COMPENSATION AND REHABILITATION[1]

EXTREME DISABLEMENT ADJUSTMENT

Introduction

In a Spring 2011 *Wings* article, I outlined some of the key provisions of the *Veterans' Entitlement Act 1986* (VEA). This quarter I'd like to drill down on one of the VEA provisions that is of crucial relevance to those Members who are over 65, are retired and are seriously unwell or approaching the end-stage of life: Extreme Disablement Adjustment (EDA).

Who is Eligible for EDA?

To be determined EDA, you must:

- be over 65;
- have injuries caused or aggravated by war or defence service;
- not be receiving a Totally and Permanently Incapacitated, Temporarily Totally Incapacitated or Intermediate Rate Disability Pension;
- have 70 Medical Impairment Points (MIP); and
- have a Lifestyle Rating of 6.

As the title of the entitlement suggests, your level of incapacity must be extreme. This does not, however, mean that you should wait until you are at that level of incapacity before you start thinking about a claim. Indeed, if you wait until this stage, you may be too late – as I'll illustrate in case studies later in this article.

What are the benefits of EDA?

Depending on your current financial circumstances, the pension consequence for you of being determined EDA may or may not be significant – if you're already receiving a DP at the 100% rate your fortnightly payment will increase by roughly 50%.

If you are severely disabled and have many years to live, this pension increase combined with the Gold Card, to which you will also become entitled (if you are currently not already), will be significant benefits.

But, if you are approaching the final stage of your life, the real benefit will be for your peace of mind. What I mean by this is that, assuming you pre-decease your spouse, she/he will receive a Defence/War Widow(er)'s Pension and a Gold Card - **automatically**. In other words, your spouse will not face the angst of needing to apply for a pension at a most emotional and vulnerable time: while she/he is grieving your demise.

A few words of Caution!

Remember:

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[1] This article has been prepared by R. N. (Dick) Kelloway, Advocate, National Vice President Advocacy and Entitlements.

- if you are preparing a primary claim for your medical conditions with a view to EDA, you will need to be able to convince the Delegate that at this late stage of your life, having lived with one or more serious medical conditions they are now so debilitating that your level of incapacity warrants the award of EDA;

- the task ahead will probably be easier if you have thought ahead and claimed your conditions, applied for increases in disability pension as the severity and lifestyle effects of those conditions has worsened with age, and are now so severely incapacitated that you meet the 70 MIP and 6 LR criteria; and

- when reading below about Medical Impairment and Lifestyle Effects, to be determined as EDA you must have lodged a claim, application or appeal under the VEA AND a Delegate of the Repatriation Commission accepted that your conditions are service-caused AND must have assessed that your medical practitioner's description of the severity of your conditions matches the GARP MIP descriptors AND must have assessed your level of incapacity as warranting an LR of 6. (As an aside, attaching to the claim/application/appeal a written report from the veteran's carer or occupational therapist as independent evidence of the lifestyle effects his condition(s) is very helpful for the Delegate.)

What does 70 MIP Mean?
To accrue 70 MIP you will need to have severe disabilities AND they will need to be accepted as being related to your service.

Some of the medical conditions that are typical amongst severely disabled veterans are outlined below. The descriptors and MIP below are taken from GARP (see my last article in the Winter 2012 Wings). Note that if your level of impairment is less severe than the descriptors below, you will receive a lower number of MIP. If your resulting level of impairment is at its most severe, the following MIP will result:

- **Loss of lower limb function:** If you are restricted to walking in and around your home, or can only walk with personal assistance or a walking frame, you will accrue 60 MIP (which is then age-adjusted, which means that MIP are deducted from this number by a factor that depends on your age).

- **Loss of upper limb function:** If you have unable to use an upper limb, you will accrue 60 MIP (which is then age-adjusted).

- **Emotional and behavioural disabilities:** If your psychiatric condition(s) are so intrusive that you cannot distract yourself from them AND your distress is all-pervasive, AND your family/recreational/social life is virtually non-existent AND you are under continuous psychiatric treatment, you will accrue 72 MIP.

- **Neurological conditions:** These arise from conditions such as Alzheimer's or vascular dementia, and the veteran is most likely unable to complete a claim or application for increase in disability pension.

    - **Cognition:** If the veteran is unable to plan activities without supervision and prompting, acquire or recall new information or is disorientated in familiar surroundings, he/she will accrue 70 MIP.

    - **Comprehension:** If the veteran is unable to understand simple instructions or is unable to read simple words/labels/signs, he/she will accrue 50 MIP.

- **Expression:** If the veteran is unable to speak, OR whose speech is limited to single words or familiar social phrases OR has lost the ability to write all but much-practiced routines (eg, his/her name), he/she will accrue 40 MIP.

- **Malignant disorders:** Malignancy can occur in virtually any body system, and will be associated with medical terms such as melanoma, neoplasm, and carcinoma.

- **Cardiovascular disease:** If you have a history of myocardial infarct (with or without successful surgery) and have frequent angina, or are on repeated or permanent doses of oral steroids for lower respiratory tract disease, you will accrue 20 MIP. A malignant disorder will attract 70 MIP if it prevents most everyday activities or results in a life expectancy of less than 25% chance of surviving for one year.

- **Multiple disorders.** Of course, if you are unlucky to have multiple conditions it is possible that you may aggregate 70 MIP with a lower level of severity of each individual condition.

What does a LR of 6Mean?
To accrue a LR of 6 your medical condition(s) will need to have the following consequences for your quality of life:

- **Personal Relationships:** You have extreme difficulty in relating to any one, or your ability to communicate is restricted due to stroke or other effects of an accepted condition.

- **Mobility:** Your mobility is so severely impeded that you are restricted to home and the immediate vicinity, unless door-to-door transport and assistance are provided; you are unable to drive a car under any circumstances whatsoever.

- **Recreational and Community Activities:** You are able to engage only in a very few satisfying recreational activities, and are restricted to a few passive activities such as watching TV, listening to the radio, reading or receiving visitors.

- Domestic Activities: You are able to carry out only very limited domestic activities, usually a restricted range of indoor activities, and may require supervision in carrying out such activities; eg., you might be able to do very light tidying and dusting, but are unable to cook or prepare meals, or have difficulty standing to set table or wash dishes.

Some Case Studies
Three short case studies follow to help you understand the issues surrounding typical successful and unsuccessful claims or applications for EDA:

- **Case 1 – Close, but not close enough.** Bob had been an aerodrome defence guard during the later part of WWII and had spent countless nights on patrol in the jungle around an air base in Borneo. His nerves were shot by the experience, and thought he was going to die on a number of occasions when fired at by snipers. One sniper's bullet creased his helmet and another tore through the sling on his rifle. During the war he became a chain smoker to ease his nerves, and over the years after the war his alcohol consumption progressed to severe alcohol dependency before his doctor told him he must stop. Ashamed of his "weakness", for years he ignored his GP's

advice and wife's entreaties to drop down to the RSL to get in a claim. Finally, with his heart failing, his emphysema so bad that he was on oxygen at all times and on most nights still reliving his terrors in the jungle, Bob consulted a pensions officer. Surprised by the sympathetic hearing he received and amazed at the significance of his experiences and resulting medical conditions, he was delighted when his pension officer described as being the most compelling claim he had ever facilitated. The problem was that Bob died before his Service and Service Medical Records were received from DVA under FOI. His wife had to go through the trauma of preparing and lodging a claim for a war widow's pension, just after she had "laid her old boy to rest" as they did not have two sticks to bless themselves with when he died.

- **Case 2 – Just in time.** George was wounded in Korea, and feared for his life during an ambush in Malaya when his platoon inadvertently ambushed a company-size CT unit. He smoked heavily as a result for most of his life and retreated from society, buying a farm in a remote highland area, which he rarely left. When the farm became too much for him, he moved to the coast and into suburbia. After his death his neighbours described him as a quiet man whom they very rarely saw. With him home in bed and close to death from lung cancer his wife came down to the Branch to see if there was anything anyone could do. A few questions about George's smoking habit and the onset of ischaemic heart disease years before and, latterly, adenocarcinoma of the lung indicated a probable link to his service. The pension officer's intuition was, however, peeked by the wife's mentioning that when George went to town, one minute he was beside her and the next he'd disappeared. She'd later find George huddled down in the car and extremely anxious to get back to the farm. The pension officer raised the possibility of PTSD arising from George's having been wounded in action in Korea and his later ambush experience in Malaya. His wife said he had been to a psychiatrist just after he left the service and had walked out after ten minutes. The "shrink was a nut-case", he'd said at the time. Doing a quick calculation of the MIP and LR that might be determined in George's case, the pension officer calculated that to get EDA George would need some MIP for PTSD. He arranged to go to George's home to have him sign a claim for a disability pension, which the wife assisted in completing. When the pension officer was ushered into George's bedroom he raised the issue of possible PTSD, wt which George broke down uncontrollably, sobbing that "there was so much to say, so much that had happened". Armed with George's agreement, the pension officer arranged for a psychiatrist to make a home visit two days later. George's wife was tasked with obtaining GP reports for his cardiovascular disease and lung cancer. The psychiatrist provided a report the next day, as did the GP along with supporting specialist reports from his case notes, and the pension officer submitted the claim and documentation that same day. The next day George's GP rang to say George was not expected to live more than a fortnight. Two days later he rang to say that George had succumbed to his diseases. One month later, following a call by the pension officer to DVA, the Delegate determined George entitled to a disability pension at the EDA rate. His widow received a phone call from DVA the next day advising her that she had been awarded a war widow's pension.

- **Case 3 – An example of planning ahead.** In my last Wing's article you will have read about Bruce, a C-47 navigator during the Berlin Airlift. We left off the case at the time that Bruce and his wife were advised by their pension officer that a reasonable hypothesis is that Bruce's alcohol dependence, hypertension, ischaemic heart disease, aortic valve sclerosis, and recent cerebrovascular accident are sequela to the near death experience he experienced at Tempelhof. Fortunately, Bruce and his wife had been assiduous in keeping the Branch informed as his health deteriorated. The pension officers had been just as attentive and had got each of Bruce's

conditions accepted as they were diagnosed. He had therefore on a 100% pension with 55 MIP and LR of 4 for the last ten years, having missed out on TPI because he had turned 65 and retired before thinking about his deteriorating health. Now permanently bed-ridden, Bruce's LR was very clearly 6. Given the severity of the effects of the stroke, his pension officer realised that Bruce's condition would gain him many more than the required 15 MIP to be assessed at 70 MIP. The claim was successful, and Bruce is now receiving a disability pension at the EDA rate. More importantly, given his medical condition, he is greatly comforted by the knowledge that his wife will receive a war widow's pension and Gold Card automatically when he dies.

Where can I find more Information?
See:

- Fact Sheet DP30 for more information on EDA; and
- Fact Sheet DP18 for information on making a claim/applying for an increase in a Disability Pension.
- Fact Sheet DP43 for information on the defence/war widow(er)`s pension rates and allowances.
- Fact Sheet DP28 for comparative information on DP at the general rate.
- Fact Sheet DP60 for information on the Defence/war widow(er)`s pension.
- Fact Sheet IS03 for information on the Income Support Supplement (ISS) to which your widow(er) may be entitled.

Conclusion
As always, before starting to prepare a claim, I strongly advise you seek the support of a VEA-trained and authorised Pension Officer or Advocate. Your Division Secretary or Welfare Officer can refer you to a qualified practitioner.

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