

Aged care visitor access code

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Summary

This is a submission to the consultation on the draft aged care visitor code, made on behalf of consumers and providers.

COVID-19 is a very dangerous disease for the aged, often fatal. The 16 deaths so far at Newmarch House show how lethal it can be in an aged care facility.

We are using a model of 25 million Australians to show the potential spread of COVID-19 to vulnerable populations, such as those in aged care and prisons.

Our model is based on the scientific research available on the infectivity of persons from infection to recovery, but this research is very uncertain. There are particular doubts about the proportions of infected persons who are asymptomatic.

It is vital that all visitors and staff have their temperatures checked each time they enter the facility. But this will not detect the 33% of adult cases estimated to be asymptomatic, or the 87% of children estimated to be asymptomatic.

It is vital that temperatures of all residents be automatically monitored, so that any new COVID-19 cases can be very quickly detected. Some of the additional funds provided to aged care facilities should be used to buy temperature monitoring equipment.

Workers on average travel about 16 kms to work, but can travel much further in regions with low population density. COVID-19 risks in rural and remote areas are thus likely to increase if present restrictions are eased to reduce economic losses.

Loss of license, as currently under consideration for Newmarch House, can be a very heavy penalty. Class actions by residents may also be very costly. Providers should not be penalised if they have conformed to the quality standards applicable at the time of infection.

1. Danger of COVID 19 in aged care services (data to 26 April 2020)

Location	Number of services	Cases	Deaths	Fatality rate
Aged care residential	24	103	16	15.5%
Aged care home care	29	40	2	5.0%
Other		5968	59	1.0%
Total		6111	77	1.3%

The above data are from the Commonwealth Department of Health [1]. They show a 15% fatality rate for persons in residential care, and 5% for those in home care, compared with

only 1% for those not in aged care. While only a few aged care homes have been named in the press as having COVID-19 cases, there were 24 such homes who reported cases up to 26 April.

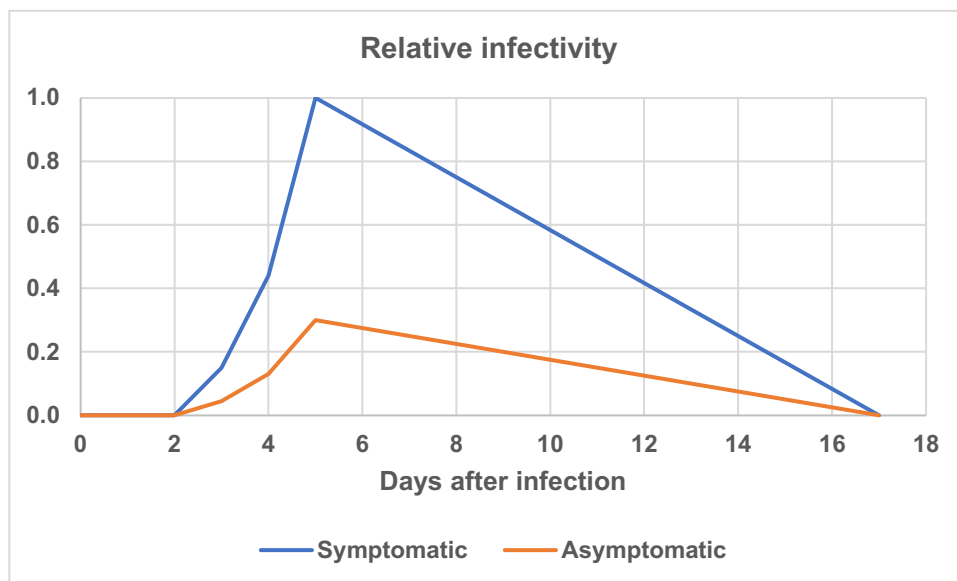
2. Our model of COVID-19

We are modelling the potential spread of COVID-19 to vulnerable persons, such as those in aged care, schools, hospitals and prisons. Our projections assume that preventive measures maintain the active cases broadly near current levels. They show the potential for asymptomatic persons to infect others at increasingly remote locations.

Our projections start with a baseline population of 25 million persons, spread over the 2288 SA2 statistical divisions in Australia. We model the journeys to work of employed persons, sometimes over long distances. We include the location and size of each potential high-risk site, such as aged care homes.

3. Uncertainty of scientific research

Our model relies heavily on the best available evidence on the infection rates of persons of different sex and age, and on infectivity after infection. University of Sydney pandemic modellers [2] have estimated that 33% of adult cases are asymptomatic, and 87% of children.



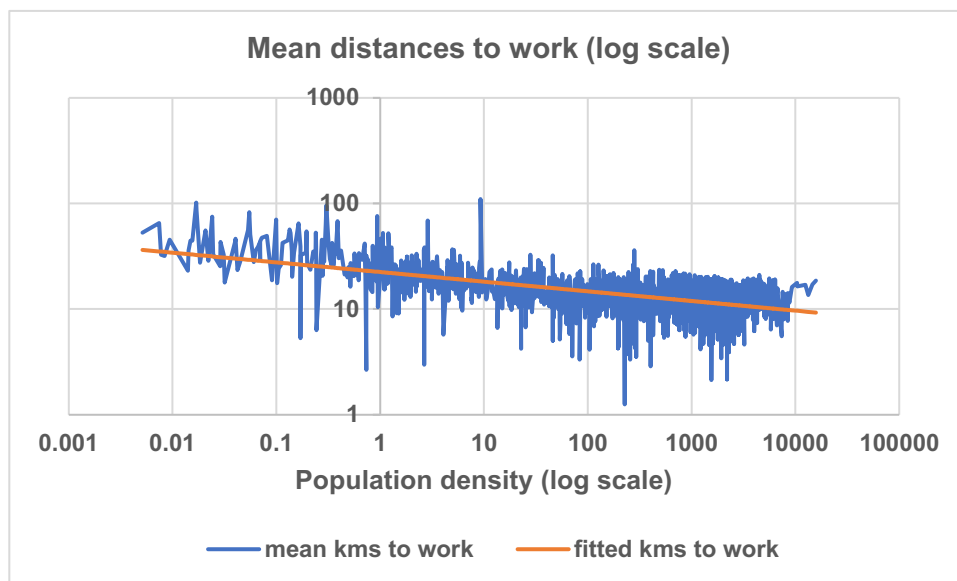
The above figure, reproduced from [2], shows that Chang et al have assumed that infectivity starts two days after infection, and continues until 17 days after infection. If these assumptions are reasonable, then an exclusion period of two weeks after contact with a known COVID-19 case is too short.

4. Vital need for temperature checks of residents, staff and visitors

Staff and visitors should have their temperatures checked before being allowed entry. Residents should have their temperatures automatically measured and communicated to a central site. Ideally, residents should wear temperature measurement devices. Wall mounted devices could measure temperatures of all nearby residents, staff and visitors, and identify cases requiring intervention. This would be consistent with our proposed data-based aged care system [3].

5. Distances travelled to work

The 2016 Census showed that the average distance travelled to work is 16 kms [4].



There are large variations between the 2288 SA2 statistical areas, but there is a clear trend for much longer journeys to work to occur in less densely populated areas. As active COVID-19 cases gradually spread out from the capital cities, aged care services in regional and remote areas will increasingly have to worry about infection risks from staff, visitors and new residents.

6. Unfair penalties on providers

Loss of license, as currently under consideration for Newmarch House, can be a very heavy penalty. Newmarch House, operated by Anglican Community Services since 2012, had 102 approved residential care places, and 16 deaths reported up to May 5 2020. Class actions by residents may also be very costly. Providers should not be penalised if they have confirmed to the quality standards applicable at the time of infection. If the Commonwealth makes any access code mandatory, will it provide legal indemnities to providers meeting the code?

References

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- [2] Chang SL, Harding N, Zachreson C, Cliff OM & Prokopenko M 3 April 2020. *Modelling transmission and control of the COVID-19 pandemic in Australia*. Downloaded 7 May 2020 from <https://arxiv.org/abs/2003.10218>
- [3] Cumpston JR, Sargeant HB & Service HB 9 April 2020. *A data-based aged-care system*. Available from <https://www.australianprojections.com.au/publications/a-data-based-aged-care-system>
- [4] Australian Bureau of Statistics. *2071.0.55.001 Census of Population and Housing: Commuting to Work - More Stories from the Census, 2016*. Downloaded 7 May 2020 from <https://www.abs.gov.au/AUSSTATS/abs@.nsf/ViewContent?readform&view=ProductsbyCatalogue&Action=Expand&Num=2.1>