


RESEARCH ARTICLE

New directions in centre-based aged care in Australia: Responding to changing funding models and the COVID-19 pandemic

Myra Hamilton¹  | Tonia Crawford² | Cathy Thomson³ | Yun-Hee Jeon² | Kimberley Bassett²

¹Centre of Excellence on Population Ageing Research, University of Sydney, Sydney, New South Wales, Australia

²Sydney Nursing School, University of Sydney, Sydney, New South Wales, Australia

³Social Policy Research Centre, University of New South Wales, Sydney, New South Wales, Australia

Correspondence

Myra Hamilton, Discipline of Work and Organisational Studies, Business School, Abercrombie Building, University of Sydney, Sydney, NSW 2006, Australia.

Email: myra.hamilton@sydney.edu.au

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Abstract

Objectives: Centre-based aged care services are a key site of early intervention and support for people with dementia and their carers. This paper examines the impact of new aged care funding structures on centre-based aged care service accessibility and delivery. It also examines the challenges and opportunities for change facing the sector in the light of the COVID-19 pandemic.

Methods: Semi-structured interviews were conducted online with 29 managers or supervisors of centre-based aged care services in Greater Sydney.

Results: The analysis reinforced the essential role of centre-based aged care services in improving the cognitive, physical and psychological health of older people with dementia and their carers. However, the changing funding context and the COVID-19 pandemic have created challenges in access to centre-based services, particularly for the most vulnerable. The challenges created by the COVID-19 pandemic also opened opportunities for the introduction of new models of service practice to meet the individual needs of older people and their carers.

Conclusions: Greater investment in, and flexibility in the funding for, centre-based aged care services is needed to facilitate access for people with dementia and their carers and improve their health and well-being.

KEYWORDS

Adult day care centers, dementia, caregivers, health services for the aged, COVID-19

1 | INTRODUCTION

Centre-based aged care is an important service that can improve the health and well-being of people with dementia and their carers.¹ They are daytime specialist facilities designed to meet the therapeutic, social or recreational

needs of older people, or to offer respite for their carers.² Increasingly, centre-based aged care services provide multicomponent support including physical activities, counselling, carer support and social support.³

The provision of social, cognitive, and physical stimuli in a centre-based setting can result in improvements in

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health and well-being, sleep and cognitive capacity among people with dementia.³ Attendance has also been shown to reduce the incidence of depression, behavioural issues and neuropsychiatric symptoms,⁴⁻⁶ reduce carer stress and enable carers to participate in paid work, improving their well-being.^{4,6-8} This increases the sustainability of the care role and may ultimately lead to postponement of placement in residential aged care.¹

In Australia, about 77% of the 413,106 people with dementia live at home, often supported by family.^{9,10} However, recent policy changes and the COVID-19 pandemic are likely to have created barriers in their access to centre-based care services.^{2,11}

In Australia, centre-based aged care services were publicly subsidised through one program for older people and people with disabilities, and a separate program for *carers* of older people and people with disabilities. In 2015, the Australian Government changed the funding model, amalgamating the two programs (and others) to form the Commonwealth Home Support Program (CHSP), which is available to Australians aged 65+ with low-level care needs. Older Australians with high-level care needs receive support through a Home Care Package (HCP). Carers can receive support through the CHSP, but this support is limited and predicated on the older person they care for using the CHSP.² A centralised online portal, 'My Aged Care', was created to manage assessment and referral.¹² These changes have altered how aged care services, including centre-based aged care, can be accessed and who can access them.

The COVID-19 pandemic and associated restrictions created major challenges for older people's engagement with their communities, including in-person services. Yet, little is known about how these challenges shaped the accessibility and provision of centre-based aged care services. This paper explores these changes and impacts through interviews with managers of centre-based aged care services in the Sydney region, asking: 'How have the changed aged care funding context and the COVID-19 pandemic shaped the accessibility and delivery of centre-based aged care services for older people with dementia and their carers in the Sydney region?'

2 | METHODS

This study used a qualitative descriptive design that allows accounts by participants to be interpreted by researchers using a non-theoretically informed lens.^{13,14} Ethics approval was granted by the University of New South Wales Human Research Ethics Committee (HC190502). A list of centre-based services in the Sydney area was compiled from publicly-available databases and consultations with

Policy Impact

The funding context and COVID-19 pandemic have created challenges in access to centre-based day-care services for people with dementia and their carers, affecting the health, well-being and sustainability of care relationships. Greater and more flexible funding is needed to allow centre-based services to meet the needs of clients.

project partner organisations. Between February and September 2020, 65 managers of the identified centre-based services were sent an email invitation to participate in the research. The response rate was 45 per cent: 29 managers at 28 centre-based services were interviewed by Authors 1, 2, 3 and 5 for 20–60 minutes by telephone or Zoom using a semi-structured interview guide ([Appendix S1](#)). Interviews were recorded, transcribed and analysed using NVivo. The analysis was a combination of deductive node development informed by the research questions, and data-driven inductive identification of themes.¹⁵ Inductive coding was undertaken by Authors 1, 2, 3 and 5, commencing with coding of the same two transcripts to check for intercoder reliability before coding the remaining transcripts. This was followed by further clustering and analysis of themes identified in the codes in an iterative process.^{15,16}

3 | RESULTS

Participating services were from socio-economically diverse suburbs across Sydney and came from a wide range of providers (see [Table 1](#)). Participating managers were a mix of team leaders/assistant managers (3), program managers/coordinators (15), facility managers (6) and area managers (5), with diverse backgrounds in nursing, social work, allied health and service administration. Typical centre-based activities across providers included the following: food-related activities (i.e. cooking, sharing recipes); cognitive activities (e.g. discussing newspapers, puzzles, visiting presenters); mobility exercises (e.g. gentle sports); cultural celebrations (e.g. art, music); and visits to local attractions (e.g. nature-based experiences).

3.1 | Changed funding context

Participants reported that the changed aged care funding context altered the nature of the service, marginalised

TABLE 1 Characteristics of participating services ($n = 29$)

Key characteristics	Types	Numbers (%)
Dementia-specific service	Yes	13 (44.8)
	No	10 (34.5)
	No, but more than 50% of clients with dementia	6 (20.7)
Ethno-specific/CALD client-specific service	Yes	4 (13.8)
	No	25 (86.2)
Funding sources	CHSP	18 (62.1)
	CHSP and HCP ^a	6 (20.7)
	CHSP and local/state government	1 (3.4)
	CHSP, HCP and NDIS ^a	3 (10.3)
	CHSP, HCP, local/state government and NDIS	1 (3.4)
Specialised or community building	Community centre/building	7 (24.1)
	Specialised	15 (51.7)
	Hospital site	3 (10.3)
	Mixed	3 (10.3)
	No	1 (3.4)
Carer support incorporated in the service	Yes	5 (17.2)
	No	24 (82.8)
Centre-based only or home/community outings incorporated	Centre-based	15 (51.7)
	Centre-based and outing	3 (10.3)
	Centre-based, outings and home visits since the COVID-19 pandemic	11 (37.9)
Provider status	For profit	3 (10.3)
	Not for profit	24 (82.8)
	Government	2 (6.9)

Abbreviations: CALD, culturally and linguistically diverse backgrounds; CHSP, Commonwealth Home Support Program; HCP, Home Care Package; NDIS, National Disability Insurance Scheme.

^aOne service has a fee-paying service combined (\$45/day or \$30/day).

the needs of people with dementia and their carers, and created a false distinction between people using different aged care programs.

...it is like a minefield unless you work with it every day, it is just so foreign.

(Participant 15)

3.1.1 | Increased complexity, decreased accessibility

Participants reported that the introduction of the online portal changed the way in which older people and their carers accessed centre-based services. Rather than approaching a service directly or receiving a referral from a health professional, older people were required to register with the portal, undergo an assessment, be allocated services and corresponding codes, then search for and contact a service through the online system. According to participants, this was complex and confusing for clients and required considerable computer literacy, deterring some clients from accessing services.

It also made matching services to clients more complex, resulting in a loss of immediacy in the referral process. This resulted in a reduction in new referrals among many service providers, with clients (especially the most vulnerable) missing out on services.

Participants also reported that the online portal resulted in a breakdown of strong pre-existing relationships between centre-based services, health professionals and clients, further interrupting smooth referral pathways. According to some participants, this was exacerbated by the competition created by the new consumer-directed care market, resulting in less collaboration when meeting client needs. More than half of the services reported providing additional (unfunded) client support to navigate the referral process. One participant put it this way:

My job isn't just what I used to do anymore because I'm following up for things that they don't understand.

(Participant 4)

3.1.2 | Reclassifying centre-based care eligibility

Participants reported that the changed funding landscape changed the service's fundamental purpose and client base. Most participants believed the new funding arrangements neglected the potential of centre-based care to meet the specialised needs of people with dementia and their carers.

The funding changes reclassified centre-based care as a service under the CHSP, which is available only for people aged 65+ (and First Nations people aged 50+) with 'entry-level' care needs. This excluded care for people with dementia with high care needs, people with younger onset dementia, and the carers of these groups. While access to the service on a full fee-paying basis was possible, the new funding and reporting structures meant services were compelled to focus on clients with low care needs.

It's [the funding] very, very thin. I think it's about \$18 an hour that we get, once you take out all the other overhead costs, we're not left with much to support the client. So, you essentially would have to run at a loss if we were to take people on that needed that higher support under the CHSP funding.

(Participant 28)

It was reported that the funding did not allow for the higher staff/client ratios required for dementia-specific services or clients with complex needs. Consequently, staff who specialised in dementia-specific care departed or were deployed to provide generalised services, resulting in the loss of specialised knowledge. Participants were concerned about the loss of dementia-focused support and expertise.

Approximately 25% of the participants reported that the new system no longer met the needs of unpaid carers. Carers now had to access centre-based respite through the funding of the older person, which required that the care recipient prioritise respite over the other care needs.

In addition, several participants reported that the new funding structures implicitly favoured the older person, not the carer.

I just don't think the people that are writing these manuals and the CHSP program truly get what kind of respite service these services are offering carers.

(Participant 14)

For example, in the changed funding landscape, the funding was bifurcated into a social support code (focused on the older person's need) or a centre-based respite code (focused on the carer's need), treated separately for funding purposes. Several participants reported that social support was sometimes prioritised by funding bodies.

3.1.3 | Challenges at the interface of the programs: 'Crossing over' between CHSP and HCP

Participants reported that the new funding arrangements created rigid administrative processes that were incongruent with the support needs of older people and their carers, creating perverse incentives for some. All participants reported that the change to the funding arrangements pushed out older people with higher care needs (HCP holders). While they could still accept people with high care needs, there were considerable barriers to doing so: the funding and output reporting were CHSP-focused, limiting the services' capacity to take on HCP clients; HCP holders were sometimes not approved by the package administrators to use a CHSP service; HCPs lacked flexibility, making it difficult for older people and their carers to opt for centre-based services; and service fees were too high for many HCP clients, prohibiting them from using the services as required.

The interface between the programs was even more difficult to navigate for those moving between programs (i.e. from CHSP to HCP). Several reported having to 'kick people out' of the service when they accepted an HCP. Others found ways to transition clients from a CHSP- to an HCP-funded place, though this required reduced hours of service use due to limited funds in their HCP. One third of the participants said that this made their clients' decision to accept an HCP difficult (the remaining participants did not comment specifically on this aspect). Some clients had declined their HCP offer because they did not want to lose their CHSP-subsidised service, especially those offered lower-level HCPs:

Technically once they've got a level one package, they need to drop any of the Commonwealth Home Support Programs. Um, but by doing that, their level one only gives them back basically what they had on the CHSP anyway, but they can't afford the social support.

(Participant 4)

The participants reported that while the new funding context created divisions between CHSP and HCP clients, often these were false divisions based on the administrative

categorisation of need rather than an understanding of the lived realities, changing circumstances and preferences of clients and their carers. In practice, clients' and carers' needs within a service increased over time. In addition, the need for the service did not change when a person transitioned from the CHSP to the HCP as they still needed social support and centre-based respite, especially with a service that they had come to know and trust.

[P]eople who receive a home care package now are deemed that they're no longer eligible to attend the centre. Where people need in reality both those things to remain at home, they need a home care package, and they need the social support, but what the government has done is they're saying that you can have one.

(Participant 17)

Yet, service continuity was difficult in the new funding context.

3.2 | The COVID-19 pandemic

The onset of COVID-19 generated additional challenges to the access and nature of centre-based services. All but

one centre-based service closed for the duration of the first national lockdown (March to May 2020), and for many, this closure extended as centres grappled with mitigating the risks associated with the return of clients. The changes to service provision are set out in Table 2.

3.2.1 | Lockdown and impacts on clients and carers

Many participants reported that this had extensive and negative impacts on clients and carers. About half reported that older clients were lonely, isolated, anxious and sometimes depressed at the loss of routine and social connectedness offered by the in-centre service. Two thirds of participants reported that their older clients' health and well-being declined due to a lack of access to the social support and physical activities.

A lot of people noticed a decline in some of their loved ones, like cognition, because they wouldn't be interacting with people as often as they were. And also, our people's physical mobility and balance declined because they weren't doing regular activity and physical work with us.

(Participant 28)

TABLE 2 Changes in service practice over the pandemic

Clients	Service types		
	Pre-COVID-19	During COVID-19 lockdowns	Post-COVID-19 lockdowns
Older people with dementia	Main focus on centre-based social support	Welfare checks <ul style="list-style-type: none"> • Phone calls 1–2 weekly • Delivery of care/activity packages weekly • Home visits Individualised/one-on-one social support 1–2 h per week Individualised transport to medical appointments Virtual service provision <ul style="list-style-type: none"> • Zoom groups, for example exercise classes • Brain training 	Welfare checks <ul style="list-style-type: none"> • Phone calls 1–2 weekly • Delivery of activity packages (less frequently) Individual social support Centre-based social support Virtual service provision
Carers	Respite as a by-product of centre-based social support and transport to and from the centre	Welfare checks <ul style="list-style-type: none"> • Phone calls 1–2 weekly Respite 2–3 h per week as a by-product of individualised social support Virtual service provision <ul style="list-style-type: none"> • Zoom carer support meetings 	Respite for limited number of carers Virtual support <ul style="list-style-type: none"> • Monthly carer support zoom meeting

And all our carers, the feedback that we've been getting from them is that... they could actually see rapid deterioration over the first few weeks, [the older] people were getting more socially withdrawn, having lethargy or apathy... A lot of them have ... become more unsettled because... when you don't have nothing to do, then... some of the challenging behaviours surface. So, they start pacing around the house, started absconding, going out. Carers' stress was very high....

(Participant 6)

Consequently, the care needs of many older clients increased, while the care available to them was reduced.

These circumstances placed added pressure on carers. All participants reported that carers experienced greater care responsibilities during the COVID-19 pandemic and fewer opportunities to take a break. Carers received less respite, partly because centre-based respite was not possible, but compounded by limited access to residential aged care respite during lockdowns. Three participants reported that some carers coped ok with the changes and were able to draw on support from elsewhere such as family and friends. However, most participants reported that carers were under high and growing stress that threatened their well-being, capacity to work and the sustainability of their caring role, leaving them feeling exhausted, desperate and isolated.

I think also it impacted the carers and perhaps even their, um, potential to continue to be carers sometimes when they don't have that sort of support.

(Participant 24)

Because of the declining condition of older clients, and the increase in carer stress, over half of participants reported that a proportion of their older clients had prematurely entered residential care during the lockdown period, stating that this would not have occurred if not for the closure of their service during the pandemic. Two thirds of the participants described receiving regular calls from carers and older people imploring them to reopen.

3.2.2 | Staff and service agility in the face of challenges

The COVID-19 pandemic also affected staff, with participants reporting that some staff were anxious about the risks to themselves and the impacts on clients. Participants reported that the staff experienced considerable change

in their workloads. Some had to shift quickly to providing in-home and online services, some were redeployed to residential aged care facilities, and some chose or were asked to take leave. Participants reported that staff were agile and flexible in adapting to changes, including when the centres reopened.

When the centres reopened, most offered scaled-back services. All participants reported extensive infection control measures, for example, wearing masks, and temperature and health screening checks on arrival. Unable to operate at full capacity due to social distancing measures, they reported limiting client numbers. Some were overwhelmed with interest from clients. For others, many clients had entered residential care or remained fearful of returning, so rationing spaces was easier. When centres reopened, they also had to adjust the services they offered to accommodate public health measures. For example, activities including singing, dancing, holding hands or touching the same items were discontinued. This meant that some of the 'sociality' of the group context was lost.

And even things like the cooking, we used to get them to help with cooking. I'm not comfortable doing it now and I don't know if we will be in the future... we really got our clients involved a lot, so we used to get them to help fold the napkins and the cutlery and put the salt and pepper out and do all those little jobs and which they enjoyed doing it, you know. Being part of and helping. I think we'll need to rethink all of those things too.

(Participant 18)

Seven services reported a reduced or discontinued transport service, a major loss for clients who lived alone and relied on transport to attend the centre. Many participants reported that some clients became confused that they could no longer converse, engage and dine with other clients as before. They missed the larger group context or had difficulty communicating with masks and across greater distances than usual.

3.2.3 | Opportunities for new models of service practice

During the initial stages of the COVID-19 pandemic, all participants reported having to think creatively and find new ways to support their clients, exploring new models of practice. The government also made new provisions available for centre-based services to build flexibility into their service outputs. Most services reported little communication with other centres during the shutdown, but all

centres implemented similar strategies to engage with and support their clients.

All centres implemented a form of welfare check involving ringing or checking on clients once or twice a week and delivering welfare/activity packages based on clients' interests to their homes. Participants also reported moving their focus from centre-based social support to individualised social support tailored to the individual clients' needs and home context, such as cognitive stimulation therapy involving games or showing photographs to encourage discussions.

All centres developed remote or virtual models of service provision to engage with clients. Some provided training and equipment such as iPads. Several developed online group activities such as exercise classes, discussion groups and brain training activities. Adopting this new service model often involved staff learning new ways to provide support and helping clients to learn how to access these activities.

The model needed to be flipped to a more sort of virtual remote model of care... So, the team developed some sort of activity packs and a door knock system where they would pop into the clients at the doorstep and provide the pack and at a socially distanced way, have a quick conversation and welfare check to see how they were doing.

(Participant 8)

Once restrictions eased, most participants reported that they continued to provide the more individualised social support as clients clearly benefited from it. Similarly, participants highlighted the importance of bringing people back to the centres for social interaction and engagement. Some participants noted that, despite not being able to run the same kind of social programs as before, the smaller groups enhanced their ability to provide 'more individualised care'.

So that's almost like a positive out of the COVID, like the sort of silver lining that individual program. The idea that you're really tailoring something for someone.

(Participant 19)

Most participants envisaged continuing their virtual services in conjunction with in-person services.

4 | DISCUSSION

Centre-based aged care is an important supportive measure for older people with dementia and their carers.¹ The

service interruptions during COVID-19 and their devastating impacts identified in this research have shone a light on how essential the services are for maintaining the health and well-being of older people with dementia and their carers, and the sustainability of informal care relationships in the community. This is consistent with emerging international evidence that identifies the pervasive impacts of interruptions to centre-based aged care on older people and carers,^{17,18} particularly in the light of broader challenges to the social connectedness, safety, health and well-being, and service access experienced by older people and their carers during the pandemic.¹⁹ It also identified the potential agility and flexibility of centre-based services to meet the personal needs of older people and carers, something also identified in international contexts,²⁰ provided that funding provisions offer adequate flexibility. As services transition to a post-COVID mode of operating, new hybrid models of service provision including both individualised supports and social supports in group settings are likely to continue.

In Australia, the barriers to accessibility created by the pandemic were in fact deepening pre-existing barriers to access arising from the changed aged care funding context. Australia's funding changes reflect a broader international trend towards more consumer-directed models of care for which access is increasingly governed online.¹¹ This makes access more complex, generating new difficulties for older people with care needs. The greater focus on the needs of the 'consumer' (the older person) also marginalises the needs of the carer. Consequently, centre-based care, like other areas of aged care, is more difficult to access for both older people and carers. However, in Australia, the additional bifurcation of low care and high care needs into two programs (CHSP and HCP) and the classification of centre-based care as a subsidised service targeted at people with *low care needs* marginalise older people with high care needs and fail to adequately recognise and flexibly accommodate the overlapping and changing needs and transitions of people with dementia and their carers. It also fails to value the social support needs of those who have high-level care needs.

5 | CONCLUSIONS

The research presented in this paper suggests that the COVID-19 pandemic created barriers to access to centre-based aged care services, with severe consequences for the health and wellbeing of older people and carers. In Australia, this compounded existing barriers to access arising from an increasingly consumer-focused, digitalised, and administratively-rigid approach to aged care

funding. To better meet the changing needs of clients, greater funding and more flexibility in the funding rules, as introduced by the government during COVID-19, are needed to improve access for older people with high needs. Furthermore, carers need support navigating and accessing the system, as well as better support for people with younger onset dementia whose needs are not met by the programs designed for older people with dementia.

This study explored the perspectives of managers of centre-based aged care in one metropolitan area in Australia, and therefore, the results are geographically specific. However, it drew from a diverse range of providers and identified challenges that are potentially applicable to other national and international contexts. The transferability of the findings needs to be examined further. In addition, the study did not capture the perspectives and experiences of older people or carers using the services. These are important missing perspectives that require further investigation.

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CONFLICTS OF INTEREST

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Myra Hamilton  <https://orcid.org/0000-0001-5999-6568>

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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