Returned & Services League of Australia

Disability Care and Support

August 2010

To:
The Presiding Commissioner
Productivity Commission
Disability Care and Support
Parliament House
Canberra ACT 2600

Dear Madam

Re: Inquiry into Disability Care and Support

We have pleasure in submitting our views to you.

This document contains five parts:

- **Part 1: The Returned & Services League of Australia**
- **Part 2: Health Needs and the Ex-Service Community**
- **Part 3: Entitlements and the DVA Ex-Service Community**
- **Part 4: Other Essential Services**
- **Part 5: Future Health Expenditure**

The Returned & Services League of Australia would like to thank you for this opportunity to provide comment to your Inquiry – Disability Care and Support

We trust our submission will receive the careful consideration which our membership has come to expect from the Productivity Commission.

Yours faithfully

RADM Ken Doolan AO RAN (Retd)

National President

Introduction

Each of us are at risk of experiencing a disability, it's an issue that affects every person, every day. As there is increased risk of acquiring a profound disability due to age, the result of an ageing population will be a continuing increase in numbers of Australians with a significant disability. The projected increase in people with disabilities and declining informal support as carers' age will result in an ever increasing demand for government budget expenditure, a budget which is already unable to cope with the funding of needed services.

As the discussion paper suggests, disability comes in many forms, each with different impacts on people's lives and with different durations. But a disability system should start with the premise that everyone is entitled to the same opportunities. Social inclusion is a term that is more frequently being used. The Australian government's approach to social inclusion is one where all Australians are valued and have the opportunity to participate fully in the life of our society.

Disability takes many forms and the Returned & Services League of Australia (RSL) most commonly sees chronic physical and/or mental health disabilities. While each condition is unique to the individual and varies widely, living with conditions such as post traumatic stress disorder (PTSD) often leads to disadvantages and an inability for people to participate in society at the level they would like to. For social inclusion to be successful, barriers currently faced by people with a disability need to be removed. Barriers are currently seen in accommodation options, transport, aids and equipment, and access to health care professionals to name but a few examples. Removal of these barriers requires a National approach. State differences and/or regional differences need to be removed.

Similarly to the aged care sector, disability spending is based on places and programs not people. There is an attempt to fit the people to the programs that have been developed, rather than fund the person who requires the support. The introduction of a National Disability Insurance Scheme (NDIS) could be partnered with a National Disability Strategy to ensure all people across all States have equal access to appropriate and sufficient support services; it has to be available to all. While eligibility criteria would need to be developed, access should be based on individuals' needs for support, not on who can afford to pay or where they are located. A 'no-fault' NDIS should support a range of benefits, including care, therapy, community access and support, and accommodation. While the RSL supports an NDIS, where servicemen and women have acquired a disability as a direct result of service to their country, compensation is to remain the responsibility of the Department of Defence or the Department of Veterans' Affairs (DVA).

Part 1: The Returned & Services League of Australia

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

The ex-service community extends beyond just those veterans and war widows/ers who are covered by entitlements through DVA; it includes all past and current serving members of the Australian Defence Force or of an Allied Defence Force, their spouse, widow or widower, and their dependents.

The RSL provides assistance and support for this larger ex-service population, and is committed to ensuring that all members of the ex-service community are enabled to live with dignity, supported in the location of their choice.

The veteran population is ageing faster than the general population, with a high percentage of men over 80 years of age entitled to benefits through the Department of Veterans' Affairs (DVA). According to DVA statistics, as at 2 April 2010 the DVA treatment population in Australia was 260,513, at least 59% are aged 80 and above.

While our World War II ex-service population is receiving support for their disabilities through aged care services rather than disability services, there are many different age groups within the ex-service community whom the RSL supports and represents, for example:

- As stated, the older World War II group is currently receiving services through the aged care sector.
- The veterans of Korea, Malaya and Vietnam are also becoming in need of support as they succumb to their physical and/or mental health disabilities. While some of these veterans are now over 65 years of age, a substantial percentage remains below. Required support services are either provided through the aged care sector or the disability sector, depending on age, thereby causing confusion when determining options to, and of care.
- The younger veterans, with their multiple deployments, are being diagnosed with similar physical and mental health disabilities that have plagued previous generations of veterans. Currently these younger veterans with physical disabilities and/or mental health disabilities are typically being cared for by a spouse or their parents. While support services may be funded by the Department of Defence or the Department of Veterans' Affairs for qualifying ex-service personnel, there is an impact on community services external to the veteran programs, especially for their families.

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

Part 2: Health Needs and the Ex-Service Community

2.1 Veterans' Physical Health

Health issues of the ex-service population continue to be studied. Analysis of health related problems through the DVA treatment population shows that veterans have higher rates of disease risk factors due to smoking, alcohol consumption, and the effects of trauma. Many veterans have multiple co-morbidities with the number increasing incrementally with age. According to DVA, the average World War II ex-serviceman has up to five co-morbidities. As the level of disability is increased by additional disease processes, the average older veteran is now significantly disabled.

Veterans are more likely to suffer from diseases of the digestive, respiratory, nervous, circulatory, and musculoskeletal systems. Recent research continues to conclude that they are more likely, compared to the general population, to develop cancer, suffer from arthritis, suffer from chronic obstructive pulmonary disease, and risk factors are also high for the development of Alzheimer's disease; with all of these disease processes causing different degrees of disability. As a result, veterans also have a higher use of medications than the general community.

Ongoing studies of veteran groups both in Australia and internationally are showing that physical and/or mental health disabilities are continuing to be identified, with some effects becoming evident many years post involvement in the armed services. Australian studies of the Vietnam cohort all indicate that their health and well-being have suffered as a direct result of service in the armed forces. Similarly international studies of more recent conflicts are concluding that health and well-being issues are more prevalent within armed forces personnel; including mental health disabilities in view of multiple deployments.

However the current system is more concerned with jurisdictions rather than considering a person as a whole. The uniqueness of each individual's particular needs may cross current sector boundaries. The RSL could provide countless examples where funding program boundaries result in a lack of service provision, some of which are more apparent due to State based program controls. For example, in one State a 63 year old was informed that they were ineligible for an Aged Care Assessment Team (ACAT) assessment despite the urgent need for 24 hour residential care, yet in another State a 62 year old is promptly assessed by ACAT and placed on an Extended Aged Care at Home (EACH) package.

The real challenge for the health, disability and aged care industry is to ensure appropriate treatment and care is both available and accessible when needed. The sectors cannot continue to be silos, nor should they be limited by State or regional boundaries. The need to link appropriate health, disability and aged care services is fundamental if people are to receive services that best suit their needs; a seamless system is of vital importance.

2.2 Veterans' Mental Health Issues

Many veterans have mental health problems, including insomnia, anxiety, depression, and PTSD. Mental health problems were under-diagnosed in the World War II cohort; however

we are now seeing the impact of war-related memories associated with the ageing processes, such as grief, loss, and accelerated dementia. The combination of PTSD with a dementia type illness is especially challenging for the person as well as for family and carers. Mental health disorders such as PTSD are well documented in relation to the Vietnam Veterans, and although treatment programs have been utilised, success has been varied; the impact of the ageing process will undoubtedly be a further challenge for this cohort with PTSD. However of concern is the rising numbers of current or recent serving ADF personnel with mental health disabilities.

The multiple deployments and diverse operations of our current (or recent) serving members of the Australian Defence Force – from combat, post conflict stabilisation and peacekeeping, to disaster relief– are feared to be having a cumulative effect, leading to PTSD, depression and anxiety disorders. Similar concerns have been raised in both the US and the UK.

A study reviewing returning veterans cared for at Veterans' Affairs facilities in the US between 2001 and 2005, found that a third were diagnosed with a mental illness (13% suffered PTSD) or a psycho-social disorder, such as homelessness and/or marital problems, inclusive of domestic violence. The Study further raised the issue of age – 'the group with the highest rate of mental problems are those between 18 and 24'. (*Casualty of War: Mental Health, TIME, March 12, 2007*). In June 2006 *The Independent* newspaper published a story regarding the mental health of UK veterans, indicating that psychiatric disorders had escalated since the beginning of the Iraq war. 'The Iraq veterans they are now treating are mostly in their twenties. Some have post-traumatic stress disorder. Others suffer from depression, high levels of anxiety, or from the effect of trying to solve their own problems using drink or drugs.'

Information in 2010 indicates that the numbers of new cases of mental health disabilities continue to be problematic. Articles from the US indicate that one in nine American soldiers is medically discharged from the armed services due to mental health disorders. The relationship between multiple deployments and increased systems of anxiety, PTSD, and depression are currently being closely reviewed, as is age. The statistics on Australian ADF personnel are not dissimilar. It has been estimated that up to 10% of our current returning combat veterans may be suffering long term mental health illnesses.

There are programs funded by the Department of Defence and DVA available to assist the ex-service community with counselling and psychiatric treatment, although for some this is very limited. The effects of a mental health disability can have far reaching impact on the life of an individual and his/her family. Partners and/or caregivers of veterans who suffered PTSD have been shown to have higher levels of depression, anxiety, hostility, obsessive compulsive symptoms, and physical complaints.

Mental health disorders can be extremely disabling, affecting an individual's well-being on every level. While there are many Australians who will experience a mental illness at some time, there is an increased vulnerability in the ex-service community. However, community based mental health services are not sufficient to meet everyone's needs.

The National Health and Hospitals Reform Commission Report (June 2009) stated that it was imperative for people living with mental illness to be supported across the whole spectrum of health and social support services, including employment support and assisted housing, as without these supports being provided in an holistic way, 'people with severe mental illness can experience a downwards spiral that impairs their ability to live a normal life.' (*National Health and Hospitals Reform Commission Report: A healthier future for all Australians, final report June 2009, pg 106*)

- **The RSL strongly recommends that there is seamless interaction between health, disability and aged care services, inclusive of appropriate accommodation.**

2.3 Children of Veterans

The findings from the Vietnam Veterans Health Study 1998 suggested that congenital abnormality and mortality rates are much higher in children of Vietnam Veterans than that of the general community. More recent studies of children of current and recent ex-serving members of the Australian Defence Forces are identifying some unusual behavioural characteristics. For these young children with disabilities the need for early intervention services is of paramount importance.

- **The RSL recommends that early intervention programs, inclusive of therapy, education and support, be prioritised for younger children with congenital or early acquired disabilities.**

Part 3: Entitlements & the DVA Veteran Community

Where appropriate, compensation entitlements are available to ex-service personnel under the Veterans' Entitlements Act 1986 (VEA), the Safety and Rehabilitation Compensation Act 1988 (SRCA) or the recent Military Rehabilitation and Compensation Act 2004 (MRCA). However, some ex-service personnel needing immediate disability care and support can have their access hindered due to delays created by various Departments debating whose responsibility it is for their ongoing care, inclusive of financial responsibility. The RSL is aware of examples of ex-service personnel developing extreme depression and suffering mental health disabilities as a result of these delays.

- **The RSL strongly recommends that the responsibility for funding the care and support of servicemen and women who have acquired a disability as a direct result of service to their country remain with the Department of Veterans' Affairs, and that sufficient funds are made available to this Department from the Budget to accommodate these members.**

Part 4: Other Essential Services

4.1 Aids and Equipment:

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

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

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

The need for appropriate aids and equipment to assist people with a disability to stay living as independently as possible in their own home cannot be under-estimated. While those with disabilities have access to aids and equipment programs, due to the extensive waiting periods for items of importance the majority of people self-purchase. For others who are unable to self-fund the required aids and equipment, their ability to remain safely in their own homes is greatly impacted, both from a physical and psychological perspective. There is much discussion in recent government papers regarding social inclusiveness, yet for many individuals the lack of appropriate aid and/or equipment causes the biggest barrier to participation in the community.

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

- **The RSL strongly recommends that all persons have fair and equal access to aids, equipment, and home modifications when needed, and that each person's need for these supports is met on a timely basis.**

4.2 Accommodation:

Of great concern for the RSL is the lack of affordable, appropriate housing for those with a disability.

All persons have the right to live in secure housing, appropriate to their needs. The RSL receives many requests from members of the ex-service community to assist with accessing affordable accommodation. While affordable housing is in short supply for the whole community, for those with a disability and financial constraints, there is a significant decrease in available options. The RSL is aware of younger veterans with physical disabilities who are unable to find suitable supported accommodation; for a number of these young servicemen/women their care and accommodation supports are forced back on parents or family. For those with a mental health disability, such as PTSD, the scarcity of affordable and/or supported accommodation impacts heavily on future planning, and of course mental well-being. The RSL is aware of younger veterans with mental health disabilities 'bouncing' between psychiatric in-patient services and insecure housing or homelessness. While an NDIS is not expected to cover the costs attached with building new facilities, accommodation is as fundamental to good health as care and support systems. Sufficient and appropriately constructed housing stock is essential if all people with a disability are to be enabled to dwell in an appropriate setting, with some security of tenure. This must also include affordable supported accommodation for those who need additional support due to significant mental health disabilities.

While the RSL acknowledges that Commonwealth, State and Territory funding has been increased into the accommodation sector, not all new buildings are being constructed to enable ease of access for disabled persons or to enable the concept of ageing in place. As we have an ageing population, all new building constructions should enable ease of access for those with a disability and for people to age in place.

- **The RSL strongly recommends an increase in supply of affordable housing, including supported accommodation.**
- **The RSL strongly recommends that all new building constructions should be built to universal disability specifications; this would also enable ageing in place to occur.**

Part 5: Future Health Expenditure

The current health system is composed of services in different silos either focusing on sickness, disability or age. The changes of responsibility in HACC also indicate that you require services because you are either disabled (if under 65 years of age) or you are aged (if you are 65+ years of age). Health promotion and health prevention are recent endorsements of government health budget allocation and must play an integral role in the future if we are to decrease the financial burdens of health support systems. However there are current health and disability issues that, if addressed, could have a major positive impact on decreasing the need for service provision and improving people's quality of life. As such the following areas are highlighted: the management of chronic pain, and Alzheimer's disease.

5.1 National Pain Strategy

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

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

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

- That chronic pain be recognised as a disease in its own right.

- That pain be given a diagnostic code along with other chronic diseases to document its
  prevalence, outcomes and costs.

- That when monitoring patients, pain be included as the fifth vital sign (with blood pressure, heart rate, temperature and breathing rate).

- That more effort be made to de-stigmatise pain (similar to the successful campaigns to
  de-stigmatise depression).

- That a multidisciplinary approach be utilised.

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

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

5.2 Alzheimer's Disease

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

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

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

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

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

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

There is a need to manage the dementia epidemic. Dementia is often referred to as a disease of ageing, it is not; while prevalence is higher in the older age bracket, dementia also affects younger persons. Appropriate funding must be allocated to continue research into this disease; research to determine early intervention strategies and potential treatment options that may significantly reduce the disability that results from this disease. However while breakthroughs are awaited, ongoing funding will be required to ensure that people affected by dementia, individuals and their families, have easy access to, and are supported with care and services in a location of their choice.

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

Conclusion

The disability system requires a fundamental and transformational change. It is currently hindered by inefficiencies, inequities and insufficient services and funding. There is much to be achieved by introducing a National Disability Insurance Scheme; it would also support a National Disability Strategy.

While prevention and early intervention have to take a key role if there is to be any impact on decreasing the impact of disability on individuals and the community in the future, there is an urgent need to develop a seamless health care system where health, disability and age care services are integrated to meet the changing and/or lifelong needs of the individuals.

Thank you for your consideration and attention to our submission. Through true integrated systems we believe Governments can achieve their health aims and objectives.