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 organisation with a firm focus on current serving and ex-serving community welfare.

Firstly, the RSL would like to take the opportunity to thank the Royal Commission for the opportunity to provide submission to this inquiry into Aged Care Quality and Safety.

In nearly all states, RSL affiliated service providers deliver care in the Commonwealth aged care system. This submission, however, focuses on the issues from a veteran consumer perspective.

Veterans:

In commencing this submission, it's important to outline why military service is unique. While there are numerous descriptions available, the following excerpt, while old, remains insightful (Glenn, G. *Serving Australia: the Australian Defence Force in the Twenty First Century*. Canberra, 1995, p. 61):

> "Those who join the Services make a professional commitment quite unlike any other. They undertake to maintain the security, values and standards of the nation against external threat. They train for the application of extreme violence in a controlled and humane fashion, whilst accepting the risk of serious injury or death in achievement of the mission....In short they undertake to train for and, if required, undertake duty beyond the bounds of normal human behaviour."

Regardless if an individual volunteered, or was 'volunteered', to serve in a particular conflict or joined the Defence Service as a profession, the resultant effects are similar in all cohorts of veterans.

Research in Australia and internationally conclusively shows that military service can effect both physical and mental health, and that for many veterans these effects will be lifelong. Almost a century ago, the Australian government accepted responsibility to compensate veterans who suffered extreme disability and the widows/ers of those who paid the ultimate sacrifice. As the years advanced, the government accepted that there were physical and mental health related conditions that could be directly related to a veteran's service in Defence. As such, legislation was introduced to ensure compensation, rehabilitation, care and support services were available to all veterans with Defence service-related health conditions.

The most common health conditions relate to mental health, such as post traumatic stress disorder, anxiety or depressive disorders, some with consequent drug/alcohol dependence; and musculoskeletal disorders, often resulting in chronic pain. Unfortunately, these conditions too often lead to psychosocial disorders and family issues.

Other conditions such as hearing loss and tinnitus, gastro-intestinal problems, and cancers, including skin cancers, are also commonly accepted conditions. While many older persons in the aged care sector may suffer from the above listed conditions, veterans have a much earlier onset of chronic health related problems and are more likely to suffer multiple chronic health conditions, or comorbidities, which impacts on their whole life's journey. Additionally, the research has also shown that the effects of living with or caring for a veteran with chronic health conditions, be they mental or physical health conditions, has also had an impact on the quality of life of spouses, including widows/ers, and families.

For many veterans the Department of Veterans' Affairs (DVA) has provided for their health treatment/care, and equipment/consumables for many years, some for decades. Unfortunately, as they must interact with a different sector, when older veterans enter Commonwealth aged care services there is a common perception that they have been abandoned by the department that was set up to look after them.

Despite the government's legislative obligation to care for veterans, which was initially established post World War 1 under the *Repatriation Act 1920*, in the recent Productivity Commission Inquiry, "a Better Way to Support Veterans", the Commission found that "*the system fails to focus on the lifetime wellbeing of veterans*" and that there needed to be a whole-of-life approach taken by Defence and DVA, to support all veterans from enlistment to death. This recommendation must incorporate meeting veterans' aged care needs.

Special Needs Status:

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 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.

Unfortunately, data on the veteran population is limited to statistics on just those with DVA entitlement. In the Australian Institute of Health and Welfare (AIHW) report, 'Australia's Health 2018' (Chapter 5), DVA estimates that it only holds information on 1 in 5 veterans. As such, factual data on the wider ex-service community remains an unknown.

According to the treatment population data from DVA, ie those with a gold or white health treatment card, as at June 2019 there were 207,160 persons holding one of these cards. Of this treatment population, 139,158 persons are aged 60 years or over, or, more specifically in relation to aged care, 109,769 are aged 70 years and over, of which 62,908 are aged 80 years and over (*DVA Treatment Population Statistics, June 2019*). While the older veteran cohort is diminishing each year, the younger cohort in receipt of DVA health care cards is increasing, indicating that the need for veteran health and care services will continue to be needed into the future.

In relation to 'special needs', veterans are indeed unique. While they form a category of their own, they can also cross other aged care 'special needs' groups, thus being impacted by factors other than just Defence service. 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;

- There are veterans from the LGBTI community;
- Many of our allied veterans are from non-English speaking backgrounds, such as European countries, Ceylon, South Korea, South Vietnam;
- The RSL assist many veterans who are financially and/or socially disadvantaged;
- We are aware of veterans who were raised in orphanages and identify as care leavers; and
- The RSL is intimately aware of our homeless veteran population.

Aside from physical and mental health being impacted as a result of Defence service, for ageing veterans needing to access aged care services, their needs are like all older Australians, ie they want to feel safe and secure and feel respected and supported. It would also be good to be acknowledged.

Veterans see themselves as a culturally specific group, different to the general population; for many the need to commemorate their fallen mates and to stay in contact with the ex-service community is of great importance. Understanding a veteran's journey and recognizing and supporting the importance of these social aspects is paramount to a veteran's quality of life.

Despite being a special needs group, not all veterans, sometimes even those with DVA entitlement, are recognized as a veteran. Anecdotally the RSL would argue that there are limited numbers of veterans or war widows/ers accurately identified at the time of entry to Commonwealth aged care, and if they are identified due to having a DVA health care card, there is limited capacity demonstrated to understand the veteran's journey. Likewise, there is a general lack of understanding of the cultural needs of war widows/ers, and that not all veteran spouses will gain this entitlement through DVA despite having the same or similar experience as those with DVA entitlement.

As previously stated, veterans and war widows/ers with DVA entitlement have been provided health care, support, equipment and services from DVA over many, many years. As DVA do not provide services for higher levels of aged care, including residential care, veterans and war widows/ers must transition from using DVA services to Commonwealth services. This comes with confusion. The RSL can detail many cases where older veterans and war widows/ers, or their families, remain under the impression that DVA will provide care and services for them for as long as needed, and that these services will be veteran specific, including residential aged care. At a time when most vulnerable, ie needing aged care, they feel abandoned by DVA and no longer acknowledged for the service and sacrifices they made for their country.

Navigation of the aged care system

The RSL continues to hear that navigating Australia's aged care system remains a complex and stressful process. Unfortunately, the system continues to result in some walking away due to the inability to navigate the system and/or their confusion around financial costs. In our submission to the Senate Inquiry Caring for Older Australians in 2010, we argued:

> *The current aged care system is complex. The need for individuals to navigate through a maze of services and assessments is confusing and time consuming. 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.

In our response to the Aged Care Legislated Review in 2016, we acknowledged that there had been some streamlining achieved as a result of the aged care reforms; however, there were still many examples of confusion, complaints or other adverse reactions for the veteran community. This statement remains as true today as three years ago.

Complexity; traversing two systems:

Veterans and war widows/ers who hold a DVA gold or white health care card, if assessed as eligible, can access care/support services funded by DVA. These services include low level in-home support services under Veterans' Home Care, clinical care under the Community Nursing program, respite services provided in home or in an aged care facility, a convalescent care program, as well as the rehabilitation appliances program. At the same time as accessing these DVA specific programs, veterans and war widows/ers are also eligible to access services under the Commonwealth Home Support Program, so long as there is no duplication of service/s.

Like all older Australians, as their needs increase, veterans and war widows/ers need to access the higher levels of Commonwealth aged care, ie home care packages or residential aged care.

Unfortunately, each of these programs still comes with their own unique assessment and application/request process.

For example:

- Veterans' Home Care: veteran/carer contacts Veterans' Home Care via DVA specific phone number; an assessment is completed via phone by a Veterans' Home Care assessor
- Community Nursing: the veteran's GP (or hospital) completes an assessment and makes the request to DVA for approval of service
- Respite services - in home respite: veteran/carer contacts Veterans' Home Care phone number; an assessment is completed via phone by a Veterans' Home Care assessor
- Respite services - in residential aged care: veteran/carer contacts My Aged Care to have aged care assessment (ACAT/ACAS) completed; following ACAT/ACAS approval, veteran/carer finds a Commonwealth government funded facility with an available respite bed; once bed is booked, veteran/carer must phone Veterans' Home Care to arrange for DVA to fund the respite stay.
- DVA convalescent program: hospital makes request to DVA for pre-approval if program is to be carried out in residential aged care; ACAT/ACAT assessment and approval is required, via My Aged Care, if the convalescence is provided in a Commonwealth funded aged care bed.
- Commonwealth Home Support Program: veteran/carer contacts My Aged Care; Regional Assessment Service (RAS) assessment completed
- Home Care Package: veteran/carer contacts My Aged Care; ACAT/ACAS completed; income testing application completed

- Residential aged care: veteran/carer contacts My Aged Care; ACAT/ACAS assessment completed and means testing application completed

While the navigation of two systems is highly confusing, DVA services are 'trusted'. As such, ceasing or merging the Veteran specific support/care services offered and funded by DVA with the Commonwealth aged care system is not an option that would be acceptable to the ex-service community. While the ex-service community, including the RSL, is adamant that these care/support services must continue to be provided by DVA, the difficulty is that there is no interface between the DVA services and the Commonwealth aged care programs – the systems do not 'talk to each other'.

For veterans/war widows already receiving Veterans' Home Care services, an assessment has already been completed. As there is no interface between DVA and the Commonwealth aged care services, in order to access services under the Commonwealth Home Support Program a further set of questions are asked when the veteran contacts My Aged Care, then a face to face assessment is conducted by an assessor from the Regional Assessment Service who will again ask the same questions.

While veterans are fortunate that they can gain access to two systems, feedback from RSL Welfare Advocates/volunteers who assist older veterans and war widows/ers to access these services indicates the onerous nature of traversing the two systems. For example, a veteran accessing Veterans' Home Care must provide their 'DVA number'. If the veteran then needs additional services from the Commonwealth Home Support Program, such as meals on wheels, My Aged Care do not accept DVA numbers thus the veteran must provide a 'Medicare number'. Once the initial phone assessment is complete the veteran is given an AC (aged care) number. The veteran now has three numbers they must remember.

A real example of the confusion this can create can be seen in the following case notes of an RSL Welfare Advocate in the ACT:

Date: 2 September 2019 at 10:48:00 pm AEST
Subject: Record of Home Visit Mon 2 Sept 2019

Home visit at 1630 hours to a Veteran and his wife, following a referral for assistance from Absolute Home Care:

Was greeted at the door, and invited in.
Discussed why I was visiting and introduced myself.
Wife explained that husband (Vietnam Veteran) has Dementia, Parkinson's, difficulty speaking and difficulty swallowing.

Explained the need for me to have signed Authorities before I could assist them both.
Started this and paperwork - asked wife if she knew if husband had had an ACAT assessment, if she had any documentation about this, what he had been assessed for and if she had his AC number. She stated that yes, he had had an ACAT, was not sure when (some years ago) and did not have a number nor any documentation.

Established that wife has EPoA for husband and she thought this had been lodged with DVA.

Established what services husband was currently receiving and if she wanted these increased and explained that these services are funded through DVA.

Suggested wife call the 1800 My Aged Care number and ask if husband had had an ACAT (I knew I could not do this because I don't have any signed Authority).

Phone call was made - a man answered, and I prompted wife to ask 2 questions:

** had husband had an ACAT assessment, if so when and what had he been approved for*
** what was his AC number and were there any approved reference codes*

Wife explained that husband was not well and has difficulty speaking, so she was ringing on his behalf.

Reply was that wife could not ask any questions because she did not have authority to do so and so she would have to be registered by providing her details over the phone and then husband would have to provide authority for her to act on his behalf, before the questions could be asked.
Wife provided her details, then the man stated that he needed 4 points of ID from the husband before we could proceed.
The phone was held close to husband's mouth and the following questions were asked, we were warned that the responses were being recorded:

1. what was his full name - wife had to prompt him to answer several times until the man was able to hear the responses
2. what was his DOB, again wife had to prompt him several times until the man was satisfied with the response
3. what was his full address, wife had to prompt him several times
4. what was his Medicare number, prompted by wife

It was a very degrading process.

Wife and I then proceeded to ask the initial questions again, each time I tried to assist her I was spoken to by the man and told to keep quiet, that I was breaching the Privacy Act and he would only speak to the wife.

I suggested to the wife that the man also needed to record husband's DVA number, this was refused.

Wife asked for details of the ACAT, this was provided, and she was told that husband had been offered a Level 4 home package in 2017 but this had not been accepted and so he was no longer on the list for a Home Care Package. Wife had no recollection of this occurring.

When wife asked how she was currently receiving home assistance, the response was that it was probably through the CHSP.
When she asked what did a level 4 Home Care Package provide for her husband she was told that she should go to the My Aged Care Website, look up the Providers in her area and then contact them to find this out.

When I prompted her to say that the current services are being provided through DVA - the response was "I don't know anything about DVA services you will have to ask them"
Man then asked if wife wanted husband reinstated to the Home Care Package List - she finally agreed and was told that she would have to wait for 48 hours then call back to the 1800 number and ask what the waiting period currently is for a Level 4 Home Care Package.

This phone conversation took 40 minutes and when concluded, both wife and I felt angry and frustrated, at the way we had been spoken to. I apologized to her for what we had been through.

Lack of interface:

In the original 'gateway' design, it was proposed that DVA services would be accessed via a portal at the gateway. This original one-stop entry point concept would have enabled veterans to access their DVA services and also be informed of other services/supports that they were eligible to access. A central client record could have also been commenced at the start of their aged care journey as it is for all other persons now entering the aged care system via My Aged Care. Unfortunately, this concept did not come to fruition. As a result, for support services at the lower end of the scale, the aged care reforms have not improved outcomes for veterans, nor facilitated access. In some respects, it has added more confusion and potential barriers.

The RSL has become aware that if veterans or their families word the request 'wrongly', there can become a virtual ping pong between Veterans' Home Care and My Aged Care. For example, in early 2019, a veteran's daughter contacted Veterans' Home Care to enquire about getting some meal assistance for her father; Veterans' Home Care referred the daughter to My Aged Care for services under the Commonwealth Home Support Program, assuming meals on wheels required. When the daughter contacted My Aged Care, she was referred back to Veterans' Home Care 'as the client was a veteran'; unfortunately, she was again referred back to My Aged Care. A simple explanation by an RSL Welfare Advocate as to the types of meal services under both programs, established that Veterans' Home Care could provide the necessary service, it just required the request to be worded differently.

Another complication arises where the spouse of a veteran is not entitled to war widow/er entitlements through DVA on death of the veteran. The RSL has examples where services are delivered to the veteran under DVA program/s, but these cease on the veteran's death. Despite the previous DVA support services benefiting the spouse along with the veteran, there is no opportunity for the widow/er to continue the services. While the widow/er will continue to receive pension payments via DVA, there is no eligibility for any DVA support services. At this point the widow/er must contact My Aged Care and change to Commonwealth funded aged care services. This not only needs to occur at a time of grieving, but predominantly means waiting for a new assessment and finding a new provider, thus impacting on continuity of support. Unfortunately, there are two other scenarios when this occurs. Firstly, if the veteran has a lengthy admission to hospital, the services are 'put on hold' until discharge. This can result in the spouse not having access to any services until the veteran is home again. Secondly, when the veteran is admitted to residential aged care, the services provided under DVA must cease and the spouse must contact My Aged Care to be assessed for new services.

Although there are times when the interface between the two systems works, it does not necessarily mean it is beneficial. For example, earlier in 2019 a war widow, who was receiving support services

through Veterans' Home Care, was assessed as requiring a home care package. In the week the war widow had been notified by the Department of Health that a package was available, she received a phone call from Veterans' Home Care stating that as she now had an allocated package, the Veterans' Home Care services would cease immediately. At this time, the war widow had not yet found a home care provider. Fortunately, following advocacy, services were able to be reinstated until the war widow commenced services through the package.

While these types of scenarios are frustrating, the areas most frequently reported as problematic are respite and services following hospitalisation.

i. Respite:

Eligible veterans and war widows/ers can access 196 hours of respite fully funded by DVA annually; respite can be provided in their own home, in an aged care facility or as a combination of both. Except for emergency situations, pre-approval is required for DVA to fund respite services. To access DVA funded respite in an aged care facility, the veteran/war widow contacts Veterans' Home Care to ensure eligibility for funding. The veteran is referred to My Aged Care to have an ACAT/ACAS completed. Once the ACAT/ACAS assessment has been completed, the veteran/carer is given a list of homes in their area to phone. In the past, Veterans' Home Care would assist veterans and war widows/ers to access residential respite, but this is no longer the case. Once the veteran/carer locates a residential care facility with a respite vacancy, they must again contact DVA Veterans' Home Care to organise for DVA to fund the respite.

As stated, there is no assistance provided to gain access to respite services. While this is not a veteran specific issue, as DVA funds the respite stay, there is an expectation from veterans and their families that DVA will assist with finding vacancies or availability of respite services in local areas. While the Carer phone lines can sometimes assist with finding vacancy, it is frequently reported by veterans' families and RSL Welfare Advocates/volunteers in all States and Territories that they spend hours on the phone contacting residential aged care facilities to find respite beds. This can also include where emergency respite is required. Unfortunately, for veterans, like all older Australians, there are just not enough respite places available.

ii. Post hospitalisation:

An all too commonly reported area of failure is veterans being discharged from acute hospital admissions without support services being organised for when they return home. Despite private hospitals with contracts to DVA having Veteran Liaison Officer positions, and public hospitals having access to social workers, it appears more education on the support programs available for veterans with DVA health care cards is required. Examples reported by RSL Welfare Advocates/volunteers include social workers organising a two week block of home supports under the Commonwealth Home Care Program for a veteran with DVA entitlement; veterans with DVA entitlement being told to call My Aged Care when they get home to get an assessment completed; veterans with DVA entitlement given leaflets about providers in their location without any further information or assistance.

While the RSL is raising this issue as it impacts veterans, particularly those who can access services under DVA, it is a much broader issue affecting all older Australians. Discharge planning is an essential component to having an older person go from an acute care episode to being sufficiently supported to

prevent failure of discharge, leading back to hospitalisation, which in turn frequently results in premature admission to residential aged care.

Information v Assistance:

Sufficient, appropriate and understandable information to assist consumers make informed decisions about aged care is now a vital aspect required to promote increased choice, control and to be truly consumer directed; however, this area remains problematic.

The RSL acknowledges that My Aged Care is progressively improving; however, the delay in My Aged Care's development resulted in other organisations/groups duplicating its intent. A quick google search shows other web based information platforms that have sprung up to deliver more 'understandable' aged care information; while some of these websites have good information, they are not all kept current nor do they carry up to date information about service providers or pricing, which can add to consumer confusion. The RSL applauds DVA on the work they undertook to develop an aged care webpage, providing links to information on Commonwealth services, and My Aged Care on providing links to DVA supports for veterans; however, like many older Australians, older veterans and war widows/ers are not IT savvy and would much prefer to just talk with someone.

Despite information being available, it still appears there is a need to understand the aged care system in order to understand the information. For those without family/friends who can navigate the system, the demand for advocacy type services to assist individuals to access appropriate care has become more important. My Aged Care is not a platform/service that provides this type of assistance. RSL Welfare Advocates/volunteers provide support to many older members of the ex-service community to navigate the aged care system. The RSL can report that demand for these aged care advocacy/navigation type services has not decreased with the introduction of the aged care reforms, in fact, it has increased.

A recent example in Victoria of a 96-year-old veteran and his wife needing health care and aged care following falls, resulted in 10 weeks of frequent movement between services. While the wife was admitted to one metropolitan hospital, the veteran was admitted to a different metropolitan hospital (local). Following acute care, the wife was sent to transitional care in a residential aged care facility, while the veteran was sent for respite care at a different residential aged care facility. It needs to be appreciated that this couple had been inseparable for 70+ years. When the availability of the respite bed 'expired' at the first facility, the veteran was transferred to another residential aged care facility. While initially informed by this facility that there was an option of permanent admission following the respite period, the family was informed that his care needs were too high thus the offer of permanent placement was withdrawn. Following an incident in the facility, the veteran was discharged back to a metropolitan hospital before being transferred to a different hospital. As the wife's health had deteriorated, she also was readmitted to hospital. At this point, both the veteran and his wife were finally in the same location. Following initial acute care, the family were informed that the couple must be discharged as they no longer require hospital care. This family had been very proactive in contacting residential aged care facilities in their area, and beyond, although were repeatedly told 'no vacancies' for a couple. While some facilities offered to put them on a wait list, the wait period was estimated at

around six months. With the hospital pressuring for discharge, and the lack of information relating to vacancies, the family were becoming increasingly stressed. Fortunately, with the assistance of the local RSL, an aged care placement consultant was brought in to assist this family; happily, the veteran and his wife will remain together.

As a consumer group with the National Aged Care Alliance, the RSL took part in the advocacy for an aged care consumer platform to assist older people, particularly those without families or those with complex needs, to be assisted through the process of accessing appropriate services. The current trial of navigator sites is the result of this advocacy and should benefit older Australians to navigate the aged care system; hopefully, these sites will, in time, assist veterans and war widows/ers to be made fully aware of additional services that can be accessed outside of the DVA system, including care coordination where needed. Sadly, these sites are yet to have training in relation to veteran specific services and entitlements. As the RSL is aware that My Aged Care do not pick up on veteran status, and in many cases neither do RAS or ACAT/ACAS assessors, this is an area that is currently particularly lacking.

Another recent Victorian example concerned a 90-year-old veteran. This veteran was wanting some domestic assistance in relation to cleaning. The veteran had been assessed via My Aged Care and a face to face assessment had been conducted by a RAS assessor; neither identified the older person was a veteran. An intake worker of a Commonwealth Home Support Program provider who conducted a home visit to discuss service options, noted the gentleman had a DVA gold card. The intake worker, a relative of a veteran, contacted the RSL to request support for this veteran to access DVA and other veteran related supports.

Unfortunately, the above two examples are not cases isolated to Victoria, similar situations are being reported by RSL Welfare Advocates/volunteers across Australia.

Availability of Information

As previously stated, data in relation to veterans and war widows/ers is only known in relation to those with DVA entitlement, it does not extend beyond those with a gold or white health care card or those in receipt of DVA income payments.

The AIHW state that veterans are an important group for health and welfare monitoring. The AIHW's report, "A profile of Australia's veterans 2018", presented an overview on veterans' health and welfare challenges and identified key data gaps. One of the gaps identified was the lack of data in relation to veterans and/or widows as a whole population, in particular they raised that aged care data is restricted to a subgroup of the veteran population, ie just DVA health care card holders.

While the data is not capturing the broader veteran community, the data is still useful for service planning purposes. AIHW's report, "A profile of Australia's veterans 2018", indicates that in 2016-17, about 51,800 veterans and/or war widows/ers were approved for Veterans' Home Care, although slightly less, at 51,000, actually received services. In the same time period, about 19,400 veterans and/or war widows/ers, received services under the DVA Community Nursing Program.

The more recent AIHW's report, "Report on Government Services 2019" indicates that these numbers have decreased in 2017-18. Due to the decline of the World War 2 cohort this is to be expected. According to the report, only 47,907 veterans and/or war widows/ers were approved for Veterans' Home Care, and only 17,566 veterans and/or war widows/ers received services under the DVA Community Nursing Program in 2017-18.

In reviewing veteran usage of Commonwealth programs, again the AIHW's reports are beneficial. According to "A profile of Australia's veterans 2018", 19,700 veterans and/or war widows/ers accessed services under the Commonwealth Home Support Program in 2016-17. The more recent data in the "Report on Government Services 2019" indicates that there were 26,039 veterans and/or war widows/ers who were in permanent residential aged care in 2016-17, although this had decreased to 23,385 in 2017-18. While figures are not large, veterans are still a representative percentage of those in care.

Unfortunately, what is not known are the number of veterans in receipt of home care packages, or those on the National Prioritisation System (previously Queue) awaiting a home care package or the correct level of package. While DVA may be aware of numbers of veterans in receipt of home care packages, or at least aware of funding spent on the subsidies, unfortunately information is not easily identifiable for the public. In relation to veterans or war widows/ers on the national prioritisation system, we know that My Aged Care does not record veteran status, as a result there are no statistics that can be reported. As such, it's difficult to know if veterans and/or war widows/ers are accessing appropriate supports or falling between the two systems.

In a system that is now focusing on consumer choice, the other area of concern is the timely availability of service-related compliance information. As significant changes were scheduled to occur in mid-2019, ie new Standards, new Charter of Rights, mandatory quality indicators, development of a serious incident response scheme, etc, in Victoria the RSL has been closely monitoring the compliance of aged care services since January 2019. What is significant is the lag time in information regarding compliance being made public. Sanctions imposed can have a lag time of several weeks or more, the issuing of a notice of non-compliance can have a lag time in excess of a month, more if the non-compliance is in relation to other obligations under the *Aged Care Act 1997*, such as financial reporting.

The RSL appreciates that there are legislative timeframes around publication of reports from the Aged Care Quality and Safety Commission, ensuring procedural fairness; however, publication still only relates to reports from full audits in residential aged care, ie accreditation/re-accreditation site audits or review audits. There is no information made public relating to assessment contacts conducted in residential aged care, unless the Aged Care Quality and Safety Commission decision maker identifies serious risk to resident health, safety or well-being or where significant non-compliance has been addressed. As such for the majority of facilities, there is no update of information between full audits; unfortunately, this does not guarantee that they are compliant with the Standards at all times. If consumers are to have real choice, they need timely information about the services they are engaging or wishing to engage. This is even further exacerbated in home care where there is no information about the quality of services delivered, unless a notice of non-compliance is issued, or a sanction is imposed.

There must be more timely public information about the quality and safety of aged care services.

Currently, Consumer Experience Reports (CERs) are the only public information source that give indication of how the residents view the service. While the concept that these reports can be used by consumers to review or even compare services prior to engaging with them, they are certainly not perfect in gauging the quality and safety of a service. A recent example is Botany Bay Gardens Nursing Home. This service had a re-accreditation site audit conducted on 19 and 20 March 2019. According to the CER completed during this site audit, the 14 residents interviewed loved the service. In fact, the only area where a resident disagreed with a statement (strongly disagreed) was in relation to "this place is well run". While there are many examples on the Aged Care Quality and Safety Commission's website, in fully compliant services, where at least one resident has disagreed or strongly disagreed to the statement, "this place is well run", Botany Bay Gardens Nursing Home was identified with significant failures. The audit found the service to have 'not met' 29 of the 44 expected outcomes of the Accreditation Standards (39 expected outcomes according to the sanctions notice) and to present an immediate and severe risk to residents. The service was not re-accredited and subsequently closed.

While not perfect, the RSL supports the increase in CERs, particularly their introduction into home care service reviews. However, there is need to look at other avenues for gaining the lived experience of the residents/consumers and to share it publicly. The introduction of mandatory quality indicators should, in the future, provide extra data that may be used to compare services. The RSL acknowledges the importance of the clinical quality indicators already chosen; however, a consumer-focused quality indicator around quality of life could provide substantially more robust data than a CER that is conducted once every few years. Between 2012 and 2016, the Department of Health hosted a working group, the Quality Indicator Reference Group. This reference group, with representatives from the Department of Health, consumer groups, aged care providers, health professionals, unions and other aged care specialists/special interest groups, reviewed quality of life and consumer experience indicators. Unfortunately, no agreements were reached in relation to instruments/tools that could be used for a consumer-focused quality indicator; the reference group ceased to exist. The RSL would be keen to see this type of quality indicator researched again and implemented.

Veteran Supplement and monitoring:

The veteran supplement was announced as part of the Living Longer Living Better aged care reform, commencing in December 2013. All veterans who have a mental health condition/s accepted by DVA as related to their Defence-service and are in receipt of a Commonwealth funded home care package or reside in a Commonwealth funded residential aged care service, are eligible to attract the veteran supplement.

There is no assessment process required as eligibility for the supplement is based purely on DVA accepted mental health conditions. When a veteran with mental health condition/s accepted by DVA enters the Commonwealth aged care system (home care package program or residential care), the DVA process to advise the veteran of eligibility for the supplement, and to request consent to pay this

supplement, is automatically completed, ie there is a data match between DVA and Department of Human Services. As part of the privacy considerations, where a veteran does not give consent, the aged care provider will remain unaware the veteran has Defence service-related mental health conditions.

The introduction of this supplement was momentous to the ex-service community. It was an acknowledgement of the impact that Defence-service had on some veterans. It was also an appreciation of the increased costs associated with delivering appropriate care to veterans with service-related mental health conditions, such as post-traumatic stress disorder. An understanding that post-traumatic stress disorder is different from other mental health conditions, both in impact and volatility.

In Home Care, the veteran supplement was initially worth an extra 10% of the home care basic subsidy; this has now increased to 11.5% for which the ex-service community is very grateful. Additional funds equal more services. For veterans in receipt of the veteran supplement in Home Care, the use of the additional funds is easily tracked, thus recognizable as directly benefiting the veteran. Unfortunately, it is a different reality in residential aged care.

In residential aged care the supplement is a set fee, currently $7.18 per day. The additional funds are designed to improve access to residential care for veterans with mental health conditions, ie to ensure that Defence service-related mental health conditions do not act as a barrier to accessing appropriate care. As payments of the Veteran Supplement are automatic once veteran consent has been received, providers are merely advised that they are receiving a veteran supplement payment. While there is an expectation on the provider to determine veteran needs, there is no monitoring mechanism to ensure that the additional funds are used to benefit the veteran.

The RSL has had many questions raised by veterans, or their families, as to what the veteran supplement should be providing; what they should be expecting. As there is no prescriptive information about what the supplement must be spent on, and no monitoring at all of what the funds are spent on, we do not know the answer. While we had concerns that the funds would just go into general revenue, the son-in-law of a Korean veteran, who resides in an aged care facility in Tasmania, has confirmed that this can be the case. Permission has been granted for the use of this veteran's details in the following example.

94-year-old Korean veteran, Arthur Stagg, was admitted to residential aged care in October 2016. Arthur has a Defence-service related mental health condition accepted by DVA. The family, who hold power of attorney, recall receiving a letter from DVA in relation to the veteran supplement and provided consent for this payment to be made. Unfortunately, the family felt that there was nothing special being provided to Arthur; nothing that catered to veterans. The family's experience was that throughout the whole aged care journey there had not been one bit of understanding of military service shown.

Two of Arthur's interests included time with his veteran mates and gardening. Arthur needed taxis to transport him to see his mates, and gardening tools and plants to tend his garden. While the veteran supplement could have been utilised to fund at least a component of these activities, instead the

family were charged for these costs. Unfortunately, when Arthur realized he was having to self-fund his gardening hobby, he lost interest.

Despite the family asking the aged care facility what the additional funds from Arthur's veteran supplement were being spent on, the facility indicated it just went into general revenue. Not being satisfied with this response, over the past 18 months the family have been trying to find out what the additional funds should be spent on and who checks this. Over this time, the family has had contact with DVA, My Aged Care, Department of Health, and Department of Human Services. Alas, they are no closer to determining what the veteran supplement should be providing. The Department of Health advised that they would seek the answers from DVA. The Department of Human Services advised that there was no legislation to hold residential aged care services accountable for the spending of the veteran supplement. DVA advised that they cannot prescribe what the additional funding is used for and that it "depends on both the individual veteran and the facility". DVA's only suggestions were for the family to talk with the facility about social activities or Allied Health that could be funded, or to "withdraw consent" for the supplement.

It needs to be noted that the family have provided information to the facility management, both verbally and in writing, about ideas of what the veteran supplement could be used for to improve Arthur's quality of life. While the facility has recently responded, their suggestions were more about facility and service improvement rather than specifically looking for activities that would benefit Arthur's mental health and well-being.

The Aged Care Finance Authority's "Seventh report on the Funding and Financing of the Aged Care Industry", released July 2019, shows that DVA paid $1.9M to aged care providers in the 2017-18 financial year in relation to the veteran supplement. As this supplement is in addition to all other applicable aged care subsidies/supplements, it is not an insignificant amount. Strangely, while aged care providers are held accountable for the proper use of other supplements, for example the oxygen supplement, enteral feeding supplement, homeless supplement, etc, the use of veteran supplement funds are not reviewed by any department. Of the $1.9M paid in veteran supplement in 2017-18, $0.3M was paid to home care providers; this money is directly benefitting the veterans by providing additional funds for services. However, $1.6M was paid to residential aged care providers, where the funds may simply go into general revenue and not be put to anything that benefits the veteran with mental health conditions.

Monitoring in general:

While veterans have had recognition under the Aged Care Act 1997 for 18 years, there is limited review of an aged care provider's ability to deliver appropriate care to the ex-service community. The RSL acknowledges that the 'special needs' status relates to allocation of places, however, aged care providers who apply and obtain places for a special needs group/s are accountable for providing culturally appropriate care for the special needs group/s.

Currently there is no monitoring of 'veteran care' in Commonwealth aged care services. The only role DVA is responsible for once a veteran enters Commonwealth aged care services, is the payment of aged care subsidies. Despite DVA funding the aged care subsidies for entitled veterans, they have no other involvement in these higher levels of aged care transferring care accountability of veterans, like all older Australians, to the Department of Health. The Department of Health argues that the monitoring of care and services provided by aged care providers lies with the Aged Care Quality and Safety Commission (or its predecessors). However, the Aged Care Quality and Safety Commission's role is to audit aged care services for compliance against the Standards; the role does not include monitoring of special needs group allocations nor if there is culturally specific care provided to veterans. It appears no government department is responsible for monitoring that care and services are delivered to veterans in a manner that is culturally specific and respectful. Similarly, it appears no government department is requesting statistics be captured on all veterans and widows/ers using aged care services, ie including Australian and Allied veterans, widows/ers, and spouses without DVA entitlement.

DVA must take responsibility to ensure that older veterans consistently receive care and support services that meet their needs.

Interestingly, in the most recent Aged Care Approvals Round, 23 residential aged care services received allocation of places for veterans. Seventeen of the 23 are commencing services that are yet to open; six were existing services. Of the six existing services with new veteran allocation, only two have any public information that indicate that they provide care services to veterans (listed on My Aged Care).

Supporting veterans:

As stated, veterans see themselves as different to the general population. Stemming from a lived, shared experience. For the majority of veterans there is an in-built need to 'look after' another veteran or mate. For veterans of World War II, Korea, Malaya and Vietnam, volunteering with ex-service organisations not only assisted in looking after each other but was also essentially useful for trying to maintain stability of own mental health. The 'friendly visitor' type program has been delivered by the veteran volunteers of ex-service organisations for decades. Visits are conducted to veterans and/or war widows/ers in their own home, in hospitals, and in aged care facilities; making sure they are safe, but also making sure they stay feeling connected to the veteran community. Unfortunately, this is getting harder.

The most frequent feedback received from RSL Welfare Advocates/volunteers, is about trying to get information from residential aged care facilities. While the RSL respects the privacy legislation, it is not difficult for staff to ask a veteran if they wish to be visited by an ex-service organisation volunteer. We believe this is even more important where veterans have no family/friends in close proximity.

Many RSL Sub-Branches around Australia have developed excellent relationships with local residential aged care facilities and local hospitals. Despite this, a change in management or staffing at the facility level can cause relationship glitches. A recent example was reported by a Welfare Advocate in the ACT where a veteran, without family and under Guardianship, had been supported by the local RSL for the last four years; they visited him regularly. Unfortunately, the RSL learnt about the veteran's death when they saw it in the newspaper, 10 days later – neither the facility nor the Guardian had provided an

update to the RSL. More unfortunately, while the RSL offered to conduct an RSL Veteran Tribute at his funeral, they were informed he had already been cremated. While this example may seem inconsequential, conducting a Veteran Tribute is one of the most significant duties that one veteran can provide for another.

Quality of Care Principles v Reablement focus:

The RSL is aware that the Royal Commission has heard much about the need for a reablement focus in aged care services. While everyone has been citing the words for many years, there has been no change; the system remains focused on illness, frailty and age.

For older persons receiving services under the Commonwealth Home Support Program or a Home Care Package, they can still access Allied Health professionals when they need them, even if the number of sessions may be limited. For veterans and war widows/ers with DVA health care cards, they have ready access to Allied Health professionals whenever assessed as requiring them.

However, this all changes in residential aged care, particularly if assessed as a 'high level of care'. Under the *Quality of Care Principles 2014*, the aged care provider is responsible for providing the funding for Allied Health services, as such veterans assessed as high care no longer have easy access to Allied Health services funded by DVA. This is a significant issue as Allied Health funded by the aged care provider often consists of an initial assessment and monthly review by the Allied Health professional, while the care staff are expected to deliver a program for each resident that they do not have time to complete.

There are many examples where the RSL has funded private physiotherapy, occupational therapy and speech therapy programs for veterans, deemed 'high care' in residential aged care, to ensure they have a continued quality of life. It did make/has made a difference to the individuals and to their families. In this respect, veterans are fortunate that they can access this type of funding support; many older Australians from the general population would not be able to self-fund these one-to-one sessions.

While the RSL appreciates that funding and staffing in aged care are significant stumbling blocks, there must be more focus put on enabling each older person to have the best quality of life possible; there must be greater emphasis on engaging Allied Health professionals to deliver appropriate and sufficient services to all residents in residential aged care. To this end, DVA entitled veterans and war widows/ers should continue to have full access to all health-related services, including Allied Health, that they have always had; these entitlements should not cease until the death of the veteran or war widow/er.

Another area affected by the *Quality of Care Principles 2014* is the supply of consumables, ie products and equipment. Items previously funded by DVA cease when a veteran is deemed 'high care' in a residential aged care facility (although we acknowledge that there are always exceptions). For example, a veteran assessed as requiring a wheelchair or special recliner chair in their own home could have this provided by DVA. As an aged care facility is to provide access to these under the *Quality of Care Principles 2014*, these items are not provided by DVA for veterans in residential aged care where assessed as 'high care'. As 'provide access to' does not equate to having equipment such as wheelchairs

for exclusive use, the veterans have to self-fund equipment that they have previously been entitled to where needed. While DVA now allow veterans and war widows/ers to take previously approved equipment items into residential aged care, a previous supply of products funded by DVA, such as continence aids, will quickly run out. Continence aids and wound dressings in residential aged care are frequent complaint themes heard by the RSL. Veterans and war widows/ers who had been assessed as requiring a certain continence aid or wound product when living in their own home, have these changed when they are admitted to residential 'high care'. The RSL acknowledges that facilities would not stock multiple different brands of aids/dressing product; however, all too often changes of the aid/product are forced upon the individual without discussion and without explanation. This appears to be more about suiting the facility routine rather than assessing the individual. Again, at a time when older persons are most vulnerable, ie newly admitted to residential aged care, for veterans and war widows/ers there is another loss of benefits from DVA.

The future:

The development of a seamless process that enables increases in care/support services based on each individual's assessed need is essential to counteract any adverse outcomes. It's what all older people deserve.

As previously stated, the RSL firmly believes that DVA funding for care/support programs must continue for all entitled veterans and war widows/ers. We further argue that all benefits under DVA health and treatment programs should continue for entitled veterans and war widows/ers until death, irrespective of where the veteran or war widow/er resides. Veterans' health needs are complex. As veterans are more likely to have multiple chronic health conditions, the ability to access Allied Health assessments and therapy must continue for quality of life.

The numbers of those with DVA entitlement are declining and will never (hopefully) be as significant as when the World War 1/World War 2 cohorts first entered aged care. In this respect, it would be possible and beneficial for all veterans to remain under the direct auspices of DVA. As the Productivity Commission stated, 'from enlistment until death'.

According to the DVA factsheet, HSV05-Moving into Residential Aged Care, "'*Special Needs' status was assigned to veterans as a result of their wartime experience impacting on their journey through life. This impact may have resulted in complex medical requirements that include the need for high levels of emotional and cultural specific support in old age."* With the changes to the aged care approval rounds, ie no longer applicable in-home care and unknown if it will continue in residential aged care, the granting of 'special needs' status to veterans will no-longer have any meaning. Even now, there appears nothing special provided to veterans in aged care.

However, maximum effect of services to veterans could be undertaken with minimal change. DVA already contract support services under Veterans' Home Care and clinical services under the Community Nursing Program for entitled veterans and war widows/ers. While the RSL is aware that there can be glitches in these services, the system is generally attuned to the needs of veterans. It is at the point of transitioning to higher levels of care under the Commonwealth Home Care Package program or residential aged care that veterans no longer feel understood or acknowledged. It would take little

change for contracts to provide increased support options. Services under Veterans' Home Care together with services under the Community Nursing Program could be packaged to provide a higher level of support, thus effectively providing the equivalent of a Commonwealth home care package. In relation to residential aged care, the RSL would not expect DVA to provide this; it would limit where services for veterans were available, thus impacting families and communities. However, DVA could fund positions such as aged care placement coordinators. These coordinators could assist veterans/families to find suitable accommodation and assist with the entry procedures, particularly at times where urgent admission is required, such as discharge from hospital, or for veterans where there is no family to assist. These coordinators could also be a source of knowledge/assistance to aged care facilities who have veterans with mental health conditions.

We need to plan now for what is about to come. The next veteran cohort that will be requiring aged care services is the Vietnam cohort. Many in this cohort have multiple comorbidities in relation to mental and physical health conditions. Their health issues are already very complex.

According to DVA treatment population statistics, there are currently 38,922 veterans and 7,896 dependents from the Vietnam conflict with a DVA health care card, ie gold card or white card (*DVA Treatment Population Statistics, June 2019*). The DVA pension statistics show that 32,845 (84%) of these veterans receive a disability payment of some form from DVA. Of more significance, 19,923 (51%) of these veterans are Totally & Permanently Incapacitated (*DVA Pensioner Summary Statistics*, *June 2019*). Put very simply, to be granted a Totally & Permanently Incapacitated (TPI) pension there must be a significant degree of incapacity that prevents the veteran from having or continuing a working life.

As can be seen, of the Vietnam veterans already with DVA health care entitlement, over half have not been able to complete a normal working life due to disabilities caused by/resulting from their Defence-service. This cohort are already requiring skilled clinical and psychological treatments. The need for specialised treatments will continue when they require aged care services.

In closing:

Firstly, the RSL wishes to acknowledge that there are some aged care providers who identify veterans and cater for their needs very well. For some providers this has been built into their processes; unfortunately, these are not the majority.

Secondly, we will restate that we would like to see DVA take on more responsibility for veterans and war widows/ers as they require higher levels of care and support. Veterans' Home Care providers and Community Nursing providers are contracted to DVA; contracted to provide veteran centric services. While these services are attuned to veterans' needs, currently as a veteran or war widow/er transitions to higher levels of care under the Commonwealth Home Care Package program or residential aged care, the services no longer demonstrate this level of understanding.

For veterans with mental health conditions as a result Defence-service, a veteran supplement was introduced to prevent 'barriers to access' to high-level Commonwealth aged care services. An acknowledgement that veterans are different, and that their care needs are complex. But despite a

supplement being introduced to fund programs/activities that could benefit the veteran, there is no accountability for residential aged care providers to use these additional funds on the veteran. This must change. The next cohort of veterans to enter the aged care system, the Vietnam cohort, will probably demonstrate just how different veterans are to the general public. They already require complex treatment regimens for both physical and mental health conditions, and they will expect these to be delivered.

Lastly, as a special needs group, there is limited recognition of 'special needs'. There is little evidence that indicates aged care providers understand that the definition of 'veteran' extends past those with DVA entitlement. There is a lack of understanding that not all persons who served with the Australian Defence Force will have DVA entitlements. In supporting veterans from CALD backgrounds, the RSL is aware that while aged care providers identify that they are from non-English speaking backgrounds, there is no recognition that they are veterans with veteran specific cultural needs and who suffer similar physical and mental health conditions as Australian veterans with DVA entitlement. Likewise, for spouses and widows/ers without DVA entitlement, there is no identification or recognition of their special needs. There must be more emphasis placed on identifying all persons from the veteran community so that appropriate care and supports can be provided.