LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE COVID-19 PANDEMIC RESPONSE
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Submission Cover Sheet

COVID-19 pandemic response

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Exercise & Sports Science Australia Submission

Select Committee on the COVID-19 pandemic response

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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 apply the science of exercise to design and deliver physical activity and exercise-based interventions to improve health, fitness, well-being, performance and assist in the prevention of injury and chronic conditions. They coach and motivate to promote self-management of physical activity, exercise and healthy lifestyles and work in the National Disability Insurance Scheme (NDIS) as personal trainers and allied health assistants (AHAs), in fitness businesses, for sporting bodies, in corporate health and as AHAs for exercise physiologists and other allied health professionals.

ESSA welcomes the opportunity to respond to the Select Committee 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 telehealth 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."**

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Whilst the National Cabinet functioned effectively in coordinating a national response in the earlier stages of the pandemic, 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; and provide support for those members who operate businesses across state borders.

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. A legislative issue impeded the delivery of high quality clinical health care, specifically the lack of a nationally consistent legislative framework for essential services which includes the comprehensive recognition of allied health services.

The need to support non-COVID-19 patients with an information campaign on what essential health services were allowed to remain open for their ongoing care was not managed particularly well by either the Australian Government or state and territory governments in the first lockdown. 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 Territorians 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 state and territory Chief Allied Health Officers 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 in 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 and it announced the appointment of a permanent dedicated CAHO, Dr Anne-marie Boxall on 9 July, 2020.

The under-investment 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 is a lack of understanding of the critical role that Accredited 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.

The ACT's **unique geographical location within the state of New South Wales (NSW**) has placed the ACT at the mercy of the Public Health Orders and poses challenges for any surge workforce and those allied health professionals who operate businesses across both the ACT and NSW.

3.0 Summary of Recommendations

Recommendation 1: That the ACT 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 ACT Government considers the implications of cross border health and allied health professionals and wherever practical harmonise directions with NSW.

Recommendation 3: That the ACT Chief Health Officer or her authorised delegates provide an exemption to allow for the delivery of essential allied health clinical care (including exercise physiology) by appointment in non-essential indoor recreational facilities (e.g. gyms and fitness centres) during lockdown phases and provide clear guidance on what kind of group and individual allied health services should continue to operate in a lock down.

Recommendation 4: That the ACT 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 ACT 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 ACT 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 ACT 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 ACT Government via the National Cabinet and/or the NFRC requests the Australian Government implement a rehabilitation strategy for patients of all ages requiring rehabilitation which includes strategic priorities for allied health and AEPs to manage the COVID-19 rehabilitation surge and the interrupted care needs of non-COVID-19 patients.

Recommendation 9: That the ACT 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 and innovations made during COVID-19.

Recommendation 10: That the ACT Government via the National Cabinet and/or the NFRC requests the Australian Government considers increased funding to an incorporated entity (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.

Recommendation 11: That ACT Health Directorate 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 12: That the ACT Health Directorate and Canberra Health Services consider utilising Accredited Exercise Scientists and exercise science students to work as allied health assistants in any future surge workforces.

Recommendation 13: That the ACT 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 14: That the ACT Government via the National Cabinet and/or the NFRC supports the retention of all temporary telehealth items for allied health and other health care at least until March 31, 2021 and re-investigates funding models that focus on a long-term, whole person and population health perspective.

Recommendation 15: That the ACT Government, the Australian Government and other state and territory jurisdiction work to harmonise requirements for COVID-19 Plans.

Recommendation 16: That the ACT 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 and that development of local manufacturing of reusable gowns be supported.

Recommendation 17: That the ACT Health Directorate either produces specific guidance for allied health professionals on the use and removal of PPE or provides links to relevant Australian Government resources.

Recommendation 18: That the ACT Government via the National Cabinet and/or the NFRC advocates for the NDIS to extend PPE support items to registration groups that capture the allied health workforce.

Recommendation 19: That the ACT Health Directorate includes information on the value of exercise during a pandemic with links to evidenced based free resources such as Exercise Right on website pages, publications and media releases.

Recommendation 20: That the ACT Government through the National Cabinet and/or the NFRC asks the Australian Government to further extend both the JobKeeper scheme and payment levels (as at 4 January 2021) and COVID-19 JobSeeker payment levels (as at 25 September 2020) until 30 June, 2021.

4.0 Inconsistencies in Essential Services Legislation & Public Health Directions

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:

- **the Australian Capital Territory (ACT) has no current legislation which defines essential services**
- Western Australia, Tasmania, and the Commonwealth have no definitions of essential services in their relevant legislation
- Victoria – the *Essential Services Commission Act 2001 (Vic)* defines "essential services" but has no specific mention of health services other than a broad catch all of "any other industry prescribed for the purpose of this definition"
- 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
- Queensland - securing the essentials of life
- 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.

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".

It may be worth considering the location of the ACT within New South Wales (NSW) and the implications that this has on AEPs and other allied health professionals who work across state borders given many AEPs work at various locations across NSW and the ACT. Definitions of essential workers and restrictions to services need to align with NSW or consider the implications for those who work cross-border.

Recommendation 1: That the ACT 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 ACT Government considers the implications of cross border health and allied health professionals and wherever practical harmonise directions with NSW.

5.0 Intersection of Essential Services and Non-Essential Services

To respond to the rapidly changing COVID-19 environment, the ACT Government declared a Public Health Emergency which provides the Chief Health Officer with additional powers to do whatever is necessary to manage the COVID-19 risk to protect Canberrans' health, including the issuing of Public Health Emergency Directions.

These directions provide details on the opening and closing of non-essential facilities, the limiting of access to these facilities and the reasons why Canberrans can leave their homes.

Whilst the issuing of public health directions in the ACT has worked relatively well, **there is a lack of understanding that both non-essential and essential services operate in the same facilities**. The decision of the National Cabinet to close gyms and fitness studios as non-essential facilities on 22 March, 2020[v] 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 the following day (23 March, 2020), 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.

Dr Lisa Studdert, Deputy Secretary for Population Health, Sport and Cancer, Australian Government Department of Health provided an exemption a few days later for small gyms, in a letter dated 26 March, 2020 (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 AEPs 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 professionals 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 facilities were deemed non-essential.

The exemption provided by the Australian Government Department of Health operated alongside the first ACT Public Health (Closure of Non-Essential Business or Undertaking) Emergency Direction 2020 (No 1) issued on 23 March, 2020 which limited closures to

> "2. A non-essential business or undertaking means any of the following, whether operated on a for profit or non for profit basis:
> ……
> c. a gym
> d. an indoor sporting centre".

The Australian Government exemption also operated alongside the second ACT Public Health (Closure of Non-Essential Business or Undertaking) Emergency Direction 2020 (No 2) issued two days later on 25 March, 2020 which mirrored an expanded definition of non-essential fitness businesses in the Prime Minister's Media Statement of 24 March, 2020 as follows:

"2. A non-essential business or undertaking means any of the following, whether operated on a for profit or not for profit basis or purely as a private social gathering:

……..

c. a gym;

d. an indoor sporting centre;

e. a health club or fitness centre;

f. a centre that provides yoga, barre or spin facilities;

…….

h. a boot camp or personal trainer, but not:

i. to the extent that it provides outdoor events for groups of no more than 10 people and where social distancing of 1 person per 4 square metres is observed."

At the same time these directions were provided, there was no clear guidance from the ACT Government on restrictions for allied health professionals working out of gyms or public facilities (e.g. hospital settings) and no clear guidance on what kind of group and individual clinical services should continue to operate. To fill this gap, ESSA provided recommendations to its members on what constituted essential clinical care, the maximum number of people in a facility and the maximum number of people in a group exercise class.

To the best of ESSA's knowledge, ACT law enforcement officers did not visit gyms as they did in other states, so neither the Australian Government nor the ACT "essential business" exemptions were tested. For the future, an expanded exemption should be made in "essential public services" which allows clinical exercise physiology and other clinical allied health services to operate by appointment in gyms and fitness centres to allow for continuity of clinical care of patients.

Recommendation 3: That the ACT Chief Health Officer or her authorised delegates provide an exemption to allow for the delivery of essential allied health clinical care (including exercise physiology) by appointment in non-essential indoor recreational facilities (e.g. gyms and fitness centres) during lockdown phases and provide clear guidance on what kind of group and individual allied health services should continue to operate in a lock down.

6.0 Public Health Messaging

During the early stages of the COVID-19 pandemic in Australia, exercise physiology patients 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".** Even the latest overview of the ACT Changes to Restrictions Stage 3, Step 3.1 which came into effect on 9am on Monday 10 August 2020 focuses on what is allowed for non-essential businesses. There is no equivalent on what essential businesses can open, especially health services.

Whilst the Prime Minister, the Hon. Scott Morrison, MP in a press conference[vi] 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[vii] 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 the ACT about the need to continue with regular healthcare, especially allied health care in order to maintain health, wellbeing and quality of life. It took the Australian Government till 5 June, 2020[viii] to produce posters about allied health services being open for business.

The ACT Government is to be applauded for the reminder for those with individual risk factors: "Talk to your doctor if you are not sure about your individual risk, or if you have questions about how you can best manage your health conditions" under Item 2 of 'How can I manage my health risk during the COVID-19 pandemic?' on the 'Protect yourself' webpage. The recommendation for Canberrans to develop their own COVID-19 Action Plan, in Item 4 on this webpage is also good advice, though ESSA notes that this plan is an Australian Government resource which was not published until 6 July, 2020.

Whilst there is a mention about personal protective equipment (PPE) for the community and allied health services on the ACT COVID website, there is no specific mention to continue seeing your regular allied health professional for essential care, nor is there an overview of what professions are allied health professions on the Allied Health section of the ACT Health website. An example of a list of allied health professions, the 'Allied health categories position paper' clearly defines the 27 allied health professions considered "essential" by the Victorian Government.

The lack of consistent, co-ordinated and clear communication in all stages of the pandemic around essential health and allied health has left many vulnerable population groups confused about accessing clinical health care. ESSA professionals working in community aged care expressed concern in the early stages 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.

This was consistent with the findings of other peak aged care bodies and a recent Australian Institute of Family Studies report[ix] released on 30 July, 2020 which found seniors had the least contact with loved ones, with only about a quarter of respondents aged over 70 saying they had daily contact with family, compared to 40 per cent of people under 40. People over 70 were also twice as likely to go a full week without talking to family. Many older people also 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.

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

- closure of large gyms (see Section 5 for more details)
- sudden closure of some NDIS and aged care essential services unilaterally by providers
- 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 9).

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 for themselves 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 Canberrans 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.

Recommendation 4: That the ACT 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 ACT 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 ACT 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 ACT 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 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 (UK) 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 in the UK 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[x] 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[xi] 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. 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 relatively recent NSW Health rapid evidence check[xii] (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.**

The NSW Health Agency for Clinical Innovation (ACI) Respiratory Network developed resources for COVID-19 rehabilitation including *Checklist for the re-opening of cardiopulmonary rehabilitation services in NSW* and the *Delivering pulmonary rehabilitation via telehealth during COVID-19*.

The National COVID-19 Clinical Evidence Taskforce is providing national, high-priority, evidence-based clinical COVID-19 guidelines for the

- Management of mild COVID-19
- Management of patients with moderate to severe COVID-19
- Management of patients with severe to critical COVID-19
- Respiratory support for patients with severe to critical COVID-19.

Neither of these Australian groups have yet developed guidelines for COVID-19 rehabilitation, though an expert panel in the fields of rehabilitation, sport and exercise medicine (SEM), rheumatology, psychiatry, general practice, psychology and specialist pain, working at the Defence Medical Rehabilitation Centre, Stanford Hall, UK has recently released a consensus statement for post-COVID-19 rehabilitation[xiii].

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. No update is available at the time of writing on the status of this briefing paper.

More recently on 29 June, 2020, leading Australian 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[xiv]."

Recommendation 8: That the ACT Government via the National Cabinet and/or the NFRC requests the Australian Government implement a rehabilitation strategy for patients of all ages requiring rehabilitation which includes strategic priorities for allied health and AEPs 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[xv] 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 the Australian Government Chief Allied Health Officer could lead.

Esteemed specialist medical practitioner in geriatric medicine and epidemiologist, Professor Joseph Ibrahim recently highlighted the failure of the aged care sector to establish communities of practice to share innovations in his Precis of evidence to the Royal Commission into Aged Care Quality and Safety (published on 12 August, 2020). By the end of May, 2020,

> "Better gathering of field intelligence, better coordination and sharing of information should have been established. In the absence of empirical research data to determine the most effective approach, we rely on lived experience and expert opinion. By this stage we should have networked all RACFs into groups to share their experiences and innovations. **Establishing a 'Community of Practice' would have achieved this with a small financial investment**."

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[xvi] 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 9: That the ACT Government via the National Cabinet and/or the NFRC requests the Australian Government tasks and resources Australian Allied Health Leadership Forum to facilitate the collection and dissemination of allied health service improvements and innovations 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 for its work. Allied Health Professions Australia also provides in-kind support to host the AAHLF Secretariat.

Recommendation 10: That the ACT Government via the National Cabinet and/or the NFRC requests the Australian Government considers increased funding to an incorporated entity (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.

8.0 Hospital Surge Workforce

Plans for a surge workforce were made within the ACT, however they were not enacted to a large extent. AEPs were considered within the in-patient setting to some extent. Non-clinical AEP staff were utilised for contact tracing and monitoring of COVID positive cases at home, however this was unplanned. Supporting the greater use of AEPs within surge workforce would be beneficial to the ACT healthcare system.

A significant issue is the unique geographical location of the ACT as an 'isolated island' within New South Wales. Its location presents a risk in its inability to source staff from other nearby cities in the case of an outbreak. Some states, including NSW and SA also called for allied health assistants to apply for casual surge pool positions. Accredited Exercise Scientists work as allied health assistants (AHAs) in many allied health practices and are ideally placed to join surge workforces and present one possible solution to a surge workforce. In addition, exercise science students are well equipped to provide support as Technical Officers or AHAs.

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 ACT public hospital staff during future events. This mapping may also look at circumstances where general practitioners (GPs) and specialists are re-deployed and allied health professionals can assist in managing patients' chronic conditions until GPs and specialists return to their regular roles.

Recommendation 11: That ACT Health Directorate 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 12: That the ACT Health Directorate and Canberra Health Services consider utilising Accredited Exercise Scientists and exercise science students to work as allied health assistants in any future surge workforces.

9.0 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[xvii] 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, 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[xviii] 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 problems reported**.

Australia's major cities experienced internet congestion[xix] from a baseline in mid-February to 30 March, 2020. AEPs operating allied health businesses in some areas reported congestion from home schooling and general demand creating barriers to deliver any telehealth services through videoconferencing.

The new Statutory Infrastructure Provider (SIP) regime[xx] 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 Canberrans accessing telehealth, with Australia ranked 67th for the average cost of entry level broadband subscriptions according to an international review[xxi] 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[xxii] 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 by older Australians 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 are 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[xxiii].

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 quoted as being:

"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 lower rate of Telehealth services delivered through video-conferencing needs further research to understand the barriers facing Canberrans 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[xxiv] reporting on how people use Medicare funded telehealth appointments to access general practice, allied health, psychiatry and nursing consults.

Telephone remains the most commonly available device for all 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 and May 2020 for telehealth items which could be claimed by exercise physiologists and other allied health professionals**[xxv].

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 by 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 for April, 2020:
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 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*[xxvi].

The Royal Australian College of General Practitioners announced on 6 August, 2020 it is working with the Australian Government to extend telehealth beyond the 30 September, 2020 deadline. A recent Australian Medical Association media release (12 August, 2020) has called on the Australian Government to extend support for telehealth until March next year.

Recommendation 13: That the ACT 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 14: That the ACT Government via the National Cabinet and/or the NFRC supports the retention of all temporary telehealth items for allied health and other health care at least until March 31, 2021 and re-investigates funding models that focus on a long-term, whole person and population health perspective.

10.0 COVID-19 Plans/Requirements/Resources

On 25 March, 2020, the Prime Minister announced the establishment of the National COVID-19 Coordination Commission[xxvii] (since been renamed to the National COVID-19 Commission [Advisory Board]) with its role 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[xxviii] 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[xxix] 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 Allied Health Professions Australia that specific industry guidance is being prepared for allied health. As at 20 August, 2020, this industry guidance for allied health is not yet available though guidance is available for health businesses.

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 15: That the ACT Government, the Australian Government and other state and territory jurisdiction work to harmonise requirements for COVID-19 Plans.

11.0 Personal Protective Equipment (PPE) & Infection Control Training

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[xxx] 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[xxxi] 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. 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 and distribution channels were advertised well in advance.

The supply chain issue and the generation of waste has been noted by Dr Forbes McGain, an anaesthetist and intensive care physician in Melbourne who has a PhD in sustainable healthcare who stated that the pandemic:

> "has created a 'mountain of waste' of single-use gloves and gowns. He sees the pandemic creating an opportunity for radical change in two related areas – the development of local manufacturing to meet healthcare supply chain needs, and the manufacture of reusable gowns.
>
> This would be an example of more environmentally sustainable practices increasing the resilience and security of healthcare systems while also boosting local employment. The pandemic has highlighted a 'real opportunity for much more interaction between manufacturing and medicine', he says[xxxii]."

Recommendation 16: That the ACT 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 and that development of local manufacturing of reusable gowns be supported.

Apart from supply, the other significant issue around PPE is the "Need for advice on the proper use and removal of PPE' an issue identified by Professor Joseph Ibrahim in his Precis of evidence to the Royal Commission into Aged Care. The ACT Government released an Information Sheet on 20 February, 2020: Donning and Doffing PPE for GPs but has not produced material specifically for allied health professionals nor co-branded existing material as being suitable for allied health professionals.

Recommendation 17: That the ACT Health Directorate either produces specific guidance for allied health professionals on the use and removal of PPE or provides links to relevant Australian Government resources.

On 29 July, 2020, the Minister for the National Disability Insurance Scheme, the Hon. Stuart Robert MP, announced temporary changes to funding arrangements to allow NDIS participants in Victoria and New South Wales to claim the cost of personal protective equipment (PPE), including masks. This announcement indicated that the ability to claim for the cost of PPE would also be extended to NDIS providers. The NDIS website later advised that new PPE support line item would be introduced for the following registration groups:

- 0104 High Intensity Daily Personal Activities
- 0107 Daily Personal Activities
- 0115 Assistance with Daily Life Tasks in a Group or Shared Living Arrangement

ESSA is concerned that PPE support items were not extended to registration groups that capture the allied health workforce (i.e. 0126 Exercise Physiology and Personal Wellbeing Activities and 0128 Therapeutic Supports).

Recommendation 18: That the ACT Government via the National Cabinet and/or the NFRC advocates for the NDIS to extend PPE support items to registration groups that capture the allied health workforce.

12.0 Support Services for Vulnerable Canberrans

ESSA would welcome the opportunity to provide the ACT Health Directorate with further information for its website about the value of exercise during a pandemic. ESSA draws to the attention of the Government resources which could provide Canberrans with free content on exercising safely. Exercise Right is an evidenced based information website inspiring people to live happier and healthier lives through motivational stories, engaging content and evidence-based tips. Over ten chronic conditions are covered: (e.g. lower back pain and diabetes) along with other information on key topics like falls prevention. The free Exercise Right at Home resources were launched by ESSA during the early stages of COVID-19 to assist people exercise at home safely to support their physical and mental health.

Exercise Right for Kids is a channel with specialised resources to inform people on the importance of exercise for children with chronic conditions and disabilities. It provides physical literacy tools including a range of research based fact sheets with fun and easy exercise tips to help encourage children to be active.

Exercise Right is recognised as an official partner of Healthdirect Australia, a national, government-owned, not-for-profit organisation which supports Australians in managing their own health and wellbeing through a range of multichannel health information and advice services. The healthdirect website continues to be the number one Australian online source of health information, with more than 34 million visits in 2018-2019. Information from Exercise Right is being used by other state government health departments for consumers.

ESSA also suggests some simple messages be added to the ACT Health 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 19: That the ACT Health Directorate includes information on the value of exercise during a pandemic with links to evidenced based free resources such as Exercise Right on website pages, publications and media releases.

13.0 Impact of COVID-19 on Businesses

COVID-19 has impacted on allied health, sport and health and wellness businesses owned and operated by ESSA members; employees of those businesses and other allied health businesses; and sole traders.

Many members lost jobs, were stood down, worked reduced hours or closed their businesses. ESSA's first bi-monthly *COVID-19 Member Impact Survey*[xxxiii], which was completed by 225 AEPs in April 2020 indicated that the most significant impacts on AEPs have been:

- reduced customer demand
- inability to provide services in the usual manner
- increased social distancing
- reduced cash flow
- a transition to online service delivery
- additional resources to keep practitioners and clients safe
- business closures and
- closure of sporting facilities and cancellation of sporting and community events.

Survey results also found that:

- 35% of AEP members experienced a reduction in their incomes.
- 36% experienced a decrease in revenue of 75-100%; 38% experienced a decrease in revenue of 50-74%; and 13% experienced a decrease in revenue of 25-49%.
- 70-85% were delivering all service options, with only 28% delivering no services at all.
- 42% reported that they had not received any new referrals since COVID-19 social distancing public health orders and the date of the survey.

ESSA's findings are consistent with the findings from broader industry reports such as a recent Grattan Institute Report[xxxiv]:

> "The situation is less clear when it comes to 'health care and social assistance'. This industry is large and diverse, encompassing nurses in public hospitals, who are very unlikely to lose their jobs during this crisis, as well as workers who are more vulnerable to job loss. For example, **allied health workers in private practice and a range of social care occupations are more at risk of being out of work. Our preferred method suggests about a quarter of jobs in this industry are at risk**."

A recent Australian Bureau of Statistics report (4 May, 2020) on *Business Indicators, Business Impacts of COVID-19* [xxxv] highlights the impact of COVID-19 on the broader healthcare and social assistance; and arts and recreation services sectors with the **three worst anticipated business impacts** being the

- **reduced demand for goods or services**
- **reduced cash flow and**
- **government restrictions**.

ESSA's second survey of members in June 2020 shows an increase in revenue as COVID-19 restrictions were lifted.

Table 1: Impact of COVID-19 on revenue on ESSA members.

	March N = 225	June N=164
Down 75 - 100%	43.75%	15.28%
Down 50 - 74%	37.50%	19.44%
Down 25 - 49%	9.38%	26.39%
Down 10 - 24%	6.25%	11.11%
Down 1 - 95	0.0%	5.56%
No change	3.13%	12.50%
Increase	0.0%	9.72%

Recommendation 20: That the ACT Government through the National Cabinet and/or the NFRC asks the Australian Government to further extend both the JobKeeper scheme and payment levels (as at 4 January 2021) and COVID-19 JobSeeker payment levels (as at 25 September 2020) until 30 June, 2021.

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 1 96 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.
GPO Box 9848 Canberra ACT 2601 - www.health.gov.au

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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 h e a l t h ca r e 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

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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 than10 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

[redacted]

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 a regional area. 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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