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AMA submission to the Senate Select Committee on COVID-19

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Contents

1. Key Points

The Australian Medical Association (AMA) makes the following key points regarding the Australian Government's response to the COVID-19 pandemic, and the Select Committee's inquiry:

Considering that this inquiry into the Government's Response to COVID-19 is being conducted during a period of transition out of physical isolation, quarantine, and other measures designed to mitigate and/or eliminate the spread of this disease, it is too early to make any real judgements and the inquiry can only deliver very preliminary findings at best.

The outcome and value of many Government initiatives (Federal and State/Territory) is unlikely to be fully understood until we are further into the pandemic, or when the pandemic has eased and Australia commences transitioning back to more 'normal' social, economic, and educational life.

The AMA is broadly very supportive of the measures, policies, and programs implemented by the Federal Government and the National Cabinet to manage the impact of the global pandemic in this country.

Through the leadership of the National Cabinet, Australia's low rate of infection and mortality (to date) indicates that Australia should be considered a world-leader in combating COVID-19.

The success of the National Cabinet in managing the COVID-19 crisis provides a very strong case for it to become a permanent feature of Australian politics.

The Government, Opposition, and minor parties have played an important role in depoliticising the response to COVID-19.

The early and decisions to declare a biosecurity emergency, and the closure of international borders (in particular, flights from China) reduced the rates of infection that we might otherwise have experienced.

The AMA strongly supported the COVID Safe App and the Government's communications campaign encouraging the population to download it.

The calibre of medical leadership is one of the main reasons Australia has been a world leader in managing COVID-19. In particular, the Chief Medical Officer, Professor Brendan Murphy, along with Professor Paul Kelly, Professor Michael Kidd and Dr Nick Coatsworth, have provided the authoritative medical expertise needed to guide Australia. They have been ably supported by State and Territory Medical Officers and Departments.

The Australian Health Protection Principal Committee (AHPPC) has operated efficiently, provided expert advice and made key decisions quickly to guide Australia through the crisis.

Any areas of concern for the AMA will likely be apparent post-pandemic, when the situation confronting the health sector, in particular the physical and mental health of the population, and the financial impact, will be better understood.

2. AMA Position on COVID-19

On 17 March 2020, the AMA Federal Council released a COVID-19 Communiqué outlining the issues the AMA identified as being crucial, and emphasising that 'the AMA believes the next stage of responding to COVID-19 requires strong medical leadership.' The Communiqué is copied below. The Committee may wish to consider how these identified issues were addressed by the National Cabinet.

2.1 Communication

Consistent, succinct and contemporaneous communication across all media from a single trusted source must be provided. The public has been receiving conflicting and inaccurate information about when they need to be tested, and how they should approach testing, and what comprises effective prevention and mitigation strategies. The messaging has been improving, but this confusion is causing undue community distress and system inefficiency.

Involvement of the medical profession at all levels in planning and disseminating the public health message is essential.

2.2 Prevention of spread

The national response should focus on a greater effort to slow the pace of COVID-19's spread in Australia as a means to 'flatten the curve' of the outbreak.

Australia must act to prevent community transmission by: effectively implementing the announced ban on mass public gatherings; encouraging social distancing; and, minimising social contact where alternatives are readily available (such as working from home, virtual meetings). Public education on effective and sensitive public distancing measures should focus on individual as well as institutional responsibilities.

Planning should be undertaken for potential advanced education centre closures, workplace restrictions, and the possibility of school closures.

Measures to ensure essential services and health service providers are adequately stocked and properly trained in the appropriate use of Personal Protection Equipment (PPE) must be an urgent priority. Access for healthcare personnel to sufficient PPE is still inadequate.

2.3 Vulnerable Communities

Communities identified as being vulnerable, and in which morbidity and mortality is expected to be higher, include: Aboriginal and Torres Strait Islander populations; people with complex and chronic disease, the elderly, persons in residential aged care; and, rural and remote populations.

We call for the limiting of non-essential travel to Indigenous rural and remote communities and ask that healthcare delivery be culturally safe. We also ask that rural health needs be considered with emerging COVID-19 related policy and care delivery decisions.

Preparation for potential virus spread in aged care must include clear, well-publicised, and timely action plans for response to concentrated virus outbreak in residential aged care centres or densely populated areas of older Australians to guide preventive and responsive actions for older Australians, aged care workers, the medical and wider health profession, and those with family members in aged care.

2.4 Medical Workforce maintenance and support

The health, safety, and wellbeing of all healthcare workers must be prioritised to maintain healthcare delivery capacity during the response to COVID-19.

Clear and consistent guidance on COVID-19 testing for health care workers is imperative and testing should be prioritised by pathology services to minimise periods off work due to isolation when not infected with COVID-19.

Preparation for a large proportion of the healthcare workforce needing to self-isolate or cease work due to exposure or illness, and resultant consequences for patient access to care, must be urgently addressed.

In order to minimise community spread of COVID-19 and maintain non-pandemic related health service provision, all doctors in private practice should have immediate access to telehealth for treatment of all patients, not just for screening and treatment of potential COVID-19 infection.

Doctors in private practice, both GPs and other specialists, must be involved in planning and implementation of the COVID-19 response, and clear, accessible and authoritative communication lines must be established.

Extraordinary workforce measures such as recruiting retired or semi-retired doctors and other health workers; reassigning healthcare workers including doctors out of their usual clinical fields; and, utilising medical students as physician extenders or clinical aides must be undertaken only with due consideration of clinical outcomes, personal and community safety outcomes, and without coercion.

Consideration of means to maintain the adequate education, assessment, and continuous professional development of all doctors, including those in training and medical students, is essential as is considering the impact of pandemic related workforce and training disruption on the continuing visa status of internationally trained doctors.

There must be planning for follow-up personal support for all health workers to ensure ongoing psychological wellbeing after this crisis has passed.

2.5 Protection of access to health care

A clear plan for the usual care of patients is needed for patients without COVID-19. It is essential that patients with other pressing clinical needs can access timely care.

The role of the Private Health system in relieving health system pressure due to COVID-19 needs to be included in planning efforts. Releasing the public hospital system from dealing with less acute health problems will help sustain access but will require whole of health sector coordination. For example, it is possible that public elective surgery may need to pause to enable capacity of the public hospital system to receive patients with COVID-19.

The AMA in 2016 called for establishment of a national Centre for Disease Control (CDC). The challenges currently being faced by the Australian community underscores the need for strengthened national coordination of pandemic response capability. Establishment of a CDC is essential at the conclusion of this current emergency.

3. Centre for Disease Control

In 2017, the AMA released a Position Statement calling for the establishment of an Australian National Centre for Disease Control (CDC). At the time, we stated that Australia needed to have a national focus on current and emerging communicable disease threats, and to engage in global health surveillance, health security, epidemiology, and research.

Australia is the only country in the OECD that does not have an independent or dedicated Centre for Disease Control.

Establishing a national CDC would enable Australia to play a global role in combating infectious diseases and potential threats. A national CDC would be able to manage pandemic threats in a more co-ordinated

manner. The AMA proposed that a CDC be properly funded and resourced to research, manage, and provide rapid risk assessments of communicable diseases, scientific briefings, surveillance reports, policy advice, and public education about potential disease threats and prevention measures.

The AHPPC has proved itself to be an effective vehicle in the absence of a dedicated CDC, and the AMA acknowledges their outstanding efforts in leading the response to COVID-19. The AHPPC has, in effect, acted as a de facto CDC.

In reviewing Australia's response to this pandemic, and the likely possibility that we will face further disease outbreaks, the AMA maintains that the creation of an Australian National Centre for Disease Control be investigated.

A CDC would have standard communication packages and resources prepared ahead of time. For example clear messaging on best practice for attending a general practice in the midst of a predictable droplet borne condition would have prevented significant confusion at the early stages of Australia's response, as well as reducing duplication of efforts which occurred in each State and Territory. Resources for clinicians, such as flow charts on the management of patients, were also developed in different jurisdictions in the early stages of the pandemic, creating some confusion.

The Australian public should remain comfortably reassured that everything that has been put into place by the National Cabinet and the AHPPC has protected the Australian community in the most effective and evidence-based ways from the wider spread of the coronavirus in this country. The AMA believes the AHPPC and the Chief Medical Officer have provided extraordinary leadership and advice, however we will continue to advocate strongly for a CDC when this current threat is suitably managed and has passed on from its immediacy.

4. Specific Issues related to the Government's Response to COVID-19

Australia moved early to activate its pandemic plan and progressively close its borders. These high-level decisions played a significant role in slowing the spread of COVID-19. However, it is obvious that we were not as well prepared as we could have been at the local level. PPE shortages, mixed messaging, failure of state/territory governments and health departments to properly engage with their workforces, limited early communication to the health sector and the longstanding failure to properly integrate general practice into pandemic planning processes meant that there was a lot of initial confusion and widespread concern that COVID-19 remained one step ahead of decision makers and that the health and wellbeing of frontline health professionals was at significant risk.

While the restrictions imposed by governments through the National Cabinet process have clearly suppressed the spread of COVID-19 and provided time to resolve many of the issues outlined above, Australia may not be so lucky next time. It is important that moving forward we review our pandemic planning and ensure that we learn from the lessons of this outbreak.

4.1 Impact on GPs and GP clinics

The AMA supported the Federal Government's JobKeeper package, along with other measures announced to support small business, as these allowed many medical practices to continue to provide vital healthcare services and advice to the Australian community during the COVID-19 crisis. Thousands of medical practices – general practices and other specialty practices – were not immune to the economic impact of COVID-19, just like every other small business in Australia.

The AMA notes that medical practices are important members of every local community in Australia, but some had to consider laying off staff due to the significant changes to their operating environment. Without this kind of support from the Government, the viability of many some practices would suffer.

The Committee would be aware that when the pandemic struck, medical appointments were cancelled across the country due to patients' fears of catching COVID-19 at medical practices. As the spread of COVID-19 lessens, we need to ensure that medical practices, like any other business, are ready to emerge on the other side of this crisis to continue delivering high quality patient care. Early reports indicate that patients are presenting with 'shopping lists' of healthcare issues they have delayed addressing due to COVID-19.

The support options made available through JobKeeper and other initiatives have helped GPs deal with the economic challenge that COVID-19 presents, specifically increases to the bulk billing incentive and practice incentive payments. Careful consideration needs to be given to avoiding a 'snap back' as many of these measures will end in September. If medical practices face the sudden loss of a range of financial supports, this may threaten their ongoing viability. With unemployment likely to reach ten per cent before the end of the year, there is no doubt that support for patients to access care will need to continue.

The AMA was outspoken about the decline in GP appointments to access usual care, noting in media releases and interviews that the consequences of not seeing your doctor for usual care could be life-threatening for many patients. A consequence of the initial isolation measures was a marked drop in GP consultations for usual care. The AMA expressed concern that any failure in monitoring patients with existing conditions could lead to their conditions getting much worse. Specific conditions, such as Type 2 Diabetes, could end up with unplanned visits to hospitals or, in some cases, lifelong or life-threatening complications if not controlled.

It must be noted that GPs and their clinics undertook all appropriate and necessary measures to protect themselves and their patients from contracting COVID-19. Medical practices adapted quickly and sensibly to the challenges that COVID-19 created. Strict infection control measures including phone triaging and, in some cases, separate clinic entrances and exits, were deployed. GPs and other medical specialists quickly adopted telehealth to treat patients who did not require a face to face visit. Waiting rooms around the country adapted to cope with the requirements of health authorities to keep people safe. Chairs were spaced 1.5 metres apart, magazines and communal toys were removed, and separate areas for suspected COVID-19 patients established. Patients with potential COVID-19 symptoms were directed to call ahead and not to drop in to practices unannounced.

Medical practices did everything they could to ensure that the chances of coming into contact with the virus were extremely low, if not negligible. We do not yet have data on the impact (if any) of increased medical problems arising from people who delayed seeing their doctor, or not going at all. This is a subject that requires further investigation.

4.2 Telehealth

The AMA played a significant role in brokering the breakthrough agreement with the Federal Government for expanded telehealth access to general practitioners and other medical specialists that allowed for continuation of normal patient care and reduced the need for scarce PPE.

The $669 million agreement for new telehealth arrangements allowed even more patients to have consultations with GPs and some other medical specialists without leaving home. The AMA welcomed

this announcement, which ensures that telehealth is widely available so that patients can access care without the risk of exposure to or spread of the coronavirus.

The telehealth arrangements support patient consultations that do not require a physical examination. In the context of a pandemic and physical isolation measures, telehealth encourages and supports patients to maintain their home isolation. Importantly, it means that doctors can conduct telehealth consultations from their practices or while they themselves may be in home isolation. Telehealth measures reduced public hospital presentations that could have occurred without this initiative.

Critically, the telehealth announcement also reduced avoidable use of PPE. Prior to the telehealth agreement, doctors required PPE for any patient with symptoms suggesting potential COVID-19. Because telehealth consultations require no PPE, this freed the scarce supply for use elsewhere in the health system.

While the Federal Government adopted a staged approach to the introduction of telehealth, it was obvious from very early on that patients needed to be given broad access to telehealth services. The AMA also had to work to address concerns over mandated billing requirements for telehealth which, in some cases, threatened the viability of some medical practices. Overall, patients are overwhelmingly embracing telehealth as an important part of their health care management, making a strong case for the Federal Government to make the COVID-19 telehealth reforms a permanent feature of our health system.

4.3 Electronic Prescribing and Interim Special Arrangements

The Federal Government has announced that it will fast-track the implementation of electronic prescriptions (ePrescriptions) by mid-2020. ePrescriptions enable patients to share their prescription electronically with the pharmacy. The AMA is working with the Federal Government throughout this process.

While ePrescriptions are not yet available, to reduce the risk of COVID-19 transmission, a number of special arrangements were implemented to complement telehealth services.

Commonwealth legislation allowed prescribers to still write and sign a paper-based prescription, however a digital image or PDF of the entire prescription could be created to send via email, text, or fax. This would be sent directly to a pharmacy of the patient's choosing. The prescriber must keep the paper prescription on file for two years for audit and compliance purposes. Originally the requirement was for prescribers to send the original prescription to the pharmacist via mail following transmission of the electronic copy, however this was inefficient and administratively burdensome for prescribers and the AMA called for a change. Pharmaceutical benefits under Schedule 8 and under Schedule 4, Appendix D in the Poisons Standard are not covered under the Special Arrangement.

The AMA considers fast tracking ePrescribing and the Special Arrangement important steps to reduce the risk of COVID-19 transmission. Electronic methods of prescribing reduce the need for patients to come into a medical practice unnecessarily, and, in conjunction with telehealth and pharmacy home delivery services, reduce the need for vulnerable patients to leave their home to receive medication.

While the Commonwealth acted quickly, the Special Arrangements were dependent on changes to the legislation for each jurisdiction. Some jurisdictions did not exactly reflect the Commonwealth policy, which caused delays and confusion in the medical profession. Queensland experienced significant delays in allowing digital image-based prescriptions. For quite some time, this was not available for medical practitioners due to Queensland legislation not being aligned until 18 May, despite the changes made by

the Commonwealth on 26 March. This caused confusion for Queensland practitioners who may have assumed they had access to the same electronic prescribing options as the rest of the nation. Fortunately, the Queensland legislation has been applied retrospectively from 26 March.

Finally, there is variation in which medicine Schedule (or specific medication) that can be prescribed via the Special Arrangement for all States and Territories. There was also variation in the type of electronic method that can be used (e.g. NSW prohibited text message and digital signatures). The AMA would suggest improved coordination of the jurisdictions to align with Commonwealth initiatives more quickly and consistently, especially when the changes are time-sensitive and are beneficial to the fight against COVID-19. The AMA recognises and supports the swift way in which the Commonwealth Department of Health acted to introduce this interim electronic prescribing option, while working on a permanent, integrated ePrescribing change.

4.4 Aboriginal and Torres Strait Islander peoples

During the early stages of the pandemic, the AMA called for Aboriginal and Torres Strait Islander people to be a top priority in national measures to control COVID-19. Aboriginal and Torres Strait Islander people have a higher susceptibility to COVID-19 due to higher rates of underlying chronic diseases, overcrowded living conditions, lack of food security, inadequate income, and other social determinants of health such as water access.

As outlined in our media commentary, the AMA heard from frontline doctors working in Aboriginal and Torres Strait Islander communities that they are significantly under-resourced and would not be able to cope if COVID-19 spreads in these areas. One AMA doctor on the frontline said, if COVID-19 enters Aboriginal and Torres Strait Islander communities, particularly in remote areas, they face the prospect of not being able to provide proper care and avoidable deaths will occur. A major concern for the AMA was that contracted medical services and their staff were being withdrawn from Aboriginal communities, and doctors in these areas were preparing for death and suffering because they did not have the resources to evacuate very ill people.

Whilst the AMA is supportive of the Federal Government's existing measures to help combat COVID-19, which includes over $50 million for telehealth services for Aboriginal and Torres Strait Islander people, and increased capacity for remote communities to prevent outbreaks through screening fly-in and fly-out workers, supporting the evacuation of early cases, and mobile respiratory clinics, further targeted measures for Aboriginal and Torres Strait Islander communities are necessary.

The AMA recommends a dedicated pool of funding for Aboriginal and Torres Strait Islander communities and organisations to draw on for specified purposes including the procurement of PPE, point-of-care tests, staffing and consumables, capital expenditure, isolation and quarantine facilities, and satellite and outreach services to address current service gaps. Importantly, the amount of funds allocated to this funding pool should be considered on a needs-basis.

Given Aboriginal and Torres Strait Islander peoples comprise three per cent of the total population, and the burden of disease is 2.3 times higher than non-Indigenous Australians, it is reasonable that a benchmark amount of around seven per cent of total COVID-19 health funding be earmarked for Aboriginal and Torres Strait Islander peoples.

Testing is critical, and it must be an urgent priority to ensure that every Aboriginal and Torres Strait Islander health service is provided with testing kits, the associated consumables, and the necessary training. Specialised Indigenous health services and programs that respond to the needs of the majority

of Aboriginal and Torres Strait Islander people who live in cities and towns must be made a priority and properly funded to provide greater protections coming out of this pandemic.

4.5 Mental Health

The AMA recognises that mental health policy and responses during COVID-19 are very complex and fraught, given that such a widescale pandemic is a phenomenon unknown in modern times. All governments endeavoured to respond accordingly, however the AMA believes that the National Mental Health Commission could have acted sooner and more assertively in leading the national response. It is also important to note that Australia's mental health system was already under stress before the COVID-19 pandemic. As the AMA and mental health experts publicly noted, urgent investments and reforms are needed to build a system capable of managing current and future mental health care.

The AMA and other key stakeholders were not contacted by the Mental Health Commission for input into the National Mental Health and Wellbeing Pandemic Response Plan until the first week of May. This work should have been undertaken much earlier, as millions of people had already been living under isolation and physical distancing for many weeks. This also meant that the AMA had a short timeframe to input into a plan of such national significance. As such, the AMA has some concerns about the National Plan, while supporting its general goals.

The AMA's submission noted the need for specific measures that would renew and expand the focus on the mental health of the population to address the needs of Australian citizens and residents as they emerge from the health and social effects of the pandemic. The AMA has publicly stated that the unprecedented nature of the pandemic, and the control measures enacted at the jursidictional and Federal level, will affect people in different ways; ranging from general stress, worry and concern to more serious mental health issues requiring clinical pathways to appropriate treatment.

The AMA notes that there are certain groups in the community who may be suffering more acute mental health issues. These include:

- people with pre-existing mental illnesses;
- those encountering higher levels of stress and uncertainty (including the recently unemployed or under-employed, and those with less stable or secure housing);
- frontline and essential workers, including health workers;
- the vulnerable and socially isolated, including those with severe mental illness;
- the elderly, both in the community and in aged care facilities; and
- children and young people, who are experiencing a disproportionate economic burden.

The new measures announced by the National Cabinet will be welcomed by the dedicated public and private mental healthcare services and practitioners who provide the best care they can. The AMA called for a national communications campaign, and we are pleased that the National Cabinet has supported this.

However, the AMA believes the National Plan should contain specific measurable outcomes, timeframes, key performance indicators, and other indicators that track and measure deliverable services. These are missing from the current plan.

There is, for example, no indication of increase in psychiatric beds required to meet demand, or the number of home visits by clinicians. There is no workforce strategy that outlines how outer-metropolitan, regional and remote se services will be delivered to the millions of people experiencing well-being and mental health problems as a result of the pandemic.

The AMA supports the initiative to gather information co-operatively and prospectively on the mental health impacts of the COVID-19 pandemic and public health measures, however, increased mental health care demand is already evident, and immediate action needs to be taken.

The AMA supports the initiative to reach out to vulnerable communities, but we want to see further direct action for these vulnerable groups such as increased staffing for the current increased demand to existing mental healthcare services.

The AMA agrees co-ordination is essential, but it is only relevant if mental healthcare services are adequately resourced to meet demand. The specific recommendations in the Plan are not adequate.

There has not been an effective population mental health approach despite over two months of COVID-19 pandemic public health measures. In particular:

- There has been little to no response to address mental health issues in the community.
- There has been no specific planning to identify and respond to likely demand for mental health services.
- Existing structural problems in governance of public mental health services (federal-state divides) have not been addressed and impede coordination of services.
- Outreach resources as the Mental Health Commission proposes are insufficient to meet existing needs.

The AMA strongly believes that there is a greater role for general practice in supporting Australia's mental health. Many health professionals, including GPs, psychiatrists, and emergency physicians, are seeing significant growth in the number of patients seeking treatment and support for their mental health.

General practitioners are best placed to manage the increased demands for mental and related physical health care. This has not been given sufficient emphasis in the National Plan. We can find only one reference to the role of General Practitioners in the 51-page document.

Not everyone will need clinical help; GPs are, and always have been, the most appropriate 'first call'. It is the GP who can assess and assist in the referral pathways to other clinical care, and also help patients manage other health issues that have arisen during this unique period. The AMA wants this Plan to actively support the role of GPs.

Private health practitioners in psychiatry, psychology and allied health have been actively providing care for patients with existing and new mental illness during the COVID-19 pandemic, rapidly shifting to flexible modes of care such as telehealth, and private psychiatric hospitals have been providing ongoing comprehensive mental healthcare during the response.

We will need increased resources to deal with the widespread impact of the COVID-19 virus. Due to decades of under-resourcing and under-staffing, public mental healthcare services were struggling to deliver accessible and high-quality care before the COVID-19 crisis.

Dedicated public mental healthcare services and practitioners have continued to provide the best care they can, within these constraints, during the crisis.

Private mental health services were providing high quality services to enhance care for persons with severe mental health services and have continued to do so during the COVID-19 crisis.

General practice, psychiatry, psychology, and community mental health services must be sufficiently resourced to meet the increasing demand for comprehensive, increasingly integrated services across the public and private sectors.

It is vital that clinical services are able to cope with what is likely to be unprecedented demand, in the short and longer term. The Plan does not detail a workforce strategy to meet demand.

As mental health needs become clearer in coming weeks and months, the AMA remains willing to assist the Federal Government in designing and delivering appropriate clinical responses. The matters raised in our submission are offered in this spirit to ensure Australians are given the best possible support and clinical care as we emerge from COVID-19**.**

5. Specific Issues that the AMA advocated for a focus on

5.1 Communications Campaign

Citizens and residents in Australia are currently being impacted, and will continue to be so, by isolation measures and physical distancing restrictions. There is also the massive, and as yet not well understood, impact from mass unemployment, loss of income, financial stress and social and emotional effects (caused directly and indirectly by COVID-19).

The AMA proposes that a national, public communications campaign be immediately created to inform and advise the population about current and future policies that will transition them and the community out of the pandemic.

The AMA is concerned about the impact of COVID-19 on people's mental health and wellbeing across the age range, and whether the mental health sector is equipped to cater for anticipated increased demand for services. As we will continue to encounter the medium and long-term social and economic disruptions caused by the pandemic, pressure on all mental health service providers will increase.

Governments can reassure the population and alleviate some of their worries through a communications campaign detailing clinical and other supports and services that can be accessed. This is particularly critical for young people, who are carrying more of the burden of COVID-19 with disruptions to the education, employment, and emotional and cognitive development.

A public communications campaign should address five areas:

1) Clinical pathways and access to mental health care, advice and support.
2) Issues that are impacting on public mental health and well-being, such as employment, housing, financial hardship, relationship stress, domestic violence, alcohol and substance misuse.
3) Assisting young people, many of whom were in casual employment and have lost their jobs, transition back into education, employment and normal socialisation.
4) Encouraging people to look after their health, given the established fall of in diagnostic testing and the failure of many people to access face to face GP services, particularly for more complex conditions.
5) Clearly communicate temporary and permanent policy and legislative changes to the public.

5.2 The Role of General Practice

A well-equipped GP-led Primary Care Sector is of vital importance in managing pandemics and the evidence to date would suggest that our strong primary care system has helped us to avoid the experience of other similar countries in tackling the pandemic.

The AMA advocated early for the introduction of broad telehealth services to provide continuity of care while ensuring that patients seeking care for potential coronavirus infections could be treated maintaining the safety of doctors, patients and practice staff. The AMA has welcomed the new MBS telehealth items and is now working to ensure that telehealth remains available to all Australians in a reasonable format into the future.

Access to PPE has been a prolonged issue for general practice, however the AMA acknowledges that global shortages and other external factors have impacted this. Increased access to telehealth has eased the necessity for some PPE, but the AMA has continued to receive reports of shortages not just of masks, but of gowns and gloves as well. The AMA has received some reports of exorbitant pricing for basic PPE which should be investigated in the future.

GP respiratory clinics have been a useful tool to ensure widespread appropriate testing is available. The Federal Department of Health's rapid roll-out of GP respiratory clinics across Australia, combined with State/Territory responses, Australian Defence Force clinics, and Aboriginal Community Controlled Health Organisation clinics have allowed GPs to continue providing regular care to their patients while ensuring patients have timely access to testing

As the pandemic progresses, the AMA's focus is turning to ensuring that patients continue to receive their regular care from the usual GP or practice. Maintaing telehealth will be essential for this.

The AMA is also focusing on the mental health impacts of COVID-19. Many health professionals, including GPs, psychiatrists, and emergency physicians, are seeing significant growth in the number of patients seeking treatment and support for their mental health.

GPs are best placed to manage the increased demands for mental and related physical health care. Not everyone will need clinical help; GPs are, and always have been, the most appropriate 'first call'. It is the GP who can assess and assist in the referral pathways to other clinical care, and also help patients manage other health issues that have arisen during this unique period. The AMA wants the Plan to actively support the role of GPs under the 'Principles for delivery of mental health care in COVID-19 pandemic response and recovery'.

5.3 Resourcing

The AMA's position is that we will need increased resources to deal with the widespread impact of the COVID-19 virus.

General practice, psychiatry, psychology, and community mental health services must be sufficiently resourced to meet the increasing demand for services. It is vital that clinical services are able to cope with what is likely to be unprecedented demand, in the short and longer term.

The AMA has identified other priorities for Mental Health in COVID-19:

- Alternatives to Emergency Department presentations, and active deployment of hospital in the home alternatives to acute hospital admission.
- Public mental health services (hospital, acute and community sectors) must have enhanced resourcing and staffing to provide care for the increased mental healthcare demands of the COVID-19 public health crisis.
- Acute hospital, rehabilitation, and long-term bed capacity must be expanded and commensurately staffed to address bed block from increased emergency department mental health presentations.

- Community mental health services must also be expanded and commensurately staffed to provide comprehensive care.
- Rapid development of metropolitan and rural outreach telehealth resources (videoconferencing) and administrative support specifically for mental health consultations, which is currently lagging in public mental health services.

There must be collaborative arrangements between public and private psychiatric hospitals and services analogous to the COVID-19 arrangements for public and private general hospital services.

As social distancing measures and travel restrictions are likely to continue, the ongoing extension of the COVID-19 telehealth provisions to metropolitan areas is necessary to provide more accessible, high-quality mental health are across private and public sectors.

Ongoing telehealth provision and deployment of new digital health services, and the related infrastructure, is particularly needed in rural and regional areas, and disadvantaged communities.

Specific, adequately resourced and staffed mental health support and care is essential for all healthcare workers (doctors, nurses, allied health) across public and private sectors working during the COVID-19 crisis, including the frontline of COVID-19, general medical/surgical services, and mental healthcare professionals.

5.4 Aged care

The AMA closely monitored the developments in aged care in relation to COVID-19. Following the Federal Government-issued guidelines for prevention and management of COVID-19 outbreaks in residential aged care facilities (RACFs), the AMA lodged a submission containing suggestions for improvement. These improvements were then communicated to the Chief Medical Officer Dr Brendan Murphy and the Aged Care Quality and Safety Commissioner, Ms Janet Anderson. The AMA is also preparing a submission to the Royal Commission into Aged Care Quality and Safety on COVID-19, which the Committee should also consider once published.

The AMA provided recommendations for improvement in the following areas:

Lowering the threshold for COVID-19 testing in RACFs. In the AMA view, testing should occur when the first resident has symptoms, as outbreaks in RACFs have the potential to spread quickly with large mortality rates. There was variation in the testing threshold across jurisdictions. The AMA also fully supports the option of testing asymptomatic residents and workers in aged care if there is a positive case in the RACF.

Unification of rules around testing of RACF residents nationwide. The AMA members noted that different states had different testing rules for RACFs, even though all COVID-19 patients presented with same or similar symptoms regardless of the state they lived in.

Improved guidance around cohorting of residents in RACFs. The AMA suggested further clarification around the rules to allow for residential aged care operators to have designated COVID-19 RACFs, where COVID-19 infected patients are cared for by dedicated COVID-19 staff. In the AMA view, such an approach could help to reduce COVID-19 transmission to uninfected staff and residents. The AMA suggested that specialised facilities which would be expertly staffed, well resourced, supported by volunteer GPs, palliative care nurses, palliative care physicians and geriatricians who can ensure that frail elderly residents do not suffer, should be considered. Advance Care Directives (ACDs). The AMA reiterated the importance of ACDs in aged care in a situation of a pandemic and called for greater support for GPs in the future in developing and implementing ACDs for RACF residents.

Palliative care in RACFs. The AMA called for improved guidelines around palliative care provision in RACFs for COVID-19 patients. This was prompted by past experiences of AMA members with RACFs refusing to provide palliative care, on the basis of a critical nursing shortage. The AMA called on the Government to ensure that RACFs have adequate staffing and supplies/quantities of palliative medicine available, arguing that, for example, subcutaneously administered palliative care medications to patients who need it should be provided in RACFs by nurses who are trained to do it.

Specialist appointments for RACF residents. AMA members shared their experiences of patients in RACFs missing their specialist appointments due to strict lock down rules implemented by some RACFs. The AMA called for clear guidance to RACFs and doctors to be provided which outlines what medical appointments their residents/patients should continue to go to.

Finally, the AMA raised the issue of medical care provision in RACFs in rural and regional areas, where doctors, most commonly GPs are required to staff the hospital, accident and emergency, and aged care. The AMA therefore suggested that perhaps a process for recruitment/training of younger doctors should be established, who would visit RACFs and be supervised by the patient's usual GP via telehealth.

5.5 Medicine shortages and patient stockpiling

The AMA communicated to the public that stockpiling medicines is not necessary, after several reports of medicine shortages at the pharmacy level throughout Australia. It is essential that the public does not stockpile medicines to ensure there is equitable access for everyone. It is vital that people can obtain the medication that they need to stay well and to prevent significant health complications. In some cases, patients who cannot access the medications they need may risk death. If individuals stockpile medicine, there is a risk that the unused medication will become out of date and therefore cannot be used.

Several restrictions and regulations were put in place to prevent and manage medicine shortages as a result of medicine stockpiling. This included pharmacy dispensing restrictions, continued dispensing arrangements, and prescribing restrictions. The AMA supports these restrictions and regulations, and had flagged a number of them as being required early on.

The AMA received reports from the Government and stakeholders that increases in Regulation 49 prescriptions (where a patient can receive the original and repeat quantities of a medication at the same time) has occurred and quickly called for its members to adhere to the Regulation 49 prescription criteria, emphasising to practitioners the strict criteria for its use.

The AMA received several calls and emails from concerned members of the public regarding medicine shortages. Hydroxychloroquine shortages were a particular concern for AMA members and their patients. There were media reports of hydroxychloroquine being used as a potential treatment for COVID-19, which were also promoted by the President of the United States of America. Clinical trials are being conducted on an international level, however at the time of writing, there is not enough evidence to use hydroxychloroquine on a national-wide scale. Hydroxychloroquine can have significant adverse effects. For example, cardiac toxicity (which may lead to heart attack), irreversible eye damage, and severe depletion of blood sugar (which may result in a coma). Further, hydroxychloroquine is used to treat malaria and some autoimmune conditions such as rheumatoid arthritis and lupus. The AMA received several reports from patients who could not get their medication for their indicated condition.

AMA members received requests from patients for hydroxychloroquine prescriptions for the purpose of stockpiling the medication. The AMA raised this issue quickly with the Department of Health and the Therapeutic Goods Administration (TGA) and communicated the issue to its members. The AMA

supported the restrictions that followed, including that only particular specialists could initially prescribe hydroxychloroquine.

The AMA continues to participate in the TGA Medicine Shortages Working Party weekly teleconferences relating to COVID-19. The AMA considers the Working Party an essential avenue for medicine stakeholders to work together to monitor and manage medicine shortage issues in relation to COVID-19.

A strategy arising out of this working party included therapeutic dose, form, and strength substitution at the pharmacy level. This allows pharmacists to substitute a patient's medication with a different dose, form, or strength, without seeking prior permission from the prescriber when a medicine shortage is determined by the TGA. The AMA supported these changes for the COVID-19 period, however some stakeholders believed therapeutic substitution within a class (without prior permission from the prescriber) should be supported. The AMA opposed this option on the grounds of patient safety. Pharmacists do not know a patient's full medical circumstance and so any substitution will be dangerous. There are still significant differences between medication within a therapeutic class (for example, centrally acting vs peripherally acting calcium antagonists).

5.6 PPE (access, availability, use)

PPE shortages have been acknowledged as a significant issue during this pandemic. Doctors have been concerned about the lack of access to basic PPE like masks, gloves, gowns and goggles as well as differing jurisdictional advice as to the appropriate use of PPE.

There has been a lack of transparency with respect to the availability of PPE at both national and state/territory level and many parts of the private sector have been unable to access PPE. This had a significant impact on the mental health and wellbeing of health care workers.

While the Federal Government has done a tremendous job in seeking to address the shortage of masks, we know that access to other PPE remains problematic. The distribution of PPE by Primary Health Networks to general practice has proven to be problematic.

The adequacy of the supply of PPE for this and future pandemics needs to be closely examined in relation to available quantities, the type of PPE being stockpiled, as well the performance of available distribution channels.

5.7 Elective Surgery (restrictions & lifting of, impact on patients)

On March 24 the AHPPC recommended cancellation of all nonurgent elective procedures in both the public and private sector due to the concerns around the level of PPE and the continued depletion of the National Medical Stockpile. They recommended that only Category 1 and some exceptional Category 2 surgery proceed after 1 April 2020.

Whilst not consulted, the AMA supported the principle of increasing preparedness to manage the growing COVID-19 cases and ensuring that stocks of PPE and pharmaceuticals used in ICU and for patients on ventilators were available for critical cases. This announcement saw the surgery levels plummet across Australia, which of course has an impact on the viability of private hospitals and with-it reducing capacity across the health sector.

On March 31 the Australian Government announced a partnership with the private hospital sector whereby the Government would offer agreements to all private and not-for-profit hospitals to ensure their viability, in return for maintaining capacity during the COVID-19 response. Included in these

viability payments was funding for staff to be kept on at private hospitals (even in the absence of patients) so that this capacity was not lost to the system.

In addition to this viability funding, state and territory governments were also able to enter into private hospital COVID-19 partnership agreements to purchase surgical capacity for public patients. The Federal Government agreed that it would increase it contribution to 50% for these patients. State and territory governments have pursued different paths to reaching these agreements and at the time of writing this submission not all jurisdictions have agreements in place, and agreements vary by state and territory.

Some jurisdictions (sometimes with the assistance from their local AMA) are likely to enter into whole state/territory agreements covering all private hospitals. Other jurisdictions are choosing to adopt a hospital by hospital approach. However, one outcome is clear – the health system ends up with different arrangements and therefore different pricing and implementation regimes across the country, and in some cases across a single jurisdiction. One area where a further improvement can be made is to improve how quickly, and consistently, arrangements can be realised at a jurisdictional and local hospital level.

In consultation with the AMA on 22 April the Federal Government announced the easing of elective surgery restrictions from 27 April, starting with hospitals initially recommencing one in four closed operating lists, with a focus on Category 2 and some important Category 3 surgeries. Selection of patients is based on clinical need.

Further, on May 15 the National Cabinet announced the reopening of elective surgery activity in an incremental and cautious way, while maintaining necessary ICU capacity for any localised outbreaks of COVID-19. Increases to the level of elective surgery are balanced against on ongoing suppression of COVID-19 in the community and the continued evaluation of medical and protective supplies. The increasing level of COVID-19 cases throughout the world is placing pressure on the ability of governments and hospitals to source suitable protective gear, but potentially also the drugs required both for surgery but also the treatment of COVID-19 patients on ventilators.

In its decision, National Cabinet agreed to reopen elective surgery, by removing restrictions and restoring hospital activity involving 3 stages. It is a decision of each jurisdiction to determine which stage applies to its circumstances, the timeline for implementation and the level of normal surgical activity is safely restored in line with the agreed principles. The stages are:

Stage 1 – up to 50 per cent of normal surgical activity levels (including reportable and non-reportable);

Stage 2 – up to 75 per cent of normal surgical activity levels (including reportable and non-reportable);

Stage 3 – up to 100 per cent of normal surgical activity levels (including reportable and non-reportable) or as close to normal activity levels as is safely possible.The level of elective surgery will be reviewed monthly from May 2020 by the Australian Health Ministers' Advisory Council (AHMAC), to ensure that it remains safe and sustainable, and in line with the agreed principles.

Whilst the impacts of the pandemic are ongoing the AMA would like to highlight that many practitioners around Australia have been without incomes since March, and at the time of writing are still on significantly reduced incomes – and yet their costs, such as rent and indemnity insurance payments remain.

The other likely outcome from the elective surgery 'pause' will be increased waiting lists for elective surgeries around the country. More than 67,000 elective operations were postponed in the six weeks

that all non-urgent surgery was suspended in Australia.[1] Recent AMA public hospital report cards have shown a bleak picture regarding elective surgery wait times, where decreased funding has been causing waiting lists to lengthen. Public hospitals have also decreased their elective capacity over the last couple of months which will put greater pressure on our already stretched public hospitals. Thankfully, Australia's response to COVID-19 has been successful, but there is no doubt our public hospital capacity can always be improved, as we expect additional elective surgery delays now for our patients.

5.8 Private Health Insurance

In its 17 March COVID-19 Communiqué, the AMA recognised the possibility that some elective surgery in public hospitals may need to pause during the pandemic while highlighting that this needed to be balanced with patients' access to timely care.

With the March 24 announcement that only Category 1 and some exceptional Category 2 surgery proceed after 1 April 2020, the AMA supported private health insurers when they announced that they would not be increasing their premiums for at least six months. The AMA also supported insurers when they announced coronavirus hardship support arrangements for members and that any additional profits resulting from the cancellation of elective surgery and some allied health services will be returned to members.

5.9 Changes to the National Scheme Governing Health Practitioner Regulation

At the request of Health Ministers, the Australian Health Practitioner Regulation Agency (AHPRA) and National Boards established a short-term pandemic response sub-register for up to 12 months to fast track the return to the workforce of experienced and qualified health practitioners. The pandemic response sub-register came into effect on 6 April 2020. The AMA supported the development of the register on the basis that it was voluntary as to whether a retired practitioner took up the opportunity – they were not compelled to, if they felt they were no longer in a position or it was appropriate to practice medicine.

The sub-register operates on an opt-out basis with eligible practitioners added to the pandemic sub-register automatically. There is no obligation for anyone added to the sub-register to practise or remain on it. As at 21 April 2020 there were 3,440 medical practitioners on the sub-register.

AHPRA has increased the meetings of its consultative Professions Reference Group from quarterly to fortnightly while dealing with the pandemic. This has allowed groups like the AMA to consult on a wide range of changes AHPRA has brought in in response to COVID-19. Key among these is the sub-register outlined above but also changes such as:

- student clinical education requirements;
- continuing professional development;
- registration processing;
- intern rotation requirement; and
- international medical graduate registration requirements.

[1] Nepogodiev, D. and Bhangu, A. (2020), Elective surgery cancellations due to the COVID -19 pandemic: global predictive modelling to inform surgical recovery plans. *Br J Surg*. Accepted Author Manuscript. doi:10.1002/bjs.11746

The AMA advocated to AHPRA for an approach that balanced the requirements of focussing on the pandemic while minimising the negative impact on medical practitioners. The AMA particularly advocated for steps that would minimise the impact on medical students and doctors in training.

5.10 Medical Indemnity

Medical indemnity surfaced as an issue for the AMA in several ways through the pandemic. The AMA led coordination efforts so that responsible Government agencies could work with Medical Defence Organisations (MDOs) to resolve emerging issues.

Firstly, medical practitioners questioned whether they were fully covered by their indemnity policies for telehealth consultations – the AMA confirmed this with the MDOs. In returning medical practitioners to the workforce from retirement, the AMA advised the Department of Health that they would need to review the arrangements they have in place for medical indemnity run off cover.

The Federal Government rushed through changes to the regulations so that retired practitioners returning to work for the COVID pandemic will retain this critical coverage. Medical practitioners who come out of retirement must ensure they have current indemnity insurance. The AMA reinforced the need to communicate this message to all practitioners with AHPRA and the Commonwealth Department of Health. Finally, State AMAs have been working with State Governments and Private Hospital groups regarding indemnity coverage for private practitioners treating public patients in private hospitals, under the National Partnership agreement.

5.11 Rural and Remote response

The AMA's major concerns for rural and remote doctors during the COVID-19 pandemic have been access to PPE, appropriate telehealth supports, and acknowledging the specific challenges faced by rural and remote communities. The AMA has provided direct feedback on these issues through attendance at the rural stakeholder roundtables Chaired by Minister Coulton, and through other weekly primary care key stakeholder meetings with the Department of Health.

Overall, the AMA has been satisfied with the planning and response, noting that PPE has been a universal issue. The early closure of remote communities created some challenges, particularly for continuity of care, however these have been managed relatively well. Contingency plans for outbreaks in remote communities fortunately have not had to be tested yet. The AMA is satisfied with the retrieval plans for COVID and non-COVID patients.

Moving forward, it is likely that there will be some issues emerging as a direct result of the impacts of COVID-19 on the Australian rural medical workforce. International medical graduates (IMGs) constitute a larger percentage of rural doctors; many were stranded overseas when travel restrictions were introduced. The AMA was pleased that the Department of Home Affairs created pathways for these doctors to return to Australia, however the lack of flights has meant that many have been unable to return.

The training of Australia's future medical workforce has also been interrupted. While it is too soon to say what the outcomes will be for the current medical students, prevocational and vocational trainees, it is almost certain that there will be some disruption in the training pipeline.

Internet access was another major concern for the AMA. Access to reliable broadband internet has been an issue for years prior to the COVID-19 outbreak, but with the introduction of telehealth and remote communications, it became more important. The AMA welcomed NBN Co's waiving of charges for additional capacity of up to 40 percent in March and the extension of this measure until July.

5.12 Outbreaks in group living facilities

The AMA supports actions that reduce the number of people held in places of detention or where vulnerable people are forced into group living. Aboriginal and Torres Strait Islander people, elderly people, people with chronic health conditions, people living with disability, people with mental health conditions, children, young people, pregnant women, primary caregivers for young children, refugees and people seeking asylum are considered at higher risk of contracting COVID-19.

The AMA supports any appropriate measures to safeguard the health and well-being of refugees, asylum seekers, those awaiting visa applications, and others in detention facilities that protects them against the possible spread of COVID-19. The AMA's long-standing position is that refugees, detainees, and asylum seekers should have access to the same standards of care as available in the community. The AMA supports removing people from detention to mitigate against contracting COVID-19, and to ensure they have access to testing and medical care.

5.13 Commonwealth Department of Health

The AMA would commend the work of the Department of Health throughout this period. The Department has proven to be very responsive to the concerns of the profession and worked to institute many changes as part of efforts to respond to COVID-19. These have included reviewing compliance activities, the operation of workforce programs, supporting moves to paperless systems, telehealth, medical indemnity, identifying rural and remote issues, and increasing communications to GPs. The role of Professor Michael Kidd, who has a unique understanding of general practice has, in particular, helped the Department to understand the important role of general practice in tackling COVID-19.

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