Universities Australia submission to the Shergold COVID-19 Review July 2022

Introduction

Universities made a major contribution to the pandemic. Helpful responses included:

- university epidemiologists and public health experts who regularly provided clear messages and advice to the community about COVID-19;
- researchers who undertook/are undertaking research on pandemic-related matters, such as mapping the COVID-19 genome to support vaccine development;
- health students and staff who assisted vaccination roll-out; and
- university clinics/ campuses that acted as vaccination hubs to increase community access.

Despite this contribution, universities were hit hard by the pandemic. Details of the pandemic's early impact on the sector overall were provided in Universities Australia's (UA's) July 2020 Submission to the Senate Select Committee on COVID-19.

This submission is specifically about the pandemic's impact on universities' delivery of entry-level (pre-registration) health profession education (HPE).

Universities provide Australia with most of its new-entry health professional workforce across allied health, dentistry, medicine, midwifery, nursing and pharmacy. Universities' HPE inputs support Australia's continued health workforce supply and healthcare delivery, the need for which was heightened by the pandemic.

Response to the review's four questions

1. What impact did the pandemic have on you and your community?

The biggest impact of COVID-19 on HPE was significant disruption to clinical placements and other face-to-face clinical learning, such as laboratories. This disruption impeded course progression, led to ongoing placement backlogs and delayed entry of new graduates into the health workforce[1] when supply was critical.

During the pandemic, universities quickly mobilised to put courses online. However, all HPE courses include compulsory service-based clinical placements and often, in-person laboratory learning. Without these, students cannot complete the approved qualifications necessary to proceed to professional registration. Attaining sufficient clinical placements is often challenging, but COVID intensified it. Pandemic-related placement issues include:

- lack of - and untapped - placement capacity - in the health system overall and in areas of known need[2]. This worsened in the pandemic as health services were themselves disrupted. Ensuring sufficient quality placement capacity is fundamental to maintaining and growing our health workforce.
- inconsistent health service directions about student placements including significant variation in whether students were:
  - allowed on placement;
  - required to be COVID-vaccinated for placement;
  - able to access vaccines; and/or
  - allowed to undertake paid health assistant work outside of placements and the impact of this on their actual placements.

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[1] In 2020 and 2021, final year students were prioritised to complete their compulsory placement requirements. Despite this, verbal reports suggest that course completions were still delayed by up to three months, although this varied by discipline and jurisdiction. The ongoing impact of placement backlogs for earlier year students is still very real as, for example, outlined in this recent ABC News Article July 2022.

[2] Such as Aged Care, Disability, Primary Care and Mental Health Care.

These issues varied by time, discipline, jurisdiction and health service and made coordination of placements between services and across borders almost impossible.
- The need to run extra clinical education laboratories due to social distancing rules. The number of laboratories conducted by academic HPE staff increased three to four-fold during COVID-19, intensifying staff workload and increasing course running costs.
- Inflexibility of professional accreditation arrangements which can be too focused on process rather than outcomes[3] – although the greater cooperation forged between universities and accreditors during the pandemic was generally helpful.

2. What worked well and what didn't, in governments' policy responses to reduce the impact of the pandemic on you and your community?

Worked well

Development of Principles for Clinical Education Continuity: In March 2020, UA brought multiple HPE stakeholders together to determine a way forward. One result was the development of joint National Principles for Clinical Education Continuity During COVID-19 by the Commonwealth Departments of Health (DOH) and Education (DESE), the Australian Health Practitioner Regulation Authority (AHPRA) and the Health Professions Accreditation Collaborative Forum (HPACF). The principles reinforced the importance of clinical education continuity to future workforce supply and were widely promoted.

Greater cooperation between universities and health professional accreditors: During the pandemic, universities and UA worked closely with health professional accreditation bodies. While not government entities per se, accreditation agencies[4] work closely with AHPRA, the health practitioner regulator. Closer working between universities and accreditors, on which we have continued to build, supported HPE continuity during the pandemic. Some of these accreditation issues continue to be progressed through the Accreditation Committee[5].

Introduction of telehealth items: These enabled continued delivery of various health services. In some cases, they also supported "virtual" placement through tele-supervision of student-delivered telehealth services.

The role of health students in the COVID-19 response: Many jurisdictions enlisted health students to support vaccine roll-out and other pandemic activities, such as testing. In some states, legislation was changed to enable this. Students' contributions accelerated community access to pandemic care. Although not recognised as placement hours, this work offered students coincidental clinical/health-service experience/learning in the pandemic.

Changes to eligibility to travel to Australia and acceptance of international vaccines: The Department of Home Affairs' inclusion of penultimate and final year international health students as eligible to apply to return to Australia to complete their clinical education helped HPE continuity. Further support for health/other international students' return to Australia was aided by Government's increasingly rapid consideration and acceptance of various international vaccines.

DOH COVID-19 Primary Care Implementation Group Meetings and other fora: Early in the pandemic, DOH established a weekly (and ongoing) stakeholder meeting. UA has attended since June 2020. The meetings provide regular updates (critical in dynamic situations) and enable stakeholders to raise awareness of COVID-relevant issues with

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[3] Although this is very variable by discipline and overall, the focus on outcomes-based accreditation is growing.

[4] Especially those governed by the National Registration and Accreditation Scheme

[5] The Accreditation Committee was established as a result of the Accreditation Systems Review recommendations. It is not a product of COVID but its work contributes to progressing some of the accreditation issues raised during COVID.

Government. DOH also conducted regular COVID-19 webinars to support evidence-based information sharing. This included a webinar for health students about vaccination. The webinar answered students' many questions about COVID-19 vaccine requirements.

Access to no-cost vaccinations for those on-shore in Australia: While aspects of the vaccine roll-out could have been improved, health student and general population access to free vaccines helped re-open placements and clinical education.

Was not helpful

Lack of a single policy forum that connects health professions education with workforce planning and lack of data to inform this: The challenges of clinical education and workforce policy development is intensified by the volume of stakeholders involved[6]. The lack of a regular forum to bring stakeholders from all disciplines and portfolios together did not help during the pandemic and exacerbates difficulties as we move forward.

Timing of introduction of the Job Ready Graduate package (JRGP) during the pandemic: Introduction of JRGP policy change in late 2020 added substantial further pressure to university operations when they were still grappling with staff shortages, inability to access job-keeper, transition to online learning and reduced international student numbers. The JRGP also limits universities' ability to support future domestic health workforce growth.

Delayed access to vaccines: The delays in vaccine roll-out to the general population placed more pressure on the system overall while delays in, and sometimes inconsistent messaging about, health students' vaccine access added to placement delays, especially where vaccinations became mandatory for placements.

Inconsistent decisions between states and territories about student placements: The pandemic was clearly a very dynamic situation. However, the inconsistency about vaccine requirements and student placements between states/territories and different health services added yet more challenge to an already complex situation.

Lack of underlying placement capacity and limited acceptance of and access to virtual placement capacity: During COVID, Australia's underlying lack of sufficient, scalable clinical placement capacity hindered (and still hinders) HPE progression and workforce growth. Limited acceptance by some professions and accreditors - coupled with the high cost of equipment for - sophisticated virtual, placement models also constrains HPE progression.

3. What should be done now to better prepare for the next health crisis?

Ensuring a sufficient, skilled and scalable workforce is essential to preparing for the next health crisis. Critical to this is:

- dedicated health workforce planning, with a focus on domestic growth;
- expanding clinical placement capacity, including viable virtual alternatives; and
- recognition of the shared responsibility of educators and health stakeholders to skilling and growing the future workforce.

[6] HPE stakeholders include: different government portfolios (DOH, DESE and DSS) and tiers (national, state. local); higher and tertiary education providers; health and education regulators; professional bodies and accreditors (all disciplines); public and private health, aged, disability and some social care providers.

From a HPE perspective, to support health workforce capacity and capability, we specifically recommend the following:

In the short term:

- university funding changes to grow health professional student volume;
- compacts with health services to ensure sufficient clinical placement capacity;
- health services research to build evidence around virtual and alternative placement models to build competent workforce. This could be funded through the MRFF;
- implementation of paid final year “health assistant” models that contribute to placement completion while providing workforce support. These models already exist in certain disciplines and could be used to greater effect;
- financial support to upskill qualified but non-working domestic/international health workers through approved short courses and micro-credentials; and
- changes to post-study work rights to promote greater employment of Australian-educated international health graduates.

In the medium to longer term:

- policy support for partnership approaches between health/care services and universities to expand clinical placement capacity aligned with workforce need; and
- development of a cross-portfolio, multi-stakeholder Health and Education forum to determine and implement a sustainable clinical education and workforce plan. A Health Workforce and Education CRC would be a good starting point.

4. What other issues would you like to raise with the Panel?

While some short-term solutions are available, many of the above issues need a longer-term approach that goes beyond different levels and terms of government and different professional and sectoral interests. It also requires embracing cultural change and ongoing adaptation to new technologies. For Australia to better prepare for health challenges in the future, short, medium and longer-term horizons need to be set and committed to in any realistic approach to addressing the complex area of health workforce formation, maintenance, upskilling and growth.