant health practitioner, other than a person mentioned in section 139A(1), who is prescribed by regulation; or
> [s 139A]
> …….
> (b) a person who was a relevant health practitioner mentioned in paragraph (a).
> ……
> relevant health practitioner means an individual who is registered under the **Health Practitioner Regulation National Law** to practise a health profession, other than as a student."

This means exercise physiologists, dietitians, speech pathologists, audiologists and other health professionals not regulated by the Australian Health Practitioner Regulation Agency cannot access *The Viewer*, Queensland Health's database on patient details and history nor are they eligible to be a member of a Queensland hospital and health board.

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Recommendation 3: That the Queensland Government reviews all its health legislation to

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- **consider defaulting to the *Private Health Insurance (Accreditation) Rules 2011 (Cwlth).***

6.0 Public Health Messaging

During the early stages of the COVID-19 pandemic in Australia, exercise physiology patient and the general public had a limited understanding of what health services were "essential" and therefore still allowed to operate. **The initial messaging focused on what the National Cabinet and states and territories deemed was "non-essential" rather than what was "essential".**

The lack of consistent, co-ordinated and clear communication around essential health and allied health services left many vulnerable population groups confused about accessing clinical health care. ESSA members working in community aged care expressed concern that older people were ignoring their immediate and ongoing health needs because of COVID-19 related fear. AEPs reported that some older people were too scared to leave their houses and their families stopped visiting them. Many older people cancelled all their previous in-home supports and their GPs informed them that they did not want to see them unless older people "needed" to see them.

Whilst the Prime Minister, the Hon, Scott Morrison, MP in a press conference[xiii] on 24 March 2020 outlined briefly that health and allied health services were essential and were excluded by the restrictions, there was no initial messaging about maintaining regular care:

> "In terms of personal services where there is a lot of contact, obviously, between those providing that service in a premise and the patrons, the following now won't be able to continue: beauty therapy, tanning, waxing, nail salons and tattoo parlours and the same for spa and massage parlours. That **excludes health-related services** in those areas, physiotherapists, things of that **nature, health-related and allied health services**".

It was another three weeks before the Australian Minister for Health, the Hon. Greg Hunt, MP issued a media release[xiv] on 8 April, 2020, urging those with chronic health conditions not to neglect their regular health care:

> "The Australian Government is urging all people with chronic health conditions to not neglect their regular health care and to continue to see their general practitioner or specialist about the management of their conditions.
>
> While COVID-19 is rightly front and centre in all our minds, it's vitally important people with existing chronic health conditions continue to consult with their doctors."

ESSA notes that the Minister's media release made no mention of the need for people with chronic health conditions to continue their regular allied health care. Similarly, there was limited messaging in Queensland about the need to continue with regular healthcare, especially allied health care in order to maintain health, wellbeing and quality of life.

As well as those older frightened Queenslanders who retreated to their homes and ceased all outside contact and care, other Queenslanders with chronic and complex conditions were impacted many factors including the:

- closure of large gyms
- sudden closure of some NDIS and aged care essential services unilaterally
- withdrawal of personal care support by staff working for NDIS and aged care providers
- cessation of some community transport services coupled with reduced access to alternative public transport services
- increased costs for NDIS services, with NDIS providers able to charge a temporary COVID-19 increase of 10 per cent, despite there being no funding increases within participant plans and
- inability to quickly transition to using telehealth services (more on this in Section 10).

One AEP highlighted a patient with muscular dystrophy who had three falls in the seven weeks of initial COVID-19 restrictions compared to one fall in the previous five years due to muscle atrophy and the deterioration of co-ordination caused by inability to access services in a large gym. Many patients like this patient missed out on essential allied health services because they were delivered in large gyms. Other **patients unable to access exercise therapy suffered a decline in their mobility, independence, confidence and an escalation of their conditions**.

National Disability Insurance Scheme participants experienced a similar level of confusion when the National Disability Insurance Agency (NDIA) encouraged NDIS participants to decide what supports they considered to be essential services. Whilst this approach was supportive of participant choice, it also added to the confusion amongst service providers, participants and their families around what services could be accessed and should be continued to be delivered.

ESSA members reported several large disability providers made blanket decisions to cease participant access to sub-contracted allied health services, including exercise physiology. Some AEPs reported up to 30 clients in one day lost access to exercise therapy because of these types of unilateral decisions.

With the imposition of higher COVID-19 fees, ESSA understands that some Queenslanders on care plans were unable to afford certain services. The NDIS COVID-19 surcharge of an additional 10 per cent on regular prices meant in some cases, people expended their budgets and were unable to access additional emergency funding due to the time lags in reviewing existing plans and developing new plans.

The paucity of information on essential allied health services being allowed to stay open has caused issues for AEPs beyond communicating with current and prospective patients. It created a risk that state and territory law enforcement agencies seeking to enforce public health orders might fine AEPs delivering essential clinical services in clinics that to an outsider look like gyms. In fact, several members were visited by Queensland Police Service officers querying why their allied health clinics were open. These members managed to avoid being fined, even though they had few concrete sources (e.g. the exemption letter from the Australian Government and their ESSA accreditation certificate) to verify their claims as providers of essential allied health clinical care. It took the Australian Government till 5 June, 2020[xv] to produce posters for use in clinics about allied health services being open for business.

A simple solution of listing at a minimum, all individual allied health professions with private health insurance or Medicare item numbers as essential health services on the Queensland COVID-19 website would provide an authoritative source for AEPs, their patients, the public and law enforcement agencies to refer to.

Recommendation 4: That the Queensland Government considers establishing an emergency healthcare services fund for vulnerable target populations unable to afford healthcare or unable to access additional Australian Government funding in times of pandemics and other disasters.

Recommendation 5: That the Queensland Government collaborates with the Australian Government to produce resources for service providers to educate staff (including plan managers and personal care workers) about the need to maintain the continuity of care for vulnerable target populations in times of pandemics and other disasters.

Recommendation 6: That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC develops a public information campaign reassuring vulnerable target populations including older people (both in the community and in residential care), people with a disability and people with chronic conditions that health and allied health care is essential and should continue to be accessed; and that they be supported to stay active and remain mobile during COVID-19.

Recommendation 7: That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC asks the Australian Government develop consistent, co-ordinated and clear messaging to educate law enforcement agencies about the range of essential health and allied health services.

7.0 Australian Government Chief Allied Health Officer and Allied Health Clinical Guidance

Allied Health Professions Australia (AHPA), the peak body for allied health professions, estimates **Australia's 195,000 allied health professionals represent more than a quarter of the heath workforce** and deliver an estimated 200 million health services annually[xvi]. This estimate includes those professions that self-regulate under the National Alliance of Self-Regulating Health Professions (NASRHP), those that independently self-regulate and those that are regulated by the Australian Health Practitioner Regulation Agency (Ahpra). Only accounting for the 11 allied health professions regulated by the Australian Health Practitioner Regulation Agency, the figures in Table 1 below highlight that there were **133,388 allied health professionals or 35.6 percent more allied health professionals than the 98,395 medical practitioners in 2018**.

Table 1: Numbers of health practitioners registered and employed in Australia from the fourteen health professions[xvii] regulated by the Australian Health Practitioner Regulation Agency under the National Registration and Accreditation Scheme (NRAS) in 2018

Medical Practitioner Profession			Nursing and Midwifery Profession		Other Heath Registered Practitioners	
Clinician	General Practitioner	30,066	Registered Nurse	254,650	Aboriginal and Torres Strait Islander Health Practitioners#	547
	Hospital non-specialist	10,759	Enrolled Nurse only	52,944	Chinese Medicine Practitioners#	4,058
	Specialist	33,303	Dual Registration	22,135	Chiropractors#	4,754
	Specialist-in-training	16,916	Midwife only	4,241	Dentists	20,589
	Other clinician	2,560			Medical Radiation Practitioners#	14,154
Non Clinician		4,791			Occupational Therapists#	18,447
					Optometrists#	5,060
					Osteopaths#	2,207
					Pharmacists#	25,139
					Physiotherapists#	27,265
					Podiatrists#	4,730
					Psychologists#	27,027
	Sub-total				#All allied health professions not including dentists	133,388
	Total	98,395		333,970		153,977

These 11 professions are regarded as allied health professions by the Council of Australian Governments (COAG) as per the Australian Government Department of Health's 2013 *Review of Australian Government Health Workforce Programs*[xviii].

Unfortunately, these numbers have not been enough to warrant the appointment of a permanent Chief Allied Health Officer despite calls for such an appointment including Professor Paul Worley, the outgoing National Rural Health Commissioner.

Professor Worley in his June, 2020 report[xix] on allied health services in regional, rural and remote Australia to the Minister for Regional Health, Regional Communications and Local Government made the following recommendation:

> "Recommendation 4 - National Leadership It is recommended that the Commonwealth appoint a dedicated full-time Chief Allied Health Officer (CAHO) to work across sectors and departments including health, mental health, disability, aged care, early childhood, education and training, justice, and social services. The CAHO will work with relevant peak bodies and consumer advisory groups to ensure equity of access to high quality allied health services for all rural and remote communities. Once established, the CAHO will provide valuable allied health input and leadership into Commonwealth government policy."

ESSA identified a gap in the quality and timeliness of clinical advice that is provided to allied health professional associations and allied health professionals generally by the Australian Government. The lack of a permanent Australian Government Chief Allied Health Officer or any senior Department of Health executive with direct allied health clinical experience or the commitment to mainstream allied health issues into existing expert groups has impacted on how allied health professional bodies can support their members with clinical advice.

As outlined earlier, ESSA relied on the interventions of the Ms Liza-Jane McBride, the Chief Allied Health Officer for Queensland and her state counterparts to support exemptions to allow high quality clinical care to continue.

In the middle of the COVID-19 pandemic, Allied Health Professions Australia liaised closely with newly appointed (on 2 March, 2020) Professor Michael Kidd AM. Professor Kidd is the Principal Medical Advisor to the Australian Government Department of Health with responsibility for the Primary Health Care 10-Year Plan, reforms to the health workforce and the $550 million Stronger Rural Health Strategy as per this Media Release[xx] from Minister Hunt.

Professor Kidd is leading the COVID-19 Primary Care Response Implementation Group, a temporary mechanism set up to respond to COVID-19 issues. Allied health professions in this forum are represented by the CEO of Allied Health Professions Australia (AHPA), Ms Claire Hewat who seeks and passes on feedback from ESSA and another AHPA members on a regular basis. In relation to general policy matters (including Medicare), this conduit appears to be working well.

ESSA applauds the Australian Government for the recent appointment of a Deputy Chief Medical Officer for Mental Health on 13 May, 2020 in response to the impacts on mental health of many Australians as the social and economic impacts of the pandemic set in.

ESSA acknowledges the appointment of an Acting Australian Chief Allied Health Officer on 3 June, 2020. ESSA notes the Department of Health website has not been updated to reflect this appointment nor has the appointee, Ms. Tania Rishniw, the Acting Deputy Secretary for Health System Policy and Primary Care interacted with Allied Health Professions Australia nor provided any public guidance or leadership via the Department's regular webinars for allied health professionals.

A more recent development occurred on 3 July, 2020 with the Australian Ministers for Health and for Regional Health, Regional Communications and Local Government announcing

> "an expanded National Rural Health Commissioner Office, which will now include non-statutory Deputy Commissioners who will support the Commissioner and provide expertise across a range of vital rural health disciplines such as nursing, allied health and Indigenous health[xxi]."

ESSA also understands that one of these Deputy Commissioners will have focus solely on allied health according to Allied Health Professions Australia.

Whilst ESSA wholeheartedly supports the appointment of a Deputy Commissioner for rural allied health, it would seem that this appointment is deemed more important than the appointment of a permanent Australian CAHO.

Recommendation 8: That the Queensland Government via the National Cabinet and/or the NFRC asks the Australian Government to expedite the appointment a permanent Australian Chief Allied Health Officer as a matter of urgency.

8.0 COVID-19 Rehabilitation Surge, Treatment and Health Care Innovation

ESSA notes that the presence of government appointed Chief Allied Health Professions Officers in the four nations of the United Kingdom has provided allied health professionals with clear leadership during the COVID-19 pandemic. This leadership has become particularly evident as the pandemic begins to ease and health care responses are reprioritised. For example, on 15 May, 2020, Chief Allied Health Professions Officers representing the governments of Wales, Scotland, Northern Ireland and England released a statement[xxii] outlining the four nations' collective strategic priorities and approach to allied health professional rehabilitation leadership during and after COVID-19.

The statement acknowledged that **allied health professionals are at the centre of shaping the rehabilitation services that will be critical to ensuring recovery from the impacts of the pandemic and the long-term sustainability of the health and social care system**.

The four Chief Allied Health Professions Officers identified "an increase in the need for rehabilitation across four main population groups

1. people recovering from COVID-19, both those who remained in the community and those who have been discharged following extended critical care/hospital stays
2. people whose health and function are now at risk due to pauses in planned care
3. people who avoided accessing health services during the pandemic and are now at greater risk of ill-health because of delayed diagnosis and treatment
4. people dealing with the physical and mental health effects of lockdown."

ESSA has seen no equivalent statement published by any jurisdiction in Australia.

A recent (15 May, 2020) Blog[xxiii] in *The BMJ Opinion* noted the impact of COVID-19 on rehabilitation in the United Kingdom:

> "The covid-19 pandemic has turned the way we run hospitals upside down, facilitating the expansion of intensive care and revolutionising the way we manage acutely ill patients. The use of virtual services to enhance communication and reduce transmission of covid-19 has been transformational for general practice as well as for hospital outpatient services. It is now **essential that we take the opportunity to develop parallel subacute services, facilities, and workforce in the community not only for patients who are ill with covid-19, but also for frail patients who require on going treatment and rehabilitation**…..

> There has been a **gross underestimate of the functional, physical, and emotional consequences of covid-19** as current NHS rehabilitation services are not set up for the recovery phase of this pandemic…..
>
> We know that covid-19 is a multisystem disease and there has been increasing understanding about the needs of recovering patients. Post-ITU survivors can experience significant respiratory, renal and cardiac problems, as well as muscle wasting, psychological/psychiatric problems and post-traumatic stress disorder. [1, 2] It is thought that some survivors may take up to a year to go back to work. These **patients require intensive support and rehabilitation in the community to allow them to regain their function, independence, and autonomy**."

A recent NSW Health rapid evidence check[xxiv] (4 May, 2020) on the rehabilitation needs of post-acute COVID-19 patients found **post COVID-19 exercise interventions were one of the keys to recovery**.

ESSA foreshadows that exercise physiologists will be integral in supporting the recovery of post-acute COVID-19 patients.

ESSA understands a briefing paper on the development of national post COVID-19 rehabilitation strategy was developed in late May 2020 by Australian Allied Health Leadership Forum for the Australian Government. Only recently on 29 June, 2020 have leading researchers called for planning for the COVID-19 aftermath to manage the aftershocks:

> "Australia needs to plan now, not just for survivors in the initial post- acute stage, but also to manage individuals affected in subsequent waves. Such patients may require rehabilitation, along with those, fearful of infection, who present to hospital late with non-COVID-19 conditions like stroke, and those with deteriorating chronic diseases who have not had access to hospital based services[xxv]."

Recommendation 9: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government implement a rehabilitation strategy for patients of all ages requiring rehabilitation with strategic priorities for allied health and exercise physiologists to manage the COVID-19 rehabilitation surge and the interrupted care needs of non-COVID-19 patients.

Ms. Suzanne Rastrick, MBE, Chief Allied Health Professions Officer for the National Health Service (NHS) in England outlined in a blog[xxvi] on 21 May 2020, **how the pandemic has influenced new ways of working and how new practices may influence allied health service improvements in the post coronavirus era**. The NHS has also established a National AHP Virtual Hub, a collaborative platform to share examples of changes made by AHPs. Reviewing the impact of new ways of working and new practices on allied health service improvements is a function that an Australian Government Chief Allied Health Officer could lead.

Another innovation is the example of a telehealth hospital, the Sydney Local Health District, Royal Prince Alfred Hospital which was highlighted in a Guardian news article[xxvii] on 13 May, 2020:

> "RPA Virtual Hospital opened on 3 February with just six nurses. It now has more than 30 nurses, as well as **medical and allied health teams**, and 600 registered patients. Operating out of Royal Prince Alfred Hospital campus, it functions in many ways like a regular hospital, with a clinical handover, ward rounds, multidisciplinary team meetings and its own governance structures…….
>
> RPA Virtual Hospital is **an example of the pandemic driving innovations that otherwise may have taken years, if not decades, of incremental changes**. Importantly, the developments are not only about policies, programs or technologies, but also reflect new relationships and ways of working that cross sectors and systems, helping to break down some of the longstanding silos that have held back innovation."

Recommendation 10: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government task and resource Australian Allied Health Leadership Forum to facilitate the collection and dissemination of allied health service improvements made during COVID-19.

The Australian Allied Health Leadership Forum (AAHLF) is the peak collective voice for allied health. Its members are:

- Professional associations through Allied Health Professions Australia (AHPA)
- Public allied health workforce and service through the National Allied Health Advisors and Chief Officers committee (NAHAC)
- The Aboriginal and Torres Strait Islander allied health sector through Indigenous Allied Health Australia (IAHA)
- Rural and remote allied health professionals and services through Services for Australian Rural and Remote Allied Health (SARRAH)
- Education and the university allied health sector through the Australian Council of Deans of Health Sciences (ACDHS).

AAHLF is recognised by the Australian Government as the peak allied health mechanism for providing coordinated allied health advice to Government but it currently receives no Australian Government funding for a secretariat whilst equivalent medical and nursing groups are funded for national secretariats. AAHLF is not a legal entity in its own right.

Allied Health Professions Australia, the peak body for the allied health professions, receives substantially less funding than the other peak health advocacy groups. Allied Health Professions Australia also provides in-kind support to host the AAHLF Secretariat.

Recommendation 11: That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government fund an incorporated entity (possibly Allied Health Professions Australia) to support a Secretariat for the Australian Allied Health Leadership Forum to the same levels as the equivalent medical and nursing national networks and consider increasing funding to Allied Health Professions Australia.

9.0 Hospital Surge Workforce

ESSA understands that many allied health professionals within the hospital sector were redeployed into areas outside of their normal employment/scope during the height of the COVID-19 pandemic. Some AEPs working in Queensland Health hospitals reported being directed to assist in flu vaccinations and fever clinics. Whilst AEPs were more than happy to assist and be responsive to demands in such unprecedented times, it had been suggested that the skillsets of AEPs could have been utilised more broadly in similar circumstances.

ESSA suggests that a mapping of COVID-19 related hospital activities against the scope of practice of allied health professionals (both Aphra and self-regulated professions) may assist with planning for the efficient redeployment of Queensland Health staff during future events. This mapping may also look at circumstances where general practitioners (GPs) and specialists are re-deployed and allied health professions can assist in managing patient chronic conditions until GPs and specialists return to their regular roles.

In response to increasing demand on the health care system, state and territory health departments initiated recruitment drives seeking pools of health professionals to assist with the COVID-19 response. Some states, including NSW and SA also called for allied health assistants to apply for casual pool positions. Accredited Exercise Scientists work as allied health assistants in many allied health practices and are ideally placed to join surge workforces.

Recommendation 12: That Queensland Health maps COVID-19 related hospital activities against the scope of practice of allied health professionals (both Aphra and self-regulated professions) to determine the highest value use of qualified allied health staff.

Recommendation 13: That the Queensland Health considers utilising Accredited Exercise Scientists to work as allied health assistants in any future surge workforces.

10.0 Transition to and Retention of Telehealth

Many Australians struggled with internet speeds and transitioning to using telehealth platforms (including allied health providers) during the early stages of COVID-19. In April 2020, the Royal Australian College of General Practitioners in a media release[xxviii] acknowledged that some people were not willing to access telehealth without onboarding support:

> "**some patients are avoiding consultations because they don't feel comfortable using new technology such as video conferencing**".

A Consumer Health Forum survey, What Australia's Health Panel said about Telehealth - March/April 2020, 2020. Accessed 22 June, 2020 https://chf.org.au/ahptelehealth of 95 members of its Australia's Health Panel found:

> "Common problems for telehealth included health professionals not embracing the option effectively, technological problems with phone or internet lines, and concern about missing services that could only be done face-to-face, for example, physical examination."

An Australian systematic review[xxix] of telehealth interventions used for home based support groups found group videoconferences into the home were feasible but need good IT support**. Audio difficulties, including delays, dropouts, and background noise were the most common problem reported**.

Australia's major cities experienced the internet congestion[xxx] from a baseline in mid-February to 30 March, 2020. A Queensland AEP operating an allied health business in regional Queensland reported congestion from home schooling and general demand in her area meant she was unable to deliver any telehealth services through videoconferencing.

The new Statutory Infrastructure Provider (SIP) regime[xxxi] from 1 July, 2020 requiring NBN Co and equivalent companies to provide a download speed of at least 25 megabits per second and an upload speed of 5Mbps during peak hours will assist with better access.

The cost of accessing the internet was a factor preventing some Queenslanders accessing telehealth, with Australia ranked 67th for the average cost of entry level broadband subscriptions according to an international review[xxxii] of the broadband market in Quarter 2, 2019.

Whilst internet access among older Australians is rising, there are still large gaps in access. A 2018 report[xxxiii] for the Australian Government's eSafety Commissioner which surveyed 3,602 Australians over 50 years of age found:

> "A smartphone was the most common device that participants aged 50 years and over had access to, with close to seven-in-ten having access to one. This was followed by laptops, desktops and tablets each of which were owned by over half of the participants. **Nine percent of participants had no access to any of the devices listed."**

More specifically, 30 per cent of those aged 80 years and over, 12 per cent of those aged 70-79 years did not have a digital device at home for personal use. Ownership of a device though did not mean that it was used as "**approximately 30-40% who had never accessed these devices**."

The use of devices was linked to digital literacy with "**three-in-ten being highly literate, three-in-ten moderately literate and around one-quarter low in terms of literacy….Three-quarters of the digitally disengaged group were aged 70 years and over**".

The Australian Bureau of Statistics reported that in 2016-2017 those who are 65 years and over have the lowest proportion of internet users (55 per cent). Only 46 per cent of all users accessed the internet for health services or health research[xxxiv].

Telephone remains the most commonly available device for all Queenslanders (and Australians) and provides easy access to healthcare in a way that people are most familiar with. It is not surprising then that telephone items used by allied health professionals were more than double the rate of video-conference items during the month of April, 2020 for telehealth items which could be claimed by exercise physiologists and other allied health professionals.

COVID-19 also presents the opportunity for permanent telehealth items and for wider primary healthcare reform as a legacy of the pandemic. Ms. Leanne Wells, CEO of the Consumers Health Forum of Australia in the same article is:

> "hopeful the government will continue the telehealth measures. '**The genie is out of the bottle," she says. 'It is very difficult to introduce something that people and clinicians really like and then take it completely off the table.'**
>
> Wells also hopes that wider primary healthcare reform will be a legacy of the pandemic. "We've been talking about primary healthcare reform for 15 to 20 years and reform has been going at glacial pace," she says. "We've got to stop the incrementalism."
>
> Wells wants to see a blended funding model and universal voluntary enrolment of patients – recommendations that date back to a 2009 report by the National Health and Hospitals Reform Commission, A Healthier Future for All Australians. This report envisaged voluntary patient enrolment with a "healthcare home" to coordinate access to multidisciplinary care, with primary healthcare supported by a mix of fee-for-service, grants to support multidisciplinary clinical services and care coordination, outcomes payments to reward good performance, and episodic or bundled payments.
>
> The report notes that "the use of episodic payments would create greater freedom for primary healthcare services to take **a long-term, whole person and population health perspective** that moves away from funding on the basis of single consultations or visits – an approach that can better meet the needs of people with chronic and complex conditions".

The following table outlines the use of temporary COVID-19 Medicare Benefits Schedule (MBS) telehealth services for which exercise physiology items were available and compares the relative percentage of services delivered in Queensland versus Australia.

Table 2: Medicare Benefits Schedule Temporary COVID-19 MBS Telehealth Services, Queensland & Australia – April, 2020[xxxv]

	QLD	% of QLD services	Australia	% of Aus services
	Services		Services	
Allied health Chronic Disease Management services				
93000 Telehealth items video-conference	2,027	24.13%	7,833	30.03%
93013 Telephone items – for when video-conferencing is not available	5,270	62.74%	16,827	64.52%
Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent				
93048 Telehealth items video-conference	166	1.98%	207	0.79%
Telephone items – for when video-conferencing is not available	936	11.15%	1,215	4.66%
Total	8,399	100%	26,082	100%

The lower rate of Queensland 93000 Telehealth services delivered through video-conferencing needs research to understand the barriers facing Queenslanders in accessing video-conferencing technology and/or the internet.

Overall rates of telehealth use have been captured by the University of Queensland's Centre for Online Health in Australia's first webpage[xxxvi] reporting on how people use Medicare funded telehealth appointments to access general practice, allied health, psychiatry and nursing consults.

Data shows there was a 10-fold increase in telehealth specialist consultations across all health professions, rising from 16,000 to 161,000 in March, 2020. Of those, 91 per cent of consultations were delivered by phone and the remainder in video consultations.

The allied health infographic includes all allied health telehealth items (over and above items in Table 2 above) apart from MBS mental health items. Of interest is the following comparison:
Allied Health in-person services: 93.9% vs videoconferencing 2.3% vs telephone 3.8%
General Practitioner in-person services: 77.4% vs videoconferencing 0.9% vs telephone 21.7%

Anecdotal advice suggests that many exercise physiologists embraced telehealth and assisted clients to transition to videoconferencing. Observations from two AEPs in Appendix B confirm their overall support for telehealth.

As to the quality of care delivered through telehealth, there is ample evidence that the telehealth works just as well or if not better in some cases than in-person services. ESSA has detailed the evidence base for exercise services to be delivered through telehealth in a *Briefing Paper prepared for Private Healthcare Australia on the clinical effectiveness of Exercise Physiology Teleconsultations*[xxxvii].

Recommendation 14: That the Queensland Government through the National Cabinet and/or the NFRC reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 15: That the Queensland Government via the National Cabinet and/or the NFRC supports the retention of all temporary telehealth items for allied health and other health care and re-investigate funding models that focus on a long-term, whole person and population health perspective.

11.0 COVID-19 Plans/Requirements/Resources

On 25 March, 2020, the Prime Minister announced the establishment of the National COVID-19 Coordination Commission[xxxviii] with its role is to coordinate advice to the Australian Government on actions to anticipate and mitigate the economic and social impacts of the global COVID-19 pandemic on all non-health sectors. Since its establishment, the Commission has developed an online planning tool[xxxix] to help businesses develop plans to ensure the safety of their staff, customers and the community.

ESSA also notes that Safe Work Australia has developed a COVID-19 risk register template[xl] and various state and territory jurisdictions have also developed their own COVID plans.

Safe Work Australia has also developed resources for workplaces in the health, aged care and NDIS industries on work health and safety, workers' compensation and COVID-19 but ESSA understands via AHPA that specific industry guidance is being prepared for allied health. As at 27 May, 2020, this industry guidance for allied health is not yet available.

In Queensland, the Return to Play Guide for Queensland sport, recreation and fitness industries[xli] allows for non-essential indoor gyms, studios and health clubs to apply to open with more than 20 people in Stage 2 if they have a WorkCover Queensland COVIDSAFE Plan (Work health and safety plan for COVID-19[xlii]) approved by health authorities.

Overall, the requirements for COVID-19 Plans vary by jurisdiction for essential and non-essential businesses. As with previous matters, **it has been difficult and time consuming for a national professional association to identify and communicate the requirements for COVID-19 plans to members working in different jurisdictions and in essential and non-essential businesses. It is also difficult for exercise physiology businesses and other allied health businesses that operate across more than one state to comply with COVID-19 Plan requirements.**

Recommendation 16: That the Queensland Government, the Australian Government and other state and territory jurisdiction works to harmonise requirements for COVID-19 Plans.

12.0 Personal Protective Equipment (PPE)

A specialist union, the Victorian Allied Health Professionals Association (VAHPA), highlighted the issues surrounding the lack of PPE for allied health professionals in this statement[xliii] on 24 April, 2020:

> "**One of the most contentious issues amidst the COVID-19 pandemic for Allied Health Professionals has been the lack of protective personal equipment (PPE) and what PPE is most appropriate for the role they perform**.
>
> Given the diversity of disciplines covered by Allied Health and even differences within those disciplines and the vast variances in presentations and workplace environments, there is no 'one-size-fits-all' solution to PPE guidance. As a result, VAHPA feels the Department of Health and Human Services (DHHS) Guidance Notes fall short of identifying **the at-risk groups of AHPs who are being placed in dangerous situations** because their employer is rigidly adhering to these government guidelines."

Recognition that PPE was an issue for allied health professionals came late in the piece only because of sustained advocacy by Allied Health Professions Australia (AHPA), the peak national body for allied health professions (of which ESSA is a member) and other allied health bodies like VAHPA. PPE for allied health professions was eventually addressed in the last and final fourth tranche, with guidance[xliv] provided on 30 April, 2020 by the Australian Government Department of Health.

Even with the guidance, there was no mechanism through the Australian Government nor through the Primary Health Networks to support the national coordination of information on how to access surgical masks from the National Stockpile. Instead, AHPA contacted of its own accord each of the five PHN alliances to try to determine what their processes were and to provide guidance to APHA members. AHPA sent this guidance on 21 May, 2020 to ESSA and other AHPA members.

ESSA had feedback from a number of members that the PHNs in which they regularly operate in (particularly in rural and regional areas of Queensland) have consistently denied AEPs access to PPE despite their work in community aged care with at-risk individuals, not to mention their regular complex condition case load. The late decision to consider the allocation of PPE to allied health professionals and information on how to access PPE has impacted on the ability of ESSA members to deliver clinical care safely and exposed them to greater than normal risks than should otherwise have happened, if sufficient stocks of PPE had been in place.

Recommendation 17: That the Queensland Government via the National Cabinet and/or the NFRC ensures the Australian Government continues to maintain adequate supplies of PPE in the National Stockpile to ensure all health and allied health professionals have access to PPE in the event of another pandemic.

13.0 Support Services for Vulnerable Queenslanders

ESSA applauds the Queensland Government's efforts in establishing the Care Army to facilitate access to supports for seniors and people most at-risk during the pandemic.

ESSA suggests that this initiative could be further enhanced with the introduction of clear pathways and processes in place to support health professionals (including allied health professionals) to make referrals to the Care Army.

ESSA is pleased to see that the Care Army website provides links to the Healthier Queensland website where information on healthy eating and exercise is promoted. ESSA suggests this website would be an ideal place to promote the message about continuing to access health services during COVID-19. ESSA would welcome the opportunity to provide the Healthier Queensland website with further information about the value of exercise during a pandemic.

ESSA also suggests that the Care Army initiative equip volunteers with some resources they can share with the vulnerable groups they support. These resources may include some simple messages about exercising to prevent an escalation of chronic conditions, the need to continue to access health services and linking people to some of the valuable services established during COVID-19 including the Older Persons Advocacy Network's COVID-19 hotline.

Recommendation 18: That the Queensland Government provides health professionals with pathways and processes to support referrals to the Care Army.

Recommendation 19: That the Queensland Government includes information on the value of exercise during a pandemic on the Healthier Queensland website.

Recommendation 20: That the Queensland Government provides Care Army volunteers with information to pass onto vulnerable Queenslanders about the need to exercise to maintain their mobility, independence, confidence.

Appendix A: Letter from Dr Lisa Studdert, Deputy Secretary, Department of Health to Allied Health Professionals, 26 March, 2020.

Australian Government

Department of Health

Dear allied health professionals

I am writing to update you on the COVID-19 pandemic situation in Australia and internationally and to outline the Commonwealth's current and future support for the central role you are playing in our national response.

Allied health professionals are fundamental in meeting community needs in this evolving and complex challenge. We need to look at ways to continue the essential services you provide for vulnerable people. I thank you for your efforts so far in helping to contain the spread of this disease, and the well-being of your clients, and encourage you to maintain your vigilance in seeking to prevent its further transmission. Infections are increasing across Australia, placing a significant burden on the health and aged care systems.

Communication

A significant amount of advice and information has already been provided to health professionals. I recognise the evolving nature of this outbreak has required public health advice to move rapidly with the emerging epidemiology. This has made it more challenging for people to keep up to date, causing some confusion and a perception of inconsistent information and information gaps.

As you are hopefully aware, a broad community education campaign on COVID-19 has been underway for over a week now. One of the important messages of the campaign is the value of basic standard hygiene messages (hand washing, cough etiquette, social distancing) in preventing transmission. Allied health professionals are highly trusted professionals in our community, and it is important you play a role in communicating this message to your patients, family and friends, along with general balanced information about this virus. The campaign resources for the general community are available at: https://www.health. gov.au/ resources

Situation as at 25 March 2020

As you are aware, the international situation has changed significantly in the past few weeks. Cases have now been reported in more than 196 countries, some with sustained widespread community transmission. In Australia, we have cases identified in every state and territory, and a growing number every day.

Disease characteristics

It is clear the great majority of people with COVID-19 infection (more than 80 per cent) have mild disease, not requiring any specific health intervention. However, this contributes to the high transmissibility of the virus, as many people with infection will continue working and interacting with the community because their symptoms are so mild.

There is very little evidence of significant COVID-19 disease in children. Initially, it was suggested children were less susceptible to infection but more recent evidence supports the fact that children may be infected, in many cases without being aware of symptoms.

Current approach to response

Our response is being guided by the Australian Health Sector Emergency Response Plan for COVID-19 (the Plan) (www.health.gov.au/Covid19-plan). A key goal of the Plan is to outline a decision making process to achieve a response that is proportionate to the level of risk, acknowledging the risk is not the same across population groups. A response that is appropriate to the impact the coronavirus outbreak is likely to have on the community, and on vulnerable populations within the community, will make the best use of the resources available and minimise social disruption.

Reducing exposure in healthcare settings

With increasing cases of COVID-19, it is important to prevent the co-mingling of suspect or proven cases with other patients in health care settings. We have previously advised members of the community that, if they believe they have been exposed to, or have, COVID-19, they should phone their GP or local health service and seek advice before attending.

The COVID-19 national hotline (1800 020 080) has now been expanded to support general practices to manage the flow of cases. This hotline is operating 24 hours a day, seven days a week. People who believe they may have been exposed to, or have, COVID-19 are encouraged to initially call the national hotline, rather than their GP or local health service, to seek advice.

Personal Protective Equipment

All the evidence currently suggests droplet spread is the main mode of transmission and that surgical masks are adequate (and much easier to fit) than P2 masks if you are in close contact with patients. There is a global shortage of masks. The highest priority of the Government is to ensure access to masks and other PPE for front line acute health service and primary care staff. This includes:

- public hospitals (supporting the states and territories), general practices, community pharmacies, and other settings where people are most likely to be presenting with COVID-19
- residential aged care facilities in the event of an outbreak

Access to masks is being kept under review as more stocks become available and if risks increase. If and when more became available, they will be prioritised first to those allied health professionals whose work entails close physical contact with their patients and only when the intervention is strictly necessary and urgent.

Telehealth

The Australian Government has expanded access to telehealth during the COVID-19 pandemic for some health services. There is expected to be more changes soon to telehealth access. The following link provides more details on the current new arrangements. I suggest you revisit this page regularly for updates. http://www.mbsonline.gov.au/ internet/ mbsonline/publishing.nsf/Content/news-2020- 03-01-latest-news-March

Gyms used for clinical treatment

While there has been a decision taken by National Cabinet to close gyms catering to the general public, small gyms used for clinical treatment can remain open as long as they meet the general social distancing requirements, namely, space for social distancing of four square metres per person and not more than 10 people attending at the same time.

The Department of Health has recently released a learning module on infection control. I encourage you to complete this. https://www.health.gov.au/news/how-to-protect- yourself-and-the-people-you-are-caring-for-from-infection-with-covid-19

Other resources for health professionals and aged care workers are updated regularly at: https://www.health.gov.au/ news/ health-alerts/ novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-aged-care-sector

No one can accurately predict how the COVID-19 pandemic will continue to develop in Australia. Our collective response has to be flexible and collaborative. The Australian Government has committed to provide the necessary resources to support the response in whatever form it needs to take.

Yours sincerely

Dr Lisa Studdert
Deputy Secretary
Australian Government Department of Health

26 March 2020

Appendix B: Observations from Accredited Exercise Physiologists on Telehealth

Common points raised:

- Issues with connection speeds of retail internet service providers, particularly in regional areas
- Many clients need help with setting up videoconferencing and in many cases, that required a an extended home visit
- Many clients declined to transition to videoconferencing because they thought the restrictions would not last long
- Telephone was used as a backup when the video did not have a reliable connection due to NBN issues and issues with the speed of the telehealth software
- Children at home doing online learning slowed down exercise physiologists' home internet connectivity

Observations from AEP 1

Video adds significantly more value than the phone but takes a while to set up. Example – only supposed to be a quick 20 minute check in and I ended up spending an hour trying to teach them how to get Zoom and get logged on, where I probably could have just got on the phone much quicker but I thought getting it done and getting it set up would be more useful in terms of using video in the future. Video is far more useful in terms of being able to deliver something like what we would normally be able to deliver face-to-face.

Observations from AEP 2

We are fortunate that we have a little bit of admin support. Admin normally does a bit of a screen with clients to determine their eligibility or suitability for video consults. Talking to other peers working in this space, others have developed screening tools to determine suitability for video consults. But there is a cohort that just decline a video consult and would rather a phone call.

There is a cohort that really love it and are quite tech savvy, and there are others who just have no idea around tech and there is a lot of time wasted trying to get them on to that medium when probably not a lot of additional benefit is provided in comparison to a phone call. Having my admin spend 45 minutes on the phone with a tech savvy 90 year old trying to get them onto Zoom was not time well spent. So, we haven't crossed that bridge too many times since.

Observations from AEP 3

I have an Allied Health Practice in regional Queensland. At this location, I have a business internet connection. I have been working from home (Telehealth) as I have school aged children (attending a local school). The internet service at home is inadequate for Telehealth services (both individual and group services) now that most children are participating in online learning.

I have tried returning to the practice (leaving the kids unsupervised for short periods of time) and the business internet is not much better. We have tried ringing Telstra for several days and have been unable to speak to anyone due to increased service demands.

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