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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

Pandemic Treaty

KEY POINTS

- Australia is actively engaged in negotiations to draft an international instrument (treaty) on pandemic prevention, preparedness, and response.
- the new treaty provides an opportunity to strengthen global response to future pandemics. It aims to strengthen collaboration across the global health sector, increase surveillance of emerging pathogens and ensure access to medical products in response to pandemics.
    - adoption of the new instrument is based on the consensus of all WHO Member States.
    - countries will retain sovereignty regarding their health policies. No international instrument, such as a treaty, could change Australia's Constitution nor prevail over Australian law.
- Australia is working to ensure our interests are preserved and our priorities advanced, including:
    - supporting equitable access to health emergency countermeasures
    - strengthening global disease surveillance and information sharing, and
    - embedding a One Health approach which recognises that the health of people is connected to the health of animals and the environment.
- Australia has participated in the WHO's consultations, through public hearings and informal consultations on key topics with experts and discussions with Member States at WHO Regional Committee Meetings.
- the Australian Government will consult with state and territory governments, and other relevant stakeholders, throughout the negotiation of a new instrument.

Background

- there have been two meetings of the Intergovernmental Negotiating Body (INB), through which all 194 WHO Member States agreed on arrangements for an international instrument. The INB deliberations were guided by a core group of 6 countries (Brazil, Egypt, Japan, Netherlands, South Africa and Thailand).
- at the second meeting held from 18-21 July 2022, it was agreed through consensus, that the instrument should be legally binding.

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- the third meeting is due to be held 5-7 December 2022, with the Bureau to circulate a zero draft of the instrument prior to this meeting.
- formal negotiations through the INB are expected to conclude with an agreed instrument considered at the 77th WHA in May 2024.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

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GP shortages and clinic closures

KEY POINTS

- Recent media has noted the difficulties people experience accessing their GP in a timely manner or near where they live.
- Articles have also focused on the medical workforce with many GP practices highlighting an inability to recruit adequate GP numbers to service patient demand.
- Along with this, in recent months some practices have closed, while others have opened and some practices/doctors have closed their books to new patients or reduced their operating hours.
    - GP Practices are private business that make a range of business decisions related to employment, location, investments and continued operation.
    - Some corporate operators with a number of practices across communities have ceased trading due to viability concerns with limited notice or collaboration with communities on ensuring ongoing access to vital GP services.
    - There is also a trend in practices operated by a single GP close, for example where a sale cannot be arranged, or the principal is seeking to retire
- The Department of Health and Aged Care is working with Rural Workforce Agencies on these issues as most are in rural areas.
    - RWAs are funded by the Government to support the health workforce in rural areas where these issues are of major concern as there may not be clinics nearby for patients to transfer to.
    - RWAs are asked to contact the practice and provide support to the doctors/ seek out opportunities for new owners/new doctors to work there or to facilitate other solutions for the community – often working with the local Primary Health Network, State Health local representatives and local councils on a positive outcome.
- The department is also seeking reports from RWAs and PHNS fortnightly on activities where they are working to support practices.
    - **Attachment A** – note privacy issues if individual practices, or some towns are named or identified.

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FACTS AND FIGURES

- The department monitors practices where the RWA or PHN are working with the practice directly and the practice has indicated there is a possibility of closure.
    - We do not monitor locations that may be under-serviced, or where the RWA/PHN is not directly involved in support.
    - We also don't monitor practices that may be opening or extending their service provision which does occur frequently.
- Positive feedback from workforce agencies indicates:
    - A willingness by local government to look for and be part of solutions for practices.
    - RWAs and PHNs in rural and regional areas are working together to provide different support elements to a practice.
    - Other local practices often able to step in and assist with patient care.
- There are also some common issues occur in practices facing difficulties:
    - There is a prevalence of practices with solo GPs, particularly those who are ageing, where the business is unable to attract new staff or attract a purchaser.
    - Practices need to employ doctors capable of supervising to widen the recruitment pool.
    - The lack of accreditation in a practice decreases it's saleability.
    - The reliance on locums to cover vacant positions is not a long-term option due to the expense and lack of stability.
- It is important to note that medical practices are run as privately owned businesses make individual decisions around their business operations. The Government does not play a role in these decisions.
- Practices decide the:
    - Hours of operation, including if they offer evening or weekend appointments.
    - Staff they employ (e.g. un-Fellowed International Medical Graduates require supervision options to get on a Fellowship training program, which many practices choose not to offer, creating turnover in doctors).
    - Remuneration packages for doctors (fixed salary versus percentage of fees).
    - Level of staff support or supervision and practice management approaches.
- While a practice may be impacted by doctor or management decisions, availability of GP services in a GP catchment may remain above average.
    - GP catchments represent the flow of patients in an area. Catchment-wide assessments are used to determine the Distribution Priority Area (DPA) status and other workforce statistics (such as GP FTE, GP clinic numbers) often indicate that service availability is still satisfactory.

- The Rural Health Workforce Support Activity, which funds the Rural Workforce Agencies, allow Government to provide targeted support to practices seeking it.
    - Rural Workforce Agencies may fund practices directly to assist with staff recruitment and retention, as well as the business side of the practice.
    - Staff supports funded can include relocation costs, new staff orientation grants, support for Continuing Professional Development costs, recruitment incentive packages, Fellowship support and exam preparation grants. Grants are dependent on the needs of the doctors in a practice, and some include support for the family members of a health professional.
    - Other practice support can include grants to support locum placements for a practice, clinical placement grants, practice upskilling grants, assistance with the costs of Quality Accreditation or Cultural Safety training costs or business sustainability grants, among others.
- Primary Health Networks (PHNs) are funded by the Australian Government and work closely with general practitioners (GPs) and other health professionals in their region through practice support to build health workforce capacity (e.g. education, training and support) and the delivery of high quality care.

Responses

- Examples that highlight this issue and the government's response include the recent closure of a practice in Brighton, Tasmania as a single practice and the closure of services associated with Tristar in Victoria and RaRMs in New South Wales.
    - **Brighton (Tas)** The RWA has worked with another practice to expand capacity to manage more patients, facilitated recruitment of a new GP and services recommenced from 17 October.
    - **RaRMS (NSW)** The RWA has worked with five affected communities. In one community new owners have taken over the practice which is now operating. In three communities negotiations are underway for transfer of ownership, in two cases involving local government establishing a corporate entity with a view to subsequent sale) though dates for completion of transfer to be finalised. In a final community the GP and practice manager have transferred to another practice in the town.
    - **Tristar (Vic)** The RWA worked closely with the local PHN and Mildura Base Hospital and facilitated work with Ahpra, RACGP and individual GP practices to ensure the community continued to have access to primary care. Local practices continue to receive additional support and local doctors employed by Tristar are being supported to move to new roles at existing practices.
- Where notified, the RWAs will often work with practices in difficulty or when the principal doctor is seeking to retire. This work is best done far in advance to ensure continuity of care for the patients. In other circumstances, the RWAs are asked to urgently support the community and practice where for example, a corporate GP practice has decided, with limited notice, to close.

- Similarly, PHNs provide targeted support to medical practices where business issues exist. In a number of cases, both the RWA and the relevant PHN will be working in tandem with a practice on different elements (for example, recruitment support by the RWA and business skills development support from the PHN).

What is the government doing to support patient care in rural areas given closures? (election commitments)

- The Government will address workforce shortages particularly beyond our capital cities, making new investments in improving access to health and aged care in rural and regional areas. A $185.3 million workforce package will support more doctors, nurses and allied health professionals to work in regional and rural communities and improve treatment and care for patients, including:
    - $24.7 million for the successful Innovative Models of Care program commencing from 2023 to attract, support, and retain rural health professionals. The program supports health care professionals and communities to implement sustainable and comprehensive solutions tailored to their unique local health care need
    - $5.6 million to expand the John Flynn Prevocational Doctor Program by more than 1,000 places by 2026
    - $74.1 million will make incentive payments of up to $10,500 available to GPs and rural generalists with advanced clinical skills to practice in rural and remote communities
    - More health workers will be eligible for salary support through the Workforce Incentive Program thanks to a $29.4m expansion
    - $11.7m for new training posts for GPs, GPs in training and rural generalists to develop skills training in areas such as obstetrics, palliative care, paediatrics and mental health
    - More GP and rural generalist registrars training in regional Australia can take advantage of Single Employer Model trials, allowing them to maintain the benefits of being employed by one body throughout their training.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

Transition of the Australian General Practice Training program

KEY POINTS

- From February 2023, responsibility for delivering the Australian General Practice Training (AGPT) program will transfer from Regional Training Organisations (RTOs) to the GP Colleges (the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP)).
- The transition aligns the GP colleges with other medical specialties, which have responsibility for training registrars, including the work of medical educators to supplement the training provided by supervisors in practices.
- There is no intention to reduce funding for the AGPT program. Any efficiencies in program delivery will be reinvested to increase financial support for supervisors and registrars.
- Grant agreements with ACRRM and RACGP were executed in August 2022.
- The Department engaged the Nous Group to assess the colleges' governance frameworks and capacity to support the administration of college-led training and assess financial management systems to manage the grant training funds. The final assessments were delivered in September 2022 and found that both colleges are ready to deliver training.
- The National Consistent Payments (NCP) model will increase transparency and consistency of support payment for program participants. This model will encourage and support training in rural and remote regions through tiered payments for training.
- In December 2021 the Australian Government announced through the Mid-Year Economic and Fiscal Outlook budget, additional investment of $14.3 million for a payment system for the streamlined delivery of payments to GP training participants.
- Under the General Practice Workforce Planning and Prioritisation (WPP) activity, funded organisations will provide analysis and advice to the department and GP colleges to inform the college's GP training distribution to meet workforce needs. This will deliver analysis of workforce data and knowledge at GP catchment level, building on and replacing current workforce planning activities undertaken by the RTOs. WPP advice will also inform the distribution targets set for the colleges from 2024.
- In August 2022, grant agreements were executed with six successful applicants for the WPP activity, each of which will lead a consortium across each jurisdiction. The department is working with WPP organisations, the GP Colleges and RTO representatives to deliver a consolidated approach to workforce need and training capacity analysis.
- The department has consulted with Aboriginal and Torres Strait Islander stakeholders who have recommended the establishment of a governance committee to advise on the utilisation of training funds to provide improved outcomes for Aboriginal and Torres Strait Islander health in a college-led training model.

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FACTS AND FIGURES

- In 2022, the AGPT had 5,237 registrars training towards GP fellowship qualifications.
- Funding of $76.3m (GST excl) has been provided to the colleges for transition since 2018.
- The agreements with GP Colleges for transition activity and delivery of training from 2023 to 2025 total $476 million.

Financial Year $m (% split)	2021-22 GST excl	2022-23 GST excl	2023-24 GST excl	2024-25 GST excl	2025-26 GST excl	Total
ACRRM	6.1 (41%)	13.2 (17%)	37.3 (24%)	36.5 (24%)	18.5 (24%)	111.6 (23%)
RACGP	8.9 (59%)	65.2 (83%)	116.1 (76%)	116.1 (76%)	58.1 (76%)	363.4 (77%)
Total	15.0	78.4	153.4	152.6	76.6	476.0

Note annual AGPT funding of $27m will be provided for the Salary Support program and $40m for 'derived' NCP both of which will be delivered through a Services Australia payment system.

- Up to $42m (GST excl) was provided for the WPP activity:

Organisation $m	2022-23 (GST excl)	2023-24 (GST excl)	2024-25 (GST excl)	2025-26 (GST excl)	Total
Partners 4 Health Ltd	1.36	3.11	3.08	1.49	9.03
General Practice Workforce Inc	0.50	0.75	0.74	0.51	2.50
Murray PHN Ltd	1.47	2.85	2.81	1.36	8.50
Capital Health Network Ltd	2.40	4.92	5.01	2.47	14.80
GPEx Ltd	0.51	0.98	0.99	0.49	2.97
WA Primary Health Alliance Ltd	0.76	1.38	1.38	0.68	4.20
Total	7.00	14.00	14.00	7.00	42.00

RELATED QUESTIONS ON NOTICE (QoNs)

- SQ21-001012 - General Practice Training Tasmania and transitioning of GP training to the Colleges by 2023
- SQ21-000567 - Contribution GP Training Enquiry
- SQ21-000129 - Funding for GP training
- SQ21-000128 - GP Training Tasmania

RECENT MEDIA

Aus Doc - 23 Sep 2022 - Signed sealed and about to be delivered the return of GP training

The article notes the execution of the RACGPs college-led training grant agreement. It notes delays fuelling uncertainty among registrars, the sub-contracting of James Cook University, the recruitment of 900 staff from RTOs and the training model with local teams and regional teams to oversee training coordination to ensure consistency.

The article discusses the RACGP plans to use intensive case management and support for registrars training in unpopular locations where workforce demand. It is suggested that the WPP activity could be "used as fodder to fix the ever-growing workforce holes in rural Australia – the problem that led the college to lose the program in the first place".

National Consistent Payments are praised for the outcome to make it easier for registrars to change locations given the same approach to education, supervision and record keeping.

Medical Republic - 4 October 2022 -How ready are we for the GP training transition

A positive article with the RACGP's view on RTO staff recruitment, noting their confidence in having the staff to deliver training. The RACGP's training model is detailed, and the college noted continued work regarding senior appointments and office locations.

The article discusses the ability to tailor regional responses and outlines collaboration to date between WPP organisations, Health and colleges and the need to ensure safe and quality training for registrars (above workforce needs) and the suitability of the WPP consortium members in being able to provide workforce intelligence.

Medical Republic - 7 October 2022 -Want a different tomorrow? ask for different things

The article notes the work required by the RACGP in the recruitment of RTO staff and office establishment to maintain the regional IP and knowledge required to provide GP training. Its states that timeframes are risky especially given the hard 'kill date' for RTOs and asserts that the lack of current protest or concern is due to a resignation that the risky course/plan has been set with the execution of college agreements.

SENSITIVITIES FOR DISCUSSION

- The RACGP is currently undergoing a recruitment process targeted at capturing skills base of current RTO staff. To date the RACGP have offered employment to 159 RTO/RACGP staff and expect to finalise offers by mid-November. Significant appointments including National program officers, Regional Directors of Training and Regional Operations Managers have been made to RTOs/RACGP staff. The College received over 900 applications for 620 advertised positions.
- The RACGP have approached the market to fill staffing gaps where there is no interest from RTO staff. ACRRM has undertaken a similar approach to recruitment, inviting select RTO staff to apply for positions earlier this year, but has largely relied on open market recruitment, which is ongoing.
- The role of James Cook University (JCU) in college-led training has been recently scrutinised. The College-led GP Training grant opportunity required training delivery to support Commonwealth funded end to end rural training programs, including those at JCU. The colleges are working with JCU to finalise heads of agreement.
- In January 2022, the RACGP entered into a strategic partnership with GP Synergy - the RACGP will utilise GP Synergy as their training entity.
- ACRRM has been concerned about the limitation of the current selection quotas (150 training places/1,500) to build its college-led model. The RDAA has supported this claim citing the inability of the colleges to fill rural training places. However, ACRRM has not been able to fill its existing allocation in recent years and, despite advertising a greater number of available places for 2023, early signals from the intake for 2023 do not show any current demand for these additional places.

- The department released the NCP framework on 9 February 2022 and has now published communications material regarding payments to be delivered through a Services Australia payment system. There have been concerns regarding the lack of registrar support for training in MM1 regions. Not all RTOs currently provide financial support to registrars in MM1 regions and support for registrars training in MM2-7 regions in reflective of the Government's priority to support rural and remote training.
- The framework does provide access to additional funds through the GP colleges. The GP colleges have noted that additional funding will be assessed on a case-by-case basis to support registrars in placements where there is workforce need.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

Long COVID

KEY POINTS

- The Department recognises that some people experience prolonged symptoms after infection with SARS-CoV-2, the virus that causes COVID-19. This is sometimes referred to as long COVID.
    - The Department acknowledges the uncertainty faced by people experiencing symptoms of long COVID and the importance of access to the appropriate services and support.
    - There are some uncertainties regarding the specific causes of long COVID and its impact in Australia, particularly in the context of relatively high vaccination rates, exposure to lower severity variants (when compared to the experience of most other countries) and the impact of antiviral medication for those at highest risk of severe illness.
    - We do not yet have a clear picture on the prevalence of long COVID in Australia. A number of data linkage and data analysis projects are underway to better understand the prevalence and impact of long COVID in Australia.
- The Department is preparing a response to the House of Representatives Inquiry into long COVID and Repeated COVID Infections.
- The Department is leading the development of the National Response to long COVID which will describe the current situation regarding understanding, measuring and managing long COVID in Australia and provide a guide to the next steps.
    - This will include investigating where the pressure points and gaps are in the health system for long COVID patients to inform any additional necessary actions and supports. As evidence regarding long COVID continues to emerge, the Response will be revisited regularly to ensure it remains relevant.
- The Australian Government is funding research through the Medical Research Futures Fund (MRFF) (**Attachment A**) and the NHMRC to improve understanding of aspects of long COVID and some of the possible long-term health impacts of COVID-19.

FACTS AND FIGURES

- Australia's pandemic response has reduced the burden of acute disease associated with COVID-19. This has been the result of early intervention across all levels of government to reduce transmission and make vaccination and oral treatments widely available.
- Australia's experience of COVID-19 differs from other countries who experienced larger outbreaks of the Alpha and Delta variants, as well as outbreaks prior to vaccine availability.
    - Australia's relatively high rates of vaccination are associated with reduced risk and severity of long COVID.
    - Most people in Australia who have had COVID-19 have been infected with the Omicron variant which has been associated with a lower risk for long COVID than infection with the Delta variant.
    - Caution should be taken when applying extrapolations based on the experience of other countries to Australia.

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- The Department considers there are broadly 3 categories through which long COVID outcomes and treatment can be understood, each requiring different levels and types of health care:
    - *post-viral syndromes* which generally self-resolve in 3-6 months and may require management in primary care
    - *disease-specific conditions* which require access to specific specialist care e.g cardiology
    - *medically unexplained physical symptoms* which persist beyond 3-6 months and require access to specific multidisciplinary care.
- Specific long COVID clinics have been established in states and territories.
- The Department has commenced preliminary work to identify the impacts of long COVID by analysing changes in health services accessed by individuals before and after COVID-19. The analysis compares MBS items claimed pre- and post-COVID-19 for each individual, evaluating statistically significant changes in health services accessed in the period after active COVID-19 infection. These include diagnostic items that may indicate persisting effects of COVID such as increased GP visits, chest X-Ray services, blood tests or use of pulmonary rehabilitation services. The overall numbers, however, are relatively small.
- The Department is working with states and territories to link COVID-19 case data. This work will support more comprehensive COVID-19 case identification and enable the study of long-term health effects associated with COVID-19.
- In addition, the Australian Institute of Health and Welfare is establishing a national linked data platform that integrates COVID-19 case information with a range of relevant existing health data sets. This platform, which will be available to Australian researchers, will contribute to understanding the longer-term impacts of COVID-19 on patients.
- Patients with long COVID can access existing MBS items for the treatment of their condition, including:
    - time tiered GP general attendance items
    - specialist doctors who also have access to a range of general consultation items.
- Patients may also be eligible for MBS Chronic Disease Management (CDM) items.
    - CDM items enable GPs to plan and coordinate their health care and can refer patients to MBS subsidised allied health services.
    - GPs can refer patients for up to 5 MBS rebated allied health services per calendar year.
- To date, the Government response has focused on gathering evidence and supporting GPs in caring for people with long COVID.
    - The Department contracted the Royal Australian College of General Practitioners (RACGP) to update the RACGP Guidelines on Caring for Adult Patients with Post-COVID-19 Conditions.
    - The RACGP also developed a patient resource to support their patients to manage their fatigue and any additional symptoms.

Attachment A

MRFF Coronavirus Research Response

- The Government recognises that health and medical research has an important role in Australia's ongoing response to COVID-19 and will consider the need for further research investments as the epidemiology evolves.

KEY FACTS AND FIGURES

- To date, $130 million has been made available through the MRFF for COVID-19 research, including on vaccines, antivirals, and health system preparedness (Attachment A).
  - $8.1 million for research on long COVID, including
    - $3.0 million to the Australian Institute of Health and Welfare to establish a national linked data platform
  - $34 million for COVID-19 vaccine-related research
    - $24.1 million for developing 9 vaccine candidates
    - $9.9 million for vaccination schedule research
  - $39 million for antiviral therapies and potential treatments for COVID-19
- Further, $39.5 million has been made available for 36 research projects relevant to coronavirus research through National Health and Medical Research Council (NHMRC).
- In addition, $25 million is being made available through the MRFF 2021 mRNA Clinical Trials Enabling Infrastructure Grant Opportunity for clinical trials of mRNA-based vaccines and therapeutics. This Grant Opportunity does not require applications to focus on COVID-19. Applications are under assessment and outcomes are expected to be announced by end 2022.

BACKGROUND

- Overall, over $430 million in Australian Government support for COVID-19 research and development has been announced so far. Another key investment was $230 million in the CSIRO's vaccine development capability in April 2020, including upgrading the high containment biosecurity research facility.

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List of Government's MRFF coronavirus research investments and details (as at 10 Oct 22)

Table 1: A diverse range of COVID-19 research activities have been funded through the MRFF

Topic	Research	Funding
Vaccine development	• Development of 9 vaccines using different technologies, including viral vector, mRNA, DNA vaccine, modified bacteria (tuberculosis vaccine), proteins (including molecular clamp, Chimeric next generation COVID vaccines, virus-like particle). • Clinical trial for vaccines (mRNA and protein)	$24.1 m
Antiviral development	• Viral inhibitors, siRNA, convalescent plasma, oligonucleotides, Ivermectin, Hyperimmune globulin, Biologics, deubiquitinase targeting, Hydroxycholoroquine, antibody-based therapies, RNA-based and novel antiviral therapeutics, viral protease targeting, ESFAM289, TLR2/6 activation with INNA-051 • Stem Cells for rapid screening of drugs as potential COVID-19 treatments	$27.1 m
Respiratory medicine clinical trials	• Tocilizumab, oral/enteral hydroxychloroquine dosing, antibiotic strategies, novel therapies in high risk cancer patients, OM85 treatment, immuno-modulatory particles and colchicine treatment, as well as repurposing existing medications	$6.8 m
Diagnostics	• COVID-19 Strategic Planning and Delivery of Testing • CovED (diagnosis of COVID-19 in the lung)	$3.7 m
Public Health	• National COVID-19 Clinical Evidence Taskforce • Mental health systems research (supporting community mental health and well being post bush fires and COVID 19, reducing depression in adults with COVID-19 related distress, adolescent mental health)	$4.6 m
Prevention, preparing the health system and other cross-cutting research	• Clinical trials (transmission prevention in aged care and in health care setting, treatments for brain and cardiac complications, role of Nutritional Supplementation) • Digital health (Integrating remote monitoring technology into digital health infrastructure, Towards a national data management platform and Learning Health System, Real-time modelling of Australia's COVID-19 response). • Communication strategies (tailored COVID-19 message for vulnerable Australians, Health Communication in Specialist Disability Accommodation and early childhood sector) • New medical devices and therapeutic approaches (via the Biomedical Translation Bridge Program) • Genomics of the virus • Immune response against the virus • Vaccine adverse events • Long-term health impacts (Molecular phenomic approaches , neurological impact) • Vaccine schedules (for immunocompromised individuals/ populations, combining different COVID-19 vaccines) • Antiviral treatment access • Virus transmission (indoor and intensive care settings) • National linked data integrating relevant existing health data sets	$63.4 m

Table 2: Details of MRFF grant rounds, recipients, and project by topic

Grant opportunity		Grant recipient (one-line project description)	Funding
Vaccine development			
2020 MRFF Novel Coronavirus Vaccine grant opportunity (competitive) • *announced by the Prime Minister on 18 February 2020* • *outcomes on 2 June 2020*		Recipient: University of Queensland Project: The Molecular Clamp Stabilized Spike Vaccine for Rapid Response' Program	$1.97 m
2020 MRFF COVID-19 Vaccine Research grant opportunity (targeted) • *Outcome on 22 March 2020*		Recipient: University of Queensland Project: Rapid Acceleration of the UQ COVID-19 Vaccine Program	$3.00 m
2020 COVID-19 Vaccine Candidate Research grant opportunity (competitive) • *Announced 11 March 2020*	Round 1 • *closed on 16 July* • *Outcomes on 20 September 2020*	Recipient: University of Melbourne Project: Research on mRNA and protein vaccines	$3.00 m
		Recipient: University of Sydney Project: a DNA based needle free vaccine	$2.95 m
	Round 2 • *closed 11 Nov 2020* • *Outcomes 11 May 2021*	Recipient: University of Sydney Project: Modified Tuberculosis vaccine to combat emerging SARS-CoV-2 variants	$1.56 m
		Recipient: University of South Australia Project: Next generation COVID-19 vaccine using the established Sementis Copenhagen [viral] Vector platform system	$2.98 m
	Round 3 • *closed 10 March2021* • *Outcomes on 30 June 2021*	Recipient: University of Melbourne Project: A next generation COVID vaccine using a vaccine platform that uses a protein scaffold.	$3.00 m
		Recipient: University of Melbourne Project: Adaptable SARS-CoV-2 (not infectious) virus-like particle (VLP) vaccine	$3.00 m
Medical Research Commercialisation Initiative (Biomedical Translation Bridge) COVID-19 Round 3 grant opportunity (competitive) • *Outcome 3 September 2020*		Recipient: Vaxine Project: The COVAX-19 vaccine	$1.00 m
2020 Rare Cancers Rare Diseases Unmet Need COVID-19 grant opportunity (competitive) • *Outcomes on 3 January 2021*		Recipient: University of Melbourne Project: Clinical trial for mRNA and protein vaccines being developed at the University of Melbourne.	$1.59 m

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Antiviral Development			
MRFF Antiviral Development for COVID-19 grant opportunity (Stage one) (Competitive) • *announced 21 March 2020* • *outcomes on 2 June 2020*		Recipient: Burnet Institute Project: Novel inhibitors of SARS coronaviruses targeting ACE2	$0.30 m
		Recipient: The Garvan Institute of Medical Research Project: Monoclonal antibody therapy of COVID-19	$0.59 m
		Recipient: Griffith University Project: Targeting SARS-CoV-2 using stealth nanoparticles loaded with gene silencing siRNA	$0.32 m
		Recipient: Monash University Project: Convalescent plasma for COVID-19	$0.37 m
		Recipient: Monash University Project: Inhaled oligonucleotides to generate a decoy receptor for the SARS-CoV-2	$0.30 m
		Recipient: Monash University Project: Ivermectin as an anti-viral against SARS-CoV-2	$0.34 m
		Recipient: University of New South Wales Project: Hyperimmune globulin: a rapid pathway to treatment of COVID-19	$2.07 m
		Recipient: The Walter and Eliza Hall Institute of Medical Research Project: Biologics for the prophylaxis and treatment of COVID-19	$1.99 m
		Recipient: The Walter and Eliza Hall Institute of Medical Research Project: Targeting the deubiquitinase activity of Coronaviruses: the VirDUB programme	$1.06 m
MRFF Antiviral Development for COVID-19 grant opportunity (Stage two) (Competitive) • *outcome on 11 September 2021*		Recipient: The Walter and Eliza Hall Institute of Medical Research Project: Biologics for the prophylaxis and treatment of COVID-19	$5.00 m
2020 COVID-19 PRO-COVER Trial (Targeted) • *outcomes on 20 May 2020*		Recipient: The Walter and Eliza Hall Institute of Medical Research Project: COVID-19 Prophylaxis with Hydroxychloroquine in Front-line Health and Allied-health Care Workers - The COVID-SHIELD Trial	$3.00 m
2020 Australasian COVID-19 (ASCOT) Trial (Targeted) • *outcomes on 2 June 2020*		Recipient: The University of Queensland Project: The Australasian COVID-19 Trial (ASCOT)	$0.35 m
2020 Rapid Screening of Approved Drugs in Stem Cell Models for COVID-19 grant opportunity • *announced 2 June 2020*	Stage 1 (Targeted) • *outcomes on 2 June 2020*	Recipient: The Council of the Queensland Institute of Medical Research Project: Preventing Cardiac Injury in Patients with COVID-19	$0.39 m
		Recipient: Peter Doherty Institute for Infection and Immunity (University of Melbourne) Project: Stem cell-derived human tissue models for the identification of drugs to treat COVID-19	$0.61 m
	Stage 2 (Competitive) Part of Round 2 of the 2020 Stem Cell Therapies Mission Grant • *outcomes on 30 June 2021*	Recipient: Commonwealth Scientific and Industrial Research Organisation (CSIRO) Project: The sySTEMs initiative: systems biology-augmented, stem cell-derived, multi-tissue panel for rapid screening of approved drugs as potential COVID-19 treatments	$1.00 m

2021 COVID-19 Treatment Access and Public Health Activities grant opportunity: **Stream 2:** accelerate the development of antiviral candidates to prevent or treat SARS-CoV-2. (Competitive) • *announced 3 December 2021* • *closed 23 February 2022* *outcomes: : 30 August 2022*	Recipient: University of Melbourne [Stream 2: Antiviral Research] Project: mRNA-based antiviral therapeutics for SARS-CoV-2 using Cas13	$1.00 m
	Recipient: University of New South Wales [Stream 2: Antiviral Research] Project: Development of antiviral RNA therapeutics targeting SARS-CoV-2 infection	$1.00 m
	Recipient: Curtin University [Stream 2: Antiviral Research] Project: Compound repurposing into novel therapeutics to treat SARS-COV2 infection.	$1.00 m
	Recipient: Monash University [Stream 2: Antiviral Research] Project: Pre-clinical testing of novel inhaled RNA therapies for stability, safety and effectiveness against SARS-CoV-2 to demonstrate proof of concept	$0.50 m
	Recipient: The Walter and Eliza Hall Institute of Medical Research [Stream 2: Antiviral Research] Project: A lethal and irresistible combination: Simultaneous targeting of the SARS-CoV-2 proteases Mpro and PLpro	$1.00 m
	Recipient: Esfam Biotech Pty Ltd [Stream 2: Antiviral Research] Project: Experimental Validation of the Target of ESFAM289 - a molecule with in vivo efficacy against SARS-CoV-2	$1.00 m
	Recipient: University of Melbourne [Stream 2: Antiviral Research] Project: Intranasal TLR2/6 activation to prevent COVID infection in the elderly	$3.88 m
Respiratory medicine clinical trials		
2020 Respiratory Medicine Clinical Trials Research on COVID-19 (Competitive) • *announced 21 March 2020* • *outcomes on 2 June 2020*	Recipient: The Council of the Queensland Institute of Medical Research Project: Tocilizumab for Treatment of COVID-19 in intensive care patients	$0.28 m
	Recipient: Queensland University of Technology Project: Use of therapeutic drug monitoring (TDM) to optimise oral/enteral hydroxychloroquine dosing in critically ill patients with COVID-19	$0.17 m
	Recipient: South Australian Health and Medical Research Institute Project: Precision antibiotic strategies to reduce invasive mechanical ventilation and mortality in COVID-19	$0.54 m
	Recipient: University of Melbourne ' Project: ProTreat: an adaptive and rapid implementation trial of novel therapies to prevent and treat COVID-19 infection in high risk cancer patients	$2.17 m
	Recipient: University of New South Wales ' Project: Repurposing existing medications to reduce severe acute respiratory distress in patients with COVID-19: the CLARITY trial	$1.41 m
	Recipient: The University of Queensland Project: Reducing acute severe respiratory events in health care workers during the COVID-19 pandemic with OM85 (extract from the walls of bacteria)	$1.25 m
	Recipient: University of Sydney Project: IMPACT-ICO: Trials of immuno-modulatory particles and colchicine to improve COVID-19 outcomes	$0.98 m

Diagnostics		
2020 COVID-19 Diagnostics grant opportunity (targeted) • *outcome on 21 March 2020*	Recipient: Peter Doherty Institute for Infection and Immunity (University of Melbourne) Project: COVID-19 Strategic Planning and Delivery of Testing	$2.70 m
2020 COVID-19 Diagnosis Platform (CovED) grant opportunity (targeted) • *outcome on 13 April 2020*	Recipient: University of Sydney Project: Transforming recognition and assessment of COVID-19 in Australia using lung CT (CovED Initiative)	$1.04 m
Public Health		
2020 National COVID-19 Clinical Evidence Taskforce grant opportunity (Targeted) • *outcome on 4 April 2020*	Recipient: Monash University Project: National COVID-19 Clinical Evidence Taskforce	$1.50 m
2020 COVID-19 Mental Health Research grant opportunity (competitive) • *announced on 25 May 2020* • *outcome on 6 October 2020*	Recipient: University of Wollongong Project: Narratives of Recovery - Practices supporting community mental health and well being post bush fires and COVID 19	$0.43 m
	Recipient: Monash University Project: Mobilising and empowering parents in the COVID-19 mental health response: A single-arm trial of an enhanced online parenting intervention to improve parent risk and protective factors for adolescent mental health	$0.61 m
	Recipient: University of New South Wales Project: A novel text mining and data linkage approach to investigate the mental health needs of the population during the COVID-19 period	$0.23 m
	Recipient: Deakin University Project: Evaluating the effectiveness of lifestyle therapy versus standard psychotherapy for reducing depression in adults with COVID-19 related distress: The CALM trial	$0.89 m
	Recipient: University of Canberra Project: Implementing Artificial Intelligence (AI) to enhance Lifeline's crisis support service capacity in response to COVID-19 and emerging crises	$0.22 m
	Recipient: University of Technology Sydney Project: Identifying the mental health effects and support needs of people bereaved during and following COVID-19: A Mixed Methods Project	$0.75 m
Prevention, preparing the health system and other cross-cutting research		
2020 Rare Cancers, Rare Diseases and Unmet Need COVID-19 (Competitive) • *announced 20 August2020* • *outcomes on 3 January 2021*	Recipient: South Australian Health and Medical Research Institute Project: Prevention of SARS-CoV-2 transmission in aged care using ultraviolet light	$1.37 m
	Recipient Flinders University Project: 3D-Printed Facial Guards to reduce P2/N95 respirator leak and protect health care workers from COVID-19	$0.97 m
	Recipient University of New South Wales Project: Statin Treatment to prevent brain complications as a result of COVID-19	$2.38 m
	Recipient University of Melbourne	$2.57 m

	Project: Use of Cardioprotective Therapy to Manage Persistent Cardiovascular Effects of COVID-19	
	Recipient: University of Melbourne Project: Protecting Aged Care Residents from the Pandemic via Specialised Nutritional Supplementation	$1.19 m
2020 Rapid Response Digital Health Infrastructure grant opportunity (Competitive) • *announced 2 June 2020* • *outcomes on 27 November 2020*	Recipient: Sydney Local Health District Project: Integrating remote monitoring technology into digital health infrastructure	$0.67 m
	Recipient: Monash University Project: Towards a national data management platform and Learning Health System	$1.92 m
	Recipient: Monash University Project: Real-time modelling of Australia's COVID-19 response	$0.81 m
2020 Communication Strategies and Approaches During Outbreaks grant opportunity (Competitive) • *announced 2 June 2020* • *outcomes on 27 November 2020*	Recipient: Monash University Project: Effectiveness of tailored COVID-19 message for vulnerable Australians	$0.32 m
	Recipient: Deakin University Project: Inclusive Health Communication in Specialist Disability Accommodation	$0.11 m
	Recipient: Macquarie University Project: Harnessing the health communication power of the early childhood sector	$0.17 m
Medical Research Commercialisation Initiative (Biomedical Translation Bridge) COVID-19 Round 3 grant opportunity (Competitive) • *announced 15 May 2020* • *outcomes on 3 September 2020*	Recipient: Dimerix Bioscience Project: novel treatment for respiratory complications due to COVID-19	$3.10 m
	Recipient: Starpharma Project: Intranasal spray using a broad-spectrum antiviral dendrimer for COVID-19 (preventative treatment)	
	Recipient: SpeeDx Project: Rapid response COVID-19 assay	
	Recipient: University of Melbourne Project: Ventilated hood for patient isolation to provide better respiratory treatment and protect hospital staff from COVID-19	
2020 Tracking COVID-19 in Australia Using Genomics grant opportunity (targeted) • *outcome 2 June 2020*	Recipient: University of New South Wales Project: Tracking COVID-19 in Australia Using Genomics	$3.27 m
2020 COVID-19 Immunological Studies grant opportunity (Competitive) • *announced 2 June 2020* • *outcomes on 6 October 2020*	Recipient: University of Melbourne Project: Defining immune responses in COVID-19 to understand susceptibility and target treatments'	$1.00 m
	Recipient: University of New South Wales Project: Cellular and molecular correlates to SARS CoV2 immunity in convalescent patients	$0.99 m
	Recipient: The Council of the Queensland Institute of Medical Research Project: Defining SARS-CoV-2 immune maintenance in the Australian population	$1.00 m
2021 COVID-19 Vaccine-Associated Thrombosis With Thrombocytopenia Syndrome (targeted) • *commenced on 1 November 2021*	Recipient: Monash University Project: A national, multi-centre study evaluating Thrombotic Thrombocytopenia Syndrome (TTS) associated with ChAdOx1 (AZD1222) and other SARS-CoV-2 vaccines (viral vector and m-RNA)	$2.92 m

2021 COVID-19 Health Impacts and Vaccination Schedules grant opportunity (Competitive) • *announced 11 May 2021* • *outcomes: 3 December 2021*	Recipient: Murdoch University [Stream 1: Health Impacts] Project: Molecular phenomic approaches to improve understanding of Post-Acute COVID-19 Syndrome – a biomarker-augmented strategy for risk based stratification and targeted intervention to improve clinical outcomes)	$3.40 m
	Recipient: University of Melbourne [Stream 1: Health Impacts] Project: Predicting the neurological impact of SARS-CoV-2 Variants of Concern-protecting Australians from long-COVID brain injury	$1.78 m
	Recipient: University of New South Wales [Stream 2: Vaccine Schedules, immunocompromising conditions] Project: Comparing Immunisation-boosting Regimens for COVID-19 Upon Initiation of immunosuppressive Therapies (CIRCUIT Study)	$2.75 m
	Recipient: Monash University [Stream 2: Vaccine Schedules, immunocompromising conditions] Project: Bringing Optimised COVID-19 vaccine Schedules To ImmunoCompromised populations (BOOST-IC)	$2.91 m
	Recipient: University of Western Australia [Stream 3: Vaccine Schedules, combine different vaccines] Project: The Platform trial In COVID-19 vaccine BOOsting (PICOBOO)	$4.16 m
2021 COVID-19 Treatment Access and Public Health Activities grant opportunity (Competitive) • *announced 3 December 2021* • *closed 23 February 2022* • *outcomes: 30 August 2022*	Recipient: Monash University [Stream 1: Treatment Access] Project: A coordinated multiplatform randomised trial for hospitalised patients with COVID-19	$4.00 m
	Recipient: University of Western Australia [Stream 3: Immune Response] Project: The Platform Trial in COVID-19 Boosting: stage 2 (PICOBOO-2)	$3.83 m
	Recipient: University of Melbourne [Stream 3: Immune Response] Project: Immune responses to SARS-CoV-2 variants across age groups and vulnerable populations	$3.00 m
	Recipient: Monash University [Stream 3: Immune Response] Project: PROPHECY: Profiling immune RespOnse in Paediatric and High-risk populations to SARS-CoV-2	$6.33 m
	Recipient: University of New South Wales [Stream 4: Transmission Research] Project: Aerosol transmission of SARS-CoV-2 experimentally and in an intensive care setting	$0.99 m
	Recipient: University of Melbourne [Stream 4: Transmission Research] Project: Aerosol Infection Research: Better mOdels to Reduce iNdoor Exposure (AIRBORNE)	$1.00 m
	Recipient: Australian Institute of Health and Welfare [Stream 5: National Linked Data Platform] Project: Towards an Australian COVID-19 Register and linked data set	$2.99 m

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

COVID epi and outlook

KEY POINTS

- It is anticipated that Australia will experience continued waves of COVID-19 infections (as is the case around the world) over the coming years. We are entering a wave of infections now.
    - it is important that all Australians continue to listen to public health advice, stay up to date with recommended vaccinations and stay at home when unwell.
    - this will help to protect the health of those at greatest risk of severe illness and safeguard our healthcare system.
- Australia is well-equipped to deal with a new wave of infections, and at present has relatively high levels of hybrid immunity (especially compared internationally).
- Since the most recent winter wave in July 2022, until mid-October 2022, there had been a nationally decreasing trend in COVID-19 notifications. Case notifications have increased significantly in the week to 1 November 2022.
    - during the week ending 1 November 2022 there were 37,097 cases reported nationally, an average of **5,300 cases per day**, representing a 17.3% increase compared to the week prior.
    - over the same period, there were an average of **1,392 people hospitalised per day** with COVID-19 nationally, representing a 0.7% decrease compared to the previous week, and an average of **44 cases in ICU** with COVID-19, up from 43 compared to the previous week.
    - Australia's mortality rate at 1 November 2022 is 598.4 deaths per one million population. This is low when compared to other OECD nations: Canada (1,214.6), UK (3,099.0) and US (3,165.4).
- Nationally, since the start of the pandemic, there have been **14,939 COVID-19 deaths** reported by jurisdictions, based on data in the National Notifiable Diseases Surveillance System (NNDSS) as at 1 November 2022.
    - reported deaths associated with COVID-19 have continued to trend downwards from the end of July 2022. For the entire pandemic, reported COVID-19 associated deaths peaked in January 2022, with a smaller peak observed in July 2022.
- The overall crude case fatality rate in the current BA.5 wave is 0.21%, which is higher than the rate observed during the BA.1 (0.14%) and BA.2 (0.10%) waves, and notably less than observed during the Delta wave (0.70%).
    - the cause of this higher case fatality rate may be attributed to changes in testing patterns as opposed to severity; as testing numbers decline with reporting of RATs no longer mandatory in some states, resulting in a higher case fatality rate.

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- Internationally, as we move into the northern winter, there has been some significant growth in case numbers in several European countries, particularly France and Germany, with associated increases in hospitalisations and fatalities.
- In our region, Thailand, Indonesia and Malaysia have all recorded significant growth in case numbers over the last 7 days and developments are being monitored closely.
- Singapore experienced a short wave driven by a new Omicron subvariant, XBB. XBB is now the dominant subvariant in Singapore, accounting for 54% of local cases. The wave was shorter than expected and peaked after only 4 weeks on 16 October with a 7-day average of approximately 8,400 cases. Since the peak, the case numbers have trended steadily downward and are now at 4,538, down 11% in the last week.

Current Variant Status

- BA.5 and BA.5 sub-lineages (Omicron) are the predominant sub-lineages being sequenced in Australian and constitute 78.1% (1358/1738) of sequences being identified in AusTrakka in the past 21 days while 7.02% (122/1738) are BA.4 sequences. These proportions for BA.4 and BA.5 have been constant for the past 4 weeks.
- BA.2 and BA.2 sub-lineages sequenced made up 13.17% of lineages reported in the same period, which is slightly up on the previous reporting period.
- Other variants have been detected in AusTrakka, including XBB (drove the recent Singapore wave), BA4.6 (commonly detected in USA Midwest) and BA2.75 (predominantly in India).
    - these variants currently make up a relatively low proportion of sequences identified in Australia.
    - based on current evidence, the WHO Technical Advisory Group on SARS-CoV-2 Virus Evolution does not feel XBB warrants designation as a new variant of concern, noting the sub-lineage remain part of Omicron, which continues to be a variant of concern.

Vaccination status

- Available data shows that people are more likely to get severe illness (admitted to ICU or death) if they are not vaccinated or are overdue for a booster compared with those who are up to date with recommended vaccination.
    - this emphasises the continued importance of vaccines in preventing severe illness.
- As at 2 November 2022, over 5 million Australians have had their fourth vaccine dose.
- Around 14.3 million Australians have had their third vaccine dose (72.2% of eligible).
    - 86.6% of people aged 50 or older have received a third dose.
    - over 96% of eligible aged care residents have had a third dose, and over 91% of NDIS participants in residential settings
- Increasing the take up of vaccines to ensure Australians have the best possible protection against COVID-19 remains a focus of the Government's communication efforts.

Situational Assessment of COVID-19

- COVID-19 Situational Assessment Reports are provided weekly by the University of Melbourne, with forecasts up to 4 weeks ahead by jurisdiction.
- The Department is anticipating a new wave of infections over the short to medium term. There is no indication of what the magnitude of this next wave will be.

Background

- Since the emergence of the Omicron variant in Australia, there have been three distinct waves of transmission, defined by the predominant Omicron subvariant circulating.
    - the first wave, driven by the BA.1 subvariant, occurred from mid-December 2021 to February 2022, with a peak of cases observed in early January 2022 (with a 7-day rolling average number of cases per day of 112,127).
    - from March to late June 2022, the BA.2 subvariant was the predominant strain; in this second Omicron wave, there was a primary peak in early April and a secondary peak in mid-May 2022 (with a 7-day rolling average number of cases per day of 56,995).
    - in early July 2022, BA.5 (including BA.5 sub-lineages) became the predominant sub-lineage detected in Australia, driving a third wave of transmission. During this wave, a peak in cases was observed during the week ending 24 July 2022 (with a 7-day rolling average number of cases per day of 47,871).

Testing / Case Ascertainment / Surveillance

- PCR testing rates remained stable across all jurisdictions, noting there have been closures of several pop-up testing centres. PCR percent positivity has remained relatively stable across all jurisdictions until the past fortnight, which has seen increases.
- Additionally, we know that many people with COVID-19 are asymptomatic and do not get tested. This also contributes to the reduction in case identification (which has been estimated to be at about 50% for most of the pandemic) via PCR and RAT reporting.
- Surveillance activities are now transitioning to a focus on trend analysis, similar to the rest of the developed world (ref: SB22-000214).
- The Australian Government is continuing to work closely with states and territories to monitor the impact of COVID-19, including via:
    - international monitoring (e.g. variants)
    - detection of rising cases (e.g. testing, aged care outbreaks and PBS scripts for oral antiviral treatments)
    - variants of concern (e.g. wastewater, AusTrakka)
    - severity indicators (e.g. hospitalisations, ICU admissions and deaths).
- Each of these sources improve our understanding of infection rates in the community and inform public health response settings.

FACTS AND FIGURES

- COVID-19 associated deaths in cases aged 80 years and over peaked in the week ending 16 January 2022 (approximately 46 deaths per 100,000 population), and a secondary peak was observed in the week ending 24 July 2022 (40 deaths per 100,000 population). In all other age groups, rates of COVID-19 associated deaths have remained low and relatively stable since early February 2022, not surpassing six deaths per 100,000 population over that period.

Case fatality rates

Table 1: COVID-19 associated case fatality rates, among cases notified to NNDSS, by age group and date of onset, 1 January 2020 to 9 October 2022^

Age groups	BA.5 15 June – 2 October 2022	BA.2 1 March - 14 June 2022	BA.1 15 December 2021 - 28 February 2022	Omicron 15 December 2021 – 2 October 2022	Delta 16 June - 14 December 2021	Pandemic 1 January 2020 – 2 October 2022
0-4	<0.05%	<0.05%	<0.05%	<0.05%	0.00%	<0.05%
5-11	0.00%	0.00%	<0.05%	<0.05%	<0.05%	<0.05%
12-15	<0.05%	0.00%	<0.05%	<0.05%	<0.05%	<0.05%
16-17	0.00%	<0.05%	0.00%	<0.05%	0.00%	<0.05%
18-29	<0.05%	<0.05%	<0.05%	<0.05%	<0.05%	<0.05%
30-39	<0.05%	<0.05%	<0.05%	<0.05%	0.06%	<0.05%
40-49	<0.05%	<0.05%	<0.05%	<0.05%	0.19%	<0.05%
50-59	<0.05%	<0.05%	0.06%	<0.05%	0.66%	0.05%
60-69	0.14%	0.11%	0.25%	0.15%	1.95%	0.19%
70-79	0.67%	0.47%	1.18%	0.68%	6.20%	0.81%
80-89	2.53%	2.12%	5.10%	2.82%	14.91%	3.25%
90+	6.65%	5.94%	10.92%	7.08%	27.92%	7.89%
Unknown	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	0.21%	0.10%	0.14%	0.14%	0.70%	0.16%

^To account for the lag between illness onset and the development of severe illness, cases with an onset date in the last two weeks have been excluded from calculations of the case fatality rate.

Aboriginal and Torres Strait Islander cases

Crude rate per 100,000 population of COVID-19 cases admitted to ICU or died by Indigenous status and age group, Australia, 1 January 2020 to 23 October 2022^

Age group	15 December 2021 – 23 October 2022 (Omicron wave)		16 June – 14 December 2021 (Delta wave)		1 January 2020 – 23 October 2022 (Pandemic)	
	Aboriginal and/or Torres Strait Islander people	Not Indigenous	Aboriginal and/or Torres Strait Islander people	Not Indigenous	Aboriginal and/or Torres Strait Islander people	Not Indigenous
0-17	16.6	6.1	2.5	0.9	19.1	7.1
18-59	68.5	15.9	21.3	10.5	90.1	28.1
60+	466.0	246.0	62.0	32.4	531.6	296.7
All	75.5	62.2	16.5	13.0	92.4	80.0

^Excludes cases for whom Indigenous status was unknown
Total includes cases with missing age

- During the pandemic, Aboriginal and Torres Strait Islander people have experienced a severe illness and death rate of 92.4, compared with 80.0 in the non-Indigenous population.
    - during the Delta wave the rate was 16.5 compared with 13.0; during Omicron to date the rate is 75.5 compared with 62.2.
- Comparisons between rates of COVID-19 in Aboriginal and Torres Strait Islander people and non-Indigenous Australians should be interpreted with caution due to incomplete data on Indigenous status in NNDSS, different population age distributions and different geographic distributions.

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Outcome: 1 - Health Policy, Access and Support

Public health advice on transitioning COVID response

KEY POINTS

Transitioning Australia's COVID-19 Response

- on 30 September 2022, National Cabinet agreed to the removal of mandatory isolation requirements for COVID-19 cases.
- as of 14 October 2022, there are no legislated requirements for people with COVID-19 to isolate. See **SB22-000213** for information on changes to mandatory isolation.
    - the removal of mandatory isolation does not diminish the importance of all Australians continuing to follow protective behaviours, including staying at home and avoiding high-risk settings while sick, keeping up to date with recommended vaccinations and mask use in crowded public indoor settings.
    - all states and territories continue to strongly recommend COVID-19 cases stay at home until their symptoms have resolved.
- on 30 September, National Cabinet also agreed that the National COVID-19 response will be guided by six key principles:
    1. minimising severe illness and death by using measures that are effective, proportionate and targeted to protect those most vulnerable to COVID-19.
    2. ensuring our health, economic and social systems can respond to future waves.
    3. managing "pandemic fatigue" and encouraging individual resilience and action.
    4. promoting vaccinations, including boosters, to improve health outcomes.
    5. supporting the economic and social well-being of all living in Australia.
    6. returning funding and policy settings to a more sustainable and balanced footing.
- COVID-19 is still circulating in the community and there will be new waves of COVID-19 infections and new variants. It remains important that steps are taken to continue to minimise the impact of COVID-19.

National COVID-19 Community Protection Framework

- to manage future waves, the National COVID-19 Community Protection Framework (National Framework) was published on 14 October 2022 following endorsement by the Australian Health Protection Principal Committee (AHPPC) and agreement by the First Deputies Group.
- the National Framework outlines measures that may be put in place in response to changing COVID-19 circumstances.
    - it includes a range of public health measures to be maintained at a base-level, with the ability to scale up to additional measures (Tiers 1 and 2), in response to changing COVID-19 epidemiological circumstances.

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  - it recognises that businesses, individuals, and communities play complementary roles in protecting the community and individuals at higher-risk from COVID-19.
  - public health measures are based on the potential to reduce transmission and severe disease, balanced with the potential impact on individuals and the wider community.

- the National Framework includes a suite of measures that jurisdictions may implement at their discretion, relevant to their epidemiological context and in accordance with their legislative frameworks.
  - key indicators provide an early warning of COVID-19 waves allowing measures to be implemented to reduce the impact of increasing case numbers.
  - the department continues to monitor the domestic and international situation and compile national data sources related to indicators to inform public health responses.
  - the department publishes weekly trends in case numbers, hospitalisations and deaths. (For more details see **SB22-000214** – COVID trend reporting and **SB22-000210** – COVID epi and outlook)
- the Australian Government (in partnership with state and territory governments) will continue to monitor COVID-19 closely and keep the community updated about any changes to recommended public health actions and measures.
- the National Framework is a living document and will be reviewed periodically to ensure relevance to the changing COVID-19 environment and emerging evidence.

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COVID trend reporting

KEY POINTS

- following a joint decision by all Australian Health Ministers, the Commonwealth in coordination with all jurisdictions transitioned from reporting COVID-19 statistics on a daily basis to a weekly trend analysis from 16 September 2022.
    - daily reporting can be misleading due to artificial fluctuations (date of notification versus date of event). Trends and smoothed seven-day averages allow for more meaningful comparisons over time.
    - the change aligns with the shift from our emergency pandemic response to living with COVID-19 and brings Australia in line with most other countries (notably the UK).
- the new weekly reporting focuses on trends as a more useful way of understanding how COVID-19 is impacting the Australian community and is more consistent with the way we report regarding other notifiable conditions (such as influenza).
- on the Friday of each week the Department publishes a wide range of statistics on its website at jurisdictional and national levels, including:
    - case notifications
    - hospitalisations
    - deaths
    - vaccination rates
    - COVID-19 treatments
    - residential aged care home outbreaks and cases.
- the published trend data is interactive, allowing members of the public to drill down into the data and focus on the information that most concerns them and their families.
- historical daily data continues to be available to view on the Department's website.

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COVID-19 vaccine availability

KEY POINTS

Supply

- The Australian Government entered into five separate agreements for the supply of COVID-19 vaccines. These included agreements with Pfizer, AstraZeneca, Novavax, Moderna and the COVAX Facility for over **250 million** doses of vaccine. **See Table 1 - Vaccine Supply and Agreements**
- The specific details of these agreements are commercial in confidence.
- This diverse portfolio of vaccines provides Australian's flexibility of choice and enables the government to address variants of concern in the future. Australia has more than sufficient doses to complete future vaccine requirements. **See Table 2 - Vaccine Stock on Hand in Commonwealth Warehouses**
- On 30 June 2022, the Minister for Health and Aged Care commissioned an independent review of Australia's vaccine and treatment purchases, led by former Secretary of the Commonwealth Department of Health and Aged Care, Professor Jane Halton AO PSM. (refer SB22-000216)
- The Government is currently considering the recommendations in the independent review as part of its long-term strategy to manage COVID-19.

Wastage

- As of 13 October, Australia's total wastage rate is **17.43%** Wastage remains within the acceptable levels indicated by the World Health Organisation (WHO).
- The WHO estimates between 15% and 40% for multi dose vials that needs to be discarded post opening.
- While all avenues to avoid wastage are explored, wastage can be expected as part of any vaccination program.
- Where practical, we are working with Department of Foreign Affairs and Trade (DFAT) to donate excess stock to our regional neighbours depending on the needs of those countries.

Donations

- Australia has already donated more than **49.5 million** doses to countries in the Indo-Pacific and Southeast Asia.
    - **23.5 million** as part of our commitment to share 40 million doses through the Department's procured supply, and
    - **26 million** as part of the commitment to share 20 million doses through DFAT's agreement with UNICEF.

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Division:	|Operation COVID Shield| Vaccine Operations and Data			

- Australia has offered a further **16.8 million** doses to the COVAX Facility for distribution to participating developed and developing countries with **770,000** doses being accepted, of which **14,400** have been donated.
- **$215 million** has been committed to the COVAX Facility's Advance Market Commitment, which has distributed nearly **250 million** doses to Southeast Asia and the Pacific.
- The COVID-19 vaccine donation market has significantly pivoted towards an excess supply environment. Recipient countries are showing limited demand for vaccines due to reduced absorptive capacity, vaccine hesitancy and considerations on which cohorts to prioritise in their vaccine rollouts.

FACTS AND FIGURES

Table 1 - Vaccine Supply and Agreements

Vaccine	Doses	TGA Approval	Rollout Date	Doses delivered (as at 21 October 2022)
Pfizer including COVAX	126 million (41 million in 2021, 60 million boosters in 2022 and 25 million in 2023)	25 January 2021	21 February 2021	70.5 million (includes 513k from COVAX and 1 million doses from Poland)
AstraZeneca	56.3 million (for delivery in 2021 and 2022)	16 February 2021	5 March 2021	56.2 million
Novavax	51 million (for delivery in 2022 and 2023)	19 January 2022	February 2022	15.7 million
Moderna	26 million (11 million in 2021, 15 million boosters in 2022)	9 August 2021	18 September 2021	25.7 million (includes 1 million EU doses)
Total Doses	**259.3 million**			

Table 2 - Vaccine Stock on Hand in Commonwealth Warehouses – as of 19 October 2022

Vaccine	Total
AstraZeneca	11,861,200
Novavax	9,706,800
Moderna 6 years+ (Red)	104,000
Moderna 6 months-5 years (Blue/Purple)	460,890
Pfizer 12 years+ (Purple)	8,513,712
Pfizer 5-11 years (Orange)	2,911,700
Moderna Bivalent 18 years+ (Blue/Green)	1,074,800
	34,633,102

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

COVID-19 Vaccine - Logistics Arrangements

KEY POINTS

Logistics Services

- The COVID-19 vaccination program is transitioning to sustainable long-term arrangements aligned with the National Immunisation program (NIP). The planned transition to states and territories managing their own ordering and distribution of COVID-19 vaccines is expected to be complete by October 2023 with readiness of the state or territory a determining factor in the timing.
- The Commonwealth will move to a single logistics provider from 1 January 2023, for the first half of 2023, utilising one of the existing logistics partners, DHL.
- A reduction to a single logistics partner is reflective of the success of the vaccination program to date and the change in the pandemic environment. This will reduce the overall logistics services costs whilst still retaining the capability to scale up if required.
- Both logistics partners, DHL and Linfox have been integral to the success of the COVID-19 vaccination program.
- The Department of Health and Aged Care (the Department) will continue to provide the same level of support to vaccination sites until transition of the program to a state and territory-based model is complete.
- The Vaccine Operations Centre (VOC) will continue to provide support to health professionals and manage incidents to ensure the safe handling and administration of COVID-19 vaccines.

Logistics Pilot Program

- The Department is working with New South Wales Health to co-design a COVID-19 vaccine storage and logistics pilot to commence in late 2022 which will inform the COVID-19 vaccine program transition to a future steady state in the second half of 2023.
- The pilot aims to test New South Wales Health's readiness to take over the COVID-19 vaccine program's storage and distribution functions for the state, in particular the Pfizer vaccine, which requires ultra-low temperature storage and handling capabilities.
- The pilot will identify challenges and opportunities for sharing across all states and territories to facilitate and prepare for transition.

Contact Officer:	Rachelle Davis	Secretary Clearing Officer:	Brendan Murphy	Clearance: 31 October 2022
Mobile No:	s22	Mobile No:	s22	
Division:	Vaccine Operations and Data			

FACTS AND FIGURES

- As at 28 October 2022, Linfox and DHL have delivered a combined 616,784 vaccine and consumable orders, totalling 94,745,794 vaccine doses, nationally.
- As at 28 October 2022, the VOC has received a total of 131,891 contacts including enquiries and incident notifications. Of these:
    - 8,825 were potential cold chain breaches;
    - 2,053 were reporting vaccination administration errors; and
    - 121,013 were related to system, delivery, order and general clinical enquiries.

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Senate Committee: Community Affairs

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Outcome: 1 - Health Policy, Access and Support

COVID-19 Data on vaccination rate

KEY POINTS

As at 2 November,

National coverage rates:

- Over 95% of the 16+ Australian population have at least two doses, over 72% of the eligible population have three doses, and over 41% of the eligible population (30+) have four doses.
- Over 80% of the national 12-15 cohort have at least one dose, and over 75% of the 12-15 have completed their primary course.
- Over 50% of the national 5-11 cohort have at least one dose, and over 40% of the 5-11 cohort have completed their primary course.

Indigenous coverage rates:

- Over 82% of the 16+ Australian Indigenous population have at least two doses, over 56% of the eligible Indigenous population have three doses, and over 33% of the eligible Indigenous population (30+) have four doses.
- Over 65% of the national 12-15 Indigenous cohort have at least one dose, and over 57% have completed their primary course.
- Over 33% of the national 5-11 Indigenous cohort have at least one dose, and over 21% have completed their primary course.

Number of doses administered:

- Over 63.9 million doses of the COVID-19 vaccination have been administered.
- Over 63% doses have been administered in Australia through primary care channels (44% through GPs and 14% through pharmacies), and over 33% have been administered through jurisdictions.

Moderna Bivalent

- There were over 60,200 doses of Moderna Bivalent Spikevax recorded into the Australian Immunisation Register.

The exact number of Moderna Bivalent recorded into the AIR is 60,216, but recommend the above as 54 of these doses were administered overseas. Therefore, 60,162 doses of Moderna Bivalent have been administered domestically in Australia.

- The majority (53,842) are the fourth (or higher) dose in an individual's sequence
- Pharmacies are administering the most Moderna Bivalent (47,396 doses), while general practitioners have administered 10,376 doses of Moderna Bivalent.

Contact Officer:	Trish Garrett	Secretary Clearing Officer:	Brendan Murphy	Clearance: 08 November 2022
Mobile No:		Mobile No:		
Division:	|Operation COVID Shield| Vaccine Operations and Data			

Children 0-4

- As at the 2 November 2022, over 850 doses have been administered to the 0-4 cohort in Australia (including internationally administered doses that have been reported into the AIR after an interaction with the Australian health system).
- Approximately 470 of these doses were the new Moderna formulation (426 administered domestically to 0-4s, and 52 administered internationally).
- Of the 0-4 cohort in Australia, 700 individuals are protected with at least one dose.

- Coverage rates have not been provided as eligibility for the dose is dependent on many factors as advised by ATAGI, and these are not captured to a comprehensive degree in the data. Coverage rates will be provided once eligibility expands for this age cohort.

NATIONAL POPULATION COVERAGE

- Vaccination coverage relates to the number of unique individuals by their dose number.
- The number of people with a COVID-19 vaccine is sourced from the Australian Immunisation Register. The population of each state is sourced from the Australian Bureau of Statistics Estimate Residential Population 2021.
- Vaccine coverage considers the usual residents of a location, and as such is based on a person's residential address. Individuals may have received vaccines internationally, which will be captured in their sequence to show their current status. Individuals who are no longer in scope for the vaccination rollout (i.e. deceased or have left Australia) are excluded from coverage numbers.

Caveat added administratively, 24 February 2023

The under 5 year COVID-19 vaccination rollout is a small population cohort, with the vaccine currently only approved for those under 5 years with severe immunocompromise, disability, and those who have complex and/ or multiple health conditions which increase the risk of severe COVID-19.

The department has not previously released COVID-19 vaccination numbers for the under 5 year cohort to date due to the small population size. In addition to needing to ensure the protection of personal information and privacy of individuals in this small group, the department is aware of data quality issues in relation to COVID-19 vaccination rates for children under 5 which have prevented us reporting these rates in an accurate or meaningful way. The data in this brief should be considered with this in mind.

Data quality issues

Vaccination coverage rates are based on the number of people who have been vaccinated divided by the best population estimates available. For children under 5, only a small subset of the cohort is eligible to receive the vaccine. This results in low coverage rates.

Data quality issues are magnified when the cohort is small. This means any small inaccuracies in the number of people who have been vaccinated will have a large impact on the overall coverage rate. So, for small groups with very low coverage (such as children under 5), we need to be extra careful in interpreting coverage data. The Department is aware of some health professionals selecting the wrong patient identifier on the Medicare card (ie the wrong person) or selecting the wrong vaccine when uploading vaccination data to the Australian Immunisation Register. As outlined above, these data quality issues have a disproportionate impact when the cohort is small, and has impacted our ability to publish reliable coverage rates for the under 5 cohort.

The Department continues to work with vaccination providers to improve data quality.

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Total population coverage for individuals by residential address and current age

	5 - 11								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses	50.80%	75.81%	48.58%	48.44%	41.62%	53.96%	59.86%	55.10%	53.21%
Individuals received 2 or more doses	40.23%	67.31%	39.72%	34.51%	31.76%	43.23%	49.93%	43.56%	40.73%

	12 - 15								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses	80.41%	96.06%	79.04%	78.26%	71.98%	78.42%	81.29%	85.53%	80.57%
Individuals received 2 or more doses	75.59%	93.25%	75.18%	70.32%	66.72%	73.66%	76.85%	81.23%	74.09%

	16+								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses [Total Population]	97.21%	96.72%	96.97%	88.65%	92.91%	93.35%	95.12%	97.78%	95.95%
Individuals received 2 or more doses [Total Population]	95.84%	95.39%	95.71%	86.65%	91.56%	91.64%	93.47%	96.64%	94.76%
Individuals received 3 or more doses [Eligible Population]	72.23%	80.66%	70.25%	79.62%	65.22%	76.11%	74.65%	74.31%	83.51%
Individuals received 3 or more doses [Total Population]	69.14%	76.86%	67.15%	68.86%	59.63%	69.62%	69.70%	71.76%	79.04%
Individuals received 4 or more doses [Eligible Population 30+]	41.74%	46.55%	43.27%	24.83%	44.73%	45.67%	48.29%	39.34%	36.16%
Individuals received 4 or more doses [Total Population]	24.36%	29.45%	24.71%	13.58%	23.10%	27.03%	29.02%	23.58%	23.56%

Data is sourced from the Australian Immunisation Register, as at 11:59pm 02/11/2022.

Population denominator for total population coverage rates is sourced from the Estimated Residential Population 2021. Population denominator for eligible population coverage rates is all individuals who have had their prior dose at least three months earlier. Please note this doesn't consider immunocompromised individuals for fourth doses as there is no way to capture that information in the Australian Immunisation Register which is used to capture eligibility based on time elapsed, dose sequence, and age.

INDIGENOUS POPULATION COVERAGE

- Vaccination coverage relates to the number of unique individuals by their dose number.
- The number of people with a COVID-19 vaccine and the population of each state is sourced from the Australian Immunisation Register, and is based on self identification as Indigenous.

- Vaccine coverage considers the usual residents of a location, and as such is based on a person's residential address. Individuals may have received vaccines internationally, which will be captured in their sequence to show their current status. Individuals who are no longer in scope for the vaccination rollout (i.e. deceased or have left Australia) are excluded from coverage numbers.

Total population coverage for Indigenous individuals by residential address and current age

	5 - 11								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses	33.49%	59.69%	28.81%	51.96%	28.20%	35.63%	54.38%	39.08%	43.55%
Individuals received 2 or more doses	21.19%	49.50%	21.19%	29.08%	17.14%	23.61%	41.67%	27.10%	23.01%

	12 - 15								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses	65.90%	83.45%	67.89%	81.28%	60.25%	62.64%	78.09%	77.58%	70.32%
Individuals received 2 or more doses	57.21%	77.58%	62.97%	67.99%	51.48%	53.60%	72.32%	71.61%	54.97%

	16+								
	National	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**
Individuals received 1 or more doses [Total Population]	85.53%	92.18%	87.85%	90.15%	82.37%	81.33%	89.23%	90.86%	87.57%
Individuals received 2 or more doses [Total Population]	82.24%	90.03%	86.04%	86.14%	78.82%	76.07%	86.90%	89.00%	82.21%
Individuals received 3 or more doses [Eligible Population]	56.37%	65.44%	53.01%	70.23%	48.99%	61.01%	60.18%	62.24%	66.53%
Individuals received 3 or more doses [Total Population]	46.19%	58.82%	45.51%	60.30%	38.48%	46.12%	52.14%	55.31%	54.34%
Individuals received 4 or more doses [30+ Eligible Population]	33.81%	39.42%	37.07%	24.86%	36.14%	37.06%	40.22%	34.87%	28.85%
Individuals received 4 or more doses [Total Population]	11.92%	17.08%	13.04%	11.21%	10.97%	13.24%	16.76%	14.60%	11.44%

Data is sourced from the Australian Immunisation Register, as at 11:59pm 02/11/2022.

Please note that identification as Indigenous is optional, and may be underrepresented.

COVID-19 DOSES ADMINISTERED

- The total number of doses includes all doses administered recorded into the Australian Immunisation Register.
- Vaccine administration counts the number of doses administered, rather than the number of people who have received a vaccine.
- All doses administered are included (regardless of age, dose number, or the status of an individual). This includes doses administered to individuals who are no longer current in the population, and will be different to coverage numbers.
- This also includes internationally administered doses which have been reported to authorised providers as part of a person's immunisation history, which are represented below against 'International' doses.
- Many are recorded against a default immunisation provider in Services Australia, which has an address in the ACT. International Doses are recorded against the provider state who entered them into the AIR, but are a separate category as they were not physically administered in Australia.

Total number of doses administered by provider state and channel

	National	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Total Doses Administered	**63,966,167**	**1,894,318**	**19,836,605**	**620,538**	**12,074,769**	**4,461,234**	**1,454,098**	**16,652,488**	**6,972,117**
Aged Care and Disability	**1,343,548**	48,888	604,698	5,317	216,927	88,525	26,079	240,536	112,578
Jurisdictions	**21,418,879**	568,909	5,229,589	352,646	3,896,992	1,891,094	646,844	6,219,228	2,613,577
Primary Care Total	**40,724,860**	812,349	13,998,135	262,365	7,957,730	2,480,424	780,794	10,188,844	4,244,219
ACCHS	**496,948**	-	145,861	102,469	115,398	15,392	6,619	58,263	52,946
GP Clinic	**27,999,636**	455,966	10,114,528	108,760	5,255,685	1,514,474	453,733	7,420,797	2,675,693
GPRC	**2,855,454**	33,125	932,232	25,754	726,422	241,626	69,372	600,709	226,214
Other Primary Care	**422,493**	118,751	52,104	4,609	111,075	11,178	779	116,026	7,971
Pharmacy	**8,950,329**	204,507	2,753,410	20,773	1,749,150	697,754	250,291	1,993,049	1,281,395
International Doses	**478,880**	464,172	4,183	210	3,120	1,191	381	3,880	1,743

Data is sourced from the Australian Immunisation Register, as at 11:59pm 02/11/2022.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

Medicine Shortages

KEY POINTS

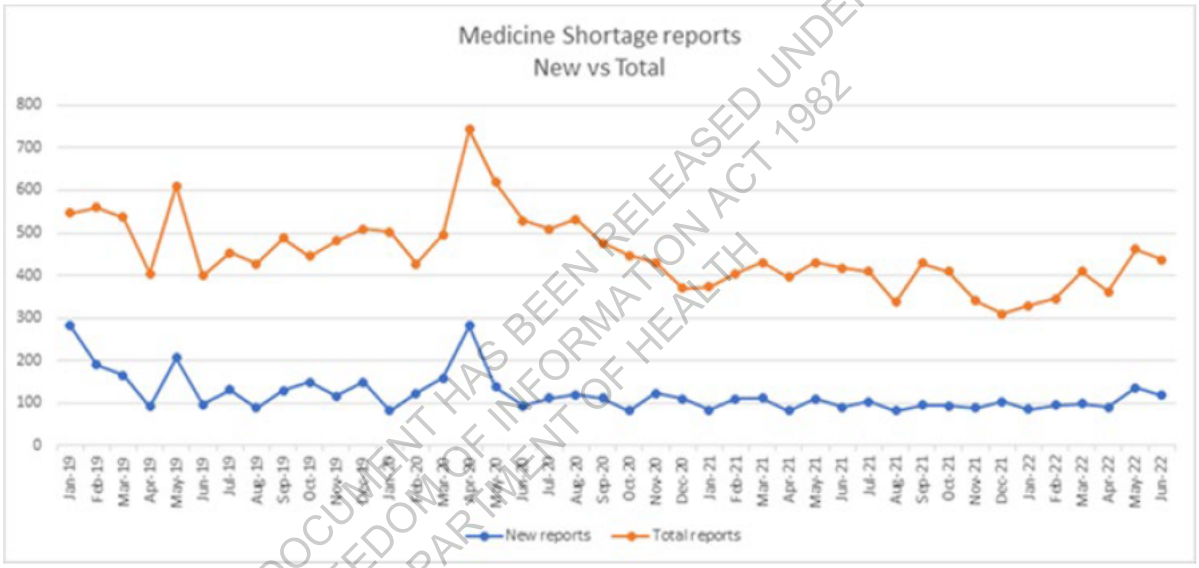
- The TGA mandates the reporting of anticipated and current medicine shortages, and permanent discontinuations of the supply, of all prescription medicines and certain Over-the-Counter (OTC) medicines ('reportable medicines').
- While the Australian Government cannot prevent shortages from occurring, we have taken action to manage shortages so that patients, doctors, and pharmacists are aware of any potential impacts.
- The TGA has been working with major wholesalers in the Australian supply chain to obtain accurate, timely data on changes in demand for medicines. This collaboration will assist the department in taking proactive steps to mitigate potential shortages of any prescription, or important OTC medicines.
- Depending on the cause of the shortages, the TGA can take the following actions to limit their impact:
    - working with medicine sponsors and other stakeholders to manage inventory, including constraining supply to enable fair distribution of stock in Australia
    - approving the supply of overseas-registered alternatives products under section 19A of the *Therapeutic Goods Act 1989* (the Act)
    - allowing pharmacists to dispense certain identified substitute medicines when a medicine is in shortage, by implementing a Serious Scarcity Substitution Instrument and
    - collaborating with health care professional and consumer groups to provide guidance on managing demand during a shortage, including issuing guidance on prioritising prescribing for certain conditions.
- In addition from 1 July 2023, Minimum Stockholding Requirements will apply where manufacturers will be required to hold a minimum of either 4 or 6 months' of stock in Australia for certain medicines listed on the Pharmaceutical Benefits Scheme (PBS), referred to as 'Designated Brands'. If the designated brand has received a price increase on or after 1 July 2022, the Responsible Person for the brand will be required to hold **6 months' supply** of the brand's 'usual demand'. If the designated brand has not received a price increase on or after 1 July 2022, the Responsible Person will be required to hold **4 months' supply** of the brand's 'usual demand'.
- Over 2,900 brands of medicines are expected to be captured under these arrangements.

FACTS AND FIGURES

- As of **28 October 2022**, there were **76** critical notifications published on the TGA's Medicine Shortages website – **39** current, **nine** anticipated, **20** resolved and **eight** discontinued notifications.

Contact Officer:	Nick Henderson	Deputy Secretary Clearing Officer:	Adj Prof John Skerritt	Clearance: 01 November 2022
Mobile No:		Mobile No:		
Division:	|Health Products Regulation| Medicines Regulation			

- A critical shortage is a shortage or discontinuation:
    - of an essential medicine included in the Medicines Watch List or
    - of a medicine for which there are no registered goods that could reasonably be used as a substitute or that would not be available in sufficient quantities to meet demand or
    - that has the potential to have a life-threatening impact on, or a serious impact on the physical or mental health or functioning of, people who take or may need to take the medicine.
- As of **28 October 2022**, there were **840** notifications of all types of medicine shortage on the TGA website – **317** current, **60** anticipated, **234** resolved and **229** discontinued notifications.
- Since early 2019, (well before the COVID-19 pandemic) numbers of reports each month have been largely stable. There was a brief increase early in the pandemic in April 2020, which was largely driven by increased demand caused by stockpiling (see graph below).



- To date, the TGA has not issued a warning letter to any pharmaceutical companies regarding non-compliant reporting of medicine shortages or discontinuations. A compliance review conducted in 2020 did not identify any major non-compliance. Additional education and engagement strategies are being developed to assist companies to better understand their responsibilities.

SUPPLY STATUS OF MEDICINES OF CLINICAL IMPORTANCE

Medicine (including use)	Expected shortage resolution dates	Top line response
Ozempic (semaglutide) injections For the treatment of type 2 diabetes	Beginning of 2023	The TGA is working closely with the supplier Novo Nordisk and other stakeholders to manage the shortage.
Trulicity (dulaglutide) injections For the treatment of type 2 diabetes	Beginning of 2023	The TGA has been working with the medicine supplier Eli Lily and pharmacy wholesalers to enable equitable distribution of available stock.

Tenecteplase (Metalyse) injections Used to dissolve blood clots (thrombolysis) in the immediate period following a heart attack	End of 2023	The TGA is working with clinical organisations and the supplier to encourage prioritisation of tenecteplase for settings where there are no alternatives. The TGA has approved supply of several overseas alternative medicines under section 19A of the Act
Naloxone medicines Used to temporarily reverse the effects of opioid overdose.	Mid-November 2022	The TGA has been working with medicine suppliers, pharmacy wholesalers and the Government's Take Home Naloxone Program to maintain supply and promote fair distribution of stock in pharmacies.
Oral antibiotic medicines To treat infections (community setting)	Between November 2022 to January 2023	Many of these antibiotics have other brands or strengths, or alternative options available TGA has approved overseas alternatives under section 19A of the Act for those shortages where further management actions are required.
Radiopharmaceutical: **Gallium (67Ga)** A diagnostic radiopharmaceutical used to demonstrate the presence of Hodgkins disease, lymphomas and bronchogenic carcinoma.	End of December 2022	The TGA has approved an overseas alternative under section 19A of the Act
Radiopharmaceutical: **Technetium-99m** preparation of diagnostic nuclear medicines used for imaging by hospitals	Extremely limited supply between 4 to 11 November 2022	ANSTO are communicating with the Nuclear Medicine Working Group, which includes representatives from state and territory health department and the Australasian Association of Nuclear Medicine Specialists, to manage distribution and broader communications.
Radiopharmaceutical: **Iodine-131** treatment of hyperthyroidism and the detection of thyroid carcinomas	Limited availability throughout the middle of November 2022	
Radiopharmaceutical: **Lutetium-177** treatment of certain metastatic neuroendocrine tumours (NETS)	Limited availability throughout the middle of November 2022	

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ATTACHMENT 1: DETAILS ON MEDICINES OF CLINICAL IMPORTANCE (Linked to SB22-000221)

Ozempic (semaglutide) injections

Commented s22 : Have done a lot of edits to Ozempic – I wonder if we need to update BPB as well to align?

- Novo Nordisk advised the TGA of shortages of both strengths of Ozempic due to an increase in consumer demand for Ozempic for weight loss. Ozempic is only approved for the treatment of type 2 diabetes.
- Novo Nordisk has recently reported the shortage will extend until at least the beginning of 2023, and that there will be no stock of Ozempic in pharmaceutical wholesalers from mid-November 2022. Further shipments of Ozempic are not expected until Q1 2023 (date yet to be confirmed by sponsor).
- The TGA has been working with Novo Nordisk, pharmaceutical wholesalers and a number of key professional organisations (including the Australian Medical Association [AMA] and the Royal Australian College of General Practitioners [RACGP]) to manage this shortage. A joint statement was published earlier this year and continues to be updated as the situation evolves. The statement encourages health professionals to prioritise prescribing of Ozempic for patients with type 2 diabetes and encourages the use of alternative treatments where possible.
- To manage the worsening supply situation the TGA met again with this group on 27 October 2022 to discuss the lack of supply and management options. Clinical guidance will be developed by clinical peak bodies and the joint statement will be updated in early November to assist health professionals and consumers manage the updated supply situation.
- To increase stocks of Ozempic in Australia, the TGA has approved the supply of overseas-registered equivalent products under section 19A of the Act; however, these are not PBS listed.

Commented s22 : This gets raised all the time

- The TGA also worked with the sponsor and wholesalers to constrain the limited stock to support equitable distribution and prevent stockpiling.
- On 1 September 2022 the active ingredient in Ozempic (semaglutide) was approved for inclusion on the Australian Register of Therapeutic Goods (ARTG) for weight loss under the brand name Wegovy. However, Novo Nordisk is not yet supplying Wegovy in Australia. Supply of semaglutide is currently limited globally and Novo Nordisk is the sole company producing this medication.

Trulicity (dulaglutide) injections

- The Trulicity shortage has occurred due to an increase in consumer demand as a flow on effect from the shortage of Ozempic.
- Eli Lily has advised the TGA that global demand for Trulicity has also increased. Supply is once again limited after a brief total stock out period at the end of October. Improved supply is expected in early 2023, in line with the Ozempic shortage.
- To minimise patient impact, the TGA has approved the supply of an overseas registered equivalent under section 19A of the Act. This is not currently PBS listed.
- The TGA has also been working with Eli Lily and wholesalers to constrain the limited stock and support equitable distribution to prevent stockpiling.

Contact Officer:	Nick Henderson	Deputy Secretary Clearing Officer:	Adj Prof John Skerritt	Clearance: 28 October 2022
Mobile No:	s22	Mobile No:	s22	
Division:	Health Products Regulation	Medicines Regulation		

- Consumers affected by the shortage are advised to contact their prescriber for advice based on their needs.
- The TGA has published a web statement with information on the Trulicity shortage to assist consumers and health professionals and will continue to work with stakeholders to keep health professionals and consumers informed of changes to supply and management of the shortage.

Tenecteplase (Metalyse) injections

- Metalyse (tenecteplase) injection is expected to be in short supply over the next 18 months. The sponsor, Boehringer Ingelheim, has informed the TGA they expect limited small shipments of Metalyse during this time; however, this will not be enough to meet usual demand. The shortage is due to manufacturing capacity constraints following increases in global demand.
- Tenecteplase is used to dissolve blood clots (thrombolysis) in the immediate period following a heart attack.
- The TGA has also approved the supply of several overseas registered alternative products under section 19A of the Act, to minimise the public health impact of the shortage.
- To reduce wastage and maximise access to this essential medicine, the TGA has approved the sponsor's submission to extend the shelf-life of certain batches of Metalyse by 12 months.
- The TGA has published clinical guidelines that stipulate conservation strategies to assist health professionals during this shortage. The guidelines have been codeveloped with multiple clinical organisations, including Cardiac Society of Australia and New Zealand, National Aboriginal Community Controlled Health Organisation and Emergency Medicine Specialists.
- The department has worked with the Clinical Trials Project Reference Group to publish supplementary advice on the Australian Government's clinical trials website australianclinicaltrials.gov.au, to assist the sector to manage trials during the shortage

Naloxone medicines

- Naloxone medicines temporarily reverse the effects of opioid overdose.
- Mundipharma Pty Ltd have notified the TGA of a shortage of Nyxoid (naloxone) nasal spray, which is likely to continue until mid-November 2022.
- The Government's Take Home Naloxone Program makes this lifesaving medicine available to anyone who may require it via community pharmacies at no charge. Demand for naloxone medicine increased to higher-than-anticipated levels when the program was expanded nationally on 1 July 2022. There has also been an increase in demand for naloxone medicines globally.
- To maintain continuity of supply the TGA has:
    - Approved the supply of two overseas-registered naloxone products under section 19A of the Act.

- Implemented maximum ordering constraints to enable fair distribution of available stock. Worked closely with the Take Home Naloxone Program and pharmacy peak bodies to discourage stockpiling in community pharmacies.

Oral antibiotic medicines

- There are a number of oral antibiotic medicines currently in shortage, including some amoxicillin and metronidazole products.
- Many of these antibiotics have other brands or strengths, or alternative options available.
- For some of these shortages, the TGA has assessed that further management actions are required to support patient care in the communityand supply of overseas registered alternatives have been approved including:
  - Amoxicillin 250mg/5mL oral liquid
  - Amoxicillin and clavulanic acid 875mg/125mg tablets
  - Metronidazole 400mg tablets

Radiopharmaceuticals

Gallium (67Ga)

- Gallium (67Ga) is a diagnostic radiopharmaceutical used to demonstrate the presence of Hodgkins disease, lymphomas and bronchogenic carcinoma.
- Global Medical Solutions Australia Pty Limited (GMS), the sponsor of LANTHEUS GALLIUM(67Ga) CITRATE 74MBq/mL injection USP (gallium (67Ga) citrate), informed the TGA of intermittent supply disruptions of gallium (67Ga) citrate because of manufacturing delays. Supply is expected to resume at the end of December 2022.
- TGA approved supply of an overseas alternative product under section 19A of the Act to mitigate the shortage, however stakeholders raised strong concerns about the high cost of the alternative being passed on to patients.
- In response, the Department has announced the introduction of a temporary MBS item from 8 November 2022 to 30 June 2023 to support patient access to critical nuclear medicine imaging services that use gallium-67. The new item will be available to be claimed with five existing MBS services that use gallium-67 and will provide additional funding to support patients to access these services, which have significantly increased in cost due to recent changes in the supply of gallium-67.

Technetium-99m, Iodine-131 and Lutetium-177

- ANSTO has notified TGA of expected supply disruption of Technetium-99m (Tc-99m), Iodine-131 (I-131) capsules and solution and Lutetium-177 (Lu-177 n.c.a). It is anticipated the impacts will be significant for the week commencing Monday 7 November 2022. Please see table below for further information.
- This is due to a predicted global shortage due to a number of reactors being shutdown around the world, including ANSTO's OPAL reactor. It is planned that OPAL will restart on 4 November.
- ANSTO are communicating with the Nuclear Medicine Working Group, which includes representatives from state and territory health department and the Australasian

Association of Nuclear Medicine Specialists, to manage distribution and broader communications.

Product	Used for	Supply disruption dates
Tc-99m generators	preparation of diagnostic nuclear medicines used for imaging by hospitals	Extremely limited supply between 4 to 11 November 2022
I-131 solutions and capsules	treatment of hyperthyroidism and the detection of thyroid carcinomas	Limited availability throughout the middle of November 2022
Lu-177 n.c.a.	treatment of certain metastatic neuroendocrine tumours (NETS)	Limited availability throughout the middle of November 2022

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 1 - Health Policy, Access and Support

COVID-19 Mortality Data

KEY POINTS

- Since the start of the pandemic to 1 November 2022, there have been 14,939 COVID-19 associated deaths reported to the National Notifiable Diseases Surveillance System (NNDSS).
    - Reported deaths associated with COVID-19 have continued to trend downwards from the end of July 2022 in every jurisdiction.
    - For the entire COVID-19 pandemic, reported associated deaths peaked in January 2022, with a smaller peak observed in July 2022.
    - Crude case fatality rates which reflect number of deaths as a proportion of reported case during specific periods were:

Waves	Delta	BA.1	BA.2	BA.5
Crude case fatality rate	0.70%	0.14%	0.10%	0.21%

    - The rate of COVID-19 associated deaths in cases aged 80 years and over peaked in the week ending 16 January 2022 (approximately 46 deaths per 100,000 population), and a secondary peak was observed in the week ending 24 July 2022 (40 deaths per 100,000 population). In all other age groups, rates of COVID-19 associated deaths have remained low and relatively stable since early February 2022, not surpassing six deaths per 100,000 population over that period.
- The Australian Bureau of Statistics releases monthly provisional COVID-19 mortality statistics based on Registers of Births, Deaths and Marriages (RBDM). Of all the deaths registered with jurisdictional Registries of Births, Deaths and Marriages between March 2020 until 30 September 2022, the ABS reports:
    - 12,545 people died with or from COVID-19. This number is expected to increase as further registrations are received from jurisdictional RBDMs. The underlying cause of death for 10,279 was acute COVID-19 infection with a further 123 deaths due to long term effects of COVID-19.
    - There were a further 2,266 people who died of other causes (e.g. cancer) but COVID-19 contributed to their death.
    - Pre-existing chronic conditions were reported on death certificates for 8,211 (79.9%) of the 10,279 deaths due to COVID-19. Of these 8,211 deaths, chronic cardiac conditions (38.9%) and dementia including Alzheimer's disease (30%) were the most commonly certified co-morbidities and pre-existing conditions.
    - There were 195 COVID-19 associated deaths among Aboriginal and Torres Strait Islander people between August 2021 and July 2022. The mortality rate from COVID-19 is 1.7 times higher in Aboriginal and Torres Strait Islander people.

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  - Those who died of COVID-19 with a country of birth of overseas, had an age-standardised death rate 1.6 times higher than that of people who were born in Australia (15.8 deaths per 100,000 versus 9.6 deaths per 100,000 people).

- There have been 4,099 COVID-19 related deaths in residents in residential aged care homes, as reported to the Department directly by aged care providers by 3 November 2022. The majority of these (3,182) have occurred in 2022.

Mortality Analysis undertaken with linked data

- The Department has commenced preliminary analysis of factors associated with COVID-19 related deaths using its Multi-Agency Data Integration Project (MADIP) data asset. This data is managed by the ABS and accessed by the Department.
  - The 'Understanding socio-demographic cohorts for the COVID-19 Vaccine Strategy' combines key health data such as the AIR, MBS and PBS with information on disability, education, government payments, income and taxation, employment etc.
  - Monthly provisional mortality data from Registers of Births Death and Marriages is also linked into the MADIP project. This enables analysis of deaths in cohorts.
  - Population groups of focus include residents in aged care homes, First Nations peoples, people with disability, and people with CALD backgrounds.
  - For example, the Department has produced some preliminary standardised death rate calculations for vulnerable populations which are being refined.
  - Methodology and initial insights will be socialised through the department's COVID-19 Advisory Committees ahead of potential publication.
- The department is undertaking a further analysis of excess mortality within priority and vulnerable population groups. This work will quantify the impact of COVID-19 on all causes of death, compared to expected mortality in a typical year.
  - ABS releases annual excess mortality publications covering all-causes of death. In 2021 there were over 5,000 excess deaths, in comparison with 1,734 fewer deaths than expected over 2020. There have been 16,375 excess deaths from January to the end of July 2022.

Background

- COVID-19 Mortality is monitored by jurisdictions and reported on a daily basis through the NNDSS to the department.
  - NNDSS data shows the most recent data available to the Commonwealth on underlying patterns, and other trends of mortality across the population. It does not include comprehensive details on factors associated with mortality and has a typical two-week lag to report deaths due to the time required to cross-check with death certificates prior to transmitting records via NNDSS.
- In addition, RBDMs report to the ABS, who produce monthly COVID-19 Mortality numbers.
  - ABS has the most complete and robust data source of consolidated deaths data based on RBDM supplied data. These figures have an underlying lag in reporting of 1-2 months for cause of death coding and validation process to be undertaken.

- Jurisdictions have also previously published daily numbers of deaths based on date of death notification to the jurisdiction, inclusive of unverified COVID-19 associated deaths.
    - Daily notification of deaths data from jurisdictions and through "Our World in Data" type platforms, are unconfirmed and preliminary data that may be retroactively revised. The date of notification basis for these sources also may not represent true mortality on that day.
- Residential aged care providers report aged care cases and deaths directly to the department through the My Aged Care portal. This is for the purposes of ensuring oversight of outbreaks and connection to necessary support services, rather than an official record of death. This data is reported publicly in a weekly aged care snapshot.
- Other departments may use different mortality figures for different purposes.

Recent facts and figures by population

Population groups	COVID-19 Deaths	Time period	Source
General population	14, 939	1 March 2020 up to 1 November 2022	National Notifiable Diseases Surveillance System, 1 November 2022
	12,545	1 March 2020 – up to 30 September 2022	ABS, based on deaths registered with jurisdictional Registries of Births, Deaths and Marriages, released 28 October 2022
	906	1 March – 31 December 2020	
	1,345	1 January – 31 December 2021	
	8,028	1 January – up to 30 September 2022	
Aged care residents	4,099	1 March 2020 – up to 4 November 2022	Self-reported by aged care providers to the Department
	686	1 March – 31 December 2020	
	231	1 January – 31 December 2021	
	3,182	1 January – 3 November 2022	
People with disability **NDIS participants**	90	1 March 2020 – 1 November 2022	Deaths that were reported to the NDIS Commission.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 3 - Ageing and Aged Care

Aged Care COVID-19 data and response

KEY POINTS

Ongoing support for aged care

- Acknowledging the ongoing risk to older people and in the high risk residential care setting, COVID-19 response measures for the aged care sector have been extended from 30 September until 31 December 2022.
- Although numbers of cases in aged care are significantly reduced, the Department of Health and Aged Care (the department) continues to support residential aged care homes with:
  - reimbursement of outbreak management costs through the COVID-19 Aged Care Support Program Extension Grant
  - access to Personal Protective Equipment and regular deliveries of Rapid Antigen Test kits from the National Medical Stockpile to support surveillance
  - access to surge workforce resources targeted at homes with significant staff shortages or large case numbers
  - access to in-reach testing services and in-reach vaccination clinics as required
  - emergency access to COVID-19 antiviral treatments from the National Medical Stockpile, and
  - regular updates on latest information through webinars and newsletters.
- Notification of an outbreak to the department triggers access to a range of supports, including departmental case management, Personal Protective Equipment, in-reach testing and surge workforce resources as required.
- In addition, to support preparedness for the summer period in particular, the Commonwealth is offering a three-day supply of Personal Protective Equipment to all homes to be delivered in November 2022. Rural and remote areas are being prioritised for delivery through dedicated supply chains provided by DHL. Homes can choose to opt out of this delivery if they are not in need of these supplies.
- Supply of Rapid Antigen Test kits continues on a weekly basis to all aged care homes until 31 December 2022 to support surveillance screening. Each aged care home can cancel delivery of Rapid Antigen Test kits if they do not require additional supply.
- The department's contract with Sonic Healthcare for prioritised in-reach PCR testing for aged care homes in outbreak also remains in place until 31 December 2022. This supplements other testing arrangements on the MBS and the use of RATs.
- Reimbursement for COVID-19 related costs continues to be available through the COVID-19 Aged Care Support Grant Extension until 31 December 2022, with additional funding added in recognition of the high volume of claims. A total of $1.023 billion is available under the Grant.

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Surge Workforce Assistance to Aged Care Homes

- Aged care providers and individual homes have a responsibility to manage staff, including surge workforce arrangements. When sufficient staff can't be found during an outbreak, they can ask the department for surge workforce assistance, for the immediate crisis.
- Contracted surge workforce capacity has increased from 1 July 2022 and will be maintained through to the end of December 2022.
- The available surge workforce is being targeted based on risk, with the most support going to those RACF with a significant number of positive staff and residents and where there are concerns around IPC practices and clinical governance.
- A total of $184.2 million is allocated directly towards workforce surge and support activities.
    - To date, a total of $132.7 million has been committed against contracts with eight workforce surge suppliers to support the program.
    - Current expenditure is $9.7 million for this financial year.
- The department has contracts with Aspen Medical, HealthX, Healthcare Australia (HCA) and Recruitment Consulting Services Australia (RCSA). Since 1 July 2022, the department has filled approximately 29 per cent of shifts requested through the casual agency portal facilitated by the RCSA.
- As at 4 November 2022, compared to the start of June 2022 there has been almost a doubling of deployable surge workforce resources from 128 to a total of 204.5 including:
    - 89 Health X nurses and care assistance compared to 30
    - 20 HCA nurses and care assistance compared to 15, and
    - 15.5 Clinical First Responders and eight Standing Force teams comprising a mix of nursing and personal staff up to 10 people from Aspen Medical compared to 13 CFRs and seven Standing Force teams.
- The Australian Defence Force provided additional workforce assistance for aged care homes between 5 February and 30 September 2022. The ADF made available over 1800 personnel during this time and supported 542 aged care homes.
- Volunteers and visitors, including partners-in-care, are also encouraged to provide social support to residents, playing a similar role to ADF general duties personnel.

Infection Prevention and Control (IPC)

- The Australian Government continues to provide ongoing support and guidance to the sector on IPC. Recent examples include:
    - continuing to provide updated national guidelines to the sector, such as the updated CDNA guidelines - National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities - released on 30 September 2022.
    - recognising the ongoing importance of having a trained IPC lead nurse in all residential aged care homes, by providing a grant to support the cost of IPC training. Having more trained nurses will support services to prevent and respond to infectious disease outbreaks including influenza and COVID-19.
    - supporting high-risk services to assess and improve their IPC capability, such as through the IPC in-reach appraisal project, which provides an independent assessment (by Aspen Medical, contracted on behalf of the department) of IPC skills including any gaps.

COVID-19 Vaccination (including Aged Care)

- As of 4 November 2022, 83.2% per cent of eligible aged care residents have received a fourth dose.
- The department is continuing to provide residential aged care homes with access to COVID-19 vaccination clinics to ensure residents have every opportunity to get their fourth (winter) dose. This is in addition to primary care vaccination services available through GP, pharmacy or self-vaccination arrangements.
- The department has engaged and funded accredited COVID-19 vaccination providers under a Whole-of-Government Vaccine Administration Partners Program panel, to provide in-reach vaccine services to residential aged care homes.

Coronial inquests

- The Government acknowledges the terrible toll that the COVID 19 outbreak at St Basil's Fawkner in Victoria and at Newmarch House in 2022 has had for everyone involved, especially the families and loved ones of people who have sadly passed away.
- As these matters is being investigated by state authorities, including the Victorian and NSW coroners, it is not appropriate to comment further.
- The department continues to work cooperatively and voluntarily with the investigations.

FACTS AND FIGURES

Current data

National snapshot

As at 8:00 am 3 November 2022 there are 1,101 active COVID-19 cases in 213 active outbreaks in residential aged care facilities across Australia. There have been 84 new outbreaks, 17 new resident deaths and 990 combined new resident and staff cases reported since 27 October 2022.

Table 1: Aged Care COVID-19 data as at 8.00am 3 November 2022[1]

Category	Active[2]	Previous 7 days	Cumulative Total	Previous 7 days
Outbreaks[3]	213	-3	8,608	84
Residential Aged Care Facilities affected	213	-3	2,739	2
Resident Cases[4]	778	-55	96,498	710
Resident Deaths[5]	N/A	N/A	4,099	17
Staff Cases	323	-47	61,518	280

Table 2: Overview of Active Outbreaks in Australia

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
Total Facilities with outbreaks	2	49	1	21	29	4	65	42	213
Total number of active resident cases	2	170	1	67	73	24	191	250	778
Total number of active staff cases	0	83	2	41	32	2	74	89	323
Total Outbreaks Opened since last Report	1	23	1	9	7	2	27	14	84
Total Outbreaks Closed Since last Report	2	18	0	17	11	3	22	14	87

[1] Outbreak opening and closure includes changes in the status of exposure sites to outbreaks (and vice versa), which are applied retrospectively to facility records. New case information can also change the status of a recovered site back to an active outbreak site. As a result, changes in active outbreak status may not align with day on day variations to active totals. These adjustments will also affect the number of cases in staff and residents reported each week.

[2] Active residents and staff cases are the total currently positive cases in active outbreaks

[3] An outbreak is considered to be active pending advice from the relevant Public Health Unit. An outbreak is defined as at least 1 positive case in a resident or 2+ cases in staff.

[4] Case numbers and numbers of deaths are dependent upon reporting from facilities and validation of deaths from state and territory governments. This is subject to change as further information is provided.

Mortality

For the period of 1 January to 3 November 2022, COVID-19 is recorded as the cause of death in 6.1% of all deaths in permanent residents in aged care homes

Since the beginning of the Omicron outbreak in late November 2021, there have been 57,116 deaths in residential aged care from all causes (report period from 29 November to 29 October 2022. COVID-19 deaths account for 5.7% of this figure.

Over the course of the pandemic, all-cause excess mortality in Residential Aged Care was below expected numbers in 2020, and within expected range in 2021.

Workforce in active residential aged care outbreaks

As at 4 November 2022, workforce surge staff have filled a total of 143,537 shifts in aged care services impacted by COVID-19, including 1670 in the past 7 days.

In the past 7 days (to 3 November) surge workforce providers have assisted 41 residential aged care homes. These shifts include roles for GPs, nurses, care workers, allied health workers, executive and ancillary staff.

Oral antiviral treatments

The oral anti-viral Lagevrio (Molnupiravir was pre-deployed to aged care homes, commencing on 6 February 2022 prior to the listing of the oral treatments on the Pharmaceutical Benefits Scheme.

The National Medical Stockpile has deployed 48,269 treatment courses of Lagevrio (Molnupiravir) to aged care homes and continues to provision supply where an aged care home is unable to access the treatments through local channels.

Broadly most aged care homes are able to access supply of these treatments through community pharmacy.

30,206 prescriptions for Lagevrio (Molnupiravir) have been issued to residents in residential aged care facilities, with a further 773 prescriptions for Paxlovid (nirmatrelvir + ritonavir) also issued since 28 February 2022 and up to 30 October.

Recent changes to national COVID-19 response

- On 30 September 2022, National Cabinet agreed to remove the need for compulsory COVID-19 isolation across all jurisdictions, effective from 14 October 2022. This change has been implemented by each jurisdiction through revisions to relevant public health orders.
- In practice, these changes mean that almost all public health restrictions on residential aged care homes have been lifted. As the risk to aged care residents remains high, aged care providers are still required to maintain a high level of Infection Prevention and Control activity and undertake regular risk assessments.
- A National COVID-19 Community Protection Framework was released on 14 October 2022 to provide national guidance on the public health measures states and territories might put in place to manage an outbreak of COVID-19.
    - The Framework identifies residential and home aged care settings as high-risk settings, and outlines measures for responding to COVID-19 at a base level, and in instances where the epidemiological situation has changed.
    - The Australian Health Protection Principal Committee has endorsed the Framework, with an aim to provide greater certainty to the general community, business and people at higher risk of severe COVID-19 illness.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 3 - Ageing and Aged Care

Aged Care Deaths Data - Victoria

KEY POINTS

- COVID-19 continues to have a significant impact on older people and residential aged care continues to be a high risk setting for COVID-19 transmission.
- Whilst vaccination and access to oral anti-viral treatments have reduced the risk of severe disease and enabled many to recover from COVID-19 infections, aged care residents remain amongst those most at risk of death from or with COVID-19. In 2022 reporting to the Department of Health and Aged Care (the department) indicates COVID-19 as the cause of death in 6.1% of all deaths in permanent residents in aged care homes.
- As at 3 November 2022, there have been 4,099 COVID-19 deaths in residential aged care homes reported to the department over the course of the pandemic.
- This information is based on case numbers and deaths reported to the department directly by aged care providers. This data is subject to change as aged care homes update the data following confirmation of cause of death. The department's dataset may also be updated with information received from state and territory health departments.
- In September 2022, media outlets (*The* Age) reported that there had been over 2,500 deaths from COVID-19 in residential aged care homes in Victoria. This data was provided by the Victorian Department of Health. At the time, the department had recorded 1,286 deaths in residential aged care homes in Victoria based on data reported to the department (meaning a difference of approximately 1,300 additional deaths that were recorded by the Victorian Government).
- Upon being alerted of the discrepancy in reported figures, the department immediately sought to clarify the data definition, source, and accuracy of both datasets and continues to work to identify any discrepancies.
- Formal reporting and recording of mortality data varies across jurisdictions, including in the definitions applied and the timeliness of the data. The department's aged care dataset is a surveillance tool but does not include formal notification or registration of deaths.
- The Australian Bureau of Statistics (ABS) reports mortality data based on the coding and recording of cause of death on death certificates.
- The department is analysing ABS data and our surveillance data to improve the accuracy of public reporting.

FACTS AND FIGURES

- Mortality data is published weekly as part of the report on *COVID-19 outbreaks in residential aged care facilities*. A state breakdown is not included, though this was included as part of the regular daily reporting on COVID-19 statistics until mid-September 2022.

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COVID-19 Deaths in Residential Aged Care Facilities – By state and year, as at 3 November 2022

	2020	2021	2022	Grand Total
ACT	0	7	49	56
NSW	29	86	1,370	1,485
NT	0	0	11	11
QLD	1	0	582	583
SA	0	3	349	352
TAS	1	0	42	43
VIC	655	135	530	1,320
WA	0	0	249	249
Grand Total	686	231	3,182	4,099

COVID-19 Death Rates – Against cases of COVID-19

	Entire pandemic (March 2020 to present)	2021 – up until 29 November	29 November 2021 to 3 November 2022
COVID-19 deaths in RACFs	4,099	182	3,231
COVID-19 resident cases in RACFs	96,498	1,307	93,141
COVID-19 deaths as a % of cases	4.2%	13.9%	3.5%

- For the period of 1 January to 3 November 2022, COVID-19 is recorded as the cause of death in 6.1% of all deaths in permanent residents in aged care homes.
- Since the beginning of the Omicron outbreak in late November 2021, there have been 57,116 deaths in residential aged care from all causes (report period from 29 November to 29 October 2022). COVID-19 deaths account for 5.7% of this figure.
- Each year, approximately 23-25% of permanent residents in residential aged care homes pass away. This has remained relatively consistent since 2015, with 2020 reporting the lowest percentage at 23.0%.
- Each year, more than 80% of departures are due to reason of death (note this is related to total departure numbers, not distinct clients).
- The department is reviewing whether mortality analysis from AIR-MADIP linked data asset should be published alongside or in lieu of surveillance data reported by aged care homes.
- The review of linked data is expected to identify deaths the department has not been made aware of as they may have occurred outside the outbreak period or aged care homes may not have been notified of the determination of death as reported on certification.
- Information collected from aged care homes is provided voluntarily and is largely for the purposes of general oversight and awareness of emerging trends. It is also recorded largely for case management purposes, including the connection to necessary supports.
- The case management dataset is not a formal dataset for public health or surveillance purposes. The National Notifiable Disease Surveillance System (NNDSS) is the primary vehicle for the recording of surveillance data. All jurisdictions report mortality surveillance data to the NNDSS, with seven day rolling averages published weekly on the department's website. NNDSS mortality data are not disaggregated by aged care resident status.

International comparisons

- As at 31 October 2022, there have been 10,377,788 confirmed cases in Australia and 15,660 deaths, 4,082 of which have been in residential aged care (26% of total COVID-19 deaths).
- That is a death rate of 0.02 against the total number of people in residential aged care.
- By comparison:
  - As at 17 October 2022, the United Kingdom had 50,087 deaths in care homes (26% of total COVID-19 deaths).
  - At 16 October 2022, the United States of America had 158,797 deaths in care homes (15% of total COVID-19 deaths).
  - At 1 July 2022, Canada had 17,177 in care home (or 43% of total COVID-19 deaths).
- Note that international comparisons of COVID-19 deaths in care homes should be interpreted with caution. This is due to differences in reporting timeframes, definitions of what constitutes a 'care home' and the availability of data.
- Canada's Long Term Care COVID-19 Tracker Project ended on 1 July 2022 due to its provincial and territorial governments and public health authorities no longer providing enough reliable, timely data.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 3 - Ageing and Aged Care

Aged Care Workforce Shortages

BUDGET

	2021-22 (Estimate) ($m) (GST Excl)	2022-23 (Estimate) ($m) (GST Excl)	2023-24 (Estimate) ($m) (GST Excl)	TOTAL *2021-22 to 2023-24* ($m) (GST Excl)
Aged Care Data and Evaluation	$3.155 million	$1.531 million	$1.609 million	$6.295 million

KEY POINTS

How many nurses are needed to meet 24/7 RN on duty and 215 care minutes? At the last hearings, the Department said that 14,000 RNs would be needed – is that still correct?

- We continually revise our forecasts and the impact of various measures on the anticipated shortfall.
- With the funding for care minutes, a wage increase, skilled migration returning to previous levels, a range of other attraction and support measures, the shortfall of nurses would decrease – potentially to something in the order of 5,000-6,000.
- *If required:* The Department of Health and Aged Care (the department) modelling has been updated since the previous hearing. The total gap for 2023-24 is 11,800 RNs. This includes both care minutes and RNs on duty 24/7.

How will you monitor the growth in the nursing workforce?

- The Quarterly Financial Reports provide a breakdown on the hours worked by direct care and agency staff by occupation.
- A provider workforce survey to be conducted in the first half of 2023 will also capture RN headcount.
- The department monitors trends in job advertisements and the size of the nursing workforce through the National Health Workforce Dataset (based on nurse registrations).

Aged care workforce shortage

- Recent reports have highlighted workforce shortages in the aged care sector:
  - CEDA's *Duty of care*: aged care sector in crisis estimated an annual shortfall of 30-35,000 direct care aged care workers due to more workers leaving and fewer migrants.
  - The National Skills Commission's (NSC) *Care Workforce Labour Market Study* projected a gap of about 211,430 total care and support workforce FTE (or 285,800 headcount) by 2049-50. NSC notes that due to economic changes and the impact of COVID, workforce gaps would be larger and emerge more quickly than forecast in the 2021 Study.

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- The departments modelling also points to a significant workforce gap. It estimates a total gap of 127,100 for the aged care sector by 2031-32, including around 21,000 for registered nurses (RNs).
    - It is difficult to directly compare the department's projections with other studies, mainly due to differences in scope, timeframe, and methodology.

Government's initiatives to improve the workforce shortage

- On 8 August 2022, the Government made a submission to the ongoing Fair Work Commission (FWC) case, supporting a real wage increase for aged care workers. The Government has also committed to funding the outcome of the case.
- Options to increase the supply of key workers through migration are being considered, including through the Pacific Australia Labour Mobility Scheme. Visa applications from registered nurses are being prioritised. At the Jobs and Skills summit, the Government announced the migration cap would increase to 195,000 this financial year.
- The Government has implemented a series of skills and training initiatives, including Fee Free TAFE (including 15,000 places reserved for aged care), and 20,000 new university places focusing on areas of national priority or skills needs, such as nursing.
- Other workforce initiatives currently underway include:
    - The Workforce Advisory Service - a free, independent and confidential service to support residential and home care service providers with workforce advice. As at 30 September 2022, the department has approved 164 applications for providers to receive an advisory service. Of these:
        - 56 providers have had a workshop with PwC to discuss findings, and
        - 36 providers have been issued reports and recommendations.
    - The Home Care Workforce Support Program to attract and train 13,000 new aged care workers for the home care sector.
    - As at 30 September, 264 Home Care Workers been placed in jobs with a further 286 placed in training which includes the Entry into Care skill set, Certificate III in Individual Support and Certificate III in Allied Health.
    - The Aged Care Transition to Practice Program to support around 1,400 new aged care nurses with training and professional development.
        - As at 1 August 2022, 517 nurses have enrolled in the programs, and 97 have completed.
    - The Clinical Placements Program to provide 5,250 quality clinical placements for nursing students in the care and support sector.

Government's commitment on 24/7 nursing and care minutes

- All residential aged care homes will be required to have a RN onsite at all times from July 2023, provide an average of 200 care minutes (including 40 RN minutes) per person, per day from July 2023, and from October 2024 provide an average of 215 care minutes (including 44 RN minutes).
- The new RN supplement will be paid to residential aged care homes with 60 or less residents to support them to recruit the workforce needed to be able to meet the requirement.

- These new requirements may place additional pressure on areas existing workforce shortages – particularly on regional and rural areas.
- A one-off 12-month exemption from the 24/7 RN requirement will be available to small residential aged care facilities with 30 approved beds or less that are located in Modified Monash Model (MMM) 5 to 7 areas.
- The Department will commission an independent organisation to develop clinically appropriate alternative arrangements to an onsite RN for aged care homes unable to recruit sufficient RNs due to workforce shortages. This work will commence by the end of the year and will involve significant consultation with relevant clinical experts.

FACTS AND FIGURES

Aged care workforce profile

- The estimated aged care workforce was around 370,000 at August 2021, 77% of the workforce are direct care staff.
- The total number of Personal Care Workers (PCWs) is estimated to be 215,000. They are the largest group of direct care workers.
- Between 2016 and 2021, there was a 32% increase in the FTE of direct care workers in residential aged care homes, and a 17% increase in the number of nurses (registered and enrolled) working across all aged care sectors.
- Around 87% of all direct care workers in aged care are females.
- Below table illustrates the estimated workforce gap for RNs (including Nurse Practitioners) and PCWs in residential aged care facilities for the next two years.

	FY 2023-24		FY 2024-25	
	RNs+NPs	**PCWs**	**RNs+NPs**	**PCWs**
A. Baseline demand (no policy commitment)	30,327	134,944	31,466	139,800
B. Additional demand due to 24/7 RN coverage	869	0	873	0
C. Additional demand due to care minutes increase to 200	8,944	4,813	9,280	4,986
D. Additional demand due to care minutes increase to 215	-	-	0	9,954
E. Baseline supply	28,382	126,078	28,783	127,838
Total workforce gap=A+B+C+D-E	**11,758**	**13,679**	**12,836**	**26,902**

Breakdown of initiatives that are likely to close the gap:

- Migration, based on historical trends – 1,800
- Impact of payrise based on internal departmental modelling – 2,300
- Combined impact of other programs, eg Transition to Practice – 800
- Increased workforce utilisation and reduced exits – 1,200

Estimated total: 6,100

Notes:

The estimates presented are designed to illustrate the possible effect of different actions but are difficult to predict with certainty.

The estimates do not include Human Resource innovations within the sector. A number of providers have their own Human Resource/Career Development Units to enhance recruitment and retention within their organisations. These include in-house skills and training programs, graduate nurse programs, career fairs and additional incentives, such as salary sacrificing, repayment of nurse registration, mileage allowance.

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 3 - Ageing and Aged Care

24/7 registered nurses implementation

BUDGET

	2021-22 (Actual) ($m)	2022-23 (Estimate) ($m)	2023-24 (Estimate) ($m)	2024-25 (Estimate) ($m)	2025-26 (Estimate) ($m)	Total *2022-23 to 2025-26* ($m)
24& RN supplement	**-**	**-**	**159.6**	**166.7**	**147.0**	**473.3**
Annual increase in spend	-	-	159.6	7.1	-19.7	-
Growth (%)	**-**	-	-	*4.4*	*-11.8*	-

KEY POINTS

24/7 Registered Nurses

- Residential aged care homes will be required to have a registered nurse (RN) onsite and on duty 24-hours a day, seven days a week from 1 July 2023, in line with the Australian Government's election commitment.
- The Royal Commission into Aged Care Quality and Safety (Royal Commission) recommended the introduction of the requirement from 1 July 2024.
- Requiring residential aged care homes to provide an RN onsite and on duty at all times is intended to improve resident safety and reduce unnecessary hospital trips.

RN Supplement

- The new RN supplement will be paid to residential aged care homes with 60 or less residents to support them to recruit the workforce needed to be able to meet the requirement.
- The supplement has been designed to top up the Australian National Aged Care Classification (AN-ACC) Daily Basic Subsidy and will deliver more funding to smaller aged care homes, tapering to no funding for facilities with over 60 residents.
- Aged care homes with over 60 residents will not receive the supplement as for their AN-ACC Daily Basic subsidy funding is sufficient to cover the new 24/7 RN requirement.

Supplement Rates

- The RN supplement rate differs between Modified Monash Model (MMM) 1-4 areas and MMM 5-7 areas in recognition of the additional costs of attracting RNs to work in rural and remote areas.
- The supplement will cap the funding provided in MMM 1-4 areas at the cost of an 8-hour overnight RN (around $257,000 per annum), while in rural and remote areas (MMM 5-7) the supplement delivers the full cost of having an RN onsite 24-hours per day not provided by the AN-ACC Daily Subsidy.

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- Providing full funding to small-aged care homes in MMM 5-7 areas will enable them to continue to deliver services in areas where there is often no alternative service available.

- As the RN supplement tops up existing care minutes funding the supplement will reduce in 2024-25 with the commencement of additional funding to deliver 215 care minutes per resident per day.

Exemptions

- Small residential aged care homes with 30 beds or less that are located in MMM 5 to 7 areas will be eligible for a 12-month exemption from the 24/7 requirement.
- The limited exemption process provides initial transitional support to small rural and remote aged care homes that face the most significant challenges attracting and retaining the workforce needed to meet the requirement. It is expected they use this time to take steps to increase their workforce.
- Eligible aged care homes that accept the exemption will be required to sign a statement confirming they will have arrangements in place to deliver safe and quality aged care in line with the Aged Care Quality Standards and other obligations under the *Aged Care Act 1997*. They will also acknowledge that accepting the exemption means they will not receive the RN supplement for the exemption period.
- Aged care homes eligible for exemption that are able to, or believe they will be able to, provide an RN 24/7 can choose to opt out in order to receive the RN supplement.
- Exempting providers from the 24/7 RN requirement does not exempt them from meeting other provider responsibilities, including care minutes.
- All residential aged care homes will be required to deliver on the requirement when the exemption period ends.
- Limiting the number of exemptions balances the need to provide support to aged care homes that face the greatest challenge meeting the requirement with the intent of the Royal Commission's recommendation to provide improved quality of care and safety to older Australians in residential aged care.

Compliance and regulatory response

- Compliance with the requirement will be monitored through new mandated monthly reporting that all providers will be required to complete. The reports will provide details of all times that an RN was not onsite or on duty in their facilities and the reason why.
- Where a facility reports that they have not met the requirement (and have not received an exemption) the supplement payment will stop until the requirement is being met.
- The Aged Care Quality and Safety Commission (the Commission) is responsible for determining the regulatory response to provider non-compliance with the 24/7 RN requirement.
- In monitoring compliance with the requirement, the Commission will apply a proportionate, risk-based approach that takes into account the reasons for any non-compliance and any concurrent risks.

FACTS AND FIGURES

- The RN supplement will support approximately 1,221 aged care homes.
- Approximately 191 aged care homes are expected to be eligible for a 12-month exemption from the RN requirement, though it's not expected that all of them will accept the exemption offer.
- The RN supplement rate, and 215 care minutes funding uplift (to AN-ACC from Oct 2024) are based off the following wage assumptions (in 2023-24 dollars):
    - **MMM 1-4:** RN wage of $63.79 per hour (plus a 30 per cent overnight loading), EN wage of $47.84 (assumed 12 per cent of 11 minute uplift of PCW/EN time), PCW wage of $41.03 per hour (assumed 88 per cent of 11 minute uplift of PCW/EN time)
    - **MMM 5-7** RN wage of $80.77 per hour (plus a 30 per cent overnight loading), EN/PCW wage of $80.77 per hour

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Senate Committee: Community Affairs

Budget Estimates 2022-2023

Outcome: 3 - Ageing and Aged Care

Financial State of the Sector

KEY POINTS

- The recent media claims that the aged care sector is at risk of collapse are untrue. Since 2018, leading peak organisations and the media have been telling us that urgent funding relief is required to prevent sector collapse. To date, we haven't seen these scenarios eventuate. For example:
    - in 2018 LASA reported: "Chief Executive Officer of Leading Age Services Australia (LASA) Sean Rooney said the latest (March 2018) report by industry analyst Stewart Brown released this week shows the financial situation for residential aged care facilities is continuing to deteriorate, putting the sustainability of the sector at serious risk."
    - in 2019, the previous peak body Aged and Community Services Australia reported that one of their surveys identified up to 15% of residential care providers may have to close services in 2020.
    - in 2020, ABC News reported "The aged care sector is today warning it is at risk of collapse unless the Federal Government funds an additional $1.3 billion rescue package."
    - in 2021, LASA reported "LASA is calling for major Government moves on residential and home care, with predictions up to 65% of age care homes will record operating losses in the next financial year, putting quality care for older Australians at greater risk." *(Note: The 2020-21 FRAACS report shows that 54% of providers operated at a loss).*
    - in 2022, The Australian reported that "Emergency funding needed as aged-care sector 'at risk of collapse'".
- It is true that the sector has experienced significant pressure over the last few years as a result of the COVID-19 pandemic, declining occupancy, and indexation continuing to outpace funding increases.
- The Department of Health and Aged Care's first Financial Report on the Australian Aged Care Sector 2020-21 (FRAACS), which was released on 4 November 2022, shows declining performance of residential aged care providers. The report is consistent with StewartBrown's Aged Care Financial Performance Survey reports.
- Significant reforms are underway which will drive structural change to funding of the residential aged care system.

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- Government funding for residential has increased significantly since the 2020-21 financial year:
    - a $10 per resident per day uplift commenced on 1 July 2021 (initially provided through the Basic Daily Fee (BDF) Supplement, and from 1 October 2022 rolled into the Australian National Aged Care Classification (AN-ACC) basic subsidy funding)
    - a substantial funding uplift of $5.4 billion (over 4-years from 2022-23) commenced on 1 October 2022 to support providers to increase direct care minutes.
    - at the average per resident level funding is expected to increase from around $193 per day under previous arrangements to around $225 under AN-ACC.
    - residential care funding will increase by 13% to $16.9 billion this financial year (2022 23). This means average Government funding per resident will be over $85,000 in 2022-23.
- Going forward funding will be set annually based on independent advice from the newly established Independent Health and Aged Care Pricing Authority (IHACPA) which will ensure care funding moves in line with the costs of delivering care.
- While overall operating results for the residential aged care sector were negative, the care income result, where the majority of provider revenue is funded by the Government, was positive, with an average profit of $25.14 per resident per day.
- While the Government progresses structural funding reforms, residential providers should focus on administrative efficiencies and opportunities to increase revenue from accommodation to improve their financial performance.

If asked: Is an emergency funding package needed?

- Significant structural reforms are underway which will ensure aged care providers are funded to cover the costs of the care they deliver.
    - the Government has committed funding to deliver 215 care minutes and 24/7 nursing and has committed to funding wage increases for aged care workers, following a decision from the Fair Work Commission.
- While the impact of the structural reforms through AN-ACC come into effect, the Government has targeted financial assistance programs in place to support providers through this period of reform and ensure continuity of care for older Australians.
    - these programs include the Business Advisory Service, the Business Improvement Fund, the Structural Adjustment Fund and the AN-ACC Transition Fund.
    - the department has provided support to over 430 providers under the Business Advisory Service, the Business Improvement Fund, COVID-19 Viability Fund and the Service Development Assistance Panel. The department is also working with over 200 providers under the Financial Monitoring and Business Assistance program.

If asked: Will the Government introduce user co-contributions?

- The Government is committed to a consumer contributions framework that is contemporary and progressive.
- Both the FRAACS report and latest StewartBrown report show care is fully funded, and residential aged care providers reported a surplus in this area of their business operations.
- By contrast, financial losses are a result of factors that are largely within the control of

residential aged care providers and there are opportunities to increase revenue from accommodation. For example:

- more than three quarters (80.9%) of aged care providers experienced a loss in accommodation (ACFR 2020-21).
- nationally, the median cost of residential care accommodation is only 58% the value of the medium house price.

If asked: Why does the FRAACS report use data more than 12 months old (2020-21)?

- The FRAACS report is the first in a series of financial transparency measures that will increase accountability and integrity, by making information on the financial performance of the sector publicly and readily available.
- Data included in the FRAACS report is provided to the department each year, as part of the annual Aged Care Financial Report process.
  - the majority of data is submitted by 31 October, however some providers (including providers with a large footprint) have alternative reporting period arrangements and submit their data by the end of April.
  - once received, data is cleansed to ensure accuracy, including cross-checking, contacting providers to request revised information, and removing errors.
- For the majority of providers, information for the 2021-22 financial year was provided only a few weeks ago and will be published in next year's FRAACS report.
- From February 2023, the Government has committed to release a quarterly financial snapshot which will provide timely information.

If asked: Is FRAACS less reliable than the StewartBrown Aged Care Financial Survey Sector 2021-22?

- The Government does not comment on detailed analysis by private firms such as StewartBrown, given we don't have access to the information providers submit as part of this survey.
- StewartBrown's reported trends are consistent with internal department analysis.
- It is important to note that results of the StewartBrown reports are based on a survey representing approximately 36% of aged care providers, whereas the FRAACS is based on sector-wide audited financial results provided to the department.
- For further information see Attachment A: Comparison of the FRAACS and StewartBrown results across key income and expense categories. This comparison shows that care costs are fully funded in both the FRAACS and StewartBrown reports.

FACTS AND FIGURES

- Overall, residential aged care profit has declined since 2017-18, dropping below zero for the second consecutive year (to minus $854 million).
- In 2020-21, 46% of residential aged care providers reported a positive net profit, representing 42% of total operational beds in the residential care sector.
- Home care results were relatively strong – the home care sector generated $248 million in profit in 2020-21 – and providers increased their operational result for a third consecutive year.
- For further information see Attachment B.

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Attachment A

A. Care Result			
Department result 20/21		SB result 20/21	
Revenue	$194.31	Revenue	$187.73
Expenses	$169.17	Expenses	$164.05
Result	$25.14	Result	$23.68
		SB result 21/22	
		Revenue	$194.77
		Expenses	$177.76
		Result	$17.01

B. Hotel Result			
Department result 20/21		SB result 20/21	
Revenue	$56.63	Revenue	$54.79
Expenses	$55.72	Expenses	$54.28
Result	$0.91	Result	$0.51
		SB result 21/22	
		Revenue	$66.33
		Expenses	$57.01
		Result	$9.32

C. Accommodation Result			
Department result 20/21		SB result 20/21	
Revenue	$35.96	Revenue	$32.86
Expenses	$36.60	Expenses	$31.99
Result	($0.64)	Result	$0.87
		SB result 21/22	
		Revenue	$32.84
		Expenses	$32.86
		Result	($0.02)

D. COVID-19 Result			
Department result 20/21		SB result 20/21	
Revenue	$10.93	Revenue	$11.23
Expenses	$8.42	Expenses	$7.52
Result	$2.51	Result	$3.71
		SB result 21/22	
		Revenue	$0.00
		Expenses	$0.00
		Result	$0.00

E. Administration Result			
Department result 20/21		SB result 20/21	
Revenue	$0.00	Revenue	$0.00
Expenses	$38.24	Expenses	$37.20
Result	($38.24)	Result	($37.20)
		SB result 21/22	
		Revenue	$0.00
		Expenses	$40.98
		Result	($40.98)

E. Non-recurrent income & expenses result			
Department result 20/21		SB result 20/21	
Revenue	$13.60	Revenue	$0.00
Expenses	$15.66	Expenses	$0.00
Result	($2.06)	Result	$0.00
		SB result 21/22	
		Revenue	$0.00
		Expenses	$0.00
		Result	$0.00

A + B + C + D + E = Operating Result	
Department Operating Result 2020-21	($12.38)
StewartBrown Operating Result 2020-21	($8.43)
StewartBrown Operating Result 2021-22	($14.67)

Note: The StewartBrown Aged Care Financial Performance Survey report counts administration as part of care, hotelling and accommodation. Administration is presented separately in this table for the purposes of comparison with the FRAACS report.

Attachment B

Financial Report on Australia's Aged Care Sector Data Table 2a. Residential care, FY19-20 to FY20-21, providers			
	FY20-21	**FY19-20**	**Change from previous year**
Residential aged care sector operational result[ii]	-$854m	-$736m	-$118m
Proportion of residential care providers operating at an EBITDA loss[i]	**FY20-21**	**FY19-20**	**Change from previous year**
For-profit providers	29%	21%	8p.p
Not-for-profit providers	30%	29%	1p.p
Govt. providers	76%	74%	2p.p
All providers	**35%**	**31%**	**4p.p**
Proportion of residential care providers by location operating at an EBITDA loss[i]	**FY20-21**	**FY19-20**	**Change from previous year**
Metro providers	30%	26%	4p.p
Regional providers	43%	40%	3p.p
Metro/Regional mix	26%	12%	14p.p
EBITDA margin result, by provider type[ii]	**FY20-21**	**FY19-20**	**Change from previous year**
For-profit providers	4.4%	8.5%	-4.1p.p
Not-for-profit providers	3.5%	5.4%	-1.9p.p
Govt. providers	-8.7%	-11.0%	2.3p.p
All providers	**3.3%**	**6.0%**	**-2.7p.p**
EBITDA margin result, by location[ii]	**FY20-21**	**FY19-20**	**Change from previous year**
Metro providers	4.5%	7.3%	-2.8p.p
Regional providers	-0.3%	1.1%	-1.4p.p
Metro/Regional mix	2.1%	4.9%	-2.8p.p
All providers	**3.3%**	**6.0%**	**-2.7p.p**

Notes: Additional information has been sourced from the Aged Care Financial Report due to it not being reported in the FRAACS report or previous ACFA reports.
i. Source: Aged Care Financial Report (ACFR)
ii. Source: Financial Report on the Australian Aged Care Sector 2020-21
P.P. = Percentage points

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