REPATRIATION COMMISSION

Submission to Productivity Commission Inquiry into Caring for Older Australians

Purpose of Repatriation Commission's Submission

The purpose of the submission is to:

- provide details about the Repatriation Commission's role in community and residential aged care;
- note the unique circumstances of the veteran community, such as special needs status and funding arrangements;
- note the cultural and social characteristics of veterans; and
- identify the issues veterans have raised in relation to the provision of residential aged care services and suggest possible solutions.

The Repatriation Commission's role in provision of services to entitled persons

The Repatriation Commission (the Commission) is responsible under the *Veterans' Entitlement Act 1986* (VEA) for granting pensions, allowances and other benefits, providing treatment and other services, and the general administration of the Act. The Repatriation Commission sets policies for the programs of care, compensation and commemoration. The Department of Veterans' Affairs (DVA) provides administrative support to the Repatriation Commission in carrying out its responsibilities to veterans and other entitled people. DVA implements and facilitates the Commission's policies.

Under the VEA, the Commission is authorised to prepare Treatment Principles, which set out the circumstances under which the Commission accepts financial responsibility for the health care of veterans, war widows/widowers and their dependants (known as eligible persons).

DVA undertakes activities to ensure that eligible persons have access to health and other care services that promote and maintain self-sufficiency, wellbeing and quality of life. Priorities for the Commission include:

- continuing access to high quality health care and rehabilitation, in partnership with public and private providers;
- maintaining and developing services targeted to the needs of an ageing veteran population to support a level of independence; and
- developing an integrated approach to support the physical and mental health and wellbeing of eligible persons.

The Commission has a significant role in the provision of community aged care services for eligible members of the veteran community.

Through DVA it provides a number of lower level aged care services including:

- Veterans' Home Care (VHC) services;
- the Rehabilitation Appliances Program (RAP) ;

- HomeFront;
- the Repatriation Transport Scheme; and
- the Community Nursing program.

Attachment A gives more information about individual DVA community aged care oriented programs.

Members of the veteran community are also eligible to access all mainstream aged and community care services administered through the Department of Health and Ageing (DoHA).

DVA works closely with the DoHA to ensure that veterans receive high quality care in Australian Government subsidised residential aged care facilities.

At 31 December 2009 there were 155,611 DVA clients 80 years of age and over who held DVA Treatment cards (Gold and White health cards). 46.3% of these were males. A survey of Australian Veterans and War Widows in 2006 revealed that most of the eligible veteran beneficiaries shared their home with their spouse or partner (48%) followed closely by those who lived alone (44%).

At 30 June 2009 there were over 25,000 veterans, war widows and war widowers in permanent residential aged care. This represented about 16% of all permanent residents in Australian Government subsidised residential aged care facilities. Around 64% of DVA eligible persons in residential aged care were females and 36% males.

Almost all aged care facilities have some eligible members of the veteran community as residents. However, very few homes cater mainly for DVA clients - in 2008-09 in only 0.6 % of facilities did DVA clients account for more than 50% of residents. Nearly three quarters of Australia's aged care homes have between 10% and 30% of their residents funded by DVA as eligible veteran community residents.

Special Needs status for veterans under aged care planning
Since 2002, veterans have been a special needs group under the Allocation Principles of the *Aged Care Act 1997*. This means that it is mandatory that annual aged care planning processes take account of the needs of all 'special needs' groups. DVA and the Ex-Service Organisation (ESO) community members are represented on DoHA State/Territory Aged Care Planning and Approval committees.

Individuals from 'special needs' groups do not have any advantage over other members of the community when it comes to allocation of a particular residential place. A person's assessed need for care and services determine his/her priority for a vacant residential place or community care package, although 'special needs' status is a factor which will be taken into consideration.

DVA Funding for Residential Aged Care
DVA is funded directly to provide the Australian Government subsidy for residential aged care in respect of eligible members of the veteran community. The funding amount is the same per person as the general community funding amount. The

2010-11 Budget appropriation to DVA for this purpose was $1.14 billion. This amount is expected to rise steadily for the next few years. DVA provides this funding to Medicare Australia and the arrangements are regulated by a Business Partnership Agreement (BPA) with DoHA signed on 30 July 2010.

DVA pays the daily care fee and income tested fee for former POWs and Victoria Cross recipients receiving Australian Government residential aged care, and packaged aged care in their homes.

Cultural needs of members of the veteran community

Veterans have specific social and cultural issues, which include:

- personal hardships as a result of war service that can affect veterans and their dependants physically and psychologically;
- critical shared experiences outside those of the general community; and
- identifying themselves as a distinct cultural group with distinct needs (e.g. commemoration of fallen comrades, observance of special days such as ANZAC day and Remembrance day, provision by government of healthcare and compensation for war caused illnesses/injuries).

The core of the veteran culture lies in the bonds of mateship, commemoration for those who did not return, and support for dependants of deceased comrades.

The impact of war-related memories associated with ageing processes such as grief and loss, depression, social isolation and dementia can be significant. The combination of Post Traumatic Stress Disorder with a dementing illness is especially challenging for the person as well as for family members and staff of aged care facilities.

DVA conducts a well-subscribed national series of seminars for residential aged care, community care and hospital providers, on what constitutes the special needs of veterans and war widows(ers), and how these might be addressed with the assistance of established Repatriation benefits and services.

The Repatriation Commission acknowledges the longstanding and significant contribution by the ex-service community towards the provision of residential and community aged care services to members of the veteran community.

There are approximately 80 aged facilities across Australia operated by ex-service community organisations, which represents about 3% of aged care facilities. These are mainly operated by the aged care arms of State RSLs, or by their sub-branches, in regional areas.

Issues raised by the veteran community in relation to aged care

In recent years ex-service organisations and individual members of the veteran community have raised a number of issues about the experience of veterans in residential aged care. These include:

Transition from home to residential aged care

Eligible veterans and war widows/ers have their health and community care needs met by DVA while living in their own home, often for many decades. When they move to residential aged care, which is administered by DoHA, the standard of

service received and access to it can change significantly. This division of responsibility between DVA and the DoHA is often complex and difficult to understand for elderly veterans and their families.

The transition from DVA's health and community care services to residential aged care can result in a lowering of the level of services to veterans and a feeling of the loss of their 'specialness' as a veteran or war widow, despite the fact that veterans are accorded the same standard of services as other residents. 'Special needs' status under the Allocation Principles of the *Aged Care Act 1997* is often mistakenly interpreted as entitling eligible veterans to a higher level of care and services than non-veteran residents in residential aged care.

While living in their own home and in low level residential aged care eligible veterans are able to access aids and appliances customised to their clinical need, funded and provided through DVA. Upon entering high level residential aged care, these same needs are met through a pool of aids and appliances provided by the aged care facility as per the requirements of the *Aged Care Act 1997*, allocated on the basis of need relative to other (veteran and non-veteran) residents. However, if an appliance needs to be customised for a particular entitled person's needs then provision at DVA expense may be considered, subject to assessed clinical need. A similar situation applies for the provision of allied health care.

Some members of the veteran community report that their experience of this transition of care can be disjointed and confusing, thereby adding complexity for elderly members of the veteran community, and have advocated for a more "seamless" service delivery.

The Productivity Commission is urged to examine these issues to determine whether there can be a more seamless pathways and greater personal assistance for people moving from home to residential aged care, including members of the veteran community. This may involve a greater role, and consequently support, for volunteer and community organisations including ex-service organisations.

<u>Transition from hospital to residential aged care</u>

A concern raised by the veteran community in relation to transition from hospital to residential aged care is the period of time Nursing Home Type Patients (NHTPs), the so-called 'bed blockers', have to wait until they find a suitable residential aged care facility. In the 2008-09 financial year an average of about 1.5% of veterans separations from hospital were NHTPs.

It is envisaged under the proposed new Commonwealth/State/Territory hospital and aged care arrangements that these waiting times for admission to residential aged care facilities will be reduced.

<u>DVA's role in delivering accountability in residential aged care</u>

While DVA ensures quality care for eligible veterans while living in their own home, this role ceases once the eligible veteran enters residential aged care where quality and compliance is managed by DoHA.

This can create confusion for veterans and their families who have been accustomed to a 'one-stop-shop' service through DVA and expect a continuation of services through DVA upon entering aged care.

The suggestion above to support volunteers, including ex-service organisations, in supporting the transition to residential aged care has obvious flow on effects for continued support post transition for veterans. The ex-service organisations would then be positioned to support the veteran in linking with DVA as needed.

Special needs status

Veterans are one of the groups accorded 'special needs' status under the allocation principles of the *Aged Care Act 1997.* However the veteran community has queried the benefits of 'special needs' status and the capacity of the aged care system to effectively address veterans' specific aged care needs.

The Repatriation Commission believes that these concerns will only be addressed by the implementation of more enhanced reporting procedures to monitor the outcomes of the special need arrangements 'on the ground'.

Accreditation processes

The accreditation processes for residential aged care facilities do not require facilities to report on how they meet the specific issues affecting veterans, other than expected individual outcomes in relation to Standard 3 (Resident lifestyle). The most relevant outcomes are emotional support (Expected outcome 3.4) and cultural and spiritual life (Expected outcome 3.8).

The Repatriation Commission believes there is a capacity to enhance the focus on outcomes for veterans as a special needs group by expanding the existing expected outcomes to require aged care providers to report on how they address the particular cultural needs of the veteran residents living in their facility.

Attachment A

DVA community care services

Veterans' Home Care (VHC) services are similar to HACC services but are specifically for veterans, war widows and widowers. VHC includes domestic assistance, personal care, safety-related home and garden maintenance and respite care. A person cannot get the same service from both VHC and HACC services at the same time, but can simultaneously receive services from both programs (e.g. domestic assistance from VHC and meals from HACC).

The **Rehabilitation Appliances Program** (RAP) provides eligible members of the veteran community with clinically required aids and appliances, to help them maintain their independence as they grow older.

HomeFront is a falls and accident prevention program which provides eligible veterans, war widows and widowers with a free annual home assessment and financial assistance (subsidy) each twelve month period towards the cost of recommended aids and minor home modifications that will reduce the risk of falls and accidents.

The **Community Nursing program** provides community nursing and/or personal care services to eligible members of the veteran community with a clinically assessed need. Services are provided in the home and aim to restore or maintain the veteran, war widow or widower's health and independence and help avoid premature or inappropriate admittance to hospital or residential care.