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AMA Submission to Inquiry into Long COVID and Repeated COVID Infections

Long COVID is a serious health issue which we are learning more about every day. A significant clinical challenge with managing Long COVID and/or post-COVID conditions is that we are still at the relative beginning of our experiences and understanding of the condition/s. What is clear is that repeat infections increase risk, as do infections in the unvaccinated.

This Inquiry will receive many submissions which will detail the difficulties of patients seeking diagnosis and treatment for an emerging, under resourced health issue, and from clinicians struggling to support their unwell patient access one of the few dedicated clinics. The AMA urges the Inquiry to take these reports seriously and make recommendations that will support patient access and support healthcare professionals to provide care.

This Inquiry also examines repeat COVID infections. Repeat infections must not be overlooked and we look forward to strong recommendations on supporting and possibly reinstating many of the recently removed public health measures that limited the spread within our communities.

The pandemic is not over and we still have much to learn about Long COVID. As such this inquiry must not come to premature conclusions and should adopt the precautionary principle when it comes to measures to manage Long COVID. To achieve this, the AMA's key recommendations are:

1. Flexible strategies: Any plans or strategies developed must be flexible in order to adapt to new information as it arrives and to accommodate the specific needs of affected communities.

2. Support the Health System: Long COVID will have impacts on the entire health system. GPs will be on the front line and will need appropriate resourcing to manage the expected increase in patients. GPs cannot be expected to take on this additional burden with no additional resources as they have throughout the pandemic. It will also impact hospitals and aged care which require additional support.

3. Prevention: Australia has moved too quickly to remove safe and effective public health measures which limit the spread of COVID-19. We need to return to a pandemic plan that relies on more than vaccination.

Long COVID

Most Australians have now been infected with COVID at least once,[1] and more people will contract the virus again or for the first time in the near future. Even people who experienced very mild COVID symptoms can experience post-COVID complications.[2]

Most infections will clear one to two weeks post-infection, however some people will experience ongoing symptoms. Currently there is no clear definition of Long COVID,[3] with some definitions stating that is when symptoms last longer than four weeks,[4] and others when symptoms persist for more than twelve.[5] The NICE Guidelines in the UK use “Ongoing symptomatic COVID-19” when symptoms of COVID-19 persist from 4 weeks up to 12 weeks and “Post-COVID-19 syndrome” when they persist past 12 weeks.

The World Health Organisation defines Long COVID as:

> “Post COVID-19 condition, also known as Long COVID, occurs in individuals with a history of probable or confirmed SARS-CoV-2 infection, usually 3 months from the onset of COVID-19. Symptoms last for at least 2 months and cannot be explained by an alternative diagnosis.
>
> Common symptoms include fatigue, shortness of breath and cognitive dysfunction, as well as others that generally have an impact on everyday functioning. Symptoms may appear following initial recovery from an acute COVID-19 episode, or persist from the initial SARS-CoV-2 infection.”[6]

In Australia, Long COVID is more commonly defined as symptoms persisting longer than twelve weeks from the onset of disease.[7]

There is a long list of symptoms that may signify Long COVID and they are experienced differently in different people which makes it difficult to diagnose and develop consistent

[1] Australian COVID-19 Serosurveillance Network. (3 November 2022). “Seroprevalence of SARS-CoV-2-specific antibodies among Australian blood donors: Round 3 update”. https://kirby.unsw.edu.au/sites/default/files/COVID19-Blood-Donor-Report-Round3-Aug-Sep-2022.pdf

[2] Center for Disease Control. “Long COVID or Post-COVID Conditions”. https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/

[3] Long COVID is sometimes also referred to as long-haul COVID, post-acute COVID-19, post-acute sequelae of SARS CoV-2 infection (PASC), long-term effects of COVID, and chronic COVID.

[4] Australian Government Department of Health. “Getting help for Long COVID”. https://www.health.gov.au/sites/default/files/documents/2022/11/getting-help-for-long-COVID_0.pdf, Claire Davies. (25 January 2022). “Key learning points: updated NICE guidance on managing Long COVID”**.** Medscape UK. https://www.guidelinesinpractice.co.uk/infection/key-learning-points-updated-nice-guidance-on-managing-long-COVID/456680.article

[5] Healthdirect. “Understanding post-COVID-19 symptoms and Long COVID”. https://www.healthdirect.gov.au/COVID-19/post-COVID-symptoms-long-COVID

[6] World Health Organization. “Post COVID-19 condition (Long COVID)”. https://www.who.int/europe/news-room/fact-sheets/item/post-COVID-19-condition

[7] National Clinical Evidence Taskforce. “Care Of People After COVID-19” V 6.1. https://clinicalevidence.net.au/wp-content/uploads/FLOWCHART-CARE-AFTER-COVID-19.pdf?=221026-230009; Healthdirect. “Understanding post-COVID-19 symptoms and Long COVID”.

treatment regimens for. Some of the most common symptoms include fatigue, shortness of breath, loss of smell, muscle ache and brain fog.[8]

Due to the variation in symptoms, difficulties diagnosing and reporting, it is very difficult to say what percentage of people infected with COVID-19 will develop Long COVID.[9] There are many variables to consider including vaccination status, whether this was the first infection or not, existing health issues, and COVID variant.

A recent systematic analysis estimated that 6.17% patients had long COVID symptoms three months after symptom onset, while at twelve months the prevalence decreased to 0.9%.[10] A recent British study found that Long COVID was less prevalent after infection with the Omicron variant than the Delta variant, with 4.5% of cases compared with 10.8%.[11] A recent study covering almost half of the German population found that children and adolescents who had been infected with COVID were 30% more likely to experience health problems three months or more after infection, while adults were 33% more likely.[12] There is evidence that being vaccinated limits the likelihood of developing Long COVID,[13] as does taking antivirals.[14]

Australia requires a data collection and research strategy to overcome the challenges of studying Long COVID. This strategy must ensure that appropriate data privacy and safety principles are followed. Appropriate funding and resourcing will ensure we can accurately describe the problem and develop the solutions.

It is also unclear what specifically causes Long COVID. There are many hypotheses on the cause, with more prominent including: lingering fragments of COVID continuing to stimulate the immune system,[15] antibodies generated by the infection are mistakenly attacking the body's own proteins,[16] and that COVID causes microscopic blood clots that inhibit oxygen flow.[17] There

[8] Office for National Statistics. (3 November 2022). "Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK". https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronavirusCOVID19infectionintheuk/3november2022

[9] Betty Raman. (24 August 2022). "Long COVID: why it's so hard to tell how many people get it". *The Conversation.* https://theconversation.com/long-COVID-why-its-so-hard-to-tell-how-many-people-get-it-188270

[10] Global Burden of Disease Long COVID Collaborators. (10 October 2022). "Estimated Global Proportions of Individuals With Persistent Fatigue, Cognitive, and Respiratory Symptom Clusters Following Symptomatic COVID-19 in 2020 and 2021". *JAMA.* https://jamanetwork.com/journals/jama/fullarticle/2797443

[11] Michela Antonelli, Joan Capdevila Pujol, Tim D Spector, Sebastien Ourselin, Claire J Steves. (18 June 2022). "Risk of long COVID associated with delta versus omicron variants of SARS-CoV-2". *The Lancet.* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00941-2/fulltext

[12] Roessler M, Tesch F, Batram M, Jacob J, Loser F, Weidinger O, et al. (2022). "Post-COVID-19-associated morbidity in children, adolescents, and adults: A matched cohort study including more than 157,000 individuals with COVID-19 in Germany". *PLoS Med*. https://doi.org/10.1371/journal.pmed.1004122

[1313] GAVI. "COVID-19 vaccination protects against Long COVID". https://www.gavi.org/vaccineswork/COVID-19-vaccination-protects-against-long-COVID

[14] Yan Xie, Taeyoung Choi, and Ziyad Al-Aly. (5 November 2022). "Nirmatrelvir and the Risk of Post-Acute Sequelae of COVID-19". *MedRxiv (preprint).* https://www.medrxiv.org/content/10.1101/2022.11.03.22281783v1

[15] Heidi Ledford. (11 May 2022). "Coronavirus 'ghosts' found lingering in the gut". *Nature.* https://www.nature.com/articles/d41586-022-01280-3

[16] Roxanne Khamsi. (19 January 2021). "Rogue antibodies could be driving severe COVID-19". *Nature.* https://www.nature.com/articles/d41586-021-00149-1

[17] Cassandra Willyard. (13 May 2020). "COVID-19 could cause microscopic blood clots." *Nature.* https://www.nature.com/articles/d41586-020-01403-8

are other possibilities and it may end up being more than one. As we are unlikely to know by the conclusion of this inquiry, recommendations must remain flexible enough to adapt diagnosis and treatment plans.

Managing Long COVID

Managing Long COVID is complex as symptoms and severity vary, and there are as yet no clear treatment protocols.

Healthdirect, the Government funded national health advice service that provides 24/7 advice for all Australians, states that "There is no specific treatment for this condition, but you can speak with your GP for help."

In Australia, the National Clinical Evidence Taskforce states in the goals of care:

> "Due to the broad range of symptoms and signs following acute COVID-19, a biopsychosocial approach to care, within the local context, is important. Take the time to listen to the patient, validate their experience and offer information about the symptoms that they are experiencing, including management options."[18]

The living guidelines also note that "Best practice would include a multidisciplinary team. This could be accessed through general practice, community health, rehabilitation programs or post-COVID-19 clinics, where these are available."[19]

The living guidelines, which are a synthesis of the best available research and evidence, are regularly updated as new evidence emerges. The AMA supports the continued work of the National Clinical Evidence Taskforce in evaluating and reporting on emerging COVID-19 therapies and in developing guidelines for treatment.

The Royal Australian College of General Practitioners (RACGP) has guidelines for GPs on managing Long COVID,[20] as well as a series of patient resources available on their website, including a symptom diary which helps track and manage recovery.[21]

Both the Taskforce guidelines and the RACGP guidelines emphasise the importance of collaboration and multidisciplinary care. Engaging allied health professionals, such as physiotherapists, occupational therapists and dietitians, to support the management of the condition will lead to better outcomes.

Unfortunately in Australia there are challenges to this collaboration. While there are dedicated Long COVID clinics across Australia that will help facilitate this multidisciplinary care, these clinics have long wait times, reported as four weeks to five months, and are metropolitan

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[18] National Clinical Evidence Taskforce. "Care Of People After COVID-19" V 6.1.
[19] National Clinical Evidence Taskforce. "Care Of People After COVID-19" V 6.1.
[20] The Royal Australian College of General Practitioners. (2022) *Caring for patients with post-COVID-19 conditions.* https://www.racgp.org.au/clinical-resources/COVID-19-resources/clinical-care/caring-for-patients-with-post-COVID-19-conditions/introduction#ref-num-1
[21] The Royal Australian College of General Practitioners. "Patient resource: Managing post–COVID-19 symptoms". https://www.racgp.org.au/clinical-resources/COVID-19-resources/patient-resources/patient-resource-managing-post-COVID-19-symptoms/introduction

based.[22] The AMA would like to see more funding and planning for these services, with stronger integration into existing health infrastructure.

These dedicated clinics are important and will continue to provide essential care for years to come, but they will not provide enough support alone. General practice is and will continue to be the frontline in the diagnosis and care of patients with post-COVID symptoms.

There is lack of clarity as to whether GPs can claim GP management plans and team care arrangement MBS items as the rules state that "Chronic medical conditions are those that have been, or are likely to be, present for at least 6 months."[23] It should be made clear when these items can be used.

The AMA has been advocating for years for the Workforce Incentive Program (WIP) to be uncapped and indexed. The WIP provides incentives to general practices to employ nurses and allied health staff in the practice. This is an excellent program that improves access and care for millions of Australians. Unfortunately the WIP has not been indexed since its initial introduction (as the Practice Nurse Incentive Program) in 2012. The WIP is also capped at five healthcare workers per practice, regardless of practice size or patient load. This limits the ability of general practice to provide services that the community needs.

More dedicated Long COVID clinics will also assist with the management of these conditions, however these must be planned with the whole health system in mind. Too often we have seen new services established which have required significant staff. These staff have come from other services, at times leaving the existing services unable to manage. Australia has a total health workforce shortage right now, and we must sensibly manage our limited resources.

Repeat Infections

Australia's best defence against Long COVID and is preventing primary and repeat infections. Australia's current policy settings are not sufficient to limit spread and repeat infections, and in fact are not designed to. Australia's current pandemic strategy is best described as a mitigation strategy that aims solely at ensuring our health system is not overwhelmed by COVID-19 through a level of immunity based on vaccination and immunity from recent infections. Infection is no longer strictly monitored and controlled, public health measures have been removed as have financial supports for people who are infected. COVID will likely be the largest killer of Australians this year.[24] The public has been encouraged to continue to wear masks, and strongly encouraged to keep up to date with their vaccinations, but the public is not following these suggestions and Australia is falling behind.

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[22] Rosie Bensley. (10 August 2022). "Australians face months-long wait for Long COVID treatment, cases expected to grow". *The Canberra Times*. https://www.canberratimes.com.au/story/7851591/sobering-1300-australians-are-getting-long-COVID-every-day/

[23] Services Australia. "Chronic disease GP Management Plans and Team Care Arrangements." https://www.servicesaustralia.gov.au/chronic-disease-gp-management-plans-and-team-care-arrangements?context=20

[24] Meg Bolton. (19 July 2022). "COVID-19 is on track to become the leading cause of death in Australia, Queensland infectious disease expert Nigel McMillan says". *ABC News*. https://www.abc.net.au/news/2022-07-19/qld-COVID19-modelling-death-rate-to-surpass-heart-disease/101249576

The AMA is extremely concerned that many COVID-19 policies to support the health system have ended or are due to end on 31 December. The AMA perceives that many politicians and policy makers viewed the implementation of public health measures through a time-limited binary lens, where once mask mandates were lifted they could not be returned. This is poor policy and demonstrates weak political leadership. There may be a point where a mask mandate, be it in limited settings or full, is the best policy for preventing infections.

The key policy that must be continued beyond 31 December 2022 is the National Partnership on COVID-19 50-50 hospital funding arrangement.[25] The Government has supported the hospital system with this additional funding through the pandemic to allow it to cope with surges. The system is now in a state of extreme crisis. This funding must be continued and should become permanent.

Australia is at the start of another wave of infections. This will be the first major wave we have experienced as a country without mandatory isolation periods and without supports for people to stay home from work. While many parts of the community have moved to flexible work arrangements, there are many industries where work from home is not an option. These tend to be in lower-paid more casual industries such as hospitality and retail.

The policy settings are not only insufficient to prevent repeat infections, they will increase the pressure on our already struggling health system.

Australia was one of the best performing countries in the world in limiting case numbers during the first two years of the pandemic. That so few Australians were infected prior to being vaccinated may mean that we will have less of a Long COVID burden. The public health measures implemented to limit this spread were difficult for many, but ultimately successful. The key to this success was that politician listened to the advice of the medical and scientific communities.

If this inquiry is to propose recommendations that will genuinely seek to limit repeat infections, then they must strongly encourage the return of medical voices to policy setting.

Health system impact

It is ambitious to make predictive statements of the specific impact of Long COVID and further repeat infections on the health system as we do not yet know the scale of Long COVID infections. However, we know that right now our health system is not prepared and is failing to deliver the level of care that Australians expect.

The single best thing we can do now is fix our health system before it is too late. Australia's health system has faced challenges before, but we have always been able to find the solutions we need to have one of the best health systems in the world. This will require significant reform

[25] Joe Hinchliffe, Adeshola Ore and Tamsin Rose. (27 October 2022). "End of 50-50 hospital funding deal with states to have 'devastating' impact, Australia's peak bodies say". *The Guardian.* https://www.theguardian.com/australia-news/2022/oct/27/end-of-50-50-hospital-funding-deal-with-states-to-have-devastating-impact-australias-peak-bodies-say

as part of strong, long-term strategic plans. It will also require significant investment, not in short-term election promises, but in real structural reform.

General Practice

General practice has been underfunded by successive governments for years. It is now buckling under the pressure of being the front line of the pandemic for almost three years. At every change in direction during the pandemic, GPs have responded quickly to enact new policies and procedures, be it rolling out telehealth overnight, keeping their practices open during the peak of the pandemic, vaccinating the majority of Australians with guidelines that changed with no notice or consultation, all the while absorbing the exorbitant price increases in basic practice supplies for an MBS indexation that was less than a quarter of what inflation currently is.[26]

GPs have done this to support their patients and their communities, and they are now supporting their patients through post-COVID and Long COVID with no additional support or resources.

It is important to note that most advice in Australia is already directing patients with Long COVID to their GPs with few resources being made available. For example, Health Direct states "There is no specific treatment for this condition, but you can speak with your GP for help."[27] The RACGP has guidelines for GPs and patient supports available, however there is only so much a GP can do on their own.

The best way to prepare the health system is to support general practice. The AMA has long term plan to fix general practice which includes:

1. **Introducing voluntary patient enrolment**

Voluntary patient enrolment (VPE) is a mechanism through which a patient can formalise their health care relationship with their usual GP or usual general practice. "Voluntary enrolment is designed to formalise and strengthen the relationship between patients and their GP to improve continuity of care and patient experience through the provision of non-face-to-face services."28 VPE will help transition general practice to a patient-centred medical home model, facilitating longitudinal care with the GP and the extended healthcare team.

[26] MBS indexation was 1.6% on 1 July 2022. Inflation in September 2022 was 7.3%. The Australian Government Department of Health and Aged Care. (8 April 2022). "July News". *MBS Online.* http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-220701#:~:text=The%20MBS%20indexation%20factor%20for,imaging%20services%20in%20Group%20I5; The Australian Bureau of Statistics. (26 October 2022). "Consumer Price Index, Australia: September Quarter 2022". https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release

[27]Healthdirect. "Understanding post-COVID-19 symptoms and long COVID". https://www.healthdirect.gov.au/COVID-19/post-COVID-symptoms-long-COVID

[28] AMA. (2020). *Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform*. Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform | Australian Medical Association page 12.

The AMA supported this policy when it was announced in the 2019-20 Budget with a $448.5 million investment over three years from 2020-21.[29] The AMA continued to support VPE and called for it to be extended to a broader population as a contributor to the development of Australia's Primary Health Care 10 Year Plan 2022–2032.[30] We were disappointed to see this plan announced in the March Budget with no funding.[31]

VPE is again under consideration by the Strengthening Medicare Taskforce. The AMA would like to see it introduced with a genuine strategy to improve patient outcomes and with appropriate funding attached.

2. **Indexing and uncapping the Workforce Incentive Program**

As noted earlier in the submission, indexing and uncapping the WIP will allow for general practice to provide much of the required collaborative, multidisciplinary care for patients with Long COVID in house.

3. **Adding and extended Level B consult**

The AMA is also advocating for an extended Level B consult. A Level B attendance item is the standard appointment you make with your GP and is the most commonly used GP attendance item. This item is for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward. The Medicare rebate will be the same amount regardless of whether you spend 6 minutes with your GP or 19. The rebate for a Level B (MBS Item 23) is $39.75.

The MBS has not been appropriately indexed for years which is making the provision of care harder and harder for GPs. In 2013–14, the rebate for a Level B was $36.30. Years of the Medicare rebate freeze and insufficient indexation since then mean that it has only increased by $3.45 in eight years.

Introducing an extended Level B, proposed for consultations 15-19 minutes in length, will encourage GPs to spend more time with patients by appropriately reimbursing them.

4. **Improving access to GP after-hours care.**[32]

Introducing and appropriately funding each of these measures would dramatically improve the ability of GPs to provide care for patients with Long COVID.

Keeping general practices open after-hours will also support general practice and encourage more care to be delivered by a patient's usual GP at times that are also convenient for patients.

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[29] The Commonwealth Government of Australia. (2020). *Budget Paper No.2 2019-20*. https://archive.budget.gov.au/2019-20/bp2/download/bp2.pdf

[30] The Australian Government Department of Health and Aged Care. (30 March 2022). *Australia's Primary Health Care 10 Year Plan 2022–2032*. https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032

[31] AMA. (29 March 2022). "Business as usual budget neglects non-Covid health needs". https://www.ama.com.au/articles/business-usual-budget-neglects-non-covid-health-needs

[32] AMA. (2022). "Modernise Medicare". https://www.ama.com.au/modernise-medicare/our-plan, AMA Pre-Budget Submission 2022-23 Chapter 4. https://www.ama.com.au/sites/default/files/2022-03/AMA%20Pre-Budget%20Submission%202022-23_Chapter%204_Primary%20healthcare.pdf

Unfortunately, current Medicare arrangements discourage GPs from offering in-clinic services after 6pm on a weeknight and on weekends.[33] This places additional burden on emergency departments.

Public Hospitals

Australia's public hospitals have been underperforming for years, as outlined in the AMA's public hospital report card series.[34] This problem was made worse by the pandemic and it will continue to deteriorate. The AMA was alarmed that the October Federal Budget cut the forward spend on public hospitals by $2.4 billion. While we understand that this was due to projections from the states and territories, the Government should have interpreted this as extremely worrying, not a positive for the budget.[35] It is inconceivable that with the large backlog of care that has developed over the period of the pandemic so far that service volumes are predicted drop in comparison to what was anticipated just a few months ago.

Throughout the pandemic, public hospitals have received additional funding from the Federal Government to cover the increased hospital costs. This funding is due to expire on 31 December. This level of 50-50 funding must not only continue but become permanent.

Australia's hospitals are in a critical condition. More than one third of Australians are waiting longer than the clinically recommended 30 minutes to receive emergency care. One in three patients is waiting longer than the clinically recommended 90 days for category 2 elective surgeries, like heart valve replacements or coronary artery bypass surgery.[36] Every state and territory in Australia fails to meet its own target on the time it takes to transfer patients from an ambulance into the care of the ED.[37] The number of available hospital beds per 1,000 people aged 65 years and over – an important measure of public hospital capacity – has been in a trend of decline for decades.[38]

If we are to successfully manage the new and repeat COVID infections on the horizon, the elective surgery backlog and the potential impact of Long COVID, we must urgently start repairing our public hospital system.

The AMA's key recommendations for fixing Australia's public hospitals:

1. **Increasing funding and remove funding cap**

The AMA would like to see the Commonwealth government increase their hospital contribution from 45 per cent to 50 per cent for activity (as per the soon to expire COVID-19 specific

[33] AMA. Out of hours primary medical care 2021 Position Statement. https://www.ama.com.au/sites/default/files/2021-12/Out%20of%20hours%20primary%20medical%20care%202021.pdf
[34] AMA Public Hospital Report Card 2022. https://www.ama.com.au/articles/ama-public-hospital-report-card-2022
[35] AMA. (27 October 2022). "Budget hospital funding reveals just how flawed current funding model is". https://www.ama.com.au/media/budget-hospital-funding-reveals-just-how-flawed-current-funding-model
[36] AMA Public Hospital Report Card 2022.
[37] AMA Ambulance Ramping Report Card. (2022). https://www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf
[38] AMA. (2022). "Public Hospitals: Cycles of crisis". https://www.ama.com.au/public-hospitals-cycle-of-crisis

partnership agreement), with State and Territory government being required to reinvest the 5 per cent of 'freed-up' funds on improving performance and capacity.

This must be accompanied by the elimination of the artificial 6.5 per cent cap on funding growth, so funding can meet community demand for hospital services as opposed to being capped.

2. Improving performance

The intention of reintroducing funding for performance improvement is to reverse the decline in public hospital performance. This funding must be in addition to activity-based funding.

3. Expanding capacity

The additional funding through the new agreement should be used for extra beds, to support hospitals to meet community demand, improve treatment times, and end ambulance ramping.

Additional funding from the Commonwealth does not mean that the states and territories can reduce their funding. The 'freed-up' fund must be reinvested into expanding capacity through improved processes.

4. Addressing demand

The AMA would like to see alternatives to out-of-hospital care funded, so those whose needs can be better met in the community can be treated outside hospital. Programs that work with general practitioners to address avoidable admissions and readmissions should be prioritised.[39]

General comment

By the time this Inquiry reports, some of the evidence and citations in this submission will be out of date. This is because we are still learning more about Long COVID and new diagnostic criteria and treatment protocols are emerging for review every day. This is positive and Australia has the infrastructure in place to translate the emerging evidence into guidelines and for these guidelines to be communicated to practitioners. What we do not have is the resources to support patients experiencing Long COVID to manage the condition.

The single best way to protect Australia against Long COVID is to fix our health system. We need to ensure our hospitals are staffed and resourced to continue to manage waves of COVID-19 infections while managing patients presenting with more serious health issues due to delayed care and the growing backlog of elective surgeries. We need to direct immediate and long-term support into general practice that has borne the brunt of COVID for almost three years and is now being asked to manage a condition with almost no other supports. Long COVID will also impact the private health system, with many private specialists already caring for patients with

[39] AMA. Local Hospital Networks and GP-led Primary Care Services Designed to Reduce Potentially Preventable Hospitalisations 2020. https://www.ama.com.au/position-statement/local-hospital-networks-and-gp-led-primary-care-services-designed-reduce

Long COVID. We cannot leave any part of the health system behind and we should ensure we use all of our resources appropriately.

As we learn more, we may be able to direct more of our resources to specific areas, for example medications or treatment plans. Right now, as the pandemic continues, we must put our efforts into the health system and limiting the spread of COVID-19.

November 2022