

# Aged care residents — and everybody else — would benefit from better control of COVID-19 transmission

Gwendolyn L Gilbert 

Encouraging public compliance with measures that limit community transmission would benefit everyone, with only minor inconvenience



**F**rom the start of the coronavirus disease 2019 (COVID-19) pandemic, it was clear that older people, particularly those in residential aged care facilities (RACFs), were at greatest risk of contracting and dying from the disease. People in RACFs have frequent close contact with their carers, who can unwittingly introduce and spread pathogens; further, older people are more vulnerable to severe

infection because of immuno-senescence and increasing comorbidity.

Community transmission is the strongest predictor of COVID-19 outbreaks in RACFs. In 2020, the incidence of COVID-19 in Australia was lower than in most comparable countries. In the context of systemic deficiencies in aged care,<sup>1</sup> many RACFs were unprepared for the major wave of community transmission in Victoria during July–September 2020 and smaller pandemic waves in other states. Decisive action contained many RACF outbreaks, but delayed or inadequate control measures allowed catastrophic spread in others.<sup>2</sup> When suitably trained workers were unavailable to replace the large numbers of staff on medical leave, many residents suffered shocking neglect. In some instances, 60–80% were infected with the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and many died; hospitals, many themselves overwhelmed by the pandemic, were often unwilling to care for them. Only 7% of COVID-19 cases in 2020 were in RACFs, but 75% of COVID-19-related deaths were of RACF residents; the mean case fatality rate was 33%.<sup>2</sup>

During the first half of 2021, international and interstate border closures, lockdowns, and other public health measures limited widespread community transmission of SARS-CoV-2; later outbreaks, of the Delta variant of SARS-CoV-2, were geographically contained. However, relaxation of border controls coincided with the emergence of the Omicron variant in November 2021, and the number of COVID-19 cases soared, including in states hitherto spared large outbreaks.<sup>3</sup> The characteristics of the Omicron variant were still unclear, but the number and site of its mutations caused concern about possibly increased transmissibility, pathogenicity, and immune system evasion.<sup>4</sup> The World Health Organization recommended that countries “continue to implement the effective public health measures to reduce COVID-19 circulation overall, using a risk analysis and science-based approach.”<sup>5</sup> Nevertheless, and contrary to expert advice, most public health restrictions in Australia had been lifted by Christmas 2021.<sup>3</sup>



The Australian COVID-19 vaccination program had begun in February 2021 and, despite initially slow progress, nearly 90% of people over 16 years of age, and 99% of those over 70, had received two vaccine doses by December. However, the assumption that widespread vaccination would limit transmission and protect the people at greatest risk of severe disease was unduly optimistic, and rising community transmission was predictably followed by RACF outbreaks. In January 2022, outbreaks were reported by 47% of RACFs in Australia, and the numbers of infections and deaths were larger than for all of 2021.<sup>6,7</sup> Many RACFs experienced several outbreaks, and unprecedented numbers of COVID-19-related deaths were reported throughout 2022, with major peaks in February and August.<sup>8</sup> Even for residents who avoided infection, restrictions on visits by loved ones — disguised and muffled by masks — and the cancellation of social events and outings contributed to accelerated physical and cognitive decline.<sup>9</sup> Although many RACFs were better prepared than in 2020, staff shortages were more serious and personal protective equipment and rapid antigen tests in short supply.<sup>6,7</sup>

This is the background to the retrospective analysis by Ellis and colleagues reported in this issue of the Journal,<sup>10</sup> the aim of which was to identify factors associated with the hospitalisation and death of RACF residents in the Queensland Metro South Hospital and Health Service. All 86 facilities experienced outbreaks during December 2021 – January 2022; 1080 of 8700 residents (12%) were diagnosed with COVID-19, 126 of whom died (12%). The findings of Ellis and colleagues were consistent with an earlier report that severe disease and death from COVID-19 were more frequent in Australia among older Australians, men, and people with dementia and other medical conditions.<sup>11</sup> The findings also confirm that the Omicron SARS-CoV-2 variant could spread rapidly despite high community vaccination rates. However, the major finding by Ellis and colleagues was that vaccination (particularly a three-dose course) afforded considerable protection against the most serious outcomes. Unfortunately, at the time of the outbreaks only one-third of residents had received three vaccine doses.<sup>10</sup>

At the time of writing (December 2022), community transmission of SARS-CoV-2 was again increasing and RACF residents and their exhausted carers were facing a third pandemic summer. While most personal risk factors for death from COVID-19 of older people are unavoidable, it is not unreasonable to ask whether more could have been (and still should be) done to protect them from the dual risks of exposure and loneliness. Stronger public messages, and at least some enforcement, to encourage public compliance with measures that limit community transmission would benefit everyone and cause only minor inconvenience.

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