Returned & Services League of Australia

Caring for Older Australians

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To: Caring for Older Australians
Productivity Commission
PO Box 1428
Canberra City ACT 2601

The Returned & Services League of Australia

Submission to Productivity Commission Inquiry – Caring for Older Australians

This document contains four parts:

Part 1: Introduction

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Part 3: The Future of Aged Care

Part 4: Wellness Focus for the Future

The Returned & Services League of Australia would like to thank the Productivity Commission for the opportunity to provide comment to the Inquiry – Caring for Older Australians.

We invite careful consideration to this submission.

RADM Ken Doolan AO RAN (Retd)

National President

The Returned & Services League of Australia (RSL) was established in 1916 and is the oldest, largest and most representative ex-service organisation in Australia. The RSL is the leading national organisation with a firm focus on current serving and ex-service community welfare.

Part 1: Introduction

The Intergenerational report 2010 reconfirms previous projections regarding Australia's ageing population, with both the number and proportion of older Australians increasing rapidly. While seniors may share some common experiences of ageing, seniors are a diverse group and experiences of getting older will depend on each person's background. For military veterans, war widows/ers, spouses of veterans, and dependants of veterans, many of these experiences have been life changing.

The uniqueness of the veteran population is that it is ageing faster than the general population, with a high percentage of men over 80 years of age entitled to benefits through the Department of Veterans' Affairs (DVA). According to DVA statistics, as at 2 April 2010 the DVA treatment population in Australia was 260,513, and an additional 87,000 people (347,640 in total) receive some type of pension or pension supplement through DVA. Of the DVA treatment population, at least 59% are aged 80 and above.

Like the general population, the male to female ratio in the older ex-service population has now changed, with war widows outnumbering the veterans for the first time; the number of older veterans and war widows with dementia is also increasing with their advancing age. As such the provision of quality aged care services that best meet the needs of the ex-service community, both current and future, is of paramount importance to the RSL.

While we currently focus on aged care issues in relation to our World War II ex-service population, there are many different aged groups within the ex-service community whom the RSL supports and represents, for example:

- The older World War II group who are now increasingly in need of assistance with their own care. For a large number of this age group, care is being provided by spouse or family members within the community with additional external services, or is being provided in residential aged care.
- The veterans of Korea, Malaya and Vietnam are also ageing and becoming in need of support, or will be within the next 10 to 20 years, as they succumb to their physical and/or mental health disabilities.
- Younger veterans with their multiple deployments are being diagnosed with similar physical and mental health issues that have plagued previous generations of veterans. Currently these younger veterans with physical disabilities and/or mental health care needs are typically being cared for by a spouse or their parents. While support services may be funded by the Department of Defence or the Department of Veterans' Affairs for qualifying ex-service personnel, there is an impact on community services external to the veteran programs, especially for their families.

For all of these groups, aged care services that offer appropriate care both now and in the future are essential.

Veterans were granted 'special needs' status in the *Aged Care Act 1997* in 2001 in recognition of service to their country. However, the definition of a veteran extends beyond just those veterans and war widows/ers who are covered by entitlements through DVA and includes the larger group of the ex-service community. The Department of Health and Ageing has defined a member of the veteran community as "..a veteran of the Australian Defence Force or of an Allied defence force; or a spouse, widow or widower of a person mentioned above".

This larger ex-service population substantially increases the numbers of persons who are included under the 'special needs' status. The RSL provides assistance and support for this larger ex-service population, and is committed to ensuring that members of the ex-service community are enabled to age with dignity, supported in the location of their choice.

Part 2: Veterans and Special needs status under the Aged Care Act:

As stated, veterans and the wider ex-service community have been recognised with 'special needs' status since 2001, being a component for consideration in the planning and allocation of aged care places since 2002. The decision to grant the 'special needs' status was based on the rapid ageing of the veteran population, their unique cultural identity, and the sacrifices and hardships endured by their service and the service of their spouses. Achieving the 'special needs' status in 2001 demonstrated Australia's debt of gratitude to the veteran community, and continues to honour and respect those who served in the defence of our nation.

In relation to 'special needs', veterans are indeed unique. While they form a category in their own right, they can also cross all other 'special needs' categories. For example:

- There are veterans who are from Aboriginal and Torres Strait Islanders' backgrounds;
- There are veterans who reside in rural and/or remote areas;
- The RSL assist many veterans who are financially and/or socially disadvantaged;
- Many of our allied veterans are from non-English speaking backgrounds, such as European countries, Ceylon, South Korea, South Vietnam; and
- Following a recent study funded by the Department of Veterans' Affairs, we also have concerns in regards to our homeless veteran population.

For many veterans and their dependants, wartime experience has dramatically impacted on their life's journey. They see themselves as a culturally specific group, different to the general population; the need to commemorate their fallen mates and to stay in contact with the ex-service community is of great importance. Thus as the veteran and war widow/er age, their needs vary from complex medical support to the need for high levels of emotional and culturally specific support.

Veterans' health issues create challenges for aged care providers. Analysis of health related problems through the DVA treatment population shows that veterans have higher rates of disease risk factors due to smoking, alcohol consumption, and the effects of trauma. Many veterans have multiple co-morbidities with the number increasing incrementally with age. Veterans are more likely to suffer from diseases of the digestive, respiratory, nervous, circulatory, and musculoskeletal systems. Recent research continues to conclude that they are more likely, compared to the general population, to develop cancer, suffer from arthritis, suffer from chronic obstructive pulmonary disease, and risk factors are also high for the development of Alzheimer's disease. While health promotion activities are of paramount importance, for many of our veterans the damage to health is already evident.

Veterans have a higher use of medications than the general community and many have mental health problems, including insomnia, anxiety, depression, and post traumatic stress disorder. The impact of war-related memories associated with the ageing processes, such as grief, loss, and dementia can be significant. The combination of post traumatic stress disorder with a dementia type illness is especially challenging for the person as well as for family and aged care staff.

Health issues of our older ex-service population are well known. The DVA Veterans' Medicines Advice and Therapeutics Education Services (Veterans' MATES) website confirms that 'the Australian veteran population is on average 80 years of age with 5 or more chronic conditions'. However ongoing studies of veteran groups both here and internationally are showing that the effects of the armed services continue to impact regardless of conflict genre. Australian studies of the Vietnam cohort continue to indicate that their health and well-being have suffered as a direct result of service in the armed forces. Similarly international studies of more recent conflicts are concluding that health and well-being issues are prevalent within armed forces personnel.

Likewise the partners or caregivers of veterans who suffered post traumatic stress disorder have been shown to have higher levels of depression, anxiety, hostility, obsessive compulsive symptoms, and physical complaints. The findings from the Vietnam Veterans Health Study 1998 suggested that congenital abnormality and mortality rates are much higher in children of Vietnam Veterans than that of the general community. More recent studies of children of current and ex-serving members of the Australian Defence Forces are identifying some unusual behavioural characteristics.

While the numbers of the ex-service community will decrease after the World War II population has passed away, the unique needs of the ex-service community will continue, and as such there will always be a need for the health, disability and aged care sectors to understand veteran specific care.

The challenge for the health and aged care industry is to ensure appropriate treatment and care is both available and accessible when needed. The need to link appropriate health services and aged care services is fundamental if older members of the ex-service community are to receive health care and aged care that bests suits their needs. Therefore a seamless system is of vital importance.

As the statistics show, a high percentage of the ex-service population are now aged. There are currently a high number of World War II veterans and war widows/ers accommodated in residential aged care. While close to 60% of the DVA treatment population are now in the older age bracket, the uniqueness of the next generation of veterans who will require care and services will bring further challenges in the future.

The RSL is aware that all positive changes made to the aged care industry will benefit the ex-service community, however we would also like to ensure that veterans' health and care needs continue to be acknowledged as unique.

- Regardless of changes to the aged care sector in the future, the RSL strongly endorses the need for veterans to maintain status of 'special needs'.

2.1 Monitoring

The RSL is an active provider of aged care services with the majority of states engaged in providing community and residential care. Nationally the RSL, including merger organisations, are providers of residential aged care in five states, and community care packages in four states. However, due to the numbers of veterans now requiring aged care services, both community and residential, veterans and war widows/ers are now commonly utilising support from mainstream services. As a result, other activities offered by the RSL include support for mainstream aged care providers in identifying and meeting the needs of the veteran community. However, to ensure these needs are consistently met processes to review a provider's ability to care for residents from 'special needs' groups needs to be adequately established.

While the ex-service community has recognition under 'special needs' status, there is limited review of an aged care provider's ability to deliver appropriate care to the ex-service community. It is important that providers who are allocated places for veterans are accountable for providing culturally appropriate care for them.

According to the DVA factsheet (HSV08):

- "Under the Act 'special needs' status means that aged care providers, such as nursing homes and hostels, need to consider the 'special needs' of the veteran community in order to have their services approved by the Australian Government."

- "As they grow older many veterans seek the comfort and reassurance of an environment that 'feels familiar' and seek the support and comfort of those who share, understand and value their past experiences. DVA continues to work with DoHA and aged care service providers to ensure that the veteran community continues to be supported into old age and the growing need for culturally responsive residential and community aged care is met."

However at this time there is no mechanism for the Department of Health and Ageing to follow up these allocations to ensure that approved providers are fully aware of the meaning

of ‘Veteran’ under the Act, or that veteran specific programs are implemented where needed or, where implemented that these are effective.

As previously stated, the RSL offers support to mainstream aged care providers to identify and meet the needs of the ex-service community. However, for many aged care providers allocations of “veteran” places only equate to caring for someone in possession of a DVA gold or white card. Despite veterans being declared a ‘special needs’ group under the Aged Care Act nine years ago, mainstream providers have still not embraced the broader definition of a veteran. The lack of a monitoring mechanism where aged care providers must demonstrate that they provide care for ‘special needs’ groups results in providers not being sufficiently accountable to identify all those from ‘special needs’ groups.

From our dealings with mainstream providers, RSL members consistently report that few are aware that the definition of a veteran under the Act not only applies to DVA beneficiaries (Gold and White cardholders), but includes another large group of people who are also deemed to have ‘special needs’ status, for example veterans’ wives/husbands, widows not classified as war widows under DVA, and allied forces’ veterans and their spouses. Many aged care providers have difficulty in recognising these people as members of the ex-service community as they do not have DVA beneficiary cards that automatically signal their inclusion in the veteran ‘special needs’ status group. This larger group of the ex-service community are not being identified by approved providers, and are not consistently being considered in veteran planning and allocation.

The Department of Health and Ageing argue that the monitoring of care and services provided by aged care providers lies with the Aged Care Standards and Accreditation Agency (ACSAA). ACSAA’s role is to audit each residential facility for compliance against the Accreditation Standards; the role does not include monitoring of ‘special needs’ group allocations. While the RSL is not recommending increasing regulatory burdens on aged care providers, a simple reporting/monitoring mechanism is required for providers to demonstrate that all ‘veterans’ are identified and their ‘cultural’ needs appropriately met. This information should also be available to the public. The RSL has identified that ACSAA’s reports of several RSL linked facilities lists ‘residents with dementia’ in the special needs section and yet does not list ‘veterans’ despite the majority of the residents being from the veteran community.

- The RSL strongly recommends that a reporting/monitoring mechanism be implemented whereby aged care providers demonstrate that they are providing appropriate care and support for residents from ‘special needs’ groups, including veterans.

2.2 Information for consumers

In relation to the annual allocation of new places in community and residential care for veterans and war widows, the amendment to the Act has served the ex-service community reasonably well in most States. However, allocation of veteran specific places under the Aged Care Approvals Round only requires approved providers to indicate in their application

for places how they can meet the ex-service community's needs. While records from the Department of Health and Ageing would indicate that new places are allocated for veterans each year, there is no information made available to the veteran community as to where these places are located or to which providers they have been allocated. The publicity of where places are allocated, and to which provider, is easily achieved. The agedcareAustralia website currently lists all Commonwealth funded aged care homes and could easily be used to provide this information. Furthermore, while this website has information on aged care places, a high percentage of the aged care facilities listed have minimal information displayed. The website should be enhanced to provide further information about care and services available within each home. While these enhancements could be completed without much additional cost, the benefit to the consumers would be enormous.

- The RSL strongly recommends that information regarding allocation of veteran places is made public.
- The RSL strongly recommends that information available on the agedcareAustralia website is enhanced to detail care and services provided by each provider.

Part 3: The future of aged care

The RSL is a member of the National Aged Care Alliance, and is a signatory to the National Aged Care Alliance Vision *Leading the Way – Our Vision for Support and Care of Older Australians*. The RSL is aware that the National Aged Care Alliance is submitting the Vision document to the Productivity Commission and we endorse the message contained in the document. For future care to be successful, services need to be: consumer focused, user friendly, equitable, seamless, linked and coordinated and, most importantly, available in a setting of the users' choice.

The RSL is also in favour of the recommendations made in relation to "Increasing choice in aged care" as noted in the National Health and Hospitals Reform Commission (NHHRC) Report *A Healthier Future for all Australians*, June 2009.

The current aged care system is complex. While there are multiple support and service options, very few are linked into the broader health system. The need for individuals to navigate through a maze of services and assessments is confusing and time consuming. With recent reforms including the transfer of full funding and responsibility of Home and Community Care (HACC) services to the Commonwealth Government, the concept of a one-stop access point can be implemented. While this concept is ideal, areas of assessment and transition processes need to be thoroughly reviewed and enhanced. At this time there are no transitional steps between care delivery systems; each system has assessment hurdles, inclusive of multiple forms and assessment procedures, different financial implications, and a lack of coordinated information to assist people to understand their options. As per recommendation 46 of the NHHRC Report (June 2010), a streamlined

assessment program needs to be introduced to ensure consistent and timely assessment across all aged care programs.

3.1 Transition Issues in the DVA veteran community

Transitioning through the different types of aged care services is an area that the RSL frequently hear adverse reports on. For members of the ex-service community who are not entitled to DVA benefits, access to HACC, Commonwealth funded community care packages or residential care has the same hurdles that are encountered by all other Australian citizens. However, for members of the ex-service community with entitlement under DVA, community services can be accessed through Veteran Home Care (VHC). The types of services offered by VHC are low level care assistance similar to services offered by HACC. While those from the ex-service community entitled to access VHC can also access HACC, this information is poorly understood. Many of our older veterans and war widows do not access services outside of DVA and, as a result, do not obtain sufficient services to meet their actual needs; reasons include:

- Not aware that they can access other services.
- Do not wish to go outside the DVA system as feel that mainstream services will not provide appropriate care.
- Do not wish to appear ungrateful to DVA.
- Do not believe that aged care services under the Department of Health and Ageing are pertinent to them.

While there are some recipients who package up their VHC services for longer than is optimal, when they are finally informed that VHC can no longer provide services to meet their needs, there are transitional issues to be dealt with the same as all others in the general community, such as:

- Waiting times to have an Aged Care Assessment Team (ACAT) assessment can be anywhere between weeks and months.
- Waiting lists for the limited Commonwealth funded community aged care packages can be anywhere between weeks and months.
- Where assessed as requiring an Extended Aged Care at Home (EACH) package, the waiting time in some areas is in excess of 12 months.

While transitional issues may be the same as for the general population, for DVA entitled veterans these issues are amplified due to the perception that their “special needs status” will give them priority for obtaining services. For many older members of the ex-service community with DVA entitlement, it is not uncommon to hear that they are very disappointed and disillusioned that DVA appeared to have abandoned them when they get old. While DVA continues to fund veterans’ care when they receive services through Commonwealth funded aged care programs, the ex-service community’s perception is that DVA ceases to provide for them. This creates much anguish and needs to be addressed. It is very unlikely that DVA will ever provide direct care services for those with higher needs, ie community care packages or residential care, therefore the following suggestion may address this issue:

The RSL is in favour of a one-stop access point to aged care services, including the delivery of information on all available options, costs, and care settings. This access point would appropriately be at HACC level. Potentially this one-stop access point could also deal with DVA entitled members of the ex-service community, for example usage of a different phone number, publicised among the DVA entitled ex-service community, automatically indicates that the call needs to be forwarded to DVA services. For this to successfully address the angst of DVA "not providing aged care services", the DVA services need to link seamlessly back into higher level packages or residential aged care.

- The RSL strongly recommends that the improvements implemented in transitional arrangements from HACC services to higher level care packages or residential aged care are also implemented within the DVA care services.

Part 4: Wellness Focus for the Future:

Our current health system is focused on sickness, illness, frailty and age. The changes of responsibility in HACC also indicate that you require services because you are either disabled (if under 65 years of age) or you are aged (if you are 65+ years of age). While health promotion and health prevention are recent endorsements of government health budget allocation, as a society we are yet to embrace a wellness model.

While questions are not directly aimed at the following topics, this inquiry does bring attention to the financial and personnel implications of the future aged care industry. With an increased population of aged persons needing services and a lesser population to fund and staff the services, there are other areas that could be explored in an attempt to decrease the burden on health, disability and aged care services. As such the following areas are highlighted: Alzheimer's Disease, the management of chronic pain, and the adequate supply and provision of aids and equipment.

4.1 Alzheimer's Disease and Veterans

We are experiencing a dementia epidemic. According to the Australian Institute of Health and Welfare (Australia's Health 2010):

> "A growing problem in older age is dementia. Numbers are expected to rise markedly as the population grows and more and more Australians reach advanced old age. Over 200,000 Australians are estimated to have dementia in 2010, with the number projected to more than double over the next 20 years. Dementia imposes a serious burden of disease for those affected, with severe levels of disability."

Dementia affects individuals, families and communities. The financial, socio-economic and disability burden of the disease is severe. According to the Access Economics report – *Keeping dementia front of mind: incidence and prevalence*, 'dementia will become the third greatest source of health and residential aged care spending within about two decades.'

When reviewing known risk factors in relation to dementia, military and ex-service veterans have higher rates of these risk factors, including lack of exercise, increased weight, poor nutrition and smoking all affecting the cardiovascular system. A recent paper from Alzheimer's Australia indicates that vascular risk factors are associated with increased incidence of Alzheimer's disease, the most common cause of dementia. The Alzheimer's Australia paper further states that midlife hypertension is the vascular factor most consistently associated with increased risk of cognitive decline and dementia; treatment of hypertension has been shown to reduce the risk of dementia.

In relation to veterans, we are aware that there is a significant problem. While data from a veterans and war widows 'self-health' survey, completed by DVA in 2006, is now four years old, the survey identified that 47% reported high blood pressure and 41% already suffered with dementia or memory loss.

While it is too late to prevent our World War II ex-service population from succumbing to this disease, the second largest group of veterans after World War II veterans are the Vietnam veterans. There are over 32,000 Vietnam veterans currently living in Australia; their average age is 62 years. Early detection of dementia in this age group could ensure appropriate early treatment, which may slow symptoms for some people and referral to services that can ease the burden of the disease and cost to families and communities. Likewise for our younger veterans, due to their multiple deployments they are also predisposed to the risk factors associated with developing dementia.

There is a need to manage the dementia epidemic. Appropriate funding must be allocated to continue research on this disease; research to determine early intervention strategies and potential treatment options that may significantly reduce the disability that results from this disease. However while breakthroughs are awaited, ongoing funding will be required to ensure that people affected by dementia, individuals and their families, have easy access to, and are supported with care and services in a location of their choice.

- The RSL strongly recommends that sufficient ongoing funding be available for a National Dementia Initiative type program, including allocation for continuing research to determine early intervention strategies and potential treatment options.

4.2 National Pain Strategy and Veterans

Chronic pain is disabling, resulting in increased use of medication and health care services, including admissions to residential aged care, and a decidedly poorer quality of life. The Access Economics Report – the High Cost of Pain 2007, reports that chronic pain costs our nation $34 billion per year. It is estimated that one in five Australians suffer chronic pain, although due to our ageing population this number is predicted to increase to one in three. The report indicates that with improved pain management the nation's yearly costs emanating from chronic pain could be halved.

Members of the ex-service community, including their families, make up a considerable proportion of those who suffer chronic pain. Due to the nature of military service, there is a

high incidence of chronic pain, particularly caused by musculoskeletal conditions. These musculoskeletal conditions are not just limited to our ageing ex-service community; the RSL is aware of many of our younger serving and ex-service members already suffering significant problems with chronic pain. While limited studies have been conducted in Australia on the prevalence of pain in the ex-service community, there are numerous international research studies on this topic all indicating that chronic pain is a significant problem in veteran communities. An American study of veterans returning from Afghanistan and the second Gulf War found that pain was the most frequently reported symptom of those returning, with 82% of those reporting pain having diagnoses of musculoskeletal and connective tissue disorders (Pain among Veterans of Operations Enduring Freedom and Iraqi Freedom, R.J Fironda, et al, 2006). Other studies have also indicated that mental health issues, such as depression and anxiety, may also be the result of chronic pain. With the high prevalence of mental health issues in the veteran community, effective treatment of chronic pain may prevent or treat many of these mental health issues.

The National Pain Strategy, finalised in March 2010, puts forward a set of recommendations for improving the treatment of all types of pain. Recommendations include:

- Chronic pain be recognised as a disease in its own right.
- Pain be given a diagnostic code along with other chronic diseases to document its prevalence, outcomes and costs.
- When monitoring patients, pain be included as the fifth vital sign (with blood pressure, heart rate, temperature and breathing rate).
- More effort be made to de-stigmatise pain (similar to the successful campaigns to de-stigmatise depression).
- A multidisciplinary approach be utilised.

As identified at the National Pain Summit 2009, the current reforms being initiated in the health care system make this an ideal time to implement the recommendations. While from a fiscal viewpoint the statistics regarding cost savings make this worthy of attention, for the health and well-being of every person it is essential.

- The RSL strongly recommends the implementation of the recommendations as detailed in the National Pain Strategy.

4.3 Aids and Equipment and Veterans

With our ageing population there is a real need to pursue areas that maintain an individual's ability to stay in their own home with minimal need for use of external services for as long as possible. The provision of appropriate aids/equipment when needed may result in decreased expenditure on health and aged care programs.

For entitled veterans, DVA supplies aids and equipment through the Rehabilitation Appliances Program (RAP). While all "gold card" holders have access to this program, those with "white cards" only have access if the aid/equipment is pertinent to their specific accepted disability; for the remainder of the ex-service community there is no support through DVA. The RSL Welfare accounts are heavily utilised to support the purchase of aids and equipment for those members of the ex-service community who are unable to obtain assistance through the DVA program.

As aids and equipment programs are a component of both Commonwealth and State Government expenditure, and there are a multitude of different schemes and programs, it is difficult to obtain accurate information on spending on aids and equipment. In 2004 the Australian Bureau of Statistics stated that one in ten Australians use and rely on aids and equipment, thus it can be assumed that government spending is very high.

In relation to our ageing population, we know that with advancing age comes the potential for increasing levels of disability. The need for aids and equipment to assist the older person to stay living as independently as possible in their own home cannot be under-estimated. While people are residing in the community there is access to aids and equipment programs, however due to the extensive waiting periods for items the majority of people self-purchase. For others who are unable to self-fund the required aids and equipment, their ability to remain safely in their own homes is greatly impacted, both from a physical and psychological perspective. There is much discussion in recent government papers regarding social inclusiveness, yet for many individuals the lack of appropriate aid and/or equipment causes the biggest barrier to participation in the community.

While there are no Australian studies on this issue, a British report indicates that if funding is appropriately provided for aids and equipment, hospital and residential care admissions can be decreased. In 2007 Heywood and Turner completed a report for the Office for Disability Issues in the United Kingdom. The report, tilted *Better outcomes, lower costs*, was reviewing evidence across the disability sector, not just disability due to ageing. Their findings indicated that where appropriate home modifications, aids or equipment were provided, there were savings, not just to government budgets but also for individuals' (and their families') health and well-being. The paper illustrates examples of savings in the cost of residential care and the cost of intensive home care (similar to Commonwealth community packages) when appropriate aids/equipment and/or home modifications were provided. There were also many references to the improved health and well-being of carers when appropriate aids and equipment are available.

- The RSL strongly recommends that all persons have fair and equal access to aids and equipment when needed.

Conclusion

Over the next 20 to 40 years the Australian aged care industry will face numerous challenges, with funding and staffing of the industry the biggest challenge to be faced. While

the RSL acknowledges that all positive changes to the industry in the future will benefit the ex-service community, it is very important that the ex-service community's "'special needs'" be maintained.

The future aged care industry needs to place the older person in the centre. All persons should be offered choice of services in the settings of their desire, which are affordable, accessible and provided as soon as needed. Services should be seamless, linked and coordinated.

Health promotion and disease prevention must continue to play a major role in our society, however developing programs and communities that assist people to maintain independence for as long as possible are essential.