# Community Care in Australia

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Most older Australians live in the community with the support of their family and assistance from community services. Australia has a long history of providing community care, with recent reforms aimed at improving access and choice. Care is provided on the basis of assessed needs and can take many forms, from basic services such as transport and domestic tasks, to complex nursing care. Most people use few services to meet low level needs, with increasing use of services in the years before death. As the population ages, demand for these services is outstripping supply. We discuss the evolution of community care in Australia, and whether the current care system addresses the needs of increasing numbers of older Australians.

## Introduction and the Australian context

Australia is an island continent of 7.7 million square kilometres occupied by 24.8 million people. It is highly urbanised, with 90% of Australians living in urban areas (Statista, 2017). Around 15% (3.7 million) are aged 65 and over. The Australian population is ageing due to the combined effects of a large post war ‘baby boom’ cohort, combined with reductions in fertility and mortality that began in the early 1970s (MacDonald, 2016). Life expectancy at birth is 80.4 for men and 84.5 for women, the fifth (men) and eighth (women) highest in the world (AIHW, 2018a). The most common causes of death for older Australians are coronary heart disease (13%), dementia including Alzheimer’s Disease (10%), and cerebrovascular disease (8%), followed by lung cancer and chronic obstructive pulmonary disease (AIHW, 2018a).

Most older Australians live in the community, often with their spouse and/or other family members (58%) or alone (25%) (ABS, 2016). Only 4.6% live in residential aged care (AIHW 2018b). Over three-quarters (76%) own their own home (Productivity Commission, 2015). There is considerable cultural diversity, oweing to high immigration levels. One in three older Australians were born overseas, including those from Europe (67% of overseas born) and South East Asia (16%) (ABS 2016). While Aboriginal and Torres Strait Islander people make up 2.8% of the overall population, they make up only 0.8% of the population over 65, owing in large part to lower life expectancy (69.1 for men and 73.7 for women).

## Historical and political context

Australia’s political system follows the Western democratic tradition, with three tiers of government – federal, state and local. The Federal government takes responsibility for areas such as income security, taxation and defence, while state and territory governments administer education, transport, legal systems and public health services. However, the Federal government is involved in a number of areas of health policy, including the national health insurance system (Medicare), regulatory and legislative matters, residential aged care and the national co-ordination of community care.

Income support for retired older Australians is provided by either the publicly funded flat-rate Age Pension (means-tested for people aged over 65.5 years) or through private superannuation. Legislative provisions for employer contributions to superannuation were not widespread until the 1990s, and consequently most older persons have limited superannuation. The majority (66%) of older Australians receive at least a part pension (AIHW, 2018), while 39% have some level of superannuation coverage. Around 15% of retirees are fully self-funded. There is also a Disability Support Pension for people under 65 years, and a Carer Support Pension. Both these pensions are also means and asset tested.

All Australians, regardless of age, have access to free public hospital care and to subsidised primary and specialist medical care. Older Australians have access to a means-tested Health Care Card, which reduces out of pocket medical and pharmaceutical expenses. Aged care is heavily subsidised, and client fees are subject to means and asset tests. The National Disability Insurance Scheme provides a range of services to eligible persons under the age of 65 with a disability, including community care services.

Government funded community care in Australia began in 1956 with a subsidy for not-for-profit organisations to provide home nursing services (see Figure 1). Other forms of home based care were introduced in 1969, and a delivered meals subsidy in 1970. However, this approach to community care was found to be inadequate and poorly co-ordinated, and significant reform was introduced in 1984-85 with the creation of the Home and Community Care program (HACC) (Gibson, 1998). This reform created a single financial and administrative umbrella program for the existing fragmented services, expanded the array of services provided particularly in relation to personal care and respite care, and heralded a significant expansion – a 134% increase in expenditure over the next 8 years.

Co-ordination of services to individual clients, particularly those with higher care needs, remained an area of concern and led to various ‘brokerage’ type models over subsequent years – commencing with the Community Options program in 1987, the forerunner to Community Aged Care Packages (CACP) which were rolled out from 1992, and the higher intensity Extended Aged Care at Home (EACH) packages first piloted in 2000. Another innovative reform, introduced in the 1980s, was the implementation of regionally based Aged Care Assessment Teams to assess client needs for service in a equitable and inclusive manner (Broe, 2016) Respite care services were expanded through the National Respite for Carers Program, and transition care packages (TCP) were introduced in 2006. Support for community care was further expanded in 2007, with more community aged care packages, community based respite care and support for assistive technology.

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| --- | --- | --- | --- | --- | --- | --- |
| **1950s** | **1960s** | **1970s** | **1980s** | **1990s** | **2000s** | **2010s - present** |
| Subsidy for home nursing services | Subsidy for other home based care | Delivered meals subsidy |  | | | Living Longer Living Better policy reforms (2013)/ Consumer Directed Care (2015) |
| Home and Community Care (HACC) | | | Commonwealth Home Support Program (CHSP) |
|  | Community Options | Community Aged Care Packages | | Home Care Packages |
|  |  |  |  |  | Extended Aged Care at Home (EACH) and EACH -Dementia | Dementia supplements |
|  |  |  | ACAT Assessment | | | My Aged Care portal |
|  |  |  | National Respite for Carers’ Program  Transitional care packages | | | |

**Figure 1: History of community care and reforms in Australia**

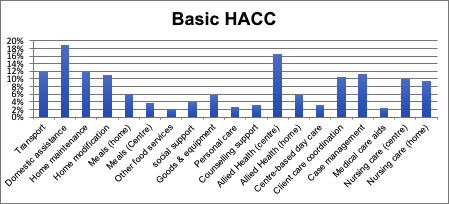
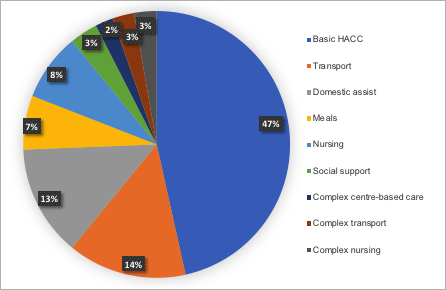
These successive reforms increased the fragmentation and complexity of aged care. In 2012, another aged care reform program was announced – Living Longer Living Better. Several programs were combined into 1) a comprehensive basic community care service – the Commonwealth Home Support Program (CHSP); and 2) Home Care Packages. There are four levels of Home Care Packages, targeting basic care needs, low level care needs, intermediate care needs, or high care needs. The latest reforms continued to emphasise co-ordinated care, but with a move to consumer directed care which seeks to tailor the mix and range of services more closely to care recipient preferences. It also gives consumers more control over the funds for their care, and how they are spent. The reforms also allowed for more market-based care, driven by consumer preferences, and less regulation.

The reforms also introduced a simplified gateway for consumers to access care, “My Aged Care”, accessed through a website or via a telephone service. This portal allows older people to arrange assessment of their care needs and their financial capacity to contribute to the costs care, and information on approved aged care services and care coordinators (My Aged Care, 2018)

**Utilisation of aged care services**

Most older people will need aged care of some sort. Among people aged over 65 years of age who died between 2010-2011, approximately 80% had used one or more aged care service within the eight years prior to their death. Over three-quarters entered the aged care system by first using community care services (Joenperä, Van Der Zwan, Karmel, & Cooper‐Stanbury, 2016).

Community care care can take many forms, including transport, social support, home modifications, home maintenance, meals, allied health, and nursing. Most people will use few services to meet low level needs across their later life, with increasing use of services in the years and months before death. An analysis of use of community care (provided under the HACC program) identified nine different service use groups, with most people using only a few basic services, and a minority with more intensive use of a number of services (Kendig et al., 2012) – see Figure 2. There was also a modest use of home modifications (11%), to improve accessibility and safety in the home.



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| **COMPLEX CENTRE-BASED CARE** | **COMPLEX TRANSPORT** | **COMPLEX NURSING** |
| Centre-base day care 92.5%  Meals (centre) 84%  Transport 84%  Social support 24.5%  Domestic assistance 22.6%  Case management 21.7% | Transport 100%  Social support 97.7%  Client care coordination 56.6%  Domestic assistance 45.7%  Case management 36.4%  Meals (home) 29.5% | Nursing care home 98.5%  Case management 71.4%  Client care coordination 56.4%  Domestic assistance 48.9%  Nursing care (centre) 47.4%  Goods & equipment 41.4% |

**Figure 2: Use of Home and Community Care Services 2006-2008: a) broad service groups; b) percentage of the Basic HACC group using each service type; c) main services used by people in the complex care groups.**

SOURCE: Kendig, H., Mealing, N., Carr, R., Lujic, S., Byles, J., & Jorm, L. (2012).

The services used by home support clients in 2016-2017 are shown in Table 1.

|  |  |  |
| --- | --- | --- |
| **Service type** | **Number of clients (a)** | **Hours/ 1000 clients (b)** |
| Allied health | 208,310 | 444 |
| Assistance with care and housing | 4,749 | 22 |
| Centre based day respite | 14,773 | 494 |
| Cottage respite | 3,559 | 235 |
| Domestic assistance | 265,612 | 1,877 |
| Flexible respite | 27,962 | 434 |
| Home maintenance | 125,413 | 278 |
| Nursing care | 100,936 | 473 |
| Other food services | 4,316 | 13 |
| Personal care | 58,667 | 604 |
| Social support—group | 88,508 | 2,109 |
| Social support—individual | 95,467 | 676 |
| Specialised support services | 56,004 | 144 |
|  |  |  |
| Goods and equipment | 13,264 | 96 items |
| Home modifications | 42,513 | $5 966 |
| Meals | 95,672 | 2 180 meals |
| Transport | 136,443 | 1,040 trips |

**Table 1: Services used by home support clients (distinct clients in each row) for 2016-17**

SOURCE: a) Australian Institute of Health and Welfare. Aged Care Data Snapshot 2017 <https://www.gen-agedcaredata.gov.au/Resources/Access-data/2018/January/Aged-care-data-snapshot—2017>, b) Department of Health (unpublished).

Residential Aged Care is not a preferred option for government, nor for older people. Less than 8% of people aged 60 years and over think they will ever need to move into residential care (Productivity Commission, 2017). However, people who have high levels of dependency, including those with advanced dementia, may be admitted to an aged care facility for full-time care. The estimated life-time risk of residential care for people aged 65 and over in Australia is around 39% (Broad et al., 2015, Forder et al., 2017), and women are more likely to be admitted to residential aged care than men (Kendig et al., 2010).

The total government expenditure on aged care services in 2016-17 is provided in Table 2, this shows that the largest proportion of costs is for aged care, while the largest numbers of clients are in community care.

**Table 2: Government expenditure on aged care 2016-2017.**

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| --- | --- | --- |
| **Aged care clients and costs during 2016–17 financial year** | |  |
|  | **Number of clients** | **Costs ($,000)** |
| Residential care |  | 12,219,328 |
| Permanent | 239,379 |  |
| Respite | 59,228 |  |
| Home Care |  | 1,614,964 |
| Home Care Packages levels 1–2 | 67,428 |  |
| Home Care Packages levels 3–4 | 34,218 |  |
| Home Support | 722,838 | 2,770,521 |

SOURCE: Australian Institute of Health and Welfare. Aged care data snapshot 2017.

<https://www.gen-agedcaredata.gov.au/Resources/Access-data/2018/January/Aged-care-data-snapshot—2017>

## Evaluation and Issues

Recent reforms to community aged care in Australia have addressed some of the long-standing criticisms of the system. Aged care policy and funding has now been consolidated into one tier of government, rather than being split across three tiers. Access and assessment points have been streamlined under My Aged Care and there have been strong moves to place funding and control of services into the hands of older people receiving care (known in Australia as consumers). However the system does have some limitations and issues so does not always meet the needs of older Australians.

Demand and supply

There are insufficient numbers of home care packages to meet the current demand. At 30 June 2018, there were 121,418 people on the national prioritisation queue for home care packages, with 64,668 assigned a lower level home care package and waiting to be transferred to a higher package. The My Aged Care website warns that the wait time for packages is likely to be over 12 months (My Aged Care, 2018). This may have led to people going into residential care prematurely and/or into hospital as they are unable to get the support they need in the home, especially in rural areas.

Even with Australia’s extensive formal support system, most aged care in Australia is provided by family members and friends (80% according to the PC report 2011) of which approximately 70% are women (including older women caring for their spouse). Support for carers is an ongoing policy issue.

The formal aged care workforce is also ageing, poorly paid, undervalued and poorly trained to provide services for an increasingly disabled client population. A recent review of the aged care workforce called for change in the way that working in aged care is viewed in the community, as well as better pay, training and career pathways for aged care workers (Pollaers, 2018) These reforms are sorely needed.

Consumer Directed Care

The aim of consumer directed care (CDC) is to give older people and their families greater choice of aged care provider, control over the services they receive as well as transparency in how funds allocated to their care are spent. An evaluation of the program was conducted at a very early stage – encompassing the first packages approved in 2010-11, so focused largely on transition to the new system rather than outcomes (KPMG, 2012). This evaluation found that most people did exercise some form of control over their care and were generally satisfied with the program but at this stage they were not able to exercise choice between providers, which is now the case. CDC is now being be rolled out in residential aged care, where it is much more difficult to transfer between service providers. CDC assumes that people are able to make a choice but this choice is limited by the supply of services, the older person and their family’s capacity and information about the quality of services.

Limitations of the market/choice model

The reforms to the aged care sector, have meant that aged care services are increasingly privatised and more for-profit providers are entering the industry. Although there is little evidence that this impacts on the quality of care provided, there is a perception that the profit motive is at odds with the care motive and may cause problems in the longer term.

There is also the problem of “thin markets”. These are areas in which there is a low volume of clients, meaning overhead costs are higher. In Australia, this is an issue for people living in rural and remote areas and/or those who have high and specialist care needs. It is unlikely that for-profit providers will provide services in these areas, leaving the not for profit sector to pick up the higher cost component of aged care. There is some recognition of this in the current funding model, but this is not generally considered sufficient. There is concern that as Australia moves further towards a market based model of aged care, some clients will be disadvantaged.

System navigation and access

Access to all aged care services is now via the My Aged Care portal. Through this portal, allocation is made either to an assessment for a home care package or residential care through the aged care assessment team (ACAT) or for the Community Home Support Program (CHSP) via the regional assessment service (RAS). This has the advantage of bringing all aged care services information and access into the one place, coming after considerable criticism about the difficulty in navigating the system. However there are still obvious shortcomings for people who can’t access a website, who have dementia, a visual or hearing impairment or whose first language is not English. Early trials of the system found that many people were lost between the initial phone call and assessment (Healthdirect Australia, 2016). In recognition of the difficulty older people and their families have navigating the aged care system, the Federal Government has recently called for tenders to trial three different approaches to system navigation.

Quality

Regulation and monitoring of quality in home care has been a challenge throughout the history of the program (Carnell & Paterson, 2017). There are currently three home care standards (effective management, appropriate access and service delivery, and service user rights and responsibilities) that are monitored through a process of quality review. However, as of 1 July 2019, the home care standards will be replaced by a single quality framework, which will apply to both residential and community aged care. Each of the new standards has a consumer statement, which reflect overall focus on consumer directed care. For example “I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well‑being” (Aged Care Quality Agency, 2018)

Lack of an evaluation framework

There is no overall government strategy on ageing and aged care and no evaluation framework, despite numerous reviews of aspects of the system (Tune, 2017). There is a significant lack of publicly available data, policy relevant evidence and gaps in ageing research. A better evidence base is needed to answer basic questions about many aspects of aged care and rigorous analysis of aged care data is essential for effective planning, policy development and provision of services (Productivity Commission, 2017).

Lack of evidence about how community care can promote health and independence

At a recent roundtable consultation with aged care providers (Dow, 2018) the lack of evidence about the benefits of community care versus residential care and which home care services are most beneficial to older consumers was raised. It is possible that home care is fostering social isolation and that in some cases older people would be better off in a communal care setting. Although older people should and do have the right to determine their care and support needs, they may not know what types of support are likely to be of most benefit. They suggested that consumers could be better supported to make choices about how best to spend their aged care funding if they had evidence about the benefits of different services, including those that will enable their continued independence. Further recommendations for improvements to community care are for reablement needs to be assessed and reablment approaches to be embeded in community care (Nous Group, 2017), for better integration between health and community supports (Tune, 2017), and for a stronger evidence-base for reablement approaches (AAG, 2017; Productivity Commission, 2011). There is also a recognised need for better palliative and end-of-life care (Dow, 2018; Palliative Care Australia, 2018).

## Conclusion

Australia has a long history of providing publicly-subsidised community care. Over time the service model has grown in complexity and in the size of the client base. Serial reviews have prompted reforms and evolution in the system, with the latest reforms featuring a single point of entry (My Aged Care, 2018), a single funding entitiy, and a focus on consumer directed care. It is too early to determine the impact of these reforms. However, there are well recognised weaknesses including long waiting lists and the need to strengthen the aged care workforce. Improvements in community care require better systems for continuous review, reinvention, and long-term planning.

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