Allied Health Professions Australia

The House of Representatives Standing Committee on Health, Aged Care and Sport Inquiry into Long COVID and Repeated COVID Infections.

November 2022

This submission has been developed in consultation with AHPA's allied health association members.

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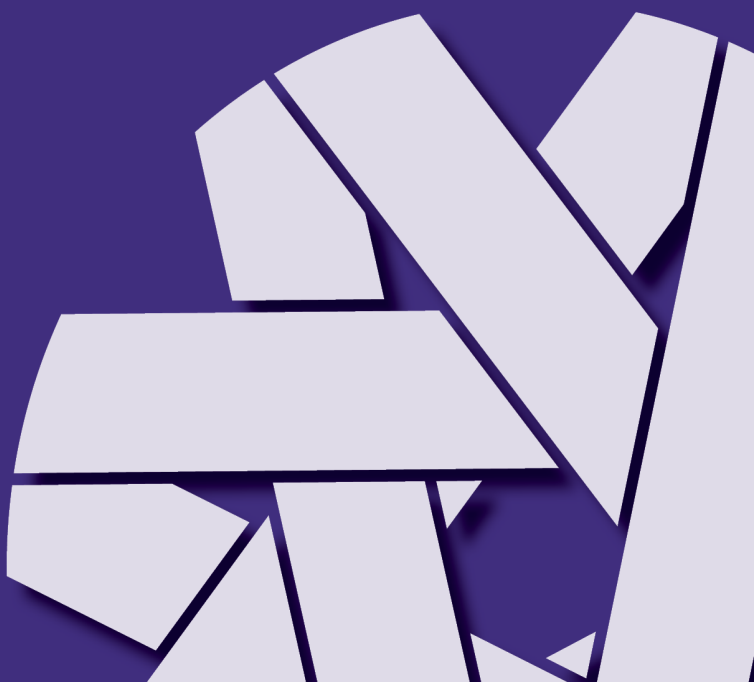


Introduction

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to The House of Representatives Standing Committee on Health, Aged Care and Sport Inquiry into Long COVID and Repeated COVID Infections.

AHPA is the national peak body representing Australia's allied health professions. We have 26 allied health member associations and a further 12 affiliate members with close links to allied health. The AHPA membership represents some 180,000 allied health professionals working across a wide range of settings and sectors.

AHPA and its member associations are committed to ensuring that Australians, regardless of their background, socioeconomic status or location, can access safe, evidence-based services to support wellness, reablement and maintenance of functionality.

Allied health practitioners provide personalised care, focusing on individuals' functionality and independence, and helping to reduce avoidable hospital admissions and re-admissions. They can assist with recovery from chronic conditions like Long COVID and support people while they recover.

The providers of allied health care are important for the delivery of the multi-disciplinary care identified as best practice for managing the impacts of Long COVID on people's lives. This can result in improved individual wellbeing as well as improved community productivity by addressing the needs of Australians affected by the symptoms of PACS.

We argue that poor management of long COVID in the Australian population could cost the economy up to $47 billion per year. Access to adequate multi-disciplinary care requires addressing structural impediments in our health system that currently hinder access to co-ordinated, multidisciplinary primary care.

Our response to the Terms of Reference focuses on the experience of allied health services providers supporting patients with Long COVID. Without better integration of care services, there remain real risks that Australians will not be able to access the services needed to manage Long COVID.

This submission has been developed in consultation with AHPA's members.

Summary

The prevalence of long COVID from extensive community exposure to COVID-19 threatens to create challenges for the community. Significant numbers of Australians have contracted COVID, and new variants increase the likelihood of further "waves of infection" (Department of Health and Aged Care, 2022).

The economic costs of this health burden could be up to $47 billion, with most of the cost associated with foregone income of consumers with long COVID who are unable to work due to symptoms.

Allied health practitioners have been identified in the literature as the primary workforce in the management of consumers with long COVID. However access to allied health services is hampered by waiting lists for public long COVID clinics and the inadequate Medicare support for allied health referrals under Chronic Disease Management plans.

The shortcomings can be summarised as:

- No national consistency to the identification and collection of long COVID data
- The Better Access Initiative extension is set to expire end 2022 and does not cover neuro-cognitive conditions
- Chronic Disease Management (CDM) Plans need to address the complexity of the long COVID condition
- Care co-ordination is not well supported in the Medicare fee for service model
- Flexible funding models needed to commission multidisciplinary allied health care for long COVID patients

Key Recommendations

Our recommendations provide an opportunity to better integrate allied health care into a multidisciplinary approach to primary care.

AHPA recommends the following strategies to improve the care provided to patients with Long COVID conditions:

- Facilitate Identification of patients experiencing post-COVID conditions
- Maintain the Better Access initiative for post-COVID conditions
- Modify Chronic Disease Management Plans to reflect the complexity of Long COVID
- Facilitate Integration of allied health practices into existing digital health infrastructure
- Fund PHNs to commission integrated models of multidisciplinary primary care for consumers with long COVID.

Background

Long COVID symptoms are expected to be experienced by between 5% and 6% of Australians who contract COVID. Estimates range from approximately **400,000** to **600,000 consumers** who may experience a range of non-specific multi-system post-viral symptoms.

An "over-representation of chronic conditions among **disadvantaged** and (often racialised) populations … **increases the risk** of both COVID-19 acute severity and long COVID".

The economic costs of poorly managing patients with long COVID could be in the order of **$30 billion** to **$47 billion**. An estimated **$1.8 - $2.8 billion will be borne by government** through increased health care costs.
M**ost of the economic burden will borne by long COVID patients** through increased healthcare costs ($7.4 - $11.5 billion) and **foregone income** ($19.5 - $30 billion).

Practitioners are recommended to adopt a **biopsychosocial approach** to care with a **multidisciplinary team** to co-ordinate person centred care.

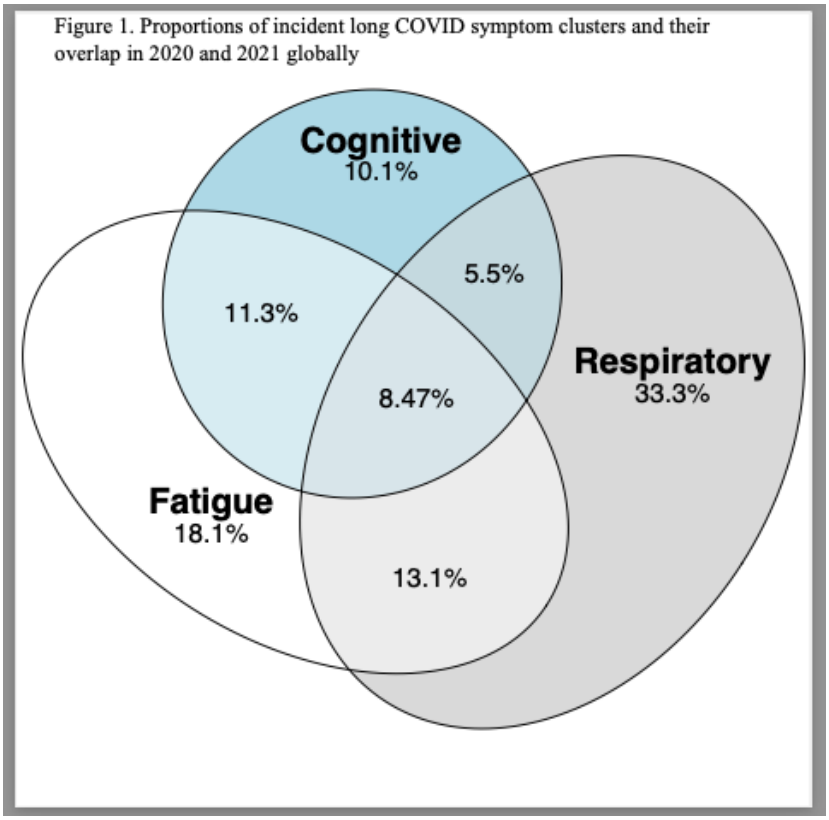
However, the system for providing support to people suffering from long COVID is **fragmented and highly variable**, depending on the circumstances of the patient and their ability to access services. The Medicare fee for service model **does not adequately support provision of multidisciplinary care** for patients with long COVID.

The post-COVID-19 presentation varies from specific serious sequelae through recovery from severe illness that required intensive care management to non-specific post-viral symptoms and the mental health impacts of the acute illness. (Royal Australian College of General Practitioners, 2022).

(Wulf Hanson S, 2022) conducted a meta-analysis that pooled information on the occurrence of three symptom clusters – cognitive, fatigue and respiratory symptoms - and derived estimates of incidence of symptom overlap for the years 2020 and 2021.

The figure below summarises their findings:

Chart 1: Incidence of Long COVID Symptoms and their Overlap



Symptom	% of cases
Fatigue	51.0%
Respiratory	60.4%
Cognitive	35.4%

Source: Wulf Hanson S et al, 2022

Over 38% of long COVID cases presented with two or all 3 of the symptom clusters. Globally, of long COVID cases 63.2% were female. The peak ages of long COVID were between 20 and 29. Of particular importance, the authors found that the severity of long COVID is equivalent to severe neck pain, Crohn's disease, or the long-term consequences of moderately severe traumatic brain injury in terms of disability (Wulf Hanson S, 2022).

The considerable overlap of symptoms in people with long COVID supports the recommendation to adopt a biopsychosocial approach to care with a multidisciplinary team to co-ordinate person centred care. (National COVID-19 Clinical Evidence Taskforce, 2022)

With estimates of 5% (Steves, 2022) to 6% (Wulf Hanson S, 2022) of people who contract COVID developing post-COVID conditions, the prevalence of post COVID conditions in the Australian population equates to approximately 400,000 people (Baillie, Teesson, Britton, & Sorrell, 2022), while the growing number of Australians contracting COVID suggest up to 600,000 people may suffer from long COVID.

In addition, (de Leeuw, Yashadhana, & Hitch, 2022) note that "over-representation of chronic conditions among disadvantaged and (often racialised) populations … increases the risk of both COVID-19 acute severity and long COVID". This will create issues with equitable access to treatment proposed for post-COVID conditions.

Management of the Long-COVID condition

The most common scenario for patients seeking support for post COVID conditions will be a range of non-specific multi-system post-viral symptoms (Royal Australian College of General Practitioners, 2022). The National COVID-19 Clinical Evidence Taskforce provides guidance on management of people with long COVID in this flowchart (National COVID-19 Clinical Evidence Taskforce, 2022).

This table identifies common and less common post COVID-19 symptoms:

Table 1: Symptoms of Long COVID

COMMON SYMPTOMS	LESS COMMON SYMPTOMS
FATIGUE	Insomnia
DYSPNOEA	Low-grade fevers
JOINT PAIN	Headaches
CHEST PAIN	Neuro-cognitive difficulties
COUGH	Myalgia and weakness
COGNITIVE DISTURBANCES	Gastrointestinal symptoms
HOARSE VOICE	Rash
CHANGE IN SENSE OF SMELL OR TASTE	Depression

Source: RACGP, 2022

Current recommendations for management of specific symptoms include referral to various allied health professions. The table overpage summarises the recommendations referring to interventions provided by allied health professionals.

Table 2: Symptoms and Strategies to Manage Long COVID

SYMPTOM	STRATEGIES
DYSPNOEA	
	Respiratory muscle conditioning
	Symptom limited exercise supervised by an experienced professional
	Speech pathology for chronic cough, hoarse voice, or dysphagia
	If symptoms interfere with nutrition, refer to dietitian
FATIGUE	
	Monitored exercise supervised by an experienced professional
	Occupational therapy if fatigue is causing difficulties with Activities of Daily Living (ADLs)
CHEST PAIN	
	Graded exercise supervised by an experienced professional
NEURO-COGNITIVE ISSUES	
	Cognitive testing, occupational therapy or speech pathology support if causing issues with ADLs
DEPRESSION/ANXIETY	
	Pain management strategies if contributor to depression/anxiety
	Access to mental health services
	Individualised exercise initiated and supervised by an experienced professional
	For nutrition support and access to food services, refer to dietitian

Source: RACGP, 2022

This strategy is also endorsed by the Commonwealth Department of Health in an undated document entitled "Getting help for long COVID" (Department of Health, 2022). See Appendix A for details.

(Sadler, et al., 2021) identify the need for a "validated case definition for chronic fatigue after COVID-19 infection… for both clinical and research purposes". They identify the fatigue syndromes following other bacterial/viral infections and the similarities between post-COVID infections and these other post-infection fatigue syndromes.

One of the most well-known syndromes is myalgic encephalomyelitis or chronic fatigue syndrome (ME/CFS). (Close, et al., 2020) assessed the economic impacts of ME/CFS in Australia and utilising their analysis we can estimate various aspects of the economic burden of long-COVID to Australians and the Australian economy.

From a 2019 economic survey of participants who satisfied varying definitions of ME/CFS and a prevalence cost model to identify an aggregate measure of the economic burden of the disease, (Close, et al., 2020) estimated the cost of ME/CFS at over $14 billion annually.

The estimated long COVID cohort in Australia is between 5% (Steves, 2022) and 6% (Wulf Hanson S, 2022) of the population infected with COVID. The World Health Organisation reports over 10 million Australians have been infected with COVID (World Health Organisation, 2022). This indicates up to 620,000 Australians could be suffering from long COVID. Other authors (Baillie, Teesson, Britton, & Sorrell, 2022) estimate long COVID cases at 400,000.

Applying the average costs identified by (Close, et al., 2020) to the long COVID cohort estimates identifies an economic burden of between $30 to $47 billion dollars annually. This model estimates Government health care costs to be $1.8 billion to $2.8 billion for long COVID and patients will incur $7.4 billion to $11.5 billion in personal healthcare costs.

Importantly, the major share of the economic cost is foregone income of people with long COVID from the reduced engagement with the labour force. This lower engagement with the labour force is also estimated to cost between $4.9 billion and $7.8 billion annually in foregone income taxes based on the 2020 income tax rates.

Details are summarised in the following table:

Table 3: Estimated Economic Costs of Long COVID

	Average costs (per person) All Respondents	Low Scenario ($million)	High Scenario ($million)
Direct patient out of pocket costs	$18,540	7,416	11,530
Reduction in personal income	$48,757	19,503	30,322
Other direct personal costs	$3,918	1,567	2,437
Government healthcare costs	$4,483	1,793	2,788
Total Annual Average Cost	$75,698	30,279	47,076

Sources: (Close, et al., 2020), (Steves, 2022), (Wulf Hanson S, 2022), (World Health Organisation, 2022)

Patient expenditure on non-prescription medications and devices accounted for a significant share of patient out-of-pocket costs identified by (Close, et al., 2020). This may not eventuate for patients of long COVID but there is a risk that long COVID patients may turn to treatments with no efficacy due to either insufficient education of health professionals or lack of access to appropriate allied health care.

(Close, et al., 2020) also identify that "Compared to the 2018 national average, patients that meet any of the ME/CFS definitions have twice as many visits with a GP (12.1 vs 6)". Inadequately managing the symptoms of a much larger cohort of long COVID patients will place significant additional burdens on the primary healthcare system. If long COVID patients follow a similar GP utilisation pattern as ME/CFS patients, it could result in an increase in annual GP visits of between 2.4 to 3.8 million visits.

Reports of increased demand for services of long COVID clinics have already been reported in the media (Cunningham, 2022) (Martin, 2022) and waiting lists of six to 12 months for appointments are reported. With waiting lists at hospital-based services, allied health practitioners become the only option available to many Australians.

In Summary, the economic costs of poorly managing patients with long COVID could be in the order of $30 billion to $47 billion.

While substantial costs of $1.8 -$2.8 billion will be borne by government through increased health care costs, most of the economic burden will be borne by long COVID patients through increased healthcare costs ($7.4 - $11.5 billion) and foregone income ($19.5 - $30.2 billion).

Funding limitations and access to allied health services

The Australian healthcare system supports general access to allied health through the following streams:

Ancillary cover from private health insurers

At 30 June 2022, 55.2% of the Australian population had some form of ancillary cover (Australian Prudential Regulation Authority, 2022). The average out of pocket cost per episode of service was $54.37 – an increase of 3% over the previous year (Australian Prudential Regulation Authority, 2022). With reimbursement of fees dependent on the extent and amount of coverage provided by each health insurance it is not clear how effective ancillary cover will be for long COVID patients.

Allied health services provided in aged care

The Royal Commission into Aged Care Quality and Safety recommended that each older person living at home or in residential care should receive a level of allied health care appropriate to their needs (Recommendations 36, 38).

Despite recent reforms, access to allied health services in residential aged care relies on the willingness of the aged care provider to provide these services through their overall allocation of care funding. Unlike nursing and personal care, there is no minimum mandatory standard of average allied health minutes per day per resident, and no guarantee that allied health needs will be clinically assessed and met via multidisciplinary coordination (see: AHPA Policy Brief and the Department of Health Scoping Study on multidisciplinary models of care).

Access to allied health services by older people living at home currently depends upon their in-home aged care package. In-home care reform is in process, but to date there appears to be no guarantee that each person will receive the clinical assessment necessary to ensure their allied health needs are met. Older persons receiving aged care can obtain allied health services via private health insurance cover and via Medicare, like all other Australians.

(Egan, 2022) suggests aged care residents are less likely to access public-funded support despite being four times more likely to have depression and nine times more likely to have anxiety disorders than the general population of older Australians. Researchers attribute this to a range of factors including inadequate skills of existing staff and lack of clear referral pathways.

Also, there appears to be little public analysis of the incidence and experience of people receiving aged care who have long COVID. The underutilisation of mental health services, coupled with the findings by (Gilbert AO & Lilly, 2021) in their review of COVID outbreaks in residential aged care facilities, suggest that Long COVID may be an under-recognised issue for this cohort

If Medicare is to be utilised to improve access to allied health services by older people suffering from long COVID, strategies to identify and remove the major barriers to older peoples' service access and uptake of mental health services, including psychology, social work and occupational therapy, will be needed.

Allied health services through the National Disability Insurance Scheme (NDIS)

Many Australians with disability are not NDIS participants and therefore are likely to rely largely on Medicare or their own funds to access allied health services.

Approximately 535,000 NDIS participants can access allied health services through their disability support plans (NDIS, 2022) and while the NDIS provides therapeutic supports, the Scheme has never funded a support that is considered a health condition and deemed not to be related to a person's disability. The most recent NDIS Pricing Arrangements states that even if some aspects of a participant's care are 'related to, or a symptom of' their disability, they will not be funded under the NDIS if there is another health care scheme or insurance policy that would cover them (NDIS, 2022).

Current policy may therefore require allied health professionals to distinguish between the health services and disability supports that they provide to a single client, and then making separate payment claims to, for example, Medicare and the NDIS. This risks the person with disability not receiving the care they need and compartmentalises a person's needs and care, rather than supporting care of the whole person.

Any trend toward greater compartmentalising treatment also undermines recognition of the long COVID syndrome and of the efficacy of taking a multidisciplinary approach to its treatment. Given that most allied health supports provided through the NDIS are billed under 'capacity building (daily activities)', it seems counter-productive to expect an allied health professional such as an occupational therapist to separate out the 'disability' and 'health' aspects of the physical strategies prescribed for a NDIS participant who has Long COVID.

Contingent coverage from "third party payers"

Third party payments are from organisations such as worker's compensation authorities and income protection insurance. This coverage is contingent on a patient's individual circumstance and the type of support permitted based on legislation and type of insurance contract entered into.

Government funding through the Medicare program

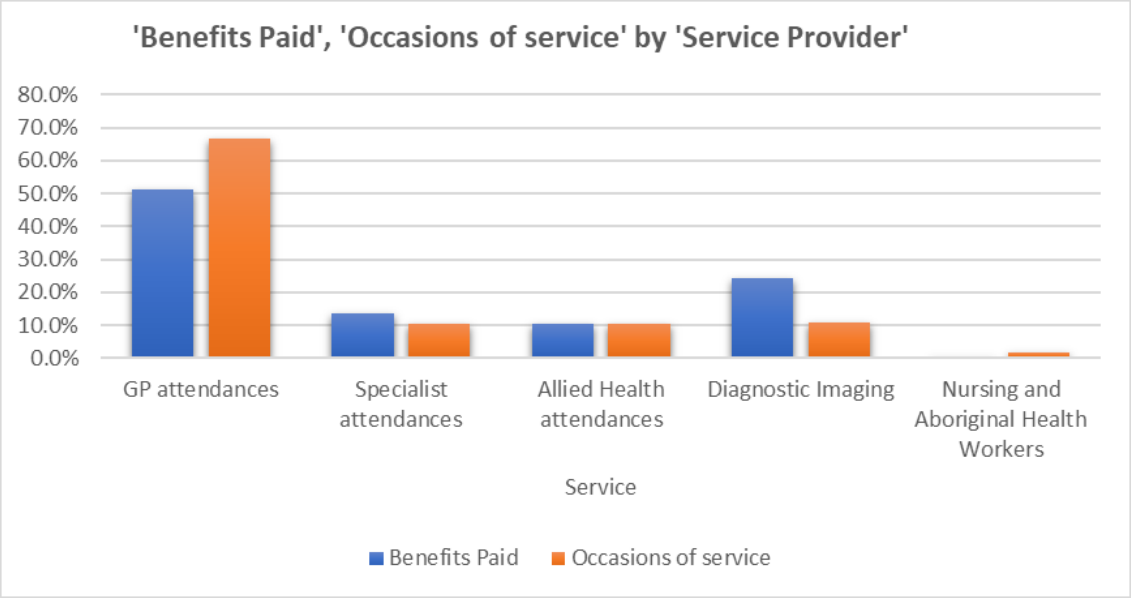
Non-hospital Medicare subsidised services totalled $17.1 billion dollars in the financial year ending 2021. All allied health Medicare subsidised services accounted for approximately 10% of this expenditure subsidising more than 26 million occasions of service. (Australian Institute of Health and Welfare, 2021).

Services are funded through various programs:

- The Better Access initiative for mental health
- Chronic Disease Management plans
- Direct bulkbilling by optometrists

The allocation of Medicare funding for out-of-hospital subsidised care is summarised in the following chart.

Chart 2: Benefits and Service Provided by Medicare subsidised out of hospital payments – Financial year to 30 June 2021



Source: (Australian Institute of Health and Welfare, 2021)

This remainder of this submission will focus on allied health practitioners' experiences of supporting long COVID patients with Medicare funding. As the universal health insurance program for Australians, Medicare, will be the foundation for allied health care for most long COVID patients.

The Better Access initiative: gives Medicare rebates to help people access mental health professionals and care. Rebates are provided for Psychological Therapy services provided by eligible clinical psychologists and Focussed Psychological Strategies (FPS) services provided by eligible General Practitioners (GPs), registered psychologists, social workers, and occupational therapists.

- In the financial year ending 2021, it is reported that Mental Health Care accounted for 44% of allied health expenditure by Medicare (Australian Institute of Health and Welfare, 2021).
- Since 2020 funding has been extended from a limit of 10 sessions per calendar year to 20 sessions per year. The limit returns to 10 sessions per calendar year on 1 January 2023. (Department of Health and Aged Care, 2022)

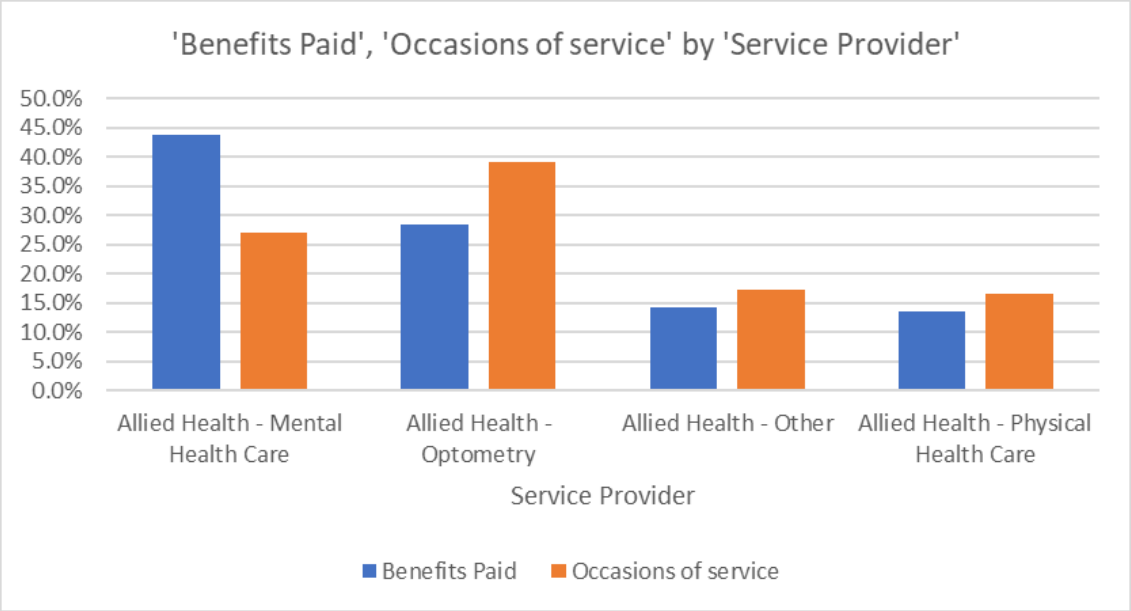
- NOTE: this funding is for psychological therapy, for example addressing depression/anxiety and not necessarily for cognitive disorders, which are common in long COVID.

Chronic Disease Management: CDM plans or team care arrangements enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions. They are designed for patients who require a structured approach, including those requiring ongoing care from a multidisciplinary team.

- A chronic medical condition is defined by the department as "one that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke." There is no list of eligible conditions, however.
- A Medicare rebate is available for a maximum of five services per patient each calendar year. There is one fee per service, regardless of the complexity of the condition or the presenting patient. Additional services are not possible in any circumstances. (Department of Health, 2014).
- In the financial year ending 2021, it is reported that Physical Health Care accounted for 14% of the allied health expenditure by Medicare (Australian Institute of Health and Welfare, 2021)
- In 2020-21, 16% of the population used a CDM plan to access multidisciplinary care (Australian Insitutue of Health and Welfare, 2022).

The allocation of funding to allied health sub-categories is summarised in the following chart.

Chart 3: Benefits and Service Provided by Medicare Subsidised Out of Hospital payments - Financial year to 30 June 2021



Source: (Australian Institute of Health and Welfare, 2021)

It is understood GPs should not refer eligible patients for psychological services under the CDM program, see Appendix B (General Practice Mental Health Standards Collaboration, 2022). This should not prevent GPs from referring their patients with long COVID to practitioners for physical as well as mental health support by utilising both programs.

Some allied healthcare providers are involved in caring for long COVID patients through integrated interdisciplinary approaches such as the Fatigue Clinic at University of New South Wales and private clinics with interdisciplinary networks of allied health providers. Additionally support for patients with post infective syndromes is provided by organisation such as Emerge Australia. These organisations attempt to utilise funding from multiple sources to provide an interdisciplinary approach to managing long COVID.

Medicare also provides funding for up to 3 allied health case conference meetings with the patients treating medical practitioner (MBS items 10955, 10957 and 10959). The aim is to "*to increase uptake of multidisciplinary case conferences, improve care co-ordination, and support the outcomes that matter most to patients and their families*" (Department of Health and Aged Care, 2021).

In this situation, Medicare **does** have a scale of fees depending on the length of the meeting. The meeting must be attended by the treating medical practitioner and at least 2 other care providers for the rebate to apply. AHPA has no data on uptake of the 3 new items for allied health multidisciplinary case conferences for chronic disease management.

In summary, the system for providing support to people suffering from long COVID is **fragmented and highly variable**, depending on the circumstances of the patient and their ability to access services.

The universal program, Medicare, provides an **inadequate number** of allied health service visits to manage long COVID symptoms and **insufficient funding**, considering the complexity of care required. Medicare's fee for service model **does not adequately support provision of multidisciplinary care** for patients with long COVID.

The Experiences of Allied Health Providers Supporting Patients

Allied health practitioners report that funding for community-based care is **contingent on income and personal circumstances, difficult to coordinate and poorly supported by Medicare**. They have identified shortcomings with Medicare funding in the following areas:

- The Medicare rebate does not reflect the **extended time required** to adequately treat long COVID patients
- The Medicare rebate does not allow allied health practitioners **time to coordinate care with other allied health professionals** unless a medical practitioner is involved
- Five visits for all allied health care per annum results in **sub-optimal, fragmented** care for long COVID patients
- Allied health practitioners **identify and support the important role for a patient's GP** to coordinate and review a patient's progress
- Allied health practitioners consider the long COIVD patient's **GP as ideally placed** to refer for additional Medicare subsidised allied health care if required.

Consultations with practitioners from our member organisations provide on-the-ground experiences supporting the issues identified in this submission. Their experiences can be summarised in the following broad themes.

- The significant SCALE of the problem for society and the economy
- UPSKILLING of the workforce and EDUCATION is needed
- REFERRAL PATHWAYS for effective patient management
- FUNDING for coordinated multi-disciplinary care in the community is inadequate

Scale of the problem

Many practitioners identified that the cohort of people suffering long COVID symptoms is on a larger scale than other conditions due to the number of Australians who have contracted COVID-19 and the propensity of those infected to suffer with long COVID symptoms. This experience accords with the epidemiological data that is emerging.

One practitioner explained:

> *"...what's so different in COVID is the denominator is huge…and it's not just a post infective thing, it's a psychosocial thing as well. … So I think potentially the number of the problem is much, much, it's much bigger."*

Upskilling/education is needed

Practitioners identified that a better understanding of the problem of long COVID is needed across the whole community. They identified that general practitioners need education to better identify, assess and appropriately refer patients with long COVID. One practitioner noted *"patients are finding it takes a really long time to get a diagnosis (of long COVID), which delays their treatment and results in a poorer outcome…"*

A survey quoted by an allied health practitioner identified that a majority of GPs did not feel confident identifying long COVID and how to treat it. General Practitioners were unanimously considered the central person to manage long COVID; they were considered as being the leader "*the GP is in the lead, it's the Medicare system. We are there as supportive [to the patient] in private practice*".

However, some allied health practitioners experienced with long COVID patients felt they had to "manage upwards" by educating GPs about treatment for their patients. As one practitioner explained:

> *"...We write suggestion letters to the doctors – we would never write a recommendation letter, but we definitely put suggestions that we've found this out and we're seeking their opinion. [For example] … if they're suffering from fatigue, these are the recommendations that [we] would suggest as the pathway … again then it's…back to education*"

In addition, practitioners identified that some of their colleagues need upskilling to deal with aspects of long COVID symptoms such as neuro-cognitive difficulties and managing for fatigue.

A further need identified by practitioners is for public education to empower patients ask their GP for help. This would provide two-fold benefits of raising GP awareness of their symptoms and to help the general public avoid unscrupulous operators preying on their illness.

> "*But really it's a 3-pronged approach – the GP, allied health professionals and the consumers themselves, because [the patients] need to be empowered to go…." I've heard that I can get help and you need to look after me. And there's this education programme where you can just spend 20 minutes and then you can get some blood tests for me." I mean, you know, I'm being facetious, but I guess the point is, it's important that patients are empowered, and they need to be at the centre of the care "*

> "*So probably my biggest thing is actually ensuring that there's that GP education first and foremost because they're going to be … finding – OR excluding – the really big problems, but then being able to explain to the patient [what it is], and then being able to refer to the appropriate sources and advocate for allied health"*

> *"You're better off putting more money and funding into educating GPs and people – like you know, the ads on TV saying "is your blood pressure high? You should talk to your GP about this medication. Well, why don't we have those ads? "Are you not recovered from COVID? Go talk to your GP. There are options out there" And then that stops them moving to those sham treatments"*

Referral pathways for effective patient management

General Practitioners are seen by allied health practitioners as central to managing long COVID patients at many stages of their care. Initially, GP care is important to rule out other pathological causes of the patient's symptoms.

Allied health practitioners however view an additional role for the GP is to help co-ordinate and structure an effective multi-disciplinary plan for the patient. The literature identifies referral to allied health practitioners to manage long-running symptoms, and yet it is important that the appropriate intervention is chosen. An initial multi-disciplinary allied health assessment was identified to structure an effective management plan.

> *"At least that's what the majority of the evidence is pointing towards. I think acknowledging that up front is going to be very important so that as allied health professionals there could be a bit of a triage system to go, you know, if you have pulmonary damage, for example, you may not need to see a psychologist for example. But if they mostly [have] neurocognitive symptoms, they have needs in neuropsychology… And that's where you must have the, allied health multidisciplinary assessment, at least in the first instance".*

Referral pathways for general practitioners with long COVID patients direct them toward hospital-based clinics with waiting lists or require the GP to create a multi-disciplinary team in the community with referrals through the programs funded by Medicare. As identified in the following section, allied health practitioners report that funding for community-based care is contingent on income, difficult to coordinate and poorly supported by Medicare.

Funding for coordinated multi-disciplinary care in the community is inadequate

Allied health care practitioners consistently identified that long COVID patients are in difficult financial circumstances and so rely on Medicare for their healthcare needs.

> *"Many people that come to see me with long COVID symptoms can't work, or can't work full-time, and so are very conscious of their out of pockets costs."*

> "*Like a lot of people that we see…[they] have been unwell for quite an extensive period of time and so their funding is quite low*."

The Chronic Disease Management program is limited to 5 visits in a year with no additional visits possible for most Australians in any circumstances. The Medicare rebate for most

physical health care services is $56 per visit greater than 20 minutes in duration (Department of Health and Aged Care, 2022). There is no additional Medicare rebate for longer consultations. Practitioners reported this discourages multidisciplinary care and quality care.

> "*I guess our model works in the five sessions, but that's assuming that we as exercise physiologist will get all those five sessions. And so …the fact that so many allied health professionals have to share these five within 12 months is just crazy*."

Alternative community-based services are not common and require support from other funding sources to be financially viable. Practitioners also argue that if patients had access to more CDM visits there would be more scope to improve the quality of multidisciplinary care.

Medicare also provides funding for up to 3 allied health case conference meetings with the patients treating medical practitioner. The aim is to "*to increase uptake of multidisciplinary case conferences, improve care co-ordination, and support the outcomes that matter most to patients and their families*" (Department of Health and Aged Care, 2021). In this situation, Medicare does provide a higher rebate for a longer conference meeting. The meeting must be attended by the treating medical practitioner and at least 2 other care providers. Practitioners were sceptical of the benefit of these meetings and the willingness for GPs to organise them.

> "*…at least now there is some support for case conferencing. But in terms of what long COVID would need and the models of care we would need for long COVID, those items, while they're helpful and we would want to see them [continue], they aren't really fit for purpose for a multidisciplinary approach to a long-term chronic illness*."

Instead of case conferences, practitioners identified funding that reflected the work actually entailed in care for long COVID patents as a solution.

> "*It's putting in the funding to improve the chronic disease management items. If they were properly funded, then that covers the time that would go into multidisciplinary [care] and talking with [other AHPs]. So maybe rather than tinkering with these items, actually make some meaningful change to the chronic disease [payments].*"

While additional services under the chronic disease management program were identified as essential for good multidisciplinary care of long COVID patients, allied health practitioners were keen to have a GP review of the patient as part of gaining additional referrals to allied health practitioners.

Shortcomings of the current structure of allied health funding

The shortcomings can be summarised as:

- No national consistency to the identification and collection of long COVID data.
- The Better Access Initiative extension is to expire soon and does not cover neuro-cognitive conditions
- Chronic Disease Management (CDM) Plans need to address the complexity of the Long COVID condition
- Care co-ordination is not well supported in a Medicare fee for service model
- Flexible funding needed to commission multidisciplinary allied health care for long COVID patients

No national consistency to identification and collection of long COVID data

The National Clinical Evidence Taskforce for COVID-19 identify that understanding the prevalence and burden of long COVID in Australia is hampered by inadequate recording of long COVID in clinical software (National Clinical Evidence Taskforce (NCET), 2022).

- Identification of Australians experiencing symptoms of long COVID is needed to help their health care team make sense of the, often diffuse, symptoms and to co-ordinate care.
- In addition, robust analysis of this cohort will be difficult without a method of identifying people with long COVID in the community.

The Better Access Initiative

The Better Access to Mental Health initiative extension expires soon and the program does not cover neuro-cognitive conditions.

- In January 2023, Australians with long COVID will have access to 10 visits for psychological therapy, reduced from the current 20 visits.
- Therapy with a mental health worker for neuro-cognitive issues is not funded under this program. Access to skilled mental health workers is vital to provide rehabilitation for patients with these symptoms.

Chronic Disease Management (CDM) Plans

The need to address the complexity of the Long COVID condition in the current funding model administered by Medicare.

- Medicare-subsidised services require a condition to be present for 6 months or longer to be eligible. Post COVID conditions are defined as conditions present 3 months after COVID. This misalignment prevents many Australians from obtaining timely support for managing these symptoms.

- Consumers must "ration" allied health services as only 5 visits are available per year. This is insufficient for a consumer suffering with multiple or chronic symptoms of long COVID.
- Allied health practitioners' time and skill in managing complex long COVID patients is not reflected in one flat fee regardless of time spent with the patient.

Care co-ordination is not well supported in fee for service model

- Care coordination is highly valuable in assisting patients to navigate their healthcare, particularly for chronic and complex conditions such as long COVID.
- Collaboration between professions may occur via case conferencing however allied health providers must be invited to participate in the case conference by the patient's treating medical practitioner.
- As the GP acts in a care coordinator role and given the stretched resources of GPs, it is likely that the full benefits of care coordination are not being achieved.
- Allied health practitioners face additional barriers to delivering multidisciplinary care to patients, such as lack of access to digital health tools such as My Health Record and secure messaging. Practitioners are also not funded to initiate non-direct patient care and collaboration, such as clinical planning discussions.

No funding source for multidisciplinary care for long COVID patients

- Integrated multidisciplinary allied health care for long COVID patients is acknowledged for patient support and recovery
- Medicare's fee structure for allied healthcare is identified by practitioners as fragmenting and hindering appropriate service provision.
- Coordination of multidisciplinary care may be better resourced through programs that can fund integrated care.
- A flexible funding source that can reflect regional demand for support services and available workforce supply can more effectively assist long COVID patients.

Recommended Strategies to Improve Access to Allied Health Care for Post-COVID Conditions

AHPA recommends the following strategies to improve the care provided to patients with Long COVID conditions:

- Facilitate Identification of patients experiencing post-COVID conditions
- Maintain the Better Access initiative for post-COVID conditions
- Modify Chronic Disease Management Plans to reflect the complexity of Long COVID
- Facilitate Integration of Allied Health Practices into existing Digital Health Infrastructure
- Fund Primary Health Networks to commission integrated and multidisciplinary care

COVID provides an opportunity to better integrate allied health care into a multidisciplinary approach to primary care. COVID provides and objective measure for eligibility of care, medical oversight is required to identify serious sequelae and allied health care is the primary course of action for the most common scenario. AHPA recommends the following strategies to improve the care provided to patients with Long COVID conditions.

Facilitate Identification of patients experiencing post-COVID conditions

Capturing data regarding the diagnosis of long COVID in either the Medicare Benefits System or clinical software will help identify incidence and prevalence with subsequent COVID variants as well as monitoring expenditure on post-COVID health care.

Maintain the Better Access initiative for post-COVID conditions

It is also important to educate General Practitioners and the community that GP Mental Health Plans and Chronic Disease Management Plans can run concurrently. Patients with post-COVID conditions often present with symptoms that require both psychological and physical care. Support for the psychological aspects of neuro-cognitive rehabilitation is also necessary.

Post-COVID conditions will likely continue well past December 2022 as COVID-19 variants continue to circulate in the community. An arbitrary cut-off for extended support of 31 December 2022 is inequitable in these circumstances.

Chronic Disease Management Plans to reflect the complexity of Long COVID

Extending Chronic Disease Management Plans for up to 10 additional visits after the initial five visits subject to ongoing GP review for efficacy provides long COVID patients and their GP with the flexibility to address their symptoms methodically with the appropriate allied health practitioner.

The recommended management for Long COVID cannot be covered within 5 visits to multiple allied health professions. Additional visits for post-COVID conditions allows for a staged approach of, for example, initial supportive treatment and then subsequent exercise-based therapies as below:

- Dietitian for nutrition support and food access
- Speech Pathology for dysphagia and chronic cough
- Occupational Therapist to identify assistance with Activities of Daily Living
- Manual therapy for respiratory muscle conditioning
- Supervised exercise-based therapy to address breathlessness and fatigue.

A scale of fees that better reflects the time allied health practitioners spend with complex patients and the time spent liaising with other practitioners and coordinating patient care will reduce the out-of-pocket burden for long COVID patients. This can improve access to appropriate care.

Integration of Allied Health Practices into Digital Health Infrastructure

Allied health practitioners face additional barriers to delivering multidisciplinary care to patients, including lack of access to digital health tools such as My Health Record and secure messaging.

Improving allied health digital infrastructure and its integration into primary health care will improve efficiencies for multidisciplinary care of long COVID but also many other chronic conditions.

Fund Primary Health Networks to commission integrated and multidisciplinary care

Allied health practitioners have identified barriers to providing appropriate care to long COVID patients through Medicare. Coordination of multidisciplinary care may be better resourced through programs that can fund integrated care.

Primary Health Networks (PHNs) have 2 key goals (Department of Health and Aged Care, 2021):

- improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes
- improving the coordination of health services and increasing access and quality support for people.

These goals are closely aligned to the goals for long COVID patient scare. PHNs can commission coordinated multidisciplinary care for Long COVID and provide a flexible funding source that can reflect regional demand for support services and available workforce supply to assist Australians more effectively with long COVID symptoms.

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Appendix A - "Getting help for long COVID" (Department of Health, 2022).

"Your GP will be able to assess your symptoms and, if needed, provide referrals to medical specialists, allied health professionals and/or multidisciplinary clinics. Depending on your symptoms, this may include referrals to one or several health professionals, such as:

- *Respiratory doctors to investigate and manage breathing difficulties, and rule out other lung diseases*
- *Cardiologists to investigate and manage chest pain, and rule out other causes*
- *Physiotherapists and exercise physiologists to support gradual commencement or return to exercise*
- *Occupational Therapists for modifications and treatment to support returning to your daily activities and improved cognitive function*
- *Dietitians to support improving appetite, managing gastrointestinal symptoms, taste or smell changes, and malnutrition*
- *Speech pathologists to support improving chronic cough, hoarse voice or difficulty swallowing*
- *Psychologists to support your mental health and wellbeing"*

Appendix B – Access to Mental Health Treatment Plans (General Practice Mental Health Standards Collaboration, 2022)

An extensive quote from the General Practice Mental Health Standards Collaboration is included below to emphasise the complexity for GPs who have patients that require psychological and other allied health support:

"Where a patient has a mental illness as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both CDM items and the GP MHTP.
Although a GP is not precluded from managing a patient under both the CDM items and the GP MHTP, the GP should consider whether it is necessary to develop two separate care plans. As a general principle, the creation of multiple plans should be avoided, unless the patient clearly requires an additional care plan for the management of a separate medical condition.

According to the MBS, a patient is eligible for access to CDM items if they have at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal. Examples of eligible conditions provided, include

- *Asthma*
- *Cardiovascular disease*
- *Diabetes*
- *Musculoskeletal conditions*
- *Stroke*

Recent advice from the Department of Human Services clearly states a mental health disorder alone does not allow access to CDM items. The specific advice received is that only where a patient also has a chronic medical condition separate to their mental health condition, may it be appropriate for the patient to be on a CDM plan in addition to a GP MHTP. They cannot be offered sequentially to treat a mental health condition."

Appendix C - Access to care from allied health practitioners in rural regional areas.

The table below summarises data of registered allied health practitioners from the National Health Workforce Dataset for 2020. The data is grouped by Modified Monash Medical Area (MMM) – 1 and 2 being capital city and large regional towns. MMM 3-7 identifies smaller regional, rural and remote settlements.

Registered Allied health practitioners – as identified across Australian regions

	Psychologists	Podiatrists	Physiotherapists	Osteopaths	Occupational Therapists	Chiropractors	Total
MMM 1	33,053	4,239	28,253	2,222	19,293	4,292	91,352
MMM 2	2,985	512	2,699	228	2,376	445	9,245
subtotal	**36,038**	**4,751**	**30,952**	**2,450**	**21,669**	**4,737**	**100,597**
MMM 3-7	3,962	822	4,166	385	3,179	918	13,432
Overseas/Unknown	561	66	1,085	43	275	181	2,211
Total	40,561	5,639	36,203	2,878	25,123	5,836	116,240

per 10,000	Psychologists	Podiatrists	Physiotherapists	Osteopaths	Occupational Therapists	Chiropractors	Total
MMM 1&2	18.58	2.45	15.95	1.26	11.17	2.44	51.85
MMM 3-7	6.51	1.35	6.85	0.63	5.23	1.51	22.08

Source: NHWDS 2020, ABS Census 2021

Allied health workforce data relating to the size and location of workforce is hindered by the fact that *"there is currently no single source of workforce information across all professions including self -regulated allied health professions."* (Health Policy Analysis, 2022) . There are several professions that provide healthcare that are not included in this dataset, such as speech pathology, dietitians, exercise physiology and social work.

AHPA has attempted to address this problem with a workforce survey to supplement the national health workforce dataset summarised above. Due to several factors the ability of our members to supplement public records has been limited. Members of AHPA who keep record of practitioners working in rural and regional Australia identify another 4,000 allied health practitioners available in these communities. Based on our methodology there is likely to be more than this number, but this cannot be quantified with any certainty.