Australian Catholic University

Online submission to the Australian Government Department of Health and Aged Care on

Role and Functions of an Australian Centre for Disease Control

December 2022

ACU submission to Australian Government Department of Health and Aged Care

(Submission made online through web portal)

Australian Catholic University (ACU) is pleased to respond to the Australian Government Department of Health and Aged Care consultation paper, *Role and Functions of an Australian Centre for Disease Control [CDC]: Prevention-Promotion-Protection* (the consultation paper).

ACU's submission focuses on the CDC's role in developing the health workforce, and responds to the following consultation question:

15. *How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?*

ACU is well placed to comment on this question.

ACU's health staff and students were part of the COVID surge workforce, and ACU witnessed the impact of COVID on the wider health workforce.

ACU's Faculty of Health Sciences is the largest educator of undergraduate nurses in Australia, and single-handedly educates nearly 50 per cent more nursing students (7,509) than all of the Group of Eight universities combined (5,015).[1] ACU is also one of the largest educators of physiotherapists, occupational therapists, and speech therapists in Australia.

15. How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?

Central coordinating role

Figure 1 of the consultation paper positions "workforce" as the bedrock of Australia's public health landscape, describing it as an "underpinning essential" along with Australia's legislation and population. However, the CDC must be able to shape this bedrock in times of crisis.

In times of war, a national government reserves powers to mobilise its population. Locally, a line of command is established at the scene of any significant accident where a single person coordinates emergency workers. The CDC should hold such powers during national health emergencies, particularly in relation to the health workforce.

In its day-to-day operations, the CDC would maintain an advisory rather than implementation role, which is the proper domain of states and territories. But during times of crisis, the

[1] Department of Education and Training, *2020 Higher Education Data Collection – Students, Special Courses*. Section 8, table 8.3. (Group of Eight universities are: University of New South Wales, The University of Sydney, The University of Melbourne, Monash University, The Australian National University, The University of Adelaide, The University of Queensland and The University of Western Australia).

CDC's advice should have a more directive power to coordinate the national health workforce.

This goes to the consultation paper's first question, "What decision-making responsibilities, if any, should the CDC have?" ACU recommends a hybrid system, where the CDC's advisory role in day-to-day matters provides information on communicable diseases, public health matters, vaccination and the like, and where its legitimacy derives from its timely, quality advice. But in extraordinary times such as a pandemic, the CDC's advice can and should acquire a much more directive force, where its legitimacy will derive from the soundness of its judgements.

ACU sees this directive role for the CDC as most important in mobilising the health workforce. During COVID-19, ACU experienced different workplace requirements demanded of its students by different states and territories, and even by individual health providers within the same state. For example, ACU's students on placement had to meet different requirements between government and employer as to their vaccination status, when they should mask, and the type of mask they should wear (which also differed by individual health service). A student who lived near a state border and needed to undertake a placement across the border faced extraordinary difficulties. Any proposed CDC should take a directive role to ensure consistent workforce requirements in a health emergency.

ACU recommendation 1: That during health emergencies, the CDC's normal advisory role acquires more directive force to determine national health workforce requirements.

Allied health workforce

Table 1 on page 16 says that allied health is "not a core function" of any proposed CDC.

This is a mistaken assumption, particularly as COVID demonstrated that all health workers, from paramedics to physiotherapists to pharmacists, were affected by the pandemic in managing multiple crises, and in the burnout that affected many of them as a consequence.

ACU recommends all health workers, including those in allied health, be considered in scope for the CDC, at least in terms of activating a surge workforce during health emergencies, and workforce planning during normal operations (for the latter, see ACU's fourth recommendation below).

ACU recommendation 2: That the CDC provides clarity on its proposed role and relationship to Allied Health, particularly in terms of activating a surge workforce and workforce planning.

Surge workforce in times of crisis

A surge workforce is needed when significant portions of the existing workforce have been furloughed, which happened in Australia after the initial COVID wave passed through.

COVID demonstrated several lessons that should be learnt about meeting surge workforce requirements. For example,

- There was no real use of artificial intelligence (AI) in Australia to relieve the burden on nurses and conserve them for bedside nursing or home visits during the pandemic. AI was used in China and Japan to relieve this burden, e.g., using robots for vaccinations or cleaning tasks, etc. However, in Australia, nurses had to be moved from the bedside for tasks where AI may have had a role. For example, Australia's vaccination centres resulted in a significant depletion of workforce in the hospitals which staffed the vaccination centres (e.g., St Vincent's in Sydney and Melbourne, Melbourne Health, etc). Obviously, the use of AI would need careful trialling given adverse reactions to vaccines, such as fainting or anaphylaxis. At least initially, clinical settings with both robotic booths and human-staffed booths would probably be required. Yet a vaccine robot will become a reality at some stage, and the CDC should anticipate this development and consider how to use it in practice. On a separate but related matter, AI could also be used to better model workforce shortages and redeployment of staff in emergency situations.

- The student health workforce was relied on by happenstance in Australia, even though this cohort ended up bolstering entire health services. ACU's students were actively recruited to work in hospitals or vaccination clinics, either in a volunteer or paid capacity, and many of these health services later told ACU they would have collapsed without them. An unintended consequence is that now, many of these students who used to study full-time and work part-time are working full-time and studying part-time, or else have suspended their studies indefinitely because of burnout from working during COVID. Galvanising the student cohort in a much more deliberate way, and anticipating unintended consequences, should be carefully considered prior to meeting surge requirements in the future.

- Other sources of surge workers were those without recent clinical experience because they were teaching in universities, or had recently retired, or did not have recent clinical experience for some other reason. Many of these potential surge workers were not able to be deployed because they lacked recent clinical experience, even though they had knowledge. This was a missed opportunity, and registration requirements lagged what was required during a health emergency. There are risks in bringing in a workforce whose clinical practice may be out of date, but the CDC could consider how to mitigate these risks while maximising the opportunity these staff present.

These potential sources of a surge workforce must be galvanised and mobilised, rather than being reliant on an individual's initiative. This goes to ACU's first recommendation, that the CDC acquire a more directive force to determine health workforce needs in emergency situations.

ACU recommendation 3: That the CDC actively plan for any future surge workforce, whether using AI, the student health workforce, or health workers without recent clinical experience, evaluate the use of this surge workforce, and publicise findings to improve further.

Mapping and projection of the health workforce

ACU agrees with the consultation paper that the CDC could map the public health workforce to better understand gaps, regulatory barriers, and aid in future planning (p. 29), but would go further and recommend the CDC *project* health workforce requirements. In this respect, ACU recommends the CDC resurrect some of the roles previously undertaken by Health Workforce Australia (HWA), a Commonwealth agency that ceased operations in 2014.

At one point, the consultation paper asks, "While [the National Health and Hospitals Reform Commission] ceased operations in 2014, it could be that such a function could exist as an arm or centre within the CDC" (p. 35). ACU makes no comment about the NHHRC but does recommend the functions of another Commonwealth agency disbanded in 2014, HWA, be incorporated as an arm or centre within the CDC.

Data about the current health workforce is inadequate. The last thorough projections for the nursing workforce, for example, were made by HWA in 2014. Periodic assessments of the nursing workforce are made by the Commonwealth Department of Health, but they are not conducted in the same detail or depth. A body responsible for workforce monitoring, reporting and planning, located as an arm of the CDC, could provide accurate and current health workforce statistics and projections.

ACU recommendation 4: That a body responsible for workforce monitoring, reporting and planning be incorporated as an arm or centre within the CDC to provide accurate and current health workforce statistics and projections.

Partnering with education providers

ACU recommends any CDC work with education providers to prepare the public health workforce for future emergencies. Education providers should not exist as a separate source of "official" information, but the CDC should partner with education providers as experts in disseminating knowledge to develop just-in-time information for clinicians.

During COVID, health services struggled to meet information needs while managing their own staffing crises. Governments were able to partner with universities to provide just-in-time information and education to clinicians, relieving the burden of sourcing and preparing this evidence-based material.

Educational partners have the resources and skills to quickly develop this educational material and should be valued as part of the response team. This partnership was highly valued by health services and clinicians during COVID-19 and should be planned for and structured into the response to any further pandemics.

ACU recommendation 5: That the CDC, as experts in disease conditions, partner with education providers, experts in educational practice, in times of crisis to provide just-in-time health education to clinicians.