COVID-19 – an Australian Perspective

Aged Care – what went wrong?
The way forward…what can we learn from our research in hospitals?

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The numbers....

COVID-19 cases in aged care services – residential care

This graph shows the number of confirmed active COVID-19 cases, deaths and recovered cases, in Australia and each state and territory, for people living in Australian Government-subsidised residential aged care facilities.

Since 22 January 2021

In total population
• 27,872 cases
• 908 total deaths

In Aged Care
• 223 outbreaks across 217 facilities
• 2027 residents infected
• 685 resident deaths
• 2236 staff infected

75% of the country's deaths have occurred in aged care

Source: Department of Health 7/12/2020

* The aged care data comprises data sourced from the Victorian Public Health Events Surveillance System (PVHSS) and Commonwealth sources.
A perfect storm?

• In 1997, the Australian Government transformed the system under the Aged Care Act into a free-market model.
• Predominantly publicly funded but largely outsourced to the private sector.
• Aged care and health care treated as two different separate industries.
• Packaged as a social model of care - reduced regulation.
• “By turning aged care into social care, the sector has been able to justify not having good infection prevention and control measures, sufficient staff ratios, and adequately trained staff.”

K Eager, Prof of HSR, University of Wollongong
“There were not enough workers to start with; the workforce that exists doesn't have the training for a contemporary aged care system. They're not equipped to manage disease complexity and they're not equipped to deal with ethical human rights issues. So, then COVID-19 arrives and there are not enough staff, staff who don't know what they're doing, staff who haven't been trained in infection control…..”

Professor Joseph Ibrahim, head of the Health Law and Ageing Research Unit at Monash University
Top 5 Lessons from Australian IPC research in hospitals......

1. Improve surveillance – data for action (infections and process indicators, AMS PPS)
2. Staffing levels and ratios are important….BUT…. 
3. …..Need to examine scope of practice of IPs and incentives for credentialing
4. Policy is hard to implement – gap between standards and what is implemented
5. Context is key – not a “one size fits all” solution
Thank you

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