The impact of COVID-19 on the recruitment of Army Health officers

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Introduction

The Australian Defence Force (ADF) has a moral, ethical and legal obligation to provide its members with first class healthcare support, commensurate with civilian best practice wherever possible, whether non-deployed, mobile, afloat or deployed. The restructure of Army Health, implemented from January 2022, will see an increase in the provision of health support to ADF personnel including the establishment of a second field hospital unit in Adelaide and additional health companies across Australia.

This restructure is a positive move in increasing the capability of the ADF to provide timely and adequate health support across the various areas of operations. However, there will be a number of logistical challenges such as procurement, allocation of equipment and recruitment of additional clinicians. An added and unforeseen complexity to this restructure is the potential impact that COVID-19 will have on the recruitment of Army Health officers.

Before the COVID-19 crisis, the Australian healthcare system faced challenges with maintaining sufficient numbers of experienced health professionals and carers to meet the growing demands of an ageing population and increases in chronic disease. The impact of the pandemic has resulted in a number of short-term and long-term pressures on healthcare systems worldwide, especially with demands on services exceeding capability. In attempting to address staffing shortfalls, long-term problems may arise, including how to retain a workforce at increased risk of COVID-19 exposure and infection and increased mental health risks.

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Purpose
The purpose of this commentary is to identify the implications that COVID-19 will have on the recruitment of Army Health officers and the subsequent impact this may have on providing effective health support to ADF personnel if appropriate mitigations are not employed. This will include an analysis of the Australian healthcare system and its proposed mitigations to address the national shortage of clinicians.

Background
COVID-19 was officially declared a pandemic on 11 March 2020 by the World Health Organization (WHO). The causative virus is designated as severe acute respiratory syndrome coronavirus (SARS-CoV-2) and patient responses vary widely from asymptomatic to requiring hospitalised ventilation. Frontline healthcare workers have been required to continually put themselves at risk of exposure of this highly contagious disease.

As a measure to protect the nation, the Australian Government rapidly enacted a number of biosecurity measures and travel restrictions. This included closing the Australian borders in March 2020; for two years the only people permitted to travel to Australia were Australian citizens, permanent residents and immediate family members. Quarantine requirements resulted in caps on arrivals each week, which, when combined with limited flights, created a backlog of Australian citizens seeking to return home. The border closure to non-citizens and residents was not lifted until February 2022.

Impact on the Australian health workforce
Due to the rapid spread of COVID-19, there was limited surge planning in place to address the impact on the Australian healthcare workforce. As noted in the WHO technical guidance, *Strengthening the Health System Response to COVID-19*, surge capacity can be enhanced through a variety of measures, including repurposing and mobilising the existing workforce, changing working patterns, bringing inactive or retired health professionals back to the workforce, calling on volunteers, and mobilising non-governmental and private sector workforce capacity.³

Within Australia, in an aim to slow the spread of the virus and to relieve the stress on civilian hospitals, lockowns and restrictions on numbers of people

congregating were introduced. However, increases in positive COVID-19 cases and hospitalisation rates required further measures be introduced, including the cancellation of non-essential medical procedures in order to reallocate clinicians to the frontline.

The ADF were tasked with providing support in aged care homes, hospitals, testing sites and vaccination centres and to occupy headquarter roles as part of the national effort. The support provided by the ADF was not just to meet the increased demand in acute and emergency healthcare settings, but also to increase testing, monitoring and surveillance capacity. This helped to ensure that essential services across all settings could be maintained.4

A major impact of COVID-19 has been burnout of healthcare staff due to the stress of working overtime in arduous conditions, including the constant wearing of personal protective equipment. This burnout has further limited the availability of staff. The Australian Government adopted several measures to address this including border exemptions for clinicians from the UK and Ireland to work in Australia, recalling retired clinicians, short-term contracts with weekly bonuses to work in remote areas and upskilling nurses to work in intensive care units (ICU).

A study conducted by the Australian and New Zealand Intensive Care Society in August 2021 found that Australia had 200 fewer ICU beds than in March 2020. Reduced staff numbers caused by work restrictions, leave, redeployment to other pandemic activity, cancellations of surgery and active re-development of ICU infrastructure have led to closure of a number of these ICU beds.5

The pre-COVID ratio of full-time nurses to critically ill ICU patients was 1:1. This critical care nurse-to-patient ratio must be maintained in ICUs, and the availability of trained nursing staff is consequently rate-limiting.6 However, as the ICU capacities began to increase, combined with shortages of nurses from burnout, diagnosis of COVID-19 or requirements to quarantine, hospitals began to struggle to meet this minimum. As a result, the professionally accepted ratio of clinicians to patients was suspended to meet the decline in health workforce numbers.


6 Litton et al., ‘Increasing ICU capacity to accommodate higher demand during the COVID-19 pandemic’.
Worldwide shortage

Nurses make up 59 per cent of the world’s health workforce. The International College of Nurses estimates there is a global shortage of 5.9 million nurses and, within Australia, there are currently more than 12,200 vacant nursing positions.\(^7\) At the start of the pandemic, Australia had 337,000 registered nurses and on average, registered 20,000 new nurses each year from Australian training institutions. These newly registered nurse figures include a high number of healthcare migrants. Figures provided by the Australian Nursing and Midwifery Federation show that skilled migrants make up 21 per cent of all newly registered nurses. The impact of the border closures has not only affected the current health workforce but also will have impacts in the mid to long-term.

Other health workforce positions affected by COVID-19 include psychologists and mental health clinicians. This is attributed to delays in training, an increase in demand and impacts from border closures. Australia has 3,615 psychiatrists, 28,412 psychologists and 24,111 mental health nurses.\(^8\) To meet the increased demands, Australia would need to double the number of psychiatrists, psychologists and mental health nurses or introduce an amended scope of practice that would enable provisional psychologists to practise.

Psychological impacts

Adding to the existing low health workforce numbers, the impacts of COVID-19 on clinicians’ mental health has also affected staffing levels. As early as April 2020, the COVID-19 pandemic was associated with substantial psychological distress, including anxiety and burnout, among Australian healthcare workers.\(^9\) A Deakin University study on the effects of COVID-19 found that clinicians working on the frontline in Australia experienced a considerable amount of psychological distress. Nurses and midwives reported more severe symptoms of anxiety than doctors and allied health staff, and their mental health scores were significantly worse than the general Australian population norm.\(^10\)

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The pandemic has placed a heavy burden on all healthcare workers and many are now indicating they intend to leave the industry. A survey by the International Council of Nurses (ICN) found that 20 per cent of National Nurses Associations reported an increased rate of nurses leaving the profession in 2020. As a result, ICN have estimated that, globally, the nursing workforce alone could hit a shortfall of 13 million by 2030.

**Impact on recruitment for Army Health officer roles**

The impact on recruitment for the ADF during COVID-19 has been mixed. After the first lockdown was announced in March 2020 Australia experienced its highest ever one month increase in the unemployment rate. This initially had a positive impact on recruitment for the ADF across a wide range of different trades (primarily general entry roles). The unemployment rates, as well as a general decline in wages and part-time work, postured the ADF to be seen as an ideal employer, due to its constant provision of employment and competitive pay and benefits.

However, demand in a number of occupations grew due to the pandemic, and Defence will continue to face significant pressure when seeking to recruit individuals with related skillsets into Defence positions.¹¹ This is most pertinent in the recruitment of Army Health officers. The Australian health workforce is already under-resourced and this will be further eroded for the next few years due to impacts on overseas migration.

Army Health roles were identified as a priority for recruitment prior to the pandemic and, as the demand in the civilian health workforce increases, there will be further pressure on filling these roles. The increase in health positions as a result of the Army restructure, combined with existing vacancies within the service category (SERCAT) 7 Army Health workforce, will require the ADF consider some interim adjustments to how recruitment is conducted.

**Current employment state of Army Health officers**

Within the SERCAT 7 workforce there are existing vacancies across medical officers, nursing officers and psychology officers (Table 1). These three roles are key to the provision of health effects for the ADF and each had an increase in separation rates in 2020–2021. Of note is that these separation rates are higher than the current separation rate for all Army officer roles which is 7.4 per cent.¹²


Table 1: State of SERCAT 7 Army Health officers as at 1 October 2021. Retrieved from 211013 – Complete Officer Report on Defence Protected Network.

<table>
<thead>
<tr>
<th>Role</th>
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<th>Separation rate – last 12 months</th>
<th>Separation rate – last 3 years</th>
</tr>
</thead>
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<td>11.8</td>
<td>8.5</td>
</tr>
<tr>
<td>Nursing Officer</td>
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<td>11.7</td>
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<tr>
<td>Psychology Officer</td>
<td>15</td>
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</table>

A number of reviews and initiatives have been conducted to address these separation rates. These have resulted in a significant increase in remuneration for medical officers and the introduction of nursing officer specialisation levels. However, if these separation rates continue to increase and are coupled with a dwindling pool of civilian health workers from which to recruit, Army Health faces a significant impact on operational capability due to an inability to provide health support commensurate with the need of the ADF’s operational, training and garrison health support.

Figure 1: Ratio of domestic skills available to employment (forecast).13

Forecasting undertaken immediately prior to the onset of the pandemic suggested that the domestic supply of health qualifications would be essentially static relative to employment over the next decade (Figure 1).14 Medical services are, and will increasingly be, in considerable demand and this will see increased pressure placed on the recruitment and retention of Army Health officer roles.

14 Baulch, Revealing the Impact of COVID-19 on Our Healthcare Workers.
It should also be noted that the health restructure has resulted in the creation of additional health officer roles for Army. This increase, as well as the demand for Australian health workers in the public and private sector, potential burnout and the requirements for leave and respite post-pandemic, has potential to impact the recruitment of both reserve and full-time health officers. Some of these factors will also impact the provision of effective health support in the ADF and the ADF health workforce, as uniformed clinicians who have deployed in support of COVID-19 have accrued high leave balances and need to take the necessary time off for respite.

Defence is expected to continue to face considerable difficulty in recruiting and retaining those in the health sector over the short term.\(^\text{15}\) Therefore, it is recommended that a number of interim strategies be investigated in regard to recruitment and retention in order to prevent adverse impacts on the provision of effective health support to ADF members. Not only is there a need to fill existing vacancies but also to help prepare the ADF for future surges in healthcare needs if a pandemic is to occur again. These interim measures could include fast tracking of graduates, waiver of citizenship or increased salary and packages.

**Fast tracking of nursing officer candidates**

COVID-19 has reinforced the vital importance of leveraging long-term sustainable investments in the health workforce to ensure there are enough health workers attracted, deployed and retained, where they are needed, and with the skills and equipment to do their jobs safely.\(^\text{16}\) The strain on the civilian health workforce, combined with the increase of health officer positions as part of the Army restructure, presents a challenge for the ADF to continue to meet the provision of ADF health support.

The Australian Army mandates that in order for a nurse to apply as an Army Reserves or full-time nursing officer they must, as a minimum, have two years recent postgraduate experience in a civilian hospital.\(^\text{17}\) This requirement is due to nursing officers traditionally being tasked to work in austere environments with limited communication or access to civilian health facilities. However, with the operating environment moving from combat and austere environments to augmenting at civilian health facilities and supporting pandemics, the fast

\(^{15}\) Baulch, *Revealing the Impact of COVID-19 on Our Healthcare Workers*.


tracking of graduates to Army nursing officer roles could allow shortages to be addressed while also providing on-the-job experience.

This is a measure that has been examined by the Royal Australian Navy for recruitment of nursing officers and is aligned with an initiative launched in 2021 by the Australian Health Practitioner Regulation Agency (AHPRA). After 500 retired doctors in Queensland volunteered for service, AHPRA realised that there was a willingness by retired personnel to return to clinical services. As such, they announced an initiative to fast-track the re-registration of clinicians and waived minimum recent experience times.

By removing the minimum two years recent postgraduate experience, the Australian Army could increase the talent pool for recruitment and compete for nursing officer candidates alongside civilian organisations. While there is a risk that clinicians may lack confidence to work as Army nurses, this risk stands true in civilian health facilities and has been accepted by the respective state Departments of Health to address the current shortfall.

**Waiver of citizenship for applicants**

To serve in the ADF, applicants must be an Australian citizen. The ADF may consider a temporary deferral of the citizenship requirement for a permanent resident of Australia if the position for which they are applying cannot otherwise be filled, but only in exceptional circumstances. Therefore, temporary skilled migration is not an option directly available to the ADF. Nevertheless it will have a direct impact on Defence and recruitment of Army Health officers.

Figure 2 – Migrant share of labour (both temporary and skilled migration) 2016.

19 Baulch, Revealing the Impact of COVID-19 on Our Healthcare Workers.
The civilian health workforce relies on overseas citizens and many health sector occupations have a high share of migrant labour, both temporary and permanent (Figure 2). However, border restrictions limited the supply of trained clinicians who have not met citizenship requirements, as well as those who have migrated to Australia but cannot meet the AHPRA registration requirements due to state closures. While some foreign-trained nurses were able to gain registration online during Australia’s lockdowns, AHPRA requires that those who have qualifications relevant (but not substantially equivalent) to Australian standards, must take a series of tests. These tests can only be completed in person in Adelaide and are scheduled four times a year. But border closures resulted in a number of clinicians being unable to travel to complete this final step in registration.

These factors combined will result in the ADF competing with the civilian health sector for a limited number of workers who are increasingly in demand. Interim measures that could be introduced include removing the need for citizenship, pending the applicant meeting security clearances, in order to recruit those who have migrated from overseas. If they are able to meet the AHPRA requirements, they would be able to meet the registration requirements for an Army clinician.

**Increase in salary**

Defence will need to carefully tailor its employment package to appeal to highly skilled and specialist workers in a increasingly competitive environment. In 2021, the ADF announced an increase in the remuneration for medical officers as part of a Human Resources management strategy. The strategy was devised so that the ADF could develop and implement a long-term sustainable medical officer workforce that meets the ADF’s capability need to deliver both general and specialist medical support. This included improving retention rates by offering clear professional pathways and additional funding for professional development opportunities. Key to this was that the creation of retention conditions to increase the tenure of ADF medical officers within the garrison environment that would potentially reduce the number of contracted doctors used to supplement ADF medical officer positions (with consequential savings attached).

Through applying similar increases in financial remuneration for other Army Health officer roles, the ADF will be a competitive employer. Civilian hospitals and state health departments have begun to compete with each other by offering...
bonuses and additional pay supplements in order to recruit and retain civilian health workers. Through conducting reviews of current salaries, and ensuring they align with civilian offerings, including increased funding for professional development and specialisation training, the Australian Army may increase its recruitment and retention of Army Health officers.

**Conclusion**

Since the onset of the COVID-19 pandemic, the demand for medical professionals has increased across the government and private sectors, and it is likely to continue to increase.\(^2^5\) Health underpins all aspects of the Australian Army. Whether it be training, garrison activities or deployments, Army Health officers are key to ensuring that the force is postured and able to complete the task at hand. The speed and scale of the response required of the health system as a consequence of the pandemic has highlighted how fragmentation within the system effects its ability to respond effectively.\(^2^6\)

Army Health is going to be challenged in the short to medium term when considering the current increase in separation rates, the increase in Army Health officer positions created as part of the Army Health restructure and the impact that COVID-19 has had on the existing civilian health workforce. This can have a direct impact on the ability of the Australian Army to meet its operational readiness and effectiveness if there is limited health support able to be provided.

Interim mitigations, including removal of recent postgraduate experience, citizenship requirements, as well as increased remuneration, have the potential to help address the impacts of COVID-19 on recruitment of Army Health officers. As the supply of civilian healthcare workers becomes further constrained, there is increased pressure on the Australian Army to posture itself as a suitable employer.

By filling existing vacancies, the wellbeing and workload of currently serving Army Health officers can also be addressed. The ADF has a robust clinical governance standard that would still be met through these individuals having AHPRA registration and clearly defined scopes of practice. For the ADF to continue to maintain a force postured for operations, these interim measures must be analysed and applied to address the immediate impact that COVID-19 will have on the health workforce.\(^2^7\)

\(^2^5\) Baulch, *Revealing the Impact of COVID-19 on Our Healthcare Workers*.
\(^2^7\) Disclaimer: The views expressed in this publication are the author’s own and do not necessarily reflect the views or policies of the Australian Government, the Department of Defence or Defence Force Recruiting.