1 Introduction

Background

This report summarises the data collected in the census of the Community Aged Care Packages (CACP) Program conducted by the Australian Institute of Health and Welfare (AIHW) during the period 16 September 2002 to 14 October 2002. The census was undertaken by the AIHW for the Australian Government Department of Health and Ageing (DoHA). The aim of the project was to gather data about CACP recipients, the assistance that they receive and providers of CACP assistance, to provide an information base for planning and policy development.

Before the conduct of the census, there was a limited amount of information collected by DoHA relating to Community Aged Care Packages. The only ongoing information about the Program is derived from administrative information provided by the Aged and Community Care Management Information System (ACCMIS) maintained by DoHA, and is based on Aged Care Assessment Team (ACAT) forms and subsidy claim forms submitted by service providers each month. This information is used to produce the annual publication *Community Aged Care Packages in Australia – A statistical overview,* commencing in 1998–99, which is available in hard copy or from the AIHW web site <http://www.aihw.gov.au/publications/index.cfm>. CACP data has also been published in a 1996 comparison of the CACP and Community Options programs (AIHW: Mathur, Evans & Gibson 1997) and following a 1999 survey of CACPs in NSW and the ACT (DHAC 1999).

It was intended that the data from the census be consistent with and comparable to national standards and relevant information in the health and community services field, and data definitions and census forms have been developed by the AIHW within this context. This census was one of three conducted in 2002 by AIHW for DoHA. The other two censuses, relating to the Extended Aged Care at Home (EACH) Program and the Day Therapy Centre (DTC) Program, also related to Australian Government programs that provide services to frail or disabled older people that enable them to continue to live in the community where possible.

The Community Aged Care Packages Program

The CACP Program commenced in 1992–93, when the total number of approved packages was 527 (AIHW: Mathur, Evans & Gibson 1997). A CACP is a planned and coordinated package of community care services to assist a person who requires management of services because of their complex care needs. CACPs are targeted at frail older people living in the community. These people would otherwise be eligible for at least low level residential care.

People become eligible for a CACP after being assessed by an ACAT and approved to receive a care package. The eligibility criteria are specified in the *Aged Care Assessment and Approval Guidelines*, issued by DoHA (DoHA 1999a). The aim of the CACP Program is to provide a wide range of services such as bathing, showering or personal hygiene, toileting, dressing or undressing, mobility, transfer, preparing and eating meals, laundry, home help, gardening and assistance with short-term illness, sensory communication or fitting sensory communication aids. The CACP Program does not provide funding for home nursing services or allied health services which are accessible to CACP care recipients though the Home and Community Care (HACC) Program. Centre-based day care services are available to CACP care recipients through other programs such as HACC on a full cost recovery basis.

Under the *Aged Care Act 1997* (the Act), a number of special needs groups have priority access to CACPs. These include people:

(a) from non-English speaking backgrounds

(b) from Aboriginal and Torres Strait Islander communities

(c) who live in rural or remote areas

(d) who are financially or socially disadvantaged

(e) who are veterans or war widows.

Housing Linked Care Packages have the same eligibility criteria as general care packages. They are targeted at persons with financial hardship living in designated rental housing developments. These could range from congregate settings with high concentrations of aged people, such as boarding houses, or detached public housing spread across a particular suburb. CACPs are not generally available to people living in supported accommodation (DoHA 1999b).

The planning process for the allocation of places for the CACP Program is based on the non-Indigenous population of 70 years and over and the population of Indigenous Australians 50 years and over, in line with the planning for residential aged care places. In legislation, there is no lower age limit. However, younger people would more commonly be provided with community care assistance through the Home and Community Care Program (HACC) or the Commonwealth-State/Territory Disability Services Agreement, as the CACP Program is not resourced to provide services to these groups. Younger people would generally only be assessed for a CACP if they had already been assessed by more appropriate service providers and there were clearly no other care alternatives in the area. In such circumstances younger people with a disability may be considered for a package if they need the intensity, type and model of care a CACP can provide and meet the eligibility criteria.

CACPs must be provided by Approved Providers under the Act. Approved Providers are allocated a specified number of packages on the basis of their application forms submitted as part of the Australian Government's Aged Care Approvals Rounds. Services are delivered through one or more service outlets operated by the Approved Providers. At the time of the census the annual cost of the CACP Program was $288.3 million (2002–03). The CACP daily subsidy rate paid to

service providers at the time of the census was $30.73 per day per operational package. In addition, care recipients could be asked to make a contribution. For those on a basic pension, this may be up to 17.5% of the basic pension, excluding the GST supplement (a maximum of $5.16 per day as at 20 September 2002), but may be slightly higher for those on a higher income.

At 30 June 2002 there were approximately 26,770 approved packages allocated, 26,403 of which were operational. Each allocated package is provided to one specific named service recipient, referred to in this report as funded care recipients. However, where all the allocated packages provided by a service outlet are filled but the funding for these packages allows for additional service to be provided to other care recipients, outlets may provide service to additional people, referred to in this report as supplementary care recipients. These care recipients must also be approved to receive a CACP by an ACAT.

To date most information on the CACP Program has been collected through the service providers claim for payment of care subsidies. This is the basis of the annual publication produced by the AIHW in its Aged Care Statistics series covering the period 1998–99 to 2001–02 (AIHW 2000, 2001, 2002c, 2003). Little or no information has been collected about service provision or about supplementary care recipients. It is DoHA's intention that information about service provision to all care recipients, including supplementary care recipients, will be collected in the future.

Structure of the report

This report summarises the information collected by the CACP 2002 census. Section 1 has outlined the CACP Program and background to the census. Section 2 discusses the scope of the collection, the census forms, collection methodology and data quality issues. Section 3 contains the main findings of the census arranged in three subsections: care recipients, service episodes and service providers (the term care recipient is used throughout this report rather than client). Detailed tables which support these findings are presented in Appendix 1. Census forms and additional supporting material for the census are included in Appendices 2–5 and are followed by recommendations on any future census (Appendix 6).

2 Data sources and limitations

Scope of the collection

In order to compile a comprehensive picture of assistance received by CACP care recipients, the census includes all people who receive assistance under the Program whether funded or supplementary care recipients. This includes care recipients who are on leave for the whole of the collection period, as these people are still considered to be clients of the Program although they may receive no assistance in the reporting period. (Services are able to claim the Community Care Subsidy for care recipients who are on leave up to the maximum period of leave in the Program.)

Private care recipients, whose care is wholly paid for through private funds, are excluded from the census.

Data sources

Census forms

The census forms for the CACP data collection are shown at Appendix 2. These consist of:

- a CACP service outlet data form (Form A) that includes questions regarding the outlet's location and characteristics, provision of information to care recipients though Care Recipient Agreements, the number and types of packages approved in each Aged Care Planning Region and the method of service provision (direct provision or brokered or subcontracted service provision);
- a care recipient data form (Form B) that includes questions regarding care recipient demographic details, accommodation arrangements, dependency level, carer characteristics, duration of assistance and care subsidy, amount and types of assistance, and leave and cessation of therapy if applicable.

Data element definitions

In recent years, the AIHW has been involved in a number of data development projects in the community care field. In 2001 the AIHW undertook data development work for the preparation of a draft data dictionary for the CACP Program. This work took into account the ability of CACP providers to apply these definitions in the field, and consistency with other relevant data collections and data standards. Data items developed as a result of this work and a draft survey form for collecting this

information were field tested with 46 CACP providers in all states and territories during July and August 2001.

The forms used in this census drew on the field tested data items and forms that were the product of this earlier data development work. Brief data definitions, a guide for use and reasons for collecting the information are outlined in the census guidelines (Appendix 3).

Collection method and privacy

Following consultation with industry peak bodies, DoHA informed all approved providers and their associated service outlets about the census by letter in July 2002. This letter invited them to attend briefing sessions conducted by the AIHW in all mainland capital cities, Launceston and Townsville during August 2002. Commonwealth officers in each state and territory organised the attendance of providers at briefing sessions.

On 29 July 2002, a second letter to providers and their associated service outlets accompanied a sample of the census forms and census guidelines, and a statement outlining the census' compliance with relevant legislation in relation to collection and disclosure of information (Appendix 4). This letter, guidelines and statement included information about:

- the purpose of the census
- measures taken to protect privacy and the use of the statistical linkage key
- the department's responsibility to care recipients and providers
- the responsibility of the AIHW to care recipients and providers
- the responsibility of providers to care recipients
- assistance available to the service providers during the census including
  - a free-call telephone help desk operated by the AIHW
  - an email helpdesk operated by the AIHW
  - a web site maintained by the AIHW
  - a self-learning package developed by the AIHW and available from the department.

Census kits consisting of multiple copies of the census forms, an additional copy of the census guidelines, a quick reference page and a sheet frequently asked questions, were sent to all service outlets in September 2002. The accompanying cover letter from DoHA briefly explained the contents of the census package and reiterated advice for providers and outlets about the availability of additional help and information regarding the census. This letter again included a statement outlining the census' compliance with relevant legislation in relation to collection and disclosure of information and a consent form to be signed by providers or service coordinators for the disclosure of information about the service (Appendix 4).

The AIHW imposes strict guidelines on the ethical conduct of its collections and in particular ensures that they comply with Commonwealth privacy legislation and the

Australian Institute of Health and Welfare Act 1987. The procedures and privacy protection measures involved in the conduct of this census were submitted to the AIHW Ethics Committee.

To ensure privacy, service providers were asked to double envelope all census responses and return them to a dedicated mail drop point at the Department of Health and Ageing in Canberra. These were hand delivered to the AIHW, where they were entered into a database using data processors located on the Institute premises. All appropriate precautions were taken to ensure that the privacy and confidentiality of material was protected including measures relating to the storage and destruction of census forms at the completion of the project.

Service providers were requested to return their census forms to DoHA by 1 November 2002. Outlets that had not provided census returns were followed up by DoHA state regional offices in January 2003. Every effort was made to accommodate late census returns and the last returns were accepted in the second week of February 2003.

Data quality and limitations

Response rates

It was difficult to estimate service outlet response rate using the census definition of an outlet. The initial intention was to send one census kit to each outlet address, according to the census definition. However as a result of a number of problems in defining an outlet and establishing an accurate outlet address list, a census kit was sent out to the contact address for each approved outlet identified on the Department of Health and Ageing's Aged and Community Case Management Information System (ACCMIS).

Table 1: Response rate for CACP service outlets (defined according to ACCMIS), CACP 2002 census

	NSW	Vic	QLD	WA	SA	Tas	ACT	NT	Australia
					Number of outlets				
ACCMIS outlets	260	174	227	89	68	37	6	43	904
Participating ACCMIS outlets[(a)]	251	170	205	84	68	37	6	24	845
					Per cent				
Estimated response rate	97	98	90	94	100	100	100	56	94

(a) In some instances administrative outlet numbers were amalgamated by the service providers before census forms were returned while others were amalgamated on receipt.

Over 900 census kits were distributed to service outlets as defined by ACCMIS. Responses were received for 94% of these outlets (Table 1). Responses were received for all operational ACCMIS outlets in South Australia, Tasmania, and the ACT and response rates of 90–98% were received for all other states with the exception of the Northern Territory which had a response rate of 56%. Using the ACCMIS database to identify the number of approved packages managed by the outlets which did not

participate in the census, it is estimated that the non-responders represented around a thousand care packages. The estimated number of packages not included in the census for each jurisdiction is as follows: New South Wales, 280; Victoria, 184; Queensland, 351; Western Australia, 51; and Northern Territory, 134.

The follow up by DoHA of outlets which did not participate in the census revealed that a significant proportion of these outlets were providing assistance to Indigenous care recipients. Consequently, the number of CACP recipients who are Indigenous is underestimated by the census.

Form A: Service outlet data

Identification of service outlets

The aim of the CACP census was to collect data from the point where service provision occurs, at service outlets. Box 1 outlines the definition of a service outlet as it was applied in the census. However, distinct identification of service outlets for the purpose of the census proved difficult as, in practice, there is no nationally consistent means of identifying CACP service outlets and, even at the jurisdiction level, CACP contact details may only be available for the provider not the outlet.

The method used to contact, recruit and collect data on outlets was to use the administrative outlet number. This number (known as the C number) is used in the ACCMIS payments database and on subsidy claim forms. In practice, however, service provided though a single group of care packages (usually referred to by its C number or ACCMIS outlet number) may all be provided by the one service outlet or may be split across more than one service outlet. Conversely, a single office may have more than one care coordinator, each looking after separate groups of packages which may have been approved under different approval/ACCMIS outlet numbers (C numbers), all of which would be considered to be providing services from the same service outlet for the purposes of the census. In some jurisdictions new C numbers are assigned when allocating additional packages to approved providers with existing allocations.

It was initially the intention of DoHA to choose one C number for each physical outlet location and to use that as the outlet number for all care recipients receiving assistance from that address. This method proved to be inadequate for reliably distributing information and collecting data from outlets and as a consequence, separate sets of information packages and census forms (census kits) were sent out for each C number.

The AIHW and DoHA reviewed the contact addresses provided for jurisdictions where outlet identification problems had become evident and individually contacted staff of a number of outlets. As a result a number of service outlets were amalgamated and for others packages were redistributed to separate outlet numbers to correctly reflect the provision of assistance to care recipients. Of the 850 outlet forms (Form A) received at the end of the census collection period, it was identified

that these were provided by 759 service outlets according to the census definition of an outlet.

Box 1: What is a service outlet?

A service outlet was defined for the purposes of the census as the level of the organisation directly responsible for service provision to care recipients. A service outlet would typically be the location where a case manager organises care for recipients, where the care recipient records are kept and where care workers pick up and return care records or timesheets. Where services to care recipients are subcontracted or brokered to another organisation, the office organising, paying for and monitoring the provision of service would be considered to be the relevant service outlet. In some instances, a CACP funded organisation may have more than one office from which services are provided to the care recipients and these are considered as separate service outlets for the census.

Form B: Care recipient data

Duration of assistance, duration of subsidy and duration of leave

The CACP census form was initially designed for a set census week. However, the census dates were changed to any week within a 4 week period in order to increase flexibility for the service providers and to allow them to choose the week that fitted best into their other commitments. The date of the beginning or of the end of the census period for each outlet was not recorded.

Service providers were asked to provide information on the date they first claimed the CACP community care subsidy for each care recipient, and the date on which the care recipient first received assistance from their outlet. In the absence of an accurate date for the collection of data by each agency the end of the overall census period (14 October 2002) was used to calculate duration of assistance and duration of subsidy. Where the care recipient was one of the 193 who ceased receiving assistance during the census week, the actual date the care recipient ceased receiving assistance was recorded in which case date of cessation is used to calculate an accurate duration of subsidy and duration of assistance. Consequently, for recipients who ceased receiving assistance after the census week reported on by the outlet but before the end of the 4 week census period the calculated duration of assistance or subsidy may be up to 3 weeks more than the actual duration.

Similarly, duration of leave could only be accurately determined for care recipients returning from leave during the census week as both the start and end date for leave was only reported for these care recipients. For care recipients still on leave at the end of the census period, no return date was recorded. For this reason, duration of leave was reported only for those care recipients who returned from leave during the census period.

Type and amount of assistance

The census collects data on all assistance provided to care recipients as part of their package. The census does not collect data on assistance provided to care recipients which is outside their care package. Types of assistance excluded from the census are those that:

- are outside the allowable CACP services in the Aged Care Act 1997
- are beyond the level of services provided to meet the care recipient's assessed needs
- complement the assistance provided under the CACP
- meet the care recipient's assessed needs but are beyond the financial capacity of the service outlet.

During data cleaning a small number of records with unrealistic amounts of service provision were observed. After consultation with DoHA service hours in excess of 25 hours in the census week for any one assistance type were adjusted to the median for that type of assistance. This affected from 0.1% to 1.0% of records for individual assistance types.

Analysis by jurisdiction

In this report analysis of jurisdiction for client information is based on the postcode of the care recipient's residential address, while jurisdiction for service providers is based on the state or territory of the outlet.

Breakdown of data by sex

Care recipient data are presented for males, females and persons. Data for care recipients whose sex was not indicated are included in the category of 'Persons', but are not shown elsewhere in the tables. Therefore, in all tables with an analysis by sex, 'Persons' will exceed the total for 'Males' and Females'.

Source of assistance from other government programs

Question 28a asked about additional types of assistance received by the care recipients from other government programs. Question 28b asked which other government programs provided (that is funded) this additional assistance. Nine per cent of care recipients are reported as receiving assistance from 'Other' government programs. Responses provided in the 'Other' category indicate that service providers may not always be aware of the source of funding of other assistance. For instance, many of these responses listed an agency rather than the program which provided the funding. The proportion of care recipients receiving assistance from the listed government programs may be underestimated since some of these programs may fund agencies listed in the 'Other' category.

General comments

This publication contains data that have been reported by service providers who undertook the census work in addition to their other service provision and administrative duties. In some instances service providers may not have had sufficient information from their available records to complete all questions for all care recipients. This has resulted in missing data and miscoding for a generally small proportion of cases.

Missing data are excluded from the calculation of percentages, and the number of cases for which data are missing is reported in each appendix table. As a consequence of this treatment of missing data, the number of valid cases analysed may vary from table to table depending upon which variables are included and the amount of missing data related to each variable.

Future recommendations

Recommendations for the conduct of any future CACP census are presented in Appendix 6.

3 Main features

CACP care recipient profile

State and territory distribution

There were 25,439 CACP care recipients recorded during the census period from 16 September to 14 October 2002. Table 2 shows the distribution of care recipients across jurisdictions. Almost two-thirds of all care recipients resided in New South Wales (36%) and Victoria (25%). Table 2 also shows the number of care recipients per 1,000 people aged 70 and over. Using this measure the highest utilisation of CACP was in the Northern Territory (31.4 per 1,000 persons aged 70 and over), followed by the Australian Capital Territory, (17.9 per 1,000 persons aged 70 and over), and Tasmania (15.1 per 1,000 persons aged 70 and over).

Table 2: CACP care recipients by jurisdiction[(a)], number, per cent and age specific utilisation rate per 1,000 people aged 70 years and over, census period 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Sex					**Number**				
Male	2,463	2,041	1,133	684	685	164	110	113	7,405
Female	6,496	4,306	2,686	1,511	1,772	586	257	137	17,884
Persons[(b)]	**9,038**	**6,407**	**3,885**	**2,210**	**2,478**	**760**	**373**	**259**	**25,410**
					Per cent				
Male	27.3	31.9	29.2	31.0	27.6	21.6	29.5	43.6	29.1
Female	71.9	67.2	69.1	68.4	71.5	77.1	68.9	52.9	70.4
Persons[(b)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
					Use per 1,000 aged 70 years and over				
Male	8.0	8.6	7.1	9.0	8.5	7.5	12.3	24.8	8.2
Female	16.5	14.5	14.1	15.9	17.3	20.3	21.6	37.8	15.8
Persons[(b)]	13.0	12.1	11.1	13.0	13.7	15.1	17.9	31.4	12.7

(a) Jurisdiction is based on the residence of care recipients. 'Australia' includes care recipients with jurisdiction not stated.

(b) Persons includes care recipients with sex not stated.

Note: Age specific usage rate was calculated for care recipients aged 70 and over per 1,000 in the population using the population estimates obtained from the ABS 2001census.

Source: Tables A1.1 and A1.2.

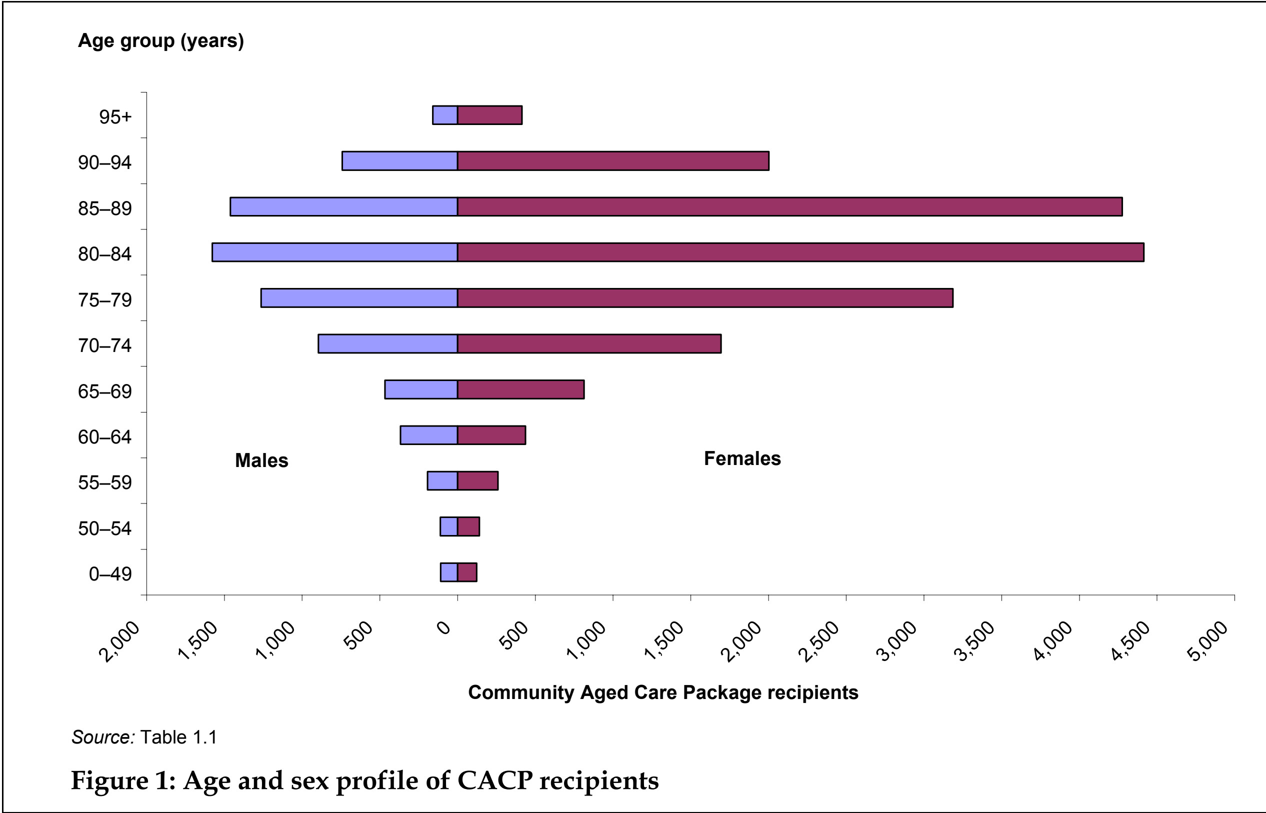
Age and sex

Seventy percent of all recipients were female, outnumbering males by over 10,000. When the number of female and male care recipients is considered in relation to the

number per 1,000 aged 70 years and over, women's utilisation rate is substantially higher than that of men (15.8 per 1,000 women aged 70 and over and 8.2 per 1,000 men aged 70 and over).

The average age of care recipients was 81 years (82 for women and 80 for men). Figure 1 illustrates the difference in the age profile for female and male care recipients. Forty-six per cent of male care recipients were aged 79 years and under, compared with 37% of female care recipients. Twelve per cent (3,033) of all care recipients were under 70 years.

The age profile of care recipients was similar across jurisdictions with the exception of the Northern Territory (Table A1.1). In this jurisdiction the average age of both males and females receiving care packages is considerably lower than the other jurisdictions (61% of care recipients were aged under 75 years, compared with just 22% nationally). This is associated with the higher proportion of Indigenous care recipients in the Northern Territory.



Source: Table 1.1

Figure 1: Age and sex profile of CACP recipients

Age specific utilisation rates reveal that CACP funded services are received by greater proportions of people in the oldest age groups (Table A1.2). Across Australia, for those aged 70 to 74 years, four per 1,000 receive CACP funded services. This figure more than doubles for those aged 75 to 79 years among whom nine per 1,000 use a CACP, and doubles again to 18 per 1,000 for those aged 80 to 84 years. The highest age specific utilisation occurs among those aged 85 years and over. In this age category 34 per 1,000 persons received CACP funded services.

Of the care recipients aged under 70 years, 94 were Indigenous people under 50 years of age (7% of Indigenous care recipients), 710 were Indigenous people aged 50 to

69 years (53% of Indigenous care recipients) and 2,193 were non-Indigenous people under 70 years of age (9% of non-Indigenous care recipients), reflecting the different age group targets for Indigenous and non-Indigenous people (Table A1.3).

Indigenous status

A total of 1,341 care recipients were identified as Indigenous (Aboriginal and/or Torres Strait Islander descent) making up just over 5% of all care recipients. As discussed previously, a number of outlets specifically targeting Indigenous people did not respond to the census. It is likely, therefore, that the proportion of Indigenous people receiving CACP funded services is greater than 5%.

The age profile of Indigenous care recipients was much younger than non-Indigenous recipients. Sixty per cent of Indigenous recipients were aged under 70 years and 7% were under 50 years, compared with 12% and 1% respectively for non-Indigenous recipients. The vast majority of Indigenous recipients were aged under 80 years (88%), while the majority of non-Indigenous recipients were aged 80 years and over (62%) (Table A1.3).

One-third (33%) of all reported Indigenous recipients resided in New South Wales, however this represented just 5% of all care recipients in that jurisdiction. Despite the very low response rate of outlets in the Northern Territory (many of which were Indigenous service providers) this jurisdiction had the highest proportion of Indigenous care recipients (58%), followed by Western Australia with 8% (Table A1.4).

Country of birth

Sixty-eight per cent of all care recipients were born in Australia, 21% were born overseas in predominantly non-English-speaking countries, and the remaining 11% were born overseas in predominantly English-speaking countries (Table A1.5). For those care recipients 70 years and over, the country of birth was compared with the same age group in the general population. There was a slightly higher proportion of care recipients born overseas in predominantly non-English speaking countries than for this age group in the general population (22% compared with 18% respectively) and a slightly lower proportion of overseas-born English speakers and Australian born care recipients (12% and 66% respectively) than in the general population (13% and 69% respectively) (Table 3).

Table 3: Comparison of country of birth of CACP care recipients and the general population, persons aged 70 years and over

	Australian-born	Overseas-born		Total
		English speaking	Non-English speaking	
	Per cent			
CACP care recipients	66	12	22	100
Census of Population and Housing, 2001	69	13	18	100

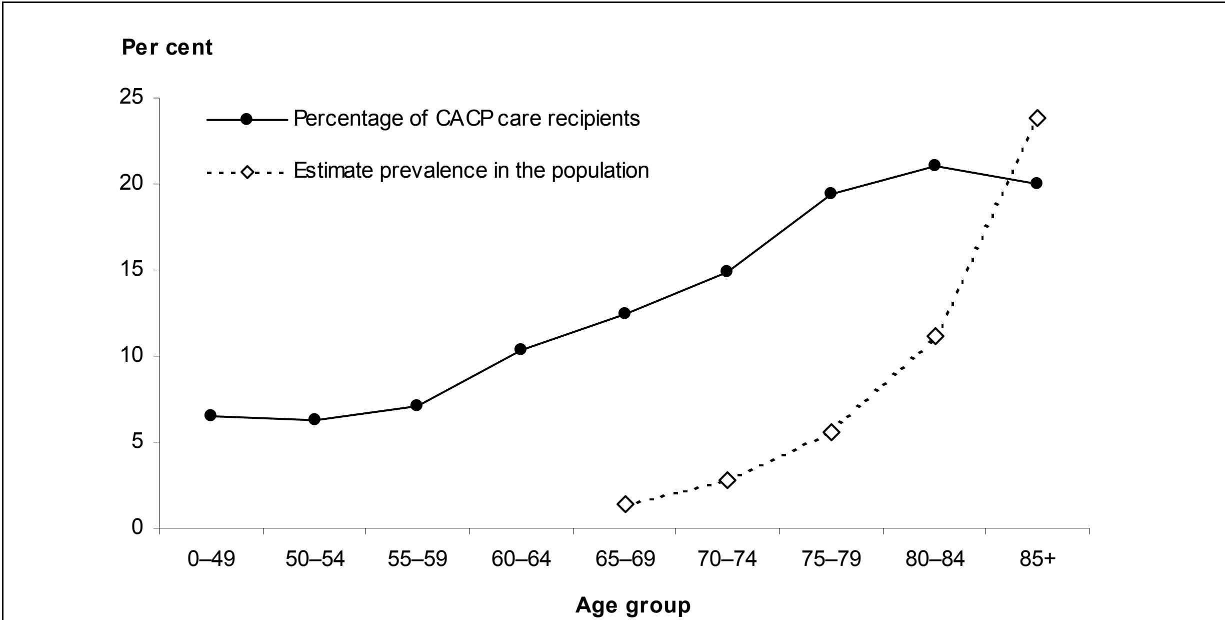
Sources: Table A1.6 and ABS 2003.

Of the three groups, Australian-born care recipients had the highest proportion of people aged under 70 years, mainly as a result of the younger age profile of Indigenous care recipients (Tables A1.3 and A1.5). Fourteen per cent of Australian-born care recipients were aged under 70 years compared with 7% of overseas-born English speaking and 10% of overseas born non-English speaking care recipients.

However, overall, care recipients born overseas in countries that were predominantly non-English speaking had a slightly younger age profile than others, with a median age of 80 years compared with median ages of 82 and 83 years respectively for Australian-born and overseas-born English speaking care recipients. There was a significantly higher proportion of overseas born non-English speaking care recipients aged 70–79 years (36%) compared with other groups (26% of Australian-born and 25% of overseas-born English speaking care recipients). Consequently this group had a lower proportion of care recipients in the older age groups (85–89, 90–94 and 95+ years).

Dementia status

There were 4,646 CACP recipients reported to be diagnosed with dementia either by a medical practitioner or by an Aged Care Assessment Team (ACAT). This represents just over 18% of all care recipients (Table A1.7). The proportion of female care recipients with dementia (19%) was similar to the proportion for male care recipients (18%). The prevalence of dementia in CACP care recipients increased from 6–7% in younger care recipients aged under 60 years to a maximum of 21% in care recipients aged 80–89. The prevalence of dementia in care recipients then decreased to 16% in care recipients aged 95 years and over.



Sources: Table A1.7, AIHW 2002b: 36.

Figure 2: Prevalence of dementia in care recipients compared with estimated prevalence in the general population

For care recipients under 85 years of age the prevalence of dementia among CACP recipients is substantially higher than the estimated prevalence in the population, resulting from their increased care needs, but is slightly lower for those over 85 years of age (Figure 2). Among the very old care recipients (95+ years) the decrease in the proportion of care recipients with dementia is most likely due to the increased care needs of those with dementia at this age, including care needs from other causes, resulting in more intensive care needs than can be met through a CACP. For care recipients aged 70 years and over the proportion of care recipients diagnosed with dementia is 20%, while the proportion of people aged 70 or more in the Australian population in 2001 who had been diagnosed with dementia has been estimated at 8% (AIHW 2002b).

The Australian Capital Territory, New South Wales and Victoria had the highest proportions of care recipients with diagnosed dementia (22%, 20% and 20% respectively), while Tasmania had the lowest with 7% of care recipients with diagnosed dementia (Table A1.8).

Financial hardship

Overall, 7,715 recipients receiving a CACP (31%) were reported to be in financial hardship, including 34% of men and 29% of women (Table A1.9). Younger care recipients were most likely to be experiencing financial hardship. Over 70% of recipients aged less than 60 years were identified as being in financial hardship. In contrast, just over 20% of care recipients aged 85 and over were identified as being in financial hardship.

Across jurisdictions the proportion of care recipients in financial hardship varied between 28% (in New South Wales) and 37% (in Western Australia) with the exception of the Northern Territory, where 67% of recipients were experiencing financial hardship (Table A1.10).

While the proportion of care recipients identified in the census as financially disadvantaged is less than that identified through DoHA's administrative data for the 2001–02 financial year (males, 42%; females, 39%; persons, 40%), the percentage of missing data is considerably smaller (less than 1% compared with 29% in the administrative data). An additional 742 financially disadvantaged care recipients were reported in the census above those recorded in the administrative data. Around 490 of these were funded care recipients and 250 were supplementary care recipients.

In the census form the question on financial hardship asked whether the care recipient was in financial hardship, but did not include the definition which was outlined in the census guidelines. For the purposes of the CACP census, a person with financial hardship is defined as someone 'who did not own a home in the two years before the time the person first commenced paying fees or receiving care, and at the reference time was in the receipt of the maximum basic rate of pension or benefit (in accordance with the *Social Security Act 1991*)'.

Department of Veterans' Affairs entitlement

Fourteen per cent of CACP recipients (3,437) were reported to be either a veteran of the Australian Defence Force or allied defence forces, or a spouse, widow or widower of a veteran.

Of the recipients who were veterans, the majority (68%), were Department of Veterans' Affairs gold card holders, 5% were white card holders, 1% held an orange card and 3% held no card. For an additional 23% of veterans no information was provided on whether they held a card or the type of card held.

The proportion of male recipients with a Department of Veterans' Affairs entitlement was higher than the proportion of females with entitlement (19% and 12% respectively). Three-quarters of veterans were aged 75 and over. In the age groups shown in Table A1.11, the highest proportion of care recipients eligible for a Department of Veterans' Affairs entitlement was between 80 and 84 years (21%).

In all jurisdictions except the Northern Territory, the proportion of care recipients who were veterans lay between 11% and 16%, with the highest proportion of care recipients who were veterans living in Queensland (16%) and the lowest proportion living in Western Australia (11%). In the Northern Territory 4% of care recipients were veterans (Table A1.12).

Type of accommodation

Sixty-two per cent of all care recipients were reported to live in a private residence that they owned (or that they were purchasing), 17% resided in public rental or community housing and 8% were living independently in a retirement village (Table A1.13).

AIHW comparison with age specific home ownership rates in the general population shows that home ownership in CACP care recipients is lower than in the general population. This difference ranges from 13 percentage points in the 75+ age group to 33 percentage points in the 35–64 year age group (Table 4).

Table 4: Comparison of home ownership among CACP care recipients (2002 census) and the general population

	Age group			
	15–34	35–64	65–74	75+
CACP census				
Number owned or purchasing private dwelling	7	511	2,049	12,963
Number in group	22	1,702	3,855	19,491
Home ownership rate (%)	31.8	30.0	53.2	66.5
Census of Population and Housing, 2001				
Home ownership rate (%)	56.1	63.5	72.0	80.6

Notes

1. This table excludes 180 care recipients for whom age was not stated, and an additional 360 care recipients for whom type of accommodation was not stated.
2. The age breakdown in this table reflects published information on living arrrangements for the general population, and differs from the age breakdown of the source table for CACP data.

Source: Table A1.13, ABS 2003a

The accommodation arrangements of care recipients in the Northern Territory were quite different to those of care recipients in other jurisdictions, with only 13% living in a privately owned residence and 64% living in a public rental or community housing residence. Among other jurisdictions, the proportion of recipients in public rental or community housing were comparatively high in the Australian Capital Territory, South Australia and Western Australia (23%, 22% and 21% of recipients in these jurisdictions respectively). The proportion of care recipients living in self-care or independent living units within a retirement villages was highest in Tasmania (14% of recipients in this jurisdiction) and the Australian Capital Territory (13% of recipients in this jurisdiction). The proportion of recipients in private rental accommodation was highest in Queensland (9% of all recipients in this jurisdiction).

Carers

More than one-half (57% or 14,231) of CACP recipients were reported to have a carer (Table A1.14). Similar proportions of male and female care recipients had carers (57% of male care recipients and 56% of female care recipients). At younger ages, however, women were more likely to have a carer (56% of those under 50 had a carer compared with 46% for men) and men were more likely to have a carer in the oldest age groups (64% of men aged 85 and over compared with 58% of women).

Of the 4,186 males with a carer, 63% had a co-resident carer and 37% had a non-resident carer. For the female recipients with a carer (9,967), 46% had a co-resident carer and 54% had a non-resident carer (Tables A1.14 and A1.15).

Forty-nine per cent of male care recipients were cared for by their spouse and 37% were cared for by their daughter or son. For female recipients with a carer, 24% were cared for by their spouse and 62% were cared for by their daughter or son. Care recipients between the ages of 50 and 75 were most likely to be cared for by a spouse. For recipients aged 75 and over carers were most commonly a daughter or son (Table A1.16). The proportion of people with dementia that had a carer was 74%, compared with 53% of recipients without dementia (Table A1.17).

Living arrangements

The majority of recipients lived alone (61%), while just over a third lived with their family (36%). Fifty-two per cent of male care recipients and 65% of female care recipients lived alone. Care recipients aged 60 and over were most likely to live alone (Table A1.18). Comparison with ABS 2001 census data shows that the proportion of care recipients living alone was higher than that in the general population across all age groups (Table 5).

Among care recipients living with family, 83% had a carer (Table 19). Care recipients who lived alone were far more likely to have no carer (60% had no carer). Men living alone were more likely not to have a carer than women living alone (66% of men living alone had no carer compared with 57% of women living alone). Thirty-nine per cent of care recipients who lived with people other than family had no carer. Men in this living arrangement were twice as likely as women to have no carer (66% of

men living with people other than family had no carer compared with 32% of women living with people other than family) (Table A1.19).

Table 5: Comparison of living arrangements among CACP care recipients (2002 census) and the general population

	Age group				
	0–34	**35–64**	**65–74**	**75+**	**Total**
CACP census					
Lives alone	22.7	45.9	55.0	64.0	61.4
Lives with family	68.2	47.8	42.7	34.1	36.4
Lives with others	9.1	6.3	2.2	1.8	2.2
Total persons (%)	100.0	100.0	100.0	100.0	100.0
Total persons (No.)	22	1,715	3,874	19,522	25,133
Census of Population and Housing, 2001					
Lives alone	3.7	10.5	22.4	39.3	9.4
Lives with family	90.3	86.6	75.5	58.9	86.3
Lives with others	6.0	2.9	2.1	1.8	4.3
Total persons (%)	100.0	100.0	100.0	100.0	100.0
Total persons ('000.)	8,501.4	6,674.6	1,147.1	886.1	17,209.1

Note: This table excludes 360 care recipients for whom age or living arrangement was not stated.

Source: ABS 2002, Table A1.18.

Need for assistance

Need for assistance in individual areas

Outlets were asked to report whether care recipients sometimes or always needed the assistance or supervision of another person in 11 different activities. There were five individual areas where the need for assistance was common for CACP care recipients. These were: using public transport, 68%; showering or bathing, 58%; carrying, moving or manipulating objects related to the tasks of daily living, 54%; walking and related activities, 48%; and dressing, 44%. For care recipients aged 50 and over, the proportion of care recipients needing assistance with these activities increased with age (Table A1.20).

A smaller proportion of care recipients needed assistance with other activities: managing incontinence (18%); eating (17%); getting in or out of a bed or chair (16%); understanding others or making oneself understood (15%); toiletting (12%); and maintaining or changing body position (11%). The proportion of care recipients needing assistance with communication, toiletting, getting in or out of a bed or chair, or maintaining body position tended to decrease with age except in the two oldest age groups.

Activity limitations

Every 5 years the ABS conducts a Survey of Disability Ageing and Carers (SDAC) (ABS 1999). This survey provides measures of disability and functioning on a number of activities including housework, property maintenance, meal preparation, paperwork, transport, health care, self-care, mobility and communication many of which are areas in which care recipients may receive assistance through a CACP. However, three areas are considered to be core activities of daily living: self-care, mobility and communication.

The SDAC measures the level of activity limitation or restriction[1] as well as the type of limitation. The four levels of limitations reported (in increasing level of severity) are mild, moderate, severe and profound. Where a person sometimes or always needs the assistance of another person with the core activities of daily living they are said to have a severe or profound core activity limitation.

The census asked service outlets to assess the care recipient's need for assistance in activities which are components of the three core activities of daily living (self-care, mobility and communication). Definitions used were based on the International Classification of Functioning, Disability and Health (ICF) (Appendix 5) (WHO 2001). These components were then grouped into the three core activity limitations. Care recipients with a self-care limitation sometimes or always needed assistance with one or more of the following: eating, showering or bathing, dressing, toiletting, or managing incontinence. Similarly a care recipient with a mobility limitation sometimes or always needed assistance or supervision in at least one of the following areas: maintaining or changing body position, carrying or moving objects, getting in or out of a chair or bed, or walking. With a communication limitation care recipients sometimes or always needed assistance with understanding others or being understood by others.

The information on the care recipient's need for assistance was translated into severe or profound core activity limitations because the presence of such limitations is considered to be one of a number of risk factors for admission into residential aged care (AIHW 2002a). Information was not collected on other activities with the exception of the need for assistance with public transport which by itself is considered to be a mild core activity limitation. Note that if a care recipient does not have a severe or profound core activity limitation, this should not be interpreted to mean that he or she does not have any difficulty with these activities.

Severe or profound core activity limitation areas cannot be interpreted as the areas in which the service outlet needs to provide assistance, as it does not take into consideration whether the care recipient had other mechanisms in place to receive assistance in these areas, for instance help from an informal carer. Review of the carer status of care recipients with different numbers of severe or profound core activity

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1. The ABS SDAC uses the term 'restriction', while the draft CACP data dictionary element is called 'core activity limitations'. In line with the draft data dictionary, the term core activity limitation is used in this report.

limitations confirmed that care recipients with more severe or profound core activity limitations were more likely to have a carer (Table 6).

Table 6: CACP care recipients, carer status by the number of severe or profound core activity limitations, CACP 2002 census

	Number of severe or profound core activity limitations			
Carer status	**0**	**1**	**2**	**3**
Has no carer	61.5	49.9	36.6	24.8
Has a carer	38.5	50.1	63.4	75.2
Persons (%)	100.0	100.0	100.0	100.0
Persons (No.)	3,817	7,674	10,867	2,469

Note: Excludes 612 care recipients for whom either carer status or the number of severe or profound core activity limitations was not stated.

Severe or profound core activity limitations

Mobility and self-care were the two areas of severe or profound core activity limitation in which most recipients required assistance. Sixty-eight per cent of all recipients had a severe or profound mobility limitation, 64% a severe or profound self-care limitation, and 15% a severe or profound communication limitation (Table A1.21).

The likelihood of care recipients having severe or profound self-care and mobility activity limitations increased with age, with those aged 95 years and older most frequently needing assistance (75% and 74% of this age group respectively). In contrast, care recipients with a severe or profound communication limitation were more common in the under 50 years age group (29% of this age group) than in older age groups (15% in the 95+ age group).

Fifteen per cent of all care recipients did not have a severe or profound core activity limitation. This group may include care recipients who have difficulty with other tasks not considered to be core activities or for whom it was possible to undertake the core activities with difficulty but without supervision or assistance (that is a mild or moderate core activity limitation). This includes people who may only be able to carry out these core activities with assistance from aids or equipment. Six per cent of care recipients did not have a severe or profound core activity limitation, but did sometimes or always need assistance with (or were unable to use) public transport. (People without other severe or profound core activity limitations but who sometimes or always need assistance using public transport are considered to have a mild core activity limitation.)

There were 7,735 recipients (31%) needing assistance in one core area, 10,957 care recipients (44%) who needed assistance in two core areas and 2,481 recipients (10%) requiring assistance in all three core activity areas (Table A1.22).

In 1998, 27% of people aged 70 and over were estimated to have at least one severe or profound core activity restriction. By 2002, this proportion would have increased slightly due to the growing proportion of people in the older age groups. However, even allowing for this change, comparison with the proportion of 2002 CACP care

recipients age 70 years and over with at least one severe or profound core activity limitation (85%) shows that the CACP Program, which targets those who are eligible for a least low level residential care, is reaching a client group with a much higher level of disability than found within the general population.

Table 7: Comparison of characteristics of CACP care recipients with the general population with a severe or profound core activity limitation among people aged 70 years and over

	Severe or profound core activity limitation				
	Self-care	Mobility	Communication	At least one[(a)]	Total 70+ persons
			Number		
CACP census, 2002	14,138	15,224	3,179	18,621	21,879
Population estimate, 1998 ('000)	267.7	364.6	126.2	422.9	1,589.4
			Per cent		
CACP census, 2002	63.6	68.5	14.3	84.6	100.0
Population estimate, 1998	16.8	22.9	7.9	26.6	100.0

(a) As an individual may have more than one severe or profound core activity, the number of persons with at least one severe or profound core activity limitation is less than the sum of the persons with individual severe or profound core activity limitations.

Notes

1. Calculations of proportions for care recipients exclude any care recipients with age and/or core activity limitations not stated.
2. The proportion of people with severe or profound core activity limitations is not completely comparable for these reasons:
   – Differences in the collection instrument. The SDAC used a structured questionnaire administered to the person concerned at a face-to-face interview, while in the CACP census the care provider made an assessment about the client's need for assistance.
   – The proportion of people with severe or profound core activity limitations is related to the age of the population. In the 4 years since the 1998 SDAC, the proportion of people in the older age groups has increased.
   – The age structure of CACP care recipients aged 70+ years will differ from the age structure in the population aged 70+.
3. The presence of a severe or profound core activity limitation is a factor in identifying those care recipients at risk of admission into residential aged care.

Sources: Table A1.21, ABS 1999 (Table 23) and AIHW analysis of ABS Survey of Disability, Ageing and Carers confidentialised unit record file.

Community care subsidy

For each care recipient receiving CACP funded service, service providers were asked to indicate whether they were claiming the Community Care Subsidy with respect to that care recipient. According to the guidelines, the response 'No' indicated that the care recipient was a supplementary care recipient.

For care recipients whose subsidy status was indicated, 24,171 (97%) were recipients for whom the Community Care Subsidy was claimed, 826 (3%) were indicated to be supplementary care recipients. No response was given for 442 care recipients, or 2% of all care recipients (Table A1.23).

CACP service episodes

Duration of subsidy and receipt of assistance

For all care recipients reported in the census, including those on leave and those who ceased receiving service during the census week, the duration of CACP subsidy

and the duration of assistance was derived. This was calculated as the period between the commencement date of the subsidy (or assistance) and the end of the census period, or the cessation date for those who ended their care (see discussion on page 9 regarding this method).

Service outlets had been claiming a CACP subsidy for over one-quarter of care recipients (27%) for six months or less (Table A2.1). For 63% of care recipients the service outlet had been claiming a subsidy for 18 months or less. For 5% of care recipients the service outlet had been claiming a subsidy in excess of five years. The average duration of a CACP subsidy was 20 months for all care recipients and the median duration was 14 months. The average according to state/territory, ranged from 15 months in the Northern Territory to 25 months in Tasmania (Table A2.2). In the Northern Territory, outlets had been claiming a CACP subsidy for 42% of care recipients for a duration of 6 months or less, compared with 27% for the same duration for care recipients Australia-wide.

The duration of assistance was the same as the duration of subsidy for 58% of care recipients. Assistance was received before the start of a subsidy for 18% of recipients, and subsidy commenced before assistance was received for 21% of recipients.

Care recipients on leave

At the time of the census, there were 1,887 care recipients on leave from their package at some time during the census week. This represents 8% of all care recipients (Table A2.3). Recipients may take leave for many reasons, such as being admitted to hospital or receiving alternative care from another source, such as respite care. Recipients were considered to be on leave if they asked not to receive services from the CACP for 5 days or more.

Women were just as likely as men to be on leave (8% of both groups were on leave during the census period). Women aged 95 years and over were more likely to be on leave than those at younger ages (10% of this group were on leave during the census period). Men aged 75 to 79 years were more likely to be on leave than those at other ages (11% of this group were on leave during the census period).

Of care recipients on leave for whom the main reason for going on leave was reported, 58% were admitted to hospital while 24% received alternative care. The remainder reported other reasons for leave, such as social leave (Table A2.4).

Of care recipients who returned from leave during the census, the majority had been on leave for a short period, with 55% of recipients being on leave for two weeks or less. Those receiving alternative care tended to take longer periods of leave than those on leave due to hospital care or another type of care (Table A2.5).

The CACP Program makes provision for care recipients to take up to 28 days of leave in the year to receive alternate forms of care and a further 28 days of leave for other leave (such as social leave) before this affects the service provider's right to claim a care subsidy for that care recipient. An unlimited amount of hospital leave may be taken without affecting the payment of a care subsidy. After these leave entitlements, care recipients are on extended leave and the payment of a care subsidy is

suspended. During the census week, 581 (173 males and 403 females, five sex not stated) care recipients were on extended leave. This represents 2.3% of all care recipients.

Cessation of assistance

During the one week census period, 193 care recipients (less than 1% of all care recipients) ceased receiving assistance from the CACP service. The most common reasons for ceasing to receive CACP assistance included moving to low level residential care (23%), moving to high level residential care (19%), death (19%), and moving to a 24-hour care facility (12%). Eight per cent of care recipients ceased because they no longer needed assistance (Table A2.6).

Types of assistance provided

A CACP provides a package of assistance managed by a care coordinator. The care coordinator manages the complex care needs of the recipients and arranges provision of the following types of assistance: personal care, domestic assistance, social support, assistance with meal preparation and other food services, respite care, rehabilitation support, home maintenance, delivered meals, linen services and transport. Definitions of types of assistance are provided in the Census Guidelines (Appendix 5.2). For the purpose of this census, care coordination and management is also classed as an assistance type.

This census gives a snapshot of the service provided to care recipients in the census week and captures only that provided during that week. For instance, case management and coordination is an integral part of any package, 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 in the assistance they are receiving through their care package at that time.

The majority of care recipients (97%) received more than one type of assistance during the census period. Most care recipients received between three and five types of assistance (Table A2.7). A very small number of recipients (less than 1%) received more than eight types of assistance during the census. Just under 3% of care recipients received no assistance.

Domestic assistance was the most common type of assistance provided, with 83% of all care recipients receiving this service (for a median of 2 hours during the census week) (Table A2.8). This was followed by 73% of recipients with active case management during the census week, and 60% receiving social support.

The service involving the highest median number of hours per person provided during the census week was respite care, with a median of 2.5 hours. Personal and domestic care were each provided for a median of 2 hours to care recipients in the census week.

With regard to ancillary services, transport was provided to 36% of care recipients and delivered meals to 21% of care recipients. The median number of transport trips was two in the census week and the median number of delivered meals was five.

Of care recipients receiving assistance, including supplementary recipients, 70% received between 2 and 8 hours of assistance during the census period (Table A2.9). About 8% of care recipients received less than 2 hours of assistance, while 10% received more than 10 hours. The Northern Territory showed the highest proportion of care recipients receiving more than 10 hours of assistance (19%), while the Australian Capital Territory showed the lowest (3%). Victoria had the largest proportion of care recipients receiving 2 hours of assistance or less (12%). Overall, there was no difference to these numbers when supplementary care recipients were excluded, and very little change across the jurisdictions.

In general, there was little difference between jurisdictions in the average number of hours of assistance received for each type of assistance, with a few exceptions (Table A2.10). Western Australia had higher use of home maintenance compared with other jurisdictions, with about half an hour more on average than other states and territories. Queensland and the Northern Territory had a higher average number of delivered meals (around eight meals per care recipient), compared with five to six meals in other jurisdictions. Victoria showed a high average number of respite hours (3.9 hours) compared with other jurisdictions.

Care recipients with dementia

For care recipients diagnosed with dementia, the median and average hours of assistance per person were higher for some types of assistance than for care recipients without dementia. The median number of respite hours was higher in care recipients with dementia than for care recipients without dementia (3.0 hours compared with 2 hours) (Table A2.11). Care recipients with dementia also had higher median hours of assistance for social support than those recipients without dementia (2 compared with 1.5 hours).

Carer status

Some differences were evident between the amount of assistance provided in a week to care recipients with a carer compared with those without a carer (Table A2.12). The median hours of respite for those with a carer was 2.5 compared with 2 hours for those without a carer (average 3.4 compared with 2.6). Care recipients without a carer received delivered meals slightly more often than people with a carer, receiving an average of 6.4 meals a week (median of six meals) compared with 5.7 meals for those with a carer (median of five meals).

Care recipients with a co-resident carer also received more respite care than those with a non-resident carer (Table A2.13). The median hours of respite for those with a co-resident carer was 3 compared with 2 hours for those with a non-resident carer (average 3.3 compared with 2.7). The median number of delivered meals received was the same for recipients with co-resident and non-resident carers (fivemeals in the week), although the average number of meals was slightly higher for those with a co-

resident carer than a non-resident carer (6.2 meals compared with 5.4 meals respectively).

Living arrangement

When median hours are considered, there is little difference evident between the amount of service delivered to care recipients according to their living arrangement. The calculation of average hours reveals differences between the groups. This occurs because the distribution is skewed to the right (that is, toward those who receive more hours of care) thus pulling the average above the median.

Care recipients living with people other than family had the highest average use of respite (3.8 hours), personal care (2.8 hours) and rehabilitation hours (1.9 hours) compared with recipients living alone or with family (Table A2.14). This group also had higher numbers of delivered meals and transport trips.

Severe or profound core activity limitations

Differences in the average and median hours of service, for care recipients with increasing numbers of severe or profound core activity limitations were minimal for most types of assistance. The largest differences were seen with respite care (increasing from an average of 2.7 hours for care recipients without a severe or profound core activity limitation to 3.9 hours for care recipients with three severe or profound core activity limitations) and personal care (increasing from an average of 1.6 hours to 2.6 hours). However, a larger increase is seen in the total hours of assistance received, from an average of 4.9 hours to 7.3 hours with an increasing number of severe or profound core activity limitations.

The proportion of care recipients receiving a particular type of assistance increased or decreased to some degree with increasing numbers of severe or profound core activity limitations with the exception of social support. The most striking trends were seen for respite care where the percentage of care recipients receiving this type of assistance increased nearly sevenfold from 2% to 13% and for personal care where the percentage of care recipients increased threefold from 22% to 72% (Table A2.15).

Financial hardship

There were no consistent differences in the amount or types of service given to those who were in financial hardship (Table A2.16). This is consistent with more detailed review of these care recipients which showed that there was no difference between those who were and were not reported to be in financial hardship with respect to severe or profound core activity limitations or proportions of care recipients who lived alone.

Other government programs accessed

Around 38% of care recipients reported receiving assistance from a government program other than the Community Aged Care Package. Of all care recipients, 19% were reported to have been also receiving services from the Home and Community

Care (HACC) Program (Table A2.17). A further 4% received assistance from the Department of Veterans' Affairs (DVA), and 3% from the Day Therapy Centre (DTC) Program.

HACC was the most common program being used in addition to the CACP Program, in all states and territories. Tasmania had the largest proportion of care recipients also receiving HACC services (32%), while South Australia had the highest proportion of recipients also receiving assistance through the DTC Program (6%). Queensland had the most care recipients receiving assistance from the Continence Aids Assistance Scheme (8%).

Delivered meals were the most common type of additional assistance provided to CACP recipients by another government program (9% of all recipients) (Table A2.18). Other common types of assistance accessed were centre-based day care, nursing care and allied health care (all 8%), as well as transport services and provision of goods and equipment (both 4%). Of these additional assistance types, nursing care and allied health care are not included in CACPs (although access is available through HACC) and centre-based day care is available on a cost recovery basis.

In New South Wales, South Australia and Tasmania, the most common service provided through another government program was delivered meals. In Western Australia, centre-based day care was the most common, while in the two territories, allied health care was most common. In Victoria and Queensland there was a more even spread of services accessed by other programs.

As noted in the data limitations section of this report, access to specific government programs may have been somewhat underestimated as a result of miscoding of responses to the 'Other' category where care coordinators were aware of the organisation providing additional service, but not their source of funding.

CACP service providers

For the purposes of the census, a service outlet was defined as a CACP-funded organisation or organisational sub-unit that was directly responsible for the provision of CACP-funded assistance to care recipients. In some instances, this meant that one CACP-funded organisation had many service outlets. The census guidelines requested that information about care recipients and the CACP-funded assistance that they received should be recorded and reported at the service outlet level. Some CACP-funded service outlets contracted out or brokered the assistance required by their care recipients to other service providers (e.g. a HACC provider). Although the service outlet may not have directly provided the assistance in these cases, the service outlet which paid for the assistance to care recipients was considered directly responsible for that assistance and was asked to report on those care recipients and the assistance they received.

Organisation types

Outlets were asked two questions about their affiliations and financial arrangements. Over 95% of outlets defined themselves as 'not for profit' and only 32 of the 759 outlets in Australia (4%) considered themselves as 'for profit' (Table A3.1). Twenty-three per cent of outlets described their organisation as local, state or commonwealth (Australian) government, 34% responded that 'Religious' best described their organisation and 42% responded 'Other' (Table A3.2). In this context, 'Other' was an amalgam of community organisations, for-profit providers, organisations that are targeted to people from a culturally or linguistically diverse background and those providing packages specifically for Indigenous Australians. The proportion of government organisations was fairly similar across jurisdictions (between 20% and 30%), with the exception of the Northern Territory, which had 42% of government outlets. The proportion of religious organisations varied from 8% in the Northern Territory to 43% in New South Wales. There were only nine outlets (1%) that identified themselves as 'Ex-services Veterans' service'.

Location of outlets, distribution and types of packages

Each service outlet is approved to deliver CACP services to a number of people as defined in their agreement with DoHA. In this agreement DoHA specifies the type of care recipients it wishes to target by specifying the types of packages it allocates to the service outlets. The main types of CACPs are general packages, housing-linked packages, dementia packages, other financially and socially disadvantaged packages, veterans packages, packages targeted to Aboriginal and Torres Strait Islander peoples and packages targeted to people from culturally and linguistically diverse backgrounds.

There were more reported packages (26,488) than care recipients (25,439) (Table A3.3). This result was expected, because there is a constant movement in the care recipient population and the number of allocated packages is set to allow for some growth in the service, while maintaining the viability of the service outlets.

Seventy-one per cent of reported packages were general packages. The highest proportion of general packages was in South Australia (78%), which was similar to all the other states except New South Wales, which reported 64% of general packages. However, the Northern Territory was markedly different to all other jurisdictions. Those agencies in the Northern Territory that participated in the census reported almost equal proportions of general packages (41%) and Indigenous packages (42%). However, the actual proportion of Indigenous care recipients for this jurisdiction is uncertain because of the low response rate in that territory.

Twelve per cent of packages were specific to people from a culturally and linguistically diverse background and the proportions of these packages varied from 16% in New South Wales to 5% in the Northern Territory. Housing linked packages represented 7% of all packages and ranged from 11% in Tasmania to 4% in South Australia. Dementia, and other financially and socially disadvantaged packages each formed about 2% of all packages.

There were a total of 759 outlets across Australia. To some extent, the size and distribution of CACP service outlets reflects the geography and population concentrations in jurisdictions. In the government allocation of packages the equitable distribution of packages according to need must take into account the population distribution across regions among other factors. As might be expected the highest number of CACP outlets was in New South Wales (219) (Table A3.3). But the second-most populous but physically smaller state, Victoria, had only 118 outlets while Queensland had 207 outlets.

The size of service outlets by jurisdiction was analysed by tabulating the number of outlets by the number of packages (Table A3.4). This analysis shows that almost 77% of all outlets have less than 50 packages. There were three jurisdictions (Queensland, Tasmania and Northern Territory) that had 94% or more of their outlets with less than 50 packages. The jurisdictions with the highest proportions of outlets with 50 packages or more were Victoria (49%) and New South Wales (30%). Victorian CACP outlets had an average of 58 packages per outlet, compared with Queensland's 20 packages per outlet. The low number of average packages in the Northern Territory (12) highlights its relatively small and widely spread population.