1 Introduction

This report summarises the result of a study which examined the characteristics and service profile of recipients of Community Aged Care Packages (CACPs) who held a DVA gold or white card and compared this group and those who did not have a DVA gold or white card. It is based on an analysis of data collected through a census of CACP care recipients conducted by the AIHW in 2002.

Background

The CACP Program and its place in the Aged Care System

CACPs are planned and coordinated packages of community care services designed to assist frail older people with complex care needs to remain living in their homes within the community. To be eligible for a CACP a person must be eligible for at least low-level residential care. The *Aged Care Act 1997* lists a number of special needs groups which should have priority access to CACPs, one of which is veterans.

The CACP Program is only one of a number of government-funded aged care programs and should not be considered in isolation. It is one of the main community care programs along with the Home and Community Care Program (HACC) and the National Respite for Carers Program (NRCP) which provide a range of assistance in the community to help people stay in their homes. The Extended Aged Care at Home (EACH) Program is a small program which provides high-level care to people in the community. The Veterans' Home Care (VHC) Program provides a more limited range of assistance to veterans and cannot be accessed by the general community. Residential respite care is also available for people living in the community. Permanent residential care services provide accommodation and support for older people who can no longer live at home. A brief summary of the interactions of the Australian aged care system is presented in the aged care chapter of *Australia's Welfare 2003* (AIHW 2003, pages 292–295). At the time of the CACP census in 2002, there were around 25,200 CACP care recipients, and nearly 49,200 permanent low care residents in residential aged care.

The CACP Program is funded by the residential care budget and places are allocated as part of the residential care allocation rounds. Receipt of assistance from a CACP is subject to the same ACAT (Aged Care Assessment Team) assessment process that is required for access to residential care or EACH packages. Having been recommended for assistance from a CACP, people may nevertheless delay accepting a package or may change their arrangements and choose to access other programs either as a matter of preference or because their needs have changed. Care recipients whose formal service needs can no longer be met through the CACP Program may move on to an EACH package or to residential aged care.

CACPs provide access to a case manager/care coordinator who arranges or provides any of the following types of assistance: domestic assistance, personal care, social support, meal preparation/other food services, delivered meals, home maintenance, respite care, rehabilitation support, transport services and/or formal linen services (see Appendix 2). Nursing services and allied health care are not available through CACPs, but are available

through the use of HACC or DVA nursing services, or state-funded nursing services in conjunction with CACPs.

Veterans' and war widows' health care entitlements

The Australian repatriation system has its roots in legislation introduced during World War I in response to a sense of national obligation to service personnel who fought for their country. At the time of the CACP census it was administered under the *Veterans' Entitlement Act 1986*. This Act provides for compensation for veterans in the form of disability pensions and war widow's pensions, income support (service pensions), health care for veterans and their dependants, and allowances and other benefits for veterans and their dependants. Eligibility and assessment rules are extremely complicated and a number of terms (including the word 'veteran', see Appendix 5 Glossary) have specific definitions under the Act (Clarke et al. 2003).

There are two categories of health care entitlement available to veterans. Veterans with a gold card are entitled to assistance from the Department of Veterans' Affairs for the treatment of all health conditions. However, veterans with a white card are only entitled to health treatment for conditions which are accepted as war or defence caused, or for specifically designated conditions (for example cancer or tuberculosis). Conditions of eligibility for gold and white cards are outlined in Appendix 3. A third card which can be issued to veterans for provision of pharmaceuticals is not considered in this study.

Most veterans with gold or white cards also have access to a number of other veteran-specific assistance such as Veterans' Home Care, the Rehabilitation Appliances Program, community nursing and other health/allied health services (see Appendix 4). They also have access to all other government-funded programs that are available to members of the general community.

Because this study is restricted to CACP care recipients who are 70 years or older, most DVA cardholders included in this study would have been veterans of World War I, World War II, the Korean War, the Malayan Emergency and the Far East Strategic Reserve, or widows of servicemen or women who served in these conflicts. Treatment population statistics compiled by the Department of Veterans' Affairs show that, of the roughly 263,000 men and women with a repatriation health card for service in these conflicts, 95% of those received their entitlement for service in World War II. For these conflicts, all of the men with a white card, and almost all male gold cardholders (99%) and female white cardholders (99%) were veterans, while 95% of the women with a gold card were dependants of veterans (DVA 2002b). It could be expected that the CACP care recipients with a DVA entitlement card would have a similar profile.

Structure of the report

Section 1 of this report has outlined the background to the CACP Program, as one of the elements of the Australian aged care system, and veterans' and war widows' health care entitlements under the *Veterans' Entitlement Act 1986*. Section 2 contains information on the scope, data sources and methodology used in the study. Section 3 outlines the main findings of the report and is grouped into four subsections: the care recipient profile, their need for assistance, their access to carers, and their service use (provided through the CACP package and from other government programs). Detailed tables (Tables A1 to A24) which support

these findings are presented in Appendix 1. Supporting information on the definitions of CACP service types, eligibility for DVA repatriation health care cards and other assistance available to cardholders is presented in Appendixes 2–4. Appendix 5 contains a glossary of terms used in this report.

2 Data sources and methods

Data sources

In September–October 2002 a census of Community Aged Care Package recipients was carried out. This census collected information about the characteristics of care recipients, the assistance they received and the service providers during the week of the census. Details of the data sources, data collection forms, methodology, census guidelines and data quality limitations for the 2002 CACP census can be found in the census report (AIHW 2004a). All analyses of the characteristics of CACP care recipients are based on the results of this census.

The census identified 25,446[5] CACP care recipients (including 826 supplementary care recipients). Of these 9.9% (2,523) were reported to have either a gold or a white repatriation health care card (Table A1). The estimated response rate for care recipients in the census was 97%.

Scope and study methodology

The central aim of this study was to construct a profile of CACP care recipients with a gold or white Repatriation Health Card (also referred to in this report as a DVA entitlement card or a DVA health care entitlement card) from the information collected in the 2002 CACP census, and to examine differences between cardholders and other CACP care recipients.

The study was limited to care recipients who were 70 years or older (20,620 care recipients). Knowledge of the age, sex and possession of a gold or white entitlement card were critical for meaningful comparisons between groups of care recipients. Therefore, records with unknown age, sex, or DVA cardholder status were excluded from the study. In addition, for analyses of specific characteristics for example country of birth, records with missing or unknown data for that characteristic were also excluded.

While the majority of CACP recipients in the 2002 census (18,316 or 82% of those 70 years or older) were not veterans, spouses or widow/widowers of veterans, it should be noted that the group who did not hold a DVA entitlement card included a small number of care recipients who were identified as a veteran, spouse or widow/widower of a veteran (131 or around 0.5% of those 70 years or older) and who may have similar characteristics to care recipients with a DVA entitlement card.

Most tables in this report present the characteristics of care recipients by age, sex and possession of a DVA health care entitlement card. This allows comparison of the actual proportion of care recipients with particular characteristics, both overall and within 5-year age groups. This is important as these actual differences may be relevant for policy development.

5 This figure includes seven recipients who were not included in the published census report because of late submission of census forms.

Box 1: What is the prevalence relative risk (PRR) and how is it interpreted

Relative risks estimate the likelihood of people in one group (in this study CACP care recipients with a DVA health care entitlement card) having a particular characteristic when compared with people in a second group (CACP care recipients without a DVA health care entitlement card).

Because the CACP census was a cross-sectional study (that is, the study looked at the characteristics of the care recipients at a single point in time) the measures being compared are the prevalence rates (or proportions) in each group.

For example, for financial hardship:

$$\text{PRR for gold cardholders} = \frac{\text{Proportion of gold cardholders in financial hardship}}{\text{Proportion of care recipients without a card in financial hardship}}$$

If the proportion in financial hardship is the same for gold cardholders as the proportion for the group without a card, the relative risk will be 1.

A relative risk of 1.3 means that the cardholders were 30% (that is (1.3 – 1)/1) more likely to be in financial hardship than care recipients without a card. A relative risk of 0.8 means that cardholders were 20% (that is (0.8 – 1)/1) less likely to be in financial hardship.

Confidence intervals for the relative risk estimates are provided. If the relative risk of 1 is between the upper and lower confidence limits the relative risk value is not considered to be statistically significant.

The prevalence relative risks calculated in this study control for both age and sex. Many of the characteristics investigated in this study are associated with both age and sex, and the entitlement groups have different age and sex structures.

Note that relative risk gives no information about the size of the absolute difference between the two groups. For example, 0.6/0.3 = 0.06/0.03 = a relative risk of 2.

Because the relative risk values reported for this study have been corrected for age and sex, they cannot be calculated directly from the total proportions presented in the tables.

In addition, Cochran-Mantel-Haenszel statistics were used to calculate the prevalence relative risk (also referred to in this report as the relative risk) for a range of characteristics of CACP care recipients with a DVA entitlement card compared with those CACP care recipients who did not have a DVA entitlement card, giving an estimate of the difference that would be observed if the groups had the same age and sex structure (see Box 1 for information on prevalence relative risk). Note that care is needed in interpreting results for white cardholders because of the small numbers, which make it difficult to precisely estimate relative risk for this group.

If a characteristic such as age or sex differs between the groups being studied, and the characteristic being studied (for example the proportion of care recipients with a carer, or the proportion of carers who live with the care recipient) independently differs with age and sex, this can affect the calculated value of the relative risk, either masking a difference or showing a difference where there would not be one if the age and sex structure were the same. For example, the age structure of gold cardholders is older than the age structure of non-cardholders. At the same time the proportion of carers who live with the care recipient is related to both age and sex (Table 1). For care recipients aged 75 or older, the overall proportion of co-resident carers is nearly the same for both gold cardholders and care recipients without a card giving a crude relative risk of 46.8/46.9 = 1.0 that is no difference.

However, after controlling for age and sex the relative risk is 0.91 (confidence interval of 0.85–0.97). In other words, if the age and sex structures of the two groups were the same, the carer of a gold card holder would be 9% less likely to live with the care recipient than the carer of a care recipient without a card.

Table 1: Carer co-residency status, gold cardholders and non-cardholders, by age and sex, CACP care recipients 2002

Sex	Entitlement group	75–79	80–84	85+	Total 75+
			Per cent		
Males	Gold card	68.8	62.8	51.7	59.4
	No card	67.6	66.1	54.1	60.5
Females	Gold card	49.0	36.3	28.8	36.3
	No card	51.2	42.9	38.1	42.3
Persons	Gold card	56.4	49.7	38.9	46.8
	No card	55.8	48.1	42.2	46.9

Source: Table A13.

Relative risk estimates for gold cardholders could be calculated for 70+ and 75+ age groups. However, because there were no male white cardholders in the 70–74 year age group, relative risk estimates for white cardholders could only be calculated for the 75+ age group. Unless otherwise stated, relative risk estimates for gold cardholders are similar when calculated for the 70+ and 75+ age groups, and only relative risks for the 75+ age groups will be quoted.

3 Main features

There were 20,620 CACP care recipients aged 70 years or older included in this study. These were the care recipients where information was available on their age, sex, whether they held a DVA health care entitlement card, and if so what type of card was held.

Eleven per cent of those included in the study (962 males, 1,318 females) held a gold card while only 1% (74 males and 102 females) held a white card. Because of the small numbers of white cardholders in the study population care needs to be taken when interpreting results for this group.

Care recipient profile

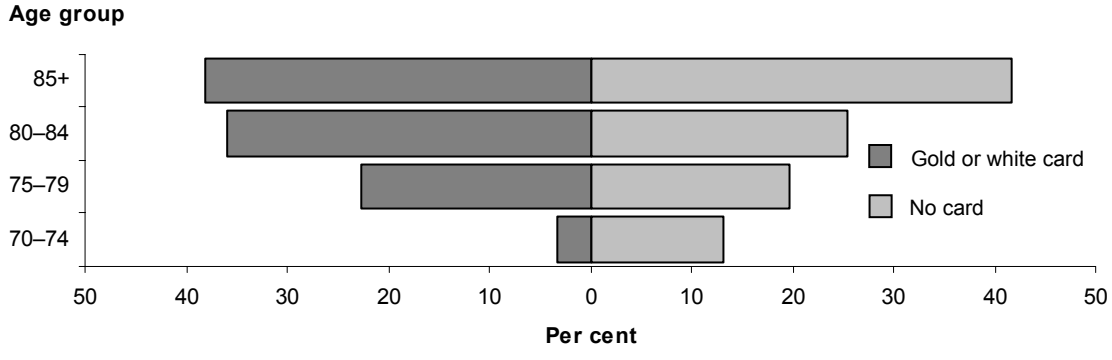
Age and sex

Care recipients are predominately female in all entitlement groups, but there was a higher proportion of males among those with a DVA entitlement card (42%) than without an entitlement card (25%) (Table 2).

Table 2: Sex of care recipients by entitlement group, CACP care recipients 2002

Entitlement group	Male	Female	Persons	Male	Female	Persons
	Number			Per cent		
Gold card	962	1,318	2,280	42.2	57.8	100.0
White card	74	102	176	42.0	58.0	100.0
Gold or white card	1,036	1,420	2,456	42.2	57.8	100.0
No card	4,593	13,571	18,164	25.3	74.7	100.0
Total	**5,629**	**14,991**	**20,620**	**27.3**	**72.7**	**100.0**

Source: Table A2.



Source: Table A2.

Figure 1: Age profile, CACP care recipients 2002

While the median age of all entitlement groups is 83 years, the age structure of DVA cardholders is generally older than those care recipients who did not have an entitlement card (Figure 1, Table A2). Seventy-four per cent of care recipients with a DVA gold or white card were aged 80 or over, compared with 67% of recipients with neither of these cards (Figure 1).

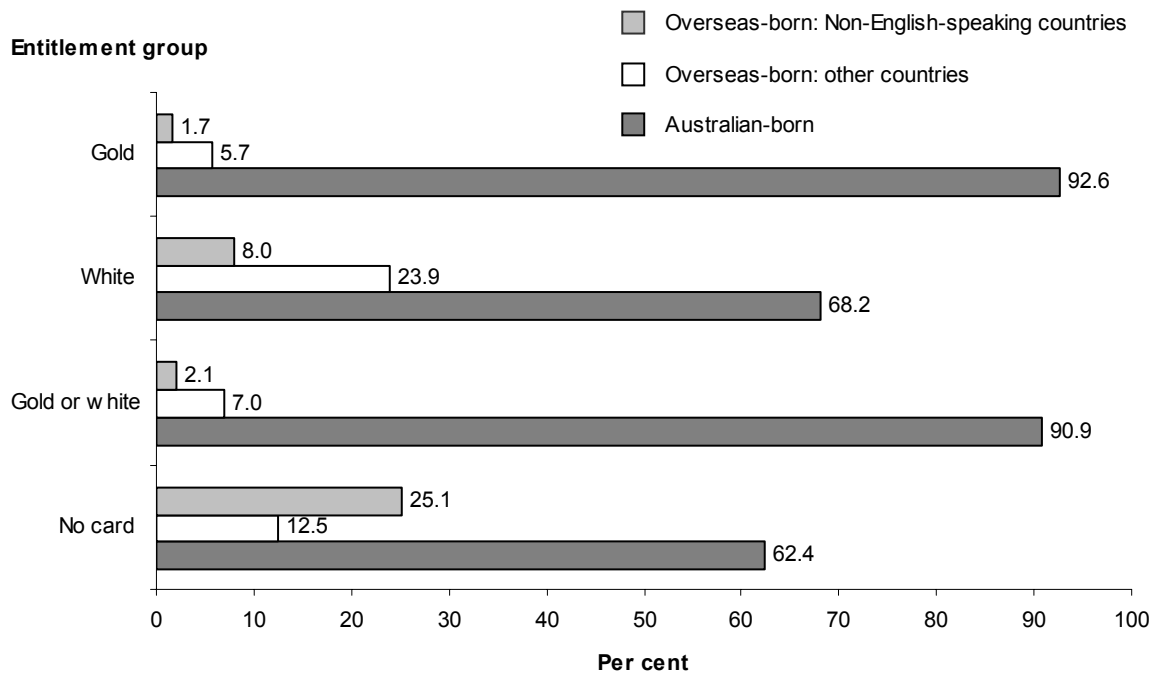
The proportion of all CACP care recipients who were cardholders generally increased with age: 3% of care recipients aged 70–74 years held a white or gold card, 14% of care recipients aged 75–79 and 16% of care recipients aged 80–84 years. However, the proportion of care recipients who were cardholders was lower in the 85+ age group (11%) than for those aged 80–84 years (Table A2).

Country of birth

Most CACP care recipients with a DVA health care entitlement card were Australian born (91%) with only 9% born overseas. By comparison, 62% of care recipients without an entitlement card were born in Australia (Figure 2, Table 3, Table A3). In addition, country of birth profiles differed for each entitlement group.

- Among gold cardholders, 93% were born in Australia, nearly 6% were born overseas in English-speaking countries and 2% were born in other overseas countries, with a similar pattern for both men and women.
- For white cardholders the pattern was similar but the proportion of care recipients who were born overseas was much higher. Only 68% of white cardholders were born in Australia while 24% were born overseas in English-speaking countries and 8% were born in other overseas countries. The proportion of people born overseas in English-speaking countries was much higher for male white cardholders (39%) than for female white cardholders (13%) (Table 3, Table A3).
- Most care recipients without a card were born in Australia, but the proportion of care recipients born overseas in English-speaking countries (13%) was lower than the proportion born overseas in other countries (25%). There was a higher proportion of both overseas born groups for the non-cardholders than for cardholders.

To some extent, these differences between those with and without a DVA health care entitlement card reflect both the different composition of the Australian population at the time of recruitment into the services together with recruitment and service restrictions, and the eligibility criteria for DVA health care entitlement cards. Australia's immigration policy meant that the Australian population prior to World War II consisted of a high proportion of people who were Australian- and European-born. In the 1933 Australian census (the last census before WWII) 86% of the Australian population were Australian-born and 12% were born overseas in English-speaking countries, with only 2% of the population born overseas in other countries (Commonwealth Bureau of Census and Statistics (Australia) 1933). In contrast, in 2001 the proportion of people born overseas (28%) was double that of 1933 (14%) as a result of post-war immigration. By 2001, the proportion of the population born overseas in English-speaking countries had decreased to 9% of the population while that of people born overseas in other countries increased to 19% (ABS 2002b, Table B06). The increase in the overseas-born population is reflected in the profile of the non-cardholder care recipient population, with a higher proportion of people from non-English-speaking countries than from English-speaking countries.



Source: Table A3.

Figure 2: Country of birth, CACP care recipients 2002

Table 3: Country of birth grouping, by entitlement group, CACP care recipients 2002

Entitlement group	Australian-born	Overseas born: English-speaking countries	Overseas born: other countries	Total 70+
		Per cent		
Gold card	92.6	5.7	1.7	100.0
White card	68.2	23.9	8.0	100.0
Gold or white card	90.9	7.0	2.1	100.0
No card	62.4	12.5	25.1	100.0
Total	**65.8**	**11.8**	**22.4**	**100.0**

Source: Table A3.

In addition, the proportion of veterans born overseas in non-English speaking countries would have been influenced by enlistment and deployment policies of WWII. People of non-European descent (regardless of place of birth) were initially prevented from enlisting in the defence forces. During the later stages of that war the enlistment restrictions were eased, but there was still a preference for restricting overseas service for non-Europeans (Hall 1990).

The higher proportion of white cardholder CACP recipients that were born overseas in English-speaking countries probably reflects the eligibility of overseas service personnel for white cards under exchange agreements between the Australian Government and New Zealand, Canada, South Africa and the United Kingdom. Most CACP care recipients with white DVA health care cards who were born in non-English-speaking countries came from Commonwealth countries.

Area of residence

State/territory

Overall around 60% of CACP care recipients lived in New South Wales (36%) and Victoria (25%) and a further 15% lived in Queensland (Table 4 and Table A4). A higher proportion of cardholders lived in Queensland and Victoria compared with non-cardholders (21% and 27% respectively compared with 15% and 25%), while a lower proportion of cardholders lived in New South Wales (32% of cardholders compared with 37% of non-cardholders). These differences were more pronounced for white cardholders than for gold cardholders.

Table 4: State of residence, CACP care recipients 2002

Entitlement group	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
Gold card	32.2	26.6	20.5	5.6	10.4	3.2	0.3	1.2	100.0
White card	27.8	29.5	22.2	5.1	10.2	4.0	1.1	—	100.0
Gold or white card	31.9	26.8	20.6	5.6	10.4	3.2	0.3	1.1	100.0
No card	36.5	24.6	14.6	8.9	10.0	3.2	0.7	1.6	100.0
Total	**35.9**	**24.8**	**15.3**	**8.5**	**10.1**	**3.2**	**0.6**	**1.5**	**100.0**

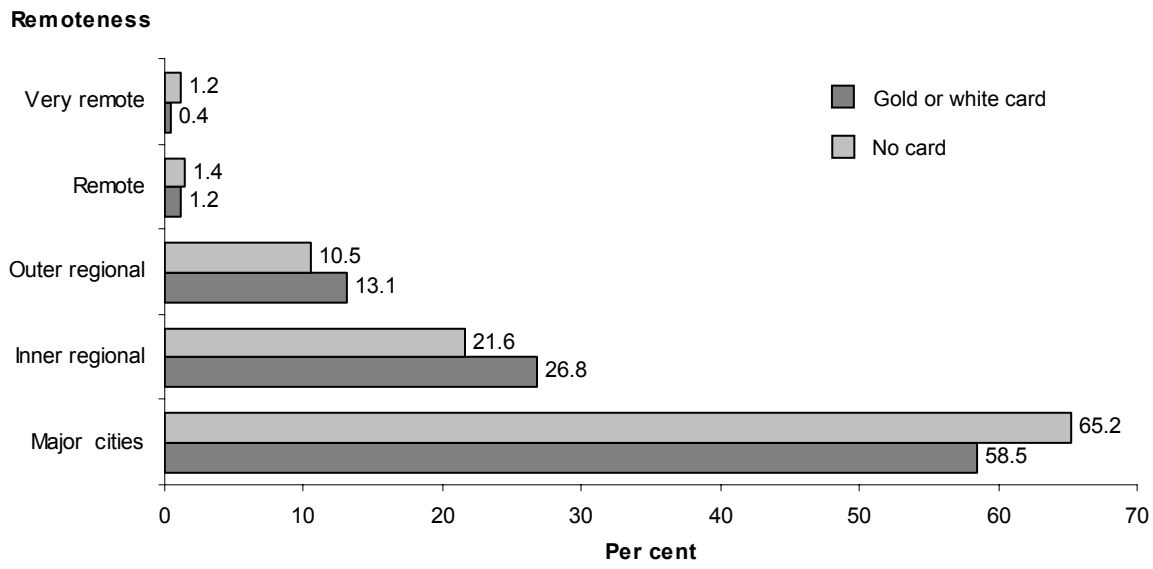
Source: Table A4.

Remoteness

Table A5 shows the proportion of CACP care recipients living in regions categorised by remoteness using the ABS Australian Standard Geographical Classification (ASGC), as derived from the care recipient's postcode. This classification system is based on the distance by road to five categories of service centre (AIHW 2004b).

Care recipients with a gold or white card were less likely to live in major cities than care recipients without a card (59% compared with 65%) or in very remote areas (0.4% compared with 1.2%), and more likely to live in inner regional (27% compared with 22%) or outer regional areas (13% compared with 11%) (Figure 1).

Differences between the genders were minimal with a slightly higher proportion of females living in major cities and a slightly lower proportion in outer regional, remote or very remote areas (Table A5).



Source: Table A5.

Figure 3: Remoteness category, CACP care recipients 2002

Living arrangements

Cardholders were more likely to be living alone (67%) than non-cardholder care recipients (62%), and less likely to be living with family (32% compared with 36%). This was true for both males and females (Table A6).

While male white cardholders were also more likely to live alone than male care recipients without a card (60% compared with 51%), females with a white card were less likely to live alone (53% compared with 66%) and more likely to live with family (45% compared with 32%).

After controlling for age and sex, gold cardholders were 13% more likely to live alone than care recipients who did not hold a DVA health care card. However, the differences for white cardholders were not statistically significant (Table A24).

Accommodation setting

Nearly 90% of CACP care recipients lived in a private residence; predominantly the residence was owned or being purchased (66% of care recipients). Six per cent of care recipients lived in a private residence rented through the private rental market, while 14% lived in community housing or public rental properties (Table 5, Table A7).

There were strong age-related trends for all entitlement groups in respect of accommodation. The proportion of CACP care recipients living in retirement villages[6] or in premises that they owned increased with age, while the proportion living in rental property decreased with age (Table 5). These age trends were apparent both overall and within card entitlement groups.

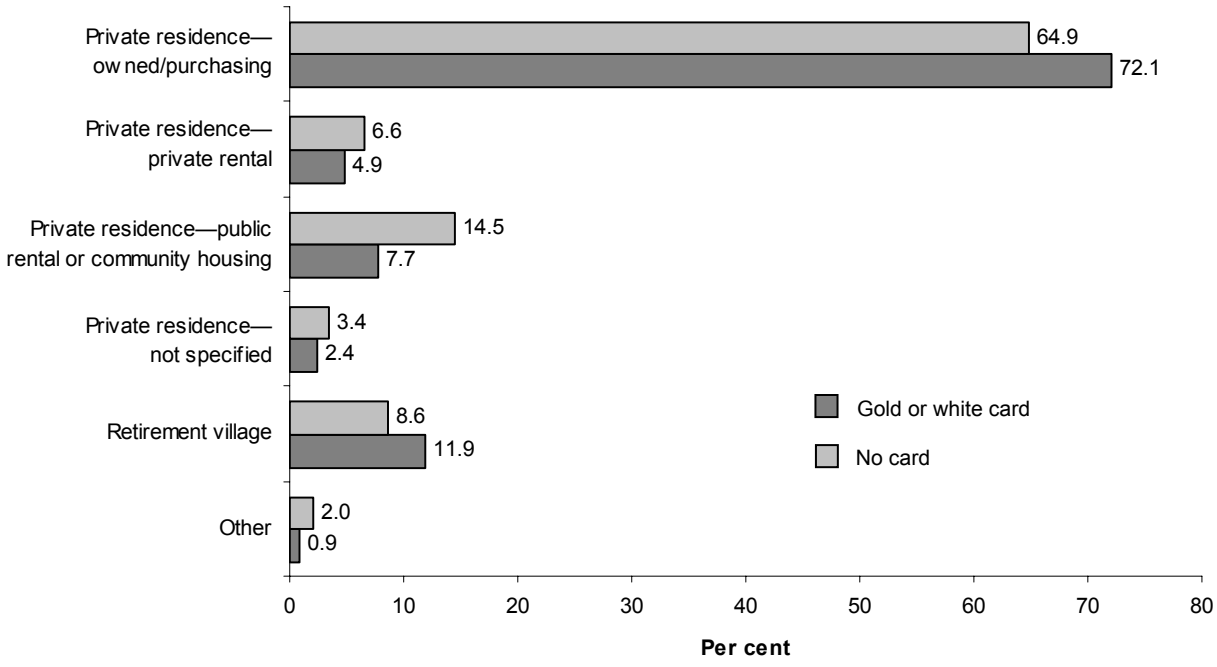
6 Note that retirement village accommodation can be either owned or leased/rented.

Table 5: Accommodation type by age, CACP care recipients 2002

Accommodation type	70–74	75–79	80–84	85+	Total 70+
			Per cent		
Private residence—owned/purchasing	55.9	63.2	67.5	68.8	65.8
Private residence—private rental	9.3	7.3	6.1	5.3	6.4
Private residence—public rental or community housing	25.6	18.0	12.5	8.9	13.7
Private residence—not specified	2.6	3.1	3.5	3.5	3.3
Retirement village	4.3	6.4	8.8	11.7	9.0
Other[(a)]	2.4	2.0	1.6	1.8	1.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes: boarding house/rooming house/private hotel; short-term crisis, emergency or transitional accommodation; public place/temporary shelter/other.

Source: Table A7.



Source: Table A7.

Figure 4: Accommodation type, CACP care recipients 2002

CACP care recipients with a DVA entitlement card were more likely to live in a private residence that they owned or were purchasing or in a retirement village, and less likely to live in a public rental/community housing property than care recipients without a DVA entitlement card (Figure 4). However, the proportion of white cardholders living in a private rental property was similar to care recipients without an entitlement card (7%) (Table A7).

Controlling for age and sex, a comparison of those living in a private residence[7] found that gold cardholders were 11% more likely than care recipients without an entitlement card to own or be purchasing their home rather than renting, and white holders were more 9% more likely to own or be purchasing their home (Table A24).

The higher rate of home ownership for veterans and war widows may be attributable to their access to low interest housing loans. These have been available since 1918 under the War Service Homes Scheme and the Defence Service Homes Scheme. In certain circumstances these subsidised housing loans also can be used to finalise a right of residence in a retirement village (Clarke et al. 2003, page 123). A 1998 survey of veterans and war widows reported that 59% of those surveyed who were living in a house or flat had received assistance through such a loan (DVA 1998).

Financial hardship

Financial hardship for CACP care recipients is defined under the Allocation Principles made under the *Aged Care Act 1997* (DHAC 1999, section 4.4). A person is considered to be in financial hardship if they:

- had not owned a home in the 2 years before becoming a CACP care recipient; and
- was in receipt of either:
  - the maximum basic rate of pension under the Social Security Act 1991, or
  - a pension under Part III of the Veterans' Entitlement Act 1986 and did not receive additional income above the free limit allowed to a person in receipt of the maximum pension under the Social Security Act 1991.8

Overall, 16% of gold cardholders and 18% of white cardholders were reported to be in financial hardship, compared with 28% of care recipients who had no card (Table A8). For all groups, younger care recipients were more likely to be in financial hardship than older care recipients (33% cardholders aged 70–74 years decreasing to 13% of those aged 85 years or older, compared with 42% and 23% respectively for care recipients without a card).

After controlling for age and sex, DVA cardholders were significantly less likely than non-cardholders to be in financial hardship—41% less likely for gold cardholders and 37% less likely for white cardholders (Table A24).

This finding in part reflects the higher rate of home ownership in DVA cardholders (see previous discussion of accommodation setting) and would in part reflect differences in income. However, the CACP census does not provide any information on income.

Nevertheless it is worth noting that some payments to veterans, in particular the disability pension[9], are considered compensation and not income for the calculation of the service pension, which is an income support payment for veterans with qualifying service and is paid through DVA. A small number of veterans, in particular white cardholders, receive

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7 This comparison excluded those residents in a private home where the type of tenure was not stated, as well as other types of accommodation.

8 This definition is paraphrased. Please refer to the Aged Care Principles for the exact definition. Note that a number of payments to veterans are not considered income under the Social Security Act.

9 This is a service related disability pension for veterans, not the Disability Support Pension which is administered by Centrelink (DVA 2004a).

income support through the social security system (age pension), where the disability pension is treated differently and included in assessments for additional social security income support payments. However, the disability pension and war widows' pension are not means tested and not taxable (Clarke et al. 2003). These arrangements may have some influence on the lower rate of financial hardship for cardholders in comparison to non-cardholders.

Need for assistance

Core activity limitations

The CACP census collected information on care recipients' need for assistance with a number of activities. This was used to determine whether the care recipients had a severe or profound limitation in any of the three core areas of daily living: self-care, mobility and communication (Box 2). In the following discussion, when an activity limitation is discussed this is always a severe or profound core activity limitation.

Self-care and mobility limitations were the most common severe or profound core activity limitations observed among CACP care recipients (65% and 70% of care recipients respectively), with communication the least common (14% of care recipients) (Table A9).

After controlling for age and sex, no significant differences were found between cardholders and care recipients without a card for mobility or self-care limitations. However gold cardholders were found to have a significantly lower prevalence relative risk of having a communication limitation when compared with care recipients without a DVA entitlement card. White cardholders had a slightly higher, but not statistically significant, risk of having a communication limitation (Figure 5, Table A24).

Box 2: Severe or profound core activity limitations

In the CACP census, a person is considered to have a severe or profound core activity limitation if they sometimes or always need the assistance or supervision of another person to carry out any of a number of tasks. The core activities are:

- ***Self-care** tasks — eating; showering or bathing; dressing; toileting; and managing incontinence.*
- ***Mobility** tasks — maintaining or changing body position; carrying, moving or manipulating objects related to the tasks of daily living; getting out of a bed or chair; walking and related activities.*
- ***Communication** — understanding others or making oneself understood by others.*

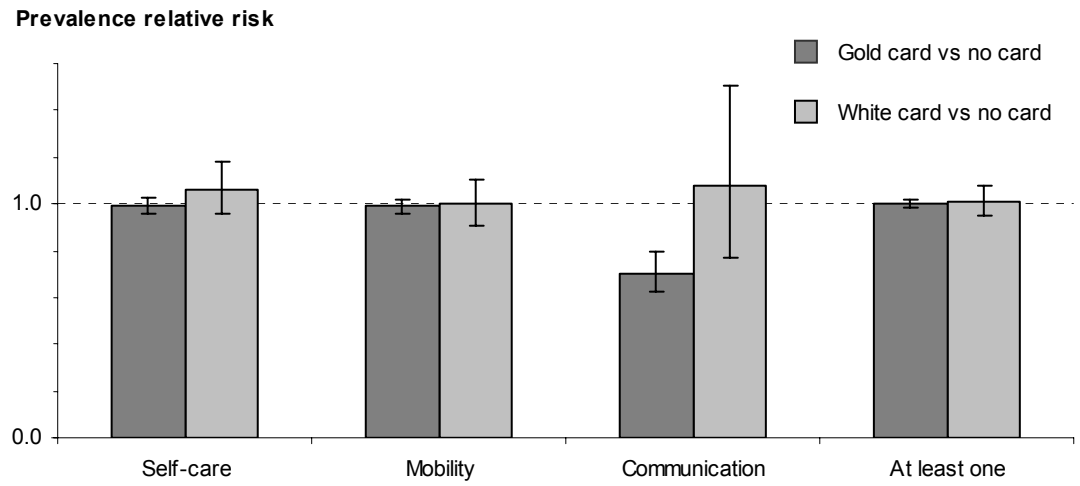
This definition is consistent with that used in the ABS Survey of Disability, Ageing and Carers (ABS 1998) and the International Classification of Functioning (WHO 2001).

Note that, while information was collected on the need for assistance or supervision with use of public transport, by itself this is considered to be a mild core activity limitation.

Self-care

Almost two-thirds (65%) of care recipients had a severe or profound self-care limitation (Table A9). There was little or no difference in the proportion of care recipients with a severe or profound self-care limitation when comparing the sex or entitlement groups (around 64–65%). White cardholders had a slightly higher proportion of recipients with a self-care limitation (68%) (Figure 5, Table A9).

This similarity between entitlement groups remained after controlling for age and sex (Figure 5, Table A24), except for white cardholders who were 6% more likely to have a self-care limitation. However, this difference was not statistically significant.



Source: Table A24.

Figure 5: Prevalence relative risk of severe or profound core activity limitations, CACP care recipients 2002

Mobility

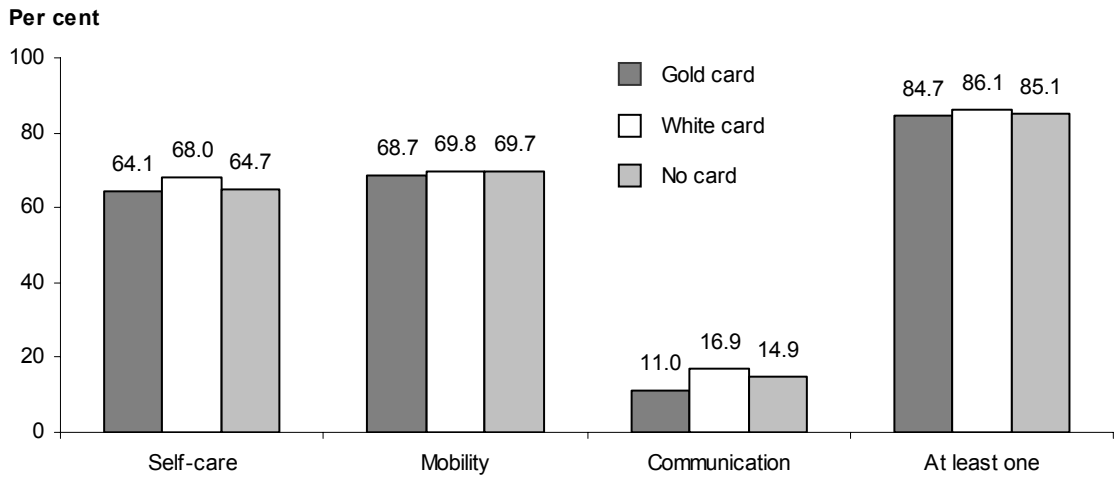
Overall, 70% of care recipients reported a severe or profound mobility limitation. The proportion with a mobility limitation was slightly higher for females (70%) than for males (68%) (Table A9). The proportion with a mobility limitation was similar across most age and entitlement groups.

After controlling for age and sex, the risk of a mobility limitation for gold cardholders and for white cardholders did not differ from the risk for care recipients without a card (relative risk 0.99 and 1.00 respectively) (Figure 5, Table A24).

Communication

Care recipients are considered to have a severe or profound communication limitation if they sometimes or always need assistance understanding others or making themselves understood by others. People who communicate independently using hearing aids, speech aids, or interpreters are not considered to have a severe or profound communication limitation.

Twelve per cent of cardholders (gold card 11%, white card 17%) had a communication limitation compared with 15% of care recipients without a card. In all entitlement groups, a higher proportion of males (18%) had a severe or profound communication limitation than females (13%) (Figure 6, Table A9).



Source: Table A9.

Figure 6: Severe or profound core activity limitations, by DVA entitlement group, CACP care recipients 2002

After controlling for age and sex, the prevalence of a communication limitation for gold cardholders was 30% lower than for non-cardholders (relative risk of 0.70 (0.62–0.80)). This difference was statistically significant. For white cardholders the prevalence of a communication limitation was slightly higher (8%) than for non-cardholders but was not statistically significant (Figure 5, Table A24).

This result is surprising considering there is a high incidence of hearing damage in service personnel. However, if this has been corrected with the use of hearing aids it would not be included as a severe or profound communication limitation. Conditions which might be expected to result in a communication limitation would include stroke, acquired brain injury and dementia. However, the incidence of these conditions in veterans does not significantly differ from non-veterans (DVA, personal communication).

Another possible explanation is that, overall, veterans with a communication limitation have higher care needs than those in the general community with a communication limitation, as a result of other service-related impairments. This could result in selective movement of veterans with a communication limitation to either residential care or high-level community care (EACH packages), and hence a lower proportion of veterans with a communication limitation in the CACP population. AIHW studies looking at other aspects of aged care service use by veterans with health care entitlement cards may shed further light on this issue.

Number of core activity limitations

Overall, 85% of care recipients had at least one severe or profound core activity limitation with little difference between the sexes (84% for males compared with 86% for females) (Table A9). Nearly half of the care recipients (44%) had two core activity limitations, an additional 31% had one, and 10% had all three core activity limitations. The only clear age-related pattern observed was the increasing proportion of care recipients with at least one severe or profound core activity limitation seen with increasing age (Table A10).

After controlling for age and sex the risk of gold or white cardholders having at least one core activity limitation did not differ from the risk for care recipients without a card (relative risk 1.00 and 1.01 respectively) (Figure 5, Table A24).

Dementia

Nineteen per cent of care recipients had a formal diagnosis of dementia with a similar rate for males and females (Table A11). The rates of dementia increased with age and peaked in the 80–84 age group before decreasing again among those 85 years or older. The lower rate in the older age group may occur because of increased care needs resulting from more severe dementia or because increased co-morbidities at older ages results in selective removal of these people from the population receiving CACP assistance. When a CACP can no longer provide the support needed, care recipients may then move to either an EACH package or residential care, both of which provide a higher level of care.

While this pattern was consistent across entitlement groups, there were small differences between cardholders and non-cardholders with a lower rate of dementia for younger aged cardholders (10% compared with 15%) and a slightly higher peak for the 80–84 year old cardholders (22% compare with 21%). This difference was more noticeable for women (24% of cardholders compared with 21% of non-cardholders).

Overall, after controlling for age and sex, the risk of dementia for DVA cardholders was similar to that for non-cardholders (Table A24).

Carers

Carer availability

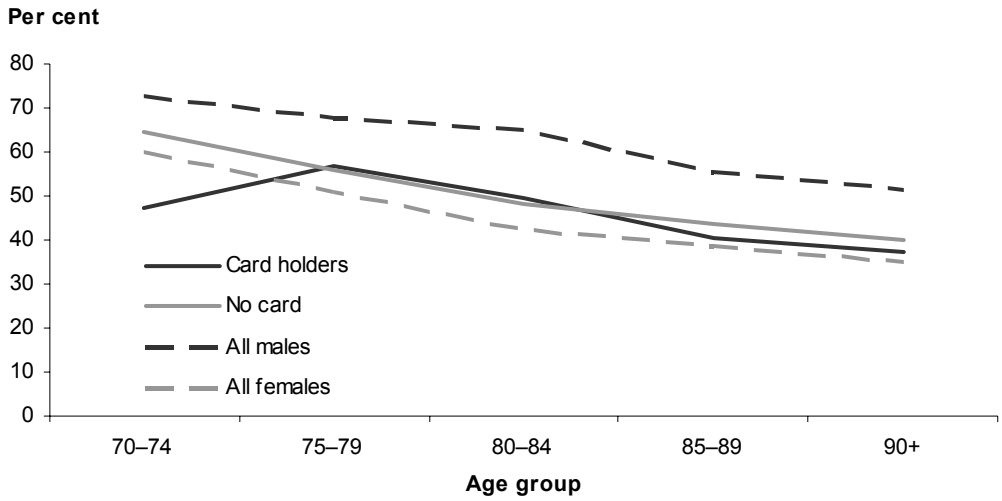
The majority of CACP care recipients had a carer (54% of gold cardholders, 63% of white cardholders and 58% of non-cardholders). With the exception of white cardholders where females were more likely than males to have a carer (64% of females compared with 61% of males), male care recipients were more likely to have a carer than females (57% of male gold cardholders and 61% of males without a card, compared with 52% and 57% respectively of females). Older care recipients were more likely to have a carer than younger care recipients (Table A12).

After controlling for age and sex, gold cardholders were 9% less likely to have a carer than care recipients without a card (relative risk 0.91) (Table A24). This was statistically significant. In contrast, white cardholders generally had a slightly higher likelihood of having a carer (6%), but this difference was not statistically significant.

Carer co-residency

Less than half of carers of DVA gold cardholders lived with the person they cared for (47%), while 52% of carers of white cardholders lived with the care recipient. A similar proportion (49%) of carers of non-cardholders lived with the care recipient (Table A13). The carer was more likely to live with a male care recipient (59% of cardholders and 63% of non-cardholders) than with a female care recipient (38% of cardholders and 44% of non-cardholders). The proportion of co-resident carers decreased with age for both cardholders and recipients without a card (Figure 7, Table A13).

After controlling for age and sex, gold cardholders were 9% less likely to have a co-resident carer than care recipients without a card, while the proportion of carers who lived with white cardholders was similar to that of care recipients without a card (Table A24).



Source: Table A13.

Figure 7: Co-residency status of carers, CACP care recipients 2002

Carer relationship

The pattern of carer relationship differed according to sex, but does not appear to differ among entitlement groups (Table 6, Table A14).

For males, the carer was most likely to be the care recipient's spouse (cardholders 48%, non-cardholders 50%). An additional 40% were cared for by their child or their child's spouse, while only a small proportion were cared for by other relatives (cardholders 7%, non-cardholders 6%) or by friends or neighbours (cardholders 6%, non-cardholders 5%). For females, nearly two-thirds (64%) were cared for by their child or child's spouse with only 22% cared for by their spouse.

Table 6: Relationship of carer to care recipient, CACP care recipients 2002

	Spouse	Child or child's spouse	Other relative	Friend or neighbour
		Per cent		
Males				
Gold card	47.4	39.5	7.0	6.1
White card	50.0	38.6	6.8	4.6
No card	49.7	40.0	5.7	4.6
Females				
Gold card	21.0	66.8	6.7	5.5
White card	39.1	50.0	6.3	4.7
No card	22.1	64.2	8.3	5.4

Source: Table A14.

For gold cardholders, the relationship of the carer was similar to care recipients without a card for both males and females. The proportion of female white cardholders cared for by a child or child's spouse was lower (50%) while the proportion cared for by a spouse was higher (39%).

In all entitlement groups the proportion of care recipients aged 75 or older being cared for by their spouse decreased as the age of the care recipient increased, and the proportion being cared for by their children or children's spouses increased. Among cardholders, the proportion of care recipients aged 70–74 years being cared for by their child or child's spouse was higher than that for those aged 75–84 years, but lower than that for those aged 85 years or older (Table 7).

Table 7: CACP care recipients cared for by their spouse, child or child's spouse, by age, 2002

Carer relationship/entitlement group	70–74	75–79	80–84	85+
		Per cent within age group		
Child or child's spouse				
Gold card	54.8	51.8	50.7	59.9
White card	50.0	37.1	44.4	54.3
No card	41.0	52.3	58.1	65.1
Spouse				
Gold card	38.7	40.1	37.6	23.9
White card	50.0	60.0	38.9	31.4
No card	47.0	37.6	29.9	20.2

Source: Table A14.

Service use

CACP service utilisation rates

The utilisation rate is a measure of the extent to which services are used by the target group, and is used to look at differences in access to services by the different entitlement groups.

Because this study has been restricted to those care recipients with known age, sex and card status, utilisation rates based on the care recipients included in the study only provide a minimum utilisation rate. While we are certain that the care recipients are allocated to their correct entitlement groups, this is achieved at the expense of full enumeration and can only provide an underestimate of the true utilisation rates.

An estimate of the possible (maximum) utilisation rates has been done by pro-rating all missing data for sex, card entitlement, DVA status, and age, in that order (Table A15). The estimated maximum rates assume that the missing data has a similar distribution to the known data, sacrificing certainty of entitlement group for a closer approximation of the actual utilisation rates. The higher estimates, which pro-rate missing data, are more likely to approximate the actual usage rate than the lower rates.

The data used to calculate the minimum and estimated maximum utilisation rates are presented in Tables A2, A15 andA16. Overall base populations used to calculate utilisation rates are presented in Table A16.

Table 8: Crude utilisation rates per 1,000 population aged 70 years or over, Community Aged Care Packages 2002

	Male		Female		Persons	
Entitlement group	Min.	Max.	Min.	Max.	Min.	Max.
Gold card	7.0	9.2	12.3	17.2	9.4	12.7
White card	4.0	5.1	32.2	44.8	8.1	10.9
Gold or white card	6.7	8.7	12.9	18.0	9.3	12.5
No card	7.6	8.0	14.8	15.5	11.9	12.5
Total	7.4	8.1	14.6	15.8	11.5	12.5

Note: Utilisation rates are calculated per thousand of the relevant population group. For example, the utilisation rate for gold cardholders is the number of CACP care recipients with a gold card per thousand gold cardholders in the Australian population.

Source: Table A17, Table A18.

The crude utilisation rate for all CACP care recipients aged 70 or older is estimated to be between 11.5 and 12.5 per 1,000 of the population aged 70 or older (Table 8). The upper limit for the estimated crude utilisation rate for both cardholders and non-cardholders is the same (12.5 per thousand) but the range is wider for cardholders with a lower estimated minimum utilisation rate of 9.3 per 1,000 DVA cardholders aged 70 or older, compared with 11.9 per 1,000 for care recipients without a card.

The estimated crude utilisation rate for white cardholders was lower than for gold cardholders—between 8.1 and 10.9 per 1,000 white cardholders aged 70 or older compared with an estimate of between 9.4 and 12.7 per 1,000 gold cardholders aged 70 or older.

For all groups and in all age ranges the utilisation rates for women were higher than for men. The utilisation rates for women were commonly around one-and-a-half times to twice the rate for men, with the exception of female white cardholders where the estimated crude

utilisation rate was between 32 and 45 per 1,000 compared with between 4.0 and 5.1 per 1,000 for male white cardholders (Table 8, Tables A17 and A18).

Table 9: Age and sex standardised utilisation ratios, compared with population without a DVA entitlement card, Community Aged Care Packages 2002

	Based on minimum utilisation rates			Based on maximum utilisation rates		
Entitlement group	Usage ratio	Lower CL	Upper CL	Usage ratio	Lower CL	Upper CL
Gold card	0.65	0.62	0.68	0.83	0.80	0.86
White card	0.68	0.58	0.78	0.86	0.76	0.98
Gold or white card	0.65	0.62	0.68	0.84	0.81	0.86

Note: Rates calculated using indirect standardisation, and overall utilisation rates for all CACP care recipients (CL= 95% confidence interval limit).

After controlling for age and sex, the utilisation rate for DVA health care cardholders was 16% to 35% lower than for care recipients without a card (Table 9). It must be recognised that utilisation of services may depend on many things such as accessibility, acceptability and appropriateness. Possible reasons for the different utilisation of CACPs by DVA cardholders include:

- preference for DVA programs, for example Veterans' Home Care (VHC) and veterans nursing services
- choosing different community care services (for example VHC and HACC) because of an increased cost associated with CACPs
- lack of understanding about general community programs among veterans
- a possible selection bias
- possibly higher dependency levels of DVA cardholders of the same age and sex, resulting in a need for higher care levels than can be provided through CACPs.

As stated in the introduction, the CACP Program is only one of a number of aged care programs. Some veterans prefer to receive assistance through the Department of Veterans' Affairs. DVA cardholders have access to community care through both Veterans' Home Care, HACC and any other community care programs available to the general community, as well as to a wide range of medical and allied health services.

Cost may be a factor in the decision on whether to take up a Community Aged Care Package. At the time of the census, CACP care recipients on a basic pension were expected to pay up to $5.16 per day ($36.12 per week) and slightly more for those on a higher income. There is a perception that VHC and HACC are less costly than CACPs. Veterans have access to up to 196 hours of either in-home or residential respite care with no co-payment (DVA 2001), and not all VHC agencies charge for personal care (personal communication from service providers). For HACC the National Fees Policy includes an assessment of the care recipients' capacity to pay, an ability to waive fees for those unable to pay, and a fees cap for care recipients who receive multiple services from HACC providers. This policy has been endorsed by all states and territories and, in 2002–03, some states had set a cap of $10 or $20 per week (Tasmanian Department of Health and Human Services 2003 p. 11, WA Health 2002 p. 2, Legislative Assembly for the ACT 2003 p. 394). Most other states had not stipulated a specific fees cap.

Concern has also been expressed that lower utilisation rates may reflect access difficulties for veterans in respect of general community programs. While veterans are considered a special needs group and the contracts between the Department of Health and Ageing and the CACP

service providers specify that certain packages must be given to veterans, the majority of packages are classified as 'general' packages. Where a service provider has to choose between a care recipient with more restricted access to other support and a person who can also access assistance from DVA, there may be some bias towards people without access to DVA services. However, data are not available to assess this concern.

Alternatively, veterans as a whole may have a higher dependency level than those in the general population and this could result in a higher utilisation of residential aged care or EACH packages. The EACH Program provides care in their own homes to care recipients who would be eligible for high-level residential care. EACH packages include access to nursing care and allied health care, assistance which is not funded through the CACP Program. However, at the time of the census this was a very small program with less than 300 packages.

This study is one of a number of projects underway which are looking at aged care service use by DVA health care entitlement cardholders. When these are completed they may shed further light on the reasons for the lower utilisation of CACPs by DVA health care entitlement cardholders. In particular, information on utilisation rates for low- and high-level residential care and on dependency levels of veterans in residential care could be useful for determining the reasons for the lower utilisation of CACPs.

Duration of subsidy

The average duration of subsidy for all entitlement groups was 21 to 22 months. While the average duration was slightly longer for females (22–23 months) than for males (20–21 months) there were no clear age-related trends in any entitlement group (Table A19).

CACP assistance

A CACP provides a package of assistance which includes a care coordinator who manages the complex care needs of the care recipients and arranges provision of the assistance available as part of the package. Definitions of the types of assistance available through the package are provided in Appendix 2.

The CACP census gives a snapshot of the service provided to care recipients during the census week and captures only what was provided in that week. Not all types of assistance are provided each week. For instance, all care recipients receive assistance from a care coordinator but in any one week this will not be needed by some care recipients, either because they are on leave or because there is no need for any adjustment to the assistance they are receiving. This analysis excludes care recipients who were on leave for all or part of the census period. This removes any bias introduced by the alteration of patterns of care during periods of leave.

In addition, only assistance funded under the CACP Program is included here; any additional assistance that is privately funded or provided through other government programs is excluded.

Types of CACP assistance received

The most common types of assistance received by care recipients during the census week were domestic assistance (88% of care recipients), followed by CACP case management/care coordination (74%), social support (64%) and personal care (58%). There was little difference between the entitlement groups in the proportion of care recipients receiving each type of assistance, nor in the order of types of assistance when ranked from most to least commonly received (Table 10).

Table 10: CACP assistance type received during census week, CACP care recipients 2002

Type of assistance	Gold card	White card	Gold or white card	No card	Total
Domestic assistance	88.9	88.7	88.9	88.2	**88.3**
CACP case management/care coordination	73.8	81.1	74.3	73.8	**73.8**
Social support	62.9	61.6	62.8	63.8	**63.7**
Personal care	55.7	56.6	55.7	58.0	**57.8**
Transport	37.1	37.7	37.2	37.8	**37.7**
Meal preparation/other food services	34.2	32.7	34.1	30.9	**31.3**
Delivered meals	29.1	26.4	28.9	21.6	**22.5**
Home maintenance	17.9	13.2	17.6	15.9	**16.1**
Temporary respite care	3.7	6.3	3.8	4.6	**4.5**
Rehabilitation support	1.9	1.9	1.9	2.4	**2.3**
Formal linen service	0.9	0.0	0.9	0.9	**0.9**

Note: Care recipients who were on leave during all or part of the census, or for whom age, sex, or DVA entitlement group were not known are excluded from this table.

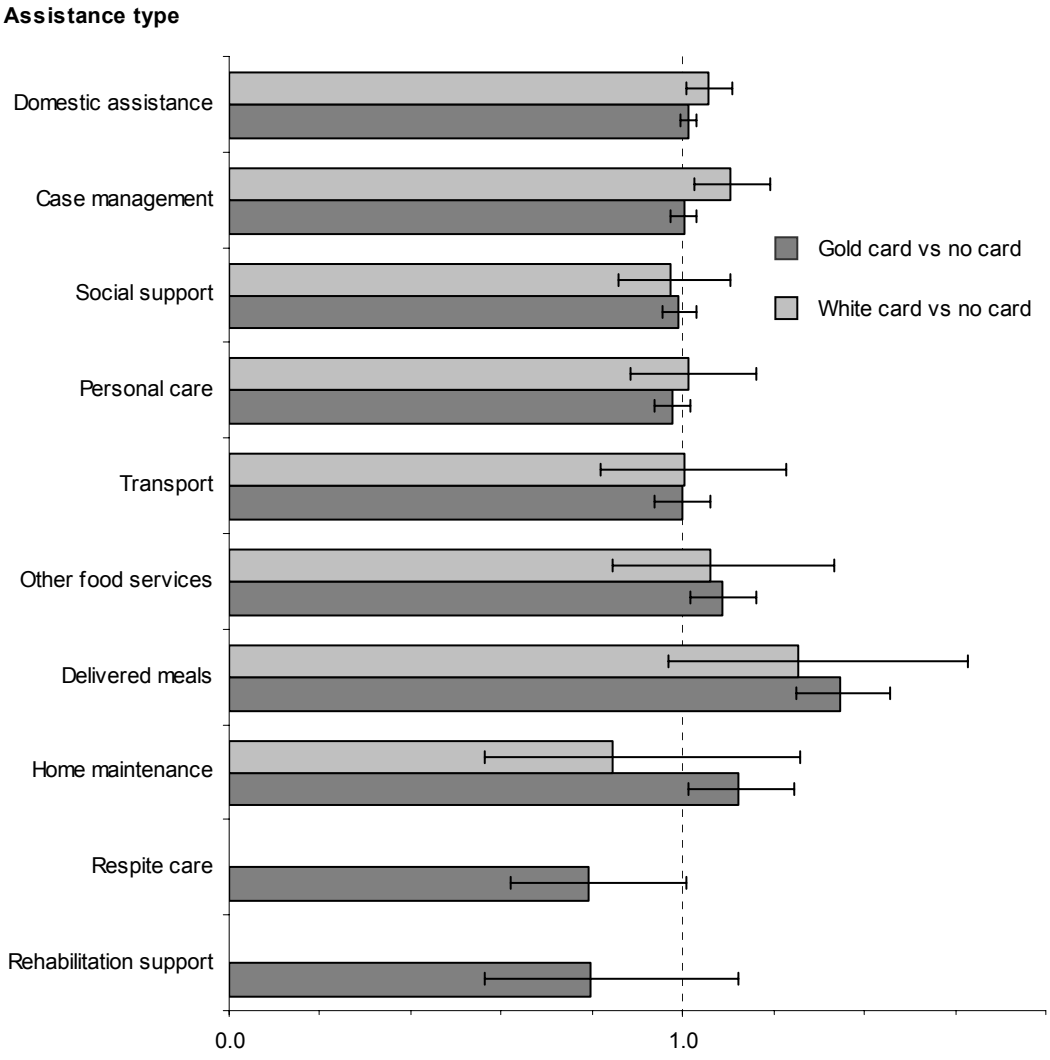
Source: Table A20.

Figure 8 shows the relative risks of gold and white cardholders compared with non-cardholders for each type of assistance, after controlling for age and sex.

For gold cardholders the types of assistance where there was a significant difference to the assistance received by care recipients without a card were delivered meals, meal preparation/other food services and home maintenance (Figure 8, Table A24). Gold cardholders were 35% more likely to be receiving delivered meals, 9% more likely to be receiving assistance with the preparation, cooking and storage of meals in the care recipients' own homes (other food services), and 12% more likely to be receiving assistance with home maintenance.

Gold cardholders were also around 20% less likely to receive rehabilitation support and respite care although these differences were not statistically significant.

For white cardholders significant differences were found with domestic assistance and case management/care coordination. White cardholders were 11% more likely to have received assistance from their case managers or care coordinators during the census week and 6% more likely to have received domestic assistance. For domestic assistance this increase was strongest for those over 80 years of age. Differences that were not statistically significant were a 26% higher likelihood of receiving delivered meals, a 6% higher likelihood of receiving other food services and a 16% lower likelihood of receiving home maintenance services. The numbers of white cardholders were too small to calculate the relative risks for



Source: Table A24.

Figure 8: Likelihood of receiving CACP assistance types for cardholders compared with non-cardholders, CACP care recipients 2002

respite care and rehabilitation support. In addition, the numbers of care recipients using formal linen services were to small in all groups to calculate an age- and sex-standardises relative risk for either gold or white card holders compared to non-cardholders.

Amount of CACP assistance

There was little difference in the total hours of assistance received by the different entitlement groups. Gold cardholders received an average of 6 hours 24 minutes assistance during the census week, while white cardholders and care recipients without a card received an average of 6 hours 15 minutes (Table 11, Table A21).[10]

10 Amounts of service reported in this study will differ slightly from those reported in the full report of the census because of the exclusion of care recipients with missing data from the study and the exclusion of care recipients who were on leave from the calculation of average amounts of assistance.

When considering individual assistance types, the amount of service received was similar with the following exceptions. On average:

- gold cardholders received more respite care (3 hours 52 minutes) than care recipients without a card (nearly 3 hours 12 minutes) while white cardholders received less (2 hours 18 minutes)
- gold cardholders received more rehabilitation support (1 hour 28 minutes) than those without a card (1 hour 19 minutes) while white cardholders received less (50 minutes)
- transport assistance for gold cardholders and those without a card was nearly 3 one-way trips in the census week, and just over 2 one-way trips for white cardholders.

Table 11: Average amount of CACP assistance, by assistance type, CACP care recipients 2002

Assistance type (units)	Gold card	White card	Gold or white card	No card	Total
Temporary respite care (h:mm)	3:52	2:18	3:41	3:12	3:15
Personal care (h:mm)	2:23	2:22	2:23	2:20	2:20
Domestic assistance (h:mm)	2:19	2:20	2:19	2:14	2:14
Social support (h:mm)	2:10	2:04	2:10	2:10	2:10
Meal preparation/other food services (h:mm)	1:46	1:38	1:46	1:40	1:41
Rehabilitation support (h:mm)	1:28	0:50	1:25	1:19	1:19
Home maintenance (h:mm)	1:58	0:51	1:58	1:00	1:00
CACP case management/care coordination (h:mm)	0:41	0:41	0:41	0:40	0:40
Total hours (h:mm)	**6:24**	**6:15**	**6:23**	**6:16**	**6:17**
Delivered meals (meals)	6.4	5.7	6.3	6.1	6.3
Transport (one-way trips)	2.8	2.2	2.7	2.9	2.9
Formal linen service (deliveries)	1.5	—	1.5	1.8	1.8

Note: Care recipients who were on leave during all or part of the census were excluded from this table.

Source: Table A21.

Assistance from other government programs

Other government programs

Forty per cent of CACP care recipients in this study also received community care assistance from government programs other than the CACP Program. This includes the Home and Community Care Program, the National Respite for Carers Program, Day Therapy Centres, the Continence Assistance Scheme and the Commonwealth State/Territory Disability Agreement, as well as assistance from DVA (Table 12).

DVA cardholders are able to access a wide range of medical, paramedical and community care assistance which are provided by DVA, in addition to government programs which are available to the general community. Examples of assistance to veterans include access to community nurses, the Veterans' Home Care Program (domestic assistance, personal care, home and garden maintenance, respite care, delivered meals, and community transport) (DVA 2002a), the Rehabilitation Appliances Program (DVA n.d.a), the Veterans' Home

Maintenance Helpline, Homefront (an annual home assessment program aimed at preventing falls and accidents by providing information on home modification), the Home Support Loan Program (subsidised loans for home modification and maintenance) (Clarke et al. 2003) and a wide range of medical and allied health services (see Appendix 4).

Table 12: Receipt of services from other government programs, CACP care recipients 2002

Entitlement group	DVA	HACC	NRCP	CAAS	CSDA	DTC	Other	Total	Total care recipients aged 70+
				Per cent					Number
Gold card	37.8	18.1	1.0	1.1	0.0	3.0	7.2	54.7	2,195
White card	15.3	23.5	0.0	4.7	0.0	2.4	7.6	44.7	170
Gold or white card	36.2	18.5	1.0	1.4	0.0	2.9	7.2	54.0	2,365
No card	0.3	20.2	1.1	1.8	0.3	3.4	8.8	30.9	17,346
Total	**4.6**	**20.0**	**1.1**	**1.7**	**0.2**	**3.3**	**8.6**	**40.2**	**19,711**

Note: Care recipients can receive assistance from more than one program.

Source: Table A22.

Thirty-eight per cent of CACP care recipients with a gold card and 15% of recipients with a white card received assistance from DVA (Table 12). Around 20% of all care recipients received assistance from HACC (18% of gold cardholders, 24% of white cardholders, and 20% of non-cardholders).

Table 13: Receipt of services from other government programs excluding and including assistance from the Department of Veterans' Affairs, CACP care recipients 2002

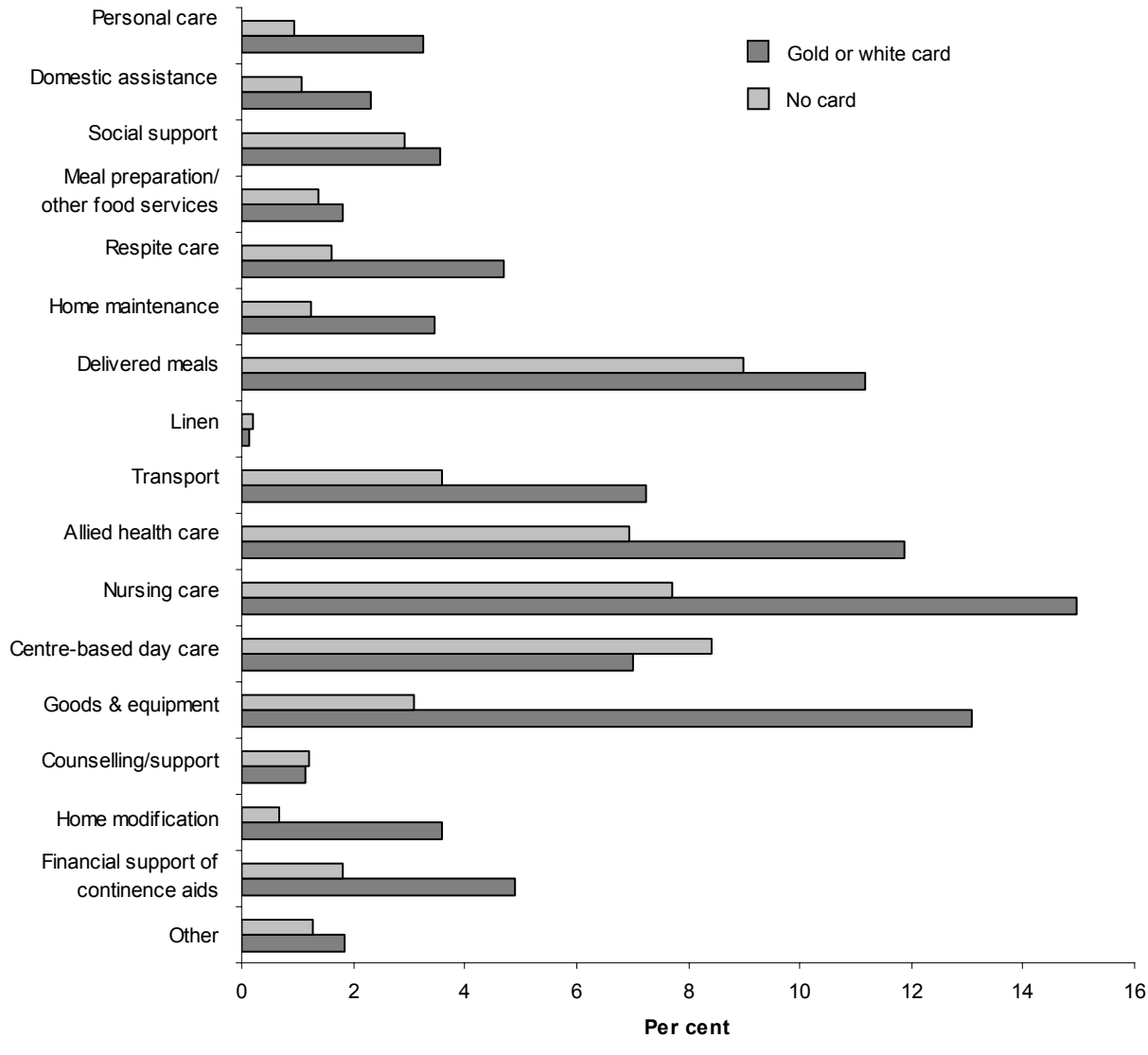
Entitlement group	Other government programs, but no assistance from DVA	Any government program (other than CACP)	Total care recipients aged 70+
	Per cent		Number
Gold card	27.4	54.7	2,195
White card	32.9	44.7	170
Gold or white card	27.8	54.0	2,365
No card	30.7	30.9	17,346
Total	**30.4**	**40.2**	**19,711**

Note: Care recipients can receive assistance from more than one program.

Overall, the proportion of CACP care recipients receiving assistance from any other government program was higher for DVA health care entitlement cardholders (55% of gold cardholders, 45% of white card cardholders) than for care recipients without a card (31%) (Tables 13 and A22). However, the proportion of CACP care recipients receiving additional assistance from government programs other than DVA is roughly similar for all entitlement groups (27% of gold cardholders, 33% of white cardholders and 31% of non-cardholders), indicating that the assistance from DVA is the main reason that a higher proportion of CACP cardholders receive additional assistance compared with non-cardholders (Table 13).

Types of assistance from other government programs

With the exception of delivered meals, the most frequently reported assistance types received by CACP recipients from other government programs are those that are not available through the Community Aged Care Package Program. These are nursing care (9%), centre-based day care (8%), and allied health care (8%). Cardholders are more likely to have accessed allied health care (12% compared with 7%) and nursing care (15% compared with 8%) than care recipients without an entitlement card. They are also more likely to have received home modification assistance than non- cardholders (4% compared with 1%). Cardholders are also more likely to have been provided with goods and equipment (13% compared with 3%). Note that the proportion of white cardholders accessing these services is generally lower than for gold cardholders (Figure 9, Table A23).



Source: Table A23.

Figure 9: Types of assistance from other government programs, CACP care recipients 2002

Nine per cent of care recipients were reported to be receiving delivered meals through a program other than the CACP Program (11% for cardholders and 9% for care recipients without a card). The proportion of care recipients reported to be receiving other types of assistance that are available through CACPs ranged from less than 1% (formal linen services) to 4% (transport services).

Generally, the proportion of gold cardholders receiving additional government assistance was higher than for care recipients without a card; the exception to this was centre-based day care (7% compared with 8%).

Conclusion

While there are some distinct differences between veterans with a gold and white card who are receiving assistance from the CACP Program and care recipients without a DVA health care entitlement card, there are many similarities.

The main differences observed in the sociodemographic profile of care recipients who were cardholders are: an older age structure, a higher proportion of care recipients born in Australia, a higher rate of home ownership, a lower rate of financial hardship and less access to a carer.

In terms of dependency, cardholders had a similar profile to non-cardholders, with the exception of a lower rate of severe or profound communication limitation.

Cardholders had a significantly lower rate of utilisation of community aged care packages, although the type and amount of assistance received by cardholders and non-cardholders from the CACPs were generally similar. However, a higher proportion of CACP recipients who were cardholders received additional assistance from other government programs, compared with non-cardholders, largely as a result of their access to assistance from DVA.

The CACP Program is only one of a number of government-funded aged care programs, and should not be considered in isolation. This study has raised questions, in particular about the reasons for differences in the utilisation rate of CACPs by veterans and in the level of severe and profound communication limitation. These differences may be associated with the level of cardholders' access to other forms of aged care. Projects which are looking at the use of other aged care services such as HACC and residential care by DVA health cardholders may shed light on these differences.