Submission in Response to the Productivity Commission Draft Report on Caring for Older Australians

Overall comments

The Repatriation Commission broadly supports the proposals in the Productivity Commission's draft report. In particular the Repatriation Commission is pleased to see proposals to establish a gateway for transition to aged care services, an independent regulatory commission to be responsible for quality accreditation, addressing complaints and recommending fees, the proposed greater flexibility in the range of care and support services, and the greater emphasis on restorative care and rehabilitation.

Other proposed reforms to the system such as increasing choice of provider will benefit all Australians, including members of the veteran community and ex service organisations, particularly ex-service aged care providers who will have the opportunity to expand their services which are valued by the veteran community.

However, the Repatriation Commission is also concerned that services in rural Australia may be compromised by a reliance on greater market competition unless adequate protections are put in place.

DVA Context

Department of Veterans' Affairs (DVA) has a declining health treatment client population which is ageing faster that the general community. The majority of DVA's aged care clients are WWII veterans and their partners who are well into their 80s and 90s, and consequently require increasing and more intense use of aged care services. Increasingly, many Vietnam veterans and their partners are also requiring government funded aged care.

Since 2008, there has been a slow decline in the number of DVA's clients in Australian Government funded residential aged care. In June 2010 there were about 25,300 eligible veterans and their dependants in residential aged care facilities, just over 14% of the 70+ year old DVA health treatment population. The treatment population is projected to decline to 115,000 in 2017 and it is expected that by that year, the number of DVA clients in residential aged care will be under 20,000 or around 17% of the treatment population.

The table below shows the actual (to 2010) and projected numbers of DVA funded residents 70+ years of age in aged care homes and the equivalent actual and projected DVA treatment population.

Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
DVA funded RAC	26,761	25,828	25,318	25,275	24,932	24,331	23,453	22,413	21,147	19,743
Treatment population	204,874	192,267	180,435	169,100	157,500	145,900	134,800	126,700	120,600	115,000

While the numbers of DVA treatment population clients will decrease, the ageing survivors' level of dependency, i.e., those with high and complex care needs, will continue to increase. It is expected that this will result in a continued increase in the DVA appropriation for the residential aged care subsidy over the next few years.

DVA will continue to have a significant involvement in aged care - both residential and community – for some time to come, including holding the appropriation for the Commonwealth subsidy for its clients in residential aged care. The 2010-11 Budget appropriation to DVA for the Commonwealth subsidy for this purpose was $1.14 billion. Entitled veterans and their dependants currently make up 15% of all residents in residential aged care facilities. There is a very strong expectation within the veteran community that DVA will continue to be the major government agency with whom they interact.

Issues of Importance to The Repatriation Commission

The Repatriation Commission is concerned to ensure that the debt Australia owes to its veterans, especially the last survivors of the World War 2 cohort, continues to be paid through the specialised services and benefits they, and their families, are provided with. This includes the benefits that veterans and their partners received through the aged care system.

At present, DVA disability pension is exempt from income testing of daily fees for service pensioners and self-funded retirees with qualifying service. It is important that this exemption be maintained in any future fee arrangement as the disability pension is provided as compensation of service-related illness and injury and not as income.

DVA also pays the daily care fees for former Prisoners of War (POWs) and Victoria Cross (VC) recipients receiving Australian Government funded residential aged care and packaged care. DVA would want to maintain this arrangement in recognition of the exceptional contribution that former POWs and VC recipients have made to the nation.

DVA, through its treatment card system, pays many of the health costs incurred by veterans and war widows, even when they are residents of aged care services. In moving to a system with increased reliance on users pays, it is important that these costs continue to be paid by DVA and that veterans and war widows do not suffer any financial disadvantage.

DVA Assessment processes background

DVA currently has two assessment processes for the community care services that it provides to eligible veterans and war widow/widowers, one for the Veterans' Home Care (VHC) program which provides a number of home care services and one for the DVA Community Nursing program. The purpose of both of these assessment processes is to determine the community care needs (both home care and clinical) of veterans and war widow/widowers, taking into account the special needs of veterans and war widow/widowers.

The assessment process within the DVA Community Nursing program is undertaken in the veteran or war widow/widower's home by a DVA-contracted community nursing provider upon referral from a doctor, hospital discharge planner or VHC assessment agency. The Community Nursing assessment is a comprehensive assessment to determine all of the clinical and personal care needs of the veteran or war widow/widower as well as identifying any other health and community care needs that they may have. The Community Nursing assessment and subsequent service provision are undertaken by the same organisation.

The VHC program has an assessment process which fits well into the model outlined in the draft report. The VHC assessment is a telephone-based broad and shallow assessment process (which may be provided in-home where necessary) undertaken by a contracted VHC assessment agency and includes collection of information on the needs of the carer. The VHC assessment process identifies the non-clinical home care services that a veteran and war widow/widower requires, including services not provided under the VHC program. A service plan is developed for VHC services and forwarded to a contracted VHC service provider to deliver the home care services outlined in the service plan. For non-VHC home care services and other health care services, a referral is made to the appropriate service provider for an assessment for the delivery of the identified home care service, where the veteran or war widow/widower has agreed to the referral.

For both the VHC and Community Nursing programs, these are longstanding assessment processes that work well for the delivery of DVA-specific services to veterans and war widow/widowers and ensure that the special needs of this group are met.

The future of DVA assessment processes

The Productivity Commission has sought views as to whether the DVA assessment processes should be merged with the proposed standardised assessment process if the needs of veterans and war widow/widowers can be met by the standardised process.

The Repatriation Commission agrees with the proposal that assessment processes be standardised. However, in relation to community care services for veterans and war widow/widowers, DVA recommend that this process remain separate, due to the special needs of veterans and war widow/widowers, while having assessment information integrated as much as possible. These special needs include not only the age of the majority of the veteran population, the differences in service requirements due to the war service undertaken by this population and the longstanding relationship that veterans and war widow/widowers have had with DVA in relation to their community care and other health care needs. Changing these arrangements by changing the assessment process without allowing DVA to continue to cater for the special needs of veterans and war widow/widowers would be detrimental to this ageing population.

It is important to note that DVA also has responsibility for providing care for younger veterans who have disabilities and will retain this responsibility under the new health reform changes. As such, DVA will still require an assessment process to ensure their needs are appropriately met irrespective of changes in the aged care sector.

DVA recognises that consumers of aged care services prefer to have as few assessments as possible for aged and community care services. As veterans and war widow/widowers often receive both DVA and non-DVA home care and health services, the Repatriation Commission recommends that these assessment processes be integrated to allow the transfer of assessment information between both DVA programs and other programs to prevent the need for multiple assessments. As such, DVA assessments could be one of the proposed integrated assessment gateways that clients could use to access community services. The transfer of assessment information must go both ways, while still allowing additional veteran information to be captured prior to the provision of services under DVA's VHC and Community Nursing programs.

The success of operating separate but integrated assessment arrangements for veterans could be reviewed as part of the proposed five year review.

It should also be noted that DVA has separate contractual arrangements with community care organisations from DoHA and State and Territory governments as well as operating under a separate, although in some ways similar, legislative framework. These separate contractual arrangements have created the requirement for separate quality assurance and regulatory arrangements. DVA agrees that due to the similarities of the community care services being purchased and/or provided, consideration should be given for a more standardised quality assurance framework and regulatory arrangements for these services.

Use of DVA Service vs HACC Services

The table below, using data from 2009/10, shows that the over 65 DVA treatment population (TP) make far greater use of care services on a proportional basis when compared with the general over 65 population. It should be noted, however, that by definition the non war widow treatment population generally have some existing medical condition which makes them more likely to require care services. The average age of the treatment population would also be older than the general population and hence require greater care. Nevertheless there is still a significant proportion of the treatment population who require services and have ready access to them. Any integration of services would need to ensure such access is continued, as part of the debt owed to those who have served.

Service	Australian Population	DVA Treatment Population
Assessment	10.55%	41.08%
Domestic Assistance	8.90%	36.14%
Personal Care	2.94%	5.42%
Respite Care	1.08%	2.94%
Nursing Care (Home)	5.78%	16.19%

A 2004 study found that that the VHC program results in overall savings to the Government and that these savings are growing over time. The savings arise from reduced health care expenditure by DVA in the areas of general practitioners,

specialists, private and public hospitals, and other health care services such as allied health, diagnostic imaging, pathology and procedures.

Co-contributions to care by the veteran community

Some home care services provided by DVA require a co-contribution from the care recipient. Noting that members of the veteran community are able to access both DVA specific, and mainstream, services the Repatriation Commission would seek to have all out-of-pocket care expenses included in the proposed lifetime stop-loss mechanism, including those associated with DVA funded care.

It is important to ensure that any co-contribution scheme is structured in such a way to ensure that appropriate care is accessible, affordable and provided. Anecdotal evidence within the veteran community indicates that some people do not seek the appropriate level of care due to increases in the fees that they are required to pay if they move to a higher level of services. This is particularly so where the need is to move from a VHC co-contribution for home care services (usually $5.00 per week but in some cases a maximum of $10 per week depending on the service being provided) to a packaged care co-contribution (all packaged care recipients can be asked to pay a fee equivalent to 17.5 per cent of the single age pension). The Productivity Commission's proposals to 'smooth' the level of co-contributions will help to address the barrier of accessing more appropriate care.

The proposed new agencies

The proposed creation of the two independent agencies, the Australian Seniors Gateway Agency and Australian Aged Care Regulation Commission, and the proposed recommendations for ensuring the aged care system caters for special needs groups, including veterans, are expected to help to address many of the concerns expressed by the veteran community about the current system. The establishment of the Australian Seniors Gateway Agency, in particular, will address the call for a more seamless pathway from the home into residential aged care.

The division of responsibility between DVA and DoHA in residential aged care is complex and difficult to understand for elderly veteran members and their families. The proposals to implement simplified gateway arrangements have the potential to overcome this difficulty as long as the DVA specific differences are well understood and explained by gateway staff.

The proposed new person centred gateways will help overcome the difficulties experienced by the veteran community in the process of managing transition from home, where there was significant DVA provided assistance available, to residential aged care.

The creation of a new independent regulatory commission will alleviate the concern within the veteran community that under the present system the Australian Government does not appear to monitor the outcomes of the special need arrangements, does not ensure adequate care standards are maintained and also does not appropriately manage concerns about the efficacy of the residential aged care complaints scheme.

The members of the veteran community will welcome the creation of these independent agencies and they are also likely to welcome the proposal that appeals against the decisions of the Australian Aged Care Regulation Commission can be made to the Administrative Appeals Tribunal.

Changes in the level of care funding

The proposed removal of the distinction between low and high care in aged care services will also simplify the process for the veteran community who have different entitlements under the two levels of care. It may however, be relevant to the current arrangements for the delivery of DVA allied health services and appliances in residential aged care.

Under the Department's Rehabilitation Appliances Program (RAP), aids and appliances (items) are supplied to enable entitled persons to remain resident and functionally independent in their own home. A limited range of RAP items are available to low care residents, and RAP items issued prior to entry into residential aged care may be retained subject to the consent of the facility. However, the Commission does not have authority to accept financial liability for RAP items for high-care residents unless the facility is exempted from the requirement to provide a particular item by the *Quality of Care Principles 1997.* Similar concepts apply for the provision of allied health services.

In relation to any new regulatory regime for aged care, DVA would need an administrative regime in which there is clarity about what providers are expected to provide for the funding received. This would greatly assist in distinguishing veterans who would be eligible for RAP and allied health services at Commission expense because they are not already being funded in other ways.