Community care provision for older Australians is growing in places and options, based on older people's preference to stay in their own homes, coupled with its cost efficiency compared to long-term residential care. Australia's aging population, cultural diversity, and dispersed population in rural and remote areas presents significant challenges in meeting these care needs.

The objective of this review is to provide a critical overview of community care services in Australia, from its origin in the 1940s through to the current array of programs that deliver care. Barriers to access for these programs, growth in funding and expenditure, evidence of client satisfaction and the problems of workforce provision are presented. It is not clear how the growing future demands for care programs, resulting from greater client expectation, increasingly complex care needs and a diminishing workforce of paid and unpaid carers, will be met. However, the economic burden is anticipated to be manageable. Despite seemingly well-structured programs, the current multiplicity and rigidity of services means care provided is sometimes unsatisfactory at the point of delivery. It remains to be seen therefore if services can be expanded, modified and developed to address current deficiencies and meet future demands.

The reality of timely and equitable care for all older Australians living in the community is elusive at present. The ongoing rationing of residential care beds coupled with people's desires to stay in their own homes means community care is here to stay. The future inevitably presents huge challenges to those planning, implementing and providing care in this setting.

(J Am Med Dir Assoc 2008; 9: 88–94)

Keywords: Community health services; health services for the aged; home care services, hospital based; home care services; Australia

RESULTS

The majority of literature pertaining to home care in Australia is qualitative. Government documents tended to cover statistical analysis, policy, and strategy.

Australian Demographics

In Australia, as a result of falling fertility rates and increased life expectancy, the population is aging. This population over the age of 65 is anticipated to increase from 2.5 million in 2002 to between 6.1 and 11.7 million in 2101. Thus the over 65s will represent between 29% and 32% of the population. This expansion mirrors the global expectation of the population over 60 tripling by 2050, with the population over 80 experiencing more than a fivefold increase. Despite concerns being raised about meeting their needs, it is of note that older people can also form a valued social resource, for example in providing care for others, sharing skills and knowledge, and engaging in volunteer activities.

Australia faces enormous challenges due to its sparse population distribution and cultural diversity. Approximately 25% of the population live in rural or remote locations. In 2002, 33.5% of people aged 70 years and over used any form of government-funded aged care services. The majority, 26.2%, use community care services with the remainder, 7.3%, living in residential care. Despite approximately 1 million Australians using community care, it is estimated that a further 400,000 older people living at home have unmet
care needs. This encompasses both existing clients with care in place and potential clients who are currently unaware of services that are available. Funding for community care represents only 7% of the total budget for aged care.5

**Historical and Political Shifts**

In the 1940s, government-sponsored community services, staffed by female volunteers, delivered meals on wheels by bicycle and provided emergency housekeeping services. In 1956, the Australian government commenced funding of community nursing services. Overall, aged care policy for the next 20 years emphasized residential care, and what we would now term inappropriate admissions to nursing homes, resulted from the absence of significant entry criteria and alternatives.6 By 1985, almost 90% of aged care funding was directed to residential care,7 and this eventually generated a fiscal crisis that resulted in the 1985 Aged Care Reform strategy. A vigorous shift back toward community-based care resulted, thereby “deinstitutionalising” the care of older people.8 Inherent within this was the introduction of stringent entry criteria for admission to nursing homes to reduce the number of older people entering residential care. Additionally, aging-in-place was introduced as part of the Residential Aged Care Reform Package in 1997 to attempt to direct the care to the person, rather than force the person to move to access the care.9 A comprehensive review of community care programs in 2002 resulted in a new strategy for community care in Australia (The Way Forward10) being launched in 2004. This aimed to deliver easy-to-access equitable quality assured care with improved coordination and consistency across the programs. However, it has been criticized5 for not adequately tackling the problems of providing support for carers or recognizing and addressing the problem of the diminishing pool of informal carers.

**Overview**

Australia has a 3-tiered system of aged care–nursing homes (high-level residential care), hostels (low-level residential care), and support programs for people living in the community.11 The main programs that provide community care in Australia are outlined in Table 1.

<table>
<thead>
<tr>
<th>Program</th>
<th>Introduced</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Options Program (COPs)</td>
<td>Piloted in 1987</td>
<td>First government-led initiative to develop a more intensive form of home-based support to avoid admission to residential care.</td>
</tr>
<tr>
<td>Home and Community Care Program (HACC)</td>
<td>1985</td>
<td>Largely supersedes Community Options Program as a case management program to broker services to defer or avoid the need for residential care.</td>
</tr>
<tr>
<td>Community Aged Care Packages (CACPs)</td>
<td>1992</td>
<td>Packages of care to substitute entry to a low-level care facility.</td>
</tr>
<tr>
<td>Extended Aged Care at Home (EACH) and EACH dementia (EACHD)</td>
<td>2000</td>
<td>Provides equivalent of high-level residential care to people in their own homes</td>
</tr>
<tr>
<td>Veterans Home Care program (VHC)</td>
<td>2001</td>
<td>Provides community care to veterans and war widows or widowers with low care needs</td>
</tr>
</tbody>
</table>

**COPs**

The Community Options Program (COPs) is a case management service established in the late 1980s to provide more intensive home-based support. It brokers the purchase of a range of different services including domestic assistance, personal care, meals, social support, respite, and others as outlined in Table 2.

<table>
<thead>
<tr>
<th>Domestic assistance</th>
<th>House cleaning</th>
<th>Washing and ironing</th>
<th>Shopping</th>
<th>Transport, eg. to appointments or bank</th>
<th>General, eg, paying bills, helping with telephone calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td>Bathing</td>
<td>Dressing</td>
<td>Personal grooming, eg, shaving</td>
<td>Eating</td>
<td>Delivering prepared meals</td>
</tr>
<tr>
<td>Meals</td>
<td>Delivering prepared meals</td>
<td>Occasionally some cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>Friendly visiting services for companionship</td>
<td>Assisting with paperwork, eg, bills and banking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td>Center-based day care</td>
<td>In home respite</td>
<td>Outings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Falls management</td>
<td>Dementia support services</td>
<td>Equipment</td>
<td>Home modifications and maintenance</td>
<td>Accommodation issues support</td>
</tr>
</tbody>
</table>
Case managers are able to additionally purchase services not available within the HACC program (eg, financial counselling) in order to integrate and flexibly supply services to clients with high care needs.12

HACC

The Home and Community Care (HACC) program delivers a spectrum of flexible services. HACC is a joint national and state and territory government program and is the mainstay of care at home for both older people and younger people with disabilities.13 It aims to provide comprehensive and integrated care to provide basic maintenance and support services, both directly and through their carers, to persons within the target population thereby enhancing their independence and avoiding premature or inappropriate admission to long-term residential care.14 Sixty percent of the funding comes from the Australian government and the remaining 40% from state and local government contributions.13 Eligibility for services is conditional on need, related to disability or illness, age (ie, over 65), or income.15 HACC also targets special needs groups including those from culturally and linguistically diverse backgrounds, clients with dementia, Aboriginal and Torres Strait Islanders, financially disadvantaged people, and those living in remote or isolated areas.13 Care is not limited to those living in their own homes but encompasses people living in retirement villages and those who are homeless. Homeless people suffer premature aging and thus require intensive care services appropriate to older people but are often excluded from programs on the basis of age. There are recommendations in place to add homeless people as a special needs HACC population.16 The 5 principle service types are domestic assistance, personal care, respite, nursing care and transport. However, HACC also provide other services including home modification and advocacy.17 For many HACC services formal assessment is not required. Otherwise, in principle, only one assessment is required. However, in reality, services are provided by a large number of small independent service organizations who all make their own assessment. In practice, this often leads to uncoordinated and fragmented care delivery. HACC National Service standards were introduced in 1991 to provide agencies with a common reference point for internal quality controls18 reorienting emphasis from compliance to continuous quality improvement. Additionally, there are moves to align all the terminology, required outcomes, and indicators for the different packages of care.19

CACPs

In 1992, Community Aged Care Packages (CACP) were introduced to support people in their home with up to 14 hours of care per week as a substitute for admission to a hostel (designed essentially for people who require assistance with Instrumental Activities of Daily Living). The CACP packages are aimed at frail older people (generally considered to be aged 70 and older for non-Indigenous people, and 50 years and over for Indigenous people) living alone or with others.20 The packages attempt to meet the complex and changing care needs of clients by providing services that are flexible and coordinated. The client’s care is assessed as complex on the principle that coordination of services is required.20 The majority of service providers are religious or charitable sector organizations. In 2005, 30,483 packages were being provided across Australia. This represents a provision of 16.3 CACPs per 1000 persons aged 70 years. Most clients are female and over the age of 80.21 Despite the program’s intention of substituting community-based care for low-level residential care, people receiving CACP have been found to be less physically dependent than their counterparts residing in hostels.22 However, by the time people “fail” a CACP and move into residential care they generally require nursing home placement, although some may graduate to an EACH package first (see below). CACPs have also been very successful at targeting resources to those with the greatest need with 79% of clients receiving more than 5 hours of help a week. Clients’ use of services is heavily influenced by the presence of a carer. Predictably, where this carer was co-resident, lower levels of CACP care was provided.22

EACH and EACH Dementia

Extended Aged Care at Home (EACH) packages of care were piloted in 2000 to provide care at home for people who would otherwise require nursing home. They are a long-term option for older people assessed as having significant and complex care needs that would prefer to stay in their own home where the complex and intensity of home care required can be provided.23 The services are similar to those provided by CACP with the addition of nursing care and the provision of more hours of care per week. Qualified nurses are involved in the assessment and ongoing review and management of the package given the complex and high care needs of the clients. Up to 22 hours of assistance is offered including terms of nursing and personal care, allied health care (eg, podiatry, physiotherapy) meal preparation, transport, home safety assessment, and modifications. However, the reality is that usually around 12 hours of care is delivered (Dr Sharzad Jafomi, personal communication, September 2007). A high percentage of EACH recipients live with their family (71%) and the majority who discontinue the package do so to enter a residential care facility.21

EACH dementia packages provide the same level of care for people with dementia. Their care needs specifically arise from the behavioral and psychological symptoms of dementia (BPSD) as opposed to purely functional deficits. The approach adopted by carers is therefore innovative and flexible with links to specialist services and support. For example the use of familiarization and distraction strategies may be used as creative approaches to support the clients’ instrumental activities of daily living. Short-term occupational therapy input can be purchased to identify triggers of behaviors and implement a therapy program.24 This may therefore be used to cope with BPSD such as refusal to take medication or verbally and physically aggressive behavior. The package is brokered by an approved aged care service provider and the care may be provided by different organizations in the area. The EACH program is still at an early stage of growth and development. In 2005 there were only 1673 packages of care. The planned
expansion of places is such that between 2006 and 2009 there will be a further 2000 EACH dementia places.21

**Transitional Care Program**

Transitional Care is the provision of short-term support and active management for older people at the interface of the acute/subacute and residential aged care sectors.1 It is goal-oriented, time-limited, and targets older people at the conclusion of a hospital episode who require more time and support in a nonhospital environment to complete their restorative process, optimize their functional capacity, and finalize and access their longer term care arrangements.25 It provides services such as physiotherapy, occupational therapy, and social work and nursing support and/or personal care.26 Additionally, case management is provided such to facilitate entry to aged care residential facilities if necessary or coordinate establishment of care packages in the community. The program operates over a 12-week period. It was introduced in response to an examination of the transition of older people from hospital to the community. ACAT assessment is required and referral can be made by members of the inpatient multidisciplinary team. Places are funded jointly by the Australian government and states and territories and the program continues to expand since its implementation in 2005.

**Hospital in the Home**

Hospital in the Home (HITH) is designed as a substitute for acute inpatient hospital care. Australia is a world leader in the delivery of health care in this setting. Hospital in the Home has shown promising results treating patients with mild to moderate community acquired pneumonia, venous thromboembolism and cellulitis.27 Similarly, in the older population, clients treated in a hospital-at-home rehabilitation program had lower rates of delirium, were more satisfied and the cost of treatment was less while remaining as efficacious as treatment delivered in a conventional inpatient setting.28 A recent Cochrane review concluded that there is insufficient evidence to support expansion or contraction of home-based alternatives to inpatient hospital care.29 although this has been criticized.30 There is ongoing research into this field examining the economics and clinical feasibility of implementing this scheme on a wider basis.

**ACAT Teams**

At present, Aged Care Assessment Teams (ACAT) act as gatekeepers, assessing clients for complex care packages (eg, EACH) and are often the first point of contact for people potentially requiring more support in the community or with residential care. ACAT teams have the ability to refer to any services but ACAT assessment is only a requirement for Commonwealth-funded care.31 ACATs receive referrals from any source and proceed to a comprehensive, holistic, multidimensional, multidisciplinary assessment. It has been argued however that the majority of clients requiring care require low intensity of services, which render multidimensional assessment too costly and intrusive to be constructive.32 ACAT teams are not designed or equipped to react to crisis. The majority of clients self refer or are referred at a time when care is required immediately. The reality is that delay from referral to assessment and then assessment to implementation of support can be up to months. This obviously leaves a period of time where need has been established objectively and subjectively and no care is in place.

**Carers**

There are 2.6 million carers in Australia, the majority of whom are female and under 64 years of age.33 It has been estimated that 74% of support for older persons is in fact provided by family and informal care. The majority of clients who were receiving COP or CACP in 2005 had a carer (60% and 65%, respectively) The carers for the COP clients tended to be coresident, whereas the clients receiving CACP’s carers tended to be non-coresident.11 A similar proportion (56%) of HACC clients have a carer available to them.33 Carers are recognized, particularly within the HACC program, and are offered services themselves including counseling, respite care, and information.5 ACAT assessors consider the carer's needs when making recommendations.

**Service Use, Outcomes, and Providers**

The Australian government seeks to provide 108 operational aged care places for every 1000 people aged 70 and over.34 This consists of 40 high-care places, 48 low-care places, and 20 community care places.35 Approximately 25% of those aged 70 years and older make some use of aged care and most use care provided in their own homes.35 The reality of the actual use of places compared with the target is such that 1 in 10 CACP and EACH places that should have been available are not filled. Clients who use home care (from any package) are older, live alone, are single, have a history of falls, have poor self-rated health status, and been previously admitted to hospital. Those suffering from any gait disability, or having a history of stroke, cancer, diabetes, or arthritis have an increased likelihood of service use.36 Clients using CACP are less dependent than clients using the Community Options Program.37 The increased use of both COPs and CACP by women probably represents the higher ratio of women to men at advanced ages.

Culturally and linguistically diverse (CALD) populations (considered to be people born in countries other than Australia, Ireland, the United Kingdom, New Zealand, the United States, Canada, and South Africa) are identified as a special needs group within the local population for the purposes of HACC provision and funding. CALD populations tend to use fewer types, less hours, and shorter durations of HACC services38 than their Australian counterparts.39 In particular, low levels of delivered meal services, social activity groups, and respite care were used. This may result from lack of culturally appropriate services, inadequate information publicizing these services, or the provision of informal support services through the community. The cultural opinion of nursing as a profession can influence the availability of qualified staff to staff these culturally specific services.

CALD populations appear to be more equitably represented within the CACP and EACH program.5
Aboriginal and Torres Strait Islander (ATSI) people are another population identified as a special needs group. A higher proportion of CACPs are used by Indigenous people living in remote or very remote Australia (41% in 2005) reflecting the demographic distribution of this population, and the lack of residential services in these areas.31 ATSI people are represented at similar rates to non-Indigenous people but have a lower rate of use of permanent residential care (1.8 per 1000) than the non-Indigenous population (7.3 per 1000).40 However, as a population ATSI have an average a 20-year lower life expectancy than the white population41 and have a poorer health status and die at a younger age than the non-Indigenous population.40 Thus, given this higher need for care, provision to this population is not equal. The Aboriginal and Torres Strait Islander Aged Care Strategy was introduced in 1994 to meet the needs of older Indigenous people providing services with a mix of residential and community care places that can change as community needs vary. This measure was specifically aimed at readressing the imbalance of care delivered to this population but service provision and delivery remains inequitable.

There is presently little research into outcomes both in terms of clinical variables and client satisfaction. Data collected from 80 CACP recipients living in the eastern suburbs of Sydney38 showed that the majority (62%) of these clients ranked their satisfaction with their care at “extremely satisfied.” This was independent of age, sex, amount and type of service, and the clients’ country of origin. Interestingly, however, this did not mirror their qualitative experiences when asked to comment. “Lack of flexibility,” “lack of continuity,” and “unsatisfactory service” were cited as concerns, highlighting the discrepancy between older people’s quantitative rating of satisfaction versus their actual experiences. There are no data reporting clinical outcomes for clients using community care in Australia. It is therefore difficult to ascertain at present or predict for the future whether care provided in older people’s homes will, for example, prevent or delay admission to residential care. Without rehabilitation strategies being intrinsically part of home care services, simply maintaining personal care needs may prove unsustainable in the long term. In 2003, 80% of the 2 million people over 60 who required assistance with personal and domestic activities and transport were receiving help informally, and 57% were receiving formal assistance. Sixty-four percent said their needs were met, 30% stated their needs were partially met, and 6% (equating to 70,000 people) reported their needs were not being met at all. Combining the partially met and unmet needs means that 433,000 Australians had unmet community care needs in 2003.5

HACC program service providers report against quality standards and undergo a 3-year appraisal. Recent results indicate that a quarter of providers received a standard of basic or poor indicating significant room for improvement. CACP, EACH, and VHC providers’ outcomes data sets are not publicly available at present.

Workforce

Of the Australian workforce, 1.4% work in residential and community care and they are overwhelmingly female.5 Staff working in the home care sector and their clients find the multiplicity of services cause inefficiencies with overlap, duplication, and poor communication.42 Clients additionally identified frequent staff turnover as detracting from continuity of care.38 Staff range from qualified nurses to untrained personal care assistants,33 and there is little consistency across the field in job titles, training, or regulation. The lack of qualified nurses reflects a national shortage and has at times led to unqualified and unregulated workers providing care. Additionally, low salary and the requirement to use private transport are prohibitive factors in recruitment.38 The shortages seen at all levels of care staff is most marked in rural and remote areas.5 Ongoing training, career recognition, and recruitment of staff from Aboriginal and Torres Island background remain unaddressed. With the aging of the population, the growth of the labor force will slow, plateauing the potential pool of workers. Compounding this is the projected number of informal carers being lower than the expected demand for HACC places.5 The reason for lower numbers of carers is multifactorial including the aging of carers themselves, tendencies to smaller families, increased rates of relationship breakdown, and increased participation of women in the workforce.

Funding

In 2005–2006 the Australian government’s expenditure on ageing and aged care was $7.1 billion. Approximately 9% of this was allocated to community care with the majority of the remaining $53 billion paying for residential care subsidies. In real terms, from 1999 to 2005 the proportion of funds allocated to community care has increased marginally.5 The financial contribution made by recipients of community care depends on the service type and the client’s capacity to pay. For people whose income does not exceed the maximum basic rate of a single person pension, the maximum fee for a CACP, EACH, or EACH-D package is 17.5% of that pension which equates to approximately $40 a week. Where clients receive additional income, providers may charge up to 50% of the income above the basic pension. As HACC is partially funded by states and territories these governments use their own fee policy for HACC services.33

The Future

The projected annual real (ie, inflation-adjusted) increase in health costs due to population growth and the ageing of the Australian population reaches a maximum value of just over 1.8% in 2012. This rate is predicted to hover until 2018, thereafter the annual rate of increase is predicted to decline by about 0.5% by 2051. The initial increase reflects the extra demands for health care from the ageing ‘baby boomer’ generation. Total healthcare costs are predicted to increases from $18.2 billion in 1996 to $35.3 billion in 2051. $12.5 billion is attributed to aging. The contribution to projected increased costs per age group decreases for age groups below 45-49
whereas there is a pronounced increase for age group 60-64 and above. An example is the increased costs for people aged 85 and over ($2.9 billion) 23% of the overall $12.5 billion. The majority of the projected cost increase can be attributed to the aging of the population. The net effect of the aging population is to increase real (inflation-adjusted) hospital costs by about $4 billion in 2051 mainly due to the increase in the number of people aged 65 and over. Acute care is projected to increase the most in terms of absolute increase with pharmaceuticals recording the smallest increase. While the ageing of the Australian population will undoubtedly be a significant driver of future health costs, it is anticipated to be manageable.2

The Australian government is currently introducing a $1.6 billion package of reforms, which included provision of an additional 7200 community care places proposing that this will enable over 15,000 frail older people to remain in their own homes over 4 years.44 This raises the government’s service provision target from 20 to 25 places per 1000 people over 70 years of aged. More places are being made available within the EACH program along with more training places for workers in aged care, more respite for carers, increased quality of care, and measures to increase the availability of assistive technology (eg, to remind people to take their medications).44 Overall this program has expanded sixfold since 2002.2 In conjunction with this financial investment, The Way Forward10 was launched as the beginning of a process to improve the community care system for the growing number of Australians who will need services in the years ahead. It looks to address poor coordination between different levels of government and within the service as well as lessening gaps and overlaps. The new proposal implements a 2-level approach to assessment to link people to the services they need depending on whether people need basic support (Basic Care Tier) or a more comprehensive package of support for higher care needs (the Packaged Care Tier.) The latter will involve, by necessity, a more comprehensive rigorous assessment with assessments still involving the in situ ACAT teams.10

The Way Forward has been criticized as not addressing the interface between aging and disability. Nor did it tackle the dwindling pool of informal carers and provision of support for carers.40 Predicting the significant deficit in the workforce and anticipated decline in informal carers leaves the provision of community care in potentially dire straits. Concurrently, older people are expected to have increasingly complex care needs. Emerging trends in population health predict increasing prevalence of dementia, increased cultural diversity in the community, and social trends tending toward increased demand for a higher standard of care. Despite the proposed government strategies and investment, whether demand can be met in terms of quality and quantity of care provided in the community remains to be seen.44 The future is precarious in the presence of pressure of privatization and potential resultant reduction in accessibility and equity of community health care.3 The pledges of further financial investment accompanied by reform look promising but could well be undermined with the infiltration of privatization.

CONCLUSION

Community care is here to stay as it is preferred by most consumers and their carers as well as being cheaper and easier to set up than residential care. Providing care to meet older people's needs is therefore vital in order to contain the potential cost of residential care. This is coupled with the fact that there will be continued rationing of residential care beds. While the scope of services superficially appears to provide care where it is required, the reality is such that older people tend to react to a crisis rather than expectantly implementing care. Then the time taken for ACAT assessment and implementation of a care package is often months. This may compel elderly people to stay at home with increasing frailty and disability without the specific health and domestic services they need. This is supported by the data demonstrating a care deficit of older people living in the community. Thus the flip side to community care is the potential for older people to be more isolated, to not receive the care they require, and the inadequacy of care provision can induce understandable frustration, anger, and guilt from families.45

The population in Australia is aging in line with the rest of the world and over the next 20 years we expect to see a population bulge in those over the age of 65. Marrying the need therefore to provide services within people’s homes with the expanding older population, requires significant planning and implementation of new strategies. The financial ramifications are expected to be manageable.2 However, whether the proposals to streamline services and improve coordination and staff training are successfully implemented remains to be seen. Maybe most importantly, there remains scope to study the clients themselves. There is little data at present as to whether we are meeting older people’s physical needs while at the same time providing a service that they themselves find satisfactory. Older people do often wish to remain in their own homes but we must ensure continued investment and service provision in delivering appropriate, timely, flexible care.

REFERENCES