UNIVERSITIES AUSTRALIA

UNIVERSITIES AUSTRALIA RESPONSE TO THE PARLIAMENTARY INQUIRY INTO LONG COVID AND REPEATED COVID INFECTIONS

December 2022

SUMMARY OF RECOMMENDATIONS

1. **Build on universities' existing repositories of COVID knowledge to better understand long COVID. Support and utilise university research capability to do this.**
2. **Incentivise and promote paid final year health student roles in health services.**
3. **Bring educators, health services, regulators and the professions together to find ways that paid experience could count towards compulsory placements.**
4. **Develop a primary health care teaching and training fund, similar to the Teaching Training and Research (TTR) fund that already exists for public hospitals/health services.**
5. **Remove roadblocks to qualifying as a health worker:**
   - **Build increased, sustainable health professional student placement capacity through policy support for university-health/care service partnership approaches; and**
   - **Consider degree-apprenticeship models.**
6. **Make it easier for current and former health workers to retrain and upskill:**
   - **Introduce FEE-HELP for micro-credentials.**
7. **Maintain a long-term outlook:**
   - **Establish a national health workforce planning body**

INTRODUCTION

Thank you for the opportunity to make a submission to this inquiry into long COVID and repeated COVID infections (from here referred to as long COVID).

Universities Australia is the national peak body representing Australia's 39 comprehensive universities. Australian universities made a major contribution to the pandemic, particularly in the areas of research, epidemiology/public health and health professions (education and/or workforce). These aspects of universities' activities continue to be relevant to the matter of long COVID and are reflected in our response to the inquiry's terms of reference[1] three and five.

[1] A full copy of the inquiry's Terms of refence is at Appendix 1.

RESPONSE TO RELEVANT TERMS OF REFERENCE

TOR 3: Research into the potential and known effects, causes, risk factors, prevalence, management, and treatment of long COVID and/or repeated COVID infections in Australia

Build on universities' existing repositories of COVID knowledge to better understand long COVID; and support and utilise university research capability to do this.

Australia has been a global leader in meeting the challenges posed by COVID-19. It has delivered a robust policy response based on high quality evidence. This response was substantially informed by university research across many fields including:

- medical and health;
- information technology, data science and computing;
- engineering;
- human society;
- education;
- psychology; and
- economics.

Universities played a major role in providing rapid evidence-based information during the pandemic in clinical and non-clinical areas. Through the Rapid Research Information Forum (RRIF)[2] universities and researchers contributed their expertise to topics that had clear policy demand at the height of the pandemic. Through the forum, the government was able to request university input on identified topics which were addressed in short timeframes in an easily digestible form. The RRIF is still active with reports prepared on behalf of the National Science and Technology Council. Examples of the RRIF's work can be found at: https://www.chiefscientist.gov.au/RRIF

Universities' ability to respond rapidly and effectively in a time of crisis resulted from decades of investment in excellence across all fields of university research. However, university research capacity has been affected over the years of the pandemic (see: Impact of the pandemic on Australia's research workforce)

Universities and university researchers are well-placed to work with government, industry and other stakeholders to build on our existing COVID knowledge to inform policy and practice responses to long COVID - its causes, effects, prevalence, management and treatment. However, to do this effectively, this infrastructure must be supported and strengthened.

TOR 5: The impact of long COVID and/or repeated COVID infections on Australia's overall health system, particularly in relation to deferred treatment, reduced health screening, postponed elective surgery, and increased risk of various conditions including cardiovascular, neurological and immunological conditions in the general population

Our main response in relation to the impact of long COVID on Australia's overall health system is in relation to health workforce. To deal with long COVID while addressing our other known health needs, we rapidly need to grow our health workforce. This need is recognised. Nurses, allied health professionals, dentists and doctors were listed as being in strong or moderate demand in Australia's recent Skills Priority List[3]. However, there are various obstacles to achieving this growth. Multiple factors contribute to the situation and present challenges to ensuring sufficient workforce supply to manage COVID-related conditions on top of existing health needs.

Universities play an important role in health professional workforce formation. We develop most of Australia's new-entry health professionals. Our sector also supports the upskilling and reskilling of already qualified international and domestic health professionals. Under the right

---

[2] The Rapid Research Information Forum (RRIF) was started in 2020 by the then Chief Scientist, Dr Alan Finkel

[3] https://www.nationalskillscommission.gov.au/topics/skills-priority-list

policy settings, and in partnership with government and other stakeholders, universities can support the required workforce growth.

Factors exacerbating workforce supply relevant to long COVID

1. *Health workforce need, particularly in nursing and allied health professions, is likely to increase further - on top of pre-existing need - given Australia's potential number of Long COVID cases.* Statistics on the proportion of people likely to have long COVID are variable[4]. However, work in Australia suggests that at least five per cent of those diagnosed with COVID will experience long COVID. Based on current case numbers, this means that as a minimum, roughly 520,000 Australians could experience long COVID[5]. Prior to contracting the virus, many of these people were fit and healthy without pre-existing conditions. (Long COVID disproportionately affects younger people). Long COVID cases therefore represent a substantial increase in the number of Australians with chronic conditions now needing care.

   Several state-led, multi-disciplinary clinics have been established to manage and treat those with long COVID. However, they do not exist in all jurisdictions. These clinics also tend to be predominantly targeted at those with more severe symptoms. The majority of long COVID patients are subsequently managed in general practice and primary care – a health domain already under workforce stress6. Moreover, while doctors are an important part of long COVID healthcare teams, much of the ongoing treatment and management of long COVID patients is undertaken by allied health professionals and nurses – workforces that are already undersupplied. In addition, approximately 40 per cent of general practices do not employ nurses and many more do not employ allied health professionals[7].

2. *Health workforce was already in short supply pre-pandemic*
   The need for significant health workforce growth in many health service settings[8] was already well established prior to COVID. Estimates from the Royal Commission into Safety and Quality in Aged Care[9] have already predicted the need for:

   - 35,900 additional nurse practitioner and registered nurse roles by 2050 (a 157 per cent increase);
   - 6,000 additional enrolled nurses (a 55 per cent increase); and
   - 6,600 allied health professionals by 2050 (an increase of 81 per cent).

   A predicted 83,000 net additional workers are needed in the National Disability Insurance Scheme (NDIS) by 2024, particularly allied health professionals, nurses and support workers[10]. Workforce shortages have also been identified in other areas such as mental health care, primary care and Indigenous health services. All these areas draw on the same health workforce.

3. *There are indications that increasing numbers of nurses and potentially other health professionals intend to leave the profession due to the increased workforce burden caused by COVID.*
   In 2021, the International College of Nursing (ICN) undertook a global survey on nursing workforce one year into the pandemic. According to the results, nearly one in five of the National Nursing Associations surveyed reported an increase in the number of nurses leaving the profession, with 90 per cent of them 'somewhat or extremely concerned' that heavy workloads, insufficient resources, burn-out and stress were the key factors driving that exodus.

[4] Some international estimates suggest that up to 30% of those infected with COVID-19 will experience Long COVID, however, likelihood is lowered by vaccines and oral antiviral use. As access to/uptake of these has been high in Australia, it is likely that the number of Long COVID cases here will be lower than in some other countries. See: https://www.sydney.edu.au/news-opinion/news/2022/06/30/long-covid-presents-a-major-health-challenge-how-can-australia-b.html

[5] Calculations are based on case numbers in Australia at July 2022 at which point almost 50 per cent of Australians had had COVID-19. However, actual case numbers are likely to be higher and will continue to rise - see: https://www1.racgp.org.au/newsgp/clinical/almost-one-in-every-two-australians-has-had-covid

[6] See: National Medical Workforce Strategy 2021-2031; and the Deloitte GP Workforce Report 2022

[7] The General Practice Nurse Workforce: Estimating Future Supply 2018

[8] Such as primary care, aged care, disability care, Indigenous and mental health care

[9] See chapter 12: Aged Care Royal Commission 2021-03 Final Report Volume 3a

[10] NDIS National Workforce Plan 2021-2025

4. *New entry workforce supply was disrupted during COVID due to constraints on the ability to move health professional students through their compulsory clinical placements.*
   Australian universities play a key role in health workforce formation. They provide Australia with most of its new-entry health professionals across allied health, dentistry, medicine, midwifery, nursing and pharmacy. Universities also provide significant input into the reskilling and upskilling of domestic and internationally trained health workers. Education and training for all of these health professions includes compulsory clinical experience within health services (referred to as clinical placement). Issues of placement capacity and coordination are not new, but COVID exacerbated them. Despite the best efforts of universities, health services and the professions, there were significant disruptions to clinical education during COVID. The result was graduation delays and placement backlogs – some of which remain[11].

   Universities have welcomed the Australian Government's extra 20,000 Commonwealth supported places, a primary goal of which is to address workforce need, including in the health professions. For these places to have maximum impact on workforce growth, placements must be found within health services for students to be able to complete their qualifications. (Even where qualified health personnel are imported from overseas, they often require bridging courses and clinical experience within Australia before they can be fully employed in health roles onshore.) Health services such as hospitals and care facilities can provide those places. However, it can be challenging for health services to juggle access to additional training places while also providing patient care. Policy that supports partnership approaches where universities work closely with health and/or care facilities to develop sustainable education and training options has been shown to be an effective way to support additional quality placement capacity – with benefits to service providers, clients, health workforce and students[12].

Options to tackle Long COVID through health workforce growth

Universities Australia sees health workforce growth and supply as a major challenge in relation to tackling long COVID especially when considered in relation to pre-existing health and workforce need. Universities play a vital role in health professional workforce growth and are committed to assisting Australia develop the health workforce it needs. We continue to actively consider ways in which universities can aid this situation. However, we can only do this effectively in partnership with government (both Commonwealth and state and territory across health, education and social services), health services, the professions and regulators. In this context, we offer the following suggestions to assist government tackle the workforce challenges long COVID presents on top of ongoing health issues.

Incentivise and promote paid final year health student roles
Although clinical education was disrupted in the pandemic, during that time many health students were actively recruited to support vaccine roll-out and fill other health service roles. Models such as the Registered Undergraduate Student of Nursing (RUSON) and Medical Assistants already exist to harness the skills of health students in the heath workforce. These roles enable final year students to make valuable contributions to the delivery of care. Incentivising and promoting greater uptake of these roles would provide a boost to the existing workforce.

Bring educators, health services, regulators and the professions together to find ways that such paid experience could count towards compulsory placements
While the RUSON and Medical Assistant roles support immediate health workforce needs, students' time in these positions does not generally count towards their compulsory placements. (The focus of these roles is workforce benefit and service exposure rather than educational experience and learning.) Developing ways in which these types of paid student roles could have a greater educational focus and count, at least in part, towards compulsory clinical experience would support new entrant workforce growth by relieving pressure on finding further placements and enabling students to still progress their studies.

---

[11] University members still report placement backlogs, however the situation is very variable across disciplines and jurisdictions.
[12] TRACS to the Future National Evaluation of Teaching and Research Aged Care Service (TRACS)

Develop a primary health care teaching and training fund, similar to the Teaching Training and Research (TTR) fund that already exists for public hospitals/health services

Exposure to service settings during initial training influences where health professional graduates choose to work once qualified and better prepares them to manage and treat the conditions patients in those setting present with. Most long COVID care is dealt with in private practice primary care settings – by GPs, nurses and allied health professionals. However, other than the Teaching Practice Incentive Payment (PIP) for medical students, there is no teaching and training funding for nurses or allied health students in primary care. This limits students' contribution to the primary care workforce and fails to expose them to primary care work – including managing long COVID – while they train.

A TTR fund for public hospitals/health services already exists[13]. Establishing a similar teaching and training fund for primary care would support health professional students to gain experience in this domain, better prepare them for dealing with long COVID and support primary care workforce growth.

Remove roadblocks to qualifying as a health worker

Universities are opening as many places as they can to health students. However, students will not be able to graduate if there are too few placements available in the health system to meet the demand. We need to provide more avenues for students to complete clinical placements.

One solution is to fund partnerships between universities and community-based health services to ensure that more students can complete their practical training on time, and that this training is completed in locations and domains where workforce shortages are most acute[14].

Another solution is to offer degree apprenticeships for emerging or existing roles, as a mechanism for guaranteeing clinical experience and workforce input. Similar models have been successfully trialled in the United Kingdom[15].

Make it easier for current and former health workers to retrain and upskill

Another more immediate solution to addressing some of our workforce needs is to encourage re-entry of already qualified practitioners back into the system. This could include domestic staff who previously left the system as well as internationally qualified practitioners who have not yet worked in the health system in Australia. In many cases, short upskilling, conversion or bridging courses could be the solution.

Universities and other education providers already offer many of these courses, which are also known as microcredentials. However, microcredentials do not qualify for FEE-HELP, meaning that students must pay upfront for the course. These upfront costs can prevent former health workers from retraining and returning to the workforce. Every time this happens the health system loses valuable clinical skills. One solution is to extend the system of income-contingent loans (FEE-HELP) to anyone undertaking a short course or microcredential, especially in areas of critical skills shortages such as health. This will allow more workers to retrain or upskill and return to workforce faster.

Maintain a long-term outlook

In addition to the above, medium to longer term planning is needed to build a sufficient, sustainable and adaptive health workforce. A multi-stakeholder collaborative forum lead by government is needed to guide longer term sustainable planning. This forum should meet regularly to determine actions in workforce formation across the whole health spectrum. Given the multitude of portfolios, departments, disciplines and agencies involved in Australia's health professional workforce development, a joined-up approach is the most effective mechanism for developing the best policy outcomes.

---

[13] See the Independent Health and Aged Care Pricing Authority (IHACPA) Cost Determinations TTR Block funding: https://www.ihacpa.gov.au/health-care/pricing/national-efficient-cost-determination

[14] Not only do we need more sustainable placement capacity overall, we need it in expanded settings – such as in aged care, primary care, mental health care, Indigenous health and disability services.

[15] These models work as threeway partnerships between education providers, employers and apprentices, with students spending 80 per cent of their time in the workplace and the remainder at university.

APPENDIX 1: INQUIRY'S TERMS OF REFERENCE

The House of Representatives Standing Committee on Health, Aged Care and Sport will inquire into and report on:

1. The patient experience in Australia of long COVID and/or repeated COVID infections, particularly diagnosis and treatment;

2. The experience of healthcare services providers supporting patients with long COVID and/or repeated COVID infections;

3. Research into the potential and known effects, causes, risk factors, prevalence, management, and treatment of long COVID and/or repeated COVID infections in Australia;

4. The health, social, educational and economic impacts in Australia on individuals who develop long COVID and/or have repeated COVID infections, their families, and the broader community, including for groups that face a greater risk of serious illness due to factors such as age, existing health conditions, disability and background;

5. The impact of long COVID and/or repeated COVID infections on Australia's overall health system, particularly in relation to deferred treatment, reduced health screening, postponed elective surgery, and increased risk of various conditions including cardiovascular, neurological and immunological conditions in the general population; and

6. Best practice responses regarding the prevention, diagnosis and treatment of long COVID and/or repeated COVID infections, both in Australia and internationally.