



Response to Productivity Commission Interim Report: delivering quality care more efficiently

Draft recommendation 1.1

The Australian government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users.

Draft recommendation 2.1

Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in healthcare to foster innovation, improve care outcomes and generate savings.

Draft recommendation 3.1

Establish a national prevention investment framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure.

Thank you for the opportunity to contribute to the Interim Report on delivering quality care more efficiently.

This response presents an opportunity to create a nationally consistent healthcare standard which will simultaneously improve outcomes for both care users and healthcare workers (HCWs) and provide an excellent return on investment. It addresses a serious, growing challenge threatening the healthcare system and will significantly reduce costs, save lives and future proof Australia's at risk, hard to replace frontline care workforce.

This response will outline the current challenge: poor quality care delivered inefficiently and unsafely, and outline a solution that offers sustainable quality care and productivity gains. It includes:

- the problem of repeatedly infecting HCWs with avoidable, airborne infectious illnesses, often causing acute staff shortages at the worst possible time in the midst of waves of infection, just when hospital capacity is overflowing;
- the long-term cost of repeatedly infecting HCWs with airborne COVID-19, causing long COVID chronic illness and long term absenteeism and significantly increasing workers compensation claims;
- the poor quality, unsafe care which infects medically vulnerable patients with avoidable airborne infectious diseases, leading to poor outcomes including death;
- the issue that infecting at risk patients with avoidable airborne infectious diseases is not only morally questionable, but economically inefficient as it causes longer hospital stays with extra medical interventions and costs, unnecessarily increasing the need for acute care;
- the opportunity that lies in a greater alignment in safety standards - a national Aerosol Hygiene protocol - like the existing Hand Hygiene standard, replacing the current fragmented, inconsistent decision making by individual, non-expert hospital administrators
- the case for a national Respirator standard in healthcare as an investment that will save money, the health of a valuable workforce and patient lives.

The cost of repeatedly infecting the healthcare workforce

Australian HCWs are in the firing line, working in one of our least safe working environments. Studies show a significantly increased risk of COVID-19 infection among frontline HCWs compared to the general community, and this is especially the case if PPE is inadequate.¹ Those who are infected with avoidable, airborne infectious diseases such as COVID-19, influenza, measles, TB, RSV etc require time off work to isolate and recover, involving significant costs associated with sick leave and replacement staff.

It doesn't have to be this way. In November 2023 the (Victorian) Ballarat Courier newspaper reported that an "exponential increase of Covid hit Ballarat" but there were "no significant outbreaks within Ballarat's St John of God hospital" despite the high community transmission. The hospital had a mask mandate throughout October and November whenever I visited a family member, which clearly protected patients, staff and visitors alike, enabling quality care to be delivered efficiently. This not only

protected individual workers, but also ensured the continuity of healthcare services by minimising disruptions due to illness-caused staff shortages. Indeed, St John of God Hospital Ballarat's acting chief executive Maureen Waddington said at the time that only "a small number of nursing staff in the oncology department contracted COVID several weeks ago, but it did not disrupt normal operations."²

Safework Australia data on healthcare workers' compensation claims³ shows that an infectious disease category did not even exist before 2021 (when the government "let it rip"). However, since then the number of healthcare workers' compensation claims for infectious disease has steadily climbed from so negligible it didn't have its own category to:

370 claims, the 7th leading claims category with 1.5% of claims in 2021,

to 2,111 claims and 4th leading claims category with 8.8% of total claims in 2022,

and up to 2,767 claims, still 4th leading claims category with 10.8% of total claims in 2023³.

This shocking data is evidence of a rapidly increasingly unsafe work sector harming workers, rendering them unproductive. It also presents an opportunity to invest in better protecting this valuable workforce.

This is not a uniquely Australian development. Canadian COVID-19 claims data⁴ shows that health care workers represent the highest cohort of COVID-19 disability claims at WorkSafeBC with 11,179 claims, 61% of total claims. The numbers reported represent claims submitted by workers for COVID-19 contracted through a work-related exposure. Unsafe working environments that cause harm to HCWs cannot be considered high quality or productive.

Increasing sick leave is also a costly problem. The Health New Zealand Employed Workforce quarterly report⁵ shows an increase in the average annual sick leave hours in nursing: from 99.4 hours in 2019 to 170.1 hours in 2024. This increase in sick leave will impact quality care and increase costs of sick pay and replacement staff.

Figure 11: Average annual sick leave hours per FTE by occupational group

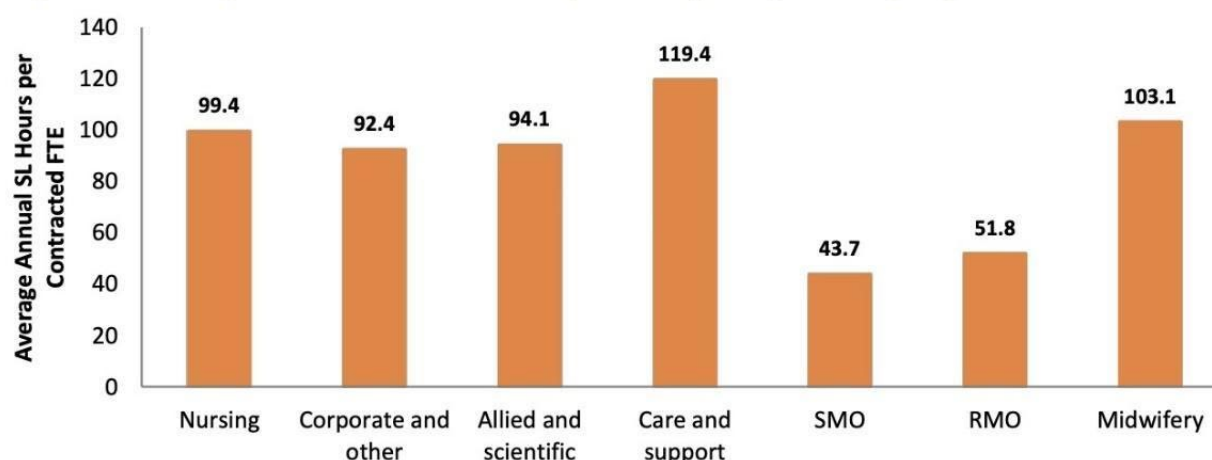
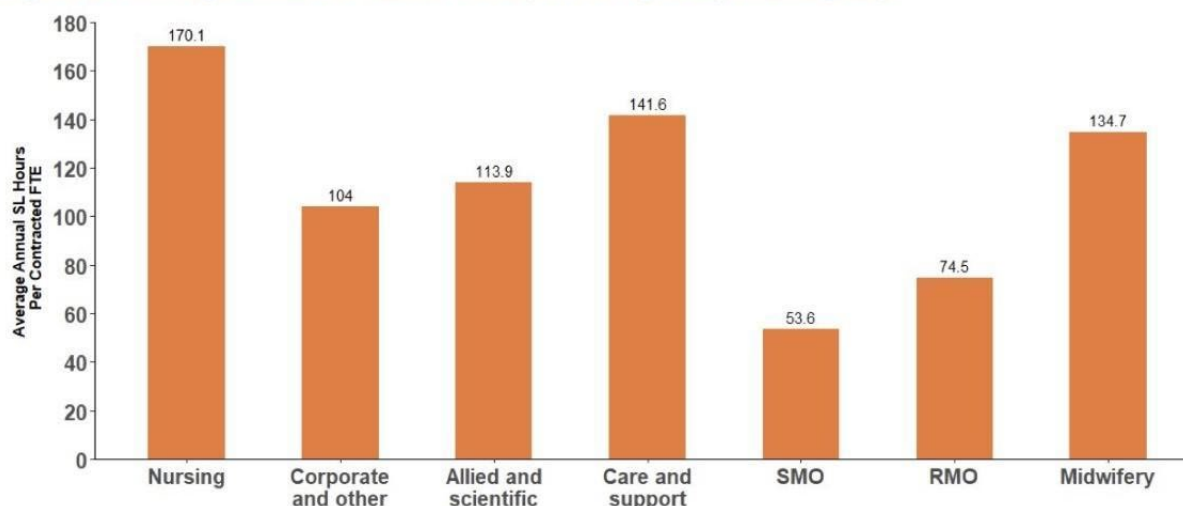


Figure 12: Average annual sick leave hours per FTE by occupational group



It is difficult for a layperson to find current statistics on Australian HCWs unable to work due to COVID-19 and/or other airborne infectious diseases. The Victoria Chief Health Officer did publicly report on the impact in 2022:

“COVID-19 also continues to cause shortages of health and care workers (HCWs), who are essential to the functioning of the healthcare system. The number of staff unable to work due to a COVID-19 diagnosis was persistently higher than 1,500 across June and July 2022 and peaked at 1,947 on 22 July 2022 (Victorian Department of Health (s), 2022). These staff furlough figures are likely a significant underestimate, as HCWs who are not active cases may still require leave due to residual symptoms or caring responsibilities for dependents. Several health services remain reliant on surge workforce arrangements.”⁶

A doctor who works at a large public hospital in NSW told ABC News that “Probably 95% of medical staff are no longer using respiratory PPE and the majority who do, wear surgical masks. Big waves in the community spill over to the hospital workers but there is no contact tracing. We've had huge numbers of staff off sick lately and it puts huge pressure on the remaining staff. When they come back, they often say they caught it at work.”⁷

Of course, it is not only sick leave in the acute phase of workplace infections that puts logistical and financial pressure on the health system. Repeated HCW COVID-19 infections lead to HCW long COVID and subsequent healthcare labour shortages. The chronic disability of Long COVID has created significant challenges not only for HCWs affected, but also for management, struggling with staffing shortages. Chronic incapacitation of HCWs threatens health care workforce stability and quality care delivery.

Studies have found that participants who experienced multiple infections were more likely to experience various long COVID symptoms with increased severity; that having two infections posed a significant risk for many long COVID symptoms; and the risk ratio increased exponentially when the number of infections exceeds two. These findings suggest that minimizing reinfection remains an important preventive measure to reduce the cumulative effects of long COVID. A Canadian study also assessed the cumulative impact of COVID-19 reinfections and found that the risk of developing long COVID was 15% after one infection, 25% after two infections and 38% after three infections.⁸ This has major repercussions for HCWs who are repeatedly infected at work.

Frontline HCWs, inadequately protected or completely unprotected from airborne transmission of COVID-19 and working in a high-risk environment, are at significant risk of repeated infections and development of long COVID. This development will only exacerbate current healthcare labour shortages and pose a serious threat to Australia's ability to respond to health crises, our health system decimated by prolonged sick leave and diminished workforce.

Australian expert in Long COVID, David Putrino, PhD, physical therapist and director of rehabilitation innovation at the Mount Sinai Health System, New York City, who has been working with HCWs with long COVID says “5%-7% of the people who are coming into our center right now are healthcare workers ... they are probably where we do start to see disproportionate effects of long COVID.” His clinic has treated around 3500 people with long COVID and sees 500-700 new patients per year.⁹

According to a January 2025 report from the US Department of Health and Human Services Assistant Secretary for Planning and Evaluation, nearly 1 in 4 healthcare workers (23.5%) with long COVID reported their symptoms significantly affected their work.⁹

Around the world, healthcare worker long COVID statistics are significant and worrying. The World Health Organisation found that more than half (59.3%) of the healthcare workers they studied in Jordan reported post-COVID-19 syndrome,¹² while a US study reported that the impact of long COVID has already worsened healthcare's severe workforce shortage: 2% of nurses did not return to work after developing COVID-19, and about 25% of those filing COVID-related workers compensation claims for lost time at work were HCWs (more than any other industry).¹³

Also in the US, a union survey revealed 18% of 2,825 nurses polled nationwide were still reporting long COVID symptoms after 12 months; as well, 60% took time off to recover, 3% were unable to return, and 38% reported that long COVID continues to affect their work. A union spokesperson noted the union's concern that "every time you are reinfected, it increases the likelihood of more severe symptoms of long COVID. This is a profession that works with COVID daily. The fact that we are no longer testing patients puts nurses at more risk".¹⁴

Evidence from the UK is even more concerning, with HCWs (using inadequate or no PPE) seven times more likely than other workers to have had severe COVID-19, and at least 199,000 NHS workers currently living with long COVID.¹⁵ The UK's Office for National Statistics states: "as a proportion of the UK population, prevalence of self-reported long COVID was greatest in ... those working in health care."¹⁵ As well, a British Medical Association survey of doctors revealed almost one in five respondents were unable to work due to their post-acute Covid ill-health and 77% believed they were infected in the workplace. Only 11% of respondents had access to an FFP2 respirator at the time they contracted COVID-19.¹⁶

Moreover, the cognitive damage associated with COVID-19 infections emphasises the importance of preventing workplace exposure. In a Canadian study, one third of non-hospitalized healthcare workers with post-COVID condition reported persistent cognitive impairment, psychological distress and fatigue, a concerning outcome which could have critical implications for quality healthcare delivery during and after the pandemic.¹⁷ By enforcing N95/P2 respirator requirements, Australia can shield its healthcare workforce from the potential neurological consequences of the virus, thereby preserving the mental acuity necessary for timely, complex decision making and safe, effective patient care.

Studies show the considerable logistical and financial strain placed on healthcare managers, working hard to try and accommodate HCWs with long COVID. Adjusting workloads, reorganising staff, and ensuring quality patient care required led to increased workload for administrators, while HCW colleagues found the extended absence of their co-workers and the additional workload stressful. Although they tried to manage the extra responsibilities, it often left them feeling overwhelmed, and in some cases, close to burnout, disrupting team dynamics and reducing morale.¹⁸

A recent study revealed that individuals with long COVID had 2.54 more missed workdays compared to those without long COVID, while absenteeism remains a significant problem for many, compromising their ability to work at all. About 20% of patients with long COVID remain absent from work for an extended period, specifically for 6 months or more. These results underscore significant productivity losses and substantial economic impacts associated with long COVID, highlighting the need for policymakers and employers to implement effective strategies to protect HCWs from this condition. The study noted the impact of long-COVID on the workforce is notably pronounced in service industries such as healthcare and social care.¹⁹

Additionally, the extended medical care needed to address long COVID disability, including specialist visits, diagnostic procedures, and rehabilitation services, leads to increased healthcare costs. This adds strain to healthcare systems, diverting resources that could otherwise be allocated to other important areas like preventive healthcare or addressing other health issues. Investing in effective prevention can reduce demand for acute and more costly services down the track, helping to slow ongoing growth in government expenditure.

It is well known that Australia is experiencing a shortage of HCWs. Projecting into the next three years, Health Workforce Australia has reported an expected shortage of more than 100,000 nurses and more than 2,700 doctors. Additionally, the Committee for Economic Development of Australia has predicted that the skills shortage in aged care could reach 110,000 or more in the next decade and well over 400,000 by 2050.²⁰ The lingering effect of the COVID-19 pandemic – which includes long COVID – is acknowledged as an important factor affecting the Australian healthcare staffing crisis.¹³ We cannot afford to continue to lose healthcare workers to the long-term effects of COVID-19; a significant loss to an essential, skilled and difficult to replace workforce just as potential new pandemic threats arise would be catastrophic. We must do all we can to protect the ability of the Australian health system to meet patient demand and ensure safe, quality care, both now and moving into the future.

The multifaceted repercussions of HCW infections, ranging from long COVID and cognitive damage to sick leave absences and chronic staff shortages, underscore the urgency of implementing comprehensive measures to safeguard those on the frontlines. A respirator standard will not only preserve the health and well-being of valued healthcare professionals, but also fortify a resilient, well-staffed healthcare system, capable of handling the challenges of the future.

The cost of repeatedly infecting medically vulnerable patients

As I finished preparing this submission, I heard from a friend currently in hospital, awaiting surgery. Their unmasked surgeon was exhibiting infectious symptoms including a runny nose, croaky voice and cough and had admitted to having some kind of respiratory infection. This medical practitioner requires my friend to unmask daily to be assessed in very close contact. No mask, no test, no protection for my clinically vulnerable friend who will likely have poor outcomes if infected during this hospital stay.

An Australian doctor working in NSW public hospitals has borne witness to these poor outcomes: "I've seen patients die after getting COVID — many have complex health issues and COVID is the final nail in their coffin," the doctor says. All of this underlines an urgent need to take stronger action, they say. "We need to be ready, willing and able to scale up and down, to put in maximum barriers to prevent patient and staff transmission."⁷

If those considering and acting on this Interim Report are serious about "stopping problems from starting or getting worse - particularly for vulnerable populations", this is a good place to start. The current lack of appropriate protection (during a winter wave of various airborne infectious diseases) in hospitals cannot be described as quality care. Patients are getting sicker in the health venue which is supposed to be helping them get better and some of them are dying from their Hospital Acquired Infections (HAIs). This is a patient safety problem which is currently going unaddressed.

Despite the widespread belief that COVID-19 is merely a cold, a multitude of evidence shows otherwise, especially for higher risk hospital patients. Data released under FOI requests shows [5,614 people were](#) suspected to have caught COVID-19 in Victorian public hospitals between 2020 and April 2023, with more than one in 10 confirmed or suspected to have died as a result of their infection. In Queensland, [similar data](#) shows an average of 13 people caught COVID-19 in hospital every day in the 18 months to June 2023, with one patient dying every two days. Associate Professor Suman Majumdar, chief health officer for COVID and health emergencies at the Burnet Institute says "These are preventable infections and therefore preventable deaths and we need

to take action to reduce them by setting targets, tracking progress and reporting transparently like we do for [other hospital acquired infections](#)."7

Many doctors such as Dr Andrew Miller, a Perth-based anaesthetist and chair of OzSAGE, an independent advisory group of experts in epidemiology, health and economics, see it as a major problem that COVID-19 is too often being treated by hospitals as a "common cold" when it should be treated as seriously as [tuberculosis](#) or [golden staph](#), and "people are unnecessarily being infected and dying" as a result. Dr Miller calls COVID-19 HAIs the 'Robodebt' of medicine, regarding it "a 'Robodebt' style failure of public health policy."7

He is not the only medical leader concerned. In 2023/24, Dr Maria Boulton raised concerns with Chief Health Officer John Gerrard that patients were catching COVID-19 in hospitals and in some cases dying as a result and that state infection control settings were inadequate. Among concerns raised by AMAQ doctors were HCWs focused on handwashing despite COVID-19 being airborne, COVID-19 positive patients not being isolated, and personal protective equipment (PPE) guidelines that weren't strong enough nor being enforced.⁷

If this Interim Report marks a genuinely new approach to prevention investment, aiming to minimise potentially preventable hospitalisations, it must start looking at the potentially preventable serious airborne infections happening in its own health venues. It is not economically feasible to continue to make hospital patients sicker. COVID-19 HAIs are shockingly expensive.

Hospital patients who acquire COVID-19 and/or other airborne infectious diseases following admission require isolation and transmission-based precautions to limit onward transmission, and may require longer, more expensive hospital stays than if they had not acquired COVID-19. The upfront cost of providing respirators is small in comparison with the cost of additional patient bed-days and extended treatment due to hospital-acquired infections.

A just published Australian study²¹ looked into the effect of hospital-acquired COVID-19 (HAI-COVID) on length- and cost- of hospital stay. The study shows that HAI-COVID is associated with increased length of hospital stay and health care costs, demonstrating harm caused both to individual patients infected with HAI-COVID and to the health care system generally.

It shows that healthcare costs for the HAI-COVID group were 131% higher than expected (AUD\$25,984 vs \$AUD11,208). For non-HAI-COVID-matched controls, actual

costs were similar to expected costs (\$AUD13,454 vs \$AUD11,753). Actual health care costs were 93% higher in the HAI-COVID group compared to non-HAI-COVID-matched controls (\$AUD25,984 vs \$AUD13,454).

For HAI-COVID patients, average actual length of stay was 15.0 days, 103% longer than expected (7.3 days). Using propensity score matching, actual length of stay was 2.5 times longer in the HAI-COVID group compared to non-HAI-COVID-matched controls

The health-economic implications of HAI-COVID are clear, HAI-COVID was associated with a significant increase in hospital length of stay, and a 2-fold increase in costs, with implications for patient care and healthcare costs. The authors contend “efforts directed at preventing HAI-COVID will likely lead to better outcomes for both patients and health care services”.

The urgent need for nationally standardised Airborne IPC protocols and quality standards

The challenge is clear, care is not efficient or quality when it repeatedly infects patients and HCWs with airborne infectious diseases in healthcare settings. Airborne Hygiene cannot be an individual choice when the financial, health and workforce costs are so high. The opportunity is to create a national standard of Airborne Infection Prevention and Control (IPC), a prevention investment which will provide consistency across the country, benefiting staff and patients and reducing increasing care costs to the government.

As reported in the Saturday Paper, “The national guidelines on preventing and controlling infection in healthcare settings formally acknowledge the virus (COVID-19) is airborne. In August (2023), they were amended to remove droplets as a transmission method. The guidelines specify that P2 or N95 masks should be worn. Experts confirm N95 respirator masks offer the highest-level protection and surgical masks are considered inadequate. The states and territories manage mask-wearing regulations and have passed the responsibility to individual hospitals. Many are easing back requirements for both staff and patients, including in some cases where patients with cancer and other vulnerabilities are being treated.”²²

It would be unthinkable to leave Hand Hygiene IPC decision making up to individual HCWs or hospital administrators. Doing this for Airborne IPC is what Dr Andrew Miller calls “an abrogation of responsibility at a state and federal departmental level”. Doctors also contend airborne infection control won't be taken as seriously as it should without

public accountability mechanisms. In her letter to John Gerrard, Dr Boulton argued hospitals should not be expected to set their own infection control policies given many hospital executives are not public health physicians, and that a statewide response should be directed by the chief health officer. John Gerrard agreed, replying “We too have been concerned about this problem for some time.”⁷

It is clear that Airborne Hygiene is a health standard so vital it should not be left up to individual HCWs, hospital administrators or even state or territory politicians (none of whom are leading experts in IPC) to set. Australian Associate Professor in Atmospheric Chemistry, Robyn Schofield explains, “It’s up to every hospital to navigate that and, of course, they don’t have the multidisciplinary team that they require to do that. And there’s no real leadership, I would say, and policy guidance around that.”⁷ The current situation results in inappropriate and ineffective standards that are inconsistent from one healthcare facility or region to the next and are causing costs to increase and patients to die. What is required is an international standard based on scientific evidence.

Australian Medical Association president and Australian National University professor Steve Robson has also called for more mask wearing in healthcare settings. He has argued passionately that “You can do it immediately. You don’t need to install infrastructure or anything like that. You can put a bloody mask on,” pointing out that the absence of active guidance on mask wearing, especially in high-risk settings, potentially contradicts the charter of healthcare rights, which declares that all patients should expect to be safe when accessing care.⁷

Dr Majumdar argues that once there is recognition that this is an ongoing issue, “We have tools that can reduce hospital acquired infections, and they need to be deployed effectively — like we do with [hand hygiene](#) and golden staph.” Studies show that HCWs masking can reduce respiratory viral HAIs [by about 60 per cent](#) — though the type of mask matters. As one study found, well-fitted N95 respirators are [75 times more effective than surgical masks](#) when both an infectious person and a susceptible person wear them.⁷

In Australia, an important recent study by the Burnet Institute²³ assessed the cost-effectiveness of clinical staff wearing N95 respirators and admission screening testing of patients to reduce COVID-19 hospital-acquired infections. It found respirators save lives and money.

Staff N95 respirators + RAT admission screening of patients was the cheapest scenario, saving A\$78.4M and preventing 1543 deaths state-wide per annum. Both interventions were individually beneficial: staff N95 respirators saved A\$54.7M and 854 deaths state-

wide per annum, while RAT admission screening of patients saved A\$57.6M and 1176 deaths state-wide per annum.

In acute care settings, staff N95 respirators and admission screening testing of patients can reduce hospital-acquired COVID-19 and COVID-19 deaths, and are cost saving because of reduced patient bed-days and staff replacement needs.

This local study, funded by the Victorian Government Department of Health, found that staff N95 respirators in acute care settings could save \$54.7M–78.4M and 854–1543 deaths state-wide per annum, depending on admission screening testing strategy.

These results support recommendations for maintaining N95 respirator use among staff within acute care facilities because surgical mask/no mask policies may look like an initial financial saving, but are actually a false economy, leading to greater expenditure by the government than the initial investment in respirators.

Burnet Institute mathematical modeller Fenella McAndrew, emphasised the hidden costs associated with choosing surgical masks over respirators in hospital settings. “It may seem like surgical masks are the cheaper option but when you consider extended hospital stays for patients and sick days taken by staff, it ends up being more expensive.”²⁴

Of course, COVID-19 is not the only threatening airborne infectious disease. Increased respirator use has merit for multiple pathogens. A prevention investment strategy that includes a respirator in healthcare standard will not only protect against COVID-19, but all airborne infectious diseases, including influenza, RSV, measles, tuberculosis etc and will also protect against any novel airborne viruses that develop in the future. It would make an excellent contribution to future pandemic protection strategies.

Recommendations for sustainable Healthcare Workplace Protection to ensure quality care and efficiency

- Australian Commission on Safety and Quality in Healthcare (ACSQHC) to create new National Standard for Masked Care, requiring ongoing use of N95/P2 respirators for all HCWs in healthcare settings
- ACSQHC to create Masked Care is Safer Care education campaign for HCWs
- Government provision of fit-tested respirators for all HCWs
- Auditing and compliance by ACSQHC, as per existing hand hygiene protocols.

Conclusion

In general, our current IPC choices are outdated, ineffective and inconsistent across the country. It's well established that COVID-19, a level-3 biohazard, is airborne as are many other infectious threats. It is time to take urgent action to set national standards for Airborne Hygiene in all hospitals, both in preparation for ongoing and future airborne pandemics, and to prioritise the ongoing safety and wellbeing of one of our greatest and most essential assets - our healthcare workforce. Far from being a restriction, it is a vital workplace protection standard. Anything less is a catastrophic failure of risk assessment.

It is time to catch up to the scientific evidence, accept the inconvenient challenge of airborne transmission of infectious disease and take steps to adequately prevent it. It is essential this opportunity is tackled now because the alternative is the slow collapse of a health system already buckling under the pressure of continuously increasing costs, staff shortages and increased demand for care.

COVID-19 and other airborne respiratory HAs are preventable infections, leading to preventable patient deaths and preventable HCW absenteeism and chronic disability, and putting preventable stress on a health system which is already in crisis.

Adopting this standard will future proof the country's unprotected, at risk healthcare workforce and unprotected, medically vulnerable patients, an investment against current costly infections and future pandemics.

Hospitals have a duty of care to patients and an obligation to provide employees with a safe working environment. This recommendation is an opportunity to lead in infection prevention and control and improve a whole range of outcomes for patients, HCWs, the community, the government and the health system itself.

Cleaner Air Collective is an Australia-wide grassroots health advocacy group with more than 380 members from diverse backgrounds & professions; our membership includes healthcare workers, teachers, lawyers, economists, engineers, creatives, academics, data specialists, disability advocates & students.

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