3

The impact of COVID-19 on the wellbeing of Australians

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Note that this article was finalised in June/July 2021 and thus concentrates on the first and second major COVID-19 waves in Australia along with the broader impact over that period. At the time of finalisation many new outbreaks were beginning around the country, most notably in Sydney, and it was too early to know how these may develop. These latest outbreaks are not addressed in detail in this article.

Coronavirus disease 2019 (COVID-19) is a disease caused by the new coronavirus SARS-CoV-2. This major health threat has caused an international crisis, leading to substantial disruption to almost all parts of society worldwide.

There are several reasons why COVID-19 has caused such a crisis. Briefly, being caused by a virus not previously seen in humans hence, there was initially no – and now only limited – immunity in the population (now largely from vaccination). It is also highly infectious and affects some people severely. Until the development of vaccines, the only practical way to contain its spread was by travel bans, strict physical distancing policies and practices (such as through closure of non-essential services and keeping a minimum distance from others) and personal hygiene. These restrictions have had a serious impact on economies and societies across the world – with travel; trade; and people's ability to work, to attend school and to socialise; all affected. The vaccines provide hope that the crisis may be able to be contained, but it is likely that a combination of public health measures and vaccines will be needed for some time to come.

At the time of finalising this article, Australia had fortunately avoided the serious health impacts seen in many other countries, where there have been large numbers of severe cases and deaths, putting a huge strain on health systems, economies and population wellbeing (MacIntyre & Heslop 2020). While detailed information of which specific factors may have contributed to the favourable situation in Australia is not yet available, the early implementation of international travel restrictions and physical distancing measures in combination with one of the highest testing rates in the world have played a key role (Cheng & Williamson 2020).

The pandemic has had a broad range of effects: direct health effects on individuals who contract the virus, along with many indirect effects on the whole community. These indirect effects include the impact of the various national and regional shutdowns aiming to control the spread of the virus.

This article focuses on the direct and indirect impact of the COVID-19 pandemic on the wellbeing of Australia's population during 2020 and the first half of 2021. Positive wellbeing is associated with being comfortable, happy or healthy and can be influenced by a number of factors. Areas of particular interest covered in this article with a potential impact on wellbeing are:

- health (direct and indirect effects such as on mental health)
- income and finance (changes to income)
- employment and work (labour market changes)
- education and skills (impact on preschooling and schooling)
- social support (social isolation and aged care)
- justice and safety (family violence and child protection)
- housing (housing stress and homelessness).

This article concentrates on the impact of COVID-19 on these 7 domains, rather than the role they play in the pandemic. It is acknowledged, however, that some do play a role – overcrowded housing, for instance, increases the risk of the virus spreading.

Several programs were set up during the periods of restrictions to help combat the potential adverse effects of the pandemic, and specific examples are described later in this article. Broader, cross-sector programs were also put in place in various local areas. For example, a number of community driven, 'place-based' responses were shown to be effective in promoting community resilience and recovery (Dusseldorp Forum 2020). These included supporting local service systems, protecting the most vulnerable, giving the community a voice, and keeping people informed.

Health

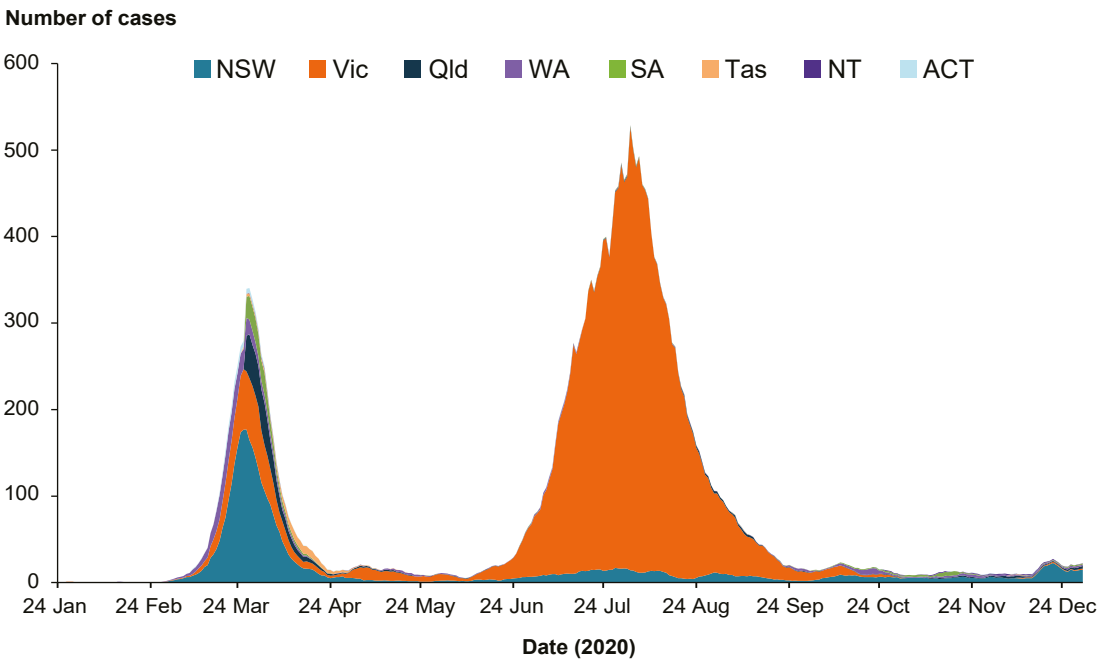
The COVID-19 pandemic has had both direct and indirect health effects. These range from the health effects for an individual with COVID-19, through to the short and longer term impacts of social disruption due to measures taken to contain the virus. Indirect health effects are wide ranging and include impacts on mental health, family violence, health care for other conditions and health behaviours. For some people there have been positive changes, but for many others there have been numerous challenges. Challenges arising from the indirect health effects of the various shutdowns were foreshadowed (Ait Ouakrim et al. 2021 [prepint]), which is why governments implemented several mitigation strategies to reduce any potential impacts.

Direct health effects

COVID-19 cases

During 2020, there were around 28,500 cases of COVID-19 in Australia (AIHW 2021e). As is the nature of infectious diseases, outbreaks occur at different times and in various locations. In Australia in 2020, there were 2 distinct peaks (or 'waves') in the number of cases (Figure 3.1) – one in March/April and one lasting from June to September. The 2 waves had similar peaks but the second one lasted quite a bit longer. The first peak affected nearly all states and territories (with the largest number of cases in New South Wales) while the second one affected Victoria almost exclusively. Over the year, the largest proportion of cases were in Victoria, followed by New South Wales. The first wave was dominated by overseas-acquired cases, while the second was nearly all locally acquired (AIHW 2021e).

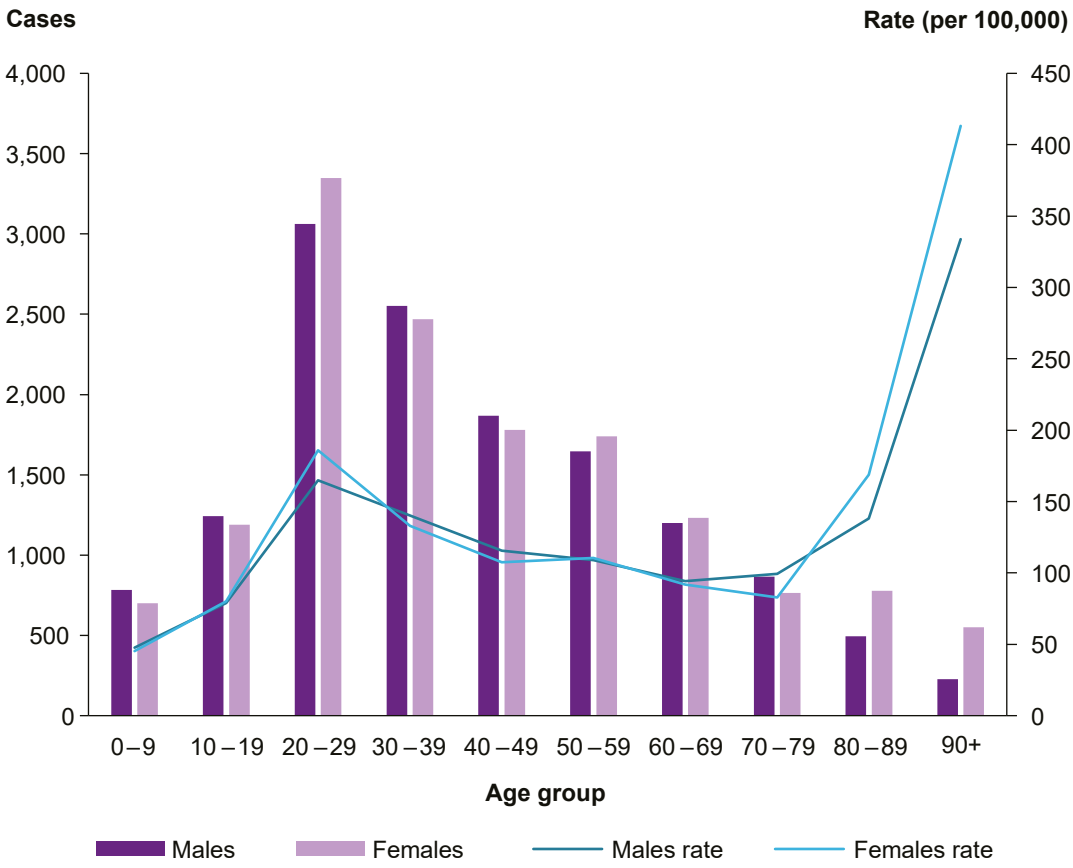
Figure 3.1: Cases of COVID-19 in 2020, 7-day moving average, by state and territory



Source: www.covid19data.com.au.

The number of cases differed by age group, but less by sex (Figure 3.2). The largest number of cases occurred among people in their 20s and 30s. In contrast, much higher rates occurred in the oldest age groups, largely due to outbreaks in residential aged care in Victoria during the second wave.

Figure 3.2: Number and rate of confirmed cases of COVID-19 in 2020, by age and sex

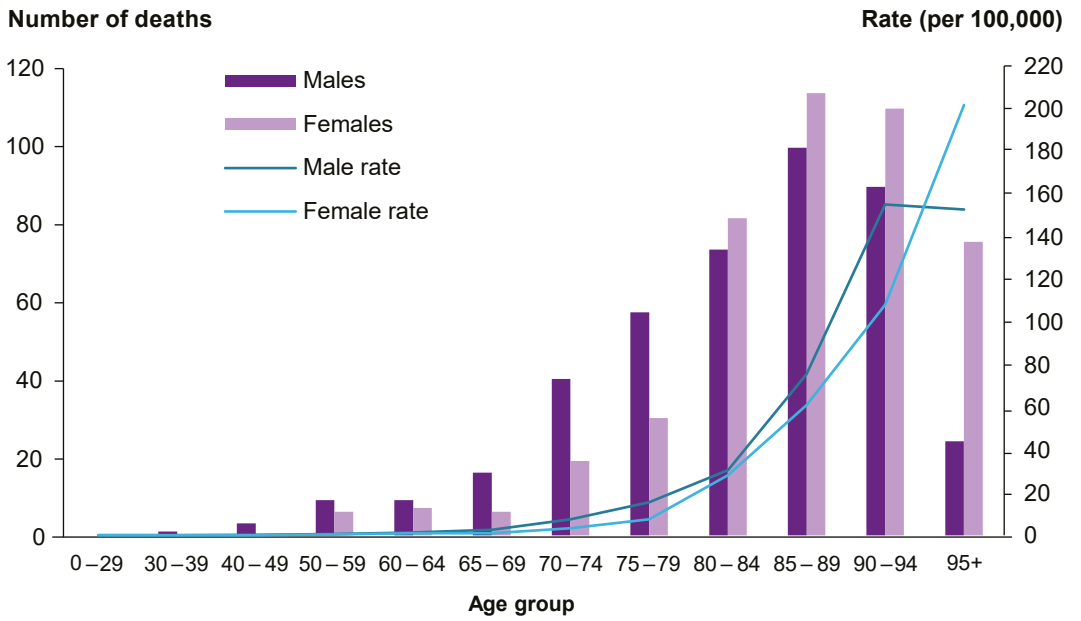


Source: COVID-19 NIRST 2021a.

Severity

In 2020, 866 deaths were directly attributed to COVID-19 in Australia; 89% of them in Victoria and 7% in New South Wales. Just over half of these deaths (446; 52%) were for females. The majority of COVID-19 deaths were in the older age groups, with the 85–89 and 90–94 age groups recording the most. There were steep increases in death rates across the age groups and higher rates for males than females, particularly in the oldest age groups (Figure 3.3).

Figure 3.3: Number and rate of COVID-19 deaths in Australia, by age and sex, 2020



Source: AIHW analysis of ABS Provisional Mortality Statistics.

The chances of dying if contracting COVID-19 (case-fatality) rises very sharply with age from about age 70, and rates are consistently higher for men than women (AIHW 2021e). Rates remain below 1% up to and including the 50–59 year age group for both males and females. By age 70–79, case-fatality rates were 11% for males and 6.4% for females. For those aged 80–89, rates increased to 35% for males and 25% for females.

Around 12.5% of people with COVID-19 were hospitalised in 2020, representing the more severe cases of the disease (COVID-19 NIRST 2021c). Average length of stay was 11 days for all COVID-19 hospitalisations, and 21 days for the group that required treatment in Intensive Care Units (AIHW 2021d).

There is now emerging evidence that some people experience a long period of chronic symptoms after developing COVID-19. This condition has been labelled post-COVID-19 syndrome but is more commonly known as 'long-COVID'. A recently published Australian study reported recovery times for 94% of all COVID-19 cases diagnosed in NSW between January and May 2020: 20% had not recovered by 30 days, 9% by 60 days and 7% by 90 days (Liu et al. 2021). Taking into account that 1.8% of cases died from COVID-19, the authors noted that around 5% of cases had not recovered at 90 days. Recovery time increased with age; women recovered more slowly than men; and those with pre-existing comorbidities were slower to recover than those without.

Population groups

Several population groups are at particular risk of developing COVID-19 or of having a higher chance of severe disease if they do contract it. These groups include residents of aged care facilities (covered in the 'Aged care' section later in this article), people living in other communal living accommodation (such as those in prisons or residential disability care), people with chronic health conditions, and health and aged care workers (AIHW 2021e). Another group also at increased risk is Aboriginal and Torres Strait Islander people, and during 2020 this community was successful in keeping infection rates very low (Box 3.1).

Box 3.1: COVID-19 among Aboriginal and Torres Strait Islander people in 2020

Aboriginal and Torres Strait Islander people and their communities are at high risk of COVID-19 outbreaks and severe outcomes due to a range of health and socioeconomic inequalities including reduced access to services, barriers to treatment (including institutional racism) and high rates of chronic disease (Yashadhana et al. 2020).

As at 9 May 2021, there had been 153 confirmed COVID-19 cases among Indigenous Australians since the start of the pandemic (COVID-19 NIRST 2021b). This represents around 0.5% of all confirmed COVID-19 cases, whereas Indigenous Australians comprise 3.3% of the Australian population. The majority (79%) of locally-acquired cases among Aboriginal and Torres Strait Islander people were among those residing in *Major cities*. At the time of writing (June 2021) there had been no deaths among Indigenous people and no outbreaks recorded in remote communities.

This extremely successful response during the first year of the pandemic was led by the National Aboriginal Community Controlled Health Organisation and involved Indigenous Australians and communities in ensuring that the priorities and solutions were safe and culturally appropriate for communities (Crooks et al. 2020). In early March 2020, the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 was established to provide culturally appropriate advice to the Department of Health, including for Aboriginal and Torres Strait Islander health services and communities on COVID-19 (Department of Health 2020a).

The worsening outbreak of COVID-19 in Papua New Guinea in March 2021 increased the risk of cross-border transmission via the Torres Strait Islands; hence, the Queensland Government fast-tracked the roll-out of vaccines to these islands (Queensland Health 2021).

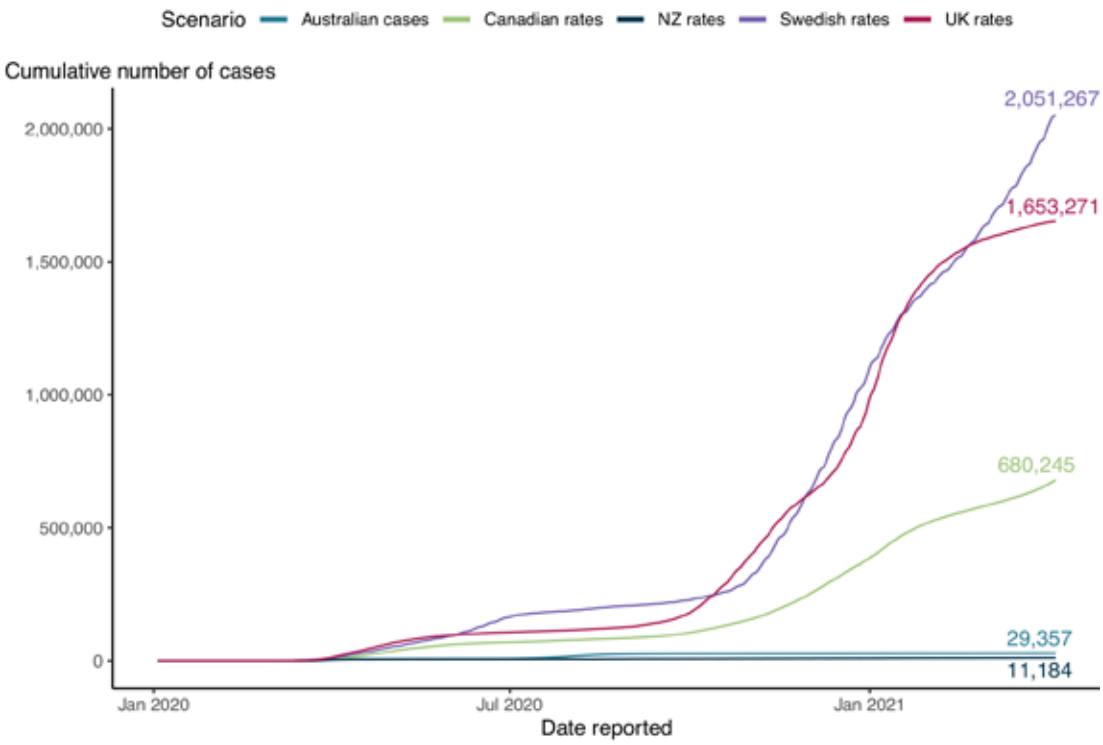
Comparisons with other countries

Australia was very fortunate in keeping cases and deaths low throughout 2020 for a range of reasons, including strict travel bans, effective public health measures (including regulation to ensure physical distancing), high rates of testing, and effective contact tracing and isolation procedures.

The magnitude of Australia's favourable situation is highlighted by comparing the rates of cases (and deaths) experienced in comparable countries with those for Australia. Four countries serve to illustrate – Canada, New Zealand, Sweden and the United Kingdom – chosen as they are comparable to Australia in ways relevant to this analysis. They have similar proportions of people aged over 65 (which will partly account for different population age structures), similar health as summarised by life expectancy at birth, and similar health systems and expenditure on health care (AIHW 2020a). These countries all applied some level of travel bans, physical distancing and other control measures, though to varying degrees. All except New Zealand experienced many more cases and deaths than Australia.

If the rates in Canada had applied in Australia, by early April 2021, Australia would have had 680,245 confirmed cases (more than 600,000 additional cases); if the rates in Sweden and the United Kingdom had applied, there would have been more than 1.6 million cases (Figure 3.4). These high numbers of cases would have put Australia's health system under extreme pressure and the number of deaths would have been much higher as a result. In contrast, New Zealand was very successful in controlling the number of cases – if their rates had occurred in Australia, there would have been around 18,000 fewer cases than there were. Applying similar methods in relation to death rates, Australia would have had between 15 and 46 times the number of deaths if the rates in Canada, Sweden or the United Kingdom had applied, and around 780 fewer deaths if the rates in New Zealand rates had applied (AIHW 2021e).

Figure 3.4: Number of cases of COVID-19: Australia and scenarios



Sources: WHO for case data and the World Bank for population data.

Indirect health effects

Mental health

For some Australians, the COVID-19 pandemic and associated restrictions appears to have had a negative effect on their mental health, while for others there were positive effects. Negative effects can include concerns about the virus itself; as well, some of the measures needed to contain its spread also had the potential for negative effects (NMHC 2020). Importantly, the periods when people needed to stay at home as much as possible to increase physical distancing meant that many were isolated from family, friends and other support networks. Flow-on effects such as sudden loss of employment and the pressures involved in adapting to remote work and schooling were also part of the picture. For some people, the resulting negative impacts on mental health may be short term; however, there is potential for the situation to exacerbate long-term mental health problems such as depression and substance abuse (WHO 2020). Conversely, positive effects may include greater social connectedness, increased rest and benefits from working at home (Gijzen et al. 2020; Helliwell 2021).

The potential for negative impacts on mental health was recognised early in the pandemic (Brooks et al. 2020; WHO 2020). To reduce these impacts, several support measures were put in place but there was still a notable increase in the use of mental health services (AIHW 2021c).

Psychological distress reflects painful psychological symptoms associated with fluctuations in mood. There is a correlation between high levels of psychological distress and common mental health disorders. Psychological distress is commonly measured using the Kessler Psychological Distress Scale—10 items (K10). The questionnaire covers things like the individual's level of nervousness, agitation, psychological fatigue and depression over the past 4 weeks. The Kessler 6 scale is an abbreviated form of the K10. Using data from a longitudinal survey (ANUpoll) together with data from before the pandemic and collected at various times during the pandemic (see Box 3.2), the following patterns emerge:

- The initial impacts of the epidemic in Australia appeared to increase levels of psychological distress. This was particularly the case for those in age groups in the 18–44 range (Biddle et al. 2020d). The proportion of all Australians experiencing severe psychological distress increased from 8.4% in February 2017 to 10.6% in April 2020, then fell to 9.7% in May 2020 – still substantially above the February 2017 levels. The increases in psychological distress were larger for younger people than for older people.
- Overall levels of psychological distress worsened between May and August 2020, and remained higher than before the pandemic, driven by worsening rates among women and people aged 75 or over (Biddle et al. 2020e). During this period, there was also a significant worsening in Victoria relative to the rest of the country.
- There was an improvement in overall psychological distress levels between October and November 2020, though levels still remained higher than before the pandemic (Biddle et al. 2020f). The improvements were seen for both males and females, and across all age groups.
- The 2021 data from the ANUpoll shows continued improvement in mental health outcomes between November 2020, January 2021 and April 2021 (Biddle & Gray 2021a, 2021b). The most recent figure has average psychological distress scores lower than they were before the pandemic. However, there are still more people with severe psychological distress (9.7%) than in February 2017 (8.4%). For those aged under 45, the improvements since the peak in April 2020 have not brought average levels of psychological distress down to where they were before the pandemic. The gap in psychological distress between the youngest and oldest age groups has widened since 2017, likely due to the effects of the pandemic.

Box 3.2: The ANUPoll

A panel survey – ANUPoll – has been referred to in several places in this article. The AIHW collaborated with the Centre for Social Research and Methods at the Australian National University (ANU) to include questions on loneliness and the level of psychological distress using the Life in AustraliaTM Panel, managed by the Social Research Centre (Social Research Centre 2021).

This representative panel of adults living in Australia exclusively uses random probability-based sampling methods and covers both online and offline populations (that is, people who do and do not have access to the internet). As well, as a panel it is possible to obtain longitudinal data including from the same respondents before the spread of COVID-19 which provides richer information than would a series of cross-sectional snapshots, especially with regards to changes through time.

The survey is based on almost 3,500 respondents in the most recent survey. A high proportion (86%) of respondents were included in earlier survey iterations, and new participants are added to replace those who have stopped participating. It includes self-reported data on several important topical issues and was conducted up to monthly during the pandemic. As well as the loneliness and psychological distress questions, other recent topics related to COVID-19 include income, labour market participation and education.

Given the potential for negative impacts on mental health, it has been important to monitor suicide levels during the pandemic. Data have been published from suicide registers in the 3 largest Australian states, all showing very similar rates of suspected suicide in 2020 as was the case in 2019:

- New South Wales: in 2020 there were 896 suspected suicides, compared with 943 in 2019 (NSW Government 2021)
- Victoria: in 2020 there were 713 suspected suicides, similar to the figure of 718 over the same period in 2019 (Coroners Court of Victoria 2021)
- Queensland: between 1 January and 31 July 2020 there were 454 suspected suicides, similar to the figure of 445 over the same period in 2019 (Leske et al. 2020).

Despite the negative impact on mental health, at this stage there appears to have been no increase in suicide rates. However, this will continue to be monitored into the future.

Further details are available from the AIHW Suicide and self-harm monitoring website: https://www.aihw.gov.au/suicide-self-harm-monitoring.

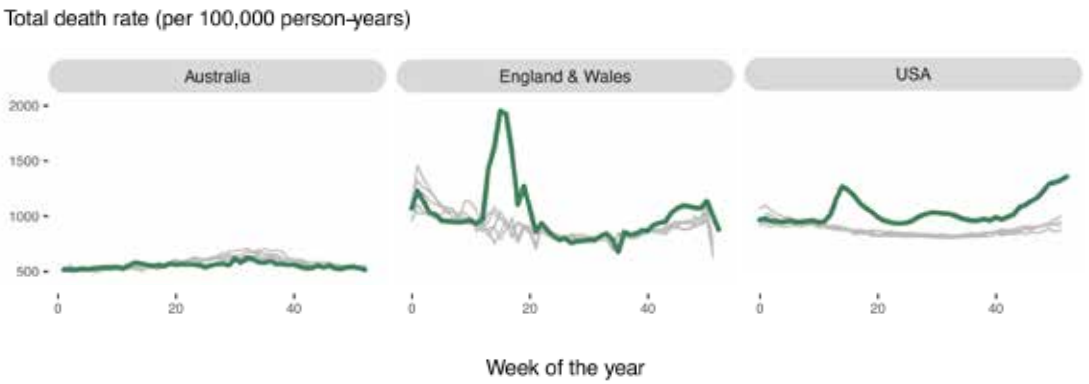
The AIHW recognises that each of the numbers reported above represents an individual. The AIHW acknowledges the devastating effects suicide and self-harm can have on people, their families, friends and communities.

If you or someone you know needs help, services are available 24 hours a day. Call Lifeline (13 11 14), the Suicide Call Back Service (1300 659 467) or Beyond Blue (1300 22 4636).

Deaths from all causes

Australia is one of the few countries where overall death rates (from all causes, based on doctor-certified deaths only) declined during 2020 compared with previous years (AIHW 2021e). The death rates in many other countries were substantially higher than in previous years. Two examples, England/Wales and the United States, are compared with Australia in Figure 3.5. COVID-19 was a key driver for the excess deaths (when deaths exceed the expected number based on recent years) in these 2 countries, but deaths from other specific diseases increased as well (AIHW 2021e).

Figure 3.5: Excess deaths during 2020: selected countries

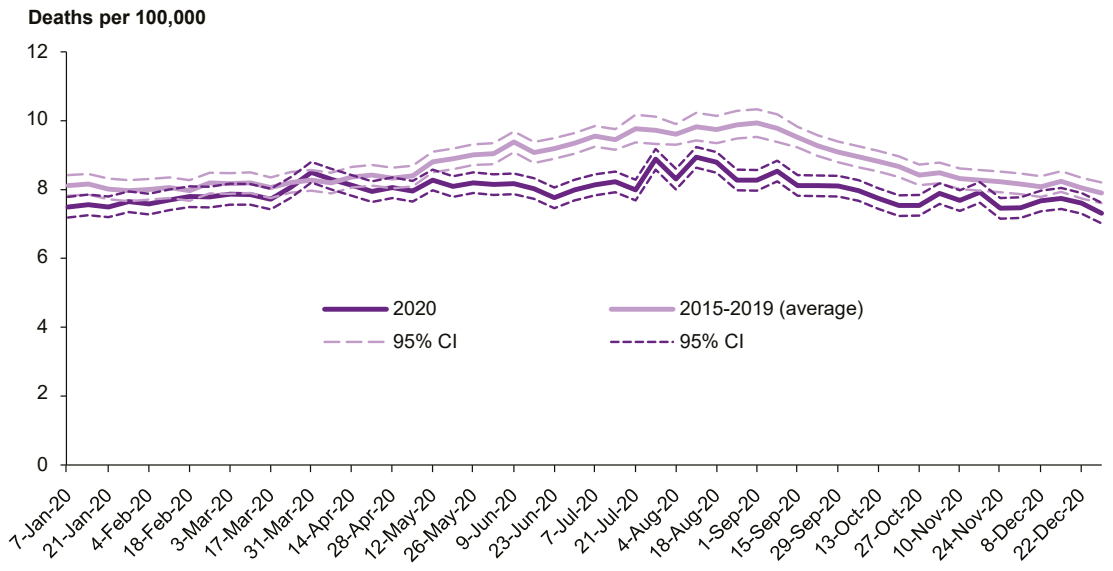


Note: Data for Australia includes deaths certified by a doctor only.

Source: Human Mortality Database Short-term Mortality Fluctuations (STMF) data series.

Figure 3.6 shows the lower rates in Australia for excess deaths during 2020 compared with average rates over the previous 5 years, with significantly lower rates in the winter months. Particular declines were seen for respiratory diseases, including chronic and infectious disease (influenza and pneumonia) (AIHW 2021e).

Figure 3.6: Comparison of all-cause age-standardised death rates per 100,000 in 2020 and average deaths during 2015–2019



Source: AIHW analysis of ABS Provisional mortality statistics.

Changes in health behaviours

In April 2020, the Australian Bureau of Statistics (ABS) Household impacts of COVID-19 Survey found that around 3 in 5 (58%) people reported increases in their personal screen time on their phone, computer, television or other device compared with what it had been before the COVID-19 pandemic (ABS 2020c). In the same month, 41% reported an increase in household chores, gardening, yard work, projects or renovations; in June 2020 this figure was 25%. Overall, a similar proportion of people reported increasing exercise and other physical activity as reported decreasing it.

In April 2020, self-reported information from the ABS Household impacts of COVID-19 Survey found that of those who usually drank alcohol, 20% of adults reported increasing their consumption, and 13% reported decreasing it in the previous 4 weeks compared with their intake before COVID-19 restrictions. In June 2020, compared with before the COVID-19 pandemic, a similar proportion of people reported increasing their alcohol consumption as reported decreasing it.

The May 2020 ANUPoll also asked respondents about changes to their alcohol consumption since the spread of the COVID-19 in Australia (Biddle et al. 2020a). Of those who reported drinking, 20% said their alcohol consumption had increased and 27% said it had decreased. Of the 20% who reported an increase in alcohol consumption, 46% said the increase was 1–2 standard drinks per week and 28% reported an increase of 3–4 standard drinks per week.

Other data sources also showed the variable increases and decreases in alcohol use (AIHW 2021a). Commonwealth Bank card data showed an overall increase in spending on alcohol during much of 2020 and into 2021, coupled with a decrease in spending on alcohol services (such as in pubs and clubs). The National Wastewater Drug Monitoring Program showed a decrease in average alcohol use in capital cities in April 2020 compared with earlier periods, and a return to pre-pandemic levels by June 2020.

In the May 2020 ANUPoll, the majority of people reported never using illicit substances (89%). For respondents who did use illicit drugs, 26% reported a decrease in their consumption, while around 18% reported an increase (Biddle et al. 2020a).

Additional positive effects

Early in the epidemic in Australia, there were indications that the public health interventions may have been having a positive impact on the number of cases of other respiratory viruses, particularly influenza. During 2020, the notification rates for laboratory-confirmed influenza were substantially lower from April 2020 onwards, suggesting that measures introduced to control COVID-19 – such as hand hygiene, and restrictions on international travel and movement within the country – may have had a positive impact on the circulation of influenza (Bright et al. 2020; Sullivan et al. 2020). Similar patterns were seen in other countries, including New Zealand and the US (Huang et al. 2021; Olsen et al. 2020).

The strict public health measures introduced to limit the spread of COVID-19 also appear to have reduced injuries due to falls and road traffic accidents, particularly during the first lockdown in March–April 2020. The number of presentations to hospital emergency departments for trauma were lower than for the same period in previous years in several hospitals across Australia (Harris et al. 2020; Jacob et al. 2020; Kam et al. 2020; Way et al. 2021). At the Westmead Hospital in Sydney, the decrease in trauma admissions in March–April 2020 was due to a decrease in presentations where road traffic collisions and falls were the cause of injury (Jacob et al. 2020). Data on national road deaths during March and April 2020 showed a 5.1% and 25% lower number of road deaths, respectively, than the average over the previous 5 years (BITRE 2020a, 2020b).

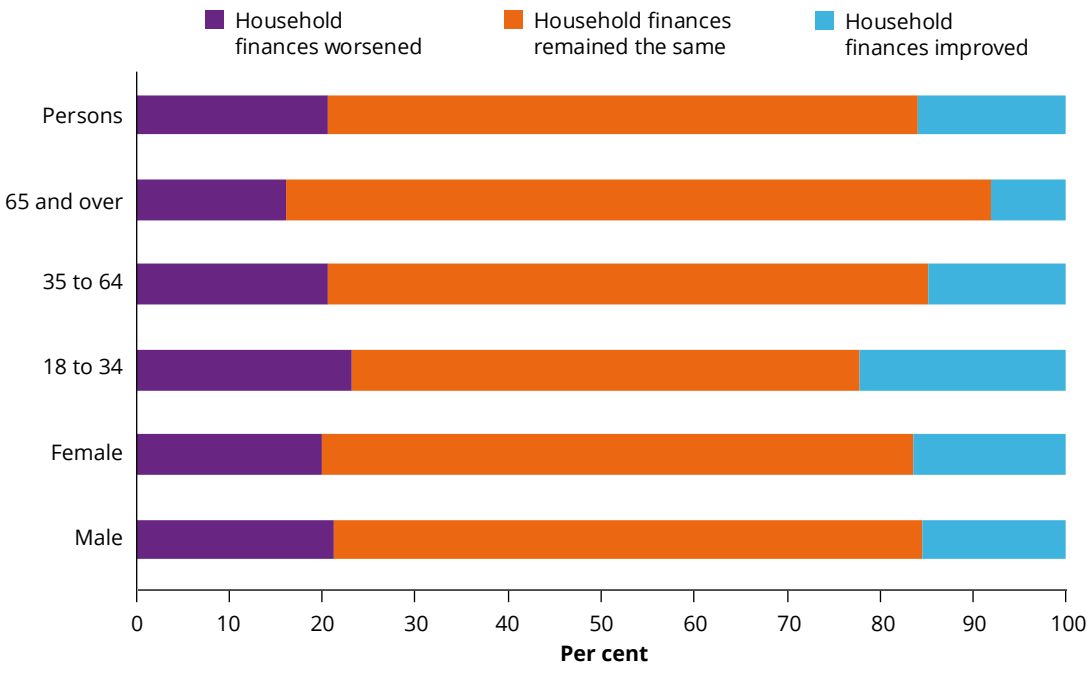
Income and employment

This section provides a brief overview of income and employment changes during the pandemic. For more information, see 'Chapter 4 The impacts of COVID-19 on employment and income support in Australia'.

Income changes

The income of many Australians substantially changed during the pandemic. Over the 12 months to February 2021, 21% said their household finances had worsened during that time, 16% said they had improved, with the remainder saying they were unchanged (Figure 3.7). Younger people (aged 18–34) were more likely to experience worsened household finances than older people, but were also more likely to experience improved household finances. Other groups that had higher proportions with worse household finances included people without a job, with disability or having a long-term health condition.

Figure 3.7: Change in household finances over 12 months to February 2021



Source: ABS 2021c.

Based on longitudinal data following a repetitive sample of people over time in the ANUPoll, average after-tax household income fell sharply (by 9.1%) between February and April 2020, followed by little further change until August 2020 (Biddle et al. 2020e). However, by November 2020 average household income had increased and was almost back to the February 2020 levels (Biddle et al. 2020f). However, these increases did not continue in 2021 and by April 2021, average household income was still 7.2% lower than in February 2020 (Biddle & Gray 2021b).

Changes in income differed across the income distribution. Overall, income inequality fell in the early months of the pandemic, but then increased in the middle months of 2020 before falling again by November 2020 (based on analysis using a summary measure of inequality, the Atkinson Index; Biddle et al. 2020f). It had increased again by April 2021 (Biddle & Gray 2021b).

Labour market changes

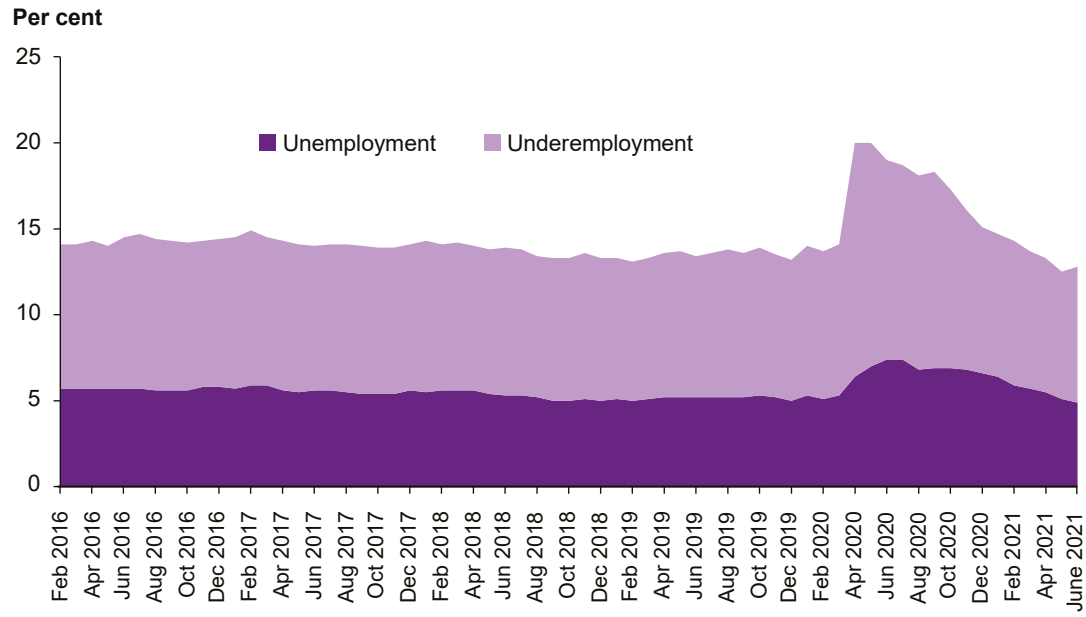
There have also been substantial changes to the labour market during the pandemic, largely from the shutdown of non-essential industries. This led to large increases in unemployment and underemployment (those who are working but want to work more hours). As well, many people have experienced substantial changes to their work environment. This included large numbers of people who have had to work from home (and, for some, concurrently supervise the schooling of children at home), and those people working in essential services who had to make substantial changes to accommodate the impact of the virus.

In April and May 2020, 1 in 5 (20%) people in the labour force were either unemployed or underemployed (Figure 3.8) – the highest underutilisation figure over the period since February 2016. The previous peak in underutilisation over the last 10 years was 15% in September 2014 and September 2015. The peak percentages for the components of unemployment and underemployment had slightly different timing:

- 14% for underemployment in April 2020
- 7.4% for unemployment in June and July 2020.

The underutilisation rate declined after May 2020 then stabilised until the end of September 2020, at around 18%. By April 2021 it had fallen further to 13.3%, similar to the levels from late 2019, and by June 2021 it was lower than pre-pandemic levels (12.8%). Underemployment was lower than it had been before the pandemic. By May 2021, the unemployment rate had declined to the same rate as in February 2020 (5.1%), and by June 2021 it was lower (4.9%). Employment was 1.2% higher in June 2021 than March 2020 (ABS 2021d).

Figure 3.8: Labour force underutilisation rate, February 2016 to June 2021



Source: ABS 2021d.

Support programs

To help mitigate the substantial impact of the COVID-19 pandemic on the labour market and resulting incomes, several government support programs were put in place – notably the JobKeeper Payment; and the Coronavirus Supplement paid to recipients of the JobSeeker Payment (an unemployment benefit) as well as several other income support payments. The Coronavirus Supplement effectively doubled the total payment made to people receiving unemployment benefits. These schemes concluded at the end of March 2021.

The JobKeeper scheme was a wage subsidy for employees of eligible businesses. In April 2020, the first month of the JobKeeper Payment, around 3.4 million employees received it. By July 2020, the number of people in receipt of the payment reached a peak of 3.7 million (unpublished data by the ATO). Note that recipients were classified as employed in ABS labour force data regardless of the hours they worked (e.g., even if they were stood down).

The number of people receiving JobSeeker Payment doubled between February and May 2020, from 720,000 to 1.46 million. Note that from 20 March 2020, JobSeeker Payment replaced Newstart Allowance as the main income support payment for recipients aged between 22 years to Age Pension qualification age who have capacity to work. Existing Newstart Allowance recipients at this date were transitioned to JobSeeker Payment.

Youth Allowance (other) unemployment recipients also increased, from 86,000 to 171,000. Numbers have fallen in most months since then to May 2021, but are still higher than prior to the COVID-19 pandemic. In May 2021, there were 1.1 million recipients of unemployment payments (Jobseeker and Youth Allowance (other) combined), 241,000 more or 27% higher than in March 2020 (891,300) (DSS 2021). Note that for most of this period, a number of requirements to receive these payments were waived (such as the assets tests and obligation to actively seek work).

The increase in government support payments, including the introduction of the Coronavirus Supplement for working age income support recipients and the JobKeeper Payment, contributed to reductions in poverty for some groups, notably single parent families (from 20% in February 2020 to 8% in June 2020) (Phillips et al. 2020). However, a substantial proportion of recipients did experience a fall in income: for example, 64% of JobKeeper recipients in August 2020 reported that their income had reduced (ABS 2020d). The impact of ending the temporary income support programs (such as JobKeeper and the Coronavirus Supplement) on income levels remains unclear as at the end of July 2021; however, employment had returned to pre-pandemic levels at that time as outlined above. Note that at the time these support programs ended, some increases were made to the JobSeeker and Youth Allowance payments. See 'Chapter 4 The impacts of COVID-19 on employment and income support in Australia'.

Child care and school education

Many children were not able to attend child care or school during the various waves of the pandemic. This meant that many parents took on additional child care responsibilities or supervision of school work, often while working from home themselves. Broader economic impacts from the pandemic – such as the job loss of a parent or guardian, decrease in hours worked, or a shift to remote working – may have had a bearing on the need (or the capacity) to enrol or send children to a preschool program provider.

In May 2020, 76% of adults with children had kept them home from child care or school due to COVID-19 (ABS 2020e). In September 2020, there were still 35% of households keeping their children at home due to the pandemic (ABS 2020f). This national figure was largely driven by the situation in Victoria with many child care centres and schools closed, and with 83% of households keeping their children at home in that state. In New South Wales, the figure was 21%.

Specific measures were put in place in the early months of the epidemic in Australia (when shutdowns were at their peak nationally in 2020) to ensure that child care centres remained viable and were able to provide care for children of essential workers and for vulnerable children. A review of the first 4 weeks of these measures showed that 86% of services were able to stay open and 87% were able to provide care for children of essential workers and for vulnerable children (DESE 2020).

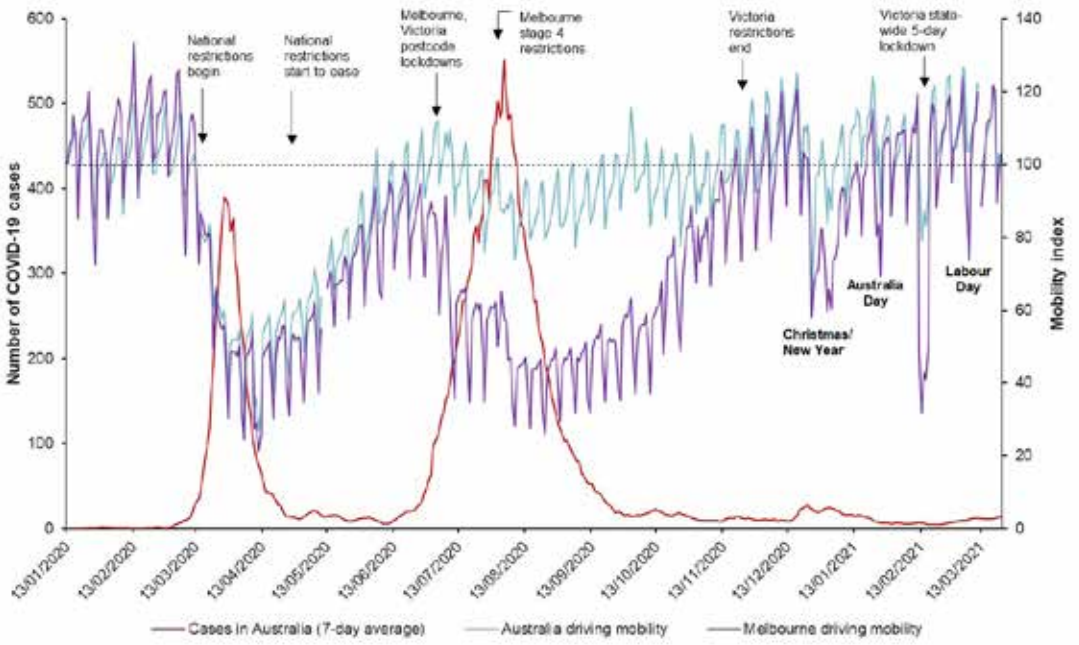
Earlier in the pandemic (in May 2020), over half of parents with school-aged children at home said their children were having difficulties concentrating while learning from home (ABS 2020e). This finding is reinforced by survey data from November 2020 indicating that around half of parents were concerned about their child's learning due to the disruptions caused by the pandemic (13% very concerned and 37% somewhat concerned; Biddle et al. 2020c). The vast majority were satisfied, however, with the way their child's education institution handled the COVID-19 situation (48% very satisfied and 40% somewhat satisfied). These satisfaction levels are higher than those in the United States where the same questions were asked (25% were very satisfied; 44% were somewhat satisfied; Biddle et al. 2020c).

The COVID-19 pandemic also had an impact on out-of-pocket fees for many households in 2020 with certain jurisdictions and/or service providers reducing or waiving fees at some point during the year.

Social isolation and loneliness

Loneliness is a risk factor for mental ill health, besides being distressing in its own right (See 'Social isolation and loneliness' at https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness). The various restrictions introduced to control the spread of the COVID-19 virus had an obvious side effect – increasing levels of loneliness in the community. Figure 3.9 shows the decline in driving mobility in Australia – and more specifically Melbourne – illustrating the degree of potential reductions in people's interaction with others.

Figure 3.9: Number of COVID-19 cases in Australia and Apple mobility index for driving in Australia and Melbourne, 13 January 2020 to 21 March 2021



Note: The mobility data represent daily changes in requests for directions in Apple Maps by transportation type (driving), compared to a baseline volume on 13 January 2020. The baseline is shown as a dotted line at 100. No data were available for 11 and 12 May 2020.

Sources: Apple Mobility Trends https://www.apple.com/covid19/mobility; WHO.

By mid-April 2020, based on self-reported information in the ABS Household Impact of COVID-19 Survey, one-third (33%) of Australian adults had reduced the frequency of their contact with family and friends since the start of the COVID-19 epidemic. The most commonly reported personal stressor at that time was loneliness – reported by 22% of people, with women reporting higher rates than men (ABS 2020a). By the end of June 2020, this figure had reduced to 9.1% (ABS 2020b).

The longitudinal ANUPoll showed that, in April 2020, 41% of male and 50% of female respondents felt lonely at some time, but those percentages fell to 31% and 40% respectively in May 2020 (Biddle et al. 2020d). The loneliness levels again increased through to August 2020 but this rise occurred only in Victoria (Biddle et al. 2020e). Furthermore, those who experienced loneliness had higher rates of psychological distress.

Life satisfaction

A life satisfaction question – which takes account of both positive and negative aspects of wellbeing – was included in the ANUPoll before and throughout the pandemic. The question used is:

> Overall, how satisfied are you with life as a whole these days, on a 0–10 scale where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.

Scores provided by participants were then averaged to construct a population-wide score.

Before the pandemic, life satisfaction had decreased between October 2019 and January 2020, followed by further declines in the early stages of the pandemic and then by increases towards pre-pandemic levels:

- It fell from an average of 7.05 (95% CI: 6.93–7.17) in October 2019 to 6.90 (95% CI: 6.82–6.98) in January 2020 and to 6.52 (95% CI: 6.43–6.62) in April 2020 (Biddle & Gray 2021b).
- It then fluctuated in the range 6.6 and 6.8 for most of 2020, getting close to the pre-pandemic levels in November 2020, when it reached 6.99 (95% CI: 6.90–7.08).
- In April 2021, it was 6.87 (95% CI: 6.79–6.95).

Regression analysis for the period from January to November 2020 showed there was a significantly greater loss in life satisfaction for people living in Victoria than those in the rest of the country (Biddle et al. 2020f). Groups with smaller losses in life satisfaction included those aged 55 and over (compared with those aged 35–44), those who lived outside a capital city, people who spoke a language other than English at home, and those who lived in the most advantaged areas in Australia. This is consistent with expectations given the greater impact of (among other things) shutdowns (through, for example, their impact on employment) for younger people, people in Victoria and people in the capital cities.

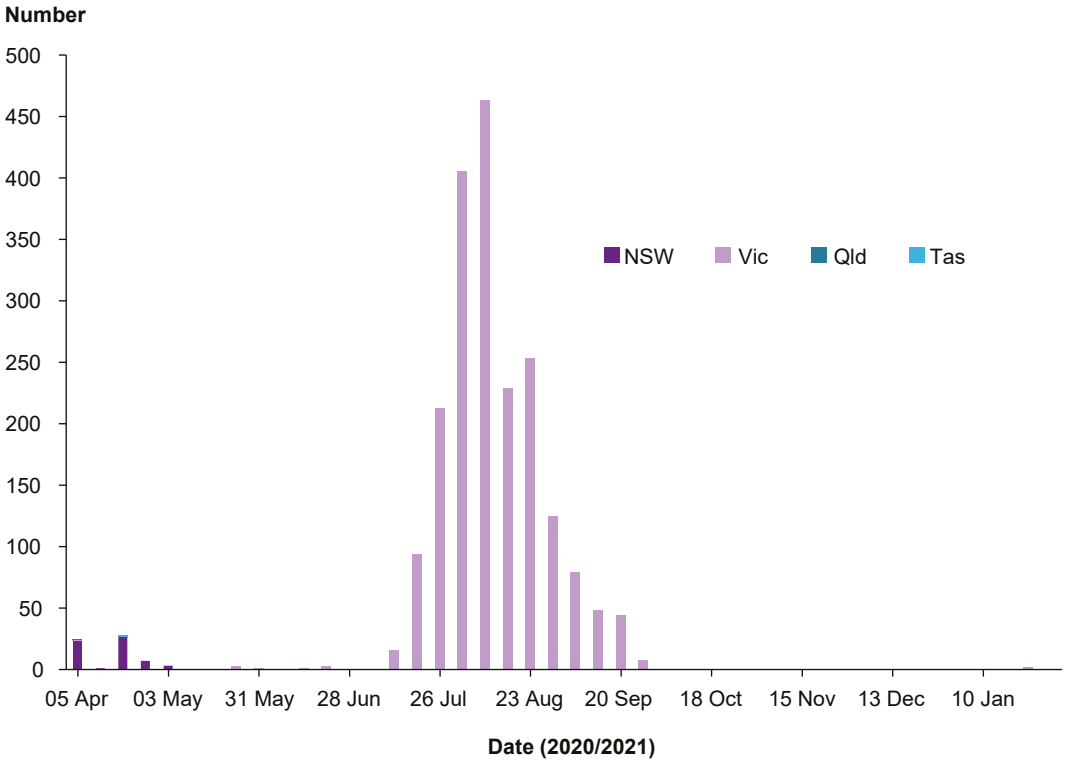
Aged care

Three-quarters (75%; 678 of 909 deaths notified to NNDSS) of all COVID-19-related deaths in Australia by March 2021 were among people living in residential aged care (Department of Health 2021). Similarly, a high proportion (66%) of COVID-19 deaths in Canada occurred among residents of long-term care facilities in their first wave of cases between March and August 2020 (CIHI 2021). In the United Kingdom, 40% of COVID-19-related deaths up to 12 June 2020 were among residents of care homes (ONS 2020a, 2020b). The high proportion of deaths reflects the increased risk of death among the frail elderly if they contract COVID-19. As at 12 March 2021, there had been 2,029 confirmed cases of COVID-19 among residents in aged care facilities in Australia, (Department of Health 2021). This was 7.0% of all cases in Australia.

Given that older people are at greater risk of poorer outcomes from COVID-19 than people aged under 60 (Holt et al. 2020) – and that people living in residential aged care often live in close proximity to each other – the aged care sector is a high-risk setting. Residential aged care facilities often deal with infectious disease outbreaks, such as influenza and gastrointestinal illness (Kirk et al. 2010); they have procedures in place to respond to and manage them such as illness detection, infection control practices and outbreak management (Department of Health 2017). However, there are particular challenges with infection control among people with dementia, making that large group in residential aged care at increased risk of contracting the virus (Numbers & Brodaty 2021).

The first outbreaks in aged care facilities in Australia occurred in New South Wales in April 2020 (Figure 3.10), resulting in 61 cases. The outbreaks were challenging to contain and highlighted the risk to people living in residential aged care (Anderson 2020). There was also a case in each of Queensland and Tasmania. After this, there were only sporadic cases in residential aged care until July when several outbreaks occurred in Victoria resulting in a large number of cases. The number of weekly cases peaked in early August 2020, and there were a total of 1,986 cases up to the end of September.

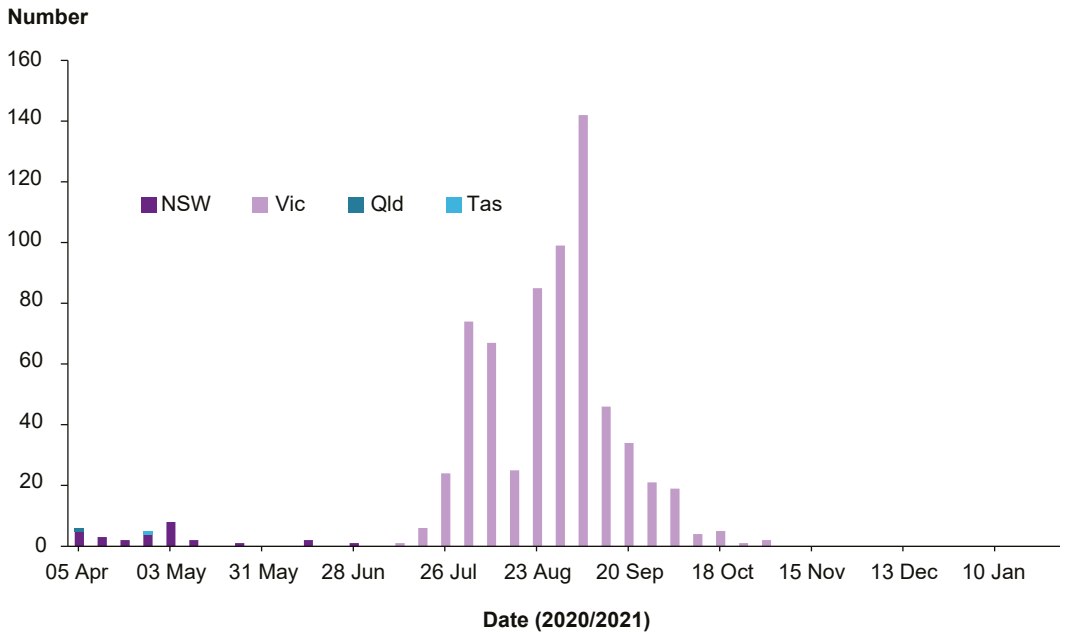
Figure 3.10: Confirmed cases of COVID-19 among aged care residents 2020



Source: Coronavirus (COVID-19) at a glance infographic collection | Australian Government Department of Health.

Deaths from these outbreaks were substantial (Figure 3.11). There were nearly 30 deaths from the earlier outbreaks in New South Wales, and over 650 in Victoria. The corresponding case-fatality rates were 46% and 33%. For deaths from COVID-19 up to the end of November 2020 (which covers the period of all deaths among residents of aged care in 2020), 304 occurred in a residential aged care facility (ABS 2021a), which is around 45% of aged care residents who died from COVID-19 in 2020.

Figure 3.11: Deaths from COVID-19 among aged care residents 2020



Source: Coronavirus (COVID-19) at a glance infographic collection | Australian Government Department of Health.

In the early stages of the epidemic, the Australian and state and territory governments put restrictions in place to protect Australians living in residential aged care, including limiting the number of visitors (Department of Health 2020b). The Communicable Diseases Network Australia released the National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (CDNA 2020).

These National Guidelines recognised the increased risk of transmission within aged care facilities, and of more severe disease among this group of residents. It also became clear that when there was sustained community transmission of the COVID-19 virus, there was a substantial risk that staff could bring the virus into the facility, as was the case during the second wave in Victoria (Gilbert & Lilly 2020). There was increased risk of this happening when the staffing level was lower, staff worked across multiple facilities or were not being fully trained in infection control procedures (Cousins 2020; Crotty et al. 2020).

The enforced isolation of people living in residential aged care had potential and realised effects on their mental health and cognition (Holt et al. 2020; Manca et al. 2020; Suárez-González 2021). The enforced isolation can increase symptoms of anxiety and depression. Both people with and without dementia are at risk of cognitive decline due to the social isolation.

As well as the tragic impact of contracting COVID-19 on residents and their families and the impact of restricting visitors, the infection control requirements introduced challenges when providing routine care (for example, exercise and healthy food provision). This situation became even more difficult when large numbers of staff tested positive to the virus and were therefore not able to attend work (Royal Commission into Aged Care Quality and Safety 2020). Long-term isolation from other residents, and particularly from family, had the potential to substantially increase loneliness of residents and adversely affect their general wellbeing (Holt et al. 2020). A large increase in depression, anxiety and confusion was noted among residents during this time (Royal Commission into Aged Care Quality and Safety 2020).

Family and domestic violence

The potential for increases in family and domestic violence due to the widespread social restrictions and resulting economic challenges was highlighted early in the pandemic. These restrictions could also make it more difficult for people experiencing violence to report the incident or leave the violent situation. Several measures were taken to help mitigate these potential impacts, including funding for extra support services, such as counselling and a national information campaign (Morrison 2020).

It is challenging to obtain comprehensive data on the extent of family, domestic and sexual violence. There are inherent challenges in measurement, the incidents often occur behind closed doors, and they can be concealed or denied by perpetrators and sometimes victims. Data sources can include only those incidents that have been disclosed by individuals or recorded by relevant authorities (ABS 2017).

Despite the lack of national data on domestic violence during the COVID-19 pandemic, several data sources outlined in this section suggest that it may be a growing problem. Further data will be needed, though, to make a definitive assessment of trends during this period.

An online survey of 15,000 women found that 4.6% experienced physical or sexual violence from a current or former cohabiting partner between February and May 2020 (Boxall et al. 2020). For 65% of these women, either it was the first time the violence had occurred, or the violence had increased in frequency or severity since February. From the same survey, 5.8% of all women reported being subject to coercive control (experiencing 3 or more forms of emotionally abusive, harassing and controlling behaviours), and, in 55% of cases, it was a first-time abuse or the abuse had worsened since February. Over one-third (37%) of women who experienced physical/sexual violence or coercive control did not seek help on at least one occasion, due to safety concerns.

More than half (58%) who experienced both physical/sexual violence and coercive control did not seek help on at least one occasion.

Police data from Victoria contained 9% more family violence incident reports in 2020 than in 2019, and average monthly numbers were higher than expected (Crime Statistics Agency 2021). Furthermore, the numbers of current partner and parent–child relationships in these family incidents was higher than forecasted.

Data on support services also show an increase in demand, though it may be a mix of factors driving these patterns, including increased availability and awareness of services, and/or a potential increase in incidents. There was a:

- 75% increase in Google searches for family and domestic violence help during the very early months of the epidemic compared with the average over the previous 5 years (Doran 2020; Morrison 2020)
- 26% increase in calls to MensLine compared with the previous year (Doran 2020).

Lastly, in the early months of the pandemic, domestic violence support workers for women in New South Wales, Victoria and Queensland reported increases in client numbers, the frequency and severity of violence, first-time violence, and the complexity of client needs (Lynch 2020; Pfitzner et al. 2020; Women's Safety NSW 2020). There were also reports of abusers using COVID-19 as a reason for violence, including limiting contact with others, and anger due to income or job losses.

The reports of changes in demand come from a range of sources, however, patterns of service use are likely to vary across sectors and geographical areas. There is also some evidence from specialist service workers in New South Wales that demand did not diminish after restrictions eased (Foster et al. 2020).

Child protection

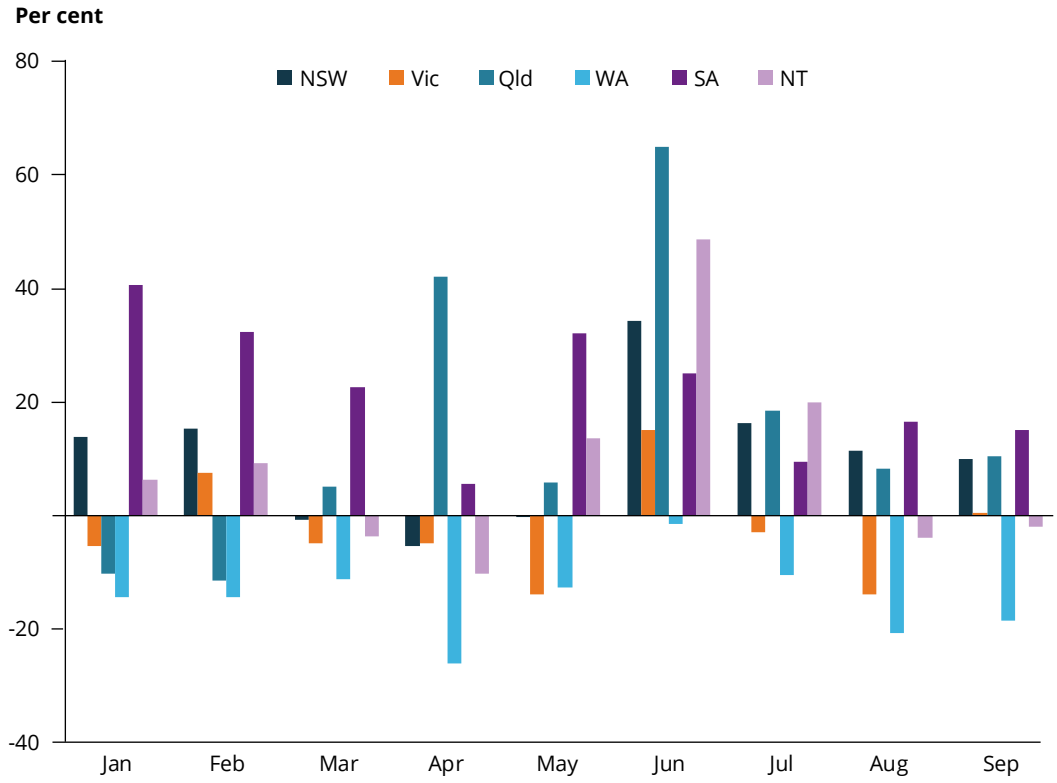
Child protection services aim to protect children from abuse and neglect in family settings. As is the case for family and domestic violence, it is difficult to collect comprehensive data on the prevalence of child abuse and neglect in the community.

Data on child protection services provide an insight into patterns and trends of notified child abuse and neglect. Suspicions about child abuse or neglect are often reported by schools, child care centres, and other people or services with whom children regularly come in contact. These reports are known as 'notifications' of suspected child abuse and neglect, and data on these can provide an early indication of potential trends. Further detail on other child protection data can be found in *Child protection in the time of COVID-19* (AIHW 2021b).

The COVID-19 pandemic has potentially limited opportunities to detect and report child abuse and neglect. Furthermore, the added challenges due to the pandemic and associated restrictions (as outlined in this article) may have made some families more vulnerable to child abuse and neglect; previous crises have shown higher numbers of child abuse reports during such times of stress (Curtis et al. 2000; Meadows et al. 2015; Risso-Gill & Finnegan 2015; Seddighi et al. 2019).

Data for the period March to September 2020 (covering the first wave of restrictions in Australia and part of the second wave in Victoria) showed that notifications commonly dropped during the COVID-19 shutdowns, and increased once restrictions eased (Figure 3.12). However, the change in notifications varied considerably across the period, both month to month and across states and territories.

Figure 3.12: Percentage change in child protection notifications between 2019 and 2020, by state and territory and month



Note: Includes states and territories with complete data over the period January 2019 to September 2020.

Source: AIHW 2021b.

A commonly observed pattern is for notifications to fall during school holidays and rise again once school resumes, as school personnel are a common source of notifications – the second highest (19%) in 2019–20 after police (22%) (AIHW 2021b). The increase after April 2020 in all 7 jurisdictions with data available was larger than in previous years, suggesting that the COVID-19 restrictions may have had an added effect (AIHW 2021b). The remote learning implemented in many jurisdictions meant that children may have been less visible to school staff for longer periods than usual. There was also a second drop in notifications in Victoria between July and September 2020, coinciding with school closures there. Similar patterns have been observed in other parts of the world, such as in New York City (Rapopert et al. 2020).

The total number of notifications for the period from March to August 2020 was higher in some jurisdictions (New South Wales, Queensland, South Australia and the Northern Territory) than for the same period in 2019, lower in others (Western Australia and the Australian Capital Territory) and similar in Victoria (AIHW 2021b). However, some increases follow a pattern of increasing numbers over recent years (such as in New South Wales), thought to be related to increased awareness of child protection issues and improvements in reporting processes.

Housing

For many Australians, housing costs such as mortgage or rent payments are one of the largest components of household spending. Many households whose income was adversely affected during the COVID-19 pandemic experienced greater difficulty in making these regular payments.

Between April and May 2020, the percentage of Australians who were not able to pay their rent or mortgage on time doubled, from 7% to 15% (Biddle et al. 2020b). This figure was higher among renters (27%) than among mortgage holders (17%) – and among renters, it was higher among low-income renters (40%) than those on higher incomes (10%).

Several initiatives were taken to assist households in need with their housing costs. In the early stages of the pandemic (around May 2020), lower payments were negotiated by 16% of mortgage holders and 11% of renters, while another 8% and 2% of these groups, respectively, negotiated a freeze on payments (Biddle et al. 2020b). Evictions were prohibited during this period. These initiatives were temporary, and many households would have later returned to making normal payments. In December 2020, 3% of mortgage holders had the payments reduced and 2% had them frozen in the previous 4 weeks (ABS 2021b). For renters, 2% had their payments reduced and 2% had them deferred (or they were in arrears) in the previous 4 weeks.

The number of clients using specialist homelessness services remained steady between January to June 2020; client groups of particular interest for whom this was the case were children aged under 18 and clients who have experienced family and domestic violence (AIHW 2020b). Client numbers were also similar to those for the same period in 2019. While these numbers were steady, various support policies were implemented by governments during this time, not all delivered through specialised homelessness services.

For more information, see 'Chapter 5 COVID-19 effects on housing and homelessness: the story to mid-2021'.

What might the future hold?

The future course of the COVID-19 pandemic remains unknown and unpredictable. Many countries continue to experience very large numbers of cases and deaths and, at the time of finalising this article, a number of areas in Australia had new outbreaks, largely linked to new strains of the virus. The vaccine rollout is underway, but it is not yet clear when adequate coverage of the Australian population will be reached. The 4 phases of the National Plan to transition Australia's National COVID-19 Response are structured around various levels of vaccination in the population (Australian Government 2021). New variants continue to emerge, and these have the potential to be more infectious, have more severe health effects or reduce the effectiveness of vaccines.

While the overall economic impact of the pandemic in Australia at the time of finalising this article has been less severe than may have been the case, the situation is uneven and some population groups (such as young people) and industries (tourism, higher education, entertainment) have been disproportionally affected.

It is important to continue to track how these factors have affected the wellbeing of Australians. This effort will continue as more data become available and the full picture becomes clearer.

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