HSU Response to the COVID-19 Inquiry

About Us

The Health Services Union (HSU) is one of Australia's fastest-growing unions, with over 102,000 members working in the health and community services sectors across the country. Our members work in aged care, disability services, community health, mental health, alcohol and other drugs services, private practices, and hospitals. Members are health professionals, paramedics, scientists, disability support workers, aged care workers, nurses, technicians, doctors, medical librarians, clerical and administrative staff, managers, and other support staff.

Summary

- COVID-19 demonstrated a failure in governments to coordinate and delineate responsibilities in response to the health crisis.
- Workers and users of the health system paid the price of a poor public health strategy which was inconsistent, constantly changing, and failed to apply best practices in infection control.
- In the health sector, COVID-19 exposed the faults in a fractured, under-supported and underinvested workforce, which made the impacts of the pandemic much worse than they could have been.
- It demonstrated the inherent risks in outsourcing and privatisation causing a lack of state capacity to respond quickly and efficiently to a health emergency.
- It also demonstrated the consequences of not taking an integrated approach to policy for the health workforce, with siloed thinking creating inefficiencies and division.
- Support for workers, including payments to stay at home when sick, retention bonuses and adequate wellbeing support to cope with the impact of the pandemic, needed to be universal and accessible.
- Our list of recommendations is outlined in Appendix 1.

A brief note on the ongoing impact of COVID-19

COVID-19 has not gone away. Whilst the most acute moments have passed, without ongoing vigilance and continued action, COVID-19 will still affect our communities. The pandemic is ongoing despite government and business attempts to return to a business-as-usual model. COVID-19 still seriously impacts our members, their health and workloads. Any reference to COVID-19 must avoid referring to the pandemic in the past tense.

Australia is well into its eighth wave, with hospitals once again showing signs of severe stress. Victoria moved back up to Stage 2 response a couple of weeks ago. While retrospective analysis is important, we need to know what the plan is to arrest the relentless waves of COVID-19 that are heavily impacting our healthcare system.

Governance

Evidence and experience around infection was not used

There was a failure to apply the precautionary principle as COVID-19 first emerged, despite the early warnings coming out of China that COVID-19 is airborne and despite evidence from the SARS 2003 pandemic, where the virus was spread via airborne transition.

There was no relevant Commonwealth standard of Infection Prevention and Control (IPC), with statutory requirements that would direct the states to facilitate a consistent application, despite

acknowledgement that Healthcare Acquired Infections are prevalent issues in all health settings, not just hospitals.

The Australian Guidelines on Prevention and Control of Infection in Healthcare directs you to the Infection Control Expert Group[1] , which failed to accept airborne spread of COVID-19 for much of the acute phase of the pandemic, as noted in early 2021: "Failure at a federal level to acknowledge COVID-19 is transmitted through the air has been putting the community at risk, senior scientists, health and safety experts and doctors have told the ABC."[2]

The vaccine rollout was inefficient

The Commonwealth rollout of the vaccine was a total failure, particularly in both Aged Care and Disability Services. Poor coordination between the states and territories, combined with a deficient vaccine stockpile and the outsourcing of vaccine distribution to individual employers, left many workers unvaccinated because they worked for the wrong provider or lived in the wrong state. In states like Tasmania, the inadequacy of the Commonwealth's botched rollout was such that the state had to assume full control of it. In reality, this should have been coordinated by the states in the first place.

CASE STUDY A – COORDINATION OF VACCINE ROLL-OUT

Tasmania: *a private for-profit provider at an aged facility vaccinated only three people. We know they had to throw out a lot of vaccines. Providers did not know the vaccination teams were coming and did not have the consent to vaccinate many residents. The disability sector was even worse in its organisation. This highlights the inefficiencies of outsourcing, where state capacity should be supported before the crisis occurs.*

Victoria: *the roll-out of vaccines to the disability sector occurred much later than other sectors. Some providers would vaccinate staff on duty, others would not.*

New South Wales*: the roll-out was so poorly managed, in the end, the NSW Government permitted workers to go to work as long as they had booked an appointment to vaccinate to cope. This left health workers, clients and patients exposed at the heights of the pandemic*

State and Commonwealth responsibilities were unclear and confused

While the ICEG claims to have overseen a coordinated state effort[3], states and territories have pulled the COVID response in different directions. Public health orders varied markedly across different sectors (e.g. residential aged care), as did the level of government consultation with unions between states and territories, leading to varied outcomes and protections for health workers.

The reduction and abandonment of isolation period requirements across states was entirely arbitrary, inconsistent, and not based on scientific evidence. This led to further reduction of isolation periods for healthcare workers (e.g., 5 days in Vic and 3 days in NSW).

[1] 'Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) | NHMRC' <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019> [accessed 15 December 2023].

[2] 'COVID-19 Leaking from Hotel Quarantine Could Be "stopped in Its Tracks" by Extra Measure, Experts Say', *ABC News*, 15 January 2021 <https://www.abc.net.au/news/2021-01-16/hotel-quarantine-gap-prevent-airborne-spread-of-covid-19/13057644> [accessed 15 December 2023].

[3] Australian Government Department of Health and Aged Care, 'Coronavirus (COVID-19) Pandemic', *Australian Government Department of Health and Aged Care* (Australian Government Department of Health and Aged Care, 2023) <https://www.health.gov.au/health-alerts/covid-19> [accessed 15 December 2023].

There was a lack of clarity and arbitrary rules around border restrictions, particularly in border towns such as Albury/Wodonga or Coolangatta/Tweed Heads. It was sometimes unclear where a facility would sit regarding public health orders and what a worker who crosses a border regularly for work is meant to do.

A lack of a lead agency such as a Commonwealth Centre for Disease Control (CDC) to lead the response to a pandemic, as in the USA and Europe, has been an enormous contributor to lack of coordination and consistency.

Outsourcing failed

Outsourcing many of the core responses to the pandemic was a disaster, as noted above regarding vaccines. Pandemic response is a core responsibility of government that should be delivered in the public interest. The HSU maintains that governments should directly deliver and resource pandemic responses to ensure they are delivered equitably, effectively and in a well-coordianted manner.

RECOMMENDATION 1: *A Commonwealth Centre for Disease Control should be established as the lead agency in response to pandemics.*

RECOMMENDATION 2: *Public health measures should be delivered through the public sector – outsourcing should have no, or a minimal role, in the management of or response to pandemics.*

RECOMMENDATION 3: *National governance mechanisms should be clear, with defined and well-understood responsibilities for states and the Commonwealth.*

RECOMMENDATION 4: *A holistic, nationally-agreed strategy for pandemic prevention that commits to rebuilding a surge workforce in preventative and acute health, medical manufacturing sovereignty and capacity for public health response units.*

Key health response measures

COVID-19 vaccinations and treatments

There was a lack of strategy or communication about which vaccines are safe or the difference between various vaccines. While New Zealand simplified this by prioritising the initial Pfizer vaccine and making other vaccines available only on exception, Australia's vaccine messaging differed between states and territories and often contradicted itself.

Poor coordination of different vaccine drives (e.g. boosters and child vaccination simultaneously) created further vaccine shortages, forcing excessive demand onto a strained supply of vaccines. On top of this, access to medically supervised vaccination for at-risk persons was few and far between. Some regional and remote workers struggled to meet vaccination deadlines without enduring significant travel costs.

CASE STUDY B – SUPPLY OF VACCINATIONS

One at-risk member was required to drive for hours from Northeast Victoria to Geelong, through Melbourne, to access a vaccine, due to this being the only clinic available to them from the vaccination website.

This poor management and coordination of the vaccine rollout and mandates left many workers confused and anxious, required to be vaccinated within patently unrealistic timeframes. Booster vaccination mandates came into effect for workers with short lead-up periods (e.g. the disability sector) despite common knowledge of significant shortages of vaccination appointments.

Vaccine delays and limited access such as through limiting age groups, are still huge problems especially now with the failure to procure and dispense the new XBB Monovalent vaccine and updated Novavax. Much of Europe, Canada and the USA have discarded the Bivalent (BA4/BA5) vaccines that we are still using (due to their poor efficacy against the XBB strains) and are providing the updated monovalent Moderna and Pfizer XBB.1.5 vaccines and the new Novavax (NVX-CoV2601) options.

No plan has been disclosed to the public or healthcare workers on the use of new vaccines, despite these new vaccines having been available for some time (and some approved by the Therapeutic Goods Administration some time ago). These limits on access and availability to vaccinations make a vaccine-reliant strategy for a "COVID-normal" society with significant shortcomings.

Treatment of Long COVID

As stated before, the SARS experience, where there was proof of an ongoing impact of infection, was not taken into account. The recommendations of the *Parliamentary Inquiry into Long COVID* must be implemented. Pandemic responses must prevent the spread of virus to prevent both the acute and long-term effects of infection.

RECOMMENDATION 5: *Vaccines against COVID-19 must be made easily accessible on an ongoing basis, with clear communications around safety and need. This could be led by the new CDC.*

RECOMMENDATION 6: *Implement the recommendations of the full report of the Parliamentary Inquiry into Long COVID.*

RECOMMENDATION 7: *In the absence of popular uptake of vaccinations, additional COVID-19 precautions must be implemented in high-risk health settings to protect health workers.*

RECOMMENDATION 8: *Vaccination requirements must be implemented in a phased manner in conjunction with vaccine supply.*

COVID-19 testing

The heavy reliance on private pathology services for the essential testing program allowed some companies to extort exorbitant fees that the public health budget had to carry.

Rapid antigen tests (RATs) were encouraged by Commonwealth, states and territories, instead of polymerase chain reaction tests (PCRs) at many points of the pandemic due to their increased cost. This lack of higher quality testing impacted low-paid workers in high-risk settings such as aged care and disability the most, who paid considerable out-of-pocket cost as COVID-19 hoarding pushed up the prices of tests.

The provision of RATs must be the responsibility of service providers, not staff. This is particularly required where it is being used for staff with furlough exemptions leaving isolation when deemed a contact but are asymptomatic.

RECOMMENDATION 9: *The provision of testing must be the responsibility of employers, including for staff members during an isolation period.*

Key medical supplies and PPE (Personal Protective Equipment)

Supply chains have been left very vulnerable. The loss of onshore manufacturing and an overreliance on imported goods left workers with serious supply shortages of essential PPE. The PPE stockpile, and the P2/N95 respirators in particular, was allowed to run very low prior to the pandemic with the Black Summer fires of 2019/20 causing severe depletion of the existing supply of N95s.

There was a need for improved PPE guidance that is clearer about when staff must use higher levels of PPE, which includes the vaccination status of clients and is cognisant of workplace settings, for example, disability workers do not work in static settings and move through residential, office, personal homes, and community settings.

Disability providers, particularly non-profit providers, had restricted access to PPE due to a lack of access. At times, PPE was not provided at all by some providers, particularly gig platforms that made staff purchase their own.

Fit testing was not always occurring, certainly not at the recommended yearly interval in mental health and did not occur at all in disability. Fit testing guidelines also give too many opportunities for services not to undertake annual fit testing. The Vic Guidance Paper 27th October 2023: AS/NZS 1715:2009 recommends that fit testing be performed at appropriate intervals. However, the ability of each health service to implement repeat fit-testing annually for all Health Care Workers required to wear PPE will depend on the size of the organisation, the risk profile of their Health Care Workers and the fit testing resources available.

RECOMMENDATION 10: *Improved guidance for PPE that indicates clearly when staff must use different tiers of PPE that is in response to risk, not just in terms of cost benefit of avoiding staff isolation.*

RECOMMENDATION 11: *Prepare sufficient national stockpiles for future pandemics and clarify access to them.*

Public health messaging

Public health messaging failed the government's COVID response. We needed consistent, clear, and unambiguous promotion of basic preventative and mitigating strategies, such as:

- Covid is airborne and hangs in the air like cigarette smoke and can travel across indoor spaces
- Well-fitted masks (N95) are highly effective at reducing infection, and while outdoors is much safer it still carries risk
- Good ventilation helps reduce risk: open windows and doors and add HEPA air filters where possible
- Vaccines decrease the risk of death and serious disease but do not stop transmission
- Isolate when infectious to protect others and do not attend work while sick (with any infectious illness, not just COVID-19).

There was no education and awareness campaign that Covid is primarily spread by airborne transmission and not limited to close contact or droplet/fomite spread as was misleadingly promoted at the start of the pandemic and has become ingrained in IPC responses (there are now many papers establishing the fact that Covid spreads via aerosols and there almost no papers supporting contact spread).

Encouraging the pursuit and false concept of "Herd Immunity" was reckless, misleading, and wrong and was done despite knowing the available vaccines did not block transmission and limiting access to any vaccines to children. Similarly, "Hybrid Immunity" was wrong and promoted despite evidence that infection disrupted and depleted immune systems and led to significant ongoing health issues, now referred to as Long Covid. The inability of public health bodies to combat this messaging weakened the seriousness with which COVID-19 prevention measures were considered.

The COVID response was further undermined when state and federal governments encouraged a wholesale return to work by updating public health advice. While the use of public health orders allowed states and territories to quickly enforce critical measures like widespread mask requirements

and lockdowns, it also meant as soon as public health orders were relaxed (including density limits), employers were led to believe COVID controls were no longer necessary.

This is despite the fact that COVID-19 has developed into numerous strains that have remained highly infectious, posing a risk to workers that must be eliminated so far as is reasonably practicable under WHS law.

Constant changes in guidance made it impossible to keep up with, while resources from different agencies and levels of government at times contradicted each other.

A shortage of targeted, sector-specific COVID guidance only added to this confusion. It was unclear whether the COVID-19 response in health facilities applied to the disability support settings and PPE guidance lacked proportionality.

For example, regarding vaccination and people with disability, many people with a disability have chosen not to be vaccinated but must still be supported, and there's little guidance about how to do this safely. Guidance documents need to clarify what the appropriate PPE level required is in the case of unvaccinated clients.

CASE STUDY C – NEED FOR SECTOR-SPECIFIC ADVICE

Residential aged care: *aged care workers being told by providers: "don't wear masks, you'll scare the residents."*

NDIS: *Workers taking clients to the supermarket at times needing to wear level 3 PPE because they are providing NDIS supports, despite the fact that in-home and community supports are associated with differing client vulnerability.*

RECOMMENDATION 12*: Simple, consistent and effective Public Health Messaging must be developed and coordinated between the states and territories which aligns to consistent public advice shared across states and territories.*

RECOMMENDATION 13: *Pandemic prevention guidance must be tailored to the sectors it applies to, supported by industry-specific public health messaging strategies.*

RECOMMENDATION 14: *Future revisions of public health orders should be communicated as supplementing, not substituting WHS responsibilities of employers to manage risks associated with transmissible viruses.*

Ensuring effective controls for airborne transmission

High rates of vaccination are an important, but not the only measure to combat the spread of COVID-19. Employers must be required and supported to minimise the transmission of airborne viruses.

In Commonwealth public buildings, there is an ongoing need to establish and enforce Ventilation and Indoor Air Quality standards for all Commonwealth public buildings to:

- maximise external air input
- enhance filtration
- ensure sufficient air changes to improve the indoor air quality.

Despite the importance of these controls in "stopping the spread", health and safety representatives struggled to access information from employers to ensure the efficacy of these controls, including (but not limited to) accurate data around ventilation and COVID exposure rates.

Future pandemic responses should recognise the critical roles HSRs play in creating and sustaining COVID-safe workplaces and provide clear guidance on what information and tools HSRs can and should request to ensure COVID-safe workplaces.

RECOMMENDATION 15: *There needs to be a concerted drive to improve non-pharmaceutical interventions such as improved ventilation, FAR-UVC and HEPA filters.*

RECOMMENDATION 16: *Health and Safety Representatives should be given dedicated support and guidelines from national pandemic response coordinators to enforce and sustain COVID-19 control measures in workplaces.*

Support for specific industries

Aged Care

Facilities under Commonwealth authority have suffered serious outbreaks of COVID-19 repeatedly for the last four years, leading to death and hospitalisations. These facilities are still suffering repeated outbreaks which is unacceptable given what we now know and the tools we have to mitigate the spread of COVID-19. These should be utilised to prevent further transmission, including masking, vaccination, and paid sick leave.

Labour outsourcing made many workers responsible for their own health and safety with catastrophic consequences. The Newmarch House outbreak, where Anglicare outsourced employment to "independent contractors" through the gig platform Mable, highlighted the unthinkable risks associated with an unregulated gig economy, particularly in a pandemic. A lack of training and suitable PPE, among other factors, lead to the death of 19 residents in the facility.[4] These risks point to the need to regulate labour hire and gig work, which we hope will be achieved in part through the *Closing the Loopholes* legislation.

Grants paid to support aged care workforces were also dished out with minimal oversight and in a manner causing division, as outlined in the financial support section below.

Student visa holders working in aged care were granted an exemption from the allowable working hours cap, which was extended month by month. Thousands of workers were left in limbo with little certainty, and providers had little certainty of workforce. These measures are not a replacement for proper investment in workforce, or appropriate as surge capacity.

RECOMMENDATION 17: *Staff need better IPC training and support to enforce universal mask-wearing, including N95s during periods of increased community transmission.*

RECOMMENDATION 18: *Support for a sustained vaccination booster program, provided on-site access for staff and residents.*

RECOMMENDATION 19: *All new pandemic prevention strategies should be supported by a multi-lingual, user-friendly education campaign.*

RECOMMENDATION 20: *The Aged Care workforce should be resourced and staffed to a sufficient level as a priority in advance of any future pandemics.*

[4] 'Newmarch House COVID-19 Outbreak [April-June 2020] Independent Review - Final Report' <https://www.health.gov.au/sites/default/files/documents/2020/08/coronavirus-covid-19-newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf> [accessed 15 December 2023].

Disability Support

The lack of a workforce strategy to manage surging demand for disability support, unlike health, meant the factors causing workers to leave the sector (e.g. casualisation, low levels of supervision, psychosocial hazards) have been left largely unaddressed for years on end. We welcome the government's commitment to a genuine workforce strategy for the NDIS, but regret that it has taken so long to begin developing one.

As COVID ran rampant throughout disability facilities, already understaffed workplaces were put under further stress, leading to a vicious cycle of burnout. These burned-out workers were ill-equipped to carry out work safely and were therefore at increased risk of contracting COVID themselves. As COVID rates climbed further, staffing ratios skyrocketed, to the point where some providers had to rely on symptomatic workers to fill rosters.

Similar non-pharmaceutical Interventions and support described for the Aged Care Sector need to be implemented for the Disability Sector. Improving ventilation and air purification can relieve the reliance on mask-wearing.

Moreover, the inability to identify workers in the disability sector due to lack of regulation and reporting meant vaccination requirements were poorly enforced. Limited information was given on how workers should interact with unvaccinated participants. There was also considerable confusion about whether settings for the COVID-19 response in health facilities applied to the disability care sector.

Incentive payments (surge allowance) for working in COVID environments are unfunded and up to individual employers to implement policy on this, and most do not. While the NDIS has some provision for accessing COVID-related expenses, these payments are not accessible to all providers and do not provide for payments to be passed onto workers. They are mostly accessed for the use of additional staffing support, PPE and other costs, not incentive payments.

The disability sector was rightfully referred to as "the forgotten workforce".[5] A bungled COVID response combined with under-staffed and undersupervised workplaces created an exodus of workers out of the sector, leaving the industry after two years of working in PPE in short-staffed environments. Union Assist staff hear this first-hand from departing members who call the union in tears.

RECOMMENDATION 21: *Furlough and surge allowance payments for future public health crises must be targeted with appropriate acguittal reguirements and regulation. They should be funded directly by government, rather than indirectly through funding in NDIS packages.*

Allied, mental and community health

The pandemic response was characterised by a persistent focus on doctors and nurses, often at the expense of other critical health workforces. Many non-hospital health workforces impacted by shortages during the COVID-19 pandemic missed out on workforce support measures, such as the Hospital Surge Allowance, purely because they are not hospital workers. This included Crisis Assessment and Treatment Teams, Homeless Outreach Psychiatric Services, Hospital Post-Suicidal Engagement and many more.

This is despite the fact the services they provide are equivalent in terms of labour and reduce the severity and prevalence of hospitalisations. Treatment, care, and support of consumers, patients and clients in the community reduce the frequency of inpatient admissions. This is essential when acute

[5] Mellissa Kavenagh, 'Disability Support Workers - The Forgotten Workforce in COVID-19', *Melbourne School of Population and Global Health*, 2021 <https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/about-us/forgotten-workforce-in-covid-19> [accessed 15 December 2023].

beds are constantly full and staff are exhausted. Had preventative health services been fully funded, we likely would have seen much less pressure on the hospital system at the heights of the pandemic.

The role of the mental health workforce during the pandemic was continually overlooked. Governments were not ready for the impact of isolation and lockdowns on demand for the mental health and psychology workforce.

Additionally, much of the support could not be delivered to those who needed it because the workforce was so stretched, the isolation of consumers and it was difficult to practice inpatient mental health.

Allied health workers were also put under intense workloads. For example, interpreters played a critical role during the pandemic but were doing 14-hour days with little additional support from the government. With the lack of support from the government, allied health workers felt it was not worth staying in the sector and that it was not worth putting up with years of costly study to then receive minimal recognition of efforts during COVID-19.

Surge workforce was hardly addressed in Allied and Mental Health, if at all.

RECOMMENDATION 22: *Investment in workforce development in stretched health sectors.*

RECOMMENDATION 23: *Have an all of workforce focus for the health sector in pandemic response.*

Primary health

Primary care lacked access to a centralised PPE resource. Consequently, many GP clinics refused to see patients with respiratory symptoms, forcing these patients into the already stressed acute hospital system. Serious mistakes were made while COVID-19 was still a public health issue, including:

- the closure of respiratory clinics in 2023
- the closure of outdoor and walk-up PCR tests
- A need to obtain GP referral to get a PCR test
- Cessation of some telehealth Medicare items that facilitated remote access to doctors and allied health professionals.

These decisions affected primary care workplaces through increased workloads, compounding the stress placed upon them while increasing the risk of transmission by forcing face-to-face provision of health services.

We also note that although the delivery of PCR testing imposed additional costs on, and required governments to source a testing workforce, these were never reasonable justifications to abandon PCR testing altogether, given that PCRs can more effectively detect COVID-19 when individuals have a lower viral load or are asymptomatic.

Primary health settings, particularly hospitals, were not immune to workforce shortages faced across the health and social assistance industry. Federal funding for hospitals has lagged behind that provided by states and territories, preventing them from investing in a workforce that can meet demand.

Increased hospital funding from the federal government during COVID-19 and surge workforce payments aided health facilities to cope with intense strain on the health system but could not undo years of under-investment in hospital staff, preventative and rehabilitative care. This became abundantly clear when ambulance ramping led to many preventable deaths of COVID-positive patients.

The impacts of minimal support for the primary health system are faced to this day – COVID infections and admissions remain high, and health workers are tasked with clearing long elective surgery waitlists

that were postponed during the lockdowns. Health workers are faced by the increased risk of infection from the large number of visitors to health facilities, with no mandatory mask settings.

Increased Commonwealth contributions to the National Health Reform Agreement as announced at December's National Cabinet meeting are welcome but must move towards achieving a 50:50 split of hospital funding between the Commonwealth and state and territory governments.

RECOMMENDATION 24: *A surge testing workforce, delivered through public health systems, must be reserved for future pandemics to ensure access to the most accurate tests possible.*

RECOMMENDATION 25: *Ongoing commitment to a 50:50 split of hospital funding shared by the Commonwealth to rebuild health workforce capacity, with sufficient investment in preventative and rehabilitative care to ensure an emergency health system that can respond to future pandemics.*

RECOMMENDATION 26: *Mandatory mask wearing for all visitors to health facilities.*

Support for workers

Support payments for workers without access to personal (sick) leave to stay home and isolate until testing negative should be universally accessible. In the disability sector, workers could not access leave unless an individual provider offered it. While providers received payments from the NDIS, they had no obligation to pass this onto workers. The lack of support for workers has resulted in them exhausting all their leave entitlements losing faith that the system will support them.

Retention bonuses in 2021 for aged care only went to registered nurses and turned workers against each other.[6] When further retention bonuses were paid to aged care workers in 2022, they were grossly inadequate, consisting of 2 x $400 payments.[7] What is more, the fact disability support workers could not access this made it appear as a forgotten sector and treated as non-essential workers in a sector with similar retention and attraction issues.

There were not adequate wellbeing supports available from the Commonwealth for workforce during the pandemic to support the trauma impact of the pandemic on workers. Suggestions of improved mental health supports during pandemics are welcome but necessitate the construction of a surge workforce that can support community mental health in a time of crisis. The protracted waitlists for psychologists and mental health support that we currently witness contradict such a recommendation.

RECOMMENDATION 27: *Provisions for paid pandemic leave in the National Employment Standards so that workers are supported to isolate for the reguired minimum period and test negative twice on a rapid antigen test.*

RECOMMENDATION 28: *Isolation support - Funded personal leave for isolation for casuals and staff who have exhausted their personal leave across the health workforces.*

RECOMMENDATION 29: *A future pandemic prevention plan should include a define framework for that ensures workforce bonuses and surge allowances are distributed eguitably.*

[6] 'Change Aged Care', *HSU NSW/ACT/QLD*, 2021 <https://www.hsu.asn.au/stay-informed/unified-magazine/spring-2021/change-aged-care> [accessed 15 December 2023].

[7] hsunet_staging, 'Staff Shortage Emergency Requires More Thans a Two-Payment Bonus', *HSU* <https://hsu.net.au/portfolio/staff-shortage-emergency-requires-more-thans-a-two-payment-bonus/> [accessed 15 December 2023].

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This submission has been prepared by HSU National but is made on behalf of our branches and members Australia-wide. HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*. The HSU has registered branches for New South Wales/Queensland/Australian Capital Territory; Victoria (4); Tasmania; South Australia/Northern Territory; and Western Australia.

Appendix 1: Recommendations

1. *A Commonwealth Centre for Disease Control should be established as the lead agency in response to pandemics.*
2. *Public health measures should be delivered through the public sector – outsourcing should have no, or a minimal role, in the management of or response to pandemics.*
3. *National governance mechanisms should be clear, with defined and well-understood responsibilities for states and the Commonwealth.*
4. *A holistic, nationally-agreed strategy for pandemic prevention that commits to rebuilding a surge workforce in preventative and acute health, medical manufacturing sovereignty and capacity for public health response units.*
5. *Vaccines against COVID-19 must be made easily accessible on an ongoing basis, with clear communications around safety and need. This could be led by the new CDC.*
6. *Implement the recommendations of the full report of the Parliamentary Inguiry into Long COVID.*
7. *In the absence of popular uptake of vaccinations, additional COVID-19 precautions must be implemented in high-risk health settings to protect health workers.*
8. *Vaccination reguirements must be implemented in a phased manner in conjunction with vaccine supply.*
9. *The provision of testing must be the responsibility of employers, including for staff members during an isolation period.*
10. *Improved guidance for PPE that indicates clearly when staff must use different tiers of PPE that is in response to risk, not just in terms of cost benefit of avoiding staff isolation.*
11. *Prepare sufficient national stockpiles for future pandemics and clarify access to them.*
12. *Simple, consistent and effective Public Health Messaging must be developed and coordinated between the states and territories which aligns to consistent public advice shared across states and territories.*
13. *Pandemic prevention guidance must be tailored to the sectors it applies to, supported by industry-specific public health messaging strategies.*
14. *Future revisions of public health orders should be communicated as supplementing, not substituting WHS responsibilities of employers to manage risks associated with transmissible viruses.*
15. *There needs to be a concerted drive to improve non-pharmaceutical interventions such as improved ventilation, FAR-UVC and HEPA filters.*
16. *Health and Safety Representatives should be given dedicated support and guidelines from national pandemic response coordinators to enforce and sustain COVID-19 control measures in workplaces.*
17. *Staff need better IPC training and support to enforce universal mask-wearing, including N95s during periods of increased community transmission.*
18. *Support for a sustained vaccination booster program, provided on-site access for staff and residents.*
19. *All new pandemic prevention strategies should be supported by a multi-lingual, user-friendly education campaign.*
20. *The Aged Care workforce should be resourced and staffed to a sufficient level as a priority in advance of any future pandemics.*
21. *Furlough and surge allowance payments for future public health crises must be targeted with appropriate acguittal reguirements and regulation. They should be funded directly by government, rather than indirectly through funding in NDIS packages.*
22. *Investment in workforce development in stretched health sectors.*
23. *Have an all of workforce focus for the health sector in pandemic response.*

24. *A surge testing workforce, delivered through public health systems, must be reserved for future pandemics to ensure access to the most accurate tests possible.*
25. *Ongoing commitment to a 50:50 split of hospital funding shared by the Commonwealth to rebuild health workforce capacity, with sufficient investment in preventative and rehabilitative care to ensure an emergency health system that can respond to future pandemics.*
26. *Mandatory mask wearing for all visitors to health facilities.*
27. *Provisions for paid pandemic leave in the National Employment Standards so that workers are supported to isolate for the reguired minimum period and test negative twice on a rapid antigen test.*
28. *Isolation support - Funded personal leave for isolation for casuals and staff who have exhausted their personal leave across the health workforces.*
29. *A future pandemic prevention plan should include a define framework for that ensures workforce bonuses and surge allowances are distributed eguitably.*