URGENT CALL FOR ACTION

SHORT WINDOW OF OPPORTUNITY TO PREVENT IMMINENT RESIDENTIAL AGED CARE HOMES COLLAPSE

MARCH 2020

CAM ANSELL & JUDI COOMBE

Across the globe, the hospital and aged care sectors have become the front line for COVID-19. Our analysis and consultation with residential care homes in Europe and the US confirms that Australia will struggle to cope with the spread of coronavirus among our elderly. In Europe, there are reports indicating that younger people are being prioritised to receive highly limited and life-saving medical resources over elders. Additional Government funding and resources are being focussed towards primary health providers and hospitals. This not only exposes older people in long term care facilities, but also the staff that care for them.

While we can expect similar pressures on staffing and facility capacity as our international counterparts, the funding system of Australia’s residential care homes is heavily dependent on around $30 billion in refundable accommodation deposits (RADs) from residents. The rapid outflow of capital funds, coupled with escalating operational losses, will shortly trigger widespread insolvencies, closures and the displacement of older people unless the Government acts urgently.

Our heavily regulated funding and compliance regime will cause us to divert critical resources away from direct care services and must be now adjusted to accommodate the pandemic.

The following must take place immediately:

1. The Government must make available temporary facilities to Providers that are unable to refund RADs (Bond Guarantee Scheme) during the pandemic;

2. The onerous subsidy claiming process (Aged Care Funding Instrument (ACFI)) should be suspended and all residents should be provided with the highest funding level to support higher staffing levels and operating costs, initially for the June 2020 quarter;

3. Commission Audits should cease in line with international strategies and support must be provided to address immediate resident needs and infection control protocols; and

4. An Aged Care Emergency Response Taskforce should be convened to ensure the swift and adequate allocation of resources to the sector, and the coordination of services between the hospitals and aged care.

We have provided our analysis to the Commonwealth Government in support of these recommendations.
CONTEXT

The catastrophic impacts of coronavirus (COVID-19) on the health and aged care sectors has been a focus on world media the last two weeks. In Spain and Italy, residential care homes have been over-run or closed down. In some cases, residents have been abandoned to die and care staff are among the highest proportion of the infected population, often working without adequate Personal Protective Equipment (PPE).

Since the early reports on the pandemic, we have been tracking the phases of the virus on aged care systems in the countries first affected. We are working with our sector experts in the UK as their infection levels increase. This information has been used to model the likely implications for Australia’s residential care homes (refer Appendix One).

Over the next few weeks, Australia’s systems will be tested at unprecedented levels and we can expect similar experiences as our international counterparts. Despite the relative strength of our health and aged care sectors, we carry the burden of a strongly regulated system and depend heavily on capital funding from residents. It is these factors that have us at a critical disadvantage and must be addressed immediately or the sector will face collapse in the early stages of infection growth rates.

This report outlines the phases we can expect and tactical actions available to Government and Providers to prepare us for the pandemic.
RECOMMENDATION 1 – CAPITAL OUTFLOWS (RADs)

In Australia, residential care homes receive lump sum deposits from residents referred to as RADs. The resident usually obtains the funds through the sale of their home. The money is used to fund the construction and refurbishment of the care homes. When a resident departs the home, the deposit is refunded in full. The Commonwealth Government guarantees the RAD in the event of provider default under the Bond Guarantee Scheme.

This system is effective as long as new residents with deposits continue to replace departing residents. New legislation introduced through *Living Longer, Living Better (2012)* reform caused a dramatic increase in RAD capital inflows and almost $30 billion is now owed to residents across the country.

Graph 1: Total Pool of Accommodation Deposits Held, 2012 to 2018

![Graph 1](image.png)

Source: ACFA

Approximately 56% of sector assets are funded by RADs and only about 20% is retained in cash. Many providers operate much lower liquidity margins.

As outlined in Appendix One, in Phase 1 and Phase 2, permanent resident occupancy levels will decline during the commencement of the pandemic’s spread. During this time, providers will be required to refund RADs at accelerating rates, without new resident RADs to replace them. As the pandemic spreads, new incoming residents will not be in a position to pay RADs as family homes will not be sold during this period. As a result, any new admissions will likely be highly acute and/or respite.

The capital outflow will cause providers to become insolvent and many will not be able to cover staff wages (despite the Government’s initial injection), resulting in care home closures across the country.

As the underwriter of the RADs, the Commonwealth will have to refund the defaulted deposits and a large proportion of the $30 billion will become exposed as confidence in the Scheme is compromised.

The Commonwealth should immediately provide access to a Scheme facility to enable the repayment of RADs where providers are unable to do so. This will stabilise liquidity within an already vulnerable sector and wider economy during the pandemic, avoiding residential care home closures and a major Scheme catastrophe. We have provided our recommendations and supporting information including the extension of a Scheme facility to the Commonwealth.
**RECOMMENDATION 2 – RESIDENT SUBSIDY FUNDING**

Providers receive Government funding based on the level of perceived care need of individual residents. The subsidy is determined using the ACFI, which requires a complex assessment of a person’s clinical, personal and behavioural support needs. The claiming process is arduous and takes care staff away from service delivery. Within this rapidly changing environment and accelerated resident turnover, we will not be able to afford the diversion of scarce resources to administrative tasks.

Early indications from our international counterparts demonstrates the frustration of allocating Government relief packages to areas of need on a timely basis. While most governments are motivated to act, the requirement to determine priority often means that they cannot allocate funds quickly. In contrast, the timeline to peak infection is extremely short.

To expedite the resourcing process, we recommend that funding increase to the highest ACFI domains (approximately $220 per resident, per day) for both permanent and respite residents for the last quarter of the 2020 Financial Year. The need to extend the support would be reviewed during this period and it would be possible to set parameters to ensure that the additional funding is appropriately applied to service delivery. Barriers between permanent and respite places allocations should be removed, with an accommodation supplement introduced for the growing number of respite residents.

This funding injection (estimated at $758 million over 3 months) will be essential to improve sustainability within an industry that was experiencing serious viability issues before the COVID-19 outbreak (refer to our HY2020 ASX Listed Companies publication here). By commencing the funding immediately, providers will be better equipped to manage or prevent an outbreak by ensuring the following:

1. Sufficient number of staff that are appropriately trained to manage COVID-19 outbreaks in facilities;
2. Greater access to PPE and other resources required for infection control; and
3. Access to COVID-19 testing kits to test residents and aged care staff and avoid further infection spread.

This strategy will also assist providers to operate through the short-term occupancy declines, and later address the surge in demand, staff challenges and accelerated resident turnover rates outlined on Appendix One.
RECOMMENDATION 3 – AGED CARE QUALITY COMMISSION AUDITS

The aged care sector is in the process of developing plans to maintain safe and appropriate services, in an environment where it is likely that there will be reduced staffing levels and inadequate resources as supplies are initially diverted to public hospitals.

Aged care staff are being asked to provide extraordinary care, which carries a high level of personal risk. We need to show compassion, understanding and remove as many barriers as is possible, so they can focus on saving lives and providing a sense of hope to our elderly and their families.

To focus on appropriate and safe care, without the distraction of a visit by the Australian Aged Care Quality and Safety Commission (the Commission), it is recommended that on-site assessments be postponed for at least six months. This strategy has been implemented in New Zealand.

The exception to this strategy would be those instances where there is a serious concern about the quality of the health care being provided to consumers. Such a concern may arise from a serious complaint to the Commission or from information provided by other agencies. In some cases, a concern already exists due to past compliance performance that requires ongoing monitoring.

While this should be treated on a case by case basis, these serious concerns will not arise for vast the majority of providers.

RECOMMENDATION 4 – AGED CARE EMERGENCY RESPONSE TASKFORCE

The reports we are receiving from our liaisons in the UK confirm the extreme pressures facing the aged care industry and what is perceived to be disproportionate diversion of resources to hospitals. The National Health Service (NHS) has sought to bolster hospital capacity and triage less critically ill older people (usually untested) to care homes, which have been left with negligible supplies of PPE, no testing equipment and dwindling basic supplies.

Although Australia has the benefit of advanced warning on the issues of co-ordination, we have the added burden of split responsibilities between the State and Federal Governments for the health and aged care systems.

To date, the Government has moved quickly to address issues as they arise or are reasonably foreseeable. However, the complex myriad of stakeholders and the scarcity of resources will require greater levels of coordination as we move toward peak infection levels. A specific Aged Care Emergency Response Taskforce (Taskforce) would have representatives of both the acute and aged care sectors and be responsible for appropriate allocation of resources and support.

The Taskforce would support the allocation of human and equipment resources, the management of downstream services, adequate supply of basic needs between the hospitals and aged care sectors and collaboration within the aged care sector.
## APPENDIX ONE – COVID-19 PHASES – RESIDENTIAL AGED CARE

### PHASE 1 – SPREAD BY TRAVEL
Mid-January to March 2020

<table>
<thead>
<tr>
<th>Phase</th>
<th>Operational Impacts</th>
<th>Financial/organisational Impacts</th>
<th>Provider Tactical Action</th>
<th>Government Tactical Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Majority of COVID-19 infections in Australia acquired overseas.</td>
<td>Increased staff costs, utilisation of staff entitlements (sick leave/ personal leave) and agency costs.</td>
<td>Creation of a staff bank.</td>
<td>Discussions with providers on funding, RAD exposure and immediate resources/support required.</td>
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<tr>
<td></td>
<td>Quarantine measures introduced.</td>
<td>Net RAD outflow with departing residents not being able to be replaced by new admissions as quickly.</td>
<td>Extended shifts and increased flexibility.</td>
<td>Temporary funding support provided to aged care providers.</td>
</tr>
<tr>
<td></td>
<td>“Social” physical distancing measures introduced.</td>
<td>Lower productivity for non-essential executives WFH with capital and transformational projects deferred.</td>
<td>Expended admissions under secure, safe guidelines.</td>
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<tr>
<td></td>
<td>Limited visitation measures encouraged at residential aged care facilities.</td>
<td>Focus shifts from revenue enhancement and cost control to crisis planning.</td>
<td>Retain focus on ACFI and RAD sustainability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolated spread of viruses through residential care via visitors and staff.</td>
<td>Quality of life for consumers starts to be compromised by visitor restrictions and limitations on socialising and lifestyle opportunities due to social distancing requirements.</td>
<td>Extending planning horizon to counter mid-term impacts, facilitate long term survival and growth.</td>
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<tr>
<td></td>
<td>Initial lockdown and border control policies introduced (restricted access).</td>
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<td>Investment in resident lifestyle activities and alternative activities – technology, etc.</td>
<td></td>
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<tr>
<td></td>
<td>• Infection rate increases across general population through community transmission.</td>
<td>Workforce pressures as a result of staff illness, family obligations, testing shortages/delays and self-isolation requirements materially impacting operational capacity.</td>
<td>Staff culture evaluation and implementation of support initiatives.</td>
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</tr>
<tr>
<td></td>
<td>• Increased lockdown measures to the wider community.</td>
<td>• High dependence on agency staff and utilisation of extended or double shifts.</td>
<td>Financial forecasting and preliminary discussion with financiers.</td>
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</tr>
<tr>
<td></td>
<td>- Restricted trading/closure of non-essential businesses.</td>
<td>• High clinical risk environment with limited RN resources focussed on daily clinical needs of residents.</td>
<td>Prepare staff for operational challenges and provide supplementary training where needed.</td>
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<tr>
<td></td>
<td>- Closure of schools.</td>
<td>• Increased pressure to accept residents (who may not have been tested) from hospitals to help with bed capacity challenges.</td>
<td>Develop strategies to accommodate staff who want to stay at work and wish to isolate themselves from families to keep them safe, such as providing short-term onsite accommodation and meals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Restrictions on access and number of people at essential services.</td>
<td>• No capacity for clinical staff to focus on revenue growth through ACFI uplift as a result of increasing resident needs.</td>
<td>Identify key staff/resources and develop succession plans.</td>
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<tr>
<td></td>
<td>- Priority access given to hospital staff.</td>
<td>• Residential lifestyle programs being limited or discontinued.</td>
<td>Development of continuity of operation plans in the event of an outbreak.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff and resident infections.</td>
<td>• Residential care hospital admissions being triaged, with greater responsibility for homes to care for more acute cases.</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td>• Changes to testing criteria and potential shortages/delays in testing.</td>
<td>• Increased challenges and pressure in managing essential supplies such as food, medication and PPE.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Most homes now operating at a deficit.</td>
<td>• Issues with medication supplies being delayed.</td>
<td></td>
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<tr>
<td></td>
<td>• Growing/widespread economic impact.</td>
<td>• Continued decline in permanent resident occupancy driven by limited new admissions and existing residents moving out to due visitation restrictions, virus concerns and family liquidity pressure.</td>
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### PHASE 2 – COMMUNITY TRANSMISSION
March/April to May 2020

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<td>• Most homes now operating at a deficit.</td>
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<td>• Increased lockdown measures to the wider community.</td>
<td>• Relief packages start to be released but do not address losses.</td>
<td>Flexible staff rostering arrangements and ongoing staff culture management/support.</td>
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<td></td>
<td>- Restricted trading/closure of non-essential businesses.</td>
<td>• RAD outflows materially outweigh inflows and deadlines breached.</td>
<td>Execution of financing arrangements (depending on the extent and exposure of capital outflows).</td>
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<td>- Closure of schools.</td>
<td>• Media contained initially.</td>
<td>Continued focus on ACFI and RAD sustainability.</td>
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<td>- Restrictions on access and number of people at essential services.</td>
<td>• Reduced access to primary health support (specialists, GPs, etc.).</td>
<td>Implementation of alternative resident lifestyle activities.</td>
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<td>- Priority access given to hospital staff.</td>
<td>• Staff retention and wellbeing issues rising.</td>
<td>Establish a targeted list of key clinical governance performance indicators and consumer quality of life measures.</td>
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<td>• Staff and resident infections.</td>
<td>• Management of industrial relation/human resource challenges.</td>
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<td>• Increased billing recovery problems as families begin to experience financial difficulties.</td>
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### PHASE 3 – LOCKDOWN
January to March 2020

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</tbody>
</table>
### Phase 3 – Peak Infection
**May to August 2020**

- **Operational Impacts**
  - Widespread infection.
  - Majority of Australian businesses and communities locked down.
  - Major slowdown in economic activity and decline in property market activity.
  - Restrictions in accessing essential supplies (e.g., food and medication).
  - Hospitals and residential care homes are ground zero.
  - High levels of staff and resident infections.
  - Significant delays and/or shortages to test for COVID-19.
  - Hospitals are at overcapacity and are significantly limiting the transfer of acutely ill residents. Combined with staff illnesses, family obligations, self-quarantine requirements and testing delays, the workforce is severely overloaded and exhausted.
  - Rapid transfer of residents from hospitals (who are not able to be tested) to residential care that have beds available but limited operational capacity (respite residents).
  - Extension of isolation areas for new/ transferred resident with dedicated staff.
  - Symptom and infection tracking with strict criteria for transfer to the “open” areas.
  - Blurring between isolation and open areas.
  - Resident clinical needs and acuity levels increasing, with many residents likely to be palliative.
  - Delay issues and/or difficulties experienced with sourcing essential supplies such as food, medication and PPE.
  - Relief packages assisting homes to stay open but some will close (or many depending on Government response).
  - High clinical risk and low priority care planning, documentation and non-clinical needs.
  - Increased transmission and infection risks from hospital transfers.
  - Limited supplies of PPE available and reduced access to networks to support care delivery.
  - RAD exposure crystallises due to higher numbers of respite residents (who do not pay a RAD) and permanent resident admissions not paying a RAD (either due to inability to sell their house or decline in means as a result of the economy crash).
  - Growing number of defaults likely to trigger major Scheme events and draw media attention.
  - Widespread non-payment by residents due to financial difficulties.

- **Financial/Organisational Impacts**
  - Increased transmission and infection risks from hospital transfers.

- **Provider Tactical Action**
  - Execute front line practical care service delivery and palliative care strategies.
  - Prioritise clinical services and reduce the frequency of some non-essential care activities such as showers.
  - Focus on high level clinical needs, symptom control and limiting the spread of transmission.
  - Implement strategy for unrecovered resident funds.

- **Government Tactical Action**
  - Commence residential aged care and hospital/primary health partnership strategy.
  - Direct funding to front line services.
  - Implement strategy for unrecovered resident funds.

### Phase 4 – Recovery/Consolidation
**September/October 2020**

- **Operational Impacts**
  - Infection levels decline.
  - Continued relaxation of community lockdown measures.
  - Workforce stabilising and returning to normal activity.
  - Business and schools reopen.
  - Fluctuations in occupancy levels as respite residents return home.
  - Increased acquisition activity and consolidation among providers driven by liquidity and operational pressures.
  - Potential turnover of staff driven by exhaustion, decreased wellbeing and low staff morale.
  - Resident’s suffering from emotional trauma and the negative impacts from physical distancing from family and friends.
  - Full extent of virus spread and associated casualties still being realised from delayed impact of COVID-19.
  - Exhaustion and high stress levels experienced from front line staff and management.
  - Assessing required investment of time/resources to re-establish business as usual practices including ACFI claiming, care planning, accreditation, new admissions, etc.
  - Regrouping and planning on future strategy and growth initiatives.

- **Financial/Organisational Impacts**
  - Limited supplies of PPE available and reduced access to networks to support care delivery.

- **Provider Tactical Action**
  - Evaluation, assessment and reflection of past 6-7 months (what worked, what didn’t, what we learnt).
  - Share knowledge within the sector of experiences and new learnings.
  - Develop plan/timeline to re-establish operation practices.
  - Reassess strategic and growth initiatives.
  - Assess acquisition opportunities.
  - Work with the Royal Commission to develop sustainable long term solutions for the sector.
  - Highlight sector environment changes and promote new initiatives practices which have emerged from past 6-7 months.

- **Government Tactical Action**
  - Continue to provide higher funding for the short term to support organisations as they transition back to business as usual.
  - Work with the Royal Commission to develop sustainable long term solutions for the sector, recognising current sector environment and impact from COVID-19 events.
Note, most statistics are up to date as at 12:00pm AEDT 27 March 2020 or latest available.

## APPENDIX TWO – INTERNATIONAL COMPARISONS (SUMMARY)

Note, most statistics are up to date as at 12:00pm AEDT 27 March 2020 or latest available.

<table>
<thead>
<tr>
<th></th>
<th>ITALY</th>
<th>SPAIN</th>
<th>FRANCE</th>
<th>US</th>
<th>UK</th>
<th>CANADA</th>
<th>CHINA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative no. latest</td>
<td>80,589</td>
<td>57,786</td>
<td>29,155</td>
<td>85,377</td>
<td>11,658</td>
<td>4,043</td>
<td>81,340</td>
</tr>
<tr>
<td>confirmed cases to date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cumulative no. latest</td>
<td>8,215</td>
<td>4,365</td>
<td>1,696</td>
<td>1,295</td>
<td>578</td>
<td>39</td>
<td>3,292</td>
</tr>
<tr>
<td>confirmed deaths to date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative no. deaths</td>
<td>6,474</td>
<td>Approx. 1,100</td>
<td>Approx. 1,500</td>
<td>Approx. 1,050</td>
<td>Limited data available, but several reports indicate the majority of deaths are in the 60+ age cohort.</td>
<td>Limited data available, but several reports indicate the majority of deaths are in the 60+ age cohort.</td>
<td>829</td>
</tr>
<tr>
<td>persons aged 60+</td>
<td></td>
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### COVID-19 testing regime

- **Very low testing regime.** Only testing people in acute condition requiring hospital care. True figures for total confirmed cases are expected to be multiple times higher than official figures.
- **Low testing regime.** Mainly testing people in acute condition requiring hospital care and focusing on high-risk age groups and comorbidities.
- **Low testing regime.** Normally low testing in aged care facilities.
- **Low testing regime.** Mainly testing people in acute condition requiring hospital care and focusing on high-risk age groups and comorbidities.
- **Low testing regime.** Low testing in aged care facilities.
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- **Low testing regime.** Low testing in aged care facilities.
- **Low testing regime.** Low testing in aged care facilities.
- **Low testing regime.** Modest testing regime. Testing people with milder symptoms as well as in acute conditions.
- **Low testing regime.** Robust testing regime. Testing in aged care facilities unknown.

### Current status of aged care sector

- **COVID-19 is wide-spread throughout nursing homes, especially in the Northern regions of Italy.** Some homes have been completely overrun by COVID-19.
- **COVID-19 is wide-spread throughout nursing homes, particularly in highly affected regions of Spain.** Some homes have been completely overrun by COVID-19.
- **COVID-19 appears to be spreading throughout nursing homes.** However, many homes in highly affected regions of France are reporting higher than normal death rates. There are fears the COVID-19 could be more widespread in aged care facilities than official figures.
- **COVID-19 appears to be spreading throughout nursing homes.** Within weeks, at least 129 residents were confirmed and 35 died. There are now more than 75 nursing homes across the country with confirmed COVID-19 cases. A home in New Jersey fears all 94 of its residents have COVID-19, demonstrating the speed at which the virus spreads in a facility.
- **COVID-19 has been identified in some UK nursing homes.** Some homes are starting to express concern over: • Getting food deliveries and the impact this will have on their residents’ nutrition. • Delayed or insufficient medication supplies. • Delays with COVID-19 testing for staff, resulting in staff needing to self-isolate which creates operational capacity pressures. • Pressure from hospitals to admit residents to free hospital beds.
- **COVID-19 is wide-spread throughout nursing homes in Canada.** Resources directed to assist the aged care sector. Confirmed cases of COVID-19 identified in at least 16 facilities to date. There are concerns over the current measures in place to prevent resident infection and controlling the spread of the virus within aged care facilities.
- **At the time of the outbreak there were some reports about many deaths among residents of long term care facilities in China.**

Sources: Data has been collected using Worldometer, Bloomberg, Statistica, John Hopkins University and the Centre for Evidence Based Medicine.
APPENDIX THREE – CONFIRMED COVID-19 CASES SINCE 100th CASE IN SELECTED COUNTRIES

Source: Our World in Data
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