



Australian Government
Productivity Commission

A Better Way to Support Veterans

Productivity Commission
Draft Report

December 2018

This is a draft report prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Opportunity for further comment

You are invited to examine this draft and comment on it by written submission to the Productivity Commission, preferably in electronic format, by **Monday 11 February 2019**. Further information on how to provide a submission is included on the inquiry website: www.pc.gov.au/inquiries/current/veterans/make-submission#lodge. You may also attend a public hearing or submit a short comment on the inquiry website: www.pc.gov.au/inquiries/current/veterans/assessment#draft.

The final report will be prepared after further submissions have been received and public hearings have been held, and will be forwarded to the Australian Government in June 2019.

Public hearing dates and venues

Location	Date	Venue
Adelaide, SA	4 February 2019	Hotel Grand Chancellor 65 Hindley Street, Adelaide
Perth, WA	5 February 2019	Mantra on Murray 305 Murray Street, Perth
Darwin, NT	7 February 2019	Hilton Darwin 116 The Esplanade, Darwin
Wagga, NSW	11 February 2019	Mercure Wagga Wagga 1 Morgan Street, Wagga Wagga
Canberra, ACT	12 February 2019	Productivity Commission Level 2, 4 National Circuit, Barton
Melbourne, Vic	13 February 2019	Productivity Commission Level 12, 530 Collins St, Melbourne
Hobart, TAS	15 February 2019	The Old Woolstore 1 Macquarie Street, Hobart
Sydney, NSW	26 February 2019	Adina Apartment Hotel 359 Crown Street, Surry Hills
Brisbane, QLD	27 February 2019	Mercure Brisbane 85-87 North Quay, Brisbane
Townsville, QLD	1 March 2019	Hotel Grand Chancellor 334 Flinders Street, Townsville

Terms of reference

I, the Hon Scott Morrison MP, Treasurer, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission undertake an inquiry into the system of compensation and rehabilitation for veterans (Serving and Ex-serving Australian Defence Force members).

Background

The recently released report of the Senate Foreign Affairs, Defence and Trade References Committee into Suicide by Veterans and Ex-Service Personnel, *The Constant Battle: Suicide by Veterans* (Senate Inquiry) documents the complexity in the overall legislative framework for compensation and rehabilitation for veterans. Submissions to the review called for an inquiry into the interplay between the various acts, including the use of the Statements of Principles and the effectiveness of the administration by the Department of Veterans' Affairs.

There have been many major reviews of veterans' legislation and programs, particularly its compensation program, over the last 40 plus years. Consistent with observations made by the Senate Foreign Affairs, Defence and Trade References Committee, the Government is now seeking a comprehensive examination of how the current compensation and rehabilitation system operates and should operate into the future.

Scope

This Productivity Commission inquiry will examine whether the system of compensation and rehabilitation for veterans (Serving and Ex-serving Australian Defence Force members) is fit for purpose now and into the future. In undertaking the inquiry, the Productivity Commission should review the efficiency and effectiveness of the legislative framework for compensation and rehabilitation of ex-service personnel and veterans, and assess opportunities for simplification.

This framework includes the *Veterans' Entitlements Act 1986*, the *Military Rehabilitation and Compensation Act 2004* and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*. The Productivity Commission should consider the interplay between the various pieces of legislation. It should also examine the effectiveness of the governance, administrative and service delivery arrangements that support the legislation (the 'supporting architecture').

The Productivity Commission should have regard to the current environment and challenges faced by veterans, including but not limited to:

whether the arrangements reflect contemporary best practice, drawing on experiences of Australian workers' compensation arrangements and military compensation frameworks in other similar jurisdictions (local and international);

the use of the Statements of Principles as a means to contribute to consistent decision-making based on sound medical-scientific evidence; and

whether the legislative framework and supporting architecture delivers compensation and rehabilitation to veterans in a well targeted, efficient and veteran-centric manner.

The Productivity Commission will also consider issues raised in previous reviews.

Process

The Productivity Commission should undertake appropriate public consultation, including holding hearings (including in regional Australia), inviting public submissions and releasing a draft report to the public.

The final report should be provided to Government within 15 months.

The Hon Scott Morrison MP
Treasurer

[Received 27 March 2018]

Foreword

We are pleased to present the draft report of the Productivity Commission's inquiry into the veteran support system.

The assistance that many people and organisations across Australia provided to us was invaluable. The list of those who engaged with us is long, but special mention goes to those serving Australian Defence Force members who met with us on bases, veterans and family members who told us about their experience, participated in our roundtables and made submissions, the Department of Veterans' Affairs and Department of Defence, researchers, insurance companies and ex-service organisations.

Your assistance and insights helped us better understand the current system and provided us with ideas on where improvements could be made.

The report sets out our current thinking and presents a number of draft recommendations that have the potential to significantly improve the wellbeing of veterans and their families. We are keen to hear your views on our draft recommendations and any further ideas you have on improving the system. We also have information requests in the report on particular areas where we would welcome your input.

Early in the new year we will be holding public hearings around Australia. The report provides details on times and locations as well as information on how to make a submission to the inquiry. Our final report will be delivered to the Australian Government at the end of June 2019.

A 'fit for purpose' veteran support system is vital if Australia is to honour its commitment to veterans. Thank you for your assistance and for your ongoing contribution to meeting this challenge.

Robert Fitzgerald and Richard Spencer
Commissioners

December 2018

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Abbreviations

AAO	Administrative Arrangements Order
AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
ADFRP	Australian Defence Force Rehabilitation Program
ADR	alternative dispute resolution
AGA	Australian Government Actuary
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
APSC	Australian Public Service Commission
ATDP	Advocacy Training and Development Program
ATO	Australian Taxation Office
AWM	Australian War Memorial
BoT	Board of Taxation
CBT	Cognitive behaviour therapy
CCS	Coordinated Client Support
CDC	consumer directed care
CDDA	Compensation for Detriment caused by Defective Administration
CDF	Chief of the Defence Force
CFTS	continuous full-time service
CI	confidence interval
CMA	contracted medical advisor
COAG	Council of Australian Governments
COIN	counter-insurgency
CSC	Commonwealth Superannuation Corporation
CTAS	Career Transition Assistance Scheme
CVC	Coordinated Veterans' Care

CWGC	Commonwealth War Graves Commission
DCO	Defence Community Organisation
DFISA	Defence Force Income Support Allowance
DFRDB	Defence Force Retirement and Death Benefits
DHS	Department of Human Services
DIPP	Defence Injury Prevention Program
DPM&C	Department of the Prime Minister and Cabinet
DRCA	<i>Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988</i>
DVA	Department of Veterans' Affairs
DWHSC	Defence Work, Health and Safety Committee
EDA	Extreme Disablement Adjustment
ESO	Ex-service organisation
ESORT	ESO Round Table
FTB	Family Tax Benefit
FTE	full-time equivalent
GARP	Guide to the Assessment of Rates of Veterans' Pensions
GARP-M	Guide to Determining Impairment and Compensation
GP	General practitioner
GST	Goods and Services Tax
HCH	Health Care Homes
ICT	Information and communications technology
IL	initial liability
ISS	Income Support Supplement
JHC	Joint Health Command
JTC	Joint Transition Command
MATES	Medicines Advice and Therapeutics Education Service
MCRA	<i>Military Rehabilitation and Compensation Act 2004</i>
MEAO	Middle East Area of Operations
MEC	Medical Employment Classification
MRCA	Military Rehabilitation and Compensation Act 2004
MRCAETS	Military Rehabilitation and Compensation Act Education

	and Training Scheme
MRCC	Military Rehabilitation and Compensation Commission
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NZVAB	New Zealand Veterans' Advisory Board
OBAS	On Base Advisory Service
OECD	Organisation for Economic Co-operation and Development
OHS	Occupational Health and Safety
PAYG	pay-as-you-go
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PCBU	persons conducting a business or undertaking
PGPA	<i>Public Governance, Performance and Accountability Act 2013</i>
PI	permanent impairment
PTSD	post-traumatic stress disorder
QA	quality assurance
RAAF	Royal Australian Air Force
RC	Repatriation Commission
RMA	Repatriation Medical Authority
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RSL	Returned and Services League
RTW	return to work
SAM	Single Access Mechanism
SERCAT	service category
SMRC	Specialist Medical Review Council
SoP	Statement of Principle
SRCA	<i>Safety, Rehabilitation and Compensation Act 1988</i>
SRCC	Safety, Rehabilitation and Compensation Commission
SRDP	Special Rate of Disability Pension
TAC	Transport Accident Commission
TPI	Totally and Permanently Incapacitated

TTTP	time taken to process
UN	United Nations
VCES	Veterans' Children Education Scheme
VCR	Veteran Centric Reform
VEA	<i>Veterans' Entitlements Act 1986</i>
Veterans' MATES	Veterans' Medicines Advice and Therapeutics Education Services
VHC	Veterans' Home Care
VSC	Veteran Services Commission
VVCS	Veterans and Veterans Families Counselling Service
VVRS	Veterans' Vocational Rehabilitation Scheme
WH&S	Work Health and Safety
WHO	World Health Organization
WPIT	Welfare Payment Infrastructure Transformation

OVERVIEW

Key points

- The veterans' compensation and rehabilitation system is not fit-for-purpose — it requires fundamental reform. It is out-of-date and is not working in the interests of veterans and their families or the Australian community.
- The system fails to focus on the lifetime wellbeing of veterans. It is complex (legislatively and administratively), difficult to navigate, inequitable, and it is poorly administered (and has been for decades), which places unwarranted stress on claimants. Some supports are not wellness focused, some are not well targeted and others are archaic, dating back to the 1920s.
- In 2017-18, the Department of Veterans' Affairs (DVA) spent \$13.2 billion supporting about 166 000 veterans and 117 000 dependants (about \$47 000 per client). And while the veteran support system is more generous overall than workers' compensation schemes for civilians, money alone does not mean it is an effective scheme.
- The system needs to focus on the wellbeing of veterans over their lifetime. This means more attention to prevention, rehabilitation and transition support, which in turn will produce better outcomes for veterans, their families and the Australian community.
- To achieve this focus, the system needs to be redesigned based on the best practice features of workers' compensation and contemporary social insurance schemes.
- This will require new governance and funding arrangements.
 - A single Ministry for Defence Personnel and Veterans should be established.
 - A new independent statutory agency — the Veteran Services Commission — should be created to administer and oversee the performance of the veteran support system.
 - DVA's policy responsibility should be transferred to the Department of Defence within a new Veterans Policy Group.
 - An annual premium to fund the expected costs of future claims should be levied on Defence.
- Responsibility for preparing serving veterans for, and assisting them with, their transition to civilian life should be centralised in a new Joint Transition Command within Defence.
- DVA's recent Veteran Centric Reform transformation program is showing early signs of success. It should continue to be rolled out to mid 2021 as planned, but adjusted where necessary to accommodate the proposed reforms.
- The current system should be simplified by: continuing to make the system easier for clients to access (a complex system does not need to be complex for users), rationalising benefits, harmonising across the Acts (including a single pathway for reviews of decisions, a single test for liability and common assessment processes), and moving to two compensation and rehabilitation schemes by July 2025.
 - Scheme 1 should largely cover an older cohort of veterans with operational service and injuries that occurred before 2004, based on a modified *Veterans' Entitlements Act 1986* (VEA). Scheme 2 should cover all other veterans, based on a modified *Military Rehabilitation and Compensation Act 2004* (MRCA), and over time will become the dominant scheme.
- The way treatments and supports are commissioned and provided to veterans and their families also needs to change. There needs to be more proactive engagement with clients and providers and better oversight of outcomes.
- The recent decision to expand non-liability coverage to mental health care was a positive one, however, the Veteran Mental Health Strategy needs to be updated urgently with specific attention to suicide prevention and access to supports for veterans.

Overview

An implicit principle underpinning the current veterans' compensation and rehabilitation system is that military service is a unique occupation. Military service involves a requirement to follow orders, frequent relocations (both for military personnel and their families) and long and irregular hours. Military personnel are also frequently placed in high-risk environments, including in war or operational service and while in training or on peacetime service. As the Department of Defence put it:

Australians join the Defence Force for a variety of reasons, but collectively they accept the forfeiture of certain freedoms enjoyed, and taken for granted, by all others in Australian society. Almost every aspect of uniformed life comes with a risk or cost to the member and/or to their families.

Support for members and their families in the event that these risks materialise is widely regarded as a condition of military service. The Australian Government is also committed (and has been since World War I) to supporting, and reintegrating into society, those who are affected by their service in the Australian Defence Force (ADF). And many ex-service organisations provide support to current and former ADF members and their dependants.

While most ADF members successfully transition and quickly re-establish civilian lives, some struggle to address the challenges they experience when they leave the military. Those discharged involuntarily can be deeply impacted. And sometimes the impacts of service do not become apparent until many years after discharge. The health and wellbeing of family members can also be affected by a veteran's military service, especially the dependants of veterans who have died as a consequence of service.

Australia's response

Australia has a comprehensive system of support for veterans which includes income support, compensation, health care, rehabilitation and other services. Access to some of the supports and services is contingent on a veteran having suffered an injury or illness (or death) related to their military service. Other supports are available irrespective of whether they incurred an injury or illness.

Australia's veterans' compensation and rehabilitation system is separate from, and more generous overall than, the system of workers' compensation and support generally available to civilian workers. It is described as 'beneficial' in nature.

The current veterans' compensation and rehabilitation system is, in the Department of Veterans' Affairs' (DVA's) words 'steeped in history, stemming back to World War I'. But

the environment in which the system is operating has changed. The nature and tenure of military service has changed, as have approaches to social insurance and the availability of mainstream health and community services. The community of Australian veterans and their families is also changing and the new generation of veterans have different needs and expectations.

The key message of this draft report is that the current veterans' compensation and rehabilitation system is not 'fit for purpose' — it requires fundamental reform.

- It is not working in the interest of veterans and their families or the Australian community.
- It is not meeting the needs of contemporary veterans and will struggle to meet the needs of future generations of veterans.
- It needs to be brought more in line with contemporary workers' compensation schemes and modern person-centred approaches to rehabilitation, health care and disability support.
- It needs to place veterans at the heart of the system and take a more holistic, flexible and individualised approach to supporting them.
- It needs new governance and administrative systems best suited to meeting the future challenges and emerging needs of veterans while operating in a modern, efficient and effective way.

A lifetime approach

Australians are willing to support veterans who are affected by their service, but they also want to know that the system designed to support them improves, and does not harm, their lives. The veteran support system is, and must be, about more than compensation and rehabilitation. It must take a lifetime approach to supporting veterans and their families and be more focused on wellness and ability (not illness and disability) and minimising harm from service. It needs to be more responsive to the changing needs and circumstances of veterans, which will require more flexibility and adaptability in supports and in the way services are provided.

Recognising that mainstream services are a necessary complement to veteran-specific services is one element of a new approach. Changes also need to be made to the way treatments and supports are commissioned and provided to veterans and their families. There needs to be more proactive engagement with rehabilitation, transition, health and mental health care providers (including requiring an evidence-based approach to treatment and supports) and better oversight of outcomes from treatment and support.

Wide-ranging reforms

Many of the changes we are recommending are about minimising the harm from service-related injury and illness and investing in veterans so that when they leave the ADF they are likely to go on to enjoy fulfilling and productive lives. A focus on the wellbeing of veterans over their lifetime will not only result in better outcomes for veterans and their families but also for the Australian community.

Some of the benefits from the proposed recommendations include:

- a set of principles and objectives to drive the system
- a greater focus on prevention of injury, rehabilitation and transition support
- improved continuity of care in rehabilitation
- better coordinated and more responsive transition support
- a simpler and easier system for veterans and their families to navigate
- better targeted and more equitable compensation
- better governance arrangements, more efficient processes and improved commissioning of services
- a greater focus on outcomes for veterans and their families and the Australian community.

Our proposed reforms are wide ranging and will take time to implement. Their staged implementation will minimise disruption costs, allow current worthwhile initiatives to be rolled out and provide adequate time for legislative and administrative adjustment.

Importantly, no veteran or dependant of a deceased veteran who currently receives a benefit or entitlement will be worse off under our proposals. Veterans and their families will be better served by a reformed veteran-focused support system, and the community will be able to have confidence that the system is delivering supports in an efficient and effective way.

1 About the veteran support system

DVA provides various forms of support to current and former ADF members and their families. The supports include:

- income support and compensation
- health care
- rehabilitation, transition support and other services to support wellbeing.

In 2017-18, DVA reported spending \$13.2 billion on the veterans' rehabilitation and compensation system (or about \$47 000 per client). Of this, about \$7.4 billion was spent on compensation and support, \$5.3 billion on health care and wellbeing, and \$437 million on

enabling services such as workplace training, financial management and information technology. DVA also spent \$60 million on commemorative activities and facilities, such as war graves and memorials.

A further \$800 million was provided to veterans and their families by the Commonwealth Superannuation Corporation (CSC) through invalidity and dependant pensions and Defence spent about \$437 million on rehabilitation and health care of serving members.

DVA currently supports about 166 000 veterans and about 117 000 dependants (mainly widows or spouses). The exact number of living Australian veterans is not known (box 1). This is just one indication of the lack of information about Australian veterans.

Box 1 **Some facts about serving and ex-serving personnel**

Who is a veteran?

Traditionally, the term 'veteran' described former Australian Defence Force (ADF) members who were deployed to serve in operational conflict environments. However, in 2017, a Roundtable of Australian Veterans' Ministers agreed that a veteran would be defined as anyone who has served at least one day in the ADF. As such, for this inquiry we have used the term 'veteran' to cover all current and former serving ADF personnel, whether they were deployed to active conflict or peacekeeping operations or served without being deployed. The veteran community also covers family members.

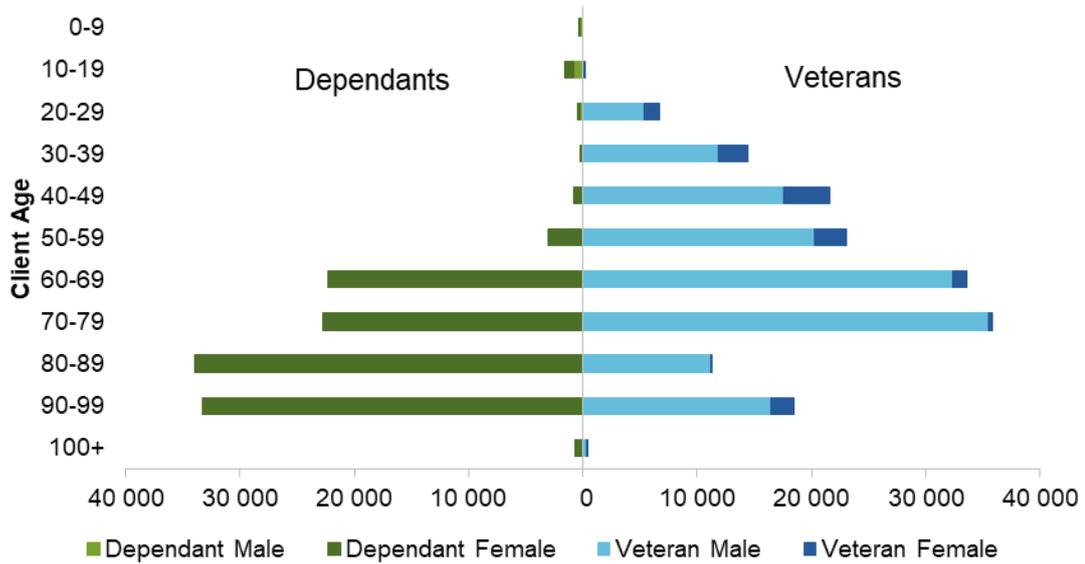
About the ADF and veteran population

- ADF members are professionals who have volunteered to serve in the military. About 5200 recruits join the ADF each year.
- In 2017-18, there were about 58 000 permanent members of the ADF and about 20 000 reservists. The Army accounts for about half of ADF personnel and the Navy and Air Force for a quarter each.
- More than two million Australians have served in the ADF since federation.
- The size and tempo of military engagements (previously falling) has increased since the early 2000s, with little sign of that trend ending.
- Personnel returning from deployment can be returning with injuries that, in prior conflicts, might have resulted in death (for example, traumatic brain injuries).
- About 18 per cent of those of who leave the ADF do so for medical reasons.

Little is known about Australia's total veteran population. The Department of Veterans' Affairs recently estimated that there are about 640 000 living veterans (including reservists).

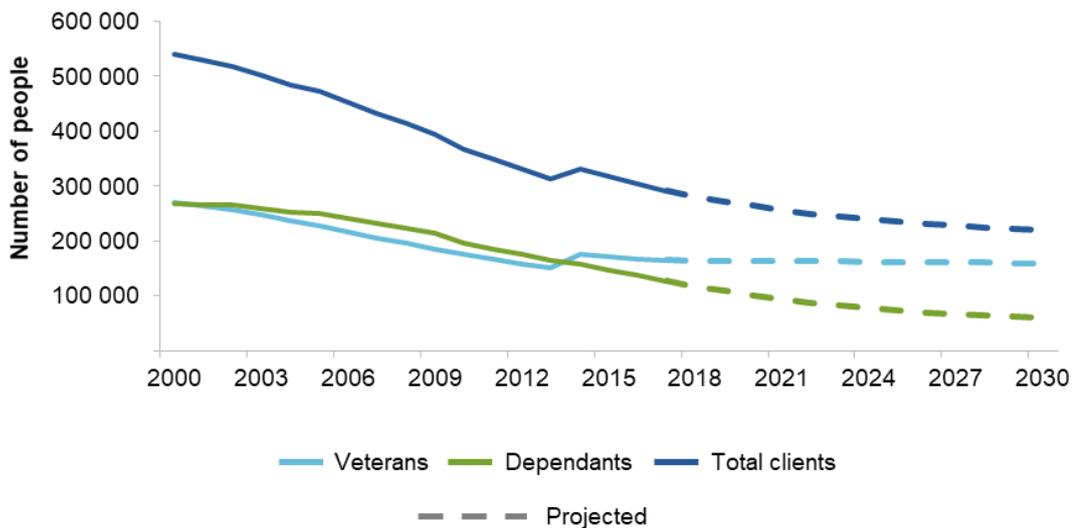
DVA clients span all generations and life stages — there are veterans and war widows aged over 100 and children of veterans as young as one year. However, the majority of DVA clients are in the older age groups — about 194 000 are 65 years or older and of these 98 000 are aged over 79 (figure 1).

Figure 1 DVA clients by age, December 2017



The number of DVA clients is declining, and has fallen from about 540 000 clients in 2000 to 291 000 in 2017, reflecting the deaths of the World War II and the Korean War veteran groups (figure 2).

Figure 2 DVA clients — veterans and dependants



The profile and needs of veterans are also changing. This is driven by the nature of recent and current military conflicts and declining numbers of older veterans.

Older veterans are more likely to require independent living assistance, aged care and health services, while the needs of contemporary veterans are focused on rehabilitation, wellness and returning to work. Contemporary veterans are more likely (than older veterans) to:

- be women (often with dependent children) — the proportion of female members in the ADF increased from 13 per cent in 2000 to around 18 per cent in 2018
- have been on multiple deployments — 38 per cent of permanent ADF members had been deployed more than once
- need to prepare for a working life after service — the median length of time in the military is seven years for members of the Navy and Army, and 10 years for members of the Air Force.

As the Minister for Veterans' Affairs, Darren Chester, recently said:

... when we think of the word veteran, we tend to think of someone in their sixties or seventies. But from an ADF perspective, our veterans are often in their late twenties or early thirties, so they have another career after they've been in the military.

The legislative framework

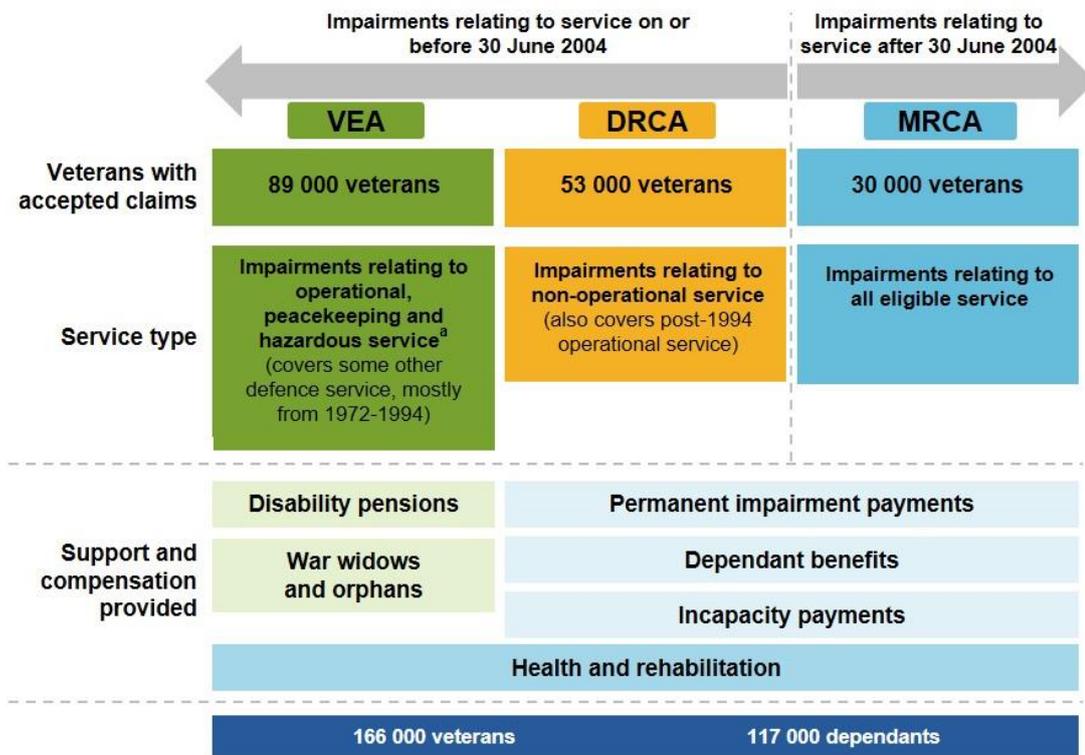
The current system has three main Acts.

- The *Veterans' Entitlements Act 1986* (VEA).
- The *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA).
- The *Military Rehabilitation and Compensation Act 2004* (MRCA).

The Acts have different eligibility requirements and provide different levels of support to veterans through different claims and appeals processes (figure 3). The timing and type of the relevant service determines which Act covers the veterans' impairment and veterans with multiple impairments can have different impairments covered under different Acts.

Under current arrangements, DVA determines if a veteran's condition is service-related under one or more of the Acts. It then identifies the payments and their amounts under separate elements of the claims process.

Figure 3 **Veteran supports are provided under three main Acts**



Many of the compensation payments for veterans align with payments in mainstream workers' compensation schemes. However, there are additional payments and allowances that are unique to the veteran support system (figure 4). Veterans are also eligible for superannuation invalidity payments, and for the age service pension, which cuts in earlier (at 60 years for those with qualifying service) than the equivalent age pension for other Australians.

When considered as a package, compensation for veterans and their families is relatively beneficial compared to other workers' compensation schemes. For example:

- a veteran with warlike service and an impairment rated at about 20 impairment points would receive lifetime compensation of about \$100 000 under the MRCA. This is about double what a civilian worker with a similar impairment point rating would receive under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA)
- a veteran who is totally and permanently incapacitated would receive lifetime compensation of between \$1.5 and \$3.9 million under the MRCA, depending on their age and need for services such as attendant care. The same person would receive between \$1.2 and \$2.8 million under the SRCA.

The beneficial nature of the supports for veterans was noted by many participants to this inquiry, with one describing the benefits to Australian veterans as 'well resourced and largely generous'.

Figure 4 **Veteran compensation — the range of payments**

	VEA	DRCA	MRCA
 Impairment compensation	General rate disability pensions Additional payments for specific disabilities	Permanent impairment payments Eligible young person lump sum	Permanent impairment payments Eligible young person lump sum
 Income replacement	Above general rate disability pensions Superannuation invalidity pensions	Incapacity payments Superannuation invalidity pensions (offset)	Incapacity payments Superannuation invalidity pensions (offset) Special Rate Disability Pension
 Dependant benefits	Widow(er)'s pension Orphan's pension Funeral allowance Bereavement payment Income support supplement Education allowance Superannuation compensation	Lump sum divisible between dependants Additional death benefit Payments for eligible children Funeral allowance Superannuation compensation	Wholly dependant partner payments Payments for eligible children Payments to 'other' dependants Funeral allowance Bereavement payment Income support supplement Education allowance Superannuation compensation
 Health care	Gold Card White Card Attendant care allowance	White Card Attendant care Household services	Gold Card White Card Attendant care Household services
 Other allowances	Energy supplement Veterans' supplement Clothing allowance Decoration allowance Recreation transport allowance Vehicle assistance scheme Service pension	DRCA supplement Service pension Veteran payment Legal and financial advice	Energy supplement MRCA supplement Service pension Veteran payment Motor Vehicle Compensation Scheme Legal and financial advice

History provides insights into why the system is as it is

History explains, in part, why we have the system we have today (box 2). Some features of the system can be traced back to World War I and its after effects — a time when life expectancy, the economic position of women, the nature of warfare, service members' pay and motivations for enlisting, and the extent of the mainstream health and welfare system, were very different to what they are today. Since then, new features have been added, often in an ad hoc manner and/or in response to particular incidents or pressure from veterans' groups. While a number of the original rationales for elements of the scheme have faded, a political desire to avoid reducing entitlements has meant that governments have not seized opportunities to remove duplication and redundancy.

In DVA's words, the three Acts 'collectively incorporate almost all of the benefits available to successive generations of veterans over the last 100 years'.

Box 2 **The veteran support system: a brief history**

The Australian Government first established a military compensation system in 1914 with the introduction of the *War Pensions Act 1914*. The Government also sought to re-establish returned soldiers without war injuries, creating a Repatriation Department overseen by a Minister and a Repatriation Commission. Some of the repatriation benefits at the time included: assistance for veterans to find employment and ‘sustenance’ payments until they did; loans to veterans to start businesses; and rental assistance.

The original veteran support legislation referred only to veterans of World War I, so subsequent conflicts required either amending the legislation (the *Repatriation Act 1920*) or creating derivative Acts. The outcome was a number of similar Acts and amended sections.

By the 1970s, there were calls to consolidate the various pieces of legislation into a single Act with a common system for wartime and peacetime veterans. As an interim measure, eligibility under the Repatriation Act was allowed for peacetime veterans. However, because of concerns about potentially disadvantaging some veterans, those with peacetime service could continue to make claims under the Commonwealth workers’ compensation scheme. The *Veterans’ Entitlements Act 1986* (VEA) simplified the system by repealing the previous Acts, but the distinction between different kinds of service, and dual eligibility with Commonwealth workers’ compensation for peacetime service, remained.

The 1996 Black Hawk disaster revealed to the public different compensation outcomes for families depending on the date of enlistment and the superannuation scheme choices of the deceased veteran. A subsequent review recommended a new military compensation scheme and changes to address inequities and anomalies caused by the interaction of VEA and the Commonwealth workers’ compensation scheme (as embodied in the *Safety, Rehabilitation and Compensation Act 1988* (SRCA)). Most of the recommendations were implemented with determinations under the *Defence Act 1903* that supplemented the SRCA benefits for Australian Defence Force personnel.

Following a further review of the military compensation scheme in 1999 (the Tanzer Review), a new scheme for all military personnel with a ‘renewed emphasis’ on rehabilitation was established with the *Military Rehabilitation and Compensation Act 2004*. However, the new Act did not repeal the VEA or the SRCA, and did not close them off for new claims relating to service before July 2004. The outcome is a highly complex system (with three Acts). The *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, introduced in 2017, largely mirrors the SRCA.

There has also been a steady accretion of the entitlements provided under the different Acts over time — in the health area, this culminated, between 1999 and 2002, in the granting of Gold Cards (treatment for all conditions) to veterans over 70 with qualifying services (regardless of whether they had service-related conditions).

2 What we have been asked to do and our approach

This inquiry came about following a recommendation made by the Senate Foreign Affairs, Defence and Trade References Committee in its report titled *The Constant Battle: Suicide by Veterans*. The Committee found the legislative framework for the veterans’ compensation system to be complex and difficult to navigate. The Committee was concerned that inconsistent treatment of claims for compensation and lengthy delays in the processing of

claims were key stressors for veterans and their families, and said it was time for a ‘comprehensive rethink of how the system operates’.

The Commission has been asked to comprehensively examine how the current compensation and rehabilitation system for veterans operates, how it should operate into the future, and whether it is ‘fit for purpose’ (the full terms of reference are at the beginning of this report).

We used a wellbeing approach and assessed the benefits and impacts of the system on the lives of veterans, and Australians more generally, in light of the costs of the system. We also looked at best practice workers’ compensation and contemporary social insurance schemes for insights on system design and principles.

Our focus was on reforming the current system so it can meet the needs of future generations of veterans and their families, while also improving outcomes for veterans and their families who are currently supported by the system.

3 What objectives for a veteran support system?

The overarching objective of the veteran support system should be to improve the lives or wellbeing of veterans and their families (this aligns with what participants told the Commission the objectives of the system should be, box 3). This has at its core minimising the harm from service to veterans and their families. This should be achieved by:

- preventing and minimising injury and illness
- restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in employment and life
- providing effective transition support for veterans and their families
- enabling opportunities for social integration
- providing adequate and appropriate compensation for veterans (or, if the veteran dies, their family) for pain and suffering and lost income from service-related harm.

Box 3 **A focus on wellbeing and rebuilding lives**

The Department of Defence said that the priority objectives for veterans' support should be:

... to ensure the long-term wellbeing, successful rehabilitation and transition for veterans into civilian life.

The Air Force Association:

Any compensation and rehabilitation system for veterans and their families must be 'fit for purpose', recognising the unique nature of military service. Its principal aim is to return the veteran who has suffered injury or illness due to service duty to his/her former physical and/or mental health state and when this is not possible provide life-long treatment and financial support.

The Defence Force Welfare Association:

If the member was broken due to military service to the Nation, then the Nation has a moral obligation to restore and financially support the person to an 'as new' condition as possible.

RSL Australia National Office:

The primary objective for an ADF member who has suffered an injury or disease should always be a return to health and a return to work, as this is the best outcome for the member's physical and mental health, their family, the ADF and any future employers.

Stephan Rudzki:

... soldiers wish to be rehabilitated and return to some form of productive work. Having a job is a very important component of overall health and mental well-being.

Mates4Mates:

It is important that veterans, their families and the whole community understand that despite a physical or psychological injury, veterans have the capacity to lead very active, purposeful and fulfilling lives ... Research indicates that employment can be a restorative psychological process. There is no substitute for what employment offers in the way of structure, support and meaning. Positive and meaningful employment experiences are linked to improved self-esteem, self-efficacy and high levels of personal empowerment — all of which have a positive effect on mental health and wellbeing.

And as with all other government programs, the objective should be achieved while ensuring value for money for the Australian community while providing supports in the most effective and efficient way. Australians are willing to support veterans and their families, but they also want to know that the money they spend is:

- providing the support that covers the needs of injured or ill veterans
- providing a veteran support system that is run efficiently and effectively, and does not cause unnecessary stress to veterans and their families
- resulting in better lives for veterans and their families.

Best practice workers' compensation schemes also focus on returning people back to work and health at an affordable and sustainable cost. And contemporary approaches to disability place an emphasis on people's ability and potential, take an active rather than a passive approach to meeting client's needs, and focus on long-term costs. The veteran support system should also take a long-term or lifetime approach to improving veterans' lives. This will not only get the best outcomes for veterans and their families — because such an approach will drive a focus on early intervention and supports that maximise veterans'

independence and economic and social participation — it will also ensure a more affordable and sustainable system by reducing long-term support requirements.

In the context of military personnel, a lifetime approach involves taking into account each of the life stages — recruitment, in-service, transition and ex-service (figure 5).

- When members are serving, preventing injury or illness is critical to minimising the harm to veterans and their families from service.
- In all the life stages, timely, appropriate and effective health care and rehabilitation is important for minimising harm (or costs) to veterans and their families.
- The way in which members make the transition from military to civilian life can be an important determinant of their long-term wellbeing (for example, if veterans are poorly prepared for transition they can experience poor mental health and long periods of unemployment). Timely and effective transition services that are available from early in a veteran’s career, during transition and post-service are therefore important.
- Post-service, some veterans may develop service-related health conditions and need timely access to supports to minimise harm — this points to the importance of a sustainable system so that veterans can be assured that supports will be available if, and when, they need them.

Using a wellbeing approach to supporting veterans and their families, together with insights from best-practice workers’ compensation and contemporary social insurance schemes, the Commission considers that the veteran support system should be:

- wellness focused (*ability* not disability)
- equitable
- veteran centric (including recognising the unique needs of veterans resulting from military service)
- needs based
- evidence based
- administratively efficient (easy to navigate and achieves timely and consistent assessments and decision making)
- financially sustainable and affordable.

These principles should underpin the future system (figure 6).

Figure 5 Life stages of full-time military personnel

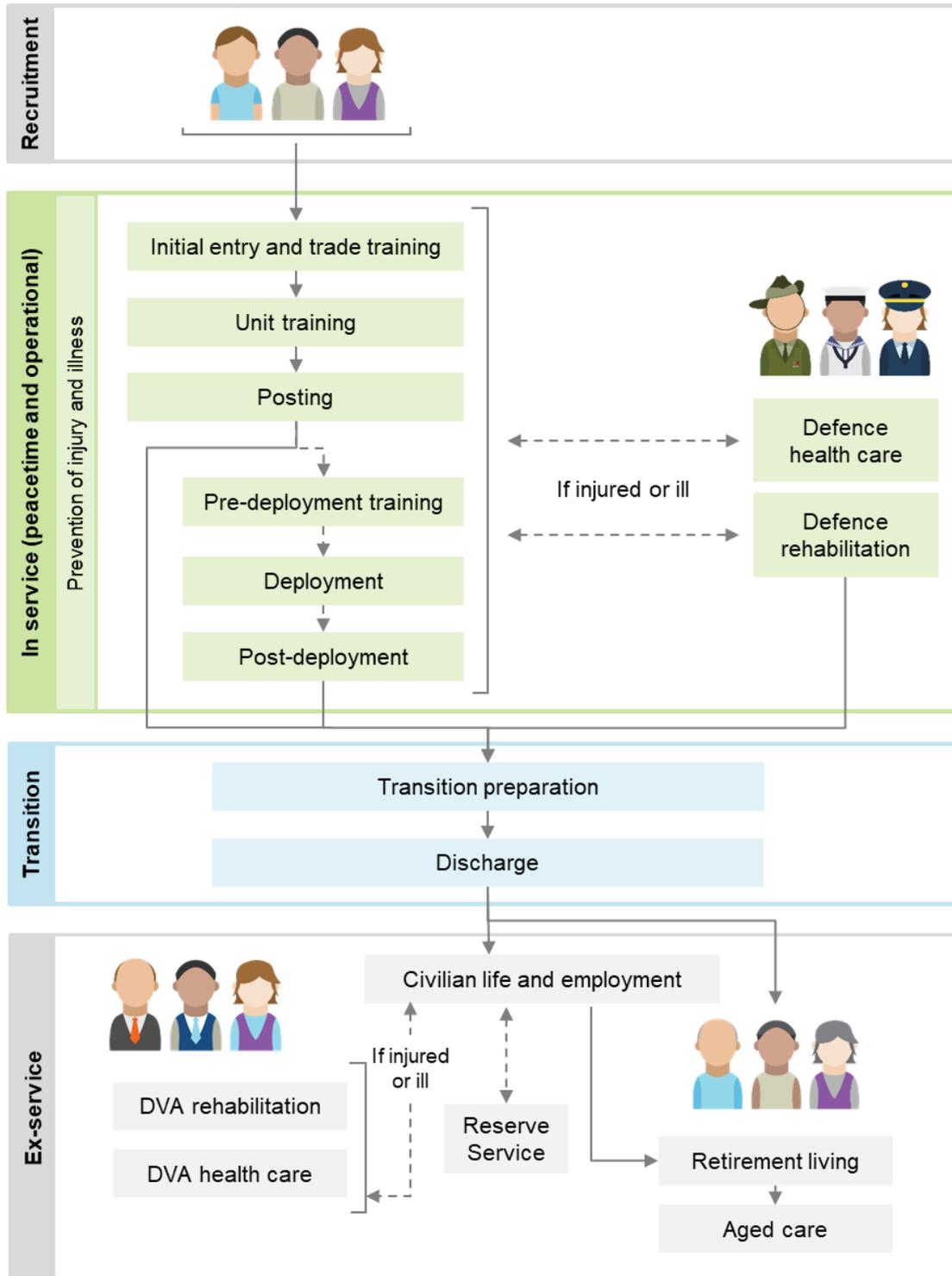
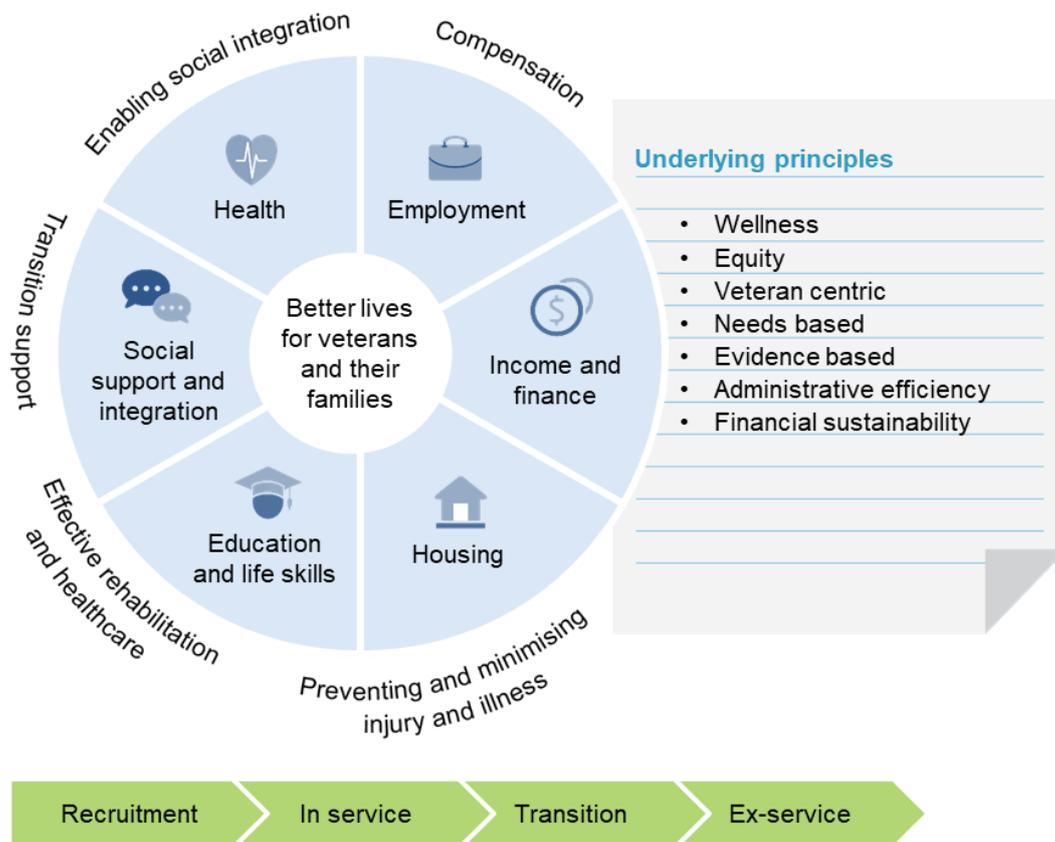


Figure 6 **A system that is about better lives for veterans and their families**



4 Why reform is needed

The current veterans’ compensation and rehabilitation system is not performing well. Veterans and their families could be getting better outcomes from the resources the Australian community is spending to improve their lives.

The system is complex and difficult to navigate ...

The veterans’ compensation and rehabilitation system is complex. It is difficult for veterans and their families to navigate and for DVA to administer. Claimants often require help from advocates to navigate the system.

Multiple Acts are one source of complexity.¹ Veterans can be eligible for compensation under more than one Act. This can be confusing for veterans and as one participant put it ‘daunting, even insurmountable’. Almost 30 000 veterans have had liability accepted under more than one of the three Acts.

One of the consequences of multiple Acts is the need for offsetting of compensation between Acts (to ensure veterans are not over or under compensated). Again, this is confusing for veterans and a source of many complaints to the Commonwealth Ombudsman. Offsetting can also lead to errors in compensation estimates which can have serious consequences for veterans. Superannuation invalidity pensions alongside the support system means further offsetting and additional complexity.

The individual Acts are also complex. There are many additional payments (over and above those typically provided by workers’ compensation schemes, for example, there are payments for damaged clothing, vehicle allowances and education payments). There are at least 40 different payments or benefits that veterans and their dependants may be eligible for, depending on the Act they are covered by and the impairment the veteran has suffered.

Eligibility for these payments can vary depending on whether the impairment is related to operational service or not. Some payments are lump sum, some are weekly; some are taxed, some are untaxed. Some benefits are in the form of health care. RSL Queensland said ‘the range of benefits is extensive and not necessarily well understood ... it remains difficult for a veteran or his family to feel confident that they have accessed all of their entitlements’.

As discussed earlier, the complexity of the veteran support system is a symptom of reactive policy making and a reluctance to take entitlements away from veterans or even rationalise them when their original rationale no longer exists. DVA highlighted this very problem and explained why, if not addressed, the system will continue to become more complex.

Implementing policy responses to specific ad-hoc requests this way adds to complexity and can ignore the needs of the whole veteran community ... such changes can also introduce relatively minor but nevertheless compounding amendments to legislation, adding to an already complex system.

... and there is inconsistent treatment of claims

Veterans with the same injury or illness can receive different levels of support because the amount of compensation payable, and how the compensation is calculated or paid, varies depending on which legislation applies. Box 4 provides an example of the different amounts of compensation that could be provided under the different Acts.

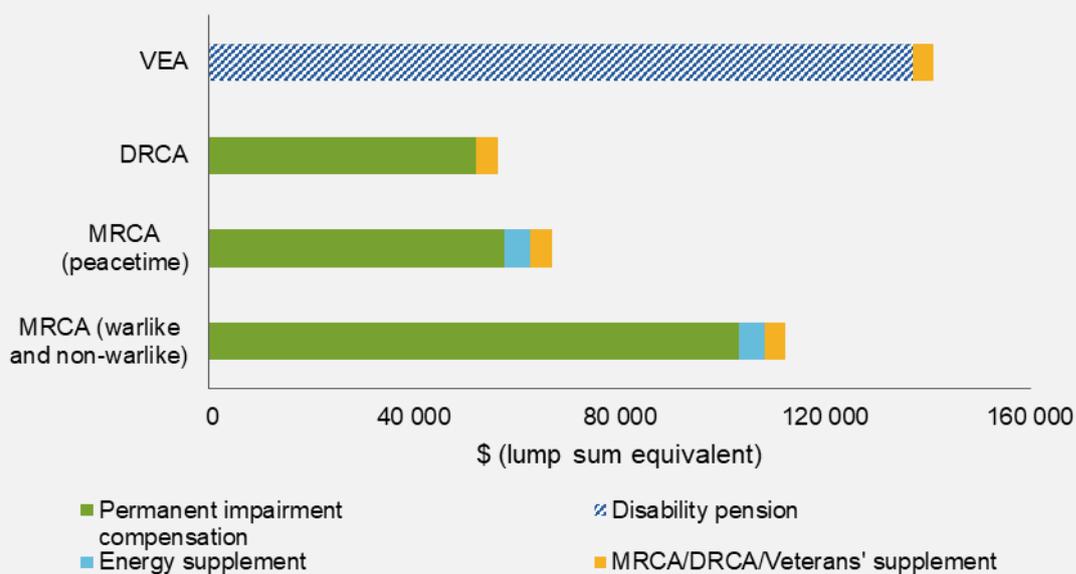
¹ There are the three main veteran support Acts, two older pieces of Commonwealth workers’ compensation legislation that are included in the DRCA and the *Defence Act 1903* that supplements some DRCA claims.

Box 4 Different Acts, different amounts of compensation for the same impairment

The amount of compensation payable, and how the compensation is calculated or paid, varies depending on which Act applies. As an example, Jane is a 30 year old veteran who has suffered a shoulder impairment graded at about 20 impairment points. While the amount and type of compensation will vary based on which Act she is covered by and the type of service under which the impairment was suffered, she will be entitled to:

- either a permanent impairment payment or a pension to compensate for the pain and suffering from the impairment. (Because Jane’s ability to work is not affected by her impairment, she will not be entitled to an income replacement payment.)
- various supplements.

Jane could expect to receive between \$56 000 and \$140 000 in lifetime financial compensation (with the VEA being the most generous Act).



Jane would also receive treatment for the shoulder impairment through the White Card, and, if she has qualifying service, will receive the Gold Card at age 70 and the service pension.

Source: PC estimates based on entitlements under VEA, MRCA and DRCA.

Veterans can receive different levels of support based on the type of service they were undertaking (warlike and non-warlike or peacetime) when an injury or illness occurred (box 4). Under the MRCA, the rates for warlike and non-warlike service are higher than those for peacetime service up to 80 impairment points (there is no difference between the rates for veterans with impairments above 80 points). The difference can be over \$100 000.

The difference between compensation for warlike and non-warlike service, and peacetime service adds complexity and requires veterans to demonstrate whether their injury was suffered as a result of warlike or non-warlike service. It also creates inequities between different groups of veterans.

Some supports are poorly targeted...

Some supports available to veterans and their families are poorly targeted. In the area of transition support, for example, veterans who are younger, served in lower ranks, and have skills that are not easily transferable to the civilian labour market tend to be most at risk when transitioning. But transition services are not targeted to this group (in fact, this group can receive the least support of any in transition).

Another example of a poorly targeted support is the Gold Card which covers the cost of a range of public and private health care services, irrespective of whether the impairment is service related (box 5). Veterans with high levels of service-related impairments who are entitled to the Gold Card, for example, have very different health needs to dependants of veterans who have died from service-related causes and are eligible for the Gold Card as part of their compensation package.

... some discourage wellness

Some of the supports available to veterans and their families discourage wellness. The Gold Card, for example, can work against the principle of ‘wellness’ by providing an incentive for veterans and their families to seek to qualify for higher levels of support. RSL NSW said DVA’s health card system ‘encourages a view of the system as a contest to be won, with the Gold Card as the prize’.

... The outcome sought for veterans should be rehabilitation, not monetary settlement. The ‘gold card’ nomenclature utilised by DVA reinforces a negative entitlement culture where success for veterans is the extraction of cash from the government, not their rehabilitation and return to being a productive member of civilian society.

Another example is the Special Rate Disability Pension under the MRCA. It provides little incentive for veterans to rehabilitate and return to work because veterans lose access to their payment entirely if they return to work for more than 10 hours per week.

And the VEA is compensation, not wellness focused (it is based on lifetime pensions and health care — this does not align with contemporary workers’ compensation schemes). As DVA said:

It is notable that the older VEA, under which nearly 16 000 primary claims were made in 2017-18, has a focus on illness and lifetime compensation payments, which is not conducive to a ‘wellness’ model.

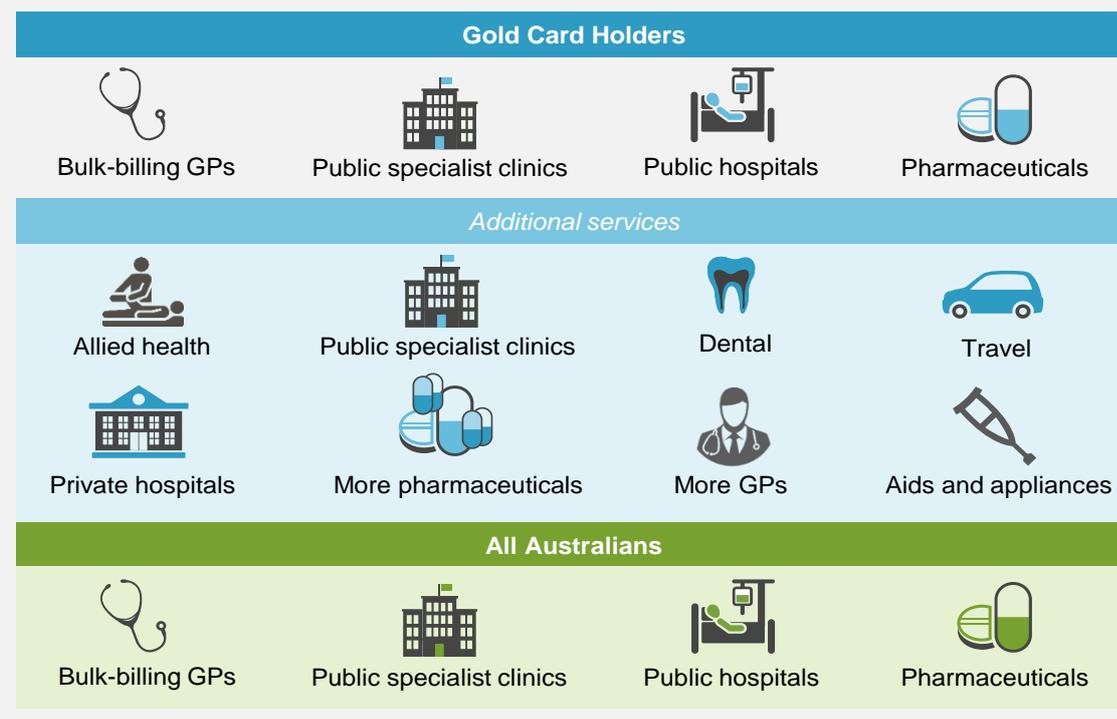
There are also a number of outdated payments (dating back to the 1920s) under the VEA that no longer have a clear rationale.

Box 5 Who is entitled to the Gold Card and what does it provide?

The holder of a Department of Veterans' Affairs (DVA) Gold Card is entitled to treatment and care for all health conditions. About 130 000 DVA clients have a Gold Card. Gold Cards are issued to:

- veterans aged over 70 years with qualifying service (about 7000 cardholders)
- veterans receiving the service pension who satisfy a means test (about 11 000 cardholders)
- veterans above a specific level of impairment or incapacity under the VEA (about 49 000 cardholders) or MRCA (about 1500 cardholders)
- dependants of deceased veterans who qualify for a war widow(er)s' pension or wholly dependent partner or child payment (about 62 000 cardholders)
- ex-prisoners of war (140 cardholders), British nuclear test participants and members of the British Commonwealth Occupation Force (650 cardholders).

The range of entitlements covered by the Gold Card goes well beyond those covered by the public health system and includes private hospital visits, private specialist appointments, dental services aged care services and travel for treatment. Gold Card holders are also exempt from paying the Medicare levy.



Inefficient processes that can place unnecessary stress on veterans

DVA's processes for administering claims are also unnecessarily complicated and processing times can be lengthy (the time taken to process claims is typically many months, however some claims can take over a year to process, box 8). This can place unnecessary stress on claimants. One participant said that DVA's claims process (and the processing delays) caused as much damage as the initial injury. Many ex-service organisations and other government agencies (including the Australian National Audit Office and the

Commonwealth Ombudsman) highlighted problems with the administration of the system and the way DVA interacts with clients (box 6).

Box 6 Some comments on DVA's administration of the system

The Commonwealth Ombudsman, commenting on a complaint against the Department of Veterans' Affairs (DVA), said:

... more work is needed to assure the public, serving personnel and veterans that processes, policies and guidance are robust and rigorous. In this case, DVA failed to ensure timely record keeping and adequate quality assurance and internal review processes were in place. Simple additional checks from the very earliest of DVA's dealings with this veteran may have prevented the snowballing of events that led to years of suffering to one man. While cases involving this level of accumulated administrative errors are rare, the individual errors are not isolated incidents.

The Australian National Audit Office:

The majority of DVA Rehabilitation & Compensation (R&C) services are being delivered to veterans and their dependents within DVA's time based performance targets, however a minority of claims take an excessively long period to process due to inefficient handling. These delays can have significant impacts for these veterans.

Employer Mutual Limited:

DVA's relationship with veterans and their families errs towards being 'transactional' rather than personalised, focused on passing them through procedures and administering payments ... In comparison to other compensation schemes, the benefit structures available to Australian veterans are well resourced and largely generous. However, one side effect observed in our review is that DVA can at times operate as a 'passive payer' rather than an 'active manager' of cases.

Mates4Mates:

We hear time and time again from veterans who are going through a claims process that much of their time and energy, for prolonged periods (sometimes due to claims rejections and subsequent appeals processes), is focused on attesting to their limitations to meet criteria for obtaining and maintaining certain incapacity payments. ... if the initial claims process occurred faster ... we could prevent people from being immersed for so long in a 'limitations' mindset so they can quickly move to a strengths-based mindset.

Other concerns expressed about the way DVA administers claims include:

- it is difficult for claimants to find information on supports
- claims assessors do not communicate well with veterans and their families
- the focus is on processes rather than veterans
- there are high error rates.

Some of the factors contributing to these concerns are a general lack of training and guidance for assessment staff (including on how to effectively deal with trauma-affected clients), high staff turnover and (until recently) outdated information and communication technology (ICT) systems.

While DVA approves most claims submitted by veterans and their families (box 8), many concerns were raised about DVA's adversarial approach to claims. However, this is

inconsistent with the mindset and attitude of most staff (as was apparent to the Commission in its dealings with DVA staff on this inquiry) who seek to operate in the interests of veterans within a complex environment.

DVA's transformation program, launched in 2016 and known as Veteran Centric Reform (VCR), is demonstrating early signs of success. The VCR program aims to improve the administration of the veteran support system by modernising DVA's ICT systems and making service delivery consistent with whole-of-government service delivery principles. Longer term, the objective of the VCR program is to create an agency focused on policy, stakeholder relationships and commissioning services.

Positive developments from the VCR program include:

- 'straight-through' processing (which permits the use of Defence data to immediately satisfy the service-related requirements of claims)
- the digitisation of records
- the roll out of 'MyService', which allows veterans to lodge an initial liability compensation claim online.

MyService is also showing early positive results (box 7). For example:

- the average time taken to process a MyService initial liability claim is 33 days, this compares to an average across all MRCA initial liability claims of 84 days
- on accuracy, although MyService is yet to be subject to a formal quality assurance assessment, informal analysis by DVA showed assessment error rates well within the Department's internal targets.

When fully rolled out across the claims process, MyService, together with Defence's Early Engagement Model (which is designed to facilitate the automatic flow of service and medical information about ADF members to DVA throughout their careers), has the potential to completely automate the claims process for most veterans. Some veterans and their families, however, will continue to need engagement with advocates and staff to manage the process and this assistance should be readily available.

Box 7 **MyService: some early signs of success**

MyService is providing veterans with a simple and convenient way to lodge an initial liability compensation claim online. It also allows claims for non-liability mental health treatment, needs assessments and access to an electronic version of health cards. At the end of June 2018 over 5000 users had lodged claims through MyService, while a link to MyGov (the whole-of-government online platform) from 30 July 2018 enables access by many more.

Recent figures show that around 10 000 claims, around half of all MRCA claims, have been lodged so far through MyService and feedback from users is positive.

MyService and culture change are ongoing improvements that have been particularly effective. (Alliance of Defence Service Organisations)

The ease of operation for veterans both current and former, to access the data base and lodge a claim is on any view, the most important groundbreaking achievement by DVA in the veterans' claims and support continuum to date. The ease of using an online claim form that is applied across all three Acts administered by DVA is simply astounding. This [is] important, because in enabling veterans to be able to complete an online claim form in the safety, security and comfort of their own home, is a hugely pleasing aspect of this process. (Royal Australian Armoured Corps Corporation)

MyService minimises the amount of data that a claimant must source by 'pulling' information automatically from existing government databases (for example, Defence PmKeys) including for identity checks and determining periods of service. And by using a rules-based approach, MyService asks the right questions to arrive at a lawful determination. In this way it effectively acts as a guide for both claimants and assessors and is a highly effective way of dealing with the complexity of the Acts.

Also inefficiencies in the review process

A common concern raised about how DVA initially assesses claims is that there is a culture of DVA denying claims. In the words of one participant:

... the approach seems to be one of finding every possible way to deny a claim, which results in further expense in appeals that should have been determined very much earlier and in a far more timely manner.

Internal review processes are not as effective as they might be at identifying errors in DVA's decision making. The majority of cases that reach the Veterans' Review Board (VRB) lead to changes to DVA's decision — the VRB appears to be acting as a 'backstop' relied on by DVA to correct decisions rather than being more thorough and accurate in their initial decision-making processes.

There are also unjustified differences in the review process between the various Acts. And there are too many decision-making bodies and review pathways. The review process needs to be consistent across all Acts, simplified and set up to support DVA to make accurate decisions in the first instance.

Incentives for strong performance and good outcomes are missing ...

The prevention of injury and illness is paramount to any workers' compensation scheme and a healthy, safe workplace. This is because the cost of injuries and illness to individuals, employers and the community is high. A unique aspect of the current veteran support system is that Defence (the employer) bears no financial responsibility for the cost of compensation, rehabilitation, transition services or medical treatment for service-related injuries and illnesses once a member leaves the service — DVA picks up the tab. A visible insurance premium would provide an additional incentive for injury prevention. The incentive is in part monetary, but also in part because the publicly available figure crystallises the extent to which the employer is acting responsibly.

Best practice workers' compensation systems also place a strong emphasis on scheme sustainability, which in turn means that they focus on reducing clients' reliance on supports (and the cost of compensation) through early intervention and building clients' skills and capabilities for independence. Under current arrangements, little (if any) attention is given to the performance and long-term sustainability of the veteran support system. This is in part because a real budget constraint is missing (the veteran support system is demand driven) and there is little accountability or incentives for DVA to operate the system efficiently and effectively. And because the system does not focus on lifetime costs, the consequence is that too little attention is placed on prevention, early intervention, rehabilitation and transition support (or 'capacity').

Responsibility for the long-term wellbeing of military personnel is also not well defined under current governance arrangements. Defence and DVA have very different and often competing objectives.

- Defence has responsibility for training and equipping current serving members to maintain the capability to defend Australia's interests around the world. Defence also has responsibility for medical treatment and rehabilitation for serving members.
- DVA has responsibility for assisting those members who have an accepted liability for a service-related condition accepted. This includes providing them with rehabilitation, treatment and compensation (consistent with the veterans' legislation).

A shared purpose could unify and help coordinate action across these responsibilities and work to promote the long-term wellbeing of veterans. Instead, we have a set of somewhat arbitrary (from the point of view of the serving and ex-serving member) functional splits and institutional separation between Defence and DVA. And the functional splits result in:

- incentives for Defence to shift costs and responsibility for some members' rehabilitation and support onto DVA (which can mean poorer outcomes for injured and ill personnel, and for the broader community)
- policy and implementation gaps. There is a lack of continuity of rehabilitation and transition support (the baton change could be much smoother). Delays in having compensation claims accepted can mean that access to rehabilitation is difficult over the period from claim lodgment to determination. While Defence provides most of the

transition support, neither Defence nor DVA has clear responsibility for preparing members for transition or post-discharge support, with the outcome that many members and their families miss out on effective transition support.

- duplicated services and inefficient administration, including around the exchange of information for the processing of claims, noting that Defence and DVA have in place a number of initiatives that may in time address this issue.

... as are outcome measures

Assessing how the veteran support system is performing is not straightforward. This is because there are almost no data on which to assess the effectiveness of the supports funded or provided by Defence or DVA (box 8). The few metrics that DVA does track are on processes. Outcome measures are missing from the picture — there is very little to demonstrate to Australian taxpayers that what they are spending on the veteran support system each year is resulting in good outcomes for veterans.

Little is known, for example, about which rehabilitation and transition services provided by Defence and DVA work well (or not), and where extra supports should be targeted. It is a similar case in the area of health services for veterans. The National Mental Health Commission, for example, commenting on mental health services said:

There are no direct measures of effectiveness (i.e. achievement of outcomes) for the mental health services provided by the ADF and DVA. The only data that is available relates to outputs (e.g. the number of services provided, and the number of people attending training), which does not provide meaningful information about whether a service has achieved its intended outcome for its client (e.g. higher resilience) or client group (e.g. lower rates of mental illness or suicide attempts).

There is also limited management, coordination and oversight of client supports and treatment. DVA takes a passive and transactional approach (rather than an active manager role) to rehabilitation and health services. And the focus of the veterans' health care system is on providing free and beneficial access to health care for DVA clients, rather than achieving good health outcomes for veterans.

Box 8 **A few insights into how the system is performing**

Client satisfaction: In late 2016, more than 3000 Department of Veterans' Affairs (DVA) clients were surveyed about their interactions with DVA over the previous 12 months. The overall satisfaction rating was 83 per cent, however clients over 65 years were more satisfied (92 per cent) than those under the age of 45 (49 per cent). Other results included:

- 73 per cent agreed that DVA is client focused and thinks about clients' individual circumstances
- 83 per cent agreed that DVA is honest and ethical in its interactions
- 60 per cent of claimants rated the time taken for DVA to process their claim or application as having met or exceeded their expectations.

Claims assessment and management: The latest DVA data shows that the time taken to process claims is typically many months (for example, the median time taken to process permanent impairment claims in 2017-18 was 155 days), while critical error rates in claims processing and compensation determinations range from 4 to 10 per cent.

Most claimants are able to successfully establish liability. Since the MRCA began, the probability of having at least one successful claim within an application exceeds 90 per cent. The overall acceptance rate in 2017-18 for individual conditions is around 56-79 per cent, depending on the Act.

Around 3-4 per cent of primary determinations are appealed, and around 50 per cent of those lead to a determination being varied or set aside. This compares to a set-aside rate of around 20 per cent in comparable civilian workplace health and safety systems.

Rehabilitation services: DVA poorly measures direct outcomes of rehabilitation. Indirect measures, such as return to work rates, are much lower than those of comparable workers' compensation schemes.

Transition support services are not highly rated by participants — 81 per cent of those who responded to a survey conducted for RSL Queensland said that they did not find ADF transition programs useful.

5 A better way to support veterans and their families

While the VCR program is showing some early signs of success, even when fully implemented, it will not address the fundamental problems of: the lack of focus on the lifetime wellbeing of veterans, the poor oversight of client supports, and the disjointed structure of the veteran support system. More fundamental reform is required if the system is to be fit-for-purpose for the future — with a strong weight on a client-centred approach, outcomes, best practice features of workers' compensation and contemporary social insurance schemes, and good governance.

New governance arrangements for a lifetime wellbeing focus

New governance arrangements are needed if the objective of the veteran support system — to improve the wellbeing of veterans and their families — is to be achieved over the longer term.

The governance arrangements required to run an effective veteran support system need to incorporate the best features of contemporary workers' compensation and social insurance schemes. A department structure is not suited to operating a contemporary workers' compensation scheme. What is required is a corporate model of governance with an independent board, operational independence from government, and a focus on managing the lifetime costs of supporting veterans. Such a model will better facilitate a focus on achieving outcomes for veterans (including achieving veterans' potential and reducing dependence), and uncovering cost-effective rehabilitation, transition support and health care.

In the interest of getting better outcomes for veterans, and in line with the way contemporary workers' compensation schemes operate, the Commission is recommending a new independent statutory agency within the Defence portfolio — the Veteran Services Commission (VSC) — to administer the veteran support system. Reportable to the Minister for Defence Personnel and Veterans, the VSC would:

- have an independent Board of Commissioners (part time) who will operate as a normal board of directors
- appoint a Chief Executive Officer
- oversee the performance of, and have autonomous responsibility for, administering the support system. The VSC would operate the veteran support system supported by data collection, analysis and feedback loops, liability estimation and management.

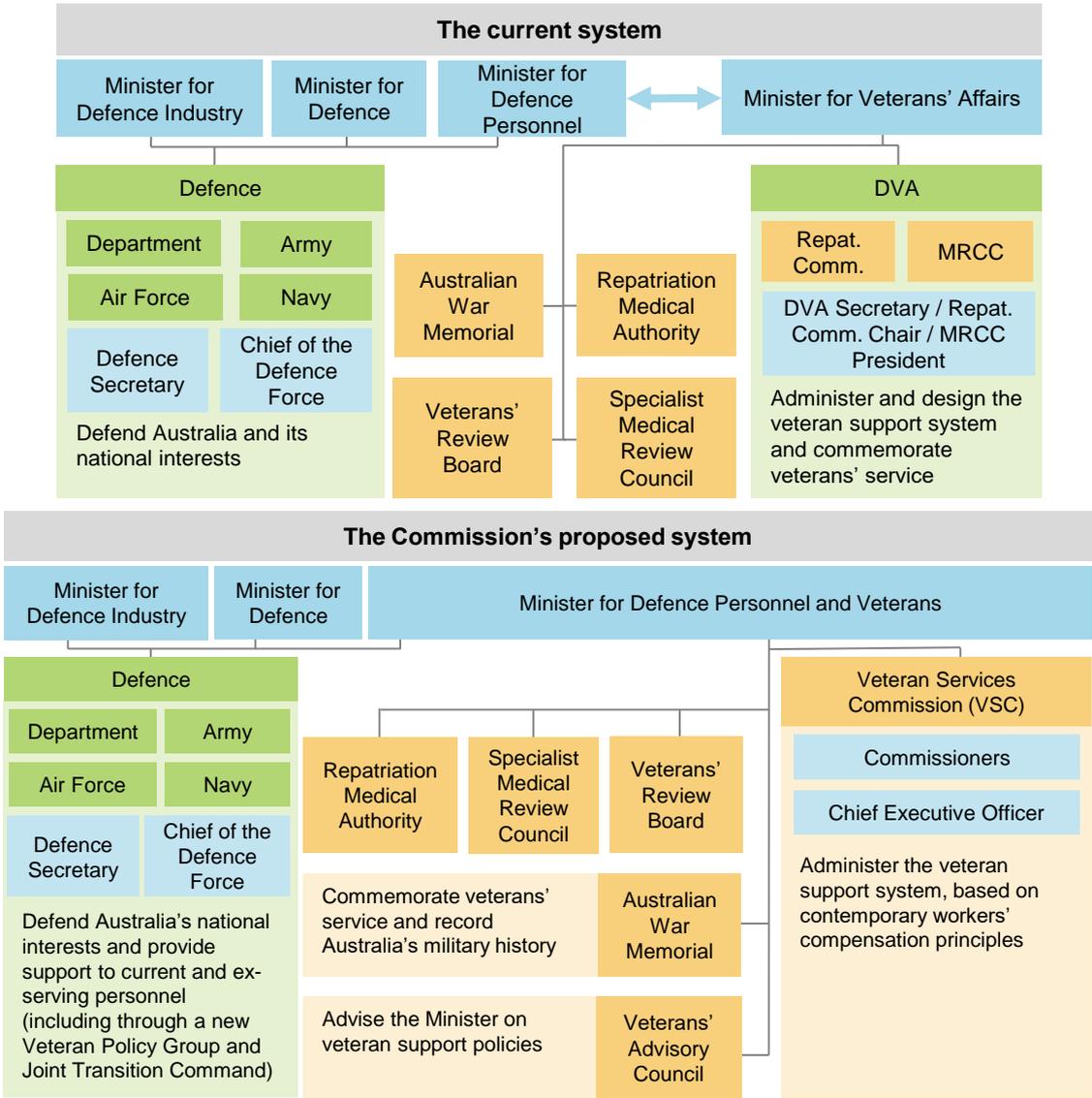
The VSC's legislated functions would be to:

- achieve the objectives of the veteran support system, including making claim determinations under all Acts
- manage, advise and report publicly on the outcomes of the system, including its financial sustainability (supported by actuarial analysis)
- fund, commission or provide services to eligible veterans, including health, mental health and community services
- enable social integration, including through ex-service organisations
- collect, analyse and exchange data about veterans and veteran supports (including early intervention)
- conduct or commission research into veteran issues.

Responsibility for strategic policy and planning for support for veterans and their families would reside within a new 'Veteran Policy Group' in the Department of Defence. The Veteran Policy Group will better align Defence's 'duty to prepare' with the Australian Government's broader 'duty of care' for service personnel and bring the long-term wellbeing

of serving and ex-serving members into consideration of broader Defence policy (figure 7). Put simply, there needs to be a much better alignment across policies that affect serving, transitioning and ex-serving personnel.

Figure 7 Current and proposed new governance arrangements



- The Commission is also recommending:
- a single Ministry for Defence Personnel and Veterans
 - an independent Veterans' Advisory Council to provide advice to the relevant Minister
 - the Australian War Memorial take responsibility for all commemoration functions and the Office of War Graves.

Under the new governance arrangements, the Repatriation Commission, the Military Rehabilitation and Compensation Commission, and DVA would cease to exist upon the establishment of the VSC.

A premium to provide an *additional* incentive for prevention of injury ...

Defence faces a range of incentives to prevent service-related injuries and illnesses — to maximise its operational capability, to look after members of its service ‘family’, to protect its reputation as an employer of choice, and to meet its obligations under work health and safety legislation. These incentives have resulted in a genuine commitment within Defence to improve work health and safety and have delivered a commendable reduction in serious injuries and illness over the past seven years.

However, a change to who pays for veterans’ compensation and rehabilitation (by levying a premium on Defence for uniformed ADF personnel) would provide an additional incentive. A premium is, in effect, a price signal about the real costs (lifetime not short-term costs) of service-related harm. It would complement existing incentives to prevent injury and illness.

... and to fund the veteran support system

A premium levied on Defence could also be used to fund compensation and rehabilitation in the future. The premium would be paid to the VSC and pooled and invested using standard approaches of workers’ compensation schemes. This approach would make transparent the lifetime costs of changes to veterans’ policy and broader Defence policies at the time policy decisions are made. This information is missing under current institutional arrangements, obscuring policy costs to Defence, the Australian Government and the community.

With the above recommended governance changes, almost all veteran support system policy levers will be with Defence which means it will have an incentive to make changes that reduce the premium (including changes to improve veterans’ wellbeing, such as ensuring rehabilitation and transition supports are effective).

To avoid undermining the incentives that a premium creates, any supplementation to cover premium increases would need to be carefully designed and considered as part of the normal Budget process and in line with existing Budget rules.

Improving veterans’ transition experience

Between 5500 and 6000 members of the ADF transition to civilian life each year (box 9). Many are relatively young — they are typically in their mid-20s, having served for almost 9 years.

Box 9 **Who is leaving the ADF?**

Of the 21 000 people who left the permanent Australian Defence Force (ADF) over the period 2012–2016:

- about 62 per cent had served in the Army
- 21 per cent in the Navy
- 17 per cent in the Air Force.

Just over two thirds of those leaving full time service were serving in the 'Other Ranks' (Private Proficient to Lance Corporal) at the time of discharge, and less than 15 per cent were officers.

Of those ADF members who transitioned in 2015, 45 per cent had served four years or less. The median length of service of permanent ADF members is currently 8.7 years.

About one quarter of those leaving the ADF continue to serve in the Reserves.

Leaving the military can be challenging and the challenges can be easily underestimated. They typically include simultaneously finding a new job, house (sometimes involving an interstate move), health care and social networks, as well as psychological changes in an individual's self-image. Despite these challenges, most veterans make a smooth and successful transition to civilian life, but not all do. As one veteran told the Commission, 'on discharge I was lost, you need to belong'.

To equip more veterans and their families for the challenges of military-to-civilian transition, effective preparation and transition support are essential. Good transition support is particularly important for young service leavers as they potentially have decades of working life ahead of them. There is also a sound economic case for good transition support, as smooth transitions contribute to the wellbeing of veterans and their families, and could potentially reduce reliance on other forms of government support.

While both Defence and DVA provide support to help smooth the transition process, the rhetoric around the importance of transition is not matched by effective action. Current transition processes were described as routine administrative 'tick and flick' exercises. One veteran said 'they paid a million dollars to train me, and 20 cents to discharge me'.

The number of Defence and DVA processes, requirements and programs can also be confusing for veterans transitioning. A further problem is that neither Defence nor DVA has clear responsibility for all aspects of veterans transition. Transition should be the responsibility of Defence.

Changes need to be made to deliver better transition outcomes for veterans and their families (figure 8). Responsibility for transition should be centralised within Defence (modelled on the existing Joint Health Command) by establishing a Joint Transition Command. This will improve coordination of transition (and continuity of rehabilitation) services and give greater prominence to transition, both among serving members and within the ADF hierarchy.

The new Joint Transition Command should be responsible for all aspects of transition preparation and support, including reporting on transition outcomes to drive further improvement. It should:

- begin to engage with veterans early in their careers by helping them to plan for their service and post-service career. As members get closer to transition, it will provide more, and better tailored, information and support to veterans and reach out to families, so that they can engage more actively in the process of transition. It will assist and facilitate access to DVA claims processes or supports, including referrals to advocacy supports, where requested
- offer continued support to those who require it for a defined period after discharge — for up to 6 months or until the end of an agreed rehabilitation plan where requested by the transitioning member. Some veterans will require no support after discharge
- engage staff, including from the ADF and DVA, with the skills to advise veterans and families on both the practical and psychological aspects of transition
- work closely with the Joint Health Command in the areas of rehabilitation support, medical examinations and medical records and DVA to facilitate access to claims processes and supports if needed.

However, there remain some issues around who should be responsible for what.

Some aspects of eligibility (post-service access to funded rehabilitation is consequent upon DVA accepting liability for a condition) and delays in having compensation claims accepted can mean veterans are not entitled to rehabilitation in the period from lodgment to determination. One option is for DVA to continue any rehabilitation programs for service-related injuries and illness set up by Defence (on the basis that lifetime costs of support could be higher if a rehabilitation program is disrupted). Because rehabilitation programs are for limited periods of time, DVA could then reassess the need for rehabilitation once the program has run its course. The Commission is seeking views on whether this approach is feasible.

The way in which Defence and DVA provide and procure rehabilitation (and health) services should also be brought more in line with the approach used by workers' compensation schemes, including more proactive engagement with providers and better oversight of outcomes. The Commission is also seeking views on models for providing rehabilitation that are more person-centred and tailored to the needs of individuals.

The enhanced transition package should also include support for veterans to gain skills and qualifications once they leave the ADF, in the form of a trial of a veterans education allowance for those undertaking full-time study.

Figure 8 **Military-to-civilian transition: a system that works for veterans and their families**



Better health outcomes for veterans

The White Card, which funds treatment for service-connected conditions (as well as treatment for mental health problems, cancer and tuberculosis, without needing to prove a link to service), is generally well-targeted and an appropriate vehicle for funding veterans' health care. Around 61 000 DVA clients have a White Card.

The Gold Card, however, does not sit well with the key underlying principles for a future scheme. It is not targeted to service-related health needs. It is not wellness-focused or

efficient (it can encourage over-servicing). And whether the ‘compensation’ feature of this card for dependants is equitable is also questionable.

Given the Gold Card runs counter to a number of the key design principles that should underpin the future veteran support system, feedback is sought on whether a future system should have a coloured health card system. It is the Commission’s view that eligibility for the Gold Card should not be expanded to any new categories of veterans or dependants that are not currently eligible for such a card. We are seeking feedback on the benefits and costs of possible alternatives to providing the Gold Card to dependants, service pensioners and veterans with qualifying service at age 70.

Improving mental health care access and services

Mental health care is a key area of need for veterans (box 10). As DVA said:

The mental health of veterans has presented as a significant issue for the veteran community in recent years, particularly as younger veterans with recent engagements have faced circumstances — both as part of service, and in returning to Australia — unlike other previous engagements. These circumstances have contributed to many veterans suffering poor mental health.

There has been a heightened focus on veterans’ mental health and suicide in recent years and a range of new policies, programs and research. The recent decision to expand non-liability coverage to mental health care was a positive step. Many participants supported the decision — some describing it as ‘life-saving’.

A number of recent initiatives are also promising — including a suicide prevention pilot in Townsville and a pilot for GP-led coordinated care. However, it is too early to evaluate these, and other, initiatives. DVA has also commissioned a number of research studies that will, in the future, inform policy (but again it is too early to draw any conclusions).

Mental health and suicide prevention is an evolving policy space. DVA’s current mental health strategy is not adequate (it does not contain any tangible goals, commitments or indicators to measure progress) and needs urgent updating. DVA needs to focus more on demonstrable outcomes. The strategy should promote access to high-quality mental health care, and facilitate coordinated care for veterans with complex needs (and where relevant, their families). It should also identify the needs of family members and appropriate responses.

Box 10 **Veteran's mental health**

Those who serve in the Australian Defence Force (ADF) are recruited and trained to be physically and mentally resilient, and to display strength and perseverance in the face of adversity.

While veterans are serving, there are a range of protective factors that are likely to reduce the risk of mental ill health compared with the general population. They include a strong sense of purpose, camaraderie and easy access to health care.

But they are also exposed to particular mental health risks, including exposure to trauma and time away from family and frequent relocations. And once veterans leave the ADF, they no longer benefit from the protective factors that supported them while serving and are at greater risk of poor mental health. Transition to civilian life can also be a risk factor in itself, as recent research into veterans' transition and wellbeing highlighted.

Changes brought about by the transition process can lead to the development and/or exacerbation of existing service related mental and physical symptoms resulting in psycho-social adjustment issues ranging from employment difficulties and family/relationship conflict, to mental health and substance abuse problems.

Rates of mental illness among ex-serving veterans are high. For example, the suicide rate for ex-serving men aged under 30 is 2.2 times that for Australian men the same age. And about one third of those who left the ADF in the past 5 years report high to very high levels of psychological distress.

DVA should also evaluate the effectiveness of its own mental health service — Open Arms (formerly the Veterans and Veterans Families Counselling Service) — to ensure that services are adequate, accessible and of high-quality. Ensuring that the veteran community is better aware of the services available is an important initial step.

Data and evidence could be improved in every area of the system

As with any workers' compensation scheme, data and evidence are critical to achieving good outcomes for veterans, uncovering better interventions, and managing emerging risks and long-term scheme costs. The VSC will place greater reliance on data and analysis and practices of continuous improvement as it will be required to compare actuarial forecasts of costs and veteran outcomes with the actual experiences of veterans. However, DVA can start work on developing performance and outcomes frameworks immediately.

The evidence base on veterans and their families would also be strengthened by:

- improving the use of the rehabilitation data and reporting on outcomes
- conducting more high-quality reviews and evaluations. DVA has a number of projects that are aimed at improving veteran wellbeing, but there is little evidence on the effectiveness of some of these services
- taking a strategic approach to research by setting out priorities in a research plan (including leveraging off the priorities of the Repatriation Medical Authority, under its new powers to fund and guide medical and epidemiological research).

The role of ex-service organisations

Ex-service organisations (ESOs) play an important role in the veteran support system. They support the broad veteran community, including dependants of deceased veterans. Thousands of hours are volunteered each year to help veterans in all aspects of their post-service lives. They undertake a wide range of activities including:

- welfare and mentoring services for veterans and their families
- commemoration and recognition activities and other social events
- transition support for members leaving the ADF
- employment services
- education and training services
- advocacy services
- assistance with filing and presenting legal or administrative challenges/appeals to DVA decisions.

There are estimated to be several thousand ESOs — and very few have a national footprint or provide the full gamut of services. There is also no peak ESO body. This lack of coordination among ESOs may be diluting their effectiveness.

Community veteran service hubs could aid better social integration, peer-to-peer support and access to advice and information for veterans and their families. The Commission heard about a number of innovative models of collaboration between relevant ESOs and the Australian, state and local governments, including multi-purpose hubs. Such hubs would not replicate existing ESOs, but would provide referral services connecting veterans and their families with relevant ESOs, supports and services, and provide a veteran and family friendly community space. The Commission will say more on the role of ESOs (and advocacy) in the final report after it has considered the recommendations of the Veterans' Advocacy and Support Services Scoping Study.

A simpler system for veterans and their families

The current system can be simplified in a number of ways.

The front end of the system should be made simpler for clients (a complex system does not need to be complex for veterans and their families). Veterans and their families should be able to understand the system, including the claims process, why claims are accepted or rejected, and what package of supports they may be entitled to.

Simplifying the system is a key component of the VCR program and initiatives such as MyService should continue to be built on. DVA has advised that the VCR program will be fully rolled out by mid-2021.

There are also a number of areas where there is scope to rationalise supports and harmonise the three Acts. Two areas where the three Acts should be harmonised are:

- the initial liability process — moving to a single standard of proof for all types of service (the Commission is seeking feedback on which standard) and adopting the use of Statements of Principles (SoPs) in the DRCA would simplify the initial liability process and ensure a single consistent decision-making process across all three Acts
- the review process — there should be a single review pathway for all veterans' compensation and rehabilitation decisions (the VEA and MRCA review pathway would apply for the DRCA, box 11) comprising reconsideration, review and resolution by the VRB, formal merits review by the AAT and judicial reviews. The role of the VRB should be modified to provide enhanced dispute resolution processes. It should no longer be a determinative body.

Box 11 The review process could be simpler and more efficient

There are unjustified differences in the review process between the three Acts. There should be a single pathway for all veterans' compensation and rehabilitation decisions. The single pathway should include:

- internal reconsideration, where a different Department of Veterans' Affairs (DVA) officer makes a new decision based on all the information available, including additional information that was not available at the initial stage of decision
- review and resolution by the Veterans' Review Board (VRB). The VRB's role should be modified to only use alternative dispute resolution processes to resolve claims by consent between the applicant and DVA. This will allow claims to be resolved in a more timely manner. Any matters that cannot be resolved could go to the Administrative Appeals Tribunal (AAT).
- formal merits review by the AAT
- on matters of law, judicial review.

Some payments should be removed, simplified or rolled into the underlying payment. These include:

- the MRCA special rate disability pension (a payment that has rarely been used)
- education payments for dependants over 16 years (which simply mirror youth allowance payments, but without an income test)
- energy and veterans' supplements (which can be removed or rolled into the underlying payments).

In other areas of compensation, more substantial reforms are warranted.

- Compensation under the MRCA varies depending on whether the impairment was suffered as a result of warlike or non-warlike, or peacetime service. On the basis that 'an injury is an injury' irrespective of the type of service, injuries, illness or deaths due to

service should be treated in the same way. One rate of compensation should cover all types of service.

- The compensation system includes a system of income replacement administered through DVA, and free invalidity and death insurance provided through the Commonwealth Superannuation Corporation. These payments are offset against each other in most cases, but clients' needs are assessed by two organisations. There is scope to simplify the administrative arrangements for these schemes.
- Under the MRCA and VEA, dependants can receive benefits (including pensions, lump-sum payments and the Gold Card) if a veteran dies and:
 - their death was related to service, or
 - the veteran had a certain level of service-related impairment prior to their death, irrespective of the cause of death (that is, the veteran could die in a car crash, or of old age, and their dependants may receive benefits).
- There is little rationale for the second of these eligibility criteria. Going forward, under the MRCA, future eligibility for dependant benefits should be restricted to dependants of veterans who died as a result of service. The effect of this change is likely to be minimal in the near term, as most MRCA dependant benefits are currently due to service-related deaths. However, it will have an effect in the long run, as the MRCA population ages.

Two compensation and rehabilitation schemes

Moving to one Act covering all veterans is the ultimate objective of simplification (many participants called for a single Act). Ultimately the MRCA should be the predominant piece of veterans' compensation and rehabilitation legislation. This is because the VEA has significant shortcomings with its focus on providing set rate pensions for life which is inconsistent with the goals of rehabilitation and person-centred wellness. Nor are the pensions necessarily reflective of the loss faced by individual veterans.

However, moving to one Act is not possible at this stage. There are many veterans on the VEA (either with current benefits or likely future claims). And many of these are older, which means that the rehabilitation and return to work focus of the more contemporary Act is less relevant.

The Commission is recommending a two scheme approach (figure 9). Scheme 1 covers veterans under a modified VEA. While there will be some modifications to the existing VEA, it will continue until natural attrition removes the need for the scheme. It is largely an older cohort of veterans with operational service who have injuries before 2004 — although any veteran who does not have a current VEA liability claim by 1 July 2025 will no longer be eligible to make claims under this scheme.

Scheme 2 is for all other veterans underpinned by a modified MRCA (incorporating the DRCA). Over time this will become the dominant scheme.

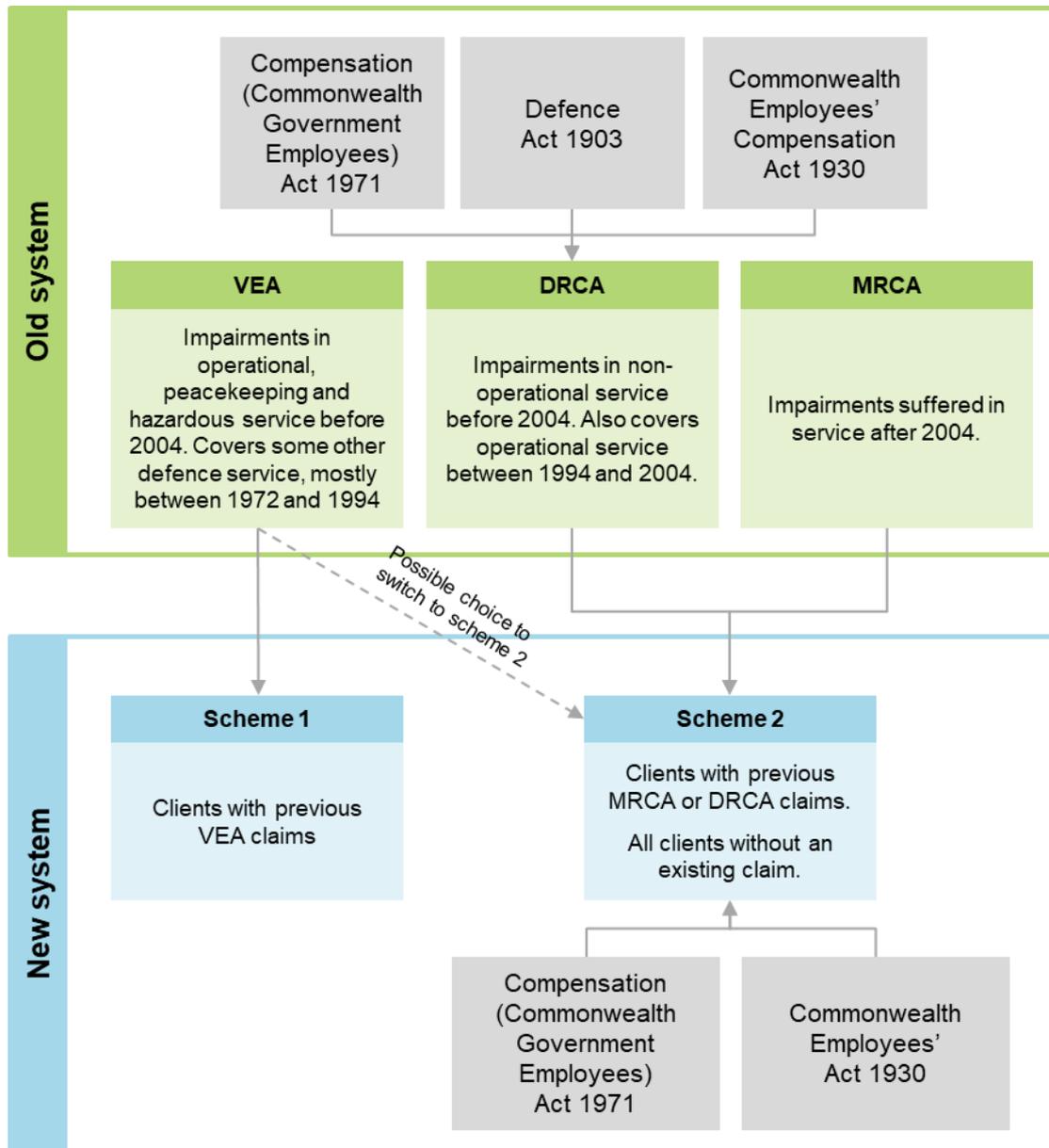
Eligibility should be based on the following principles:

- veterans should only be eligible to make claims under one scheme — that is, all future claims for each individual veteran would be processed under either scheme 1 or scheme 2
- veterans should not have their current benefits affected, however some veterans in scheme 1 should be given a one off opportunity to switch their current and future benefits to scheme 2 (figure 10).

Figure 9 Compensation available under the schemes

	Scheme 1	Scheme 2
 Impairment compensation	General rate disability pensions Additional payments for specific disabilities	Permanent impairment payments
 Income replacement	Above general rate disability pensions Superannuation invalidity pensions	Incapacity payments Superannuation invalidity pensions (offset)
 Dependant benefits	Widow(er)'s pension Orphan's pension Funeral allowance Bereavement payment Income support supplement Education allowance (under 16 only)	Wholly dependant partner payments Payments for eligible children Payments to 'other' dependants Funeral allowance Bereavement payment Income support supplement Education allowance (under 16 only)
 Health care	Gold Card White Card Attendant care Household services	Gold Card White Card Attendant care Household services
 Other allowances	Service pension Motor Vehicle Compensation Scheme	Service pension Veteran payment Motor Vehicle Compensation Scheme Legal and financial advice

Figure 10 Eligibility under the two schemes



Applying these principles will reduce the need for compensation offsetting, reduce complexity and speed up the transition towards scheme 2.

Veterans with impairments for which DVA has accepted liability under the VEA would remain on scheme 1 with all their future claims processed under this scheme (regardless of their current eligibility for other Acts). However, younger veterans are likely to benefit from the rehabilitation and income replacement focus of scheme 2. Veterans 55 years of age or younger as at 1 July 2025 would be given the option of switching their current benefits and future entitlements to scheme 2, and would receive financial advice to make this decision.

Other veterans — including those currently covered by the MRCA or DRCA, and those without a current or successful VEA claim as at 1 July 2025 — would be covered by scheme 2 for all future claims.

The design of the schemes is complicated by the fact that some veterans have current claims under multiple Acts. The Commission is proposing to set eligibility for this group on both their age and the current benefits they are receiving, but is seeking further input on this issue.

When a veteran that already has an accepted liability claim dies, the dependants would receive compensation based on the scheme that applied to the veteran. If the veteran did not have an existing or accepted liability claim as at 1 July 2025, dependants would receive compensation through scheme 2.

An indicative timeline for reform

Some of the proposed changes to the governance arrangements in the veteran support system, such as the creation of the Veterans' Advisory Council, can be implemented quickly. Establishing the Joint Transition Command should be a priority — it should be in place by mid-2020.

However, the more foundational changes (including moving DVA's policy responsibility into Defence, creating the independent VSC and levying a premium on Defence) will be more disruptive. Work to establish the VSC should commence as soon as possible, having regard to the rollout of the VCR reforms that are due to be completed by mid 2021. Based on an indicative timetable, the VSC should begin operating on or before 1 July 2022.

The legislative reform process should be phased over time, with the process culminating in the adoption of the two scheme approach. The starting point for reform should be simplifying and streamlining the Acts themselves. At the same time, some simple harmonisation between the DRCA and the MRCA could be achieved, such as aligning the incapacity payments between the Acts, and using SoPs in the DRCA. These reforms would set the framework for the eventual merging of the Acts.

By mid 2025 the two scheme approach should be implemented. This would involve merging the DRCA into the MRCA, and having in place mechanisms to allow veterans to be assigned to schemes or exercise options for switching (where permitted). This time frame will allow time for the governance reforms to be implemented, as well as allow veterans time to adjust to the new approach and consider their options.

What are the benefits from the proposed reforms?

While the Commission has not quantified the benefits of its reforms, they are likely to be significant and cross multiple domains, including:

-
- better lives or wellbeing gains, improved work health and safety and injury prevention (fewer veterans and their families having to deal with injury, illness or death)
 - improved and more continuous rehabilitation and transition supports (veterans and their families will be better prepared for the challenges of transition)
 - a simpler, fairer and more accessible system of compensation
 - more consistent assessment of claims easing pressures for claimants
 - a quicker and simpler review process to resolve issues in a timely way
 - a better evidence base to inform the design and delivery of services, programs and policies which should lead to improved outcomes for clients.

There will also be efficiency gains from the proposed changes (including those that place a greater focus on accountability and lifetime costs of support and reduce duplication). A greater focus on wellness and lifetime costs should also translate into increased economic and social participation of veterans and reduced use of income support. While we have not at this stage costed many of the proposed changes (in large part because of a lack of data), we will seek to do this in consultation with Defence and DVA between the draft and the final report.

Draft recommendations, findings and information requests

Understanding the objectives of the veterans' compensation and rehabilitation system is important for assessing how well the current system is performing and what an improved system would look like.

Objectives and principles

DRAFT RECOMMENDATION 4.1

The overarching objective of the veteran support system should be to improve the wellbeing of veterans and their families (including by minimising the physical, psychological and social harm from service) taking a whole-of-life approach. This should be achieved by:

- preventing or minimising injury and illness
- restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in work and life
- providing effective transition support as members leave the Australian Defence Force
- enabling opportunities for social integration
- providing adequate and appropriate compensation for veterans (or if the veteran dies, their family) for pain and suffering, and lost income from service-related injury and illness.

The principles that should underpin a future system are:

- wellness focused (*ability* not disability)
- equity
- veteran centric (including recognising the unique needs of veterans resulting from military service)
- needs based
- evidence based
- administrative efficiency (easy to navigate and achieves timely and consistent assessments and decision making)
- financial sustainability and affordability.

The objectives and underlying principles of the veteran support system should be set out in the relevant legislation.

Prevention

The Australian Defence Force (ADF) is committed to providing a safe and healthy working environment for its members and it has achieved commendable reductions in serious injuries and illnesses over the past seven years. Nonetheless, more can be done to give the ADF better tools to help it achieve its commitment to improved work health and safety.

DRAFT FINDING 5.1

There are no compelling grounds to change the current arrangements where Australian Defence Force (ADF) members are subject to Commonwealth work health and safety legislation. In fact, the introduction of the *Work Health and Safety Act 2011* has been instrumental in helping to improve work health and safety outcomes in the ADF.

DRAFT FINDING 5.2

Since Defence introduced Sentinel (a work health and safety incident reporting system) in 2014, it has expanded its coverage (there is now service-wide access), improved the ease of use of the system for serving personnel and put in place processes to ensure that reported incidents are acted on.

However, despite these efforts, underreporting of work health and safety incidents on Sentinel (other than for serious, defined events that must be notified to Comcare) continues to be an issue.

INFORMATION REQUEST 5.1

The Commission was told that the data recorded on Sentinel significantly understates the true incidence of most types of work health and safety incidents. What aspects of Sentinel contribute to this and what might be done to improve reporting rates?

DRAFT RECOMMENDATION 5.1

Defence should investigate the feasibility and cost of augmenting the Sentinel database with information from the Defence eHealth System. In the longer term, when Defence commissions the next generation of the Defence eHealth System, it should include in the system requirements ways to facilitate the capture of work health and safety data.

The Departments of Defence and Veterans' Affairs should investigate the feasibility and cost of augmenting the Sentinel database with information from the Department of Veterans' Affairs' datasets, which would provide insights into the cost of particular injuries and illnesses.

DRAFT RECOMMENDATION 5.2

Defence should use the injury prevention programs being trialled at Lavarack and Holsworthy Barracks as pilots to test the merit of a new approach to injury prevention to apply across the Australian Defence Force (ADF).

Defence should adequately fund and support these programs, and ensure that there is a comprehensive and robust cost–benefit assessment of their outcomes.

If the cost–benefit assessments are substantially positive, injury prevention programs based on the new approach should be rolled out across the ADF by Defence.

DRAFT RECOMMENDATION 5.3

Beginning in 2019, the Australian Government should publish the full annual actuarial report that estimates notional workers' compensation premiums for Australian Defence Force members (currently produced by the Australian Government Actuary).

Rehabilitation and wellness services

Significant reform is required to the way Defence and the Department of Veterans' Affairs (DVA) procures, organises and monitors rehabilitation services. Changes are also required to rehabilitation arrangements in the transition period to ensure continuity of care.

Given that the Veteran Services Commission (VSC) (draft recommendation 11.2) will replace DVA, recommendations in this and subsequent chapters directed at DVA should also be read as referring to the VSC.

DRAFT FINDING 6.1

Defence has a strong incentive to provide rehabilitation services to Australian Defence Force (ADF) members who have a high probability of redeployment or return to duty, but a weaker incentive to rehabilitate members who are likely to be transitioning out of the ADF. This is because ex-serving members become the responsibility of the Department of Veterans' Affairs (DVA) and Defence does not pay a premium to cover liabilities. Access to rehabilitation supports can also be disrupted during the transition period.

DVA pays limited attention to the long-term sustainability of the veteran support system (in part because the system is demand driven) and this reduces its focus on the lifetime costs of support, early intervention and effective rehabilitation.

DRAFT RECOMMENDATION 6.1

The Australian Defence Force Joint Health Command should report more extensively on outcomes from the Australian Defence Force Rehabilitation Program in its Annual Review publication.

INFORMATION REQUEST 6.1

The Commission is seeking information (both quantitative and qualitative) on return-to-work outcomes from Australian Defence Force and Department of Veterans' Affairs rehabilitation programs. Areas of particular interest include the appropriateness of comparing return-to-work outcome measures in military and civilian contexts, and what approaches to return to work are effective both in-service and post-service.

DRAFT RECOMMENDATION 6.2

The Department of Veterans' Affairs should make greater use of the rehabilitation data that it collects and of its reporting and evaluation framework for rehabilitation services. It should:

- evaluate the efficacy of its rehabilitation and medical services in improving client outcomes
- compare its rehabilitation service outcomes with other workers' compensation schemes (adjusting for variables such as degree of impairment, age, gender and difference in time between point of injury and commencement of rehabilitation) and other international military schemes.

DRAFT RECOMMENDATION 6.3

Defence and the Department of Veterans' Affairs need to engage more with rehabilitation providers, including requiring them to provide evidence-based approaches to rehabilitation, and to monitor and report on treatment costs and client outcomes.

Changes are also required to the arrangements for providing and coordinating rehabilitation immediately prior to, and immediately post, discharge from the Australian Defence Force (ADF). Rehabilitation services for transitioning personnel across this interval should be coordinated by Joint Transition Command (draft recommendation 7.1). Consideration should also be given to providing rehabilitation on a non-liability basis across the interval from ADF service to determination of claims post-service.

INFORMATION REQUEST 6.2

The Commission is seeking further views on the potential use of consumer-directed care for the rehabilitation services provided to veterans, or on alternatives for providing more tailored, person-centred rehabilitation services.

Transition to civilian life after military service

While most veterans make a relatively smooth and successful transition to civilian life, some find transition a difficult and stressful time. Neither Defence nor DVA has clear responsibility for all aspects of veterans' transition, and services are not targeted to those most at risk. To improve military-to-civilian transition, and to clarify roles and responsibilities, the Commission is recommending creating a new command responsible for transition preparation and support.

DRAFT FINDING 7.1

The Departments of Defence and Veterans' Affairs offer a range of programs and services to support veterans with their transition to civilian life. Despite some improvements in recent years, these efforts remain fragmented and poorly targeted, with few demonstrated results. While many discharging members require only modest assistance, some require extensive support especially those who are younger, served in lower ranks, are being involuntarily discharged for medical or other reasons or who have skills that are not easily transferable to the civilian labour market.

DRAFT RECOMMENDATION 7.1

The Australian Government should recognise that Defence has primary responsibility for the wellbeing of discharging Australian Defence Force members, and this responsibility may extend beyond the date of discharge. It should formalise this recognition by creating a 'Joint Transition Command' within Defence. Joint Transition Command would consolidate existing transition services in one body, with responsibility for preparing members for, and assisting them with, their transition to civilian life. Functions of Joint Transition Command should include:

- preparing serving members and their families for the transition from military to civilian life
- providing individual support and advice to veterans as they approach transition
- ensuring that transitioning veterans receive holistic services that meet their individual needs, including information about, and access to, Department of Veterans' Affairs' processes and services, and maintaining continuity of rehabilitation supports
- remaining an accessible source of support for a defined period after discharge
- reporting on transition outcomes to drive further improvement.

INFORMATION REQUEST 7.1

The Commission is seeking feedback on the period of time that Joint Transition Command should have responsibility for providing support to members and former members of the Australian Defence Force who require that support.

DRAFT RECOMMENDATION 7.2

Defence, through Joint Transition Command (draft recommendation 7.1), should:

- require Australian Defence Force members to prepare a career plan that covers both their service and post-service career, and to update that plan at least every two years
- prepare members for other aspects of civilian life, including the social and psychological aspects of transition
- reach out to families, so that they can engage more actively in the process of transition.

DRAFT RECOMMENDATION 7.3

The Department of Veterans' Affairs should support veterans to participate in education and vocational training once they leave the Australian Defence Force. It should trial a veteran education allowance for veterans undertaking full-time education or training.

INFORMATION REQUEST 7.2

The Commission is seeking information to inform the design of the proposed veteran education allowance. In particular:

- *at what rate should the veteran education allowance be paid?*
 - *should eligibility for the veteran education allowance be contingent on having completed a minimum period of service? If so, what should that minimum period be?*
 - *should any other conditions be put on eligibility for the veteran education allowance?*
-

INFORMATION REQUEST 7.3

The Commission is seeking further information on the transition needs of members when they leave the Reserves.

Initial liability assessment

Having liability accepted for an injury, illness or death is the first step in most claims for compensation, treatment and rehabilitation in the veteran support system. The way initial liability is assessed varies by Act and by type of service. These variations are no longer justified and should be reduced or eliminated where feasible.

DRAFT RECOMMENDATION 8.1

The Australian Government should harmonise the initial liability process across the three veteran support Acts. The amendments should include:

- making the heads of liability and the broader liability provisions identical under the *Veterans' Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- applying the Statements of Principles to all DRCA claims and making them binding, as under the MRCA and VEA
- adopting a single standard of proof for determining causality between a veteran's condition and their service under the VEA, DRCA and MRCA.

INFORMATION REQUEST 8.1

The Statements of Principles are created on two different standards of proof for the underlying medical-scientific evidence — a ‘reasonable hypothesis standard’ and a ‘balance of probabilities’ standard.

The Commission is seeking participants’ views on which standard of proof the veteran support system should use going forward. What would be the impacts of that choice on future claims and government expenditure, and how could they be quantified?

DRAFT RECOMMENDATION 8.2

The Australian Government should amend the *Veterans’ Entitlements Act 1986* (VEA) to allow the Repatriation Medical Authority (RMA) the legal and financial capacity to fund and guide medical and epidemiological research into unique veteran health issues, such as through a research trust fund.

Following any investigation, the RMA should be required to publish the list of peer-reviewed literature or other sound medical-scientific evidence used, as well as outline how different pieces of evidence were assessed and weighed against each other. This may require legislative amendments to the VEA.

Additional resources should also be given to the RMA, so that the time taken to conduct reviews and investigations can be reduced to around six months.

INFORMATION REQUEST 8.2

The Commission is seeking participants’ views on whether there is merit in the Specialist Medical Review Council remaining as a standalone organisation, or whether its role should be folded into an augmented Repatriation Medical Authority review process that brings in additional medical specialists.

Claims administration and processing

There are significant and ongoing problems with the way DVA administers claims. DVA is attempting to fix these problems under its Veteran Centric Reform (VCR) program, which began in 2016. VCR has had some successes, most notably the introduction of an online claims system, but issues including slow and poor quality claims assessments remain. Close monitoring of the effective roll out of the VCR, both in terms of timeliness and outcomes is required.

DRAFT RECOMMENDATION 9.1

The Department of Veterans' Affairs should report publicly on its progress in implementing recommendations from recent reviews (including the 2018 reports by the Australian National Audit Office and the Commonwealth Ombudsman) by December 2019.

DRAFT FINDING 9.1

MyService, in combination with a completed Early Engagement Model, has the potential to radically simplify the way Australian Defence Force members, veterans and their families interact with the Department of Veterans' Affairs (DVA), particularly by automating the claims process.

But achieving such an outcome will be a complex, multi-year process. To maximise the probability of success, Defence, DVA and the Department of Human Services will need to:

- continue to work closely in a collegiate and coordinated fashion
- retain experienced personnel
- allocate sufficient funding commensurate with the potential long-term benefits.

DRAFT RECOMMENDATION 9.2

The Department of Veterans' Affairs should ensure that staff, who are required to interact with veterans and their families, undertake specific training to deal with vulnerable people and in particular those experiencing the impacts of trauma.

DRAFT FINDING 9.2

The Department of Veterans' Affairs needs to negotiate a sustainable and predictable funding model with the Department of Finance based on expected claims and existing clients.

This should incorporate the likely efficiency savings from the Veteran Centric Reform program via initiatives such as MyService.

DRAFT FINDING 9.3

The Commission does not support deeming initial liability claims at this stage. Progress on the Veteran Centric Reform program in the Department of Veterans' Affairs should continue to significantly improve the efficiency of claims processing and management. Should these reforms fail to deliver further significant improvements in the timely handling of claims, then the need for statutory time limits should be reconsidered.

DRAFT RECOMMENDATION 9.3

If the Department of Veterans' Affairs' quality assurance process identifies excessive error rates (for example, greater than the Department's internal targets), all claims in the batch from which the sample was obtained should be recalled for reassessment.

DRAFT FINDING 9.4

External medical assessors provide useful diagnostic information about veterans' conditions and are a necessary part of the claims process for the veteran support system. However, they should only be called upon when strictly necessary and staff should be provided with clear guidance to that effect.

The Department of Veterans' Affairs needs to ensure that the current review into external medical assessors fully considers all aspects of Recommendation 10 of the Senate committee inquiry into veteran suicide.

DRAFT FINDING 9.5

Under the Department of Veterans' Affairs' (DVA's) stewardship, the Veteran Centric Reform (VCR) program has produced a number of early successes. However, given DVA's poor history of change management, close supervision and guidance will be required to ensure VCR continues to be successfully rolled out. Regular progress reporting and ongoing assurance reviews will facilitate this outcome.

DRAFT FINDING 9.6

Ex-service organisations play an important role in the veteran support system. However, the lack of coordination among them may be diluting their effectiveness.

Reviews

Most decisions made by DVA to provide (or not provide) compensation or support to veterans can be challenged through administrative review processes. However, there are a number of issues with the existing processes which warrant reform and a common approach is required for all claims.

DRAFT FINDING 10.1

Current review processes are ensuring that many veterans receive the compensation or support that they are entitled to under the law, albeit sometimes with significant delays. The majority of cases that are reviewed externally result in a change to the original decision made by the Department of Veterans' Affairs.

DRAFT FINDING 10.2

The Veterans' Review Board and Administrative Appeals Tribunal are not providing sufficient feedback from their review processes to the Department of Veterans' Affairs to better inform decision-making practice. Further, the Department is not incorporating the limited available feedback into its decision-making processes. This means that opportunities for process improvement are being missed.

DRAFT RECOMMENDATION 10.1

The Department of Veterans' Affairs (DVA) should ensure that successful reviews of veteran support decisions are brought to the attention of senior management for compensation and rehabilitation claims assessors, and that accuracy of decision making is a focus for senior management in reviewing the performance of staff.

Where the Veterans' Review Board (VRB) identifies an error in the original decision of DVA, it should clearly state that error in its reasons for varying or setting aside the decision on review.

The Australian Government should amend the *Veterans' Entitlements Act 1986* to require the VRB to report aggregated statistical and thematic information on claims where DVA's decisions are varied through hearings or alternative dispute resolution processes. This reporting should cover decisions of the Board, as well as variations made with the consent of the parties through an alternative dispute resolution process. This should be collected and provided to DVA on a quarterly basis and published in the VRB's annual report.

DVA should consider this reporting and respond by making appropriate changes to its decision-making processes.

DRAFT FINDING 10.3

While many veterans are managing to negotiate the current pathways for reviews of decisions made under the various veteran support Acts, there are unjustified differences and complexities in the rights of review available to claimants under each Act.

DRAFT FINDING 10.4

The Veterans' Review Board, while highly regarded by veterans, has functions that overlap with those of the Administrative Appeals Tribunal. Rather than being used occasionally to resolve difficult or exceptionally difficult cases, the Department of Veterans' Affairs is relying on the Board's external merits review as a standard part of the process for addressing many claims.

DRAFT RECOMMENDATION 10.2

The Australian Government should introduce a single review pathway for all veterans compensation and rehabilitation decisions. The pathway should include:

- internal reconsideration by the Department of Veterans' Affairs. In this process, a different and more senior officer would clarify the reasons why a claim was not accepted (partially or fully); request any further information the applicant could provide to fix deficiencies in the claim, then make a new decision with all of the available information
- review and resolution by the Veterans' Review Board, in a modified role providing alternative dispute resolution services only (draft recommendation 10.3)
- merits review by the Administrative Appeals Tribunal
- judicial review in the Federal Court of Australia and High Court of Australia.

DRAFT RECOMMENDATION 10.3

The Australian Government should amend the role and procedures of the Veterans' Review Board (VRB).

Rather than making decisions under the legislation, it would serve as a review and resolution body to resolve claims for veterans. All current VRB alternative dispute resolution processes would be available (including party conferencing, case appraisal, neutral evaluation and information-gathering processes) together with other mediation and conciliation processes. A single board member could recommend the correct and preferable decision to be made under the legislation, and the Department of Veterans' Affairs and the claimant could consent to that decision being applied in law.

Cases that would require a full board hearing under the current process, or where parties fail to agree on an appropriate alternative dispute resolution process or its outcomes, could be referred to the Administrative Appeals Tribunal.

Parties to the VRB resolution processes should be required to act in good faith.

DRAFT RECOMMENDATION 10.4

The Australian Government should conduct a further review in 2025 on the value of the continuing role of the Veterans' Review Board, once significant reforms to the initial claim process for veterans are established. In particular, the review should consider whether reforms have reduced the rate at which initial decisions in the veteran support system are varied on review. If the review finds that the Board is no longer playing a substantial role in the claims process, the Australian Government should bring the alternative dispute resolution functions of the Board into the Department of Veterans' Affairs or its successor agency.

INFORMATION REQUEST 10.1

The Commission is seeking further information on whether there are any decisions that are not reviewable, that should be reviewable.

Governance and funding

Under the current governance arrangements, no single agency has responsibility for the lifetime wellbeing of veterans. Strategic policy in the veteran support system appears to be largely reactive, with changes often making the system more complex and expensive. Also, the veteran support system, which has large contingent liabilities, is funded on a short-term basis, and long-term costs are poorly understood. New governance and funding arrangements are required to develop and administer a new veteran support system for future generations of veterans and their families.

DRAFT RECOMMENDATION 11.1

A new 'Veteran Policy Group', headed by a Deputy Secretary, should be created in Defence with responsibility for veteran support policies and strategic planning.

Ministerial responsibility for veterans' affairs should be vested in a single Minister for Defence Personnel and Veterans within the Defence portfolio.

DRAFT RECOMMENDATION 11.2

The Australian Government should establish a new independent Commonwealth statutory authority, the Veteran Services Commission (VSC), to administer the veteran support system. It should report to the Minister for Defence Personnel and Veterans and sit within the Defence portfolio (but not within the Department of Defence).

An independent board should oversee the VSC. The board should be made up of part-time Commissioners appointed by the Minister who have a mixture of skills in relevant civilian fields, such as insurance, civilian workers' compensation and project management, as well as some with an understanding of military life and veteran issues. The board should have the power to appoint the Chief Executive Officer (responsible for the day-to-day administration).

The functions of the VSC should be to:

- achieve the objectives of the veteran support system (draft recommendation 4.1) through the efficient and effective administration of all aspects of that system
- manage, advise and report on outcomes and the financial sustainability of the system, in particular, the compensation and rehabilitation schemes
- make claims determinations under all veteran support legislation
- enable opportunities for social integration
- fund, commission or provide services to veterans and their families.

The Australian Government should amend the *Veterans' Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004* to abolish the Repatriation Commission and Military Rehabilitation and Compensation Commission upon the commencement of the VSC.

DRAFT RECOMMENDATION 11.3

The Australian Government should establish a Veterans' Advisory Council to advise the Minister for Defence Personnel and Veterans on veteran issues, including the veteran support system.

The Council should consist of part-time members from a diverse range of experiences, including civilians and veterans with experience in insurance, workers' compensation, public policy and legal fields.

DRAFT RECOMMENDATION 11.4

The Australian War Memorial (AWM) already plays a significant and successful role in commemoration activities. As a consequence of the proposed governance and administrative reforms, the Australian Government should transfer primary responsibility for all commemoration functions to the AWM, including responsibility for the Office of Australian War Graves.

DRAFT RECOMMENDATION 11.5

Once the new governance arrangements in draft recommendations 11.1 and 11.2 have commenced, the Australian Government should make the veteran support system a fully-funded compensation system going forward. This would involve levying an annual premium on Defence to enable the Veteran Services Commission to fund the expected future costs of the veteran support system due to service-related injuries and illnesses incurred during the year.

INFORMATION REQUEST 11.1

The Commission is seeking feedback on the extent and design of the veteran support system funding model, particularly whether the fully-funded system should cover future liabilities only, or whether existing liabilities (including the Veterans' Entitlements Act 1986) should be capitalised into the insurance pool.

The compensation package

The compensation package is complex — with offsetting provisions applying between the three main compensation Acts, and a system of superannuation invalidity and life insurance operating alongside the compensation system. Reform is needed to simplify the system, and improve equality between veterans.

DRAFT RECOMMENDATION 12.1

The Australian Government should harmonise the compensation available through the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) with that available through the *Military Rehabilitation and Compensation Act 2004*. This would include harmonising the processes for assessing permanent impairment, incapacity and dependant benefits, as well as the range of allowances and supplements.

Existing recipients of DRCA permanent impairment compensation and dependant benefits should not have their permanent impairment entitlements recalculated. Access to the Gold Card should not be extended to those eligible for benefits under the DRCA.

DRAFT FINDING 12.1

The principle of not providing two sources of income replacement to the same veteran is sound. There is no case for changing the current offsetting arrangements between government-funded superannuation payments and incapacity payments.

DRAFT RECOMMENDATION 12.2

The Department of Veterans' Affairs (DVA) and the Commonwealth Superannuation Corporation (CSC) should work together to streamline the administration of superannuation invalidity pensions and veteran compensation, including by:

- moving to a single 'front door' for invalidity pensions and veteran compensation
- moving to a single medical assessment process for invalidity pensions and veteran compensation
- developing information technology systems to facilitate more automatic sharing of information between DVA and CSC.

With the establishment of the proposed Veteran Services Commission (draft recommendation 11.2), consideration should be given to whether it should administer the CSC invalidity pensions.

INFORMATION REQUEST 12.1

What are the costs and benefits of further integration between superannuation insurance benefits and the veteran compensation scheme, and how might this integration be achieved?

Compensation for an impairment

There are a number of changes that could be made to permanent impairment payments under the *Military Rehabilitation and Compensation Act 2004* that would simplify the payments, improve access and equity.

The veteran permanent impairment and incapacity payments, and dependant benefits include many provisions that are unique to the veteran compensation system — they do not have parallels in other workers' compensation schemes. And there is little rationale for a number of these payments. They also add complexity, lead to inequities and can hinder the rehabilitation focus of the veteran support system. Most of these provisions do not lead to large increases in compensation — removing or improving these provisions is unlikely to have a substantial effect on the compensation received by veterans.

DRAFT RECOMMENDATION 13.1

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the requirement that veterans with impairments relating to warlike and non-warlike service receive different rates of permanent impairment compensation from those with peacetime service.

The Department of Veterans' Affairs should amend tables 23.1 and 23.2 of the Guide to Determining Impairment and Compensation to specify one rate of compensation to apply to veterans with warlike, non-warlike and peacetime service.

INFORMATION REQUEST 13.1

The Commission is seeking information on the new level of permanent impairment compensation that would be reasonable, taking into account the costs, benefits and equity implications to veterans, governments and the broader community.

DRAFT FINDING 13.1

The requirements that a condition be permanent and stable before final permanent impairment compensation is granted, under the *Military Rehabilitation and Compensation Act 2004*, are needed to prevent veterans from being overcompensated for impairments that are likely to improve.

DRAFT RECOMMENDATION 13.2

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the option of taking interim permanent impairment compensation as a lump-sum payment. The Act should be amended to allow interim compensation to be adjusted if the impairment stabilises at a lower or higher level of impairment than what is expected within the determination period.

DRAFT RECOMMENDATION 13.3

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to allow the Department of Veterans' Affairs the discretion to offer veterans final permanent impairment compensation if two years have passed since the date of the permanent impairment claim, but the impairment is expected to lead to a permanent effect, even if the impairment is considered unstable at that time. This should be subject to the veteran undertaking all reasonable rehabilitation and treatment for the impairment.

DRAFT FINDING 13.2

There is little rationale for providing additional non-economic loss compensation to veterans for having children, and the current payment leads to inequities and complexities. This payment is unique to the veteran compensation system.

DRAFT RECOMMENDATION 13.4

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the permanent impairment lump-sum payments to the veteran for dependent children and other eligible young persons.

DRAFT RECOMMENDATION 13.5

The Department of Veterans' Affairs should review its administration of lifestyle ratings in the *Military Rehabilitation and Compensation Act 2004* (MRCA), to assess whether the use of lifestyle ratings could be improved.

If the use of lifestyle ratings cannot be improved, the Australian Government should amend the MRCA and the Guide to Determining Impairment and Compensation to remove the use of lifestyle ratings and provide veterans permanent impairment compensation consistent with the lifestyle ratings that are currently usually assigned for a given level of impairment. Existing recipients of permanent impairment compensation should not have their compensation reassessed.

INFORMATION REQUEST 13.2

The Commission is seeking further information on the costs and benefits of removing the remuneration loading and replacing it with superannuation contributions for veterans with long-term incapacity. What are the barriers to providing superannuation to veterans on incapacity payments, and how could these be overcome?

DRAFT RECOMMENDATION 13.6

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the option of taking the special rate disability pension. Veterans that have already elected to receive the special rate disability pension should continue to receive the payment.

DRAFT FINDING 13.3

Changes to eligibility for the service pension and other welfare payments means that the package of compensation received by veterans on the special rate of disability pension is reasonable. Despite strong veterans' representation on this issue, there is no compelling case for increasing the rate of the pension.

DRAFT RECOMMENDATION 13.7

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* (MRCA) to remove automatic eligibility for benefits for those dependants whose partner died while they had permanent impairments of more than 80 points or who were eligible for the MRCA Special Rate Disability Pension.

DRAFT RECOMMENDATION 13.8

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the additional lump sum payable to wholly dependent partners of veterans who died as a result of their service. The Australian Government should increase the wholly dependent partner compensation by the equivalent value of the lump-sum payment (currently about \$115 per week) for partners of veterans where the Department of Veterans' Affairs has accepted liability for the veteran's death.

Streamlining and simplifying additional payments

Many of the payments available to veterans are outdated (some have not changed since the 1920s), do not meet their intended objectives and result in another layer of complexity in the veteran compensation system. The additional payments are mostly small and the benefits do not always outweigh the costs of the added complexity. The following recommendations are about simplifying, streamlining or updating additional payments so they better meet their objectives.

DRAFT RECOMMENDATION 14.1

The Australian Government should amend the *Social Security Act 1991* and relevant arrangements to exempt Department of Veterans' Affairs adjusted disability pensions from income tests for income-support payments that are currently covered by the Defence Force Income Support Allowance (DFISA), DFISA Bonus and DFISA-like payments. The Australian Government should remove the DFISA, DFISA Bonus and DFISA-like payments from the *Veterans' Entitlements Act 1986*.

DRAFT RECOMMENDATION 14.2

To align education payments across the veteran support system, the Australian Government should amend the *Veterans' Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004* to remove education payments for those older than 16 years of age. Those who pass a means test will still be eligible for the same payment rates under the Youth Allowance.

To extend education payments for those under 16 years of age, the Australian Government should amend the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to adopt the Military Rehabilitation and Compensation Act Education and Training Scheme.

DRAFT RECOMMENDATION 14.3

To help simplify the system, smaller payments should be consolidated where possible or removed where there is no clear rationale.

The Australian Government should remove the DRCA Supplement, MRCA Supplement and Veteran Supplement, and increase clients' payments by the equivalent amount of the supplement.

The Australian Government should remove the Energy Supplement attached to Department of Veterans' Affairs' impairment compensation, but other payments should remain consistent with broader Energy Supplement eligibility.

DRAFT RECOMMENDATION 14.4

To streamline and simplify outdated payments made to only a few clients, they should be paid out and removed. The Australian Government should amend the *Veterans' Entitlements Act 1986* to remove the recreation transport allowance, the clothing allowance and the decoration allowance and pay out those currently on the allowances with an age-adjusted lump sum.

DRAFT RECOMMENDATION 14.5

The Australian Government should amend the *Veterans' Entitlements Act 1986* (VEA) to remove the attendant allowance and provide the same household and attendant services that are available under the *Military Rehabilitation and Compensation Act 2004* (MRCA).

Current recipients of the VEA allowance should be automatically put on the same rate under the new attendant services program. Any further changes or claims would follow the same needs-based assessment and review as under the MRCA.

DRAFT RECOMMENDATION 14.6

The Australian Government should amend the *Veterans' Entitlements Act 1986* Vehicle Assistance Scheme and section 39(1)(d) (the relevant vehicle modification section) in the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* so that they reflect the *Military Rehabilitation and Compensation Act 2004* Motor Vehicle Compensation Scheme.

Health care

An efficient and effective veteran health system needs to target the right services to the right people in terms of need (financially or in terms of health requirements). Some of the eligibility criteria for the veteran health system potentially needs to be re-targeted towards ensuring that those in most need receive the most care. DVA also needs to improve its monitoring of client outcomes and service providers' effectiveness.

DRAFT FINDING 15.1

Funding the treatment of service-related conditions, as is done through the White Card, is well-justified — it appropriately targets veterans with health needs and is similar to workers' compensation healthcare entitlements.

The Gold Card, however, runs counter to a number of the key principles that should underlie a future scheme — it is *not* needs based (because it is not targeted to service-related health needs), wellness focused (there can be an incentive to remain unwell), or efficient (by potentially encouraging over-servicing).

DRAFT RECOMMENDATION 15.1

Eligibility for the Gold Card should not be extended to any new categories of veterans or dependants that are not currently eligible for such a card. No current Gold Card holder or person who is entitled to a Gold Card under current legislation would be affected.

INFORMATION REQUEST 15.1

Given the Gold Card runs counter to a number of key design principles, the Commission is seeking feedback on whether a future system should have a coloured health card system. If not, what are the other options?

In particular, the Commission is seeking feedback on the benefits and costs of providing the Gold Card to dependants, service pensioners and veterans with qualifying service at age 70.

DRAFT RECOMMENDATION 15.2

The Department of Veterans' Affairs should amend the payments for the Coordinated Veterans' Care program so that they reflect the risk rating of the patient that they are paid for — higher payments for higher risk patients and lower payments for lower risk patients. Doctors should be able to request a review of a patient's risk rating, based on clinical evidence.

DRAFT RECOMMENDATION 15.3

The current (2013–2023) Veteran Mental Health Strategy has not been very effective and should be updated in light of recent policy changes (such as non-liability access) and research findings on emerging needs.

The Department of Veterans' Affairs (DVA) (in consultation with the Departments of Health and Defence) should urgently update the Veteran Mental Health Strategy, so that it guides policy development and implementation over the medium term. It should:

- be evidence-based, including outcomes from policy trials and other research on veterans' mental health needs
- set out clear priorities, actions and ways to measure progress
- commit DVA to publicly report on its progress.

The Strategy should include ways to promote access to high-quality mental health care, and to facilitate coordinated care for veterans with complex needs. It should also have suicide prevention as a focus area and explicitly take into account the mental health impacts of military life on veterans' families.

DRAFT RECOMMENDATION 15.4

The Department of Veterans' Affairs (DVA) should monitor and routinely report on Open Arms' outcomes and develop outcome measures that can be compared with other mental health services.

Once outcome measures are established, DVA should review Open Arms' performance, including whether it is providing adequate, accessible and high-quality services to families of veterans.

INFORMATION REQUEST 15.2

The Commission is seeking participants' views on fee-setting arrangements for veterans' health care that would promote accessible services while maintaining a cost-effective system.

What would be the benefits and costs of separate fee-setting arrangements for Gold Card and White Card holders? To allow cardholders more choice of provider, should providers be allowed to charge co-payments? Should co-payments, if permitted, be restricted to treatment of non-service related conditions?

INFORMATION REQUEST 15.3

The Commission is seeking participants' views on the desirability of subsidising private health insurance for veterans and dependants in place of other forms of healthcare assistance.

Data and evidence

The gaps in information about veterans are significant and there is limited evidence on the effectiveness of services provided to veterans. This inquiry was limited by the lack of data and the poor linking of data. Reform is needed to improve data held on veterans and build an evidence base on what does and does not work.

DRAFT FINDING 16.1

There is a lack of robust data and evidence on many crucial aspects of the veteran support system. This impedes the design and delivery of effective supports for veterans and their families.

DRAFT RECOMMENDATION 16.1

The Department of Veterans' Affairs should develop outcomes and performance frameworks that provide robust measures of the effectiveness of services. This should include:

- identifying data needs and gaps
- setting up processes to collect data where not already in place (while also seeking to minimise the costs of data collection)
- using data dictionaries to improve the consistency and reliability of data
- analysing the data and using this analysis to improve service performance.

DRAFT RECOMMENDATION 16.2

The Department of Veterans' Affairs should conduct more high-quality trials and reviews of its services and policies for veterans and their families by:

- evaluating services and programs (in ways that are commensurate with their size and complexity)
- publishing reviews, evaluations and policy trials, or lessons learned
- incorporating findings into future service design and delivery.

DRAFT RECOMMENDATION 16.3

The Department of Veterans' Affairs should set research priorities, publish the priorities in a research plan and update the research plan annually.

Bringing it all together

One of the key drivers for this inquiry was the complex legislative framework underpinning the veteran compensation system. The Commission is proposing simplifying the system by moving to two schemes, while minimising disruption to existing claimants. Importantly, our proposed changes will mean there will be one scheme and one Act in the long term. Although legislative simplification is not a solution for all the issues facing the veteran support system, and some complexity will remain, this approach sets up Australia to have much better, fit-for-purpose compensation and rehabilitation arrangements for the future.

DRAFT RECOMMENDATION 17.1

By 2025, the Australian Government should create two schemes for veteran support — the current *Veterans' Entitlements Act 1986* (VEA) with some modifications ('scheme 1') and a modified *Military Rehabilitation and Compensation Act 2004* (MRCA) that incorporates the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) ('scheme 2').

Eligibility for the schemes should be modified so that:

- veterans who only have a current or accepted VEA claim for liability at the implementation date will have all their future claims processed under scheme 1. Veterans on the VEA Special Rate of Disability Pension would also have their future claims covered by scheme 1. Veterans under 55 years of age as at the implementation date should be given the option to switch their current benefits and future claims to scheme 2
- veterans who only have a current or accepted MRCA and/or DRCA claim, (or who do not have a current or accepted liability claim under VEA) as at the implementation date will have their future claims covered under scheme 2. Other veterans on MRCA or DRCA incapacity payments would have their future claims covered by scheme 2
- remaining veterans with benefits under the VEA and one (or two) of the other Acts would have their coverage determined by the scheme which is the predominant source of their current benefits, or their age, at the implementation date.

Dependants of deceased veterans would receive benefits under the scheme in which the relevant veteran was covered by. If the veteran did not have an existing or successful claim under VEA as at the implementation date, the dependants would be covered by scheme 2.

Veterans who would currently have their claims covered by the pre-1988 Commonwealth workers' compensation schemes should remain covered by those arrangements through the modified MRCA legislation.

INFORMATION REQUEST 17.1

The Commission is seeking feedback from participants on how the two scheme approach would work for veterans who currently have claims under multiple Acts. What factors should determine which scheme these veterans are covered by for their future claims? Should these veterans be given a choice of which scheme would cover them going forward?

1 About this inquiry

Key points

- This inquiry came about following a recommendation by a Senate inquiry into suicide by veterans. The Senate inquiry found the legislative framework underpinning the veteran compensation and rehabilitation system to be complex and difficult to navigate, and raised concerns about unwarranted stress placed on veterans and their families as a result of the claims process. It called for a ‘comprehensive rethink of how the system operates’.
- The Commission has been asked to look at how the veteran compensation and rehabilitation system currently operates, how it should operate into the future, and whether it is ‘fit for purpose’.
- Our approach to assessing how the current system is performing, and what a future system should look like, is to look at the benefits and impacts of the system on the lives of veterans, and Australians more generally, in light of the costs of the scheme. We also looked at workers’ compensation, social insurance and international military compensation schemes to inform our ideas and recommendations for a better system.
- While traditionally the term ‘veteran’ described former Australian Defence Force (ADF) members who had been deployed in operational conflict environments, Australian Veterans’ Ministers agreed in 2017 to define a veteran as anyone who has served at least one day in the ADF. As such, we use ‘veteran’ to mean all current and former permanent serving ADF personnel. And we use the term ‘veteran community’ to cover veterans, their partners and children, widow(er)s of deceased veterans and their dependents, and parents and siblings of veterans.
- We engaged with many individuals and organisations on this inquiry — including veterans, their families, ex-service organisations, the Department of Defence, the Department of Veterans’ Affairs, other government departments, service providers, researchers and insurance companies. We also visited a number of military bases and held both general and topic-specific roundtables (covering legislative reform, rehabilitation and military families).

This inquiry is about the system that supports veterans and their families. The system provides compensation, rehabilitation and other forms of support to current and former ADF members and their families. Access to some of the supports and services is contingent on a veteran having suffered an injury or illness (or death) related to their military service. Other supports are available irrespective of whether they incurred an injury or illness.

The genesis of this inquiry is a recommendation by the Senate Foreign Affairs, Defence and Trade References Committee in a report titled *The Constant Battle: Suicide by Veterans*. The Committee found that the legislative framework underpinning the veteran compensation and rehabilitation system was unnecessarily complex and difficult to navigate and was concerned about inconsistent treatment of claims for compensation, lengthy delays in the processing of claims and unwarranted stress for veterans and their families (SFADTRC 2017). The

Committee said it repeatedly heard that ‘excessive legislative complexity was a burden on veterans, advocates and the operations of DVA [Department of Veterans’ Affairs] itself’ (SFADTRC 2017, p. 67).

The Committee said it was time for a ‘comprehensive rethink of how the system operates and will operate into the future’ (SFADTRC 2017, p. 68), and that:

... there should be no topics which are off-limits including the differences in relation to operational service, standards of proof and the provision of services through the Department of Veterans Affairs (DVA) or alternative government agencies. The committee recognises that this will not be an easy or uncontroversial review process. Systematic reform may even moderately disadvantage some individual veterans in the process of improving outcomes for serving members and veterans overall. (SFADTRC 2017, pp. xxv, 68).

It also noted that previous recent reviews of military compensation have been ‘too willing to accept the status quo’ and the review needed to ‘re-examine long-standing issues in this portfolio’ (SFADTRC 2017, p. 68).

On 27 March 2018, the Australian Government requested the Productivity Commission to undertake an inquiry into the system of compensation and rehabilitation for veterans.

1.1 What has the Commission been asked to do?

The Commission has been asked to examine how the current compensation and rehabilitation system for veterans¹ operates, how it should operate in the future, and whether it is ‘fit for purpose’. In undertaking this task, we are to:

- review the efficiency and effectiveness of the legislative framework, and assess opportunities for simplification
- examine the effectiveness of the supporting governance, administrative and service delivery arrangements
- have regard to the current environment and challenges faced by veterans, including:
 - whether the arrangements reflect contemporary best practice, drawing on workers’ compensation arrangements and military compensation schemes in Australia and internationally
 - the use of Statements of Principles — which are legislative instruments that set out the requirements for a veteran’s impairment to be linked to their service
 - whether the arrangements deliver compensation and rehabilitation to veterans in a well-targeted, efficient and veteran-centric manner.

The Commission is also to consider issues raised in previous reviews (box 1.1).

¹ We also refer to the compensation and rehabilitation system for veterans as the veteran support system throughout this report.

Box 1.1 **Reviews of the veteran support system**

Previous reviews

Over the past 40 years there have been many reviews of Australia's veteran support system. Some of the more notable include:

- 1975 '*Independent Enquiry into the Repatriation System*' by Justice Toose
- 1994 '*A Fair Go: Report on Compensation for Veterans and War Widows*' by Professor Baume
- 1999 '*Review of the Military Compensation Scheme*' by the Department of Defence, chaired by Mr Noel Tanzer. The recommendations of the Tanzer review led to the introduction of the *Military Rehabilitation and Compensation Act* in 2004
- 2003 '*Review of Veterans' Entitlements*' chaired by Justice John Clarke. One of the key outcomes of this review was a renewed focus on rehabilitation
- 2011 '*Review of Military Compensation Arrangements*' chaired by the Secretary of the Department of Veterans' Affairs, Ian Campbell.

While these reviews resulted in reforms to the system, one consequence of the many changes is a high degree of complexity. As the Department of Veterans' Affairs (DVA) observed:

... often the terms of reference for each inquiry or review have been relatively narrow, constraining impacts to specific elements or areas of support. And while most of the inquiries and reviews ... resulted in direct or indirect changes to some part of the system of military compensation, the nature of some of those changes were generally piecemeal and ad hoc, and often took little account of flow-on effects to overall complexity ... the almost continual series of inquiries and reviews, with their compounding resulting changes on the system, have themselves contributed to what is now a complex military compensation system. (sub. 125, p. 4)

Concurrent reviews

Several reviews were also underway at the same time as this inquiry.

- Australian National Audit Office performance audit of DVA — released June 2018. This report focused on DVA administrative processes (ANAO 2018b).
- Commonwealth Ombudsman's Investigation into the Actions and Decisions of the Department of Veterans' Affairs in Relation to Mr A — released July 2018 (Commonwealth Ombudsman 2018).
- Senate inquiry into transition from the Australian Defence Force — commenced May 2018 reporting date not announced (JSCFADT 2018).
- Senate inquiry into the 'Use of the Quinoline anti-malarial drugs Mefloquine and Tafenoquine in the Australian Defence Force' — to be released in December 2018 (JSCFADT 2018).
- 'Veterans' Advocacy and Support Services Scoping Study' by Robert Cornall (the 'Cornall Review') — for release in December 2018 (Australian Government 2018b).
- 'Independent review of the implementation of the recommendations of the Joint Defence/DVA Inquiry into the Jesse Bird Case after 12 months' by Robin Creyke — the reporting date has not been announced (Chester 2018a).

We have drawn on these reviews, where relevant, to buttress our own understanding and analysis. For the draft report, we have not considered advocacy issues in any detail given the parallel Cornall Review. We will cover this issue in more detail in the final report.

1.2 What the inquiry covers

The current system for veteran support has three main Acts:

- *Veterans' Entitlements Act 1986*
- *Military Rehabilitation and Compensation Act 2004*
- *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.²

These three Acts all contain provisions for rehabilitation and compensation for veterans and their families, entitlements such as pensions and health cards for veterans, and other services such as transition support. As DVA said:

These three Acts collectively incorporate almost all of the benefits available to successive generations of veterans over the last 100 years. (sub. 125, p. vii).

The Acts and their entitlements are administered by DVA.

Although the terms of reference specifically mention only the above Acts, other arrangements are relevant to the inquiry. These include the invalidity and death insurance contained in military superannuation arrangements, which interact with the three Acts. And because compensation, rehabilitation and other supports for veterans are only required when personnel are injured, become ill or die as a result of service in the ADF, this inquiry also looks at ADF's prevention policies, and its healthcare and rehabilitation services. Services designed to help ADF members transition out of the military are also considered.

1.3 Who are veterans?

Defining veterans

Traditionally, the term 'veteran' described former ADF members who were deployed to serve in operational conflict environments (those in the military that fought outside Australia against hostile forces or served during the world wars). However, in 2017, the Australian and State and Territory Ministers responsible for veterans' issues agreed to define a veteran as anyone who is, or has in the past, served in the ADF (Tehan 2017b). This definition captures all current and past members of the ADF, whether they were deployed abroad and regardless of the nature of their service.³

² In addition, the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act* also grandfathers two previous pieces of Commonwealth workers' compensation legislation — the *Commonwealth Employees Compensation Act 1948* and the *Compensation (Commonwealth Government Employees) Act 1971*. The *Defence Act 1903* also supplements some claims under the Act.

³ DVA uses the term 'veteran' to refer to someone with at least a single day of 'continuous full time service' — this excludes reservists who have not served on a continuous basis or been on deployments (DVA, sub. 125, p. xiv).

The terms of reference for this inquiry ask the Commission to examine the compensation and rehabilitation arrangements for both serving and ex-serving members of the ADF.⁴ As such, while some participants raised concerns about the new definition of a veteran (box 1.2), for this inquiry we have used the new broader definition of ‘veteran’. That is, we use the term ‘veteran’ to cover all current and former serving ADF personnel unless otherwise specified, or the context makes clear that reference is only to either serving or non-serving veterans.

Box 1.2 Mixed views on the new definition of a veteran

Some stakeholders were sceptical of the new definition of a veteran as anyone who has served in the Australian Defence Force (ADF):

Bluntly, it’s nonsense to argue that a person with just a few days service in the ADF can be regarded as a veteran and neither the general public nor the ADF fraternity would accept that it is so. (ACT branch of the Vietnam Veterans’ Federation of Australia, sub. 42, p. 2)

Others raised concerns about whether this definition could create undue expectations of veteran support:

Support for veterans of military operations should be, unequivocally, more beneficial than for members of the ADF who have not endured the threats and stresses of operational service. We suggest that the extension of the definition of the term ‘veteran’ to mean any person who has spent at least one day in the ADF can cause confusion in the discussion about ‘veterans’ benefits. Consideration now needs to be given to a form of terminology that defines those members of the ADF who have served in war and war-like situations, such as the previous term ‘returned servicemen or women’. (Vietnam Veterans Association of Australia, sub. 78, p. 4)

Other stakeholders noted the varied interpretations of the meaning of the word ‘veteran’:

There are many different usages of the term by the public, media, and in the various Acts. There are different views promoting strong feelings within sections of the older ‘Veteran’ community, regarding those ex-ADF with ‘real war’ experiences and those who have none. Many younger ‘veterans’ who have seen operational or warlike service consider the term ‘Veteran’ applies only to the older generation — World War II, Korean or Vietnam Veterans, and not them. (Defence Force Welfare Association, sub. 118, p. 12)

Some were supportive of the new definition and further argued for all serving and ex-serving ADF members to receive the same entitlements to support:

If the term Veteran is all embracing ... then there should never be different health and welfare support services for those with or without warlike service. If a Veteran is a Veteran, then a TPI [Totally and Permanently Incapacitated] is a TPI, and there should be no discrimination in compensation methodology or support services. The Government has redefined the term ‘Veteran’ and now they need to recognise that. (Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women of Australia, sub. 134, p. 4)

Serving generally means those in ‘permanent’⁵ service, and non-serving means those that have discharged from such service, noting that some join the Reserves after discharge. The Commission also notes that cadets and reservists (who have never deployed or served on a

⁴ The veteran support system also covers some police officers who went on peacekeeping operations overseas (before 1 July 2004) and those who fought for allied nations in the World Wars.

⁵ ‘Permanent’ members of the ADF are those serving under service categories (SERCATs) 6 or 7. Those under SERCAT 6 need not be serving full time (DoD nd).

‘permanent’ basis) are covered under the veteran support legislation and, where we refer to these groups, we use the terms cadets and reservists rather than veterans.

Veterans’ families

The terms of reference use the term ‘veteran’. However, because the veteran support system also supports widow(er)s and other family members (‘dependants’), they are also covered as part of the broader ‘veteran community’.⁶ In fact, a large proportion of DVA benefit recipients are dependants (chapter 2) (DVA 2018m). Families can also be affected by military life and veterans’ transitions to civilian life, and family support can enhance the effectiveness of system supports provided to veterans.

1.4 The Commission’s approach

The Commission has been asked to look at whether the veteran support system is, or how it can be made, ‘fit for purpose’, now and for the future. References to ‘efficiency’, ‘effectiveness’ and ‘fitness for purpose’ in the terms of reference also raise questions about the adequacy and fairness of veteran supports and entitlements, and whether they represent value for money from the community’s perspective.

When thinking about a system to meet the needs of future generations of veterans, we looked at the changing nature of military service, the changing profile of the veteran community, emerging challenges and the strengths and weaknesses of the current veteran support system.

We took a wellbeing approach to assessing the veteran support system and options for reforming the system. This involved taking into account the community-wide costs and benefits of policies and policy changes and included:

- engaging with veterans and their families, ex-service organisations and others affected by veteran support policies
- looking at the objectives of the veteran support system, determining what the system should be measured on (drawing on best-practice principles of contemporary workers’ compensation arrangements and veteran support schemes in other comparable countries) and then assessing the system against those criteria
- analysing the benefits and costs of policies and reform options in qualitative and quantitative ways (including considering benefits and costs in their fullest sense to include the value of not only the monetary or material aspects but also the social, psychological and other elements of people’s wellbeing).

⁶ We use the term ‘veteran community’ to cover veterans, their partners and children, widow(er)s of deceased veterans and their dependents, and in some circumstances the parents and siblings of veterans.

We met with a range of individuals and groups, held roundtables across the country, and received submissions from a range of interested parties. We had extensive discussions with DVA (including visiting its offices to observe claims processing in action) and other government agencies, and visited several military bases to help gain insights on prevention and transition issues and to hear the views of current serving members (box 1.3).

Box 1.3 Consultation

In preparing this draft report, the Commission sought views from government departments, ex-service organisations, veterans, their families and other interested parties. We released an issues paper in early May setting out some issues and questions of relevance for the inquiry, and invited submissions. We also met with many interested parties and conducted visits and roundtables across the country.

Submissions

We have received 115 brief comments (through a portal on the inquiry's webpage) and 153 formal written submissions (these are published on the Commission's website). Submissions and brief comments came from a variety of sources including veterans and their families, government departments, health professionals, academics, lawyers, advocates, and ex-service organisations.

Meetings and site visits

In addition to numerous face-to-face and telephone meetings with stakeholders, the Commission went on numerous site visits, including to:

- the Department of Veterans' Affairs regional offices in Sydney to witness the claims process
- various Australian Defence Force (ADF) bases including Kapooka Army Base (Wagga Wagga), Forest Hill Royal Australian Air Force Base (Wagga Wagga), Bandiana Army Base (Wodonga), Lavarack Army Barracks (Townsville), and Garden Island Fleet Base East (Sydney) where we saw the ADF's prevention policies, and its healthcare, rehabilitative and transition services
- visits to meet various stakeholders in cities including Brisbane, Sydney, Melbourne, Canberra and Adelaide
- visits in New Zealand including with the New Zealand Department of Veterans' Affairs and Ron Paterson (author of the 'Review of the Operation of the Veterans' Support Act [NZ]').

Roundtables

The Commission held roundtables in all capital cities and Townsville where veterans and their families, ex-service organisations and various other stakeholders presented their views on the issues affecting veterans, families and their support services generally. Some of the roundtables focused on specific areas:

- a roundtable in Brisbane focused on the legislative complexity of the veteran support system and workshopped some potential solutions
- the Sydney roundtable focused on rehabilitation
- a veterans' families roundtable was held in Canberra.

In addition, the visits to Kapooka Army Base and Lavarack Army Barracks both contained (ADF only) roundtables on issues relating to prevention, rehabilitation, health care and transition.

The Commission appreciates the contributions of everyone who provided input to the inquiry (appendix A).

Other aspects of the approach we have adopted to evaluate the veteran support system include:

- *a long-term view of veterans' needs and wellbeing* — what happens during service can affect veterans' calls on the support system after they leave the military. We have considered each stage of the life cycle of military personnel — in-service, transition and ex-service
- *a focus on outcomes* — while constrained by existing data, our approach involves assessing the system based on what is known about outcomes (for veterans and families but also the wider community). We have also looked at ways to develop an evidence base against which the system can be evaluated going forward
- *viewing supports as a package* — sometimes public debate about veteran supports focuses on particular support in isolation. To provide a more complete picture, we sought to look at support packages holistically (and, where undertaking line-by-line comparisons or evaluations of particular supports, to be aware of their place in broader packages)
- *considering system sustainability* — if the system hopes to garner support, it needs to ensure taxpayer funds are being used well and that it can cope or adapt to new challenges and support veterans as their needs, circumstances and broader social settings change.

This draft report sets out the Commission's preliminary analysis and draft findings and recommendations. It is provided to elicit further views and information, and to provide an opportunity for any additional issues that should be considered for the final report to be raised. The Commission welcomes written comment on this report, and will undertake further consultation to facilitate feedback from participants. Submissions are due by 11 February 2019. Further information on how to provide feedback on the report is provided at the front of this report.

2 Military service and the veteran community

Key points

- Military service is a unique occupation which presents a number of challenges and risks to Australian Defence Force (ADF) members and their families. These include higher than average risk of injury or death, lack of autonomy and frequent relocations.
- More than 2 million Australians have served in the military since federation. About 102 000 Australians have died overseas in service (and many more have been wounded). Most of the deaths (98 per cent) occurred in the two World Wars. Reflecting the changing nature of military engagement, most injuries and deaths today occur during training exercises.
- The nature of military service and the way service is recognised has changed over time:
 - Those who served in World War I not only endured very arduous conditions and extraordinary hardship, they were also paid less than the minimum wage. Returned soldiers also had a limited social security system to rely upon and access to comparatively basic medical and rehabilitation services.
 - Today, service is professionally based with strict training requirements, structured opportunities for career progression, access to in-house medical and rehabilitation services and comparatively generous pay and allowances, some of which explicitly recognise risk.
- There is a lack of data on the Australian veteran population, their families and their wellbeing. The exact number of living veterans is not known but the Department of Veterans' Affairs recently estimated that there are about 641 300 serving and ex-service — 58 200 veterans of post-1999 conflicts, 41 500 Vietnam War veterans, 19 300 World War II veterans and 100 000 reservists and ex-reservists.
- Most members leave the military and successfully transition into civilian life (and lead lives similar to the general population). However, some experience poorer outcomes. For example:
 - medically discharged members are more likely to rate their quality of life as poor compared to members discharged for other reasons
 - suicide rates by male ex-serving veterans under 30 years old are about twice those for the equivalent group in the general population
 - mental health disorders appear to be more prevalent for veterans than in the wider population
 - some data suggests that ex-serving veterans experience a higher rate of homelessness than the general population
- Veterans' families can also be adversely impacted, not least those whose partners or parents have died as a consequence of service.

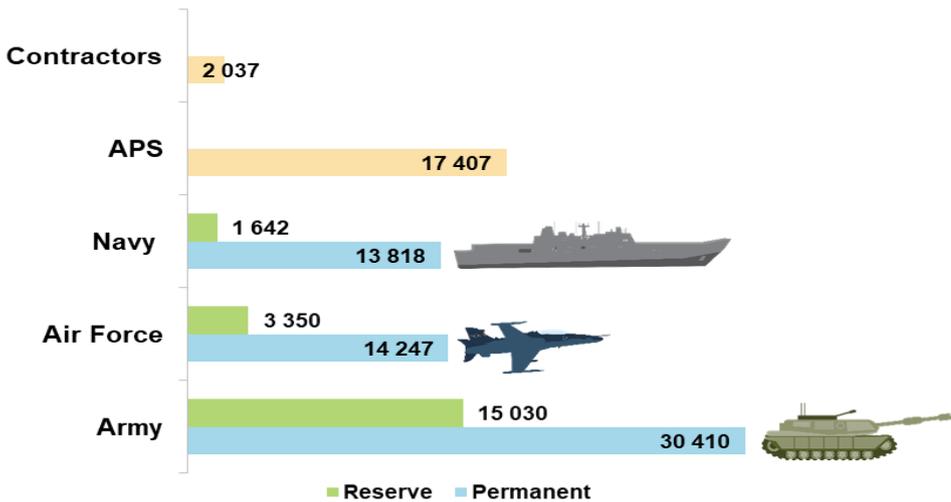
The veteran community is made up of serving and ex-serving members of the ADF and their families. The Commission looked at each of the stages of the life stages of veterans — in service, transition and ex-service — to assess the ‘fitness’ of the veteran support system. To help gain an understanding of the needs and lives of veterans and their families, and the supports they may require, this chapter looks at military life and the characteristics of the veteran community.

2.1 The Australian military

The ADF defends Australia and its national interests (DoD 2017f, p. ii). Almost two million Australians have served in the armed forces since federation fighting in conflicts as diverse as deployments to World War I and II, Vietnam, Korea, Iraq and Afghanistan (Chester 2018e, p. 2). Australia has also played a major supporting role in peacekeeping and other missions.

The ADF is divided into three branches — the Army (which accounts for about half of ADF personnel), the Navy and the Air Force (which account for a quarter of ADF personnel each) — with about 58 000 full-time members and 20 000 paid reservists (DoD 2018f, pp. 80, 83). The ADF is also supported by about 17 000 public servants (and 2000 contractors) at the Department of Defence (DoD) (DoD 2017f, p. 88, 2018f, p. 83, figure 2.1).

Figure 2.1 **Number of ADF members and DoD workers in 2017-18^{a,b}**
Permanent^c and reserve^d forces



^a Public servants were measured as full-time equivalents. ^b Contractor numbers are not available for 2017-18 so the figure for 2016-17 was used. ^c Permanent forces are what the Australian Defence Force terms ‘average funded strength’. ^d Reserve force numbers are the number of members paid during the financial year.

Source: DoD (2017f, p. 88, 2018f, pp. 81, 83).

Between 1999 and 2016, more than 76 000 ADF members deployed on domestic border security, humanitarian and international operations — about 18 per cent of these were reservists — with some members deploying on multiple occasions (DoD 2016a, pp. 145, 148). Currently, about 2400 members are on operations, mainly in the Middle East on peacekeeping missions and domestically for border protection, and the most recent Defence Census indicates that about 55 per cent of all serving members have been assigned to combat or related operations both domestically or internationally at least once (DoD 2016b, p. 19, nd).

Who joins the ADF?

The ADF requires people who are fit, adaptive, able to acquire skills, and can follow orders under strenuous circumstances. Recruitment into the ADF is based on a mix of physical, intellectual and mental attributes. The ADF fitness requirements are much higher than most civilian occupations and the screening for pre-existing (physical and mental) health problems excludes a large portion of the adult population. The fitness requirements are ongoing and failure to meet them can result in discharge.

About 5200 recruits (4200 without previous military experience) join the ADF each year — about 72 per cent are male and 28 per cent female (DoD 2018f, p. 81). (The proportion of female ADF personnel has been steadily rising — from 12 to 18 per cent between 1991 and 2018 (ADF 1991, p. 6; DoD 2018f, pp. 80, 109–110).)

Australians join the military for a range of reasons. Some seek a challenge or sense of purpose; some value the culture and camaraderie; others feel it is a civic or humanitarian duty; while others are attracted by the remuneration, benefits and career progression of the military. Often a mix of motivations is at play.

As participants emphasised, unlike the military in many other nations (and some Australians who were conscripted during the Vietnam War), current ADF members are entirely volunteer professionals (RSL QLD, sub. 73, p. 9).

The median length of service is almost 9 years, which is longer than the typical civilian stays with the same employer (D’Arcy et al. 2012, p. 2; DoD 2009, p. 9, 2018m, p. 1). A ‘typical’ military career is described in box 2.1.

The nature of military service

Many participants in this inquiry highlighted the distinctive character and aspects of military life (box 2.2) and previous reviews also recognised these features (Campbell 2011a, p. 96; DoD 1997, pp. 7–8; Tanzer 1999, p. 167). While other occupations have some similar characteristics (for example, paramedics are exposed to trauma, truck drivers to significant danger and primary production workers frequently relocate), military service is clearly a unique occupation.

Box 2.1 **Life in the military**

During training, recruits lives are dominated by the military. Most of their spare time is occupied with Australian Defence Force (ADF)-related activities, their waking and sleeping hours are regulated and use of alcohol (and other substances) is restricted and enforced to a greater extent than for most of the community. The training requires recruits to undertake various physical and mental challenges, sometimes including deprivation of food and sleep. Recruits are also taught how to think and react instinctively to various situations in the face of danger. Those who are training to be officers may also be provided with a free university education at the Australian Defence Force Academy while receiving a salary (ADF 2018).

Once training is completed, members have more control over their spare time. They work hours ('parade') set by their commanders, with the proviso that they can be ordered to work unpaid overtime at any time. However, they have limited choice about where they work and can be relocated, or deployed overseas for set periods of time. If they choose to live on base, they receive subsidised food and accommodation, while those who live off base receive a rental allowance (or subsidised mortgage loan) and free meals during work hours. ADF members also have access to free health care, and subsidised child care.

Members are allocated time to exercise as part of their core hours in order to meet the physical fitness requirements that are a condition of employment, although these fitness restrictions differ by gender and scale down with age.

Every two to three years the member will be re-posted and generally have to relocate (typically in regional areas where ADF bases are mostly located) — between 78 and 91 per cent (depending on service branch) of ADF members have had to undertake a service-related move (DoD 2016b, p. 31). Families are not required to live with the member, but the ADF will provide assistance to members' families who choose to move. Although members' preferences are taken into account in determining their posting location, the ADF's strategic needs are the first priority in such decisions.

At various points during their military career, a member may be deployed to overseas in various capacities — including peacekeeping, combat or humanitarian efforts — depending on their role. Overseas deployments may place them in extra danger and involve long and arduous workloads. Regardless of the amount of down time a member might have on deployment, they are considered to be on duty 24 hours per day, 7 days per week. Although the member is technically compelled to go on a deployment if ordered to do so, in practice deployments are highly sought after and there is often an element of choice involved.

Members will typically discharge after almost 9 years (although some members have much shorter and longer careers) (DoD 2018m, p. 1). Although the member may make plans for their post-service life years before separation, unless the member was medically discharged, the actual discharge process will typically only have brief involvement from the ADF. The member then has to adjust to life outside the military.

Box 2.2 Stakeholder comments on military service

Many veterans, ex-service organisations and government departments described the unique and distinctive features of military service.

Vietnam Veterans and Veterans Federation ACT commented on the task given to the military:

No other Australian is expected to, or may be directed to, engage in war or war-like activity either within the country or overseas to defend their nation's interests. (sub. 42, p. 2)

RSL National described the burdens of going on deployment:

When deployed, these service men and women remain away for extended periods and do not return home to their families at night, for months at a time, and often work extended hours in hazardous circumstances while their families accept and deal with emotional and physical separation from them, as well as concern for their wellbeing. (sub. 113, p. 8)

The Air Force Association differentiated the Australian Defence Force (ADF) from emergency services:

Military service is often equated to police, fire, ambulance and other emergency services, and although personnel in these professions are also prone to traumatic experiences and face similar and unique challenges, they face very different obligations to ADF members. There is no other employment category in this country that requires an employee to lay down their life, be classified as a 'harm person', or to surrender many of the freedoms the Australian community enjoy. (sub. 93, p. 1)

Vietnam Veterans Association of Australia described the traumas that can occur during training and deployment:

Military service is unique. In both Peace time and during War, all military personnel are trained, some as their primary function, to kill other human beings. Efficient and effective training simulates the horrors of war, including killing others, even for those who do not ultimately experience war.

However, the horrors of war once seen, cannot be unseen, once experienced, cannot be unexperienced. (sub. 78, p. 1)

The Department of Veterans' Affairs noted the lack of legal safeguards for military personnel:

An ADF member is not, by legal definition, an employee. Military personnel are subject to military law and are not protected by the full range of industrial law. There is an argument that military personnel are required to forgo their basic human rights of 'life, liberty and security of person' as prescribed in Article 3 of the 1948 Universal Declaration of Human Rights. (sub. 125, p. 6)

The Department of Defence noted the difficulties members can have adjusting to civilian life:

For veterans who have spent years operating in environments of perceived or imminent threat, having to adapt their responses to a more benign civilian environment can be challenging. This includes working within leadership/management structures and systems which are fluid and less well defined, and where decision-making may allow negotiation, input and consensus. This is in direct contrast with the autocratic decision-making process applied in military environments, where the military approach is that orders are followed and not necessarily questioned. The mental shift required to transition between such fundamentally opposed management approaches is significant and not well understood. (sub. 127, p. 8)

The Defence Force Welfare Association commented on the lifetime impact of military culture:

Team needs take priority over individual needs and rights. Total trust in other team members is essential because the consequences are so dire. A person who only looks after him or herself, is inconsiderate of other team members, is an anathema ... This deliberately created military culture becomes ingrained. That is partly why some Veterans refuse to seek support, not wanting to give up or to be a burden to others. Pride is important but it can be misplaced. And 'welfare' is a pejorative word, no matter how many experts claim otherwise. Needing 'welfare' is seen as an indication of failure or weakness, so self-harm rates for those discharged are higher than for those still serving. (sub. 118, p. 14)

Serving in the ADF is likely to be more dangerous than most civilian occupations, although comparable injury rates are not available. Wartime brings risks including hostile interactions with the enemy, risk of triggering improvised explosives and potentially hazardous foreign environments. Some of the uniquely hazardous elements of military service during peacetime time include live fire exercise, physically intense training and use of explosives. These distinct features of military life lead to exposure to risk of injury and trauma the impacts of which are significant:

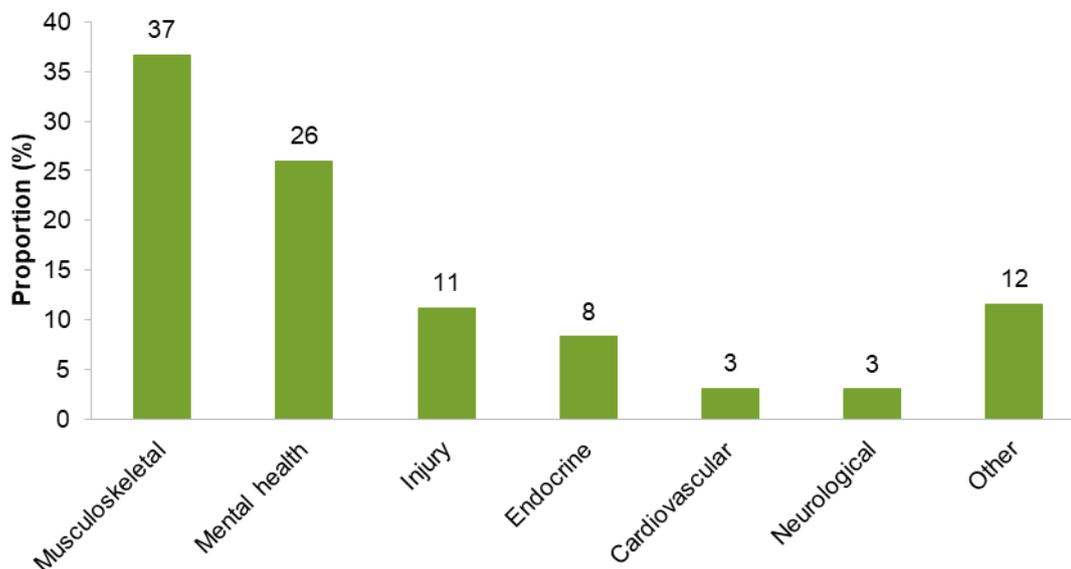
- Injuries incurred by ADF personnel include crushed vertebrae and spinal injuries, brain injuries, gunshot wounds, falls causing back and shoulder issues, knee injuries, amputations, hearing loss, and back and lower limb injuries caused by requirements to carry heavy loads.
- In 2017-18, there were 3 fatalities, 277 personnel suffering serious injury and illness and 8937 members suffering minor injuries or illness (DoD 2018f, p. 106).
- Some of the illnesses are latent, including mental health disorders, and often only present themselves after a member has left the service — sometimes decades after.

Where trauma, disease or injury prevent ADF members from meeting the stringent fitness requirements, they are usually medically discharged. The contrast is that in a civil setting employers are usually required to make reasonable adjustments to accommodate the needs of their employees following a change in physical or mental state. This means that post-injury return to work can be more difficult or impossible in the military. The most common conditions that lead to a recommendation for medical discharge are musculoskeletal injuries and mental health (figure 2.2).

Some of the other features of military service include:

- *loss of autonomy*: disobeying any lawful order can result in jail time
- *inability to resign before a set date*: or face criminal penalties
- *an intense and strenuous training regime*: training varies across the service branches and particular roles but can involve intense physical activity, sleep and food deprivation and various mentally challenging exercises
- *regular relocation*: ADF members are typically required to move locations every two to three years. This can be disruptive to both members and their families
- *challenges of deployment*: deployment can also mean sleep and food deprivation (and other stresses and environmental factors) and prolonged separation from family members
- *lack of industry regulation and union representation*: ADF members do not have a union that contributes to negotiations about their pay and conditions (highlighted by Defence Force Welfare Association (DFWA), sub. 118, p. 14 and Vietnam Veterans Association of Australia, sub. 78, p. 2).

Figure 2.2 **Conditions leading to recommendation for medical discharge**
Primary condition, 2007—2016



Source: Joint Health Command (2017, p. 22).

The military fosters a unique culture, largely on purpose. This culture has many positive features, such as selflessness and mateship, but some aspects can be detrimental in the long term. For example:

- initial training reduces individuality through re-socialisation and forced homogeneity of appearance and behaviour, tightly controls daily routine and exposes the individual to frequent stressors designed to deplete resistance to orders
- punishment for poor performance and being trained to ‘tough it out’ can mean personnel are reluctant to accept any kind of (perceived) failure.
- the all-encompassing nature of the military may mean that members are not practiced in various aspects of civilian life (like renting a house independently or obtaining civilian medical treatment) (Defence Force Welfare Association, sub. 118, pp. 14-16).

The result of this process, and subsequent years in the military, is a mindset focused on the team rather than the individual, an aversion to perceived weakness, a reluctance to seek help, and (for some) difficulty functioning in the civilian world, particularly in the early stage of transition (Defence Force Welfare Association, sub. 118, pp. 14-16). As DVA put it:

Military culture can be expressed as a form of ‘selfless service’ in that the duty of military personnel is above and beyond an individual’s needs: it reflects higher order needs of the military unit, of the entire military force, and of the country.

Accordingly, serving and former military personnel might still tend to view personal issues and individual wellbeing as inappropriate or selfish. Accordingly, individual health issues and

problems might go unreported. The avoidance of care does not mean there is an absence of need, and this is a critical element of support for veterans. (sub. 125, p. 12).

Despite this, most service members leave the military and successfully transition into civilian life. After a period of adjustment, they typically lead lives similar to the general population (section 2.2). However, the transition process can trigger or exacerbate service-related conditions. For example, service members who were exposed to trauma while serving can find it difficult after service to come to terms with actions taken while serving (NMHC 2017). Military personnel have higher than average rates of mental health disorders, especially after service, and in some cases this manifests in difficulties integrating back into civilian life (section 2.2).

Some of the other challenges transitioning members face include loss of identity, separation from social support, having to make choices that were previously made for them and the different mindsets of the civilian and military worlds. The transition experience has been compared to divorce and unemployment in terms of its impact (chapter 7). Another comparison is the ‘culture shock’ of an expatriate returning from a long period of time overseas — the experience is simultaneously familiar and alien. And although many members find the skills gained in their service to be transferable, the challenges of transition can be compounded by not being able to find employment where the member has a highly military-specific skill set.

Differences across service branches and service type

Military service is not homogenous and employment in the ADF can be very different depending upon the branch, role and service type. Obvious differences include the physical environment (such as deployments at sea compared to land-based deployments), different training requirements and the proximity and nature of combat risks.

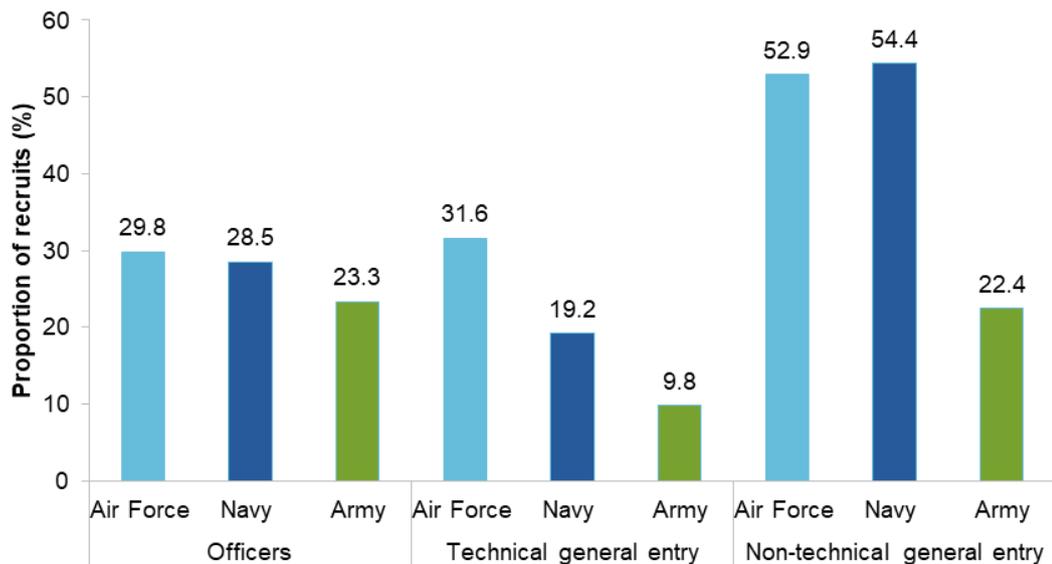
These differences manifest in differences in outcomes, including injury rates and injury type. For example, the Army — while making up about half of ADF fulltime personnel and 57 per cent of combined reserve and fulltime forces (DoD 2018f, pp. 81, 85) — is responsible for about 71 per cent of claims relating to post-2004 service (DVA MRCA claims data). Naval (serving and ex-serving) personnel have a higher incidence of suicide (box 2.12) and a disproportionate share of claims for bipolar disorder, tinea and migraines (DVA MRCA claims data).

Consistent with these differing injury and claim rates, discharges from the Army are more likely to be on medical or other involuntary grounds (about 27 per cent) than the other service branches (about 23 per cent and 13 per cent for the Navy and Air Force respectively) (DVA and DoD 2018, p. 30).

There are several other differences across the service branches. Women have the highest concentration (among new recruits) in the Air Force and the lowest in the Army, and they are typically most represented in non-technical general (non-officer) entry roles (figure 2.3).

The median length of service differs between the service branches — 10 years in the Air Force, 7 years in the Army and Navy (DoD 2016b, p. 17).

Figure 2.3 Proportion of female ADF recruits by service branch and entry stream in 2016-17



Source: DoD (2017k, p. 12).

There are also differences in the patterns of injury and illness between operational and peacetime service. For example, veterans with operational service (in any of the branches) appear to have a higher incidence of post-traumatic stress disorder (PTSD) once they have left military service (box 2.11) and they proportionally claim more for this condition (DVA claims data).

The changing nature of military service

The nature of military service has evolved as Australia’s strategic needs, military operations and technologies have changed. For example, most of Australia’s military casualties in the first half of the twentieth century were attributable to the brutal combat and conditions of the world wars — about 98 per cent of all deaths by the Australian military on deployment occurred during the two world wars (box 2.3). Today, most injuries occur during peacetime — about 76 per cent of all MRCA claims relate to peacetime service (DVA claims data). As the Alliance of Defence Service Organisations noted:

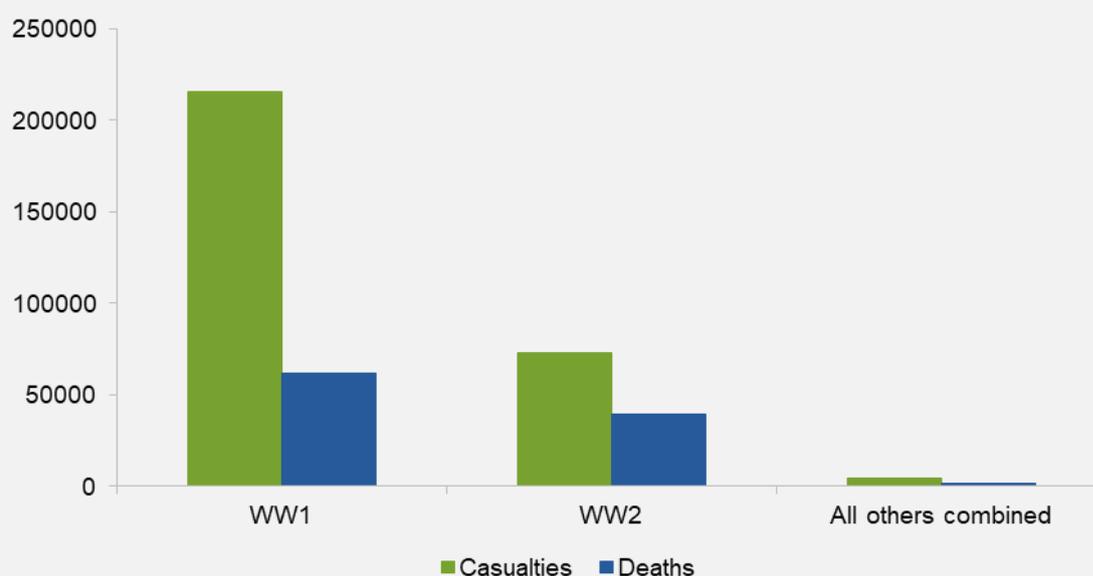
The mass slaughter on the Western Front stands in stark contrast to the very low number of deaths in the MEAO [Middle East Area of Operations] over almost three times the duration of combat operations. Battlefield casualty evacuation, inflight triage and rapid transfer to major hospital facilities once the casualty is stabilised are key differences. (sub. 85, p. 43)

Box 2.3 Scale of Australia's military campaigns

Australia's history of engagement in overseas military campaigns predates Federation. Major conflicts involved deployments to the Boer War, World War I and II, Vietnam, Korea, Iraq and Afghanistan. Australia also played a major support role in peacekeeping and other missions across Europe, Africa, the Middle East and East Timor.

By far, Australia's largest conflicts were its involvement in the two world wars. In part, this reflects the scale and nature of the conflicts. For example, during World War I, about 330 000 (out of a population of less than 5 million) Australians deployed overseas and in World War II about 1 million served in the military (out of a population of just about 7.5 million), either at home or abroad. Today the ADF stands at about 58 000 with about 2400 deployed overseas (DoD 2018f, p. 80, nd).

Australian casualties in overseas^a military operations^b



^a Or with Australia during the World Wars. ^b As at 2013. Deaths are taken from the Roll of Honour and deaths that occur deaths in the World Wars and include deaths that occurred during service for several years after the formal end of the wars. The casualty records are narrower, and end when peace was declared. Casualties sums up deaths, serious injuries and those who were taken captive as prisoners of war. Casualties (not including deaths, which are known) post-Vietnam are not known, so are probably underestimated here.

Sources: Australian War Memorial (2013) and National Archives of Australia (2018).

The conditions of the occupation and its professionalism have also changed. Those who fought in World War I were low-paid civilian volunteers who were expected to fight for the duration of the war and then transition back into the workforce at a time of limited government welfare and health care (chapter 3). Today the military is a well-remunerated professional force with access to comprehensive health care inside the military (and access to mainstream universal health care outside the military), and deployments are much shorter (typically 4-8 months, although some go on multiple deployments) (DoD 2016b, pp. 19–20).

Even so, there are numerous ways in which modern warfare can have a deeper psychological impact. Quoting the former Army psychologist, Damien Hadfield, the head of the NSW RSL James Brown commented:

... many factors could lead to the conclusion that the modern battlement is more stressful than the old ... 'A soldier in the trenches of France in World War I found himself in horrible conditions, but there was some sense of reality' ... 'The enemy was generally to the front, behind him was relatively safer, and to become cut-off meant big trouble.' Now soldiers in all ground-operation roles are within close range of lethal enemy fire, and many in non-combat roles are powerless to do anything to improve their chance of survival. (2014, p. 114)

Brown also argued this can be made worse by some members feeling their service was easier than what the diggers at Gallipoli went through. One officer commented to Brown:

It's not Gallipoli and that's all their families understand. They get home and the people around them want to know how many battles they were in, how many enemies they shot, and they don't understand it's not World War I anymore. More importantly, the soldiers don't feel they lived up to the Anzac legend. (2014, p. 112)

Families of veterans

About two thirds of serving members are married or in an interdependent relationship and about two fifths have dependent children (DoD 2016b, pp. 15, 49). The ADF provides families with a number of services such as assistance with childcare, employment for partners, education and more. Families also benefit from the rent and mortgage subsidies that are provided for members.

Family life during service

Many basic aspects of the lives of defence families mirror those of civilian families. However, having a partner or parent in the military can present several challenges.

- Regular postings and relocations can disrupt families by interfering with children's schooling, requiring partners to find new work and making it more difficult for families to build strong roots in their community (box 2.4). A recent study on current serving ADF members showed about 60 per cent had been in the same home for four years or less whereas 43 per cent of the general public have moved house in the past five years (Daraganova, Smart and Romaniuk 2018, p. 94; Smart, Muir and Daraganova 2018, p. 8). It was also found that children of serving ADF members moved schools more frequently than civilian children (Smart, Muir and Daraganova 2018, p. 8).
- Irregular (and sometimes long) hours of military service can cause distress and disturbance to regular family life — service members spend about 78 nights a year away from home on average and about two thirds of members work more than forty hours a week. Regular service-related absences can also make it more difficult for partners to work: about 17 per cent of service members whose partners do not work cite their

service-related absences as being the main reason for being out of the labour force (DoD 2016b, pp. 22–23, 27).

- Deployments can cause long separations between service members and their families. This could cause a range of problems for children and partners, and some studies have found that partners perceive deployment to impact their family life even where there is no evidence of an effect on physical and mental health of families (Dobson et al. 2012, p. 43; McGuire et al. 2012, pp. 10–15) (box 2.4).
- The psychological distress experienced by some service members has been shown to have a direct impact on the wellbeing of their families (McGuire et al. 2012, pp. 10–15).

Box 2.4 Studies on the impact of deployment on families

There are only a few Australian studies on the impact of deployments on the wellbeing of service members' families but these point to some negative impacts.

The Middle East Area of Operations Census Study summary report found that over 60 per cent of those surveyed stated that their military commitments had negatively affected their marriage and children. More deployments and greater time on deployment were both associated with increased negative effects on families (Dobson et al. 2012, p. 82).

The Vietnam Veterans Families study compared the outcomes of children of Vietnam veterans (those who deployed) to children of Vietnam-era military personnel who were not deployed. It showed higher incidence of mental health problems, suicidal thoughts and behaviours and substance abuse among the children of the deployed veterans (Forrest, Edwards and Daraganova 2014, p. 105).

The Timor-Leste Family Study compared outcomes of families of veterans who deployed in Timor-Leste to families of veterans who did not deploy and found little association between deployment and physical and mental health — the number of deployments also did not seem to matter. The authors concluded that this may reflect 'healthy family effects' where families that would be disrupted by deployment put pressure on their partners not to deploy, skewing the results. An exception to this trend was the reported behaviour of children, which was negatively affected by having more deployments (McGuire et al. 2012, pp. 10–15).

However, the psychological distress of family members was found to be strongly correlated with the mental health of the veteran (especially for those with PTSD), indicating any mental health effects of general service or deployment will affect families as well (McGuire et al. 2012, pp. 10–15).

There is some evidence from the United States that deployment can benefit families of veterans — in particular the security and opportunities created by greater household income and the sense of pride to be supporting their country seemed to offset many of the problems intrinsic to overseas deployment (Hosek, Kavanagh and Miller 2006, p. 19). These results may not necessarily generalise to the Australian veterans and their families.

However, military service can also have positive effects on family life, such as greater financial resources that provide opportunities that would not have been available otherwise. Research in the United States has found a beneficial net impact on families:

We conclude that the projected long-term impact of military service on families is generally positive, particularly for ethnic families who might otherwise have had less access to socioeconomic opportunity. We further note that any such advantage of military service for families may operate more strongly for children than for spouses. (Burland and Lundquist 2013, p. 166)

Of course, these effects may not generalise to the Australian experience, which involves different government support to low-income households which may reduce relative positive impacts of military pay. Research of recently serving Australian veterans (serving and ex-serving) pointed to both positive and negative impacts of military service on families (box 2.5).

Areas in which positive effects predominated were (a) relationships with immediate and wider family members, and (b) for civilian spouses/partners, their financial situation. Areas in which negative effects predominated were mental health, employment and careers for civilian spouses/partners. Areas in which the majority reported no effects were (a) physical health for all types of FWS [Family Wellbeing Study] family members, and (b) mental health, employment, careers and their financial situation for the parents and adult children of ADF members. (Daraganova, Smart and Romaniuk 2018, p. 253)

Also, ‘combat exposure’ — as distinct from the more common experience of overseas deployment — has been found (in international studies) to have a more detrimental impact on families long-term wellbeing (Burland and Lundquist 2013, p. 166). The Australian Families of Military Research and Support Foundation said:

... research findings support the contention that partners of combat veterans have a significantly higher risk of developing psychological problems as a result of living with, and caring for, their veteran partners, and that the prevalence of these problems compares unfavourably with the general population. (sub. 34, supplementary paper, p. 3)

Box 2.5 Wellbeing of recently serving veterans' families

The recently released Family Wellbeing study, conducted as part of the Transition and Wellbeing Research Programme commissioned by the Department of Veterans' Affairs, looked at the wellbeing of families of ADF members (and former members) who served sometime between 2010 and 2014. Because little is known about the ex-serving community, stratification was not possible and it is not known how representative the study is.

Smart et. al summarised their overall findings:

Overall, the Family Wellbeing Study provided a positive picture of how Australian families of military members were faring. Most families of Current Serving and Ex-Serving ADF members seemed to be progressing well across many life areas, with only a few exceptions ...

These findings suggest that, despite the pressures that a military family lifestyle can bring, Australian military families are generally resilient and find ways of coping. (2018, p. 16)

The wellbeing of spouses and children of current serving and ex-serving veterans was compared across a number of indicators:

- financial hardship: families of ex-serving members were significantly more likely to experience numerous types of financial hardship than families of serving members — including inability to mortgage or rent on time and having to ask for financial help from friends or family
- residential and school mobility: families of ex-serving members tended to move less frequently than serving members
- spouse employment: less than half of spouses of military personnel had paid employment as their main source of income. Spouses of ex-serving members were more likely than spouses of serving members to have their partners' employment as their primary source of income (about 51 per cent and 44 per cent respectively)
- family relationships: similar proportion of spouses of serving and ex-serving members rated their relationship with their partner as unhappy. Spouses of ex-serving members were much more likely than spouses of serving members to categorise their relationship as abusive (8.4 per cent compared to 3.1 per cent)
- mental and physical health, risk taking: spouses of serving and ex-serving members had broadly similar levels of poor physical health and poor quality of life. However, spouses of ex-serving members were much more likely than spouses of serving members to have had suicidal tendencies in the past 12 months and to have ever been concerned about their partners mental health.

Unfortunately, none of these indicators were matched (adjusting for demographics) to similar figures for the broader Australian public.

Source: Daraganova, Smart and Romaniuk (2018, pp. 113–117, 124–125, 129–132).

Family life after service

Family members can play a critical role when defence force members are re-integrating following deployment, and when they are transitioning out of military service — providing some of the support and companionship that has been removed from their lives. Some families can have trouble adjusting to their partner leaving the military with many of their social connections being tied to the ADF (box 2.6). Many partners become primary

caregivers to veterans if they are severely injured as a result of their service and benefit along with the veteran from government supports such as attendant care. Where ADF members are killed during service, or where veterans die later as a result of service, this loss will significantly affect their widow(er)s and children, and the parents and siblings of the veteran.

Box 2.6 Participants' views on the challenges faced by veterans' families

The War Widows' Guild of Australia emphasised the disruption that constant relocations can have on the families of serving members:

The Defence Family is expected to move frequently, meaning spouses (or significant others) are uprooted from their place of employment, neighbourhood, friends and families. Often there is no prospect of being re-employed in the new location. Family support may be unavailable in a new environment and friends may be non-existent. All these factors together ensure that the family suffers just as significantly as the member. Children are moved within educational institutions which is disruptive and unsettling for the child. (sub. 87, p. 1)

Another participant, Melanie Pike, described the challenges of living with a veteran that has suffered service related injuries:

So often, we the partners and family members, are in the background fighting our own battle to survive in this incredibly difficult and overwhelming space we find ourselves in. The ripple effect of living with someone who suffers from war related mental and physical injuries can never be underestimated nor ignored. (sub. 56, p. 1)

One participant, Fiona Brandie, described the challenges and hardships she faces as an unpaid carer for her veteran husband with minimal support:

Over the past three years the burden has been solely mine to care for my (below school age) children, manage the household, hold down a full-time job and provide support to my mental ill spouse who often presented extreme symptoms and behaviours (I won't go into specifics except to say there were a number of times when I was put in fear in my own home) ...

I used to be a happy person with a normal life; now I'm receiving treatment for anxiety, depression and adjustment disorder. I also cannot see anyone in uniform — even in innocuous circumstances, such as diggers collecting donations for Legacy — without having a panic attack. The costs of my own psychological counselling, prescription medications, GP referrals, time lost off work, etc must all be self-funded. (sub. 103, pp. 1–2)

RSL Queensland:

... life in Defence brings about many challenges, particularly for families. Postings often result in numerous relocations, severing ties with local community and friends. Personnel can be away on deployments for extended periods of time, leaving their spouse to bare the brunt of household responsibilities. The risk of injury and developing mental health issues is relatively high compared to other professions. Difficulties for their spouse to find or maintain meaningful employment can create additional stresses. ...

On average, the Defence Family rate their Quality of Life (QOL) as 6.7 out of 10. This is significantly lower than the general population, for which the average is 7.6. (sub. 73, pp. 44, 47, from The Defence Family Research Project, Key Findings Report)

Recognition and remuneration

Military service is ‘recognised by a number of Australian Government arrangements that are specific to Defence personnel. This includes remuneration and compensation arrangements’ (Department of Defence, sub. 127, p. 8). For example:

- remuneration arrangements and allowances — starting at about \$60 000 for an Army private, service personnel on average are paid about 30 per cent more than public servants employed at similar levels of seniority in DoD (Peever et al. 2015, p. 55 box 2.7). ADF members also receive tax-free deployment allowances (which explicitly recognise exposure to ‘hazards’), location allowances and a service allowance that specifically rewards the special restrictions that the military imposes on its members (box 2.7).
- comprehensive free health care designed to conserve ADF members for operational duties
- rehabilitation services, including early intervention and support to return to work
- a culture of support for the welfare and whole-of-life needs of members (though this is always balanced against the needs of the military)
- medals, memorials, commemorations and other honours as well as the high regard of the military in the community
- a relatively beneficial (by international standards) compensation and rehabilitation system for injured veterans (chapters 3 and 12).

Other benefits from military service include a sense of camaraderie and purpose. Commenting on the intrinsic rewards of serving in the ADF, one veteran said:

I loved my career in the RAAF and it was the most significant experience that not only changed my life but also gave me a purpose. I cannot express what the experiences I had and the years of service have meant to me. It is simply indescribable. I enjoyed the camaraderie and the unity and the exhilaration of everything I did, saw and shared. The experiences I had are things that can never be experienced in a normal working environment (Neil Robson, sub. 146, p. 2).

Box 2.7 Australian Defence Force remuneration

The base pay rates of Australian Defence Force (ADF) personnel are a function of rank, competency in a particular role (referred as 'grade') and time (reflected in 'increments'). Between these two, members of lower ranks are able to be paid substantially more than their superiors depending on role and experience.

Pay scale^a of selected ADF ranks

Army rank	Navy rank	Air Force rank	Salary range (\$)
Colonel	Captain	Group captain	147 773 — 197 144
Lieutenant colonel	Commander	Wing commander	125 680 — 174 970
Captain	Lieutenant	Flight lieutenant	68 955 — 128 141
Lieutenant	Sub lieutenant	Flight lieutenant	57 321 — 109 179
Second lieutenant	Acting sub lieutenant	Pilot officer	53 555 — 100 483
Sergeant	Petty officer	Sergeant	62 146 — 102 737
Corporal	Leading seaman	Corporal	53 702 — 93 945
Private	Seaman	Aircraftman/women	47 377 — 85 302

^a Excludes the \$14 000 service allowance which all members below the rank of Lieutenant Colonel (or equivalent) receive.

ADF personnel also receive allowances for postings to remote locations within Australia (up to about \$28 000 each year) and tax-free allowances for overseas deployments (up to about \$160 each day). There are also qualification and occupation-based allowances (such as for proficiency in a particular language).

In addition, the ADF recognises other 'unique' features of military employment though a *service allowance* (currently just under \$14 000) received by all personnel under the rank of Lieutenant Colonel (or equivalent):

Service allowance compensates for the special demands of Service life to the extent that they are not fully compensated by the payment of on-occurrence allowances, additional leave or other benefits. The allowance compensates a member for factors such as, but not limited to:

- the requirement to be on call and the liability to work long and irregular hours including weekends, public holidays and shifts;
- the turbulence in postings caused by the liability to be moved frequently, and often at short notice, to meet the needs of the Service and the effects of this on the member and the member's family;
- the requirement to submit to discipline and control in personal and employment matters in which a civilian generally has some freedom of choice;
- the requirement at times to live and work in uncomfortable conditions; and
- the requirement to frequently be away from the home location.

Source: DoD (2017c, 2017d).

2.2 A profile of the veteran community

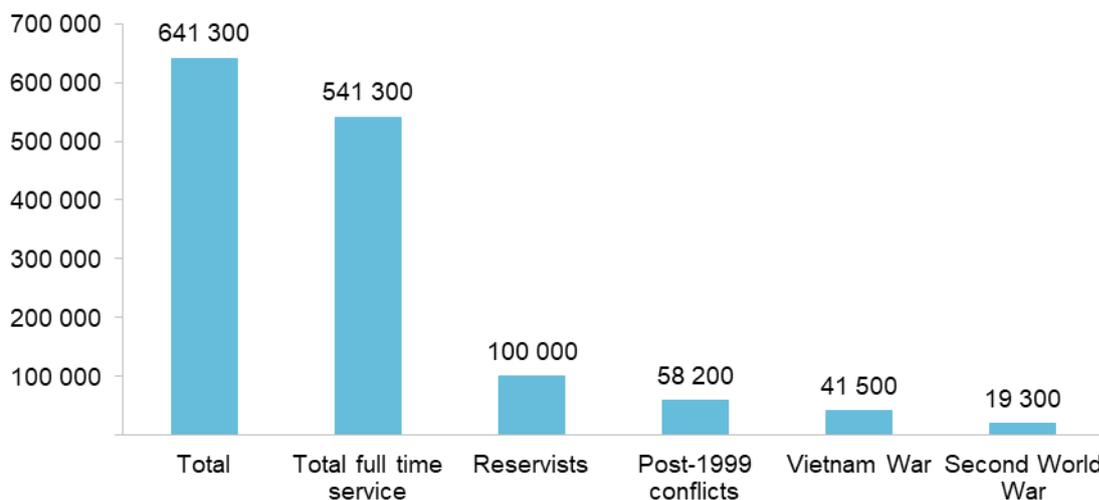
There is limited data and evidence on the veteran community.¹ In some areas, such as overall mortality and employment, veterans appear to achieve outcomes that are as good as, and in some cases better than, the general community. However, in areas such as mental health (PTSD, depression and substance abuse) and suicide, homelessness and family breakdown, veterans do not fare as well as their civilian counterparts. Within these broad trends, there are differences between cohorts of veterans.

Demographics

The number of living Australian veterans is not known. The RSL estimates the number of veterans to be somewhere between 310 000 and 500 000. Recent work by the DVA estimates that there were about 641 300 living veterans (serving and ex-serving) and reservists (who have never deployed or served on a permanent basis) at the end of June 2018 (figure 2.4).

Figure 2.4 **DVA estimates of the number of living veterans and reservists**

Split by conflict^a and service type^b



^a Where the veteran has service in more than one conflict, they are recorded by most recent conflict.

^b Reservists does not include reservists who have previously undertaken full-time continuous service or 'qualifying service' (see chapter 3 for definition).

Source: DVA (2018f, p. 23).

¹ A study by AIHW (2018a), released in November 2018, provides a comprehensive summary of the currently available evidence on the profile of Australian veterans (and reservists).

Clients accessing supports through DVA are known to be a minority of the total veteran community. As DVA said:

Except for veterans who have enlisted since early 2016, or were transitioned since mid-2016, the majority of living veterans are not known to DVA. (sub. 125, p. 8)

Of the estimated veteran and reservist population, about 165 800 (a quarter) are DVA clients (as at 30 June 2018, DVA client data). A third of all ADF veterans who have served since the Vietnam War are DVA clients, as are a fifth of veterans who have served since 1999 (sub. 125, p. 8).

What is known is that the veteran community is a diverse group. As DVA said:

The stereotype of a veteran as an elderly white male does not represent the demographics of the current Australian veteran population. The veteran community is far from homogeneous; it has significant diversity, including:

- age: from younger veterans to older WW2 veterans
- gender: veterans are mostly male, but with an increasing number of female veterans
- different forms of military training and operational experience (including war, peacekeeping, border protection, and others)
- dependants: mainly females and children.

Other characteristics all vary widely across the veteran population, including: ethnicity and religion; education; post-military service employment and economic means; health and wellbeing status; and community participation. (sub. 125, p. 8)

Estimating the number of dependants is even more problematic. There are about 33 000 spouses of ADF members and about 117 000 DVA dependent clients (including dependants of veterans who have died or been severely impaired) (DoD 2017a, p. 53; DVA 2018f, p. i). However, it is not known how many living ex-serving personnel have partners or children. Based on the information that is available, however, it seems that most veterans have partners:

- About two thirds of serving members are married or in an interdependent relationship, while about a third are single (DoD 2016b, p. 15).
- About two thirds of recently transitioned veterans were living with their partners (Van Hooff et al. 2018b, p. 44).

That said, a recent survey of the serving and ex-serving veteran community found that ex-serving members were more likely to be living alone and had a smaller average household size than serving members (Daraganova, Smart and Romaniuk 2018, p. 109).

Employment

Veteran employment statistics are also sparse. However, a recent Mental Health Prevalence Study that followed serving (between 2010 and 2015) and transitioning ADF personnel (between 2010 and 2014) provides some useful insights on employment.² The study found that, of those who had recently transitioned out of the full-time ADF:

- 84 per cent were engaged in ‘purposeful activity’
- almost two-thirds (63 per cent) were in civilian employment (of those who were unemployed, 44 per cent reported that they had been unemployed for three months or longer).
- more than half (56 per cent) remained in the Reserves, and about half of these (26 per cent) as Active Reservists
- about 7 per cent were unemployed (Van Hooff et al. 2018b, pp. iv, 41, 44).

Defence has also recently started surveying discharging members and found that employment outcomes are broadly similar to the general population for those who voluntarily discharged but poorer for those who are medically discharged. The rates of employment and labour force participation were also found to be generally similar to the broader community (but may not be representative due to low response rates) (DoD 2017g). Chapter 7 looks in more detail at the employment challenges faced by transitioning members.

Health

Robust evidence on the health and wellbeing of veterans is also patchy. Common problems include:

- a lack of comprehensive health data on the veteran community (serving or ex-serving, operational and peacetime service)
- a lack of comparable data for the general population for some health problems (including mental health)
- an inability to determine the causal impact of military service on veterans’ health and wellbeing (box 2.8).

The available information that looks at all recently serving and ex-serving veterans (both domestic and operational) seems to imply that veterans who have served since 2000 have much lower mortality than the general community, but have a higher prevalence of mental health disorders. Ex-serving veterans also have higher rate of suicide (especially those under age 30).

² The response rate for this study, however, was low — 18 per cent of the Transitioned ADF population (4326 ADF members) and 42 per cent (8480) of the 2015 Regular ADF population completed the survey.

Box 2.8 **Some issues in understanding veteran health studies**

Limited scope of most studies

Most studies on the health of (especially older) veterans tend to focus on veterans of particular conflicts (such as the Vietnam War or the Korean War) or on particular vocations (Aircraft engineers for example). For recently serving veterans, only a few studies have been able to look at a broad sample of both serving and ex-serving veterans with both peacetime and operational service:

- the 2010 ADF Mental Health Prevalence and Wellbeing Study that looked at mental health of all currently serving members (both those with peacetime and operational service experience) (McFarlane et al. 2011, box 2.11)
- the series of studies on serving and ex-serving members conducted as part of the Transition and Wellbeing Study project being conducted by DVA (DVA 2018a, box 2.12)
- the Australian Institute of Health and Welfare work on suicide of veterans who have served since 2001 enabled by the implementation of the Australian Defence Forces PMKeys data system (AIHW 2017b, 2018f, box 2.13)

Lack of a comparison with the general population

In some instances, such as the recent Physical Health Status study (Kelsall et al. 2018) conducted as part of the Transition and Wellbeing Study series, there was a decision not to make many comparisons of health outcomes for the general public (adjusting for age and gender) while, in other cases, the data simply was not available. For example, the last comprehensive snapshot of the mental health status of the Australian public was the National Mental Health Survey by the ABS in 2007, so it is difficult to make up-to-date comparisons between veterans and the general population for mental health conditions.

Difficulties in inferring causation

Because of ADF's recruitment policies (people with some existing health condition are excluded), and the health effects of service (ongoing physical fitness and access to health care), military personnel would be expected to be healthier than the general population *all else held equal* (McFarlane et al. 2011, p. 2). This 'healthy soldier effect' makes determining the marginal impact of service on the physical and mental wellbeing difficult.

Another confounding issue is that when some conditions manifest themselves in serving members, they may be medically discharged. Hence, interpreting differences in the health status of serving members to ex-serving members as the causal effect of military service can be misleading as one may expect ex-serving members to be less healthy than the serving population even in the absence of a negative health impact of military service.

Studies on veterans of recent conflicts found no relationship between deployment and health or mortality in comparison to personnel who did not deploy. However, the one study that did allow for longitudinal analysis (the Census Health Study) found a higher incidence of various health conditions following deployment to the Middle East. The conditions included: psychological distress and PTSD symptoms, alcohol usage, suicide ideation, cardiovascular risk and lung function issues (box 2.9).

Box 2.9 Conflict-specific studies on veteran health outcomes

Studies of older conflicts

- Korean War veterans have greater prevalence of various health conditions (especially cancer), greater hospitalisation and lower life satisfaction (AIHW 2003; Sim, Ikin and McKenzie 2005)
- The evidence on the health effects of service in the Vietnam war on veterans is mixed.
 - One study found that overall mortality for Vietnam veterans was lower than for a comparable Australian male population (Wilson, Horsley and van der Hoek 2005b).
 - Another study that controlled for this effect compared the mortality of National Servicemen who went to Vietnam with those who did not go (both groups were selected in the same way and the decision to send some to Vietnam was not based on fitness). The men who went to Vietnam had a higher overall mortality rate than those who did not go (Wilson, Horsley and van der Hoek 2005a).
 - One study uses the conscription lotteries to identify men who did and did not go to Vietnam and finds no evidence of elevated mortality from 1994 to 2007 among Australian Vietnam-era army conscripts (Siminski and Ville 2011).

The Deployment Health Surveillance Program

This Centre for Military and Veterans' Health program involved four locational deployment studies: the East Timor International Force Pilot Study (2007), the Solomon Islands Health Study (2009), the Bougainville Health Study (2009) and the East Timor Health Study (2009).

None of these studies found that overseas deployment strongly influenced ADF members' health and mortality, compared to those who did not deploy. In fact, deployed personnel were generally healthier and less likely to die than the comparison group. However, as these studies were not longitudinal, there were significant potential healthy worker effects^a that were not controlled for.

The Military Health Outcomes Program

This program looked at the relationship between recent deployments to the Middle East and health and mortality. It comprised:

- the *2010 ADF Mental Health Prevalence and Wellbeing Study* (box 2.4)
- the *Middle East Areas of Operations (MEAO) Census Health Study* — which measured the current health of ADF members who were deployed to the MEAO (2012)
- the *MEAO Prospective Health Study* — which measured the health of personnel both prior to and after deployment. It is one of the few Australian longitudinal studies on deployment (2012)
- the *MEAO Mortality and Cancer Incidence Health Study*, which collected relevant data on deaths and cancers from the Australian Institute of Health and Welfare for personnel who participated in the Deployment Health studies (2013).

These studies found no relationship between deployment and health or mortality in comparison to personnel who did not deploy with the exception of only longitudinal analysis (the Census Health Study) that found higher incidence of various conditions and distress markers.

^a Those who go on deployment would generally be expected to meet higher health and fitness standards than those who are not deployed. Therefore directly comparing their outcomes may lead to bias.

For some older cohorts of veterans, such as those who served in Vietnam and Korea, there is both higher mortality and higher prevalence of many serious health disorders, including cancer (box 2.9).

The lone, recent study that attempted to compare the health status of both serving and ex-serving veterans (who recently served) to the general public could only compare self-perceived health status. It found that veterans had lower self-perceived health status, although this result could be driven more by mental than physical health (Kelsall et al. 2018).

About three quarters of ex-serving personnel and two thirds of serving personnel have had service-related injuries (not necessarily eligible for support) — the two cohorts had similar kinds of injuries (Kelsall et al. 2018). Despite this, DVA’s client data and modelling of the veteran population indicates that at least 21 per cent³ of veterans and reservists have disabilities that DVA provides supports for.

And while the underlying incidence of injury and illness among veterans is unknown, when it does occur it significantly affect a veteran’s wellbeing. For example, Kelsall et al. (2018, p. 337) found that medically discharged veterans were 13 times more likely to rate their quality of life as poor compared to those who were discharged for other.

Mortality

Several studies on recent veterans indicate this group has lower mortality than the general population. The AIHW found that contemporary male veterans (both serving and recently transitioned) have about half the mortality rate of the general community, adjusting for age (figure 2.5).⁴ An earlier study which looked at mortality of veterans who had deployed in the Middle East Area of Operations found that their mortality rate was *less than half* of those veterans who did not deploy to this area (box 2.9) (Kanesarajah et al. 2013, p. 16). This result was robust across gender, age and service branch. Because only those with the highest medical rating can be on deployment, there is a possible healthy soldier effect.⁵

Another AIHW study compared male veterans aged between 50 and 84 (who served sometime between 2002 and 2015) to male civilians of the same age bracket (not weighted by the distribution of ages within this range). It found that the veterans died at about a third the rate of civilians during this period (AIHW 2018c, p. 19).

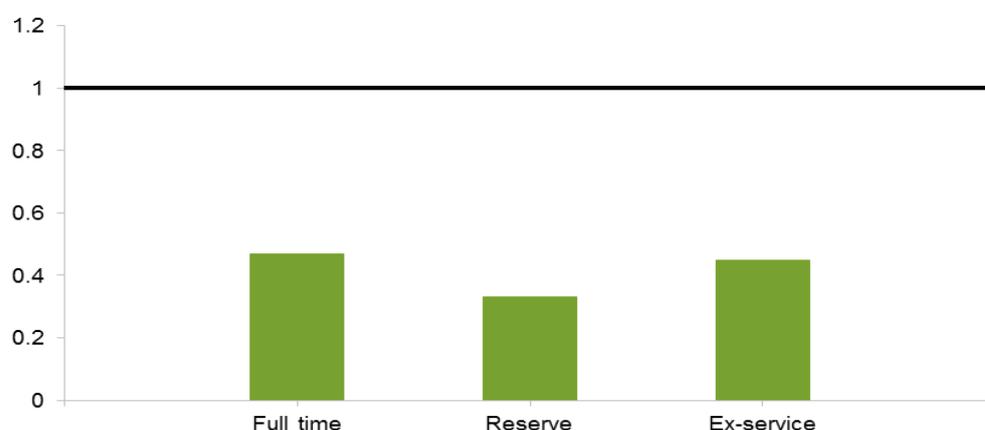
³ DVA’s (sub. 125, p. 25) indicated that (as at July 2018) 137 062 veterans have accepted conditions for which DVA has accepted liability, while DVA (DVA 2018f, p. 23) estimates there are about 641 300 living veterans and reservists (as at June 2018).

⁴ The AIHW mortality figures exclude deaths overseas, including those on overseas deployment. This omission does not seem critical given the studies discussed below which show no difference between deaths of those in the Middle East Area of Operations were about half that of those who remained in Australia.

⁵ Those in the ADF that did not deploy to the Middle East had a higher rate of mortality than those in the general community mainly due to transport accidents (about 4 times the mortality rate of transport accidents adjusting for age and gender).

However, some studies indicate that older cohorts of veterans have higher mortality rates than the general populace. For example, a study on the mortality of Korean War veterans found that had about 21 per cent higher mortality than Australian males of the same age (Harrex et al. 2003, pp. 83–85). Further, another study that compared the mortality of servicemen who fought in Vietnam to those who served in Australia found higher mortality (and incidence of cancer) among those who fought (Wilson, Horsley and van der Hoek 2005a, pp. xix–xx). So it could be that for at least some conflicts, late onset disease due to service overwhelms any healthy soldier effects.

Figure 2.5 Serving and ex-serving mortality rate
Standardised mortality rates^a



^a Standardised mortality is a comparison of the mortality of a particular group to the general population, adjusting for age. A figure less than one indicates lower mortality while greater than one would indicate higher mortality.

Source: AIHW (2017b, p. 32).

Mental health in serving personnel

The 2010 ADF Mental Health Prevalence and Wellbeing Study (box 2.10) looked at the prevalence of mental health disorders among serving members and found that, compared with the general population, serving members had statistically significantly higher incidence of a range of mental health disorders including depression, obsessive-compulsive disorder and PTSD. Further, they had higher rates of suicide ideation and planning (about twice as likely) but actual suicide attempts are about the same as the general population (McFarlane et al. 2011, p. xxi). However, there was not a strong correlation between deployment and the incidence of most mental health disorders (although this could reflect survivor bias where those with mental health issues following deployment discharge).⁶

⁶ As analysis of recently transitioned ADF shows that deployment *is* associated with higher prevalence of many mental health disorders, this seems quite likely (Van Hooff et al. 2018b, pp. iii-ix, 122-137).

Box 2.10 **2010 ADF Mental Health Prevalence and Wellbeing Study**

The ADF Mental Health Prevalence and Wellbeing Study (MHPW) was the first comprehensive snapshot of the mental health of the serving population and the only one to compare them to the general population (controlling for age and gender). Conducted between April 2010 and January 2011, it covered nearly half the Australian Defence Force (ADF) (which at that time was about 50 000 full time members). The study compared prevalence rates of various mental health disorders to the general population (controlling for age and sex) using the 2007 ABS National Survey of Mental Health and Wellbeing. It also considered the optimal cut-offs for relevant mental health measures and the impact of occupational stressors.

The study found that the prevalence of all mental health disorders in the previous year was similar to that of the general population, but was about 5 percentage points higher over the lifetime of an ADF member. The incidence of specific mental health disorders, such as affective disorders (depression and its variants), was also found to be significantly higher in the ADF over both a year and lifetime timeframe (about 4 and 7 percentage points higher respectively).

The one year prevalence of specific affective and anxiety disorders in the ADF was generally higher than the broader population. In particular, depressive episodes and PTSD were much more prevalent among the ADF than in the general population (about 3 percentage points higher each) while panic disorders were less prevalent (about 1 percentage points lower).

The MHPW showed no strong correlation between deployment and the incidence of most mental health disorders. The only disorder that was found to be statistically significantly higher for those who had been deployed was obsessive-compulsive disorder (about 4 times the rate). Depressive episodes, panic attacks and PTSD were found to be higher among those *without* previous deployment (albeit without statistical significance).

The study commented that the high exposure to trauma of those without deployments could be an explanatory factor. Other possibilities are that those who develop a mental health disorder are more likely to leave the ADF and as a result fall out of the statistics, or there might be healthy worker effects due to the higher health and fitness requirements for members to be deployed.

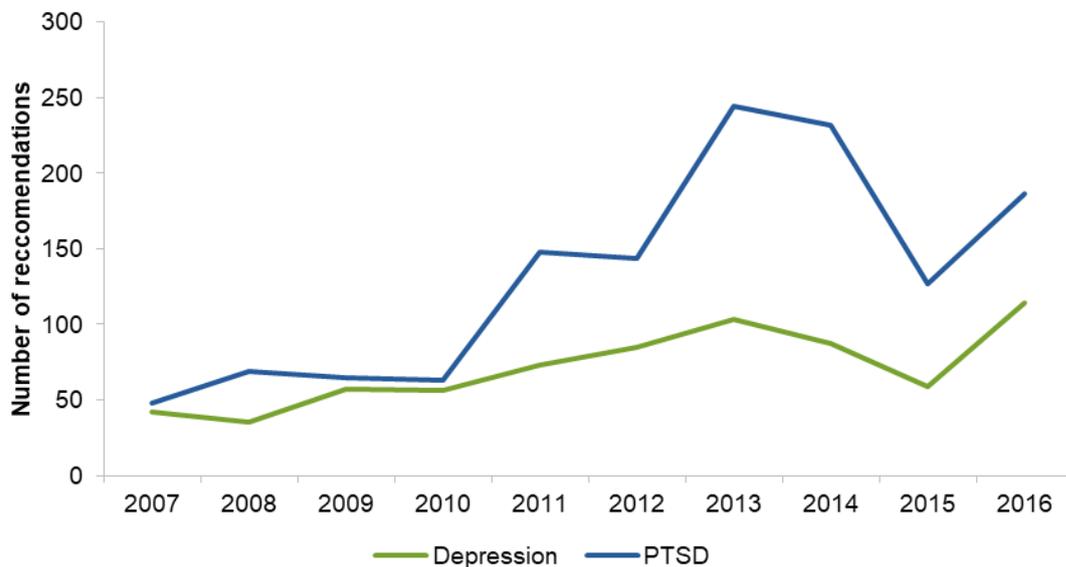
The MHPW also documented the most common lifetime traumas experienced by those in the ADF and which of these had the highest correlation with prevalence of PTSD. Unfortunately the study did not delineate which of these traumas occurred during deployment or even during military service, so there is no counterfactual. Those who were kidnapped, raped, stalked, beaten by a spouse, or had accidentally killed someone, had the highest rates of PTSD (78.5, 42.3, 38.4 and 31.1 per cent respectively). Meanwhile, undertaking peacekeeping or combat service, without exposure to other traumas, were themselves not associated with a particularly high rate of PTSD (about 9.2 and 10.4 per cent respectively).

The MHPW also considered the suicidality of the serving population. In general, it found that suicide ideation and planning were higher (about twice as likely) in the serving community but actual suicide attempts were about the same as the general community.

Source: McFarlane (2011, pp. ii, xiv–xv, xix, xxi, xxiv, 32, 48, 50–51, 55).

Mental health disorders also appear to be becoming more of a problem over time — with PTSD and depression-related recommendations for medical discharge increasing in recent years (figure 2.6). About 26 per cent of all recommendations for medical discharge from the ADF are mental health related (Joint Health Command 2017, p. 22).

Figure 2.6 **Number of recommendations^a for medical discharge**
PTSD and Depression



^a Recommendations for medical discharge by Joint Health Command may be more or less than the actual number of medical discharges in that year.

Source: Joint Health Command (2017, p. 22)

Mental health in ex-serving personnel

The Mental Health Prevalence: Mental Health and Wellbeing Transition Study, commissioned by DVA, provides a comprehensive snapshot of the mental health of recently transitioned ex-service personnel between 2010 and 2014 (box 2.11).

Box 2.11 DVA Mental Health Prevalence and Wellbeing Study

The Mental Health Prevalence (MPW), Mental Health and Wellbeing Transition Study extended the approach taken by the earlier Military Health Outcomes Program by looking at both transitioned and current serving personnel. The study focused on:

- ADF members who transitioned from the Regular ADF between 2010 and 2014
- a random sample of Regular and Reservist (who have never been full time) ADF members serving in 2015
- family members nominated by the above.

The study focused on the twelve month and lifetime prevalence of various mental health disorders and found:

- those who left the ADF entirely had higher rates of most mental health disorders than those that remained as (either active or inactive) reservists
- DVA clients who recently transitioned were far more likely to suffer from mental health problems than other recently transitioned members. This is especially noteworthy given the data was collected before the rollout of non-liability healthcare for all service types
- those who were recently medically discharged are far more likely to suffer from most mental health problems than those recently discharged for other reasons. About half of those medically discharged will have suffered an anxiety type mental health disorder and about 40 per cent will have suffered from an affective (mood) disorder. The same pattern is seen when analysing the incidence of specific mental health disorders
- having previous deployment was found to be highly correlated with anxiety mental health disorders among transitioned ADF but not with affective mental health disorders — the incidence of PTSD was more than seven times as high among those with previous deployment compared to those without.

The MPW also looked at suicidality in the ex-serving population and found that a range of factors were associated with higher rates of suicidal thoughts and behaviours:

- having completely left the ADF (reservists had lower incidence of suicide)
- involuntary medical discharge
- the Army had higher suicidality than the Navy which in turn had higher suicidality than the Air Force
- being a non-commissioned officer
- fewer years of military service
- being a DVA client.

The MPW did not find a significant correlation between deployment and suicidal tendencies.

Source: Van Hooff et al (2018b, pp. iii–ix, 70, 93, 122–137).

This study found:

- the prevalence of mental health disorders in the ex-service community was higher than for serving personal
- the prevalence is probably also higher than the general population (as serving personal had previously been found to have higher incidence than the public) but this study did not compare them to the Australian population⁷
- DVA clients were far more likely to suffer from mental health problems than other recently-transitioned members
- veterans who were medically discharged were about twice as likely to suffer from either depression or bipolar affective disorder than those that were discharged for other reasons (Van Hooff et al. 2018b, p. 93)
- having previous deployment was found to be highly correlated with anxiety-related mental health disorders (such as PTSD) among transitioned ADF but not correlated with affective mental health disorders (such as depression).

Suicide

The Australian Institute of Health and Welfare (AIHW) looked at the incidence of suicide among serving (full-time and reservist) and ex-serving personnel between 2002 and 2016 (box 2.12).⁸ This study showed that serving personnel, full time or reservist, are about half as likely as the general population to suicide but recently transitioned ex-serving personnel were about 18 per cent more likely (AIHW 2018f, p. 1). However, when examining only (male) ex-service personnel under the age of 30, the rate of suicide was about twice the Australian average for the cohort of the same age (AIHW 2018f, p. 1; figure 2.7). There has also been a clear upward increase in the rate of suicide amongst the under 30 year olds in the ex-service community. This has coincided with the increased number of mental health discharges noted above. Earlier studies by AIHW found some factors that are associated with higher rates of suicide among ex-service personnel include:

- being a non-commissioned officer
- shorter time in the military (though not statistically significant)
- being involuntarily medically discharged (compared to voluntary discharge) (AIHW 2017b; box 2.12).

⁷ The last National Mental Health Survey by the ABS was conducted in 2007 and given that social attitudes have become more accepting of mental health problems over time, its estimates of mental health prevalence for the general community are probably an underestimate.

⁸ The AIHW matched information from the PMKeyS database, maintained by DoD, and matched it with the National Death Index, maintained by AIHW (AIHW 2017b, p. 15).

Box 2.12 Incidence of suicide of serving and ex-serving ADF

The Australian Institute of Health and Welfare looked at the total rate of suicide amongst serving and ex-serving personnel between 2001 and 2015 and how this correlated with certain variables. To construct this dataset, personnel data from Department of Defence's PMKeyS database was matched with the National Death Index, held by AIHW. This was then supplemented by information from DoD's database of confirmed and suspected suicide deaths ('Defence Suicide Database') and cause of death information from the National Mortality Database.

Controlling for age, male veterans who had recently exited the ADF entirely had a higher incidence of suicide than the general community while those who remained full-time or in the reserves had about half the incidence of suicide. Unfortunately, this study only standardised the comparable death rates for men; it presented crude suicide rates for female veterans but these were not adjusted for age.

The AIHW also modelled the odds ratios^a of suicide risk for ex-servicemen using service branch, rank, length of service, age and reason for discharge as variables. It specifically excluded previous deployment as a variable because it correlated highly with age and the crude rates of suicide for men with or without previous deployment were similar.

It found that non-commissioned officers and medical involuntary discharge were both associated with a statistically significantly higher rate of suicide. Those who had served in either the Navy or Air Force and those with less than a year of service also had higher rates of suicide but these effects were not statistically significant.

Odds ratios of suicide, together with 95% CI^b for related characteristics

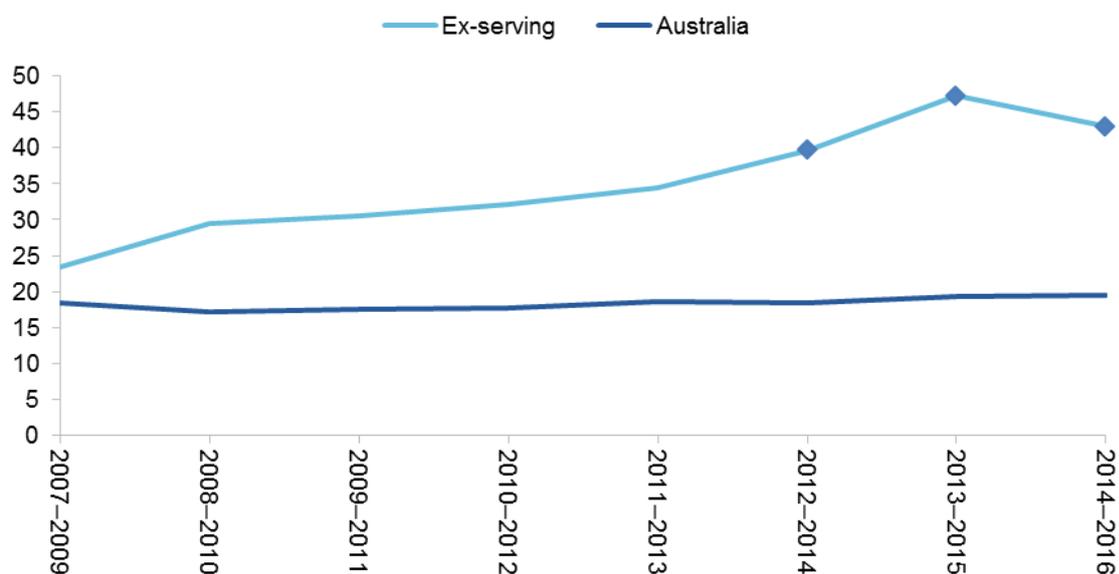
<i>Characteristic</i>	<i>Odds ratio^c</i>	<i>Lower 95% CI</i>	<i>Upper 95% CI</i>
Army vs Navy	0.7	0.45	1.09
Air Force vs Navy	0.8	0.44	1.42
All other ranks vs commissioned	2.2	1.16	4.06
Length of service (Years) <1 vs ≥10	1.7	0.98	2.94
1-5 vs >10	1.0	0.59	1.66
5-10 vs >10	0.9	0.51	1.47
Medical involuntary vs voluntary	1.9	1.22	2.80
Non-medical involuntary vs voluntary	0.9	0.58	1.31

^a Odds ratios are the ratio of the probability of an event occur with a particular exposure to the probability of the event occurring without exposure. ^b CI stands for confidence interval. ^c Numbers in bold are statistically significant.

Source: AIHW (2017b, pp. 25,64-69).

Figure 2.7 **Suicide rates among under 30 years old (male) ex-service members^a (%)**

Rate per 100 000 people, aged-adjusted



^a Markers indicate years in which the difference in suicide rates was statistically significant.

Source: AIHW (2018f, p. 1)

Homelessness

There is no comprehensive dataset on veteran homelessness and the existing studies are not representative. That said, surveys of inner-city homeless populations find veterans are overrepresented. For example, while ex-serving veterans comprise about 2 per cent of the general population⁹ the State of Homelessness study found veterans were 5.5 per cent of the homeless population across various city centres (Flatau et al. 2018, p. 29). And Homelessness NSW found that 8 per cent of the homeless in inner city Sydney identified as veterans (Homelessness NSW nd).

Some distinct characteristics of contemporary veterans

Some of the characteristics of ADF members have changed over time. Broader societal changes have generally been reflected in the military (albeit sometimes with a lag). For

⁹ Using the highest estimates of the size of the ex-serving population (565 000) implies that veterans are about 2 per cent of the general population. Based on DVA estimated numbers of living veterans (643 000) minus the noted 58 000 full-time and 20 000 reservist ADF personnel (DoD 2018f, pp. 80, 83) to work out the number of ex-serving veterans. The Australian population is about 24.9 million, implying ex-serving veterans are about 2 per cent of the general population (ABS 2018c).

example, while historically women were excluded from most military roles (outside of nursing), now they can serve in any capacity.

In many respects, the characteristics of contemporary veterans are similar to the those of similarly aged civilians. Numerous participants commented on these traits. For example, the Alliance of Defence Service Organisations (ADSO) said of contemporary veterans:

Compared with earlier generations:

- their expectations of government are higher
- they expect professional resolution of their issues using the latest technologies
- they insist that advocates focus on the veteran and family
- they specifically want advocates' support with: suicide awareness, the veteran and family in crisis and reintegration into community. (Alliance of Defence Service Organisations, sub. 85, p. 11)

And, as is increasingly common among Australians generally, veterans are using social media to air grievances. RSL Australia said 'the advent of social media means that any concerns with any organisation, justified or otherwise, have the ability to proliferate rapidly and become difficult to control or overcome' (RSL Australia, sub. 113, p. 7).

The age profile of contemporary veterans also impacts the type of services they require. As RSL Australia said:

... younger veterans do not wish to remain off work and on a lifelong pension if there is any possibility of a return to work and their expectation is entitlements that provide medical support, rehabilitation and employment support and an opportunity to move on to the next stage of their life and continue to support their family. (sub. 113, p. 28)

These characteristics of contemporary veterans will become increasingly important for policy makers and those delivering services for veterans.

3 The veteran support system

Key points

- The Department of Veterans' Affairs (DVA) supports over 283 000 clients at an annual cost of about \$13.2 billion (just over \$47 000 per client). Over \$5 billion is allocated to rehabilitation and healthcare services and \$7.4 billion to compensation and income supports.
- The majority of DVA's clients are older veterans and widows of various conflicts including Vietnam and World War II, with most resources directed towards this group. That said, there is a growing contingent of younger veterans.
- The veteran support system arose out of the hardships created by the world wars. The design of the system reflected the circumstances of the time — when the nature of warfare, military personnel's pay and motivations for enlisting, economic participation by women and the extent of the public health and welfare system, were very different to today.
- The system has expanded incrementally, often in an ad hoc manner. While a number of the rationales for elements of the scheme have faded, a desire to avoid reducing entitlements means that opportunities to remove duplication and redundancy have been missed.
- One result of this is that, today, the veteran support system is complex. Support is provided under three main pieces of legislation and covers:
 - *Liability based supports*, which give veterans (and their families) treatment for their condition, compensation for loss of earnings and pain and suffering (or for death), rehabilitation and community care supports (such as attendant care).
 - *Parallel human services* — a set of veteran-only supports that (often more generously) mirror the healthcare, aged-care and aged-pension services available for civilians.
- The system also draws a distinction between veterans based on where and when they served. A veteran may have claims under multiple Acts for the same condition, which can require complex offsetting arrangements.
- Several government bodies are involved in administering the system, with the Department of Veterans' Affairs having the primary role.
 - Ex-service organisations support the veteran community, including by providing advocacy services for veterans submitting or appealing claims and financial support.
- DVA's client base and costs are declining — mainly because of the loss of the large cohorts of older veterans and war widows. However, at the same time, the cost of new military injuries and illnesses appears to be increasing. The costs of the relatively small veterans' invalidity and death insurance system administered by the Commonwealth Superannuation Corporation are also increasing.

From its beginnings as a system of compensation and repatriation for the returned veterans and widows of World War I, veteran support has evolved into a generous but also complex system. Understanding the original rationales for the various elements of system, and how

they have evolved, is instructive for identifying the system's merits and areas for potential improvement. This chapter traces the development of key features of the veteran support system (section 3.1), before describing the system as it is today (section 3.2). It then gives a snapshot of the system's entitlement mix and costs (section 3.3).

3.1 How the system of veteran support evolved¹

The system originated with the first Anzacs

Prior to World War I, war veterans relied on a mix of private charity (through 'patriotic funds') and discretionary benefits provided by the Department of Defence under the *Defence Act 1903* (Lloyd and Rees 1994, p. 30; Sutherland 2004, p. 41).

When Australia became involved in World War I, there was pressure for a more robust war veteran support system.

- Compensation was needed to help recruit volunteers (even those already in the defence force could not be compelled to serve overseas) who were to be paid less than the minimum wage.
- Australian Government workers' compensation did not apply to overseas military forces and government and welfare services at that time were very basic.
- The benefits available from Defence for war widows or incapacitated veterans were highly discretionary.
- Veterans of the Boer and Sudan conflicts were not given access to any compensation which could have dampened recruitment efforts if not for a new war pensions scheme (Lloyd and Rees 1994, pp. 21, 26; Sutherland 2004, pp. 41–42).

The Australians deployed in World War I faced terrible conditions and hardship, and the scale of sacrifice required by the nation was huge. As the Alliance of Defence Service Organisations said:

During WWI, from a population of around 4.9 million, 416 809 men² (38.7% of male population) enlisted, of whom 61 514 were killed and around 156 000 wounded, gassed or taken prisoner. In other words, around 43.9% of veterans, or around 14.5% of the male population, returned with some level of incapacity. The consequences overwhelmed the Nation. (ADSO, sub. 85, p. 44)

The Australian Government responded firstly with the *War Pensions Act 1914*, which provided pensions for widows and disabled veterans that were proportional to the previous military pay of the veteran (this later moved to a system based on degree of impairment).

¹ Section 3.1 draws largely on official histories commissioned by DVA (Lloyd and Rees 1994; Payton 2018) and other sources, including previous reviews, journal articles and participant submissions.

² Of those who enlisted, about 330 000 personnel were deployed (NAA 2018).

Although the Commonwealth workers' compensation scheme of the time was based on lump-sum payments, the veteran scheme was based on lifetime pensions.

The pension basis ... was a necessary approach to compensation for the injured veterans of World War 1 and their dependants. The Australian economy could not have afforded the relatively generous [lump sum] provisions of the MRCA [*Military Rehabilitation and Compensation Act 2004*] scheme applied to such a large number of injured veterans and dependants. (Peter Sutherland, sub. 108, p. 1)

Commenting on the rationale for lifelong pensions for widows, Peter Sutherland said:

Until the 1960s, most marriages were long-lasting ... and many wives were expected to stay out of the workforce and be supported by their husbands. This provided a rational basis for the war widow pension. (sub. 108, p. 1)

The Government later sought to aid the reestablishment of returned service personnel (both with and without war injuries) and in 1918 created a Department of Repatriation overseen by a Repatriation Commission (a seven person honorary group headed by a Repatriation Minister), which drafted the regulations that specified most of the repatriation benefits (Lloyd and Rees 1994, pp. 87–88; Payton 2018, p. 1). The benefits included:

- assistance for veterans to find employment, and 'sustenance' payments until they did
- loans to veterans to start businesses and for various other purposes
- rental assistance (Lloyd and Rees 1994, p. 53).

Senator Edward Millen (the first Minister for Repatriation) outlined the goals of repatriation.

[Repatriation is] not the mere conferring of money or other gifts on a soldier for services rendered, but ... implied an effort on behalf of the nation ... to aim at and as far as possible secure the satisfactory reestablishment in civil life of the returned soldier. That carries with it the obligation that where men returned maimed or wounded, in order to secure their satisfactory reestablishment in civil life, everything possible should be done to secure their return to health, or to make good the physical defects from which they are suffering. (Toose 1976, p. 26)

This new repatriation system also included medical treatment for veterans injured as a result of their service. A network of repatriation hospitals (which included former military hospitals) was established. Initially, treatment was restricted to the war-related injuries of veterans but was (to a limited degree) extended to war widows, war orphans and widowed mothers of unmarried deceased soldiers in 1924 (Clarke, Riding and Rosalky 2003, pp. 486–487).

Australia was unique in providing a coordinated government program to aid veterans *without* war injuries to settle back into civilian life.

Some of the distinctive features of today's veteran support system emerged at this time, including:

- an absence of time limits on claims
- a separate veterans' department

-
- a legislative architecture that meant that some veterans were eligible under multiple Acts — those with peacetime service were covered by the Commonwealth workers' compensation legislation and the early Repatriation Acts were specific to World War I and had to be amended, or duplicated, each time a new conflict occurred, meaning veterans of multiple conflicts could be covered by multiple Repatriation Acts (Lloyd and Rees 1994).

However, unlike today's veteran support system, this scheme was restricted to war veterans; peacetime ex-servicemen had to rely on the same workers' compensation arrangements as regular Australian Government employees (Sutherland 2004, p. 42).

Various ex-service organisations (ESOs) were established during this time, including what would later be called the Returned and Services League (RSL) in 1916. A bargain struck between the RSL and then Repatriation Minister Edward Millen saw it become (for several decades) the sole voice of the veteran community — with direct Cabinet access — and a powerful lobbying force for veterans' supports (Beaumont 2013, pp. 525–526).

The interwar period and World War II

Poor economic conditions after World War I and its massive human toll put a lot of pressure on both the veteran support system and veterans. According to early Repatriation Commission reports, the number of recipients was still increasing nearly a decade after the war.

During this period, the Repatriation Department gained a reputation for being stringent in its application of the eligibility criteria for war pensions. After pressure from the press and ESOs, the government established the Blackburn Royal Commission to examine war pension eligibility (Lloyd and Rees 1994, p. 212). The Commission largely supported the eligibility criteria and the Repatriation Department's application of them, and recommended only some small amendments. After further pressure from ESOs, in 1929 the government established two appeal tribunals to assess eligibility and the level of disability (Lloyd and Rees 1994, pp. 214–215). These tribunals were the first external merits review bodies sustained in the country's legal system and have influenced merits review in the veteran support system ever since (the current Veterans' Review Board, for example, has a certain number of ex-service personnel, much like these original tribunals).

Following a brief, temporary contraction in payment levels (for dependants but not veterans directly) and restricted eligibility provisions during the early years of the Great Depression, the Australian Government sought to expand access to benefits.

- It widened the eligibility criteria for benefits through a number of legislative amendments to the Repatriation Act, including by introducing and later extending the 'benefit of the doubt' and 'onus of proof' clauses. The effect of the former was that when a delegate was unsure one way or the other, a claim would be accepted and the latter put the onus

on the Repatriation Department to accept a claim unless it could be disproven³ (Lloyd and Rees 1994, p. 327).

- The Government also responded to ‘burnt out digger’ syndrome, where returned servicemen were said to have shorter lifespans than their civilian counterparts even in the absence of a proven disability or illness. To what degree this phenomena was due to mental illnesses, economic pressures (with decreased veterans’ earning capacity) or other factors is unknown, but it resulted (in 1936), after some pressure from ESOs, in the ‘service pension’ which duplicated the age pension but was available five years earlier (because of the veterans’ shorter expected lifespan) or if the veteran was ‘permanently unemployable’ (Lloyd and Rees 1994, pp. 226–227, 229–230). (The service pension remains today, although contemporary veterans typically outlive their civilian counterparts — chapter 2.)

These and other provisions created a relatively generous veteran support system:

In 1939 Australia’s war pensions were 50 per cent higher than Canadian pensions and 25 per cent higher than those of New Zealand ... As a proportion of enlisted men, Australia had 41 per cent receiving veterans’ benefits, compared with 5 per cent in Great Britain and 25 per cent in Canada. (Lloyd and Rees 1994, p. 237)

World War II brought an expansion of the repatriation system to cover the one million Australians who served. The Repatriation Act was extended to those who served within Australia as well as abroad in this conflict. Reflecting the ‘fervid patriotic context’ of the war, war pension rates were raised and eligibility was extended so that injuries no longer had to be ‘directly attributable’ to war service and need only to have ‘arisen out of or is attributable to service’ (Lloyd and Rees 1994, pp. 242–3). Veteran health care entitlements were also extended during the war (see below). And perhaps due to the impacts on the domestic economy of the war, benefits aimed at establishing returned soldiers, such as business loans, were also extended to those who served only within Australia. Some veterans, including those whose previous occupations had an oversupply of labour, also had access to free training, along with a ‘support allowance’ while they studied, which ranged from short vocational courses to university-level education (Lloyd and Rees 1994, p. 263).

Critiques and reviews

The early veteran support system, although experimental and sometimes prone to failures (such as land settlement programs), helped the return of service personnel and supported them and their families — especially war widows, orphans and veterans severely injured on duty, who otherwise would have had to rely on the welfare system and private charity. As one historical account noted, in the absence of veteran support ‘the quantum of human wretchedness, physical pain, mental anguish and poverty in the Australian community over

³ Veteran support legislation no longer places any onus of proof on either the DVA or the claimant to prove or disprove claims, instead adopting an inquisitorial approach (chapter 8).

three quarters of a century would have been incomparably greater’ (Lloyd and Rees 1994, p. 366). In this context, the system earned widespread support.

The strong support for the system meant that calls to independently reform the veteran support system — such as a proposal for a Royal Commission to examine anomalies in the Repatriation Act — were not supported. By late 1930s, ESOs and the Department preferred the status quo to reform for fear that independent examination by ‘laymen’ could result in curtailment of benefits (Lloyd and Rees 1994, pp. 237–238). This resistance by stakeholders and administrators as well as the generally sympathetic public meant there were relatively few critiques of the system for some time.

This changed with the publication of ‘Be In It, Mate!’ by John Whiting, a former repatriation hospital doctor, in 1969. While Whiting was supportive of pensions and medical treatment for injured war veterans, he was highly critical of the eligibility criteria used by the veteran support system. He noted that a number of World War II veterans who had never left the country, nor were ever in imminent danger, were receiving (veteran) disability pensions for age-related conditions. Whiting also criticised politicians and ESOs for their role in extending the system and argued that eligibility was not based on sound medical science (Lloyd and Rees 1994, pp. 325–326; Payton 2018, pp. 67, 70).

The Repatriation Department responded that eligibility was based on more than medical evidence and that politicians, in designing the system, had also accounted for ‘social, economic, ethical and emotional factors’ (Lloyd and Rees 1994, pp. 329–330; Payton 2018, p. 70).

The Government, in part because of the influence of Whiting’s critique as well as the emerging legislative thicket (see below), commissioned several reviews of the repatriation system, including a 1973 Senate inquiry and a 1975 report by Justice Toose.

The Senate report noted the increasing financial liability of the veteran support system and the increasingly complex Repatriation Act. The Committee report also recognised the opportunity cost of veterans’ benefits and sought ‘a proper balance between an appropriate range of benefits on the one hand, and to investigate means of reducing the cost to the taxpayer where feasible’ (Senate Standing Committee on Health and Welfare 1973, p. 39).

The Committee recommended that:

- payment of pensions be moved to the Social Security Department (with the Repatriation Department to focus on assessment)
- there be a move in emphasis from pension compensation to rehabilitation
- the legislation be redrafted and consolidated
- some of the evidentiary standards provisions (such as ‘benefit of the doubt’ provisions) be tightened (Senate Standing Committee on Health and Welfare 1973, pp. 30–33).

The RSL and other ESO groups opposed these proposals and the Government gave assurances that they would not be followed (Lloyd and Rees 1994, p. 334).

The ‘Independent Enquiry into the Repatriation System’ by Justice Toose, which evolved out of the initial internal review by the Department, was tasked with reforms for the ‘rationale, efficacy and simplification of the Repatriation System’. However, it did not achieve substantial simplification and accepted the rationale for all existing benefits (with the exception of the assessment of incapacity) (Lloyd and Rees 1994, p. 336). Toose produced a list of principles that promised benefits to the veteran community but did not make mention of trade-offs or budget constraints (Toose 1976, pp. 40–41).

Legislative complexity increased after the World Wars

Because the original veteran support legislation was drafted to refer only to veterans of World War I, subsequent conflicts required either amending the main repatriation legislation (the *Australian Soldiers’ Repatriation Act 1920*, ‘Repatriation Act’) — as was done for veterans of World War II and the Korean War — or creating parallel Acts that largely mimicked it. The latter approach was used for (among others) veterans of the Indonesian Confrontation, the Malayan Emergency and the Vietnam War. The outcome was a Repatriation Act with dozens of ‘tacked on’ sections and five parallel Acts.

Other ESOs were developed over time to aid these new generations of veterans, who often felt dissatisfied with the RSL establishment. This was most notable for the Vietnam veterans whose most influential ESO, the Vietnam Veterans Association of Australia (VVAA), was a major lobbying force in the 1970s and 1980s (Lloyd and Rees 1994, pp. 310, 313).

In the 1970s, the Government recognised the desirability of consolidating the six pieces of legislation detailing war veteran benefits into a single piece and sought a common system of veteran support for peace and wartime veterans. While both the Senate report (1973) and Toose (1975) recommended consolidation, this was not achieved until the *Veterans’ Entitlements Act 1986* (see below).

As an ‘interim’ measure until a single military compensation scheme could be designed, in 1973 the Government allowed eligibility under the Repatriation Act for peacetime veterans (Clarke, Riding and Rosalky 2003, pp. 85–86). However, for fear of potentially disadvantaging some veterans, those with peacetime service were allowed to still make claims under the Commonwealth workers’ compensation scheme (creating ‘dual eligibility’) but with complex offsetting arrangements to prevent double dipping. Dissatisfaction with this arrangement among veterans, and the problems that stem from it, continue 45 years later (chapter 12).

Health care and other entitlements were also extended

Veteran healthcare entitlements were widened in 1943 to include treatment for all conditions⁴ (a precursor to the Gold Card) — even those not related to war service — for veterans receiving either the full general rate or the special rate war pension (Toose 1976, p. 442). Eligibility for treatment for all conditions was further extended to:

- all World War I veterans in 1958, war widows in 1959 and veteran service pensioners (subject to a means test) in 1961 (Clarke, Riding and Rosalky 2003, pp. 487–488)
- peacetime national servicemen in 1973 (and therefore the same compensation and healthcare benefits available to war widows were extended to peacetime veterans' widows) (Clarke, Riding and Rosalky 2003, p. 487)
- World War II veterans with at least 50 per cent disability pension and any amount of service pension (in 1982), female World War II veterans (including nurses) (in 1988) and a few other groups (Clarke, Riding and Rosalky 2003, pp. 487–489).

Initially, veteran disability pensions were counted in the means testing for the service pension but, in the 1970s, parts of the pension were exempted from the test (25 per cent in 1973, 50 per cent in 1975, 60 per cent in January 1982 and 100 per cent in November of the same year) (Clarke, Riding and Rosalky 2003, p. 86). This allowed many veterans to receive both the service pension and a disability pension.

After several subsequent reforms and court decisions in the 1970s, a beneficial 'reasonable hypothesis' test (section 3.2) was developed to determine liability for operational service veterans.

Another reform in this era was DVA no longer directly providing health care and introducing healthcare cards. In 1979, the Department began allowing clients to visit GPs and dentists of their own choice. This outsourcing of health care was extended in 1987 when veterans were given one of four coloured cards which allowed treatment by providers of their choice for certain conditions (specified by the colour). In 1996 these were rationalised into the Gold Card — given to all those who previously received treatment for all conditions in repatriation hospitals such as dependants, severely disabled veterans and certain service pensioners — and the White Card for treatment of service-related conditions only. These reforms coincided with the transfer of repatriation hospitals to state and private providers (Clarke, Riding and Rosalky 2003, p. 491).

Several extensions of healthcare entitlements also occurred shortly after.

- In 1999, the Government extended eligibility for the Gold Card to World War II veterans with qualifying service and in 2002 further extended it to post-World War II veterans

⁴ Some types of treatment were specifically excluded, including alcoholism, drug addiction, chronic or incurable diseases requiring prolonged treatment in institutions, and 'conditions for which the member was entitled at law to receive free treatment from another source'. These exclusions were relaxed in 1972 (Toose 1976, p. 390).

over the age of 70 with qualifying service (Clarke, Riding and Rosalky 2003, pp. 489, 491).

- The Orange health care card was introduced in 2002 to give access to pharmaceuticals for Commonwealth and other allied veterans living in Australia (Clarke, Riding and Rosalky 2003, p. 491).

Further extensions of veteran benefits occurred after a review by Clarke which led to (among other changes) the creation of the Defence Force Income Support Allowance (DFISA) in 2004 (chapter 14). Essentially, this had the effect of exempting veteran disability pensions from social security means testing (for benefits such as the age pension) (Creyke and Sutherland 2016, p. 389). Clarke justified this approach by pointing out that war veterans did not have their veteran disability pension counted in the means testing for the service pension and so could receive both the service pension and the veteran disability pension without any reduction in payment. Rather than remove this exemption for war veterans, Clarke recommended extending similar benefits to all ex-service people (Clarke, Riding and Rosalky 2003, p. 629).

Clarke also recommended against any further grants of the Gold Card to post-World War II veterans at age 70 unless it were means tested (Clarke, Riding and Rosalky 2003, p. 503), but this recommendation was not accepted (Vale 2004).

Towards three Acts

Following the reviews discussed above and subsequent changes in the policy environment — such as shifting views on the importance of rehabilitation, limited military deployments and events that highlighted the inequities of multiple compensation systems — there was a growing impetus to rationalise and refocus veteran support.

The VEA simplified the system by repealing the previous six pieces of war veteran compensation legislation, but it retained the distinctions between different kinds of service by creating a complex, sometimes unclear and overlapping, set of different service types to determine the level and types of entitlement (section 3.2). The Government had intended to pursue further simplification and to tighten eligibility — through removing eligibility for those with peacetime service and offsetting and limiting access to the beneficial standard of proof for widows — but this change was defeated in the Senate amidst pressure from ESOs (Lloyd and Rees 1994, pp. 348–353).

The VEA also represented the culmination of a shift in the focus of veteran support from rehabilitation to compensation. As RSL Queensland said:

Immediately post-World War 2 (WW2), under the *Repatriation Act 1920*, there was a much greater focus on assisting WW2 veterans back into meaningful work. However, with WW2 veterans moving on with their lives, this approach was gradually diluted. Following the introduction of the VEA in 1986, the compensation focus was complete and any interest in rehabilitation was essentially lost. (sub 73, p. 6)

By contrast, Commonwealth workers' compensation policy, which also applied to peacetime veterans, was shifting towards rehabilitation and return to the workforce. This was achieved through the passage of the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) (Howe 1988, p. 2193). Because the VEA still retained a pension focus, the Government decided the SRCA would be the main military compensation legislation for new injuries, until a new Act could be created. In 1994, eligibility under the VEA for peacetime service ended but dual eligibility for those with operational service was created under the SRCA, allowing war veterans to choose between the VEA and SRCA (or both with offsetting — section 3.2; DVA, sub. 125, p. 91). Allowing new claims under the VEA for veterans with operational service appears to have been maintained so these veterans would not be disadvantaged.

The Government also decided to reform the VEA at several points. One important change was introducing Statements of Principle (SoPs), in 1994, to streamline and standardise the use of medical evidence in compensation claims (chapter 8). The Government, in a partial shift from the VEA's pension focus, also added a rehabilitation scheme to the Act in 1997 (DVA, sub. 125, p. 88). However, the scheme was voluntary and (as discussed above) came well after similar compulsory schemes became part of civilian workers' compensation.

Another impetus for reform and rationalisation was a training disaster in 1996, wherein 18 ADF members were killed when two Black Hawk helicopters collided. Because of dual eligibility, some families of the deceased had access to different levels of compensation (based on the date of enlistment and superannuation scheme choices). This highlighted inequities in the system and led to the 1997 Department of Defence 'Inquiry into Military Compensation arrangements of the Australian Defence Force' (DoD Review). The DoD review concluded a new military compensation scheme should apply to both peacetime and wartime service. In the interim, it made several recommendations to address the inequities and anomalies caused by interaction of VEA and SRCA. Most of the recommendations were implemented with determinations under the *Defence Act 1903* that supplemented the SRCA benefits for ADF personnel.

Following the DoD Review, the Australian Government sought options to create a new military compensation scheme that superseded the previous two schemes. This led to the *Review of the Military Compensation Scheme* in 1999 by the Department of Defence, chaired by Noel Tanzer.

The Tanzer Review was asked to provide the architecture for the new military compensation scheme. Some of its key recommendations were that:

- a single new scheme should replace previous arrangements for claims after the enacting of this legislation
- as a guiding principle, the 'unique nature of military service' and the 'element of exposure to risk of injury/disease arising out of, or in the course of, employment' are best accounted for in the *remuneration* arrangements during military service rather than the *compensation* arrangements after injury

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- the new scheme should be funded by a ‘premium’ calculated by the Australian Government Actuary and paid for by Defence (Tanzer 1999, pp. 91–98).

Only the first recommendation was implemented. There was a new scheme for all military personnel 5 years after the Tanzer review when the *Military Rehabilitation and Compensation Act 2004* (MRCA) was passed. However, this Act did not repeal the VEA or the SRCA and did not close them off for new claims relating to service before 1 July 2004. The Act itself blended elements of both the previous pieces of legislation — taking most of the eligibility provisions from VEA (while adopting a simplified version of its multiple service categories) and combining them with the compensation and rehabilitation elements of the SRCA. The level of pain and suffering compensation for war veterans was designed to be comparable with VEA and for peacetime veterans, comparable with SRCA.

By bringing new veterans into a scheme with modern compensation principles — including rehabilitation, return to work and clear delineation between payments for pain and suffering and payments for loss of income — the MRCA was a marked improvement in veteran support policy.

The MRCA’s most significant amendment since its passage was a single appeal pathway for the review of original determinations (DVA, sub. 125, p. 88).

Recent reforms

In 2017, the Government split the military-specific sections of the SRCA into a standalone piece of legislation — with no substantial amendment — called the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA). This allowed all the main pieces of veteran legislation to be administered by the Minister for Veterans’ Affairs.

In 2016-17, the Department of Veterans’ Affairs began reforming and modernising its administrative processes via the Veteran Centric Reform program (box 3.1).

Other recent changes include the extension of non-liability health care for mental health conditions to all serving and ex-serving ADF members (previously only available for those with operational service) and an interim (means-tested) income support payment for veterans while liability for their mental health condition is being determined (the ‘veteran payment’) (DVA, sub. 125, p. 99; DVA 2018s).

And after the Invictus Games in October 2018, the Government announced several further initiatives aimed at veterans, including its intention to develop an ‘Australian Veterans’ Covenant’, a new Australian Veterans’ Card and Lapel Pin (Morrison and Chester 2018b) and an \$500 million expansion of the Australian War Memorial (Morrison and Chester 2018a).

Box 3.1 Veteran Centric Reform Program

The Department of Veterans' Affairs' (DVA) Veteran Centric Reform (VCR) program is the umbrella term for a wide range of initiatives, investments and reforms that DVA is currently implementing.

The overarching goal of the VCR program is to improve the administration of the veteran support system by modernising DVA's antiquated ICT systems and making service delivery consistent with whole-of-government service delivery principles. Longer-term, the VCR's objective is to create 'an agency focused on policy, stakeholder relationships and service commissioning', where 'most ... clients will be able to self-manage through online means', while DVA staff are free 'to focus more on those clients with complex and multiple needs, based on an integrated whole-of-client view and effective case management systems' (Lewis 2018).

Specific initiatives and programs already implemented under the VCR program include the creation of 'streamlined' and 'straight-through' processing (chapter 8), the widespread digitisation of records, the rollout of the *MyService* online portal for submitting claims (chapter 9), and improved data analysis to identify clients (sub. 125, p. vi). To implement the VCR program, DVA has been allocated \$303 million in funding over the last three financial years, most of which was for major ICT infrastructure investments to update over 200 antiquated systems (Australian Government 2016a, 2017b, 2018a). The full VCR program is expected to last six years, with much of the most difficult work still to commence. The VCR program is discussed in detail in chapter 9.

3.2 An overview of the system today

The continuous, piecemeal evolution of veteran supports and lack of robust rationalisation has resulted in a highly complex support system for veterans and their families.

The supports provided to the veteran community, which are mainly administered by DVA, fall under two main umbrellas:

- *liability-based supports* — access to these supports is contingent on a veteran having suffered injury or illness (or death) related to their military service.
- *a parallel human services system* — for veterans with certain types of service, DVA offers a range of services that duplicate, often more generously, those available in the mainstream health, community and welfare systems.

Veterans also have access to transition support when they leave the military (chapter 7).

And DVA funds commemorative activities and facilities, such as war graves and memorials (about \$60 million in 2017-18) (DVA 2018f, p. i). DVA described this function as 'a relatively small but enormously significant part of DVA's role' and noted that:

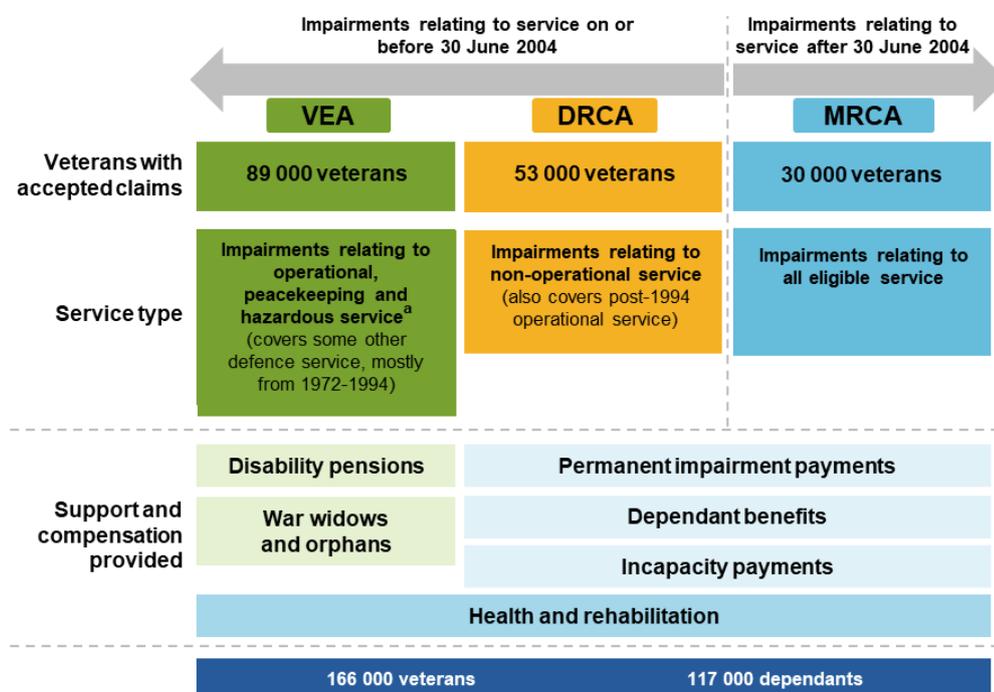
This program, which has recently included the significant Centenary of Anzac events, supports and delivers events and material that commemorate and recognise important previous military engagements. (sub. 125, p. 12)

Liability-based supports: the legislation and eligibility requirements

Liability-based supports for veterans and their families are available under three main pieces of legislation (figure 3.1).

- The *Veterans' Entitlements Act 1986* (VEA): which, as noted above, is a pension and healthcare system with little emphasis on rehabilitation, return to work and compensation for lost wages. It covers 'eligible war service', 'hazardous service' and 'peacekeeping service' prior to 2004 and 'peacetime service' between 1972 and 1994.
- The *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA): the Commonwealth public servants' workers' compensation system with an emphasis on rehabilitation. It covers peacetime service prior to 2004 and all forms of continuous service (including war service) between 1994 and 2004.
- The *Military Rehabilitation and Compensation Act 2004* (MRCA): a combination of elements of the VEA, DRCA and other workers' compensation schemes. It is mostly a relatively generous workers' compensation system with elements of the VEA such as its liability provisions. It covers all post-2004 service including continuous full-time, reservists and cadets.

Figure 3.1 **Liability-based supports**
Entitlements and number of recipients



^a Also includes participants in the British Nuclear Tests conducted between 1952 and 1965.

Data source: DVA (2018f, pp. i, 23).

In addition to these main Acts, several other pieces of legislation are also important. The DRCA ‘grandfathers’ some of the benefits of the previous two Commonwealth workers’ compensation systems⁵ and some of its benefits are also contained in determinations under the *Defence Act 1903*. In total there are up to six relevant pieces of legislation determining veteran entitlements.

Veterans and their families can also access invalidity and death insurance through military superannuation (provided by Commonwealth Superannuation Corporation — box 3.2) and the health, aged and community care and social services systems. In addition, ESOs provide support to the veteran community.

Box 3.2 About the military superannuation schemes

Serving Australian Defence Force (ADF) members receive government-funded invalidity and death insurance through military superannuation schemes. ADF members can receive superannuation benefits from one of three funds.

- *The Defence Force Retirement and Death Benefits scheme* — this scheme commenced in 1972, and was closed to new members in 1991. It is a defined benefits scheme that provides a lifetime pension for members who have served a set number of years — usually 20 years.
- *The Military Superannuation and Benefits Scheme* commenced in 1991 and was closed to new members in 2016. It includes both employee contributions and a defined benefit component (where a pension is provided based on years of service and salary).
- *ADF Super* which commenced in 2016. It is an accumulation-based superannuation scheme.

Under these schemes, the medical state (which could be not being able to meet the fitness requirements) resulting in discharge does not need to be related to service for veterans to receive invalidity pensions. And a member’s death does not need to be related to service for their dependants to receive a payment. Death benefits are offered as a lump sum while the invalidity pensions are offered only as a pension that is proportional to the claimant’s pre-injury military salary. The insurance components of the three schemes are broadly similar.

About 21 000 veterans or dependants were receiving a pension under one of these schemes due to invalidity at the end of June 2017 (dependants can receive a reversionary invalidity pension upon the death of a veteran receiving an invalidity pension). An additional 48 000 veterans were receiving a defined benefit pension due to age.

Source: AGA (2018b).

⁵ That is, the DRCA preserves the impairment compensation from the previous workers’ compensation schemes. For those whose conditions stabilised between 1949 and early-1971, the *Commonwealth Employees Compensation Act 1930* impairment compensation provisions apply; for those whose conditions stabilised between late-1971 and early-1988 the impairment compensation provisions of the *Compensation (Commonwealth Government Employees) Act 1971* apply; and for those whose conditions stabilised after late-1988 (but relating to service undertaken before 30 June 2004), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* applies.

A maze of service types

There are a number of service types under the VEA (box 3.3) and the MRCA that determine eligibility and the level of benefits.⁶ These service types overlap and can be confusing — with similar terms describing different concepts and similar concepts having different terms.

Box 3.3 A maze of service types under the VEA

Some of the service types that determine what benefits veterans are entitled to under the *Veterans' Entitlements Act 1986* (VEA) include:

- *eligible war service* — including continuous full-time service during WWI or WWII and any 'operational service' (s. 7 VEA)
- *operational service* — includes service:
 - outside Australia during WWI or WWII, certain service within Australia in WWII and various post-WWII operational areas
 - any 'warlike' or 'non-warlike' service, which are terms that the Australian Defence Force (ADF) has used since 1994 to classify service for the purposes of pay and conditions for serving members (ss. 6A–F VEA).
- *qualifying service* — allows access to the service pension, Gold Card and aged care once threshold ages are reached. The veteran must have incurred danger from the enemy during a 'period of hostilities' (the world wars plus a few other conflicts), or have warlike service or meet one of a few other categories (including veterans of allied countries) (s. 7A VEA).
- *warlike service* — those military activities where the application of force is authorised to pursue specific military objectives and there is an expectation of casualties, including a state of declared war or other conventional combat operations against an armed adversary (DoD 2017c)
- *non-warlike service* — those military activities short of warlike operations where there is a risk associated with the assigned tasks, where the application of force is limited to self-defence and where casualties are not expected (DoD 2017c)
- *defence service* — (sometimes referred to as 'peacetime service') under the VEA, this encompasses any continuous full-time service for three or more years between 7 December 1972 and 7 April 1994, unless the service member was medically discharged.
- *hazardous service* — includes maritime service in the Persian Gulf, and UN peacekeeping missions in Mozambique, Haiti and Yugoslavia (s120 VEA). Since 1997, any service that would be classed as hazardous service would now be declared a non-warlike service (Clarke, Riding and Rosalky 2003)
- *British nuclear test defence service* — service by any members near Maralinga, Emu Field or Trimouille Island during specific dates throughout the 1950s and 1960s (ss. 69B(2)-(5) VEA)
- *peacekeeping service* — members of a Peacekeeping Force raised for peacekeeping, observing or monitoring (including Australian police members involved in such operations), also referred to as non-warlike from 1997.

⁶ The DRCA does not define different kinds of service and simply terms all those eligible for benefits as 'employees' which in turn is defined as all serving and ex-serving members of the Defence Force subject to numerous exceptions (section 5).

Although the VEA has a range of service types (box 3.3), the level of liability benefits is the same for all service types; the differences between them is whether or not the veteran’s claim is assessed against the ‘reasonable hypothesis’ test for determining liability (discussed below) and whether the veteran has access to non-liability supports.

Unlike the VEA, under the MRCA, the level of liability benefits differ between service types, along with the use of the ‘reasonable hypothesis’ test (box 3.4).

Box 3.4 Service types under the MRCA

Service under the *Military Rehabilitation and Compensation Act 2004* (MRCA) falls into three categories:

- *warlike service* — from the Australian Defence Force (ADF) terms, using the same definition. Examples include Operations Slipper and Enduring Freedom in Afghanistan from 2001 and Operation Catalyst in Iraq between 2003 and 2009 (Military Rehabilitation and Compensation (Warlike Service — 2017 Measures No. 1) Determination 2017).
- *non-warlike service* — from the ADF terms, using the same definition. Examples include peacekeeping missions during the breakup of the former Yugoslavia and support activities around the Middle East for Operation Okra in Iraq/Syria after 2014 (Military Rehabilitation and Compensation (Non-warlike Service — 2017 Measures No. 1) Determination 2017).
- *peacetime service* — any service in the ADF (including in the Reserves) other than warlike or non-warlike service.

Warlike and non-warlike service together can also be referred to informally as ‘operational service’ (as in Campbell 2011a), which is broadly equivalent to operational service under the *Veterans’ Entitlements Act 1986*.

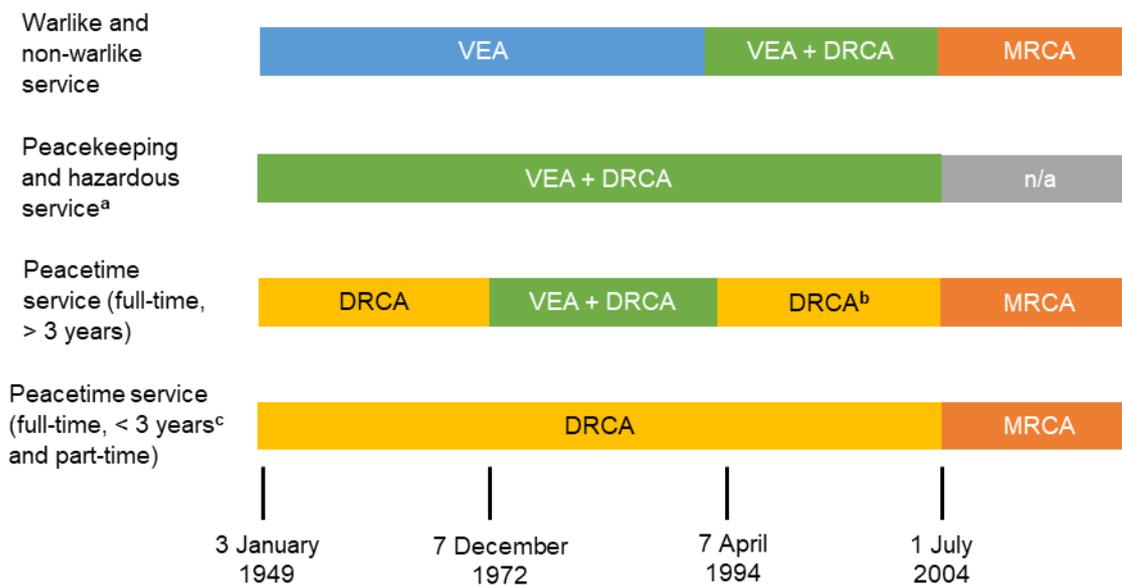
Multiple eligibility

The legislation is overlapping and so a number of veterans have eligibility under multiple Acts:

- veterans with three or more years of ‘peacetime’ service between 7 December 1972 and 6 April 1994 are eligible under both the VEA and DRCA for the same condition
- those with any ‘peacekeeping’, ‘hazardous’ or ‘British nuclear test’ defence service between 3 January 1949 and 30 June 2004 (although these terms were not used for any service after the mid-1990s) have eligibility under the VEA and DRCA (and/or its predecessors) for the same condition
- veterans with ‘warlike’ or ‘non-warlike’ service between 7 April 1994 and 30 June 2004 have eligibility under the VEA and DRCA for the same condition
- veterans with service pre and post-1 July 2004 may have eligibility under all three main Acts (figure 3.2).

Because of this multiple eligibility, complex offsetting arrangements are in place (chapter 12).

Figure 3.2 A timeline of the types of service covered by different Acts



^a The terms ‘peacekeeping’ and ‘hazardous’ service were subsumed into ‘non-warlike’ service during the late 1990s. ^b Veterans who enlisted prior to the introduction of the VEA (22 May 1986) and continually served up to and after 7 April 1994 are also covered by the VEA for peacetime service during 1994–2004. ^c Unless discharged on medical grounds.

Source: Based on information provided by DVA.

Liability

Before compensation or health care is provided under any of the three acts, DVA must have accepted liability by being satisfied that the veteran’s condition — injury, illness or death — is related to their service (chapter 8). These liability decisions are typically undertaken with a ‘beneficial’ approach (box 3.5).

Liability under the DRCA follows the same evidentiary and legal norms of workers’ compensation and common law. In essence, DVA is liable for all injuries (physical and mental) that are caused by or occur during service (regardless of cause). For diseases, DVA is liable if the veteran’s service made a causal contribution. All claims are assessed on the balance of probabilities (the civil law standard of proof), which requires it to be more likely than not that the condition relates to the veteran’s service.

Liability provisions under the VEA and MRCA differ from the DRCA. The VEA and MRCA both require a causal linkage between service and a condition, established through the Statements of Principles (SoPs). The SoPs are legislative instruments that outline a set of causal ‘factors’ for a condition, at least one of which must be linked to a veteran’s service to establish a causal linkage. There are two sets of SoPs for every condition.

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- For peacetime service, one set of SoPs has been created to set out what needs to be demonstrated to meet the balance of probabilities (‘reasonable satisfaction’) standard of proof.
 - For operational (warlike and non-warlike) service under the MRCA and the equivalent under the VEA, there is another set of SoPs which set out what needs to be demonstrated to meet the (less stringent) ‘reasonable hypothesis’ test.

Effectively, this allows claimants to have the medical-scientific basis of the link between their operational service and their medical condition considered using a lower standard of proof than for claims relating to peacetime service.

Box 3.5 ‘Beneficial’ legislation

The veteran compensation legislation is described by stakeholders, justices and politicians as ‘beneficial’ for veterans and their families. There seems to be at least two ways this beneficial nature manifests itself:

- the way the legislation is drafted (with its eligibility and benefits)
- the way administrators and courts interpret the rules.

When considered as a package, compensation provided by the system is generous (chapter 12), and the eligibility rules have numerous traits that are ‘beneficial’ for claimants. For example:

- there is no time limit on claims applications, and veterans can generally resubmit claims
- under the *Veterans’ Entitlements Act 1986* (VEA) and *Military Rehabilitation and Compensation Act 2004* (MRCA), evidence provided by veterans to support their claim is considered in light of the difficulties of record-keeping during service and the passage of time since (chapter 8)
- under the VEA and MRCA, veterans with operational service are subject to a lower standard of proof (the ‘reasonable hypothesis’ standard) when connecting their condition with service (chapter 8).

Appellate courts have also confirmed on numerous occasions that — independent of the leniency allowed by the letter of the law — justices have generally interpreted the veteran compensation laws favourably for veterans. As early as 1944, it was said of the predecessor to the VEA:

In constructing the Repatriation Act the objects which it seeks to achieve must be constantly borne in mind ... It is to receive a benevolent interpretation ... (Justice O’Sullivan, quoted in Creyke and Sutherland 2016, p. 8)

This principle has been reaffirmed in more recent decisions:

Australian repatriation legislation has long contained provisions for the resolution of disputed claims unusually favourably to claimants, as compared with claims for other Government benefits. These procedural advantages are only understandable as a national acceptance that volunteering to put life and health at risk for the nation demands special recognition when that risk eventuates. (Federal Court Justice Heerey quoted in ADSO, sub. 85, p. 9)

Liability-based supports: the available services and payments

Once liability has been accepted for a condition, a veteran (or dependant) may be eligible for a range of entitlements. Some of these, such as rehabilitation and some health care, are available immediately, while others, such as compensation payments and the Gold Card, have additional requirements. Dependants also have access to a range of other benefits once DVA has accepted liability for a veteran's death as related to service (dependants of veterans who were severely impaired prior to death can sometimes be automatically eligible as well, chapter 12).

Rehabilitation

During a veteran's service, the ADF provides vocational rehabilitation to injured members. Following discharge, DVA can provide rehabilitation *after* liability has been accepted (chapter 6).

VEA rehabilitation (the 'Veterans' Vocational Rehabilitation Scheme') is a free, voluntary service which has a vocational focus (it also includes psychosocial and medical management aspects where relevant to increasing employability) (DVA 2017l).

Under the MRCA and DRCA, rehabilitation has a holistic approach with three main focuses:

- medical management: aims to help to restore or maximise a person's physical and psychological function by helping them to manage their treatment or health needs
- psychosocial: interventions aimed at improving a client's quality of life and their independent functioning
- vocational: can include vocational assessment, guidance or counselling, functional capacity assessments, work experience, vocational training and job seeking assistance (DVA 2017o).

The MRCA/DRCA (but not the VEA) can require the veteran to complete rehabilitation prior to payment of certain forms of compensation.

Compensation

Veteran compensation is generally provided for lost wages due to their condition ('economic loss') and for pain and suffering ('non-economic loss').

The VEA blends compensation payments for both loss of income and pain and suffering in its 'disability pensions'. This pension is payable at four different base rates depending on the level of impairment, age and the ability of the veteran to work: the 'general rate', the 'intermediate rate', the 'extreme disablement adjustment rate' and the 'special rate' of disability pension (previously referred to as 'TPI' — totally and permanently incapacitated).

In addition, those receiving VEA disability pensions below the special rate can also include payments for specific types of injuries such as being blinded in one eye and amputations of limbs (DVA 2018o).

The MRCA and DRCA both have ‘permanent impairment’ payments to compensate for pain and suffering, although there are differences between the two Acts (including the guides to assessment and the treatment of subsequent injuries — chapter 12).

The MRCA and DRCA both also offer incapacity payments to compensate veterans for their lost wages resulting from their condition. These payments generally offer between 75 and 100 per cent of the difference between their pre and post-incapacity earnings. As with permanent impairment payments, there are several important differences between incapacity payments under the MRCA and those under the DRCA (chapter 13).

Health care

Under all three acts, once liability is accepted the veteran can access health care to treat their condition. This is facilitated through the ‘DVA Health Card — Specific Conditions’ (White Card), which allows only treatments that relate to the veteran’s service-related condition. This card allows the veteran to access services from any DVA-approved health care provided on an uncapped, no gap basis (DVA 2017j). (It is also the means by which veterans access non-liability health care, discussed below.)

The veteran also has access to the ‘Repatriation Pharmaceutical Benefits Scheme’ (RPBS) for medications that treat their conditions that relate to service. This scheme is similar to the mainstream ‘Pharmaceutical Benefits Scheme’ but has more medications covered and smaller co-payments (DVA 2017k).

Veterans with very severe service-related disabilities under the VEA and MRCA receive the ‘DVA Health Card — All Conditions within Australia’ (Gold Card). The Gold Card allows access to almost all forms of primary, secondary and allied health under the similar no gap and uncapped basis as the White Card (there are certain exceptions such as optical and certain dental procedures that have caps and or co-payments). Gold Card holders also have access to the full RPBS schedule regardless of whether they have conditions that relate to service (DVA 2018q).

Veterans can also be eligible for travel allowances (and or be provided transport services) to get to and from medical appointments.

Veteran death benefits and other family supports

Dependants’ benefits for a veteran’s death (or severe impairment) vary between the different Acts (chapter 12).

Under the VEA, partners (de-facto or spouses) and children (under 16, or under 25 and undertaking full-time studies) dependant on veterans have access to war widow(er)'s and orphan's pensions respectively if the death of the veteran is related to their service. And for dependants of certain categories of veteran, these pensions are granted without the need to prove a link between service and the veteran's death (DVA 2017i). Various types of bereavement payments are also available. Certain categories of dependants also have access to the Gold Card.

Dependants of veterans (as defined above) aged under 16 years, or up to 25 years if undertaking full time study and not employed full time, can also access the 'Veterans' Children Education Scheme' (called the Education and Training Scheme under MRCA) which has broad similarity to the youth allowance from the Department of Human Services for those over 16 years old (chapter 14). This scheme is also available to dependants of severely impaired veterans.

Under the DRCA, benefits to dependants are provided when a veteran dies due to service. The main benefit is a lump sum payment (currently of up to \$550 231), to be split among the dependants of the deceased (chapter 13).

Generally, a 'dependant' is a family member (such as a child or partner) who was, at the time of death, dependent on the deceased for financial support. Under the DRCA, a spouse living with the veteran immediately before their death is deemed to be 'wholly' dependent, regardless of independent income.

Under the DRCA there is also a fortnightly payment and lump sum for children (up to the age of 16, or to 25 if a full-time student not employed) who would have been wholly dependent on the deceased veteran, had they not died (chapter 12).

Under the MRCA, wholly and partly dependent partners of veterans (those in a significant emotional and financial relationship) can receive compensation when a veteran dies if the death relates to service (or the veteran had a severe service-related impairment before their death, chapter 12).

In addition to the above family benefits, all three Acts may reimburse the costs of a funeral for the deceased veteran, up to a maximum amount (DVA 2017h, 2017m).

Allowances and other benefits

There are also different allowances and in-kind benefits available to veterans with service-related disabilities under the three Acts. The main allowances and benefits are:

- veterans home care (which largely duplicates what is available through the community aged care services provided by the Department of Health's Home Care Packages)
- attendant and community care
- community nursing

-
- home and vehicle modifications
 - household services allowance
 - counselling services (DVA 2018e).

The parallel human services system

For veterans with certain types of service, DVA offers a range of services that duplicate, often more generously, services available in the mainstream health, community and welfare systems.

Qualifying service supports

Veterans with war service that meets the conditions for ‘qualifying service’ (box 3.3) have access to three main supports without the need to prove a link between any conditions and their service.

One of these is the service pension, which is paid at the same rate, and subject to the same means tests, as the mainstream age pension. These pensions can be received in addition to VEA disability pensions and/or incapacity payments (although DVA will include incapacity payments in the means test). There are three variants of the service pension.

- *Age service pension*: available at age 60 (five years earlier than the mainstream community), is taxable and is subject to the same asset and income testing as the social services age pension.
- *Invalidity service pension*: paid to veterans who are permanently incapacitated from working due to their health condition, regardless of whether their condition is related to their service. It is non-taxable until the veteran reaches age 65.
- *Partner service pension*: partners of veterans who are receiving or are eligible for service pensions. Taxable and subject to means tests (DVA 2016e).

The Gold Card is another support available to veterans who have qualifying service (and certain other categories, chapter 15) and are 70 aged years or older, without the need to prove a condition was related to their service. And many of the aged and community care services that are available on a liability basis to Gold and White Card holders are also available to veterans in receipt of a Gold Card due to qualifying service (DVA 2018e).

Non-liability health care

The DVA offers free, uncapped health care (‘non-liability health care’) for certain conditions without the need to show a linkage to service through the provision of White Cards. The following conditions are covered (chapter 12):

- any mental health condition

-
- cancer (malignant neoplasm)
 - pulmonary tuberculosis.

Treatment for all mental health conditions is now available (through the White Card) to all current and former members of the ADF with at least one day of continuous full-time service (CFTS). This includes reservists who have rendered any period of CFTS and national servicemen.

Treatment for the other two conditions is more restricted and only available to those covered by the VEA or those with warlike and non-warlike service under the MRCA (DVA 2018r).

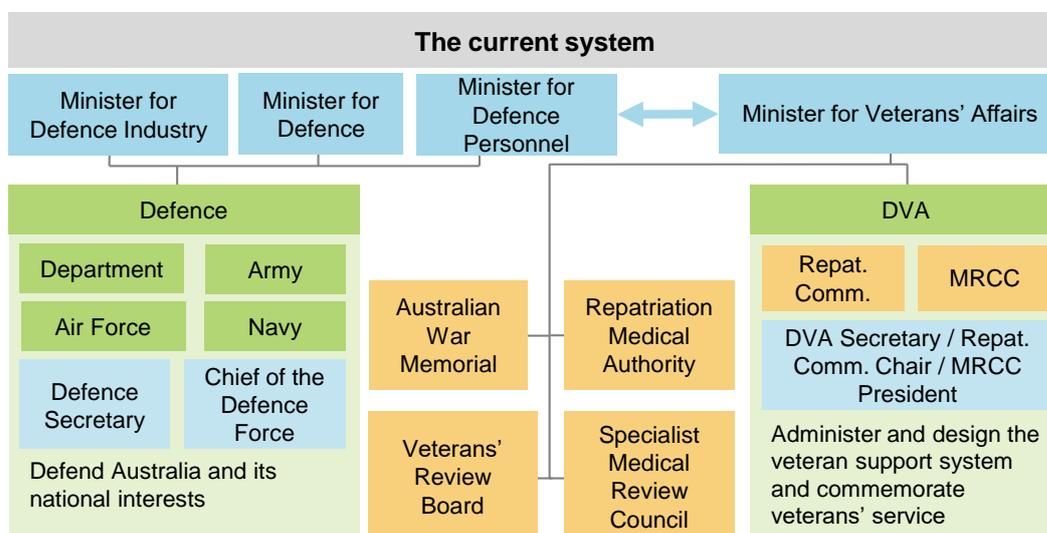
Governance arrangements

Several government bodies are directly involved in governing the current system of veteran support — Defence and the Department of Veterans' Affairs (DVA) and a number statutory authorities, including the Repatriation Commission and the Military Rehabilitation and Compensation Commission (figure 3.3; chapter 11).

DVA handles all claims under the three Acts and the payment of monetary benefits and it funds the medical and rehabilitation services. The Department is also the primary policy agency for veterans benefits with oversight on both its policy and operational functions being performed by the Repatriation Commission (for the VEA) and the Military Rehabilitation and Compensation Commission (MRCC, for the MRCA and DRCA). These two Commissions share common functions and membership, with the MRCC having a few specific extra members — two from Defence and the CEO of Comcare.

Most State and Territory Governments also have veterans' ministries or small offices within ministries that are generally directed to towards policy advice, advocacy and accessibility to veterans of services provided at the state level. Some governments also have employment-related initiatives and localised support activities.

Figure 3.3 **Governance of veteran support**



Ex-service organisations and their advocates

The veteran support system is highly dependent on veteran advocates (typically volunteer) provided by the ESOs. Advocates help veterans understand their entitlements and put in claims to DVA. They can also represent veterans to the department and act as representatives (in place of lawyers) at appeal.

ESO's also perform a wide variety of other functions, including providing income support, housing assistance and transition services for veterans and their families, and providing opportunities for social connections with the veteran community. They are also involved in consulting with government on policy.

3.3 The system's cost and client mix

In 2017-18, DVA reported spending \$13.2 billion for the veteran rehabilitation and compensation system, for compensation, income support and health care for about 283 000 clients — 166 000 veterans and 117 000 dependants (family members) of veterans. About \$7.4 billion was allocated to compensation (and income support), \$5.3 billion to healthcare (and rehabilitation and community care), \$437 million on enabling services such as workplace training, financial management and information technology, and \$60 million for commemorative activities and facilities (DVA 2018f, p. i). This equates to about \$47 000 per client. In the same year, about \$800 million in invalidity pensions and death benefits were paid to veterans and their families by the Commonwealth Superannuation Corporation. The Australian Defence Force (ADF) spent around \$437 million on health and rehabilitation

services for current serving members (AGA 2018b, p. 15; Joint Health Command, pers. comm., 5 November 2018).

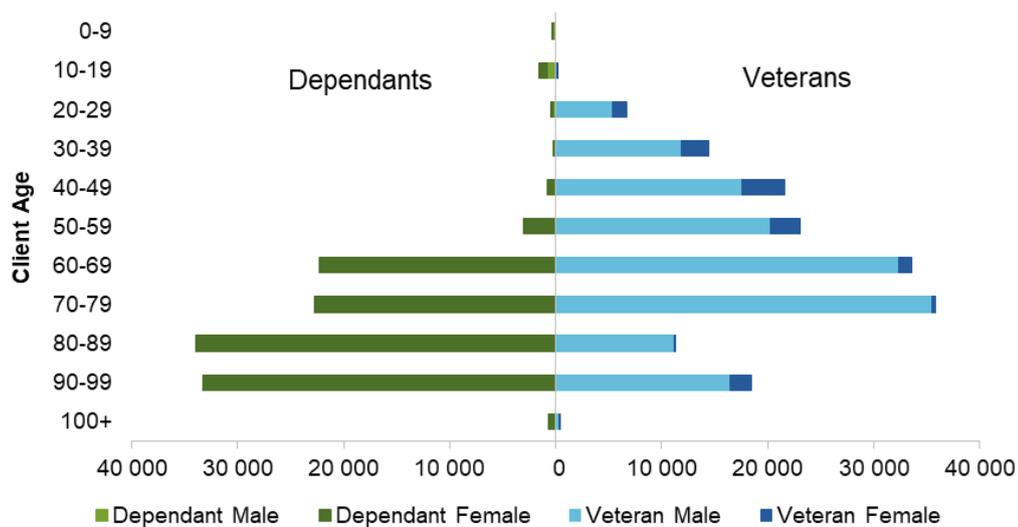
Summing this expenditure (excluding ADF health care), \$14 billion was provided in 2017-18 to support veterans and their families — this is equivalent to 43 per cent of the Department of Defence’s (DoD) \$32.8 billion budget in the same year (DoD 2018f, p. 148).

About DVA clients

DVA clients⁷ span all generations and life stages — there are veterans and war widows aged over 100 and children of veterans as young as one year. And there are veterans from every conflict since the First World War, peacetime veterans, reservists, some cadets and some peacekeeping police forces, and dependants of these (widows and orphans of veterans).

However, the majority of DVA clients are in the older age groups — about 70 per cent are 65 years or older and about a third are 80 years or older — with the overall gender split roughly even. Veterans that are DVA clients are predominantly older males (over 90 per cent are male and 60 per cent are over the age of 60). Dependants that are DVA clients are mainly older females (about 99 per cent female and about 95 per cent are at or over the age of 60) (Commission estimates based on unpublished DVA data, figure 3.4).

Figure 3.4 DVA clients
Male and female veterans and dependants by age



Source: Productivity Commission estimates based on unpublished DVA data.

⁷ This section uses demographic data on DVA clients that was current at December 2017 — the latest available to the Commission prior to finalisation of the draft report.

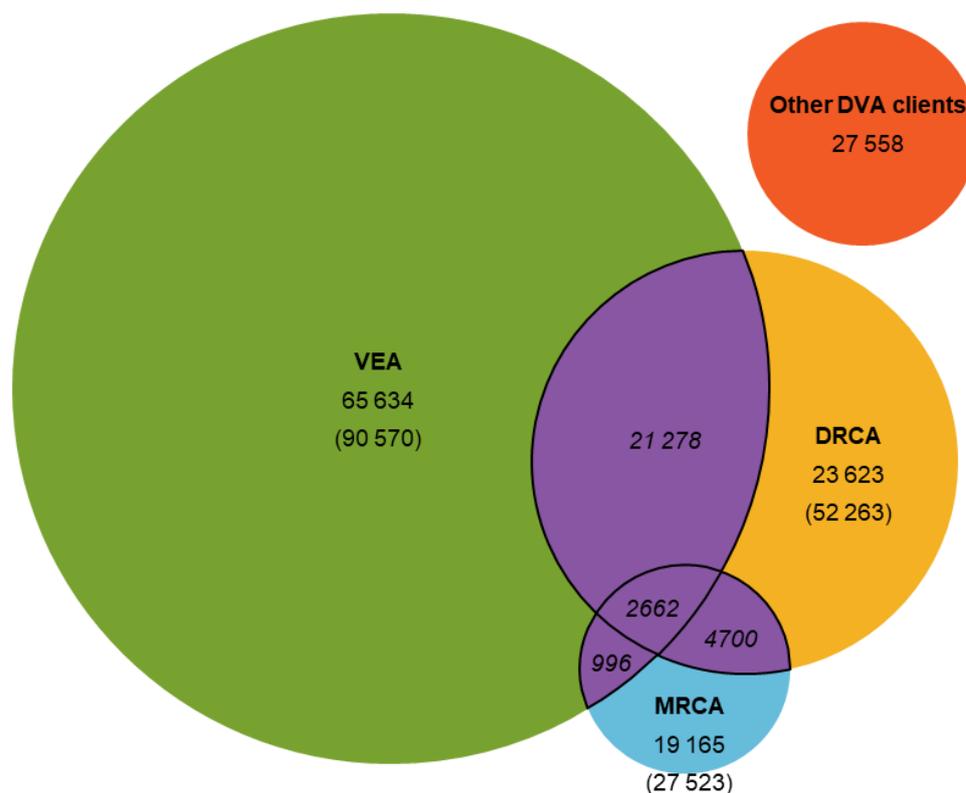
DVA’s client numbers have been falling since about 2000 and are expected to continue to do so until at least 2030. This mainly reflects that the cohort of older veterans and widows of World War Two veterans is shrinking rapidly (discussed below).

Commenting on its changing client base, DVA said ‘this change ... has created both more intensive health needs of an older, but declining, cohort, and more complex needs to younger cohorts’ (sub. 125, p. 14).

DVA clients — what Acts are they covered by?

More than 90 000 veterans have conditions accepted under the VEA, about 52 000 under DRCA and about 28 000 under MRCA (figure 3.5). Many veterans (about 30 000) have accepted conditions under multiple Acts — the majority of these are veterans with claims under both VEA and DRCA (21 278).

Figure 3.5 **Veterans (DVA clients) with accepted conditions by Act^{a,b,c}**
As at June 2017



^a A DVA client with an accepted condition is a veteran with an injury or illness that DVA has accepted is related to service. ^b These figures do not align precisely with the figures in the latest DVA annual report.

^c Numbers in brackets are the total number of people under an Act, including those that are also eligible under other Acts.

Source: DVA (sub. 125, p. 25).

Expenditure on entitlements under the three Acts

The breakdown of expenditure under the three Acts is different depending on whether you look at cash outflows only or include changes in DVA's liability for future expenditure under MRCA and DRCA (as DVA includes in its expenditure figures in its annual reports).

Based on actual payments (and excluding departmental expenses), the VEA's share of expenditure is 91 per cent of all DVA expenditure (figure 3.6). This pattern is evident in both major categories of DVA expenditure.

- *Health care, attendant care and rehabilitation*: about 96 per cent of DVA's funding in this category is under the VEA. This reflects the older profile of VEA clients, that almost all Gold Card holders (about 98 per cent) are under the VEA⁸ and that non-liability health care (although available to all) is legislated in the VEA (Commission estimates based on unpublished DVA data; DVA 2018am).
- *Compensation and income support*: the vast majority (about 87 per cent) of funding in this category is also under the VEA. This mainly reflects the larger cohort and the fact that income support for MRCA clients is legislated under the VEA (Commission estimates based on unpublished DVA data).

A further breakdown of the different programs funded under VEA is provided in figure 3.7.

Outlays under the other Acts are smaller — \$717 million for MRCA and \$204 million for DRCA in 2017-18 (unpublished DVA data). For MRCA clients:

- compensation for pain and suffering (the 'permanent impairment' category) accounted for over half of all MRCA expenditure
- compensation for lost wages ('incapacity payments') and health care/rehabilitation each accounted for about a fifth of spending
- about 2 per cent of MRCA spending was on dependant benefits (unpublished DVA data).

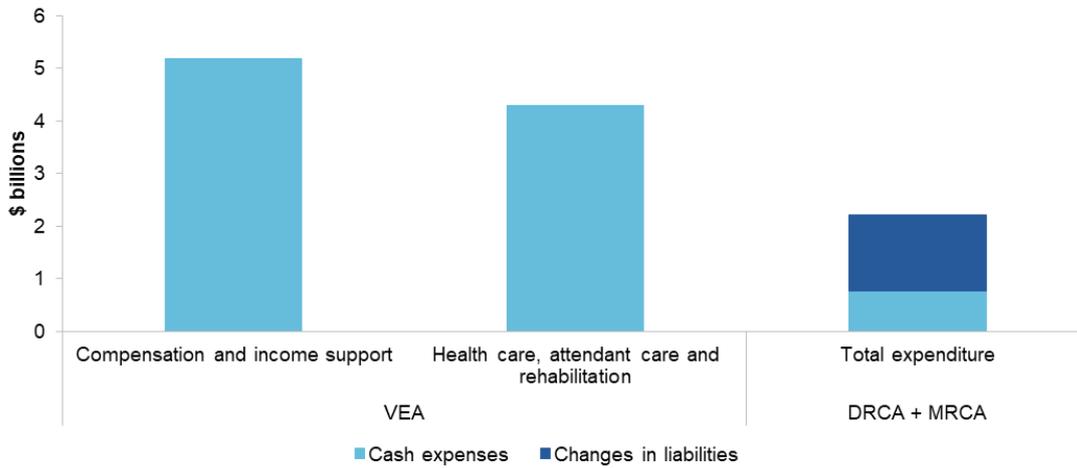
The pattern of DRCA outlays is similar to that for the MRCA.

However, the proportion of DVA's costs attributable to the MRCA and DRCA is higher when the changes in the liability under these Acts for future expenditure (relating to service up to June 2018) are included (dark blue column extension, figure 3.6). With these, the MRCA and DRCA together account for about 25 per cent of DVA's costs. The MRCA is relatively new and most of the expected costs that have been accounted for in the liability provisions (relating to previously rendered service) will not eventuate for decades.

⁸ The most common eligibility pathways for the Gold Card are via qualifying service/age and being a dependant of a deceased veteran (under various circumstances). Each of these are concentrated in older cohorts of DVA clients.

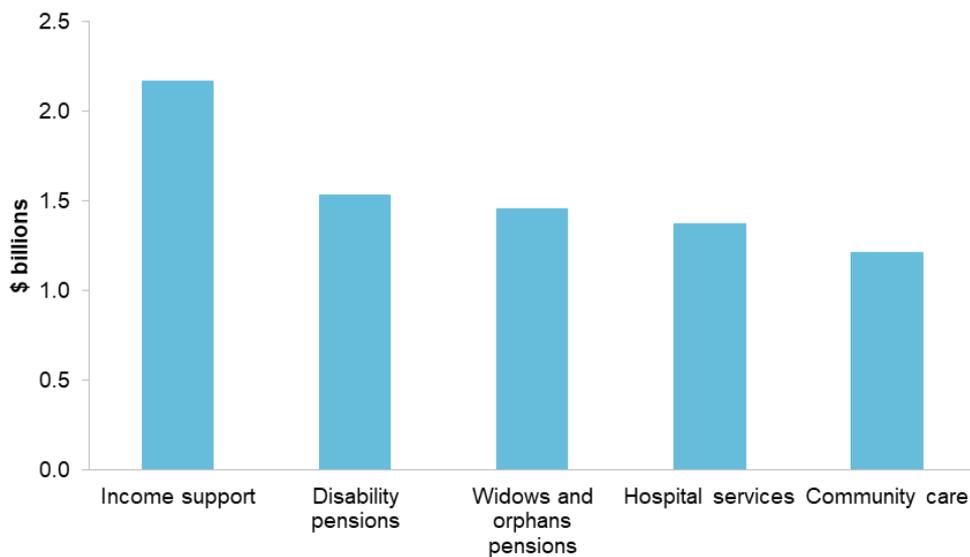
In the remainder of this chapter, when expenditure under the three Acts is discussed, the change in liabilities under the MRCA and DRCA are not included, in part because equivalent figures are not available for liabilities under the VEA.

Figure 3.6 Costs under VEA and other Acts
2017-18



Source: Productivity Commission estimates based on unpublished DVA data.

Figure 3.7 Spending on VEA programs
2017-18



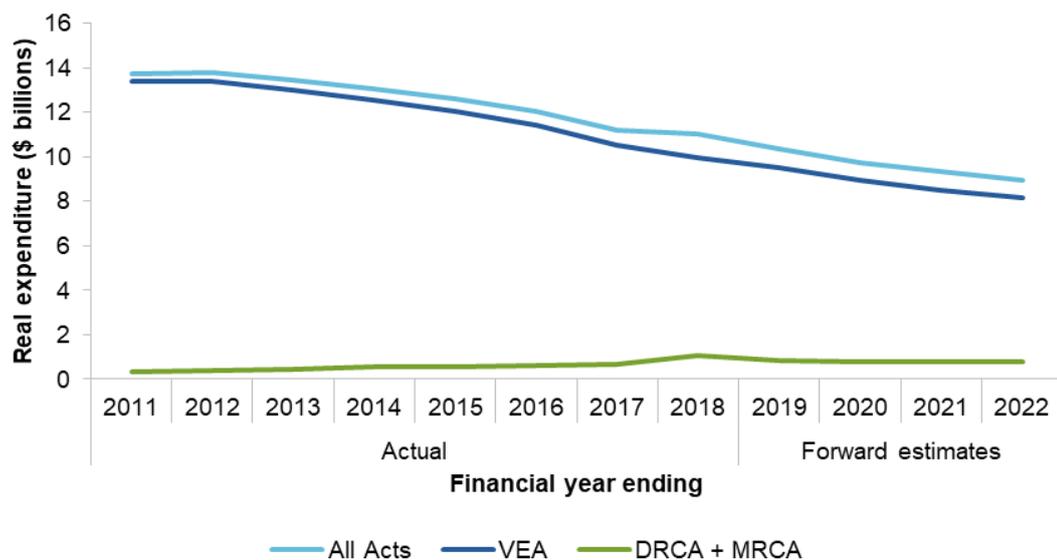
^a Excluding departmental costs.

Source: Productivity Commission estimates based on unpublished DVA data.

What do we know about costs going forward?

The total cost (in cash outlay terms) of supporting veterans and their families has been falling since about 2011-12, with this almost entirely being driven by declining VEA expenditure. VEA expenditure has fallen by 25 per cent in real terms between 2010-11 and 2017-18 — a trend that is projected to continue (figure 3.8). Over the same period, MRCA and DRCA cash expenditure together roughly tripled (in real terms). However, MRCA and DRCA expenditure is still much smaller than VEA expenditure, and the latter Act is likely to be the most expensive piece of veteran support legislation for quite some time — the VEA is expected to still account for about 91 per cent of all DVA cash outlays in 2021-22 (the latest year for which forecasts are currently available).

Figure 3.8 **Spending on veteran support is falling**
Real cash expenditure on veteran supports excluding commemorations^{a,b}



^a Adjusted for Consumer Price Index inflation using ABS (*Consumer Price Index, Australia, Sep 2018*, Cat. no. 6401.0) for historical data and for forward estimates by the assumed inflation rate of 2.5 per cent which is the Reserve Bank of Australia's medium term target. ^b Includes department expenses.

Source: Productivity Commission estimates based on DVA (2011a, 2012, 2013b, 2014d, 2015d, 2016h, 2017n, 2018ab).

The falling client base is driving lower total costs

While an array of factors influence DVA's costs (box 3.6), the key driver of the recent decline in DVA expenditure is its shrinking clientele — even though the decline in the number of clients precedes the recent fall in costs (figure 3.9).⁹

⁹ This may be due to the effects of age-based eligibility for some DVA benefits, including the service pensions and the Gold Card, which may have increased costs as clients aged.

Box 3.6 What drives the cost side of the equation?

The main cost drivers of the veteran support system are the number of clients (veterans and their families) and the cost of providing clients with support. The largest source of costs in the short-term will be the large existing clientele, from older conflicts, but going forward it is the flow of new clients of recent military service that will determine scheme costs.

The future number of DVA clients has two drivers:

- new clients *entering* the system by making claims — typically years after the point of injury or exposure causing illness
- clients *exiting* the system, predominately as clients die.

The cost of providing supports to DVA clients depends on the age of the claimant, assessed impairment points, lifestyle rating, whether the incident resulting in the impairment is related to operational service or not, and the unit cost of supports (the cost of health care and rehabilitation) (AGA 2018b).

Claims can be from new clients and existing clients (with additional claims).

The flow of new claims into the system, by both new and existing clients, is affected by a number of factors:

- underlying incidence of injury, illness and death arising from military service
- the awareness of supports
- the ease of putting in claims
- changes in healthcare needs (due to ageing for example)
- economic conditions that can affect a veteran's financial needs.

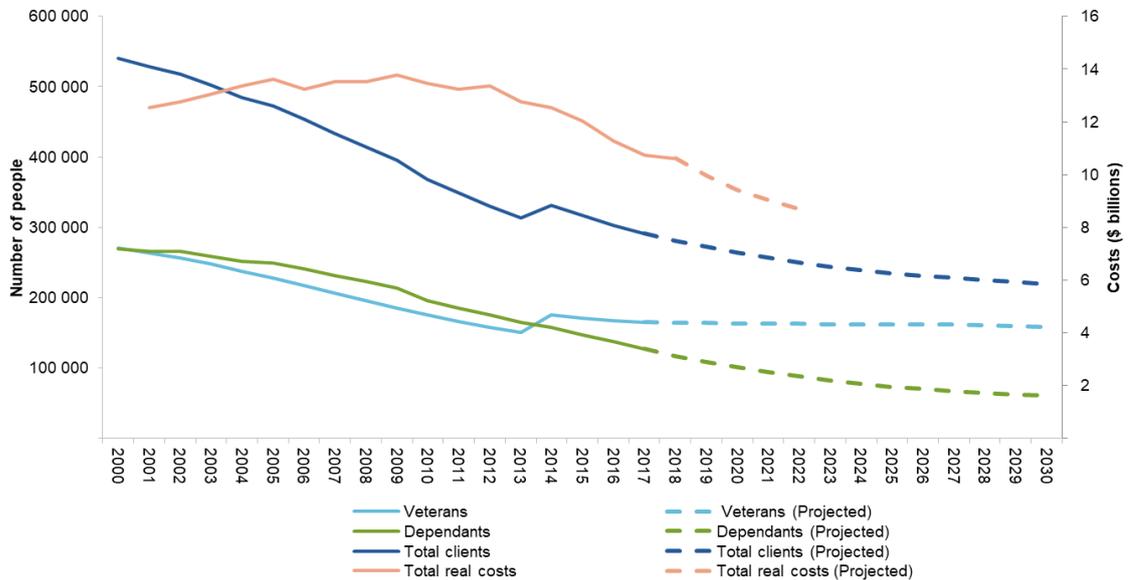
As with the changes in expenditure noted above, the changes in client numbers varies under the different Acts:

- we are seeing a significant reduction in total number of clients supported under the VEA — mainly a sharp decrease in the number of dependants (especially widows of World War II veterans), whereas the number of veterans supported under this Act is declining relatively slowly
- the number of veterans supported under the DRCA and MRCA is rising rapidly (although the number of dependants with entitlements under these Acts is increasing very slowly).

Overall, the declining number of clients under the VEA is far exceeding the increasing number of clients under the DRCA and MRCA (figure 3.10). This decline in client numbers is expected to slow but will continue until at least 2030. The number of widows will continue falling faster than the fall in veterans until at least this date.

Figure 3.9 DVA client numbers and expenditure is falling

Veteran and dependant clients, and real cash costs^a

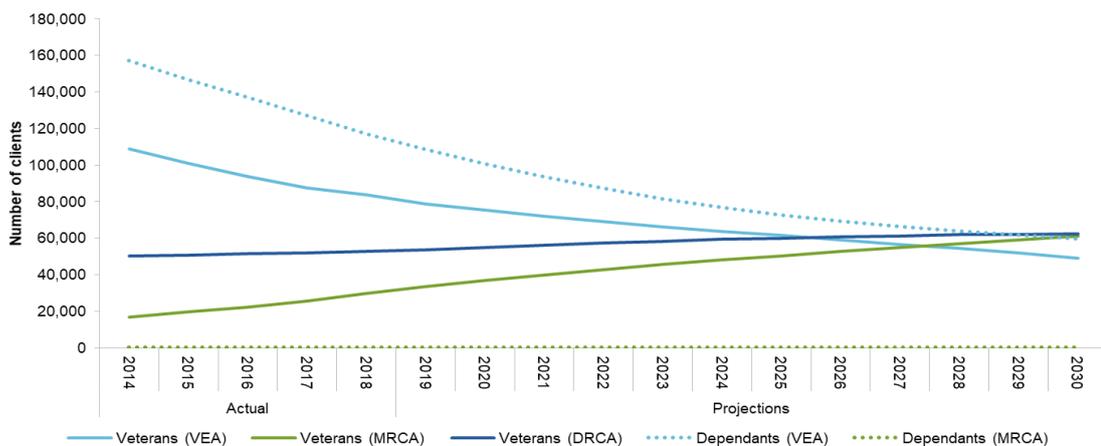


^a Using ABS (*Consumer Price Index, Australia, Sep 2018*, Cat. no. 6401.0) to adjust for inflation in historical data. For forecasts, inflation was assumed to be the mid-point of the Reserve Bank of Australia’s medium-term inflation target (2.5% each year). Costs are cash expenditure excluding accruals, commemorations and departmental expenses, and so may differ from the figures in DVA annual reports.

Source: Productivity Commission estimates based on DVA (2018ab, pp. 30, 43) and unpublished DVA data.

Figure 3.10 VEA veterans will remain clients for a long time

Actual and projected veterans^a and dependants^b by Act



^a Total veterans under the VEA may be underestimated due to some, with multi-eligibility, being counted under the other Acts. ^b DVA does not (typically) report on the number of dependants under the DRCA.

Source: DVA (2018m).

Estimates suggest the aggregate cost of new injuries is increasing

While DVA's total client numbers and total cash costs are falling and will continue to do so for some time, recently there has been an apparent increase in the expected cost of supporting veterans injured during recent service, under the MRCA, which has potential implications for the cost of the system going forward.

The Australian Government Actuary (AGA) prepares an annual report on the nature and quantum of its liabilities relating to compensation for military personnel injured in the course of duty (for claims under MRCA and DRCA). The AGA estimates an annual 'notional premium' that represents the expected cost of new compensation for all claims that will arise from service rendered in the following year (as a share of military payroll).

Estimating future costs for any system presents a number of challenges because of limited data. And, as highlighted by the AGA, there are a number of features of the military compensation system that add significant uncertainty into any estimates of future cost (compared with other workers' compensation schemes):

- the risks faced by ADF personnel depend on external factors, most notably the Government's national and international security policies
- the unique nature of military service which involves an unavoidable exposure to high levels of risk
- the absence of any limit on the period in which a claim must be made
- the more generous nature of support provided under some heads of damage, most notably medical services.

Also, in actuarial terms, MRCA is far from fully mature with experience limited to at most thirteen and a half years after the injury date. This is in the context of payment obligations that could continue for 50 or more years after the injury date (entitlements are still being paid by DVA for dependants of World War I veterans). The AGA also does not have access to detailed Defence data about injuries suffered by service members. As the AGA put it:

It needs to be remembered that the estimates given in this report are actuarial central estimates. This means, in broad terms, that the estimates should be just as likely to be too high as too low. However, the true liability cannot be known and the range of factors which might impact on future claim numbers and sizes means that estimates presented here are subject to considerable uncertainty.

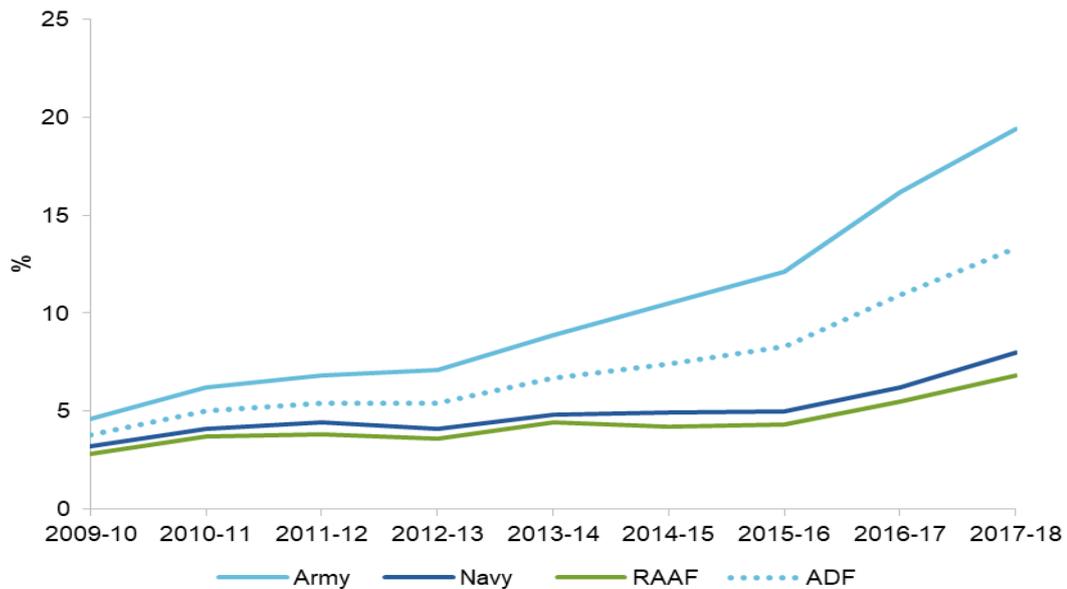
The very long term over which these liabilities will be paid out makes the results very sensitive to relatively small changes in assumptions. This is particularly the case for payments that are expected to persist over an extended period, such as long-term incapacity and medical expenses. (AGA 2018a, pp. 13–14)

With these caveats in mind, the AGA's estimate of the MRCA liability associated with new injuries that would be caused by service in 2017-18 was about 30 per cent higher than the previous year (in nominal terms). Over the last five years, it has increased in both nominal

terms (from about \$280 million to \$800 million) and as a share of military payroll (from about 5 per cent to 13 per cent) (AGA 2013, p. 102, 2018a, p. 138; figure 3.11).

Figure 3.11 Cost of injury rising over time — notional premiums^a

Estimated liabilities created by service in the coming year divided by forecasted payroll (per cent)



^a Notional premiums are estimated using DVA claims data from DRCA/SRCA and MRCA.

Data source: AGA (2013, 2014, 2015, 2017, 2017, 2018a).

There are a number of potential reasons for this rise in the estimated cost of new injuries to the DVA system (box 3.7).

Box 3.7 What is driving the increasing expected cost of injuries?

Excluding changes in interest rates, which have no impact on actual outlays, there are several potential drivers of the increased expected cost of new military injuries.

Increasing number of claims under DRCA and MRCA

New initial liability claims under the DRCA and MRCA have increased significantly — on average over 20 per cent per year over the last five years (2012-13 to 2017-18) (calculated from DVA (2014b, 2015c, 2016b, 2017d, 2018f)). The Australian Government Actuary (AGA) pointed to a number of new Department of Veterans' Affairs (DVA) initiatives that could be driving up the number of claims, including:

- enabling claims to be submitted online
- the use of on-base DVA advisers
- closer liaising between the ADF and DVA
- enabling veterans to claim for multiple conditions using the one form (AGA 2018).

Other changes that could be impacting on claims include the new automatic acceptance of claims under some circumstances ('straight-through' and 'streamlined' processing — chapter 8), the recent launch of the 'MyService' online portal — chapter 9) and a reduction in the time DVA takes to process most types of claims (DVA, sub. 125, pp. 79, 86).

Increasing medical expenditure

The AGA estimates of the lifetime liability associated with the medical cost of new injuries have risen on average 55 per cent each year over the last five years (calculated from AGA (2013, p. 102, 2018a, p. 138)). The AGA noted that the increase in the estimated liabilities has been driven by a relatively small increase in medical outlays, and reflects the life-long nature of medical expenditure. This increase in outlays is likely to be partially driven by increased number of Gold Cards issued under the MRCA — from about 600 to 2300 over four years (DVA 2018am) — although the AGA has difficulty attributing these costs to particular dates of injury. (On examining the distribution of claims severity, the AGA (2018a, p. 70) also found a pronounced peak at 51 impairment points — achieving an assessment of at least 50 impairment points can allow access (for some) to the Gold Card and other benefits — chapter 12.)

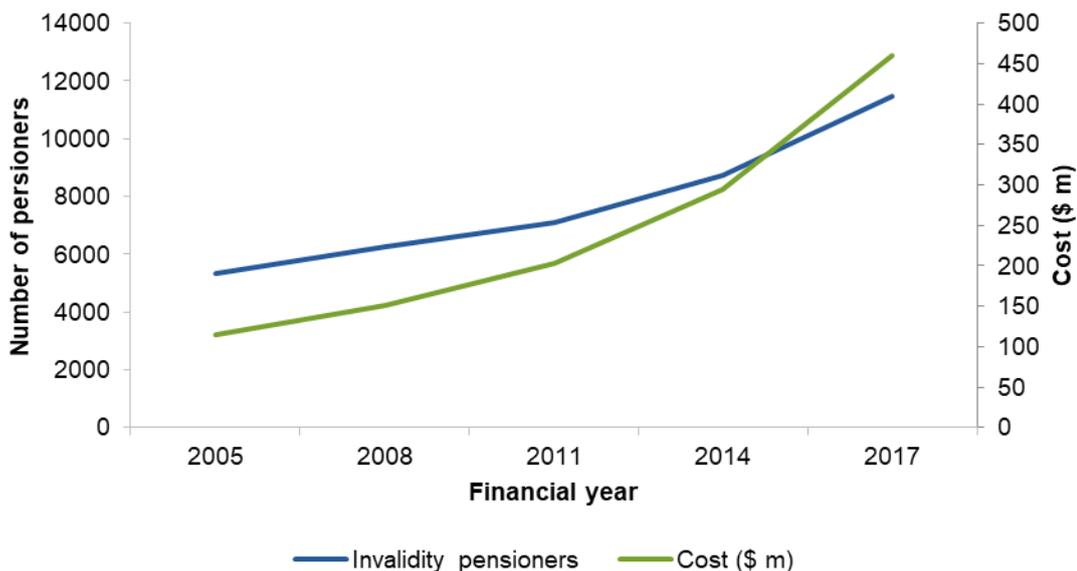
Increasing aggregate cost of permanent impairment payments

The AGA estimates of the lifetime liability associated with impairment payments for new injuries have risen, on average, 36 per cent each year over the last five years. The increase in permanent impairment costs follows a similar pattern to medical costs but is less pronounced. This difference partially reflects that permanent impairment costs are capped under the MRCA while healthcare expenditure is potentially unlimited. Another factor driving the increase in impairment payment costs seems to be the tail end of the Afghanistan conflict, which has increased the proportion and number of claims relating to operational service. Impairment payments relating to operational service are more expensive both because the average level of impairment is higher for these claims and because the payment rates for all levels of impairment incurred through operational service (up to a certain level) are higher (AGA 2018b; chapter 13).

Costs and client numbers of military superannuation insurance are also increasing

Since 2005, there has been a fourfold increase in the nominal cost of pensions under the superannuation insurance system, partly due to a doubling in the number of invalidity pensioners under the system (figure 3.12). The increased number of pensioners is partially explained by the doubling in the number of veterans being medically discharged between 2007 and 2017, including mental health discharges — recommendations for medical discharge due to post-traumatic stress disorder (PTSD) and depression roughly tripled over this period (DVA and DoD 2018, p. 29; Joint Health Command 2017, p. 23).

Figure 3.12 **Number of invalidity pensions^a and their total cost**



^a Numerous widows of invalidity pensioners are also receiving 'reversionary pensions'.

Source: AGA (2006, p. 8, 2009, p. 20, 2009, p. 20, 2012, p. 14, 2015, p. 20, 2018b, p. 15).

The costs are growing partly because more veterans are receiving Class A invalidity pensions rather than Class B — the proportion of new pension commencements that are Class A has increased from 50 to 70 per cent since 2005 (figure 3.13). As they are intended for individuals with little to no capacity for civilian work, Class A pensions provide a higher stream of payments than the Class B pensions, which are meant to supplement civilian income. Factors that may have increased the number of invalidity pensions and the higher proportion of Class A pensions include:

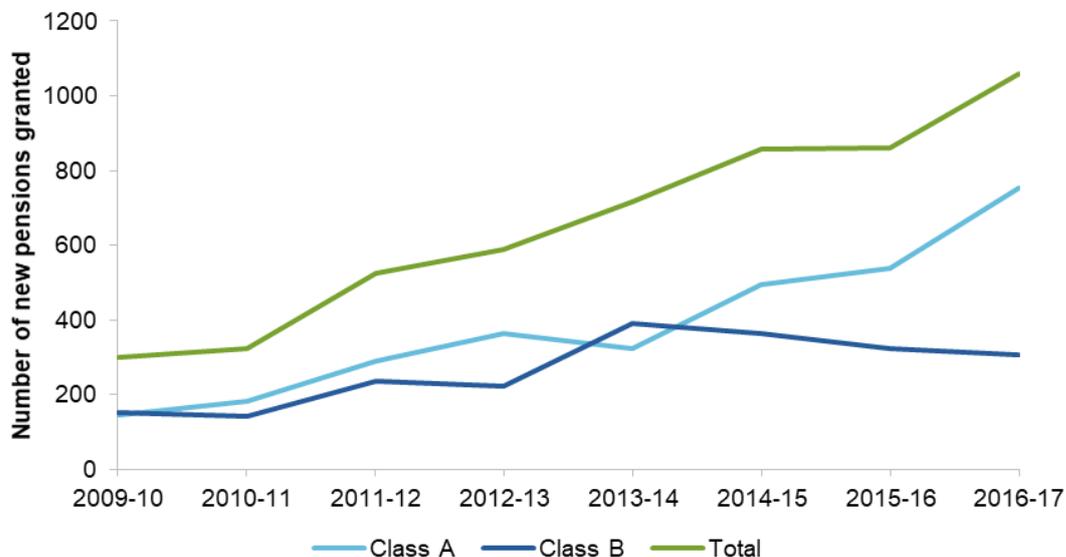
- increasing acknowledgment of PTSD and other mental health conditions
- Defence has encouraged earlier reporting of injuries and incidents. This may have made individuals more aware of military compensation payments and invalidity pensions, and may in turn have made it more acceptable to claim these benefits

- a higher number of ‘retrospective medical discharges’ — where members were discharged for other reasons but later apply to be reclassified as a medical discharge.
- the slowdown in the pace of overseas deployments — people who may have been concealing injuries in order to go on deployments may come forward when this possibility is closed off (AGA 2018b, pp. 25–27).

The AGA believes that some of the reasons for the increase in the number of new invalidity pensions may be transitory — including increasing awareness of benefits and the slowdown of deployments — and will not be repeated into the future (AGA 2018b, p. 27).

In addition, the Commission notes that increases in invalidity pensions could also have been partially driven by the increased proportion of discharges that are medical (from 9.5 per cent to 18.3 per cent between 2007 and 2017) and, as noted above, there has been an increased number of recommendations for medical discharge associated with PTSD and depression (DVA and DoD 2018, p. 29).

Figure 3.13 New invalidity pensions granted each year
Divided into Class A and Class B



Data source: AGA (2018b, p. 24).

The AGA estimated a ‘notional contribution’ of 21.6 per cent for the new (beginning 2016) ADF Cover scheme — the insurance component of ADF Super — and this is expected to rise to about 30 per cent. This corresponds to a notional premium of around 18 per cent¹⁰ as

¹⁰ More precisely, the ‘notional contribution’ would need to be discounted by about 10 per cent to get the ‘notional premium’ due to definitional differences between superannuation salary (which is the denominator of the former) and payroll (which is the denominator of the latter).

a proportion of payroll. This compares to the 13.3 per cent notional premium calculated for benefits offered by the DVA under MRCA (above).

These premium and contribution calculations rely on AGA projections of future claiming behaviour, using claims data on invalidity pensions and liaison with the Commonwealth Superannuation Corporation and DoD. They embody assumptions about future trends in factors, including the pace and intensity of overseas deployment and the impact of workplace health and safety practices in the military. The resulting uncertainties mean that, while policy makers need to be cognisant of the AGA estimates, they should also interpret and use them with care.

4 Objectives and design principles

Key points

- The Australian Government is committed to supporting veterans and their families who are affected by service. This commitment, or ‘duty of care’, covers members both in-service and beyond.
- The overarching objective of the veteran support system should be to enable veterans and their families to live normal and meaningful lives by improving their wellbeing, taking a whole-of-life approach. This has, at its core, minimising the harm from service to veterans and their families, and should be achieved principally by:
 - preventing and minimising injury and illness
 - restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in employment and life
 - providing effective transition support for veterans and their families
 - enabling opportunities for social integration
 - providing adequate and appropriate compensation for veterans (or if the veteran dies, their family) for pain and suffering and lost income from service-related harm.
- This objective should be achieved while ensuring supports are provided in the most effective and efficient way. Taking a whole-of-life approach is important for getting the best outcomes for veterans and their families and ensuring an affordable and sustainable system.
- The key principles that should underpin a modern veteran support system are that it be: wellness focused (*ability* not disability), equitable, veteran centric, need- and evidence-based, administratively efficient, affordable and sustainable, and responsive to the unique needs resulting from military service.
- These objectives and principles are consistent with best practice workers’ compensation and contemporary social insurance schemes (the focus being on wellness, return to work, person-centred supports, long-term costs and sustainability).
- Distinctions between different types of military service for the purpose of compensation are inequitable and should be removed or reduced where practical and cost-effective.
- History, and the Australian Government’s longstanding commitment to supporting and reintegrating into society those affected by their military service, explains why there is a separate and beneficial veterans’ system. The unique needs of veterans and their families, including in relation to transition and mental health, also justify some bespoke, well-targeted services.

The Commission has been asked to look at whether the system of compensation and rehabilitation for veterans is ‘fit for purpose now and into the future’. It has also been asked to look at whether the arrangements reflect best practice in the context of workers’ compensation arrangements (both locally and internationally).

Understanding the objectives of the veterans' compensation and rehabilitation system is an important first step to determining how well the current system is performing and what an improved system would look like. Section 4.1 explores the issue of what the objectives of the veteran support system should be. Section 4.2 looks at best practice workers' compensation and contemporary social insurance schemes for insights on system design and underlying principles for effective support systems. Section 4.3 discusses some policy design issues.

4.1 What should the objectives of the veteran support system be?

A longstanding commitment to support those affected by service

Support for serving members and their families is widely regarded as a condition of service. Australians serve in the Australian Defence Force (ADF) knowing that they could be injured, or they may die, as a result of their service, and expect (like anyone who is employed) that they (or their family) will be supported in the event of a work-related injury, illness or death.

The Australian Government is committed (and has been since World War I) to supporting, and reintegrating into society, those who are affected by their service in the ADF (box 4.1). The Prime Minister Billy Hughes first made this commitment to the Australian troops when he stated at the 1917 Premiers' Conference that:

We say the care of the returned soldier is one of the functions of the Commonwealth Government. ... They go out to fight our battles. We say to them: 'When you come back we will look after you' ... (Hughes 1917, cited in Lloyd and Rees 1994, p. 69)

Bob Hawke, when he was Prime Minister, also commented that the Australian Government:

... firmly believes that we should be generous in our treatment to those who have suffered disabilities because of their participation in war and in the treatment of the widows and orphans of those who have died as result of war service. (Hawke 1985, cited in Clarke, Riding and Rosalky 2003, p. 96)

And more recently, Darren Chester, the Minister for Veterans' Affairs, said 'I recognise the Australian community has a clear expectation that veterans and their families will be well looked after' (Chester 2018f, p. 9688).

Many participants to this inquiry also spoke about the Government's commitment to veterans and the recent announcement of a military covenant confirm this commitment to supporting ADF personnel and veterans (box 4.1; Morrison and Chester 2018b).

In effect, the Australian Government has made a social contract with serving personnel that, in return for their service, they (and their families) will be looked after if they incur a service-related injury, illness or death. This social contract, or acceptance by the Australian Government of a 'duty of care' to veterans for service-related injuries and illness (while they

are in service and beyond), could influence recruitment and retention of ADF members. As the Royal Australian Armed Corps Corporation said, the many speeches by members of government over a hundred years are:

... a comprehensive, unequivocal statement by the Government of Australia that it owes a duty to those who serve this country and that the binding duty to adequately provide for injured veterans, veterans' widows and dependents is a burden that this country has and will continue to be borne. (sub. 29, p. 7)

The Department of Veterans' Affairs (DVA) also said:

... a fundamental role of DVA has been the provision of a substantial part of the 'offer' that is made by the nation to each service member prior to and on enlistment. This offer recognises the willingness of the enlistee to commit to service, be subjected to military discipline, and to be placed in harm's way for Australia. In return, the Australian Government will look after them, including when they leave service. (sub. 125, p. 3)

Box 4.1 A commitment by Australians to veterans and their families

A number of participants to this inquiry referred to the commitment of the Australian Government to provide for injured or ill veterans, and for veterans' widows and dependants.

Vietnam Veterans' Federation of Australia:

No other Australian is expected to, or may be directed to, engage in war or war-like activity either within the country or overseas to defend their nation's interests. For almost a century this exclusivity has been recognised by Australian Governments and the citizens and justified by unique and specific Acts of Parliament which provide continuing support to veterans. (sub. 34, p. 11)

War Widows' Guild of Australia:

The member who joins the military commits to perform a service which will maintain the security of our country. They are obliged to serve this country at the behest of this country's political leaders with little or no ability to refuse.

We join the Alliance of Defence Service Organisations (ADSO) call to ensure that all levels of government honour the social contract with the veteran and their family. This country must commit to ensure that the veteran and his/her family are well supported following service with compensation or pensions that ensure that the standard of living is not below the poverty line. (sub. 87, p. 1)

Giselle Fleming:

The Australian government has a responsibility to ensure it supports the people, families and communities who have chosen to serve their country. (sub. 33, p. 2)

Veterans' Advisory Council and the Veterans' Health Advisory Council:

As we exit the centenary of Anzac commemorative period, consideration of a Veterans'/Military Charter or Covenant is appropriate as an agreement of responsibility and trust between all service personnel, the government and the people of Australia. This would be a no cost to budget action, and will provide the moral and legal grounds to provide the government guarantee to all veterans' services. (sub. 96, p. 4)

Sacrifices made by serving members on behalf of the community are also recognised through a range of dedicated avenues. These include remuneration, commemorations such as the annual Anzac Day public holiday and related ceremonial activities, war memorials and installations, the maintenance of war graves, and honour rolls (chapter 2).

The community also shows appreciation by donating to ex-service organisations, and by showing respect for service when directly interacting with members of the veteran community.

And, as discussed in chapter 2, Australia has had a separate veteran support system for over a hundred years. DVA, commenting on the objectives of the current veteran support system, said it was:

... to provide support to those who serve or have served in the defence of our nation (and to their families), when they have been injured, suffered illness, or have died in or as a result of their service.

Ensuring that veterans who leave service are, with their families, fully able to participate in civilian life, and can thereby enrich our communities, is one of the highest aims for any system of military compensation and rehabilitation. (sub. 125, p. 1)

While DVA acknowledged the longstanding commitment of the Australian Government to supporting veterans, it also said that ‘such longstanding acceptance should not and does not confer immunity from examination as to relevance and appropriateness’ (sub. 125, p. 2).

Improving wellbeing should be the overarching objective

When thinking about what the objectives of a veteran support system for the future should be, the key question is — how can the Australian community best support or best meet the needs of veterans?

When we asked participants to this inquiry what the objectives of a future system for supporting veterans should be, many said they should be about improving the lives or wellbeing of veterans and their families. Many also said that the system should take a long-term and ‘holistic’ approach to supporting veterans. For example:

- the Department of Defence (DoD) said that ‘the priority objectives for veteran support should be to ensure the long-term wellbeing, successful rehabilitation and transition for veterans into civilian life’ (sub. 127, p. 4)
- the Veterans’ Advisory Council and the Veterans’ Health Advisory Council said ‘every effort must be made to ensure that those who have entered the profession of arms can access appropriate health, mental health, welfare, compensation and rehabilitation services both during and after their service obligation. Access to services should be streamlined, intuitive, and non-confrontational’ (sub. 96, p. 2)
- Maurice Blackburn Lawyers said ‘the military compensation scheme, including the legislation and administration of the scheme by the DVA, should take “an holistic approach to injured personnel by integrating the safety, rehabilitation, resettlement and compensation elements”’ (sub. 82, p. 4).

Another common theme from submissions was that the veterans' system should recognise the unique nature of military service and be focused on rebuilding lives or returning military personnel back to their former state (where possible).

- The Air Force Association said 'Any compensation and rehabilitation system for veterans and their families must be "fit for purpose", recognising the unique nature of military service. Its principal aim is to return the veteran who has suffered injury or illness due to service duty to his/her former physical and/or mental health state and when this is not possible provide life-long treatment and financial support' (sub. 93, p. 6).
- The Defence Force Welfare Association (DFWA) said: 'If the member was broken due to military service to the Nation, then the Nation has a moral obligation to restore and financially support the person to an "as new" condition as possible. In no other occupation can a person be deliberately put in harm's way' (sub. 118, p. 31).
- The Returned & Services League (RSL) Australia argued that 'The primary objective for an ADF member who has suffered an injury or disease should always be a return to health and a return to work, as this is the best outcome for the member's physical and mental health, their family, the ADF and any future employers' (sub. 113, p. 3).

It is also the Commission's view that the overarching objective of the veteran support system should be about improving the wellbeing of veterans and their families. The system should have at its core minimising harm to veterans from military service and rebuilding lives affected by service. And as with all other government programs, the support system should achieve this objective while ensuring value for money for the Australian community and providing supports in the most effective and efficient way. This includes avoiding unnecessary and costly duplication of services and ensuring that funding provided to improve the lives of veterans is focused on the areas where it can have maximum impact.

A number of participants also pointed to the importance of ensuring both good outcomes for veterans while ensuring value for taxpayers' money (box 4.2).

The Commission also agrees that, when thinking about the wellbeing of veterans and their families, and the costs to the community (or taxpayers) of supporting veterans, it is important to take a long-term or whole-of-life approach. This is important for getting the best outcomes for veterans and their families and for ensuring an affordable and sustainable system.

The *Defence Mental Health and Wellbeing Strategy 2018—2023* already recognises the need for a whole-of-life approach to supporting ADF members. The vision for this strategy is that Defence personnel will be '*Fit to Fight, Fit to Work, Fit for Life*' and that Defence will:

... lead a whole-of-organisation approach to mental health and wellbeing, from time of recruitment, through military and public service careers and through to transition and life beyond Defence. (DoD 2017h, p. 6)

DVA also acknowledges that a core issue 'as it progressively implements the veteran-centric model will be the extent to which it focuses on the *whole-of-life wellbeing* of veterans', and that this is not its current focus:

If this were to be DVA's central tenet for its operations, it would reflect a philosophical move away from focusing on payments, benefits and compensation, to a stronger focus on veterans' health, wellbeing, rehabilitation and productivity. (sub. 125, p. 18)

A whole-of-life approach involves taking into account each of the life stages of military personnel — recruitment, in-service, transition and ex-service (figure 4.1).

- When members are serving, preventing injury or illness is critical to minimising the harm to veterans from service and the lifetime costs of injuries and illnesses to the compensation and rehabilitation system (this is in the context of the unique occupational risks associated with military service, chapter 2).
- In all the lifestyle stages, timely, appropriate and effective rehabilitation and health care is important for minimising harm (or costs) to veterans and their families and taxpayers. Early and effective rehabilitation can reduce the overall cost of care, the number of medical discharges and the need for compensation.
- Timely and effective transition support in-service, during transition and post-service are also important because the way members make the transition from military to civilian life can affect their longterm wellbeing (for example, if veterans are poorly prepared for transition they can experience poor mental health and long periods of unemployment). Post-service, some veterans may develop service-related conditions and need timely access to supports (such as health care, rehabilitation and compensation) to minimise harm — this points to the importance of a sustainable system — veterans want assurance that supports are available if, and when, they need them.

Box 4.2 Good outcomes for veterans *and* value for money matter

Slater + Gordon Lawyers:

There have been a number of budget allocations in the last two years designed to improve their [DVA's] services. My fear now is that there will be a lack of auditing to ascertain whether these significant budgetary increases will actually provide a positive change to veteran support services. Without an auditing process, valuable taxpayer dollars could be wasted without any accountability or redress. This is of serious concern to me as I am faced, on a day-to-day basis, with the consequences of what the system can do to injured veterans and their families. (sub. 68, p. 10)

Employers Mutual Limited:

Constantly reviewing the quality of providers and the effectiveness of treatments being administered is essential. If this does not happen, DVA risks funding redundant treatments, which does not benefit either the veteran or DVA's bottom line. (sub 90. p. 6)

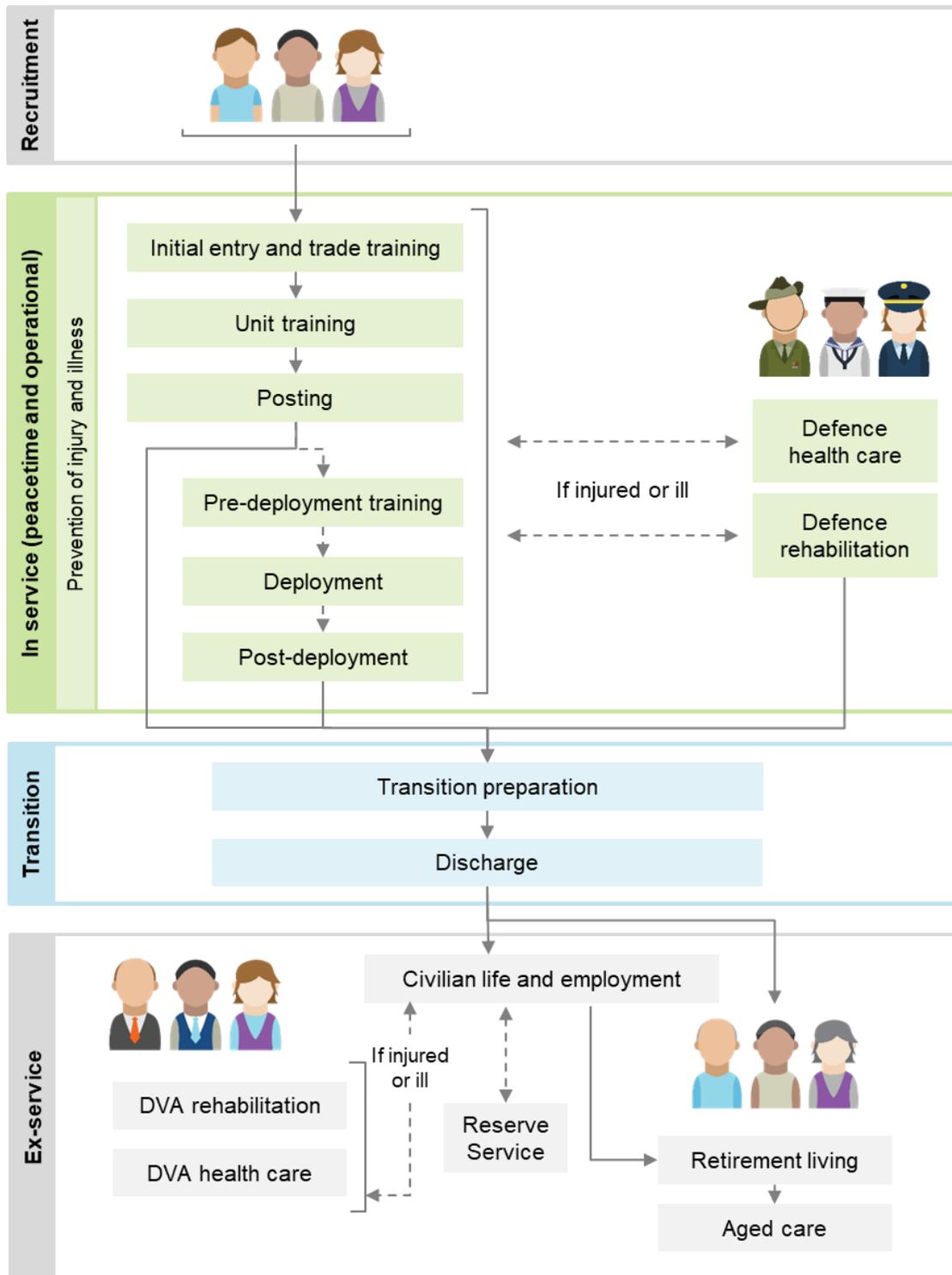
Stephan Rudzki:

Both Defence and DVA spend considerable sums of money on the provision of external medical services, but I am unaware if there has been any determination of the cost effectiveness of those services in terms of reduced morbidity and improved employment outcomes. (sub. 40, pp. 4—5)

Returned & Services League NSW said that one of pressing requirement is:

Minimisation of inefficient spending (on everything from one-size-fits-all medical treatments to DVA offering services already provided by ESOs [ex-service organisations]) as a means of maximising both well-being of veterans and their families, and value for taxpayers. (sub. 151, p. 5)

Figure 4.1 Life stages of military personnel



What do we know about what is important for veterans' wellbeing?

To design a future support system that has at its core improving the lives of veterans and their families, it is important to understand what is important for their wellbeing.

When we asked about veterans' needs and what was in their best interest, participants said that veterans' needs (which for the most part have not really changed over time) cover the following broad areas:

- health care for injuries and illnesses sustained during service
- rehabilitation, including vocational re-training
- transition support, including support to adapt military skills to civilian life
- income support
- social support from families and others (box 4.3).

That said, since the system's inception (about 100 years ago) knowledge about how to best respond to veterans (and the general community's) needs has broadened significantly.

Box 4.3 What participants said about veterans' needs

Stephan Rudzki:

Veterans' needs remain unchanged. They require ongoing health care for injuries/illnesses sustained during service. They want to be working as best they are able. They require income support if they are unable to work. But employment is a key component of health and well-being, and specific efforts should be addressed to assist transitioning members to obtain employment. (sub. 40, p. 1)

TPI Federation Australia:

The system of Veterans' support should provide the Veteran with their full entitlements under the various Acts to ensure for the welfare, medical, and financial support to allow the Veteran to live a life commensurate with any civilian counterpart. (sub. 134, p. 18)

Hume Veterans' Information Centre:

Priority objectives for Veteran Support: 1. Health and wellbeing of the veteran. 2. Rehabilitation. 3. Occupational Re-training / job placement. 4. Compensation. 5. Support/compensation to veteran families. (sub. 121, p. 1)

Department of Defence:

Veterans' basic needs have not fundamentally changed over time. A veteran re-entering civilian life still needs the means with which to support themselves; they also need to adapt their military skills to the civilian workforce. (sub. 127, p. 6)

Department of Veterans' Affairs:

A number of key issues have emerged both in Australia and internationally for the newest cohort of veterans. While these issues are not new, for veterans they are having to be addressed in the context of modern-day society. The main issues here include veteran mental health and suicide/self-harm, transition and integration, employment, homelessness, and incarceration. (sub. 125, p. 13)

... while the group of female veterans is relatively small, there are specific new support needs for this group as they transition out of service, which are being articulated through the Female Veterans Policy Forum, for example. (sub. 125, p. 10)

The domains of veterans' wellbeing

Drawing on examples elsewhere (AIHW 2018d, pp. 5–6; Thompson et al. 2016, p. 15), and what we were told about what is important for the wellbeing of veterans, the Commission has set out a model of veterans' wellbeing (figure 4.2). The wellbeing domains in the model are interrelated. For example, a veterans' health can affect their employment, income and finance, and social integration. The domains are discussed in more detail below and their relationship to supports is discussed in the following section.

Figure 4.2 **A model of veterans' wellbeing**
Domains of wellbeing



Source: Productivity Commission, drawing on AIHW (2018d) and Thompson et al. (2016).

Health

Health is important for how people feel and function and it contributes to both social and economic wellbeing (AIHW 2018d). It is also important for the wellbeing of the broader community as healthy people are more productive and better able to engage with others. Understanding the health and risk factors of veterans is important for designing supports for veterans. As discussed in chapter 2, military service promotes protective factors (by providing a focus on physical fitness and access to health care) that can lead to improved health outcomes, but it can also place veterans at a greater risk for particular diseases and exacerbate certain conditions. As DVA said:

Veterans in Australia form a diverse and dispersed group of the population, with health and rehabilitation needs different to other parts of the population. They may have been transitioned

from service with severe physical injuries from their war service or from their service under warlike conditions, or they may have suffered mental trauma from those situations, or both. Some veterans may unknowingly have ailments with no immediate symptoms; however, these conditions may be triggered at some point in the future with symptoms requiring treatment, or may never manifest. Veterans with peacetime or non-operational service may also have an immediate injury, or one that may manifest some years later. (sub. 125, p. 12)

The Commission heard from many participants about the importance of support for mental health for veterans, including that veterans are able to access psychiatric services. Orygen, The National Centre of Excellence in Youth Mental Health, for example, said:

For young ex-serving personnel, their duration of service and a potential loss of protective factors following separation from the ADF are risk factors for mental ill-health. These issues should be considered when developing veteran rehabilitation services. (sub. 67, p. 2)

As discussed in chapter 7, in a recent survey 1 in 3 transitioned ADF members reported high to very high psychological distress (Van Hooff et al. 2018b). And the rate of suicide among young ex-serving men (under 30 years old) is 2.2 times that of Australian men of the same age (AIHW 2018f, p. 1).

The increasing proportion of women in the military also has ramifications for understanding veterans' health needs. For example, female veterans are more likely to need support for issues such as domestic violence, female health, and physical or sexual abuse or harassment (DVA, sub. 125, p. 14).

Employment

The evidence shows that employment provides individuals with a sense of purpose and plays a substantial role in their quality of life — including in their mental health. These benefits manifest themselves through greater financial independence, facilitating social relationships and enhancing emotional wellbeing (AIHW 2018d, p. 13). Veterans face distinct challenges in securing employment after their discharge. While the military offers a unique experience and skill set (communication, teamwork, problem solving, self-management, planning), some veterans can find it difficult to translate these skills into the civilian environment. Some veterans will also enter the civilian workforce with a disability or long-term health condition.

Some of the protective factors of service can also be lost as members transition to civilian life, including a sense of belonging, identity and purpose, social support and a structured environment (NMHC 2017, Orygen, The National Centre of Excellence in Youth Mental Health, sub 67, p. 2). Veterans may not have sufficient skills for managing in civilian life (because while in the military some aspects of civilian life, such as housing and health care, were largely taken care of for them). As a result, some veterans may be at risk and will require support during the transition period. These issues are discussed in detail in chapter 7.

A successful transition to civilian work is also associated with improved mental health, enhanced self-esteem, and overall improved quality of life (AIHW 2018d; O'Connor et

al. 2016). The importance of rehabilitation and a return to work (or meaningful activity) for the wellbeing of (particularly contemporary) veterans and their families was a reoccurring theme (box 4.4).

Box 4.4 The importance of work for wellbeing

Many submissions mentioned the importance of work for the wellbeing of veterans.

RSL Australia said:

The primary objective for an ADF member who has suffered an injury or disease should always be a return to health and a return to work, as this is the best outcome for the member's physical and mental health, their family, the ADF and any future employers, and the majority of injuries and diseases may allow a return to work relatively quickly after initial recovery. (sub. 113, p. 3)

Mates4Mates said:

It is important that veterans, their families and the whole community understand that despite a physical or psychological injury, veterans have the capacity to lead very active, purposeful and fulfilling lives. ... Research indicates that employment can be a restorative psychological process. There is no substitute for what employment offers in the way of structure, support and meaning. Positive and meaningful employment experiences are linked to improved self-esteem, self-efficacy and high levels of personal empowerment — all of which have a positive effect on mental health and wellbeing. (sub. 84, p. 3)

Employers Mutual Limited said:

Compelling international and local evidence indicates that employment is generally good for health and wellbeing, while long-term absences from the workplace, work disability and unemployment have a negative health impact. (sub. 90, p. 5)

Stephan Rudzki said:

... soldiers wish to be rehabilitated and return to some form of productive work. Having a job is a very important component of overall health and mental well-being. (sub. 40, p. 4)

Income and finance

Financial status is also a known factor in wellbeing, including by influencing an individual's independence, access to quality housing and family stability. Low socioeconomic status can cause poorer health outcomes and physiological distress for a person (AIHW 2018d, p. 22). There is some evidence to show that veterans can experience financial challenges as they adjust to civilian life (chapter 7). DVA noted that:

Financial counselling might also be an area of emerging need, where some former ADF members may struggle to manage their finances once outside of a military structure. There is strong evidence of an interrelationship between financial difficulties and poor mental health; in addition, money issues are widely associated with spouse or partner disputes and family breakup. (sub. 125, p. 13)

Part of this is due to the higher relative income of serving members but also the impact of reduced time in the civilian workforce on earning capacity. As a result, veterans can face reductions in their incomes (chapter 7) at a time when they may face additional costs as they transition (relocation costs, housing and healthcare costs). And veterans who leave the

military because of illness or disability can have reduced capacity to earn an income and may need income support. Families can also need financial support, and compensation for loss of income, when a veteran dies as a result of service.

Social support and integration

Social support and integration act as protective factors on individual wellbeing. A person who is well supported has a lower risk of poor health outcomes and lower mortality. There are two broad types of social support: formal services and supports offered by government and non-government bodies, and informal support provided by friends and family (AIHW 2018d, pp. 9–10).

Formal social support and integration services offered to veterans by government include transition support and commemorations, parades and other public ceremonies — which connect veterans to the broader community and honour their contribution. DVA said:

The commemorations function is considered an integral part of the Government’s commitment to the members of its serving forces. Through acknowledging and remembering past service and sacrifice, this function not only develops the community’s acknowledgement of military service and veterans’ role in it, but it also reinforces veterans’ understanding of their own role and purpose, thereby contributing significantly to validation of their service and their mental health and wellbeing. (sub. 125, p. 12)

The peer support offered through ex-service organisations can also have a substantial impact on veterans’ wellbeing by providing connectedness and a way of being linked to their military past. It is also the case for many dependants of veterans who have died as a result of service, such as war widow(er)s, who find support in peer-based organisations.

Families can play an important role in supporting the wellbeing of veterans at all stages of their military career. As the Family Wellbeing study said, ‘a common saying in the military is that when one person joins, the whole family serves’ (Smart, Muir and Daraganova 2018, p. 5). This support role becomes particularly important during transition when, as noted above, members can find the experience challenging and this can affect them, which in turn can affect the health and wellbeing of the veteran’s family. As one veteran said:

When I discharged from the Military and moved away from all my military friends, I had no friends in the civilian world. I was completely isolated to be honest. ...

Getting a support network outside of my family was important because the whole carer fatigue angle is really corrosive to family relationships. They want to care for you and they want to support you but at the same time it is a massive burden. (DVA 2018v)

Housing

Secure housing is important for health, employment, education and social connections. As discussed in chapter 2, while members are serving in the military, they either live on barracks or are assisted to find and rent (or buy) accommodation. Some veterans when they

leave the service can find it difficult to independently secure suitable housing. International evidence suggests that veterans are at greater risk of homelessness (chapter 6). And while there is a lack of good Australian data (chapter 2), surveys of (self-identifying) inner-city homeless populations have found that veterans were overrepresented in centres (Flatau et al. 2018, p. 29).

Education and life skills

Education, training and general life skills are an important part of ensuring an individual can lead a fulfilling life. Quality education helps people to find high-paying and purposeful employment, and stay competitive in a rapidly changing labour market (AIHW 2018d, p. 20). As discussed above, many veterans have highly military-specific skillsets and qualifications and so require additional training to find suitable employment after separation. Likewise, there are many general life skills that are essential to leading a normal life that could be absent or diminished due to military service. These include: independently seeking medical care (as all health services for serving personnel are provided by the ADF), applying for and obtaining employment, and securing housing (both discussed above).

4.2 Best-practice features of other schemes

Workers' compensation schemes

A focus on the wellbeing of veterans and the community and taking a whole-of-life approach to supporting veterans is consistent with contemporary best practice workers' compensation arrangements. In these schemes, the focus is on getting the best outcomes for injured workers at the most affordable and sustainable cost.

Clearly stated objectives, set out in legislation, are a feature of best practice workers' compensation schemes. The main objectives of workers' compensation schemes are to encourage injury prevention, and to rehabilitate and compensate injured workers fairly while being financially viable (box 4.5). As the seminal report of the New Zealand (Woodhouse) Royal Commission on Compensation for Personal Injury said:

Injury arising from accident demands an attack on three fronts. The most important is obviously prevention. Next in importance is the obligation to rehabilitate the injured. Thirdly, there is the duty to compensate them for their losses. (Woodhouse 1967, p. 19)

Box 4.5 Objectives and best-practice criteria

Insurance Council of Australia (ICA)

The ICA considers the following as appropriate objectives of workers' compensation schemes:

- to contribute to the prevention of injuries
- to promote prompt, effective and proactive treatment and management of injuries
- to support injured workers in returning to work/assist with full recovery
- to compensate fairly
- be affordable, financially viable (charge employers premiums that are affordable, reflect risk and fully fund the liability).

May and Casey

May and Casey identify similar objectives to the ICA and set out the following best-practice criteria for an effective workers' compensation scheme.

- *Scheme stability and predictability*: a fully funded scheme, with stable and predictable performance, which allows the scheme to be sustainable without legislative change for a substantial period (in excess of five to seven years).
- *Affordability*: premiums are affordable for those required to pay them.
- *Work outcomes are optimised*: the health benefits of work are recognised and all stakeholders — employers, employees, doctors, health-providers, insurers/claims agents — are focused on workers recovering at, or returning to, safe work depending on their capacity.
- *Fair and just compensation*: ensuring injured workers are fairly and consistently compensated for injuries, with a focus on those who have suffered severe or catastrophic injury.
- *Scheme efficiency*: that the majority of premiums collected is returned to injured people and administrative costs associated with running the scheme are kept to a minimum, while keeping system-generated stressors to a minimum.
- *Scheme adaptability*: the capacity to respond to changes in economic and social climates and the efficient collation and analysis of data to measure scheme outcomes and performance.

The Heads of Workers' Compensation Authorities, commenting on features of well-functioning schemes, said:

There is now a well-documented body of evidence of features which contribute to well functioning schemes. These include a workplace approach to managing injury, rehabilitation and return to work, supported by strong financial incentives and obligations to get injured workers quickly and safely back to work and for workers to participate in focused programmes aimed at return to work including retraining and location of suitable employment. As well, quality primary decision making in relation to claims, clear non-adversarial dispute resolution forums to resolve contested claims and integrated administrative and service delivery systems are design features of schemes which display exemplary features. (1997, p. 46)

Sources: ICA (2015), May and Casey (2014) and Heads of Workers' Compensation Authorities(1997).

Best-practice schemes are also underpinned by guiding principles, such as:

- work is good for your health — once an injured worker has recovered sufficiently, further recovery will be aided by resuming work
- appropriate incentives — to encourage positive outcomes for injured workers and for the scheme’s financials
- target supports and services to the more seriously injured — and limit benefits for minor injuries to what is essential
- strive for efficiency — a streamlined scheme, managed efficiently, will benefit all participants and will maximise the proportion of payments made to claimants
- establish clear expectations — to minimise ambiguity and increase accountability
- minimise politics — purely political agendas should not drive scheme design or management (ICA 2015, p. 12).

In the context of workers’ compensation, the Insurance Council of Australia said ‘best practice means sustainability’, where a sustainable scheme ‘satisfies stakeholders expectations over an extended period so there is no financial need or a political imperative to reform the scheme’ (ICA 2015, pp. 4, 9). EML also said that ‘there is an overarching understanding that compensation schemes need to be financially sustainable in the long term’ (sub. 90, p. 2).

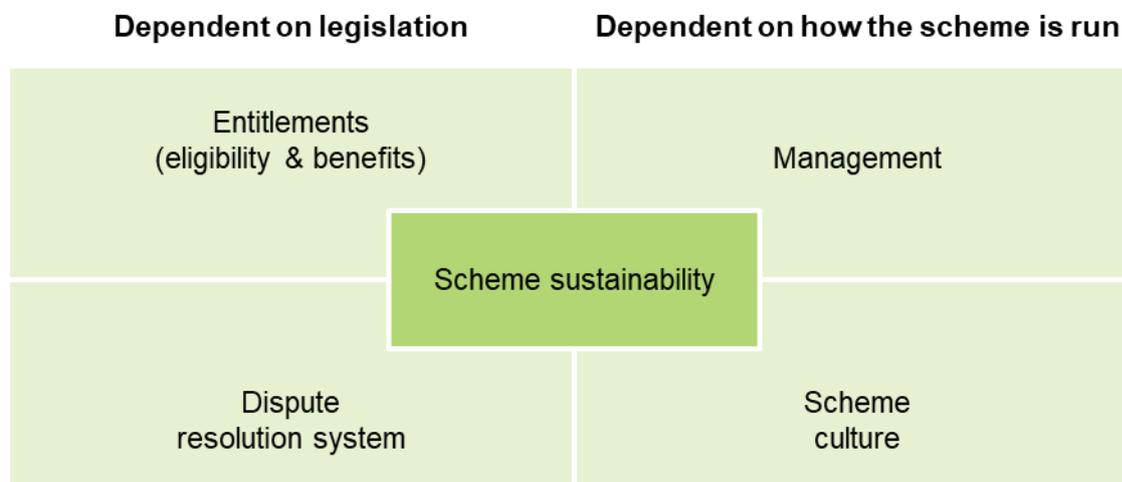
In a financially sustainable scheme, premiums paid by employers fully fund the cost of the scheme (that is, the costs of claims, scheme expenses and a return on capital). The premiums also need to be affordable, and emerging risks need to be identified and managed.

The features identified as driving scheme sustainability include:

- balance — a best-practice scheme is not so generous that it is unaffordable, but also not so limited that it causes hardship or community concern
- fairness — the scheme is considered by stakeholders to be fair
- consistency — a scheme with consistency in design and management (across different parts of the scheme and across time) will be more sustainable
- culture — a culture where the focus is on ‘capacity rather than incapacity’.

A sustainable scheme also requires the various scheme components — scheme management, scheme culture, entitlements and dispute resolution systems — to be working consistently (figure 4.3).

Figure 4.3 **A sustainable scheme requires different components working consistently**



Source: ICA (2015).

In part because of the need for schemes to be free of political influence, a board with a commercial structure (and relevant expertise) is considered best practice for the scheme regulator.

Other features of a best practice workers' compensation scheme include:

- administrative dispute resolution processes (rather than judicial), with decisions made by a tribunal that is inquisitorial rather than adversarial in nature
- one level of appeal from a decision — on medical issues this should involve a medical panel, on other issues by senior members of the tribunal
- access to courts only when there are important or novel issues involved
- evidence-based management of the scheme — consistent and reliable data analysis is important for identifying and responding to emerging pressures
- a positive culture with outcomes such as:
 - higher employer engagement in claim outcomes
 - open and transparent decision-making
 - low appeal rates for decisions.

To enable a focus on rehabilitation and sustainability, workers' compensation schemes are increasingly focusing on improving scheme administration and case management. Successful case management has a number of elements including building effective rapport and buy-in from clients, triaging clients to identify where most support will be needed and fast processing to allow access to support as early as possible. Such an approach is important

for ensuring maximum return-to-work from rehabilitation, enhancing client wellbeing and containing scheme costs (SwissRe 2016, p. 4).

Contemporary disability support schemes

Recent reforms in disability support (and human services generally) also reveal a number of trends and changes in philosophy that are relevant for veteran support. Key changes in this area include:

- individualisation of supports and a wellbeing focus
- consumer-directed services
- a long-term view of costs and benefits (box 4.6).

At the heart of the changes is a focus on building the *ability* of individuals to engage with and contribute towards society (the ‘social model’) rather than assuming their limitations based on their diagnosed *disability* (the ‘medical model’) (PC 2011, p. 98). Using the example of someone who has lost a limb, Daniel Gade pointed out the differences in approach between the two models:

The medical model of disability says that an amputee is automatically ‘disabled’ by virtue of his limb loss — even if he is capable of leading a largely independent, normal life — and is devoted strictly to restoring, to the extent possible, the lost functionality of the limb. Support under this model focuses almost exclusively on the patient’s infirmity, and in some ways defines the patient by his impairment; the disabled person is viewed as a victim, and the purpose of the disability system is seen as providing benefits, rather than encouraging a return to functionality.

A more modern approach is the broader, ‘social model’ of disability, which assumes that a physical ailment is only one component of determining whether a person is truly ‘disabled’. The social model adds environmental and personal factors to the physical diagnosis. It takes account of the fact that a wheelchair user, for example, is much more ‘disabled’ in an environment in which his movement is constrained by obstacles — curbs, stairs, and so forth — than he is in an environment in which he can easily get around using lifts, elevators, and ramps. (2013)

The social model of disability, with an emphasis on people’s ability and potential, sits well with a focus on wellbeing (noting the evidence about work and social participation and wellbeing). As the Organisation for Economic Cooperation and Development said:

The term ‘disabled’ should no longer be equated with ‘unable to work’. Disability should be recognised as a condition but it should be distinct from eligibility for, and receipt of, benefits, just as it should not automatically be treated as an obstacle to work. The disability status, i.e. the medical condition and the resulting work capacity, should be re-assessed at regular intervals. (2003, p. 11)

Box 4.6 **Features of the contemporary disability support approach**

Individualisation of supports and a wellbeing focus

The shift to individualisation of supports is largely about a focus on the wellbeing of individuals. This typically involves allocating supports more flexibly on an individual basis rather than having a black letter, welfare approach. It enables decision makers to meet the needs of the individual to engage in the community and exercise greater control over their life. In some cases, individualisation is not feasible and would generate little gains over a simple, objective set of criteria for access — typically this is more the case for monetary transfers than for in-kind services.

Consumer-directed markets

The trend towards individualisation is further assisted by having consumer-directed services. There are various approaches to this, but typically the client is given a capped budget that they can use to purchase their services in a competitive market. This further enables individualisation and a wellbeing focus because clients will seek services that best suit their needs within a budget that is sustainable. This trend is most apparent in the National Disability Insurance Scheme and certain accident compensation schemes where almost all services are market provided and subject to capped budgets. As with individualisation of support, consumer-directed services are a means and not an end. They should be used where feasible and desirable but, where they are not, alternative policy tools are available — such as government directly contracting services where competition is limited by thin (or absent) markets.

Long-term view of costs and benefits

Another shift in focus has been towards taking a long-term view of the costs and benefits of government-funded supports. This is achieved through the use of large, longitudinal datasets on support packages and their costs as well as client outcomes. This can remove false economy and achieve long-term cost reduction — for example, a person with a disability receiving funding to modify their own vehicle rather than relying on more expensive taxi subsidies. These systems also enable reliable inference about the benefits and supports — for example, whether a surgical intervention would better improve a patient's lifestyle more than treatment through ongoing medication (even where costs are similar).

This long-term focus is not feasible across every government service and even within consumer-directed schemes it has its limitations. Analysis of scheme costs and benefits in the aggregate can reveal trends and filter down to better decision making at the individual level but there will always be a great deal of discretion required at the level of the individual decision maker.

Sources: PC (2011, 2017c).

The social model is an *active* rather than *passive* approach to meeting client's needs. Welfare only requires a passive approach because, once eligibility is established, it is about paying benefits while the active social insurance approach requires continuous reassessment of need and tailoring of support. As Employers Mutual Limited (EML) said:

Social insurance schemes around the world are maturing to deliver highly-personalised services, with choices for case management ranging from self-management to support and intervention-based models — all ultimately depending on individual needs. There is growing acknowledgment that active support for families in turn helps injured persons, too. Alongside

personalised case management, there is an overarching understanding that compensation schemes need to be financially sustainable in the long term. (sub. 90, p. 2)

A number of stakeholders alleged that DVA's approach is more closely aligned to the passive approach. For example:

The culture is one of being rewarded for increasing disability, with little incentive to get better. (Peter Reece, sub. 49, p. 2)

... the key deficiency in DVA's current approach is the lack of clear messaging regarding the importance of wellness. (RSL Queensland, sub. 73, p. 7)

There is an inadequate focus on managing individual veteran treatments and scheme costs (i.e. a passive approach), resulting in over-servicing, as well as the regular administration of concurrent, ineffective and/or potentially harmful treatments. (EML, sub. 90, p. 6)

Veteran support schemes in similar countries

Veteran support schemes in similar countries have common and different features to Australia's system (box 4.7).

While the different approaches adopted internationally provide ideas on what could be considered in Australia, there is no clear, single 'best-practice' scheme. This is in part because what works overseas will not necessarily work in an Australian setting, given the different social and institutional arrangements (for example, the United States health care and social support system is very different to Australia's). RSL Australia cautioned against trying to import a foreign system 'based wholly on that country's cultural and historical context, including their military conflict context in the past and its influence on national cultural character'.

The nature of Australia's military, its historically voluntary nature and its impact on the evolution of Australian culture and identity is central to much of Australia's perception of and treatment of veterans and how we see the future of veterans' support in this country. It would seem better to work within the system that we have, that has grown around our cultural and historical context, to repair the shortcomings in the system, than to adopt a system based on a different cultural identity and context that may prove wholly inappropriate for the Australian context. (sub. 113, p. 11)

Box 4.7 Features of international schemes

The Commission looked at the features of some military compensation schemes in ‘comparable’ countries and found variation across the schemes in their complexity, objectives and focus, service delivery models, treatment of peacetime service and their eligibility rules. There is no clear ‘best approach’, and the fact that scheme features vary across countries, and across time, with close military ties suggests that the schemes should be tailored to suit particular circumstances.

That said, most schemes include ‘rehabilitation’ and ‘compensation’ among their stated objectives, although few reference ‘prevention’. While having similar stated objectives, the emphasis varies between schemes. The United States’ and United Kingdom’s schemes appear to focus mainly on compensating veterans for injury, illness and death while Canada and New Zealand, like Australia, have shifted to a greater focus on rehabilitation and veteran wellbeing more generally.

Although most of the overseas schemes we looked at have undergone some recent reform, scheme complexity appears to have increased. Changes have included: expanded injury/impairment categories, payment levels and types (for both economic and non-economic loss), pension and/or lump sum payment options, further distinctions between service type, and ‘grandfathering’ for service prior to the introduction of the new schemes. This mirrors the Australian experience. Only the United States operates a single scheme while New Zealand, the United Kingdom and Canada have two; Australia is the only jurisdiction with three schemes.

There is variation in the mix and delivery of services across international schemes. Some schemes only provide compensation (such as the United Kingdom, which has universal healthcare through the National Health Service) with little or no rehabilitation while others have a rehabilitation focus (New Zealand’s Scheme 2). Some cover attendant care (New Zealand and Australia) while in others this is dealt with in separate mainstream systems (United Kingdom). Methods of service delivery also differ greatly. For example, in the United States the government provides health care (tiered based on need and means) while the Canadian system has a card system that allows clients to use their own doctors.

Treatment of different service types also varies. For example, the United Kingdom makes no distinction between different service types while in New Zealand only war veterans have access to veteran-specific compensation — peacetime veterans have access to mainstream workers’ compensation arrangements.

The methods of determining eligibility and the benevolence of entry pathways also varies. The United Kingdom requires claims to establish a connection between injury and service on the balance of probabilities (similar to the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*) while New Zealand has adopted Australia’s Statements of Principle. The United States has a hybrid approach where ‘deemed lists’ of conditions allow automatic or easier acceptance of claims but these only cover a subset of possible conditions. Historically, many countries, including New Zealand and the United Kingdom, had dual standards of proof but have since moved to a single standard.

On the issue of the level of benefits provided, Returned & Services League Australia said:

With regard to compensation in the broader sense, the range of entitlements and benefits offered to Australian veterans compares favourably to those offered to Canadian veterans and New Zealand veterans and superior to those of the US and UK. (sub. 113, p. 26)

Sources: Campbell (2011b); NZLC (2008); Paterson (2018); UK Ministry of Defence (2016); US Department of Veterans Affairs (2018a, 2018b).

4.3 What principles should underpin the support system?

Based on the overarching objective of improving the lives or wellbeing of veterans and their families (or minimising the costs or effects of service) and taking a whole-of-life approach, the priorities of the system are about restoring veteran to their pre-service state. The veteran support system must:

- provide incentives for prevention or minimisation of injury and illness
- promote timely, effective and holistic rehabilitation and transition support and health care
- provide adequate and appropriate compensation
- enable opportunities for social integration.

It is well established that work is good for health and it helps recovery and for that reason has been a focus of rehabilitation in workers' compensation schemes. While the Commission considers that a return to the workforce should remain the primary goal of rehabilitation services for veterans, it recognises that a broader conception of rehabilitation is also necessary, to enable veteran re-entry and effective participation in life. As Mates4Mates said:

... the intent of any agency providing rehabilitation services should be focused on assisting people to function as effectively as possible after an injury, illness, disease or accident. It should be targeted at assisting them to relearn old skills or find new and alternative ways of doing things to lead effective lives. (sub. 84, p. 1)

The system should promote wellness, return to work and recovery for life.

And while veterans and their families should also be provided with adequate compensation for injury, illness or death due to service, compensation should not discourage veterans from engaging effectively in rehabilitation. There is some evidence to suggest that being eligible for compensation can worsen an injured person's health. There are two reasons for this:

- being involved in the compensation process can create an incentive for the injured person to remain unwell
- the compensation process itself can be stressful and give rise to renewed victimisation of the injured person (May and Casey 2014).

These risks point to the need for careful design and administration of the compensation element of the veteran support system.

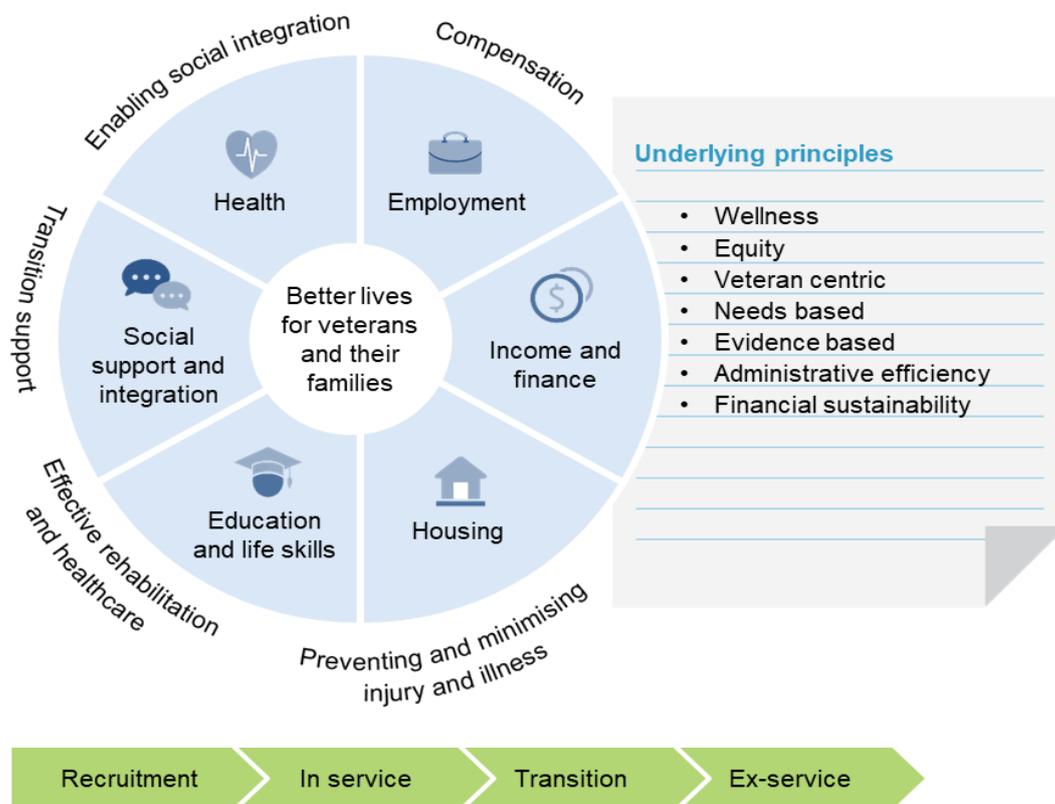
And any government system should aim to be efficient, affordable (for taxpayers) and sustainable. A focus on efficiency and financial sustainability requires an understanding of cost drivers and support outcomes (which requires monitoring and analysis of data). A focus on sustainability is the means for achieving the best outcomes for both veterans and their families, and the community.

The Commission’s view is that the following principles should underpin a future system. It should be:

- wellness focused (*ability* not disability) — with a focus on return to work and recovery for life
- equitable — there should be equal treatment of equal claims
- veteran centric — including recognising the unique needs resulting from military service
- needs- and evidence-based — supports should be targeted to those with the greatest need (most serious injuries) and treatments based on the latest evidence
- administratively efficient — the system should be easy for clients to navigate and as simple as possible to administer
- financially sustainable and affordable.

The Commission has used these principles to assess the current veteran support system and the design of a future system (figure 4.4). The inner sections of this figure are the domains of veteran wellbeing, while the outer circle outlines are the objectives of veteran support. The principles underlying this system sit beside it.

Figure 4.4 **Objectives and principles of veteran supports**



DRAFT RECOMMENDATION 4.1

The overarching objective of the veteran support system should be to improve the wellbeing of veterans and their families (including by minimising the physical, psychological and social harm from service) taking a whole-of-life approach. This should be achieved by:

- preventing or minimising injury and illness
- restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in work and life
- providing effective transition support as members leave the Australian Defence Force
- enabling opportunities for social integration
- providing adequate and appropriate compensation for veterans (or if the veteran dies, their family) for pain and suffering, and lost income from service-related injury and illness.

The principles that should underpin a future system are:

- wellness focused (*ability* not disability)
- equity
- veteran centric (including recognising the unique needs of veterans resulting from military service)
- needs based
- evidence based
- administrative efficiency (easy to navigate and achieves timely and consistent assessments and decision making)
- financial sustainability and affordability.

The objectives and underlying principles of the veteran support system should be set out in the relevant legislation.

4.4 Some policy design issues

Should there be distinctions between types of military service?

The veteran support legislation distinguishes between different types of military service for determining access to, and the level of, benefits for veterans. Under the *Veterans' Entitlements Act 1986*, for example, some of the service types are 'eligible war service', 'operational service', 'qualifying service', 'warlike service', 'non-warlike service' and 'peacekeeping service'. The type of service a veteran is deemed to have undertaken determines whether or not the veteran's claim is assessed against the generous 'reasonable hypothesis' test for determining liability and whether the veteran has access to certain supports (such as the service pension). Under the *Military Rehabilitation and Compensation*

Act 2004 (MRCA), the level of liability benefits differs between service types, as does the use of the ‘reasonable hypothesis’ test (chapter 8). What this means is that veterans with identical injuries can be entitled to different levels of compensation and support.

Some participants argued that the distinctions are unfair and should be removed (box 4.8).

Box 4.8 Participants’ comments on the distinction between types of service

Some participants said that making entitlements contingent on service types is inequitable:

That unfairness ... was also perpetuated by the differential contained in the VEA [Veterans’ Entitlements Act] and continued through to the current day in the MRCA [Military Rehabilitation and Compensation Act] whereby risk is specifically rewarded for what was once ‘qualifying service’, now titled ‘warlike service’. The fact remains that peacetime service can be equally as dangerous as warlike, perhaps rewarded by allowances, but not reflected in compensation and other additional benefits. (Peter Reece, sub. 49, p. 3)

I do not agree with the manner in which injuries, disease or conditions are treated for purposes of assessment of entitlements depending on how they were sustained whether it be warlike, non-warlike, peacetime or reserves. This creates a divide within the Defence community and a perceived bias amongst veterans. (Slater + Gordon Lawyers, sub. 68, p. 13)

The Australian Defence Force [ADF] trains for war. Whether service is related to peacekeeping, WW2, Korea, Vietnam, Iraq, or Afghanistan there is no discrimination of service. The commitment of those who serve remains as it has always been — service is service. In November 2017 ... It was agreed that a veteran would be defined as ‘a person who is serving or has served in the ADF’. ... The adoption of this definition is recognition that, regardless of the type of service rendered by an individual, they are considered a veteran and their service should be appropriately recognised and compensated where necessary. (Veterans’ Advisory Council and the Veterans’ Health Advisory Council, sub. 96, pp. 3—4)

The ADF trains for operational deployment in ways as close as possible to operational situations. Distinguishing between, say, the Black Hawk helicopter incident in Queensland and a similar incident in an operational deployment lacks an appreciation of the intensity of ADF training. (Vietnam Veterans’ Federation of Australia, sub. 34, pp. 24—25)

However, others supported service distinctions for these purposes:

Efficient and effective training simulates the horrors of war, including killing others, even for those who do not ultimately experience war. However, the horrors of war once seen, cannot be unseen, once experienced, cannot be unexperienced. The Association is of the firm view that medical, compensation and rehabilitation support should be more beneficial to those veterans who have served in war or in war like conditions. (Vietnam Veterans Association of Australia, sub. 78, p. 1)

... the veteran with Warlike Service must be treated with special distinction in respect of compensation and support. The justification for this belief simply is that war-like service produces physical and mental disabilities far more extreme than those resulting from peacetime operational service. (Vietnam Veterans and Veterans Federation ACT Inc and Belconnen Returned & Services League Sub Branch, sub. 42, p. 2)

... the current differential should remain but there should be no differential when assessing compensation for death and severe impairment. (Returned & Services League Queensland, sub. 73, p. 14)

The Commission heard that ADF members ‘train hard to fight easy’ and that peacetime service (particularly training exercises and ‘high-fidelity’ simulations) can be almost as risky as deployment. One veteran described the Army as ‘a training organisation that occasionally goes to war’. Serving members also generally do not choose what activities they engage in

as part of their service. In essence, the argument is that ‘an injury is an injury’ and that the distinctions are inequitable. Others argued that the distinctions should remain because war or warlike service is very different to, and more dangerous and demanding than, peacetime service and should be treated ‘with special distinction’ (box 4.8).

The Commission’s analysis of MRCA claims shows greater incidence of many conditions arising out of wartime service. For example, although claims relating to operational service accounted for about 24 per cent of all MRCA claims, they accounted for about 74 per cent of claims relating to post-traumatic stress disorder and nearly two thirds of the claims for alcohol use disorder (Commission estimates based on unpublished DVA data).

That said, the risks of peacetime service should not be underplayed. Analysis of MRCA claims undertaken by the Commission also shows that 89 per cent of fracture and sprain and strain claims relate to peacetime service (Commission estimates based on unpublished DVA data). The Black Hawk disaster (chapter 3) highlighted some of the risks of peacetime service, as well as the differences in compensation based on the circumstances of individuals.

Given its extra hazards and hardships, the Commission agrees that war or warlike service warrants recognition and reward above that provided for peacetime or operational service. But there are deployment allowances, awards and other direct mechanisms for this.

The Commission also agrees that, *to the extent* that one ADF member incurs more extreme physical and mental impairments than another, the former should receive a higher level of compensation. This would be the case under a system that compensates based on need or the level of impairment. For example, if members engaged in war or warlike service did incur more extreme physical and mental impairments than other members, they would receive more compensation because of higher payments for higher levels of impairment.

In the Commission’s view, veterans’ compensation arrangements ideally should treat injuries of a particular type and severity equally. And to the extent that operational service is riskier than peacetime service, it does not justify the *same* injury being treated differently based on where and when it occurred. In principle, therefore, compensation for the pain and suffering a person incurs should not depend on the type of service they were undertaking when the injury or illness occurred.

That said, in some cases, removing distinctions between different types of military service could involve substantial costs (particularly if entitlements were standardised to the highest level). There would also be transitional issues. As such, when considering reform options, there is a need to balance the principle of not discriminating between forms of service with the costs of reforms.

To what extent are separate veterans’ services and supports justified?

While history provides insights into why there is a bespoke veteran support scheme (chapter 3), many stakeholders argued that there continues to be a need for separate

military-specific arrangements because of the unique nature of military service. The DFWA said:

Support for serving and former ADF men and women must be as unique as their service is unique. It is inappropriate, indeed dangerous . . . to attempt ‘normalising’ support to general community and business practice.

Military Service is fundamentally unique. The reciprocal obligation this places on the State is as inescapable as it is enduring. (sub. 118, p. 14)

A number of the previous reviews of veteran support accepted the view that the unique nature of military service warrants a separate support system, albeit with little specific explanation. The Campbell Review, for example, stated:

The Committee confirms the unique nature of military service and the requirement for a military-specific compensation scheme that recognises that military service is different from civilian employment. The Committee concluded that compensation arrangements separate from the civilian compensation arrangements should be continued. (Campbell 2011a, p. 93)

However, there is a question about the extent to which the unique features and impacts of military service require special or differentiated supports and services. Many other occupations are distinctive and unique in their own way — though not as markedly as the military — but these differences do not necessitate special arrangements. For example, emergency services personnel who suffer from repeated exposure to trauma or violence are treated through mainstream health and social support systems, including mainstream compensation and rehabilitation schemes. The higher rates of trauma and injury in these vocations mean that these workers access the services at a greater rate on average than workers in many other sectors, but it does not necessitate a different system. And some previously separate aspects of the veteran support system, such as the repatriation hospitals established after World War I, have since been replaced with mainstream services.

There are obvious benefits in using the one, standardised mainstream system for multiple occupations, including economies of scale and scope, proficiency and equity.

That said, there are a number of arguments why military service, and veterans’ circumstances, do warrant a separate support system or a separate approach to providing particular support services. The Commission recognises that there also is a broad community expectation that veterans should be well supported because of their contribution to the protection and service of the nation, and that there should be a beneficial approach to compensation. However, the policy responses to such expectations must also take into account what is in the best interests of veterans and their families, the overall community benefit and the appropriate targeting of limited resources.

For the unique risks and onerous conditions of military service?

One argument for veterans receiving higher levels, of or easier access to, support is the often arduous and risky nature of service. However, the military already provides remuneration

and allowances that are directly tied to the risks and onerous conditions and the Government recognises these aspects through recognition programs (chapter 2). It is therefore not clear cut that this aspect of military service *itself* warrants separate and/or more generous compensation and support arrangements for veterans.

A problem with providing more generous compensation to compensate for risks and conditions of military service is that it can result in inequitable outcomes. For example, if the risks and other demands of service are reflected in pay and allowances, it would seem inequitable that a veteran who suffers a particular accident — say loses a limb — should get more compensation for that loss than an emergency services officer, construction worker, truck driver or indeed any other civilian who suffers the same loss (in the same way that it is inequitable that military personnel who suffer a particular loss during war should get more compensation than military personnel who suffer the equivalent loss while training in Australia).

Further, some supports provided by the system are not closely tied with the level of risk. None are linked to the extent of the onerous duties undertaken by people while in the military, except insofar as this is indirectly reflected in service type. By comparison, military pay and allowances vary with length of service and the duties performed. This means that some veterans who have been exposed to significant risk or who have undertaken several years (or decades) of onerous work during their service will receive little or no support from the system.

Nevertheless, as discussed in chapter 3, governments have frequently justified extensions to supports as a means of recognising the risks and onerous nature of military service. Several participants in this inquiry also highlighted this rationale. Finding the right balance has been an important consideration and has informed our approach for a reformed system for the future. We recognise the case for a beneficial approach for veteran compensation and support while also recognising that such an approach must be balanced against the competing needs of the community and should be more targeted to the needs of veterans and their families.

The particular needs of veterans

As a result of the effects of military life and service, veterans have some particular needs (section 4.1) that can warrant special access to mainstream services or specialised services. There are three main aspects that could warrant a different approach.

- The nature of military service can leave discharged personnel ill-equipped to cope with the transition to civilian life and this may warrant extra support services for veterans while they are transitioning (chapter 7).
- There may be some conditions that exposure to military life makes much more likely than for the normal civilian population that are very difficult or costly to identify (or prove the exact cause of). Many conditions also benefit significantly from intervention at the earliest stage. For these conditions, there may be benefits in a specialised system for veterans. It may be more efficient and result in better outcomes, for example, to give

veterans non-liability access to treatment for mental health conditions (a change that was introduced in July 2016) (chapter 15).

- Some veterans are said to hold the view that unless a service provider (say a general practitioner) has experienced a veteran's lot (or at least had training to help understand the nature of the experience), they are not well placed to administer to veterans. This might justify some form of educational augmentation for such professionals, even if it may not necessitate significant changes to the services themselves.

There is also the stigma some veterans associate with accessing mainstream welfare. The Commission heard that some veterans do not like going to Centrelink offices (notwithstanding the range of government business they handle and the many other Australians who use them). The DFWA, for example, spoke about the military mindset and how it can affect the views of veterans:

Team needs take priority over individual needs and rights. Total trust in other team members is essential because the consequences are so dire. A person who only looks after him or herself, is inconsiderate of other team members, is an anathema ... This deliberately created military culture becomes ingrained. That is partly why some Veterans refuse to seek support, not wanting to give up or to be a burden to others. Pride is important but it can be misplaced. And 'welfare' is a pejorative word, no matter how many experts claim otherwise. Needing 'welfare' is seen as an indication of failure or weakness, so self-harm rates for those discharged are higher than for those still serving. (sub. 118, p. 14)

Other rationales for retaining separate services and entitlements

There are three other possible rationales for retaining separate services and entitlements.

- Many of the current services and supports provided to veterans are not only separate from mainstream services but also more generous than those provided to other civilians. While many of the services and entitlements available to veterans may not have been in place during their service (and therefore cannot be regarded as a condition of service), veterans are likely to have made future plans based to some extent on the maintenance of benefits. Any options to revert benefits to those available under the mainstream system would need to consider either grandfathering or phasing out higher existing entitlements.
- There may be some instances where mainstream services are clearly inadequate or deficient. While the 'first best' and most equitable solution would be to fix those services, including being responsive to veterans' lived experiences, in the short term there would be a case for retaining separate services for veterans in those areas. There is a case for some ongoing differentiated services and we address these matters throughout the report. These should be based on good evidence and ongoing evaluation to ensure they are delivering outcomes for participants over and above that provided to the general community.
- There would be transitional costs and difficulties involved in any move to mainstream particular veterans' services. As with any area of policy, the costs of reform options need to be considered along with the benefits.

4.5 Summing up

Many considerations are involved in assessing the current veteran support system.

Military service is unique in nature and the Australian Government has a ‘duty of care’ to those who serve and sacrifice in the defence of the nation. This duty of care includes a need to seek to minimise (as far as practicable) the harm from service, and to look after those affected by service, both during and beyond their period of service.

Against this background, the Commission considers that the overarching objective of the veteran support system should be to enable veterans and their families to live normal and meaningful lives by improving their wellbeing, taking a whole-of-life approach. This has at its core minimising the harm from service to veterans and their families, and should principally be achieved by:

- preventing or minimising injury and illness
- restoring injured and ill veterans to their pre-injury state by providing timely and effective rehabilitation and health care so they can participate in work and life
- providing effective transition support
- enabling opportunities for social support
- providing adequate and appropriate compensation for veterans (or if the veteran dies, their family) for pain and suffering and lost income from service-related injury and illness.

This objective should be achieved while ensuring supports are provided in the most effective and efficient way. Taking a whole-of-life approach is important for getting the best outcomes for veterans and their families, and ensuring an affordable (for taxpayers) and sustainable system.

Consistent with best practice workers’ compensation and contemporary disability support schemes, the principles that should underpin a modern veteran support system are:

- wellness (*ability* not disability), veteran-centric (including recognition of the unique needs resulting from military service), equity and supports based on need
- administrative efficiency, financial sustainability, affordability, and evidence based.

Distinctions between different types of military service for the purpose of compensation are inequitable, and should be removed or reduced where practical and cost effective.

History, and the Australian Government’s longstanding commitment to support and reintegrate into society those affected by their military service, explains why there is a separate and beneficial veterans’ system. The unique needs of veterans, including in relation to transition and mental health, also justify some bespoke, well-targeted services for veterans’ and their families.

5 Preventing injury and illness

Key points

- The costs of service-related injuries and illnesses in the Australian Defence Force (ADF) are high. Service-related injury and illness cause pain and suffering for veterans and their families, reduce the ADF's operational capability and impose a significant burden on taxpayers (who pay for veterans' health care, rehabilitation and compensation).
- There is no military-specific work health and safety legislation — the ADF is subject to the Commonwealth *Work Health and Safety Act 2011*.
 - Some parts of the Act do not apply to the ADF, and the Chief of Defence can exempt the ADF from certain work health and safety regulations where it is involved in overseas operations: these exemptions, though, are relatively minor.
- Defence's *Work Health and Safety Strategy 2017–2022* gives effect to the work health and safety objectives of Defence and is complemented by parallel efforts to change the culture within Defence (as outlined in *Pathway to Change: Evolving Defence Culture 2017–2022*).
 - The ADF has significantly improved its safety record in recent years. The annual number of ADF personnel who suffered a serious injury or illness fell by more than 80 per cent over the period 2010-11 to 2017-18.
- The ADF command at all levels has an incentive to prevent injury and illness (particularly to maximise force readiness but also for reputational reasons) and are committed to improving work health and safety outcomes.
 - However, realising that commitment is hampered by deficiencies in data on the incidence of service-related injuries and illness and a lack of information that crystallises the lifetime cost of support and compensation for those injuries and illnesses.
- Improvements in data on incidents and associated costs are a necessary (but not sufficient) precondition for improving prevention strategies and outcomes.
 - In recent years, Defence has improved the recording of work health and safety incidents (via its Sentinel reporting system).
 - However, more needs to be done. Sentinel should be augmented with other data sets such as the Defence eHealth System and DVA's claims database.
- The annual publication of the complete actuarial report calculating notional workers' compensation premiums would bring added scrutiny and accountability for ADF command and sharpen their incentives to reduce service-related harm.
- Targeted injury prevention strategies can considerably reduce the incidence and severity of injuries and their associated costs.
 - Evidence shows that significant reductions are possible from well-designed reforms (for example, an earlier Defence Injury Prevention Program achieved reductions in injuries of up to 70+ per cent). Contemporary trial programs to replicate that earlier success warrant support and, if successful, should form the basis for a service-wide rollout of that program.

The costs of work-related injury and illness are shaped by the extent and effectiveness of preventative measures. This chapter looks at the incentives the Australian Defence Force (ADF) faces to prevent service-related injury and illness.

- Section 5.1 looks at why preventing injury and illness is so important.
- Section 5.2 outlines the regulatory framework governing work health and safety (WHS) for ADF members.
- How WHS is delivered across the ADF is outlined in section 5.3 and the ADF's WHS record is discussed in section 5.4.
- Section 5.5 discusses possible changes to create stronger safety incentives across the ADF and to achieve better prevention outcomes.

5.1 Why preventing injury and illness is so important

The costs of service-related injury and illness in the ADF are high. Service-related injury and illness inflicts pain and suffering on military personnel and their families. It reduces the ADF's operational capability. And it imposes a significant burden on taxpayers from costs such as in-service medical treatment and rehabilitation, and from the Government's liability for compensation and rehabilitation payments for veterans after their discharge.

As an indication of the scale of the pain and suffering caused by service-related injury and illness, in 2017-18, the Department of Defence (DoD) reported:

- three fatalities
- 277 people sustained a serious injury or illness
- 8937 people sustained a minor injury (2018f, p. 106).

In the same year, the Department of Veterans' Affairs (DVA) received 13 185 liability claims and 7295 permanent impairment claims under the *Military Rehabilitation and Compensation Act 2004* (DVA 2018f, p. 226).

Although the ADF's WHS incident reporting system does not capture time lost as a result of injury or illness, studies of the ADF and of serving US Army personnel suggest the effect of injury and illness on operational capability is significant.

- Pope (2002b), using data from the 2000 *ADF Health Status Report*, found that on any given day at least 4.1 per cent of full-time ADF personnel were not fit for deployment because of injury. He also observed that injury or illness was not just a temporary setback for military personnel — recruits who were injured were 10 times more likely to be discharged from the ADF than recruits who were not (US research also shows that soldiers with a recent history of injury were seven times more likely to be injured again (Schneider, Bigelow and Amoroso 2000)).
- A study of over 500 000 serving US Army personnel found that on any given day in 2014 over 10 per cent were limited in what duties they were allowed to perform as a result of medical restrictions arising from lower limb injuries (Holsteen et al. 2018). Since the

ADF has common or similar approaches, equipment and platforms to the US military there is reason to believe that the capability degradation resulting from injuries in the Australian Army would be similar to that indicated by this study.

And these lost time indicators are likely to be lower bound estimates. This is because when a member of a unit is not fit for service and that member is critical to the overall effectiveness of that unit, their unavailability can render the whole unit unfit for deployment. If this is the case, the effect of injury or illness on operational capability is a multiple of that suggested by the raw data.

The cost to taxpayers from in-service medical treatment and rehabilitation for injured or ill ADF personnel and from compensation and rehabilitation payments for veterans post discharge is also significant.

- The cost of medical services provided by Garrison Health Services to serving personnel in 2017-18 was about \$440 million (pers. comm., Defence, 5 November 2018).¹
- The estimated lifetime compensation cost of claims arising just from service rendered during 2017-18 is about \$798 million (AGA 2018a, p. 138).

It therefore follows that measures to prevent and/or reduce the incidence and severity of service-related injury and illness could substantially reduce costs to veterans and their families, Defence and taxpayers. As a qualitative study into military injury surveillance systems observed:

... even small relative reductions in injury rates, achieved through injury prevention efforts, would result in significant improvements in military capability and reductions in costs, force attrition, and personal suffering. (McKinnon et al. 2009, p. 470)

5.2 Regulatory framework governing the WHS of ADF personnel

Workplace health and safety regulation is designed to reduce the incidence and severity of work-related injury and illness and their related costs.

Work health and safety in the ADF is regulated primarily under the Commonwealth *Work Health and Safety Act 2011* and associated *Work Health and Safety Regulations 2011*. While some parts of the Act do not apply to the ADF — for example, incident notification is not required in warlike deployments and ADF members are exempt from becoming a health and safety representative (Chief of the Defence Force 2012, p. 4; DoD 2017i, p. 2) — the exemptions are relatively minor.

This WHS legislation, which took effect on 1 January 2012, is based on model WHS legislation developed by Safe Work Australia in consultation with the states and territories.

¹ These costs cover medical treatment and rehabilitation for serving members, irrespective of whether their injury or illness was service- or non-service-related.

In effect, the legislation requires Defence to focus on ‘maximising the prevention of injury and illness and minimising the impact of any injury that does occur’ (ANAO 2016, p. 22).

The Act aims to protect workers against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work. As Defence observed:

Defence has significant obligations under the *Work Health and Safety (WHS) Act 2011* to prevent service-related injury and to reduce the cost to capability. This includes proactively identifying emerging occupational issues that may cause hurt or harm to Defence personnel. (sub. 127, p. 16)

Compared to the legislation it replaced, the 2011 Act broadened the range of people who have a duty of care. In addition to broadening the responsibility from employers to other ‘persons conducting a business or undertaking’ (PCBUs), duties to manage risks are imposed on all parties who are in a position to contribute to the successful management of workplace risks (box 5.1).

Box 5.1 Agents with a duty of care under the WHS Act 2011

The primary mechanism in the *Work Health and Safety Act 2011* for achieving its objective of protecting workers against harm is the imposition of ‘health and safety duties’ on various agents. These agents are:

- *Persons conducting a business or undertaking* (PCBU) — (the principal duty holder under the Act) who have a duty to ensure the health and safety of workers engaged by that person while the workers are at work in the business or undertaking, as far as is reasonably practical.
- An ‘*officer*’ of a PCBU — (a person who makes or participates in making decisions that affect the whole or a substantial part of the business or undertaking), has a positive duty to exercise due diligence in ensuring the organisation complies with the law.
- *Workers* — have a duty of care toward their own and others’ safety.

At the time the new model WHS legislation was being developed, the Department of Defence noted:

The harmonisation of work health and safety legislation has focused the efforts of health and safety in Defence on legislative compliance and the efforts required to comply with changes to legislation. (2012a, p. 279)

When the Commission met with serving members, a common view from all three Services and levels of command was that the 2011 Act was a catalyst for a reinvigorated focus within the ADF on the prevention of service-related injuries and illnesses.

Data on the incidence of serious injuries and illnesses (figure 5.1) also shows a significant improvement in WHS outcomes from around this time. And while there is no conclusive evidence to explain why this occurred, participants suggested two possible factors:

- a change in who could be held accountable for a breach in the duty of care
- a change in what the consequences of a breach could be.

The reinvigorated focus was partly attributed to the (then) perception that the new Act would significantly extend the duty of care to an ‘officer’ of an organisation. And this concept of ‘officer’ under the Act was apparently initially misunderstood to mean an officer in the common language of the ADF, rather than the actual, much narrower, definition under the Act — which referred to ‘A person who makes, or participates in making, decisions that affect the whole, or a substantial part, of a business or undertaking of the Commonwealth’ (WHS Act 2011, s. 247(1)). In practice, only a few, quite senior, commanders would qualify as an ‘officer’ with a duty of care obligation under the Act.

The WHS Act 2011 also created new and broad statutory enforcement powers, including the imposition of criminal offences for breach of statutory duties under the Act, which can attract significant fines and terms of imprisonment (box 5.2).

Box 5.2 Work Health and Safety Act 2011

The Commonwealth *Work Health and Safety Act 2011* came into effect on 1 January 2012. The Act contains a number of offences and, in particular, three categories that relate to the failure to comply with a health and safety duty:

- category 1 offence — a person engaging in conduct that exposes an individual to whom a duty is owed to a risk of death or serious injury being reckless to the risk
- category 2 offence — a person failing to comply with a duty that exposes an individual to risk of death or serious injury
- category 3 offence — a person failing to comply with a duty.

These arise from various sections in the Act:

- s. 31 — reckless conduct (category 1)
- s. 32 — failure to comply with health and safety duty (category 2)
- s. 33 — failure to comply with health and safety duty (category 3).

The maximum penalties for these offences depend on the defendant, and are:

	Category 1	Category 2	Category 3
Individual	\$300 000/5 years imprisonment	\$150 000	\$50 000
Person/officer of a person conducting business or undertaking	\$600 000/5 years imprisonment	\$300 000	\$100 000
Body Corporate	\$3 000 000	\$1 500 000	\$500 000

The Act provides for a number of sentencing orders in addition to those available under Part 1B of the *Crimes Act 1914*, including adverse publicity orders, orders for restoration, work health and safety project orders, injunctions, and training orders.

Source: Commonwealth Director of Public Prosecutions (2018).

Defence is also subject to the *Public Governance Performance and Accountability Act 2013* (Cwth). This Act requires Defence to ‘establish and maintain an appropriate system of risk oversight and management of the entity’. This requirement is directed at enabling stronger governance to underpin all decision-making and should, in theory, reinforce the intent of the WHS Act.

The regulator responsible for monitoring and enforcing compliance with the Commonwealth WHS Act is Comcare. As Defence stated:

Comcare, as the workplace health and safety regulator for Defence, already conducts inspections and reviews with Defence in relation to incidents and injuries. Comcare has previously taken action under WHS legislation where it is clear that Defence has done the wrong thing in its non-operational activities, and Comcare could be expected to take similar action in the future (either through court action or enforceable undertakings). (sub. 127, p. 19)

Table 5.1 shows Comcare’s monitoring activity of ADF (excluding cadets) compliance over the past five years.

Table 5.1 Comcare compliance monitoring activity for the ADF^a

<i>Activity type</i>	<i>2013-14</i>	<i>2014-15</i>	<i>2015-16</i>	<i>2016-17</i>	<i>2017-18</i>
Incident notification	152	93	79	117	111
WHS concerns	20	17	14	6	10
Hazard notifications	19	2	1	0	2
Proactive activities	6	3	2	5	25

^a The level of monitoring activity is influenced by different policy approaches, Comcare’s priorities and resources. As a result, activity levels year-on-year is not indicative of any underlying WHS risk in the ADF.

Source: Comcare (pers. comm., 25 October 2018).

Comcare’s investigations have resulted in two criminal actions against the Department of Defence for breaching the WHS Act. The first of these relates to two army recruits who suffered severe electric shocks during a training exercise in regional Victoria (Cunningham 2018). The second relates to a college student who was injured on an Army cadet camp (Comcare 2018b). Both cases are proceeding through the courts and pleas are yet to be taken.

Of note is that these are only the second and third time that the Commonwealth has been charged with criminal offences under the WHS Act, and these cases provide a salutary reminder that the Act and the regulator have teeth.

Comcare also sits as an observer on the Defence Work Health and Safety Committee (section 5.3), which means it is privy to WHS issues affecting the ADF that are brought to that committee’s attention.

Is ADF-specific WHS legislation needed?

Previous reviews of military compensation and rehabilitation considered whether the ADF should be subject to either generally applicable or ADF-specific WHS legislation.

The 1999 Tanzer review received evidence that Commonwealth occupational health and safety (OHS) legislation at that time was overly prescriptive, administratively cumbersome and heavily process oriented. Defence argued before that review that Commonwealth OHS legislation imposed significant compliance and administrative costs without corresponding benefits of improved safety performance of the ADF (Tanzer 1999, p. 40).

These concerns led the review to recommend that the ADF should not be subject to the (then) *Occupational Health and Safety (Commonwealth Employment) Act 1991*, but should instead, be subject to ADF-specific OHS legislation — to be either included in new compensation legislation or enacted separately in standalone OHS legislation (Tanzer 1999, pp. 91–98). However, these recommendations were not adopted when the Military Rehabilitation and Compensation Act recommended by the review was enacted in 2004 (Campbell 2011b, p. 248).

The same issue was revisited by the 2011 Campbell review. That review cast doubt on the value of putting OHS and workers' compensation into one body of legislation. It noted that OHS legislation is quite different to workers' compensation legislation and all jurisdictions appear to successfully operate with separate legislation to deal with each area. The review also observed that amendments to the 1991 Act had meant that the ADF was exempt from certain OHS requirements, and this had effectively removed some of the compliance costs that the Tanzer review had concerns about.

The Campbell review also noted that in the period since the Tanzer review, it was not aware of any Chief of the Defence Force or Service Chief expressing the view that a separate OHS Act was warranted because the federal OHS Act imposed unacceptable restrictions on ADF activities (Campbell 2011b, p. 249).

In view of the above and moves to develop and introduce new, model WHS legislation in all jurisdictions, the review found the Tanzer report's proposal for ADF-specific OHS legislation no longer had any relevance or benefit to the ADF (Campbell 2011b, p. 249).

The model Commonwealth WHS Act has been in operation since 2012 — long enough for any serious failings to emerge. However, participants raised no concerns in meetings with the Commission or in submissions that the Act is inappropriate for the ADF or that ADF-specific OHS legislation is needed.

Some submissions, however, obliquely endorsed the application of federal OHS legislation to the ADF. For example:

Within the context of military training the ADF and individual unit commanders should be no less responsible for the provision of a safe workplace than other Australian employers. (Vietnam Veterans Association of Australia, sub. 78, p. 8)

... commanders have a ‘duty of care’ towards their subordinates to mitigate risks. They have the same obligations that exist in civil law. The responsibility for ‘duty of care’ is reinforced during all supervisory and management level training, including Commander’s Course. (Air Force Association, sub. 93, p. 5)

The Centre accepts that [the Commonwealth, model] WH&S legislation does apply to the ADF and to individual commanders, with necessary carve outs which reflect the unique nature of military service and operational requirements. (RSL Veterans’ Centre East Sydney, sub. 114, p. 10)

In light of the above, and the WHS performance of the ADF (section 5.4), the Commission considers that there are no compelling grounds to change the current arrangement where the ADF is subject to federal WHS legislation.

DRAFT FINDING 5.1

There are no compelling grounds to change the current arrangements where Australian Defence Force (ADF) members are subject to Commonwealth work health and safety legislation. In fact, the introduction of the *Work Health and Safety Act 2011* has been instrumental in helping to improve work health and safety outcomes in the ADF.

5.3 How is WHS delivered in the ADF?

At present, work health and safety in the ADF is driven by a number of factors.

As noted, it faces external pressures to prevent service-related injury or illness via its legal obligations under the *Work Health and Safety Act 2011*.

The ADF also faces strong internal pressures to prevent service-related injury or illness. Primary among these is a powerful incentive to prevent injury and illness in order to maximise force readiness.

Reducing injuries allows a greater number of soldiers to be available to do their job (Stephan Rudzki, sub. 40, attach B, p. 27).

Defence is committed to maintaining a safe, healthy and positive working environment for all workers to enable them to contribute to delivering Defence’s capability requirements. (DoD 2015, p. 139)(DoD 2015, p. 139)(DoD 2015, p. 139)(DoD 2015, p. 139)

Our mission — to defend Australia and its national interests — at times, requires our people to operate in hostile or hazardous environments. Protecting our people is therefore paramount in all activities undertaken by Defence. We cannot protect our nation if we do not first protect the health and safety of our people. (DoD 2017j, p. i)

Also important is the need to ensure the health and safety of its personnel in order to protect its reputation as an employer of choice and to help it to attract and retain personnel.

Finally, the very nature of the ADF's 'business' has formed a strong culture of looking after members of your service 'family' — your fellow 'comrades under arms'. (While a somewhat nebulous concept, this was a common message the Commission heard when it met with service men and women, of all ranks and across all services.) As Defence put it:

Defence's ability to create a workplace characterised by respect for each individual and with a focus on safety, is one of the foundations of establishing trust in both the workforce and the broader community, and in building capability that is sustainable. (sub. 127, p. 19)

These incentives — as Comcare observed — have resulted in a genuine commitment to providing a safe and healthy working environment for serving personnel (box 5.3).

Box 5.3 A regulator's view of commitment to work health and safety

Comcare's view is that Defence (and the Australian Defence Force (ADF) within Defence) is committed to effective work health and safety. It has formed this view through its role as an observer on the Defence Work Health and Safety Committee (DWHSC) and from the feedback of Comcare's inspectors and auditors who deal regularly with the ADF. From these sources, Comcare has observed evidence of:

- Formalised work health and safety (WHS) governance through the DWHSC and other bodies
- The involvement of senior leadership at the DWHSC level
- Dedicated WHS teams and safety systems
- Detailed WHS risk assessments and escalation of key risks to enterprise-level consideration
- A commitment to safety and incident reporting, including significant investment in systems to facilitate this reporting
- The use of incident data to identify patterns and trends, and to prioritise responses
- The engagement of outside businesses to assist in hazard identification and response
- Facilitating site visits for Comcare staff, including proactive visits and pre-event briefings on major training activities that present high risk
- Commitment to meet Comcare twice yearly through the Defence Liaison Forum
- Offers to Comcare to attend service safety boards as observers.

However, Comcare notes that given the ever-present risk that Defence's activities could result in harm to its workforce, it is appropriate that Defence continues to invest heavily in WHS and seeks to manage risks in a systemic manner.

Source: Comcare (pers. comm. 23 October 2018).

How does the ADF give effect to its WHS commitment?

To coincide with the implementation of the Commonwealth *Work Health and Safety Act 2011*, Defence released a *Defence WHS Policy Statement*, signed by the then Chief of the Defence Force and Secretary of Defence, which affirmed its commitment to providing a safe and healthy working environment for all employees (DoD 2018i).

To give effect to that commitment, Defence introduced a *Work Health and Safety Strategy 2012–17* in January 2012, aimed at ensuring that, ‘no person will suffer a serious preventable work related injury or illness’. That strategy complemented parallel efforts to change the culture within Defence in order to improve the health, wellness and safety of its people — through its *Pathway to Change* strategic cultural reform program launched in 2012. (Cultural change is critically important to prevent unacceptable behaviour like bullying and sexual harassment or abuse, which can otherwise lead to mental health problems and, in extreme circumstances, to suicide (Callinan 2018).)

That original WHS strategy has since been succeeded by Defence’s *Work Health and Safety Strategy 2017–2022* (and is similarly complemented by an updated *Pathway to Change: Evolving Defence Culture 2017–2022*) (DoD 2017f, p. 105).²

Governance of the WHS strategy is through the Defence Work Health and Safety Committee (a 2/3 Star-level committee), which is responsible for driving a consistent approach to work health and safety across Defence and is accountable to the Secretary and Chief of the Defence Force (DoD, sub. 127, p. 16).

The Australian National Audit Office (ANAO) described Defence’s WHS strategy as one that:

... involves the provision of information, policy, guidance, training and leadership and a strengthened focus on reporting incidents through the enterprise-wide Work Health and Safety Management System, Sentinel. ... The Defence Work, Health and Safety Committee ... provides the oversight and governance to encourage a consistent approach to safety across all areas of Defence. (2016, p. 22)

The primary source of ‘information, policy and guidance’ material for all Groups and Services is the Defence Safety Manual. The current manual (*SafetyMan*) was introduced in August 2017, and replaced the previous three-volume Defence Work Health and Safety Manual. *SafetyMan* has significantly reduced duplication and simplified the language employed in order to improve understanding among all users (DoD 2017i).

Defence’s annual survey of attitudes to work health and safety indicate that its approach to disseminate WHS information, policy and guidance among ADF personnel has been successful. For each year from 2012-13 to 2016-17, the survey found around 92 per cent of ADF personnel knew where they needed to go to get safety information relevant to their work area (table 5.2).

² This overarching WHS strategy is augmented by other Defence operating and regulatory systems, such as Sea and Air Worthiness systems, which deliver on specific safety regulations.

Table 5.2 Attitudes to work health and safety: Agree responses

<i>Attitude survey statement</i>	<i>I know how/where to obtain safety information relevant to my workplace</i>	<i>Health and safety is treated as an important issue in my workplace</i>	<i>When I report an accident/injury/incident/hazard, I believe that appropriate action will be taken</i>
2012-13	92	90	84
2013-14	92	91	85
2014-15	92	92	85
2015-16	92	90	85
2016-17	91	88	84

Source: DoD (Annual Reports, various years).

The importance of incident reporting systems in the context of prevention

As noted, the Defence WHS strategy embodies ‘a strengthened focus on reporting incidents through the enterprise-wide Work Health and Safety Management System, Sentinel’ (box 5.4).

Box 5.4 Sentinel and how it works

Sentinel is the Defence Work Health and Safety (WHS) Management Information System. It was implemented in August 2014 and has facilitated a consistent pathway for reporting and analysing WHS incidents in Defence.

Sentinel collects a wide range of information throughout an incident report, including but not limited to: names of person/s involved in the incident, date of birth, gender, business unit, location, activity (when incident occurred), mechanism of injury, nature of injury, body part involved, a description of the incident, classification, severity, object causing injury, relationship to Defence (APS, ADF, Contractor, Cadet), root cause, reported date, occurred date and created date.

Sentinel’s functionality is not limited to WHS incidents. The system also extends to recording WHS Hazards, WHS Risks, WHS Audits, Rehabilitation cases, Occupational Health Monitoring and Regulator Relations.

Defence uses the Safety Trend Analysis Reporting Solution (STARS) system to analyse and report on any data captured in Sentinel. STARS also houses WHS incident data gathered since the early 1940s. A suite of analysis reports are currently available in STARS, covering a number of specialised topics, such as asbestos, sport and training, parachuting, small arms, manual handling, hazardous chemicals, electrical, fuel and fatigue. STARS has approximately 2000 users across the Defence Organisation, allowing business units to keep abreast of relevant WHS trends and to respond with risk mitigation actions as required.

Source: Pers. comm. (response to request for information) Defence, 30 May 2018.

A common theme in Australian and overseas literature on the prevention of injury and illness in defence forces is the critical role of a comprehensive and credible reporting system to

identify incidents and causation, and to prioritise mitigation activities at both the micro and macro level. For example:

- Pope (2002a) highlighted the success of injury reporting systems in preventing anterior cruciate ligament injuries in recruit training.
- Jones et al. and McKinnon, Ozanne-Smith and Pope identified the core role of reporting systems in developing a force-wide approach to WHS in the US and Australia, respectively, through monitoring the success of that approach and in informing where changes are needed as circumstances change:

... the top priority for injury prevention must be the formation of a comprehensive medical surveillance system. Data from this surveillance system must be used routinely to prioritize and monitor injury and disease prevention and research programs. (Jones et al. 2000)

The role of [injury surveillance systems] in military injury prevention programs is to identify activities, venues, and other sources (e.g., equipment, substances) of high injury risks. This information can then be used to guide, prioritize, and focus the more detailed and resource-intensive investigations and causal analyses that must generally underpin countermeasure development and implementation. (McKinnon et al. 2009, p. 470)

Some submissions also drew attention to the critical role of surveillance systems in preventing service-related injury and illness. Stephan Rudzki (sub. 40, attach. B), for example, noted:

The best way of improving injury incidence and outcome is through a comprehensive system of injury surveillance. There is a clear imperative to improve the surveillance, prevention and management of injury. (pp. 52–3)

An understanding of where, when and how injuries occur and who they occur to is critical for the development of interventions designed to prevent and control injuries. (p. 90)

And the Defence Force Welfare Association stated that:

For risk to be minimised it must first be recognised. There are numerous examples where the command chain has not recognised risk, or perhaps how high the probability of the risk occurring and the extent of the impact. The following are historical examples, together with some where there is still some contention:

- a. Agent Orange.
- b. F111 De-seal-Re-seal Programme.
- c. Load Lifting in training and combat and musculo-skeletal injuries.
- d. Mefloquine.
- e. Inappropriate spraying of residual insecticide in ADF bases in South Vietnam. (sub. 118, p. 57)

Since it was introduced in 2014, Sentinel has been the subject of ongoing refinements to improve access to the system for all personnel in all services and to make it easier for all personnel to report service-related injury and illness. For example, a revised version of Sentinel was released in February 2016, and a suite of Sentinel training products for all Defence personnel was released in May 2016.

These refinements were aimed at improving the agency-wide use of Sentinel and, in turn, at reducing risks through more accurate and timely data and analysis of incidents, injuries and illnesses (ANAO 2016, p. 24).

5.4 ADF work health and safety outcomes

Command commitment to preventing excessive casualties in the ADF, as noted by a number of inquiry participants, is nothing new:

Minimising risk in the ADF. The concept seems reasonable, almost self-evident. General Slim sacked commanders whose troops developed unacceptable rates of Malaria. Monash protected his troops by all available mechanical means, rather than impale them on enemy bayonets. (Robert Black, sub. 45, p. 3)

There has been, and continues to be, considerable emphasis by military health services on mitigating the hazards likely to be encountered by military personnel during their peacetime or warlike service. Prevention of illnesses and injuries has been a major imperative for military health services as this both conserves personnel and is a force multiplier in the military context. There has been a far greater emphasis by the military in prevention in areas such as health education and promotion, public health, immunisations, medical and dental fitness assessment and surveillance than in other working populations. (Warren Harrex, sub. 89, p. 1)

But, there is some evidence to suggest that in the past, that commitment has not been all-pervasive across all services and all activities.

The Commission met with many current and former members of the ADF who were critical of the workplace health and safety practices they experienced in their service, and of the prevalence of injuries and illnesses resulting from those practices. Some examples included undergoing parachute training and being forced to jump into high, gusty wind conditions, and excessive pack weights and length of training runs that resulted in preventable injuries.

Some submissions told a similar story. Peter Hawes and Neil Robson, for example, described the poor WHS environment they were subject to:

I was happy and healthy when I joined the services and ready to do my duty. To go wherever I was asked to go, and to do repairs and other military activities in the field and while at home base that would make even the most liberal union or OHS representative cringe and run away in horror. (Peter Hawes, sub. 47, p. 4)

I performed all the roles related to SURFIN [Surface Finisher] duties whilst in service and the working environment involved confined spaces and the use of some significant chemicals in the form of paint, solvents and treatments used in everyday tasks. After almost 11 years of service as a SURFIN my body had reached a level of toxic sensitivity to the paints and solvents used. Isocyanate Sensitisation is when the body has reached saturation level and can no longer sustain or tolerate any further exposure. My body had continually been embalmed with a cocktail of chemicals and coatings used on aircraft and roles within my service and understandably had enough. (Neil Robson, sub. 146, p. 3)

However, the Commission also received submissions that indicated that much of the criticism of the ADF’s approach to preventing injury and illness it heard in meetings with ex-serving personnel reflected the legacy of past, poorer WHS attitudes, and that recent years have seen a marked shift to a genuine, service-wide commitment to improved WHS.

There are many safety measures already in place. Accidents happen for a variety of reasons. I believe that ‘accident prevention’ is a very high priority area for the ADF. (Don Sullivan, sub. 53, p. 11)

General opinion is that ‘can do’ attitudes ignoring unnecessary risk are waning. (Air Force Association, sub. 93, p. 6)

This view (that attention to WHS and WHS outcomes are improving) is supported by the results of annual Defence surveys of attitudes to work health and safety (table 5.2). The surveys indicate that in each year over the period 2012-13 to 2016-17, between 88 and 92 per cent of ADF personnel agreed with the statement that ‘Health and safety is treated as an important issue in my workplace’.

Data on the number of people involved in serious, notifiable WHS incidents also provides evidence that the ADF’s approach is working — and delivering significant benefits (table 5.3).³

Table 5.3 ADF work health and safety incidents

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Fatality ^a	23	16	15	5	12	9	8	3
Serious injury or illness ^a	1 587	1 237	982	559	449	330	274	277
Dangerous incidents ^a	1 722	1 611	1 493	745	603	396	382	566
Minor injury	na	na	na	na	10 980	10 406	9 783	8 937
Near miss	na	na	na	na	1 256	1 243	1 305	1 745
Exposure	na	na	na	na	1 864	3 454	4 191	3 464
Average funded strength ^b	59 084	57 994	56 607	56 364	57 512	58 061	58 680	58 475

^a Fatalities, serious injury or illness, and dangerous incidents are notifiable to Comcare. ^b Includes full-time Reservists.

Source: DoD (Annual Reports, various years).

³ In 2016, the ANAO observed that changes in reporting requirements within Defence make it difficult to compare changes in WHS performance since 2012. However, as some of those changes addressed systemic underreporting and in view of the scale and consistent reductions in serious, notifiable injury/illness and dangerous incidents (where underreporting is less likely to occur), the Commission considers that the data in table 5.3 is a credible indication of the underlying trend for serious WHS incidents.

As table 5.3 shows, over the period 2010-11 to 2017-18 (before and after the introduction of the model WHS Act 2011 and the *Defence WHS strategy 2012–17*), the annual number of people who suffered serious injury and illness has fallen steadily (by about 82 per cent). The reported number of people involved in dangerous incidents over that same period show a similar, consistent decline — falling by about 67 per cent in total.⁴ This decline occurred against a backdrop of an annual ADF average funded strength over that period that was relatively stable at about 59 000.

Data on the number of ADF notifiable incidents occasioning serious injury or illness over the period 2006-07 to 2016-17 show a similar story — with a rising trend in notifiable incidents occasioning serious injury or illness from 2006-07 arrested in 2010-11, and a subsequent fall in such incidents from 2010-11 to 2017-18 of about 84 per cent (figure 5.1).

Figure 5.1 ADF notifiable incidents occasioning serious injury or illness



Source: DoD (Annual Reports, various years).

This improved performance on notifiable WHS incidents has not, however, been mirrored in minor injuries, near misses and exposures.

The raw data on the reported WHS incidents in table 5.3 shows a reduction in minor injuries of about 18 per cent since 2014-15, but near misses and exposure over that period have increased (about 40 per cent and 85 per cent, respectively). Moreover, a recently published study on the injury experience of Navy recruits in 2015 found that 148 of 306 recruits (48 per cent) suffered a lower limb injury over their 11 week training course (Bonanno et al. 2017, p. 300)(Bonanno et al. 2017, p. 300)(Bonanno et al. 2017, p. 300)(Bonanno et

⁴ Because of their comparative rarity, fatalities are statistically less indicative of how an employer meets their obligations to be a good employer (Wilson, Ledson and Robinson 2013, p. 7).

al. 2017, p. 300) — which equates to an incidence rate of about 230 lower limb injuries per 100 full-time equivalent years of service. This rate is very similar to the lower limb injury incidence rate reported by Goodall et al. (2013) in a cohort of Army recruits in 2007.

Thus, while notifiable incidents have fallen substantially, there still appears to be considerable scope to improve WHS outcomes more generally.

5.5 Scope to improve WHS outcomes further

In the period since the introduction of the model WHS Act and the *Defence WHS Strategy 2012–17*, the ADF has continually refined its approach to WHS and has achieved commendable reductions in serious injuries and illnesses and dangerous incidents.

Nonetheless, information presented to the Commission in meetings with participants, in submissions and in the literature on preventing service-related injury and illness suggests more can be done to give the ADF better tools to help it realise its commitment to improved WHS. Areas warranting attention include:

- the information base underpinning the ADF’s approach to WHS
- specific injury prevention programs
- a workers’ compensation premium to signal the full (lifetime) cost of service-related injury and illness.

The information base underpinning the ADF’s approach to WHS

While the Sentinel information management system (box 5.4) plays a central role in the ADF’s approach to improving WHS outcomes, participants raised two concerns about its fitness for purpose:

- the likely significant under-recording of non-notifiable WHS incidents
- the ‘narrowness’ of the information captured by Sentinel and the need to augment that with information from other relevant databases.

These concerns are important because they affect the volume of incident data, which effects the statistical power to detect emerging problems and to monitor the success of the ADF’s WHS activities (Pope et al. 2015). They are also important because they affect the ability to identify injury and illness early and thereby facilitate early medical intervention, which can prevent the aggravation of that harm to something more serious and potentially less amenable to successful treatment.

Underreporting of injury and illness in the Sentinel system

The literature on WHS in the ADF indicates that Sentinel is likely to be significantly under-recording the true incidence of non-notifiable WHS incidents. For example, Pope and

Orr's (2017) findings suggest that the Sentinel database only captures about 10-20 per cent of the true incidence rate for injuries that are of sufficient severity to require a consultation with a healthcare provider. Anecdotal comments from serving personnel to the Commission in meetings and during its tours of Army and Air Force bases expressed a similar concern.

Although this view was common among serving personnel the Commission spoke with, RSL Queensland's view was that the ADF's incident reporting system was generally adequate:

... the ADF now takes fulsome steps to prevent service-related injuries, and that injury reporting and record keeping is generally now appropriate. Historically there were significant issues associated with reporting injuries ... (sub. 73, p. 27)

Some of the reasons for under-recording are endogenous to the system — such as less than service-wide coverage (access to the system), the ease (or not) of use of Sentinel, and confidence by military personnel that reporting will lead to change. Others, such as the reticence of military personnel to record their injuries or illnesses in Sentinel, are largely exogenous to the system.

Coverage

When Sentinel was first introduced, access to the system was poor for some groups. For example, Navy and some other parts of the ADF did not have ready access to the Defence Restricted Network — which made it impractical to log incidents in the Sentinel system. As well, Sentinel was not available in disconnected environments (such as Navy vessels on deployment) and on some IT platforms in services within the ADF that were not integrated with Sentinel (ANAO 2016, p. 23).

Since then, Defence has addressed many of these barriers to access and has significantly extended the effective coverage of Sentinel across the Services.

User-friendliness and confidence in the system

During visits to Army and RAAF bases, the Commission was told that the user-friendliness (or 'unfriendliness') of the Sentinel system affected the willingness of personnel to record WHS incidents on the system. This was particularly the case when those responsible for reporting WHS incidents faced competing demands on their time to get other (and what they viewed as more imperative) work done in the limited number of hours in the day available to them.

Although written with reference to Sentinel's predecessor (DEFCARE), the issues affecting user-friendliness and compliance identified below are equally applicable to Sentinel:

The major difficulty with this type of data capture system is compliance. Individuals must be strongly motivated to complete an injury report, obtain supporting statements from supervisors, witnesses and managers, and submit the report to the central database. The process can be readily

halted at any step if the task becomes too onerous, if the assistance of others is not readily available, if the injury becomes less significant, if the submission channels are not clear or effective, or if the individual becomes distracted by other life events. (Pope 2002b, p. 4) (Pope 2002b, p. 4)(Pope 2002b, p. 4)(Pope 2002b, p. 4)(Pope 2002b, p. 4)(Pope 2002b, p. 4)

However, since Sentinel was rolled out in 2014, it has been continuously modified and enhanced to improve its functionality and user-friendliness. Some of the key modifications are described in box 5.5.

Box 5.5 Changes to improve Sentinel's functionality and user-friendliness

Key modifications since Sentinel's inception include:

- improving the Event Module to include a 'check list' on the side of the screen to navigate the user through the necessary steps (as numerous users were initially failing to complete their role in Sentinel)
- adding a checklist to ensure all appropriate entries were made to reduce the number of Events that the Australian Defence Force failed to notify Comcare about (as a result of some steps not being followed)
- improving and changing the appearance of the five key modules in Sentinel (Risk, Event, Hazard, Audit and Regulator Relations). This included fields that were marked 'mandatory' and explanations in those fields to help the user provide context to what they were recording on the system. The outcome of updating the modules resulted in improved reporting and added clarity in reporting for all Groups and Services within Defence.

Source: DoD (pers. comm., 8 October 2018).

The willingness of ADF members to report WHS incidents on Sentinel is also strongly influenced by their confidence that such reporting will lead to the remediation of identified WHS risks. McKinnon, Ozanne-Smith and Pope (2009) and Pope, MacDonald and Orr (2015), for example, note that those supplying and entering data in injury surveillance systems will not do so reliably where this confidence is absent.

However, Defence's annual survey of attitudes to work health and safety indicate that the Sentinel system performs well on this basis, although more could be done. As that survey shows, over the period 2011-12 to 2016-17, a consistent 84–85 per cent of respondents agreed with the statement 'When I report an accident/injury/incident/hazard, I believe that appropriate action will be taken' (table 5.2).

DRAFT FINDING 5.2

Since Defence introduced Sentinel (a work health and safety incident reporting system) in 2014, it has expanded its coverage (there is now service-wide access), improved the ease of use of the system for serving personnel and put in place processes to ensure that reported incidents are acted on.

However, despite these efforts, underreporting of work health and safety incidents on Sentinel (other than for serious, defined events that must be notified to Comcare) continues to be an issue.

INFORMATION REQUEST 5.1

The Commission was told that the data recorded on Sentinel significantly understates the true incidence of most types of work health and safety incidents. What aspects of Sentinel contribute to this and what might be done to improve reporting rates?

Reticence of serving members to record their injury or illness

Three (interrelated) factors are particularly significant in the reticence of serving ADF members to report an injury and illness:

- a pervading culture in the military of perseverance and toughness
- concern that reporting an injury or illness could have an adverse effect on a member's prospects of deployment or, in extreme cases, result in their discharge from the ADF
- stigma associated with admitting to suffering from a mental illness.

The first of these is a well-known barrier to comprehensive injury and illness reporting. A culture of machoism, which results in sentiments like 'don't be a woose' and 'tough it out', is inimical to the early and comprehensive self-reporting of injury and illness. In their study of military injury surveillance systems in the ADF, McKinnon, Ozanne-Smith and Pope observed:

One important global factor [affecting data collection in injury surveillance systems] identified was military culture. Military environments such as the ADF, which inculcate an expectation of enduring physical hardship, can be perceived as running counter to the aim of injury prevention. The reporting of injuries that is critical to gaining comprehensive and representative data in military [injury surveillance systems] can be hampered in military contexts by a pervading ethos of perseverance and toughness ... (2009, p. 475)

Defence has recognised 'culture' as a barrier to the reporting of injury and illness and has taken steps to address this issue. The initial Defence *Pathway to Change: Evolving Defence Culture*, for example, noted that:

We particularly need to remove the stigma of communicating distress to those who have a responsibility for our welfare; whether it relates to injury or other ailment, perceived threat, intimidation or harassment ... As one Review termed it, we need to adopt a 'Reporting' culture. (DoD 2012b, p. 23)

The second factor — the concern that reporting an injury or illness could have adverse career effects — is particularly strong in the military context.

The ANAO (when examining the usefulness of the Sentinel system in assisting Defence to manage WHS risks in the ADF) identified deficiencies in Defence's injury/illness reporting system for just this reason:

... the ANAO was informed during numerous audit interviews with a range of ADF staff of reluctance within some parts of the ADF to report incidents due to perceived potential negative career impacts. (ANAO 2016, p. 9)

This reluctance to report potentially career limiting injury or illness stems from the inherent requirement that ADF personnel must maintain a sufficiently high standard of fitness to be 'fit for service'. The ADF Medical Employment Classification (MEC) System defines a serving member's employment prospects based on their medical fitness. It ranges from MEC1 (Fully employable and deployable), MEC2 (Employable and deployable with restrictions), MEC3 (Rehabilitation), MEC4 (Employment transition) to MEC5 (Separation).

Each Service has the right to retire members on the grounds of invalidity, that is, a physical or mental incapacity to do their duties (Warfe, Jones and Prigg 2000, p. 45). Thus, a fundamental problem is that where an injury or illness is likely to trigger an assessment of a reduced fitness for duty (and deployment) — or, in extreme cases, a discharge from service — if it is reported, there are very real incentives for serving members to not report it.

While a reluctance to report a mental illness may be partly explained by the above two factors, the stigma associated with mental illness is a sufficiently unique characteristic that it merits particular mention. Stigma is not normally associated with reporting an injury and illness — for example, reporting a broken leg from a parachute jump gone wrong or a bout of malaria picked up patrolling some swamp carries little to no stigma.

Mental health is different. A number of submissions noted that stigma, culture and adverse effects on one's career were all factors behind the reticence of serving ADF members to admit to mental illness. Slater + Gordon, for example, noted:

It is widely understood that ADF personnel will not report mental health injuries for the following reasons:

- (1) There is a perceived stigma with reporting mental health issues. Members remain of the view that they would be treated differently if they sought care and that seeking care would harm their career.
- (2) Serving members do not wish to jeopardise their ongoing employment or future chances of deployment, promotion or career opportunities.

(3) Complaining of health problems is somehow letting down their mates and not being part of the team.

(4) If time off work is needed they will be isolated, demoted, downgraded or given less meaningful jobs.

(5) An anti-reporting ethic of keeping silent, not being seen to be whinging, working in an environment of strong peer group pressure where members are expected to be strong and stoic despite living in the face of pain and emotional stress.

(6) A culture has been created where to seek help is an admission of weakness. (sub. 68, p. 84)

Underreporting of mental illness is a particular concern. As the *Defence Mental Health and Wellbeing Strategy 2018–2023* states, mental illness is responsible for the major share of compensation costs and lost time:

Mental illness is costly to the organisation, sometimes forcing highly skilled people out of their roles and causing lost productivity. The workers' compensation aspects are also significant. Psychological claims account for only 19% of all accepted claims but account for 57% of all total expected or actually incurred costs and 56% of all lost time to injury. (DoD 2017h, p. 15)

This makes it all the more important for the ADF to get a handle on its incidence and likely causes in order to better inform what WHS action it might take to reduce the incidence and severity of that illness.

To its credit, the ADF has done a lot to promote mental health and wellbeing and, in the process, to reduce the stigma attached to mental illness and improve reporting rates (table 5.4). (In the absence of counterfactual data, though, it is not possible to determine the effect these reforms have had on mental health reporting rates.) In many respects, these reforms parallel efforts in the broader community to de-stigmatise mental illness — which has seen a greater focus on mental health and the growth of organisations like *Beyond Blue*.

Table 5.4 Mental health reforms affecting the ADF

<i>Year</i>	<i>Reform</i>
2002	First ADF Mental Health Strategy Introduction of Defence Suicide Prevention Program
2009	Review of Mental Health Care in the ADF and Transition through Discharge Government response initiates ADF mental health reform program Longitudinal ADF Study Evaluating Resilience
2010	Military Health Outcomes Program, including ADF Mental Health Prevalence and Wellbeing Study
2011	ADF Mental Health and Wellbeing Strategy
2012	2012–2015 ADF Mental Health and Wellbeing Plan Establishment of ADF Mental Health Advisory Group Introduction of mental health service delivery model
2013	eMental Health Strategy for Australia Pathway to Change: Evolving Defence Culture Upskilling Mental Health Providers The Veterans' Mental Health Strategy 2013–2023
2014	Review of alcohol use in the ADF and implementation of the ADF Alcohol Management Strategy Review of implementation of the recommendations from the 2009 Dunt Review ^a
2015	DVA Social Health Strategy 2015–2023 for the Veteran and Ex-Service Community Government response to Mental Health Review by the National Mental Health Commission Senate inquiry into the mental health of ADF personnel returning from combat First Principles Review
2017	Australian Institute of Health and Welfare ADF Suicide Report 2001–2014 National Mental Health Commission Review into suicide prevention and Government response Senate inquiry into suicide by veterans and ex-service personnel Fifth National Mental Health and Suicide Prevention Plan Development of Defence Mental Health and Wellbeing Strategy 2018–2023.

^a *Review of Mental Health Care in the Australian Defence Force and Transition through Discharge.*

Source: DoD (2017h).

The Commission observed first-hand the changing attitude in the ADF to mental illness. One example was a senior serving commander ‘going public’ with their battle with mental illness and lower ranks commenting that this has had a tangible knock-on effect of reducing the stigma of mental illness and increasing serving members’ willingness to acknowledge and report their own mental health concerns.

Nonetheless, while much has been (and is being) done to address the stigma of mental illness in the ADF, it appears that stigma is still alive and well (albeit in a reduced lifeform).

Mental illness also does not lend itself well to incident reporting. In this regard it is akin to hearing loss, which is not so much a consequence of a specific incident but rather the result of an accumulation of contributing events and evident only after gradual onset. As such, underreporting of mental health issues in the Sentinel system is likely to remain high.

What then — in addition to existing mental health reforms — can be done to get better information on the incidence and likely causation of mental illness and to better inform WHS efforts to address this problem?

One suggestion put to the Commission was to augment the Sentinel system with other databases to get a better handle on the true incidence of WHS incidents, including mental illness. In particular, some participants suggested that the joining up of the Defence eHealth System and Sentinel would help address deficiencies in the information base guiding Defence's WHS strategy.

Increase the breadth of data informing WHS strategy

Whatever the current proportion of WHS incidents recorded by Sentinel, it is axiomatic that more and better data could improve the ADF's ability to detect emerging problems, to monitor the success of its WHS activities and to better target WHS/prevention activities.

The US Army's Total Army Injury and Health Outcomes Database is an example of how disparate but related databases can be harnessed to identify WHS risk factors and adverse health outcomes, and to evaluate the effectiveness of intervention strategies (box 5.6).

When the Commission visited RAAF and Army bases at Wagga Wagga, Kapooka, Bandiana and Lavarack, a number of personnel commented that while Sentinel is good for recording injuries, it is poor for recording illnesses or other 'accumulated harm' (such as hearing loss or mental illness). This is a particular concern given that mental health conditions are accounting for increasing numbers of medical discharges in recent years (chapter 3).

Box 5.6 The US Total Army Injury and Health Outcomes Database

To uncover the complete spectrum of injury morbidity and mortality among Army Soldiers, the US Army Research Institute of Environmental Medicine developed a research database, the Total Army Injury and Health Outcomes Database (TAIHOD).

The TAIHOD is a research tool with great potential for identifying risk factors, documenting adverse health outcomes, and evaluating intervention strategies, among deployed and non-deployed active duty service members.

The TAIHOD comprises data from multiple Department of Defence agencies, including records of hospitalizations, outpatient visits, deaths, disabilities, flying duty medical examinations, accident reports, clinical evaluations from Gulf War registrants with the Comprehensive Clinical Evaluation Program, and reports of spousal abuse, as well as demographic information, self-reported health behaviour information from surveys, and occupational noise exposure data.

The TAIHOD has great potential for Force Health Protection-related research focusing on the health of service members during armed conflicts and during peacetime activities. And, by virtue of the breadth and depth of the information it contains, it is particularly useful for assessing pre- and post-deployment health for the entire population of Soldiers serving on active duty.

Source: Bell et al. (2004).

To address this potential weakness in the data informing and guiding Defence's WHS efforts, they suggested Sentinel data be augmented with information from other databases. The main candidate for this is the Defence eHealth System, which contains health information at the point of care. Another suggestion was the DVA's data set on injury and illness claims, which would provide information on the cost of particular injuries or illnesses. Cost data, we were told, would be invaluable in 'weighting' the significance of particular injuries and illness and allow a better prioritisation of remedial WHS activity.

The need to augment Sentinel data with point-of-care health data is also a consistent theme in the literature on preventing injury and illness in the ADF:

... it would seem important that the evident deficit in incident reporting and data capture is noted and addressed. ... it would appear prudent that developers and administrators of military WHS incident reporting systems ensure that point-of-care reporting mechanisms are incorporated in these systems to maximise data capture and so support WHS incident and injury risk management by commanders. (Pope and Orr 2017, p. 15)

A Defence/DVA initiative aimed at reducing the time to make determinations of liability and invalidity offers an insight into how the deficiencies in incident reporting and data capture that have been attributed to Sentinel might be overcome.

In 2016, Defence and DVA entered into a *Joint Memorandum of Understanding on Cooperative Delivery of Care and Support*. Collaboration under that MoU includes an initiative to establish an Electronic Information Exchange Strategy (DoD, sub. 127, p. 14). The information exchange strategy aims to allow effective and efficient sharing of electronic information contained in the following systems:

- the 'Defence One' Human Resource Management System
- the Defence eHealth System
- Defence's Safety Trend Analysis Reporting Solution system — which is used to interrogate Sentinel data
- 'Objective', the Defence Record Management System
- DVA systems.

This initiative offers a template for how other datasets might be harnessed to expand the breadth and depth of information guiding Defence's WHS strategy.

While this exchange is primarily aimed at sharing information in order to reduce the time to make determinations of liability and invalidity, DVA indicated that it could have benefits through informing Defence's approach to WHS:

DVA believes that enhanced systematic information sharing between the two departments [Defence and DVA] regarding the translation of service incidents into compensation claims provides a significant opportunity for Defence to proactively identify and manage occupational risk in the absence of a price signal. (sub. 125, p. 35)

The level of underreporting of WHS incidents on the Sentinel system is unlikely to be resolved in the near term. Augmenting the Sentinel database with information from the Defence

eHealth System and information on the cost of injury and illness from DVA's datasets would help address this deficiency and, in the process, improve the breadth and depth of data available to inform the Defence work health and safety strategy.

Given that the current Defence eHealth System is due to be replaced in the next 3–4 years (Defence expects to go to tender for its health knowledge management platform for the ADF in early 2019), a longer term option to enrich the WHS data available to Defence would be for it to consider how that new system could facilitate the capture of WHS data. This, for example, could include a tick a box function to identify that the point-of-care presentation is a service-related condition.

DRAFT RECOMMENDATION 5.1

Defence should investigate the feasibility and cost of augmenting the Sentinel database with information from the Defence eHealth System. In the longer term, when Defence commissions the next generation of the Defence eHealth System, it should include in the system requirements ways to facilitate the capture of work health and safety data.

The Departments of Defence and Veterans' Affairs should investigate the feasibility and cost of augmenting the Sentinel database with information from the Department of Veterans' Affairs' datasets, which would provide insights into the cost of particular injuries and illnesses.

Targeted injury prevention programs

The scale and significance of service-related injuries among ADF personnel is clear (section 5.1 and table 5.3). Australian (Pope 2002b) and Canadian studies indicate that most of these injuries occur in sport, physical training and other physical activities, rather than being conflict or deployment-derived injuries:

The 2008/2009 Health and Lifestyle Information Survey ... found that in the preceding 12 months 23% of Canadian Forces (CF) personnel had sustained a repetitive strain injury and 21% an acute injury. These injuries were mainly attributed to physical training/sports/Adventure training. CF occupational fitness requirements necessitate participation in vigorous physical training, sports and military exercises, placing this population at increased risk of non-battle related injury, with adverse implications for operational readiness. (Valle and Payne 2010)

Previous examples of targeted injury prevention programs have shown this approach can deliver substantial reductions in the incidence and severity of injuries of non-battle related injury. For example, Andersen et al. — reporting on Pope (1999) — observed:

A modified training course for female recruits was also implemented in the Australian Army. The modified course lowered march speeds, utilised softer march surfaces and lowered total running distance. ... The stress fracture incidence amongst the female recruits dropped from 11.2 to 0.6% after implementation of the study ... (2016, p. 7)

Of particular relevance here is the example of the Defence Injury Prevention Program (DIPP), which operated briefly in the early 2000s. Stephan Rudzki (sub. 40) noted that when the program was implemented across various cohorts of ADF personnel in 2003, it achieved injury rate reductions of between 13 to 70 per cent (table 5.5).

Table 5.5 Defence Injury Prevention Program injury statistics — 2003

<i>Population</i>	<i>Time period</i>	<i>Injury rate (injuries per 100 per month)</i>	<i>Reductions in injury rates</i>
Staff – Australian Federation Guard (Canberra)	1 Jan 2003 to 31 Mar 2003	8.2	15% compared with 2001–2003
Office Cadets – Australian Defence Force Academy (Canberra)	1 Jan 2003 to 31 Mar 2003	11.3	32% compared with 2002–2003
Recruits – 1 st Recruit Training Unit (RAF, Edinburgh)	1 Jan 2003 to 31 Mar 2003	27.3	71% compared with 2001–2003
Recruits – Army Recruit Training Centre (Kapooka)	1 Jan 2003 to 30 June 2003	22.3	70% compared with 1995–1999 and a further 13% compared with 2001–2003
Officer Cadets – Royal Military College (Canberra)	1 Jan 2003 to 31 Mar 2003	15.8	13% compared with 2002–2003

Source: Rudzki (sub. 40, attach. B).

Stephan Rudzki also described the success of the program in reducing injuries when it was implemented by 3rd Brigade in Townsville in 2004. For that group the program delivered:

... reductions in injury rate of 2.7/100/month, 4.4/100/month and 1.5/100/month [equating] to injury reductions of 81, 132, and 45. This means that the program prevented 258 injuries during the peak winter season. ... In addition to the reduction in incidence, there was also a reduction in the severity of the injuries reported ... (sub. 40, attach. B, p. 49)

An evaluation of the DIPP in 2005 by the Defence Inspector General found that it provided a sound, structured approach to injury prevention and delivered considerable benefits to Defence (through improved capability and significant cost savings) for a relatively modest investment (Department of Defence 2006, p. 7). However, the DIPP was terminated ‘because of the lack of a committed internal Defence owner and dedicated resourcing’ (Stephan Rudzki, sub. 40, p. 3).

This evidence, together with the ongoing significance of injuries to the ADF and concerns that Sentinel is significantly underreporting WHS incidents (which constrains the ADF’s ability to identify WHS risks and initiate remedial action to address them), suggests there is a place for a similar program in the current ecosystem of WHS management.

Stephan Rudzki suggested that it would be feasible (and, highly beneficial) to resurrect the DIPP in an enhanced form, utilising advances in technology and a dedicated data collection system (sub. 40, p. 3). Trial injury prevention programs currently underway at Lavarack

Barracks in Townsville (3rd Brigade) and at Holsworthy Barracks in Sydney (Special Operations Command) could be useful models to test this proposition and provide the basis for the service-wide reintroduction of effective injury prevention programs.

These programs are designed to both prevent physical injury and to maximise capability (that is, to meet the ADF's core goal — *Every soldier physically tough*). They broadly replicate and enhance the successful DIPP (which had at its core a comprehensive injury surveillance system).

The Lavarack trial replicates the DIPP insofar as personnel presenting to a point of care for treatment for muscular–skeletal injuries will report their injury on a standalone database (Fusion Sport's 'Smartabase'). This report will be in addition to and after that presentation is recorded on the Defence eHealth System. Information reported on Smartabase is anonymous, insofar as it would be recorded at the company — not the individual — level. It is also only accessible to those with permission to interrogate that database.

The (significant) enhancement is that this injury reporting system is combined with:

- scientific assessments to determine an individual's injury risk profile (using Sparta Science's force plate technology and injury prediction software)
- a real time data collection and monitoring system (from Smartabase)
- a periodised strength and conditioning program to improve baseline performance and deliver enhanced combat readiness that, informed by data from the Sparta Science and Smartabase systems, is tailored to each individual.

This combination accommodates the level of training needed to achieve the physical capabilities required for deployment, but does so within a system that monitors performance and provides close to real time feedback that provides the ability to predict and prevent injuries in the first instance, or to track and validate rehabilitation methods where injuries do occur.

The Special Operations Command program is broadly similar. It, too, incorporates a comprehensive electronic data collection and monitoring system, the information from which provides a biometric assessment of each individual's strengths and weaknesses and can be interrogated to identify their injury risk profile and to inform an individually tailored training regime designed to eliminate or mitigate the risk of preventable injuries.

Initial results from the Lavarack program indicate a level of musculoskeletal and soft tissue injury reporting significantly greater than corresponding records on Sentinel. This injury incident data will enable the tracking of injury trends in a way not possible with Sentinel (with its apparently inherent high level of underreporting for non-notifiable incidents) and will provide local commanders with the capacity to quickly identify and compare the incidence of injury in units under their command and put in place any necessary change to eliminate or mitigate injury risks.

While a replication of the very high reductions in injury rates achieved by the DIPP may not be a realistic expectation for these programs (some of the low hanging fruit of injury

prevention has inevitably been plucked since the DIPP was terminated), it seems reasonable to assume that substantial reductions in injury rates are achievable.

The business case for the Lavarack trial program presented to command indicated it could achieve a 5–10 per cent reduction in injuries (DoD, pers. comm., 9 October 2018). Set against the reductions achieved by the DIPP, this seems a very conservative goal.

At this stage, the estimated cost of implementing the Lavarack program is just under \$1 million. However, even if the program only achieves the lower bound reduction, the benefits of the program (in terms of reduced human suffering, improved force readiness, lower in-service medical treatment and rehabilitation costs, and lower costs of compensation and rehabilitation liabilities) would vastly outweigh the costs.

The Commission's estimates (just taking into account potential savings from lower in-service medical and rehabilitation costs, and fewer claims for compensation and rehabilitation) suggest an injury reduction rate of 2 per cent would justify the trial costs.

These trial programs offer a unique opportunity to observe the value of a new generation approach to injury prevention, the lessons from which could usefully be applied across the ADF.

Accordingly, the Commission considers that every effort should be accorded to support these programs, monitor their effectiveness and, most importantly, conduct comprehensive assessments of these trials' worth. This should include (but not necessarily be confined to) adequate funding for the programs and ancillary support such as physical training instructors and physiotherapists, organisational support in facilitating approvals as needed (for example, ethics clearances if such were required), and the resources and access to information to facilitate a comprehensive and robust cost–benefit assessment of the programs' outcomes.

DRAFT RECOMMENDATION 5.2

Defence should use the injury prevention programs being trialled at Lavarack and Holsworthy Barracks as pilots to test the merit of a new approach to injury prevention to apply across the Australian Defence Force (ADF).

Defence should adequately fund and support these programs, and ensure that there is a comprehensive and robust cost–benefit assessment of their outcomes.

If the cost–benefit assessments are substantially positive, injury prevention programs based on the new approach should be rolled out across the ADF by Defence.

A workers' compensation premium

A unique aspect of the veterans support system is that Defence does not pay for the cost of compensation resulting from service-related injury or illness among its employees. In terms of prevention, the price signal of a premium (which varies in response to claims experience)

is one important instrument used in workers' compensation schemes to drive safer workplaces.

Like all workplaces, Defence has a number of drivers (described above) to create a safer environment for ADF members, albeit within operational environments often involving inherent risks and dangers. Nevertheless, the absence of a financial driver is a missing element.

The question is — would Defence paying a workers' compensation premium (which signals the full cost of compensation for service-related injury and illness) affect its behaviour in terms of preventing injuries and illnesses, and providing early intervention and rehabilitation support?

The Commission is interested in a workers' compensation premium from three perspectives:

1. as an added incentive for Defence to improve its WHS outcomes
2. as additional information to assist Defence realise its commitment to improve WHS outcomes (for example, on the size, source and trend of the costs of service-related injury and illness)
3. as an alternative funding model to annual Budget allocations to cover the cost of compensation and rehabilitation for veterans.

This section looks at the first two issues. The merits of levying a premium on Defence to fund the cost of compensation and rehabilitation for veterans are discussed in chapter 11.

Putting a workers' compensation premium into context

Before looking at the potential role of a workers' compensation premium as an incentive or source of information to improve WHS outcomes in Defence, it is important to get a sense of the magnitude of Defence's potential workers' compensation premium.

As discussed in chapter 3, the Australian Government Actuary (AGA) estimates the notional premium needed to meet the cost of compensation and rehabilitation claims under the *Military Rehabilitation and Compensation Act 2004* (table 5.6). These estimates suggest that an annual premium of about 13 per cent (\$798 million) across the ADF would be required to fund those claims, although its distribution among the Services would vary, with Army facing a premium of about 19 per cent, and the Navy and Air Force facing premiums of about 8 and 7 per cent, respectively (AGA 2018a, p. 138).

Table 5.6 2017-18 notional premium by Service

	<i>Army</i>	<i>Navy</i>	<i>Air Force</i>	<i>Total</i>
Notional premium (\$m)	571	124	103	798
Forecast salaries 2017-18 (\$m)	2 945	1 543	1 518	6 006
Notional premium (% of salary)	19.4	8.0	6.8	13.3

Source: AGA (2018a), unpublished.

A workers' compensation premium as an added incentive

As noted, Defence already faces incentives to reduce the incidence and severity of injury and illness among its personnel, and there is evidence of improvements in more recent times. These incentives arise from its existing WHS regulatory obligations, together with its inherent incentives to maximise operational capability, to look after your 'family' of comrades in arms, and to guard its reputation as an employer of choice in order to attract recruits and retain serving personnel. But there is scope for a premium to complement these incentives.

The advantage of a premium is that it is a clear and simple indicator, providing Defence with a financial incentive for preventing and managing injury and illness. This point was made in the Tanzer review, which noted that if the objective of improving occupational health and safety is to be achieved, a premium-based model:

... would be desirable because the annual cost to Defence would be linked to current injury cost and knowledge of that should have an effect on approaches to safety and injury prevention. (1999, p. 3)

A number of submissions made similar comments, for example:

Defence has no financial incentive to reduce or completely resolve injuries or illnesses prior to discharge. (Stephan Rudzki, sub. 40, p. 4)

... premiums reflect the claims history and actuarial projections of risk and so employer safety performance is reflected back to the management ... this does give financial incentive to address risk and work practices ... (Peter Alkemade, sub. 66, p. 3)

Stephan Rudzki emphasised that where the long-term costs of injury/illness are largely hidden, the incentive to reduce them is low. He argued that introducing an explicit and transparent workers' compensation premium would make apparent the long-term costs of injury/illness, and would be a key first step to improving accountability for performance and providing a feedback loop (via reduced premiums) for better performance (sub. 40, attach. B, p. 245).

Some participants, though, were sceptical that a premium could be an effective incentive. Peter Sutherland, for example, stated:

There is a fundamental conflict between appropriate support for injured personnel and the pressure on unit commanders to have an effective unit ready for deployment in accordance with rotation requirements. There needs to be recognition of this dilemma and practical mechanisms to address it. I doubt that a premium system or a mechanism for financial accountability would prove effective. (sub. 108, p. 5)

But this same conflict exists in the context of commanders having to balance compliance with WHS legislation and pressure to maintain units ready for deployment. Given that such pressures have delivered improved WHS outcomes without degraded deployment readiness, there is little reason to believe that the incentive effect of a premium would not be similarly accommodated.

The Defence Force Welfare Association dismissed the concept of financial incentives to prevent injury as one having no applicability to the operations of the ADF:

The bean-counter focus on financial accountability regarding preventing injury is inappropriate. The purpose of the ADF is to defend Australia's interests. That undertaking involves deliberately putting ADF members in 'harm's way', sometimes with a high risk of injury or death. ... The financial considerations injected into this question are an insult to the ADF and its values, and have no place in the assessment of risk. (sub. 118, p. 58)

This view, though, is difficult to accept. The most senior levels of Defence and the ADF are committed to improving WHS outcomes — to ensure that Defence capability is maximised and sustainable (DoD 2017j, pp. i, 2). And evidence from civilian workers compensation schemes indicate that premiums can play a significant role in driving improved WHS outcomes. Thus, given that a premium is a (proven) tool to help realise that commitment it would appear that it is relevant and applicable to the operations of the ADF.

Defence and DVA also questioned the merit a workers' compensation premium, citing practical issues that complicated the calculation of a premium. Defence, for example, argued:

Given the unavoidable high-risk nature of operational service, it is unlikely that a premium or other price signal to Defence would be acceptable unless, as a minimum, it excludes operational service. But even then, many ADF activities, even in peacetime, and not just when training for operations, are inherently dangerous. There are also practical issues with calculating a premium for injuries, illness or death related to non-operational service that would make the exercise difficult and complex, such as:

- sorting operational v non-operational compensation payments;
- some conditions are not due to any particular type of service (e.g. fair wear and tear);
- several conditions together may give rise to incapacity payments;
- health care is not split by condition; e.g. GP visits, while Gold Cards cover all conditions, whether service-related or not; and
- non-liability health care costs are not attributed to service type. (sub. 127, p. 18)

While some of the features of military service noted by Defence and DVA add uncertainty to estimates of future costs, these complex challenges are not insurmountable (rather they require careful consideration in the way a premium is calculated, see chapter 11).

A premium is not designed to undermine ADF's core functions (such as operational requirements and having a fit well-trained, fully prepared force), rather it is about making transparent the actual costs of service related harm, better understanding how the approach taken to safety and injury prevention affects the incidence and cost of that harm and encouraging good practice in risk management.

An important feature of a premium is its transparency. Currently, the AGA's full report is not made public, although a five or six page summary is included as notes to DVA's financial statements in its annual report. This means that the visibility and worth of a notional premium as an incentive — by making the ADF command accountable against a benchmark (notional) annual cost of compensation — is reduced. Making the whole AGA report public would shine further light on the impact that Defence activities have on the cost of service-related injuries and illnesses among ADF members.

Given that the ADF would only have to achieve a reduction in injuries or illnesses each year of 0.1 per cent in response to the incentive effects of those notional premiums to justify the cost of calculating them,⁵ it is highly likely that the benefits of those premiums exceed their cost.

DRAFT RECOMMENDATION 5.3

Beginning in 2019, the Australian Government should publish the full annual actuarial report that estimates notional workers' compensation premiums for Australian Defence Force members (currently produced by the Australian Government Actuary).

Another factor that affects the real-world impact of a premium on Defence is the extent to which it actually bites. The current annual reporting of a notional premium and the partial publication of that report is an important first step. But additional steps are warranted, including applying a premium against the Defence budget (draft recommendation 11.5). These and other issues are discussed in more detail in chapter 11.

Nevertheless, as raised by Defence and others, the premium needs to be reflective of practices under the control or influence of Defence if it is to be an incentive for driving improvements in harm prevention within the ADF.

⁵ Zero point one per cent of the annual liability cost of service-related injury and illness (\$798 million) and of the assumed service-related cost share (some \$220 million) of the total medical and rehabilitation expenditure of Garrison Health Services, is about \$1.02 million, which exceeds the estimated cost of producing the notional premium estimates.

A workers' compensation premium as an added source of information

In addition to its value as an incentive to improve WHS outcomes, an annual premium has value as a source of information about an organisation's WHS performance. As Stephan Rudzki noted:

... the use of a notional insurance premium based on state workers compensation actuarial models, would be a very useful key performance indicator for Government in determining Defences efforts in injury prevention and injury management. (sub. 40, p. 4)

A premium — by identifying the lifetime costs associated with service-related harm — also effectively places a 'weighting' on the consequences of failing to provide a safe and healthy work environment. It therefore provides information beyond that available from raw injury and illness incident data. This information is critical to informing Defence about both health and safety issues (for example, its Defence WHS strategy) and policies that influence lifetime costs.

While both a notional and actual premium are a valuable source of information, imposing an actual premium will demand higher quality data about injuries and better explanations about what factors are driving changes in the premium (chapter 11).

A premium — by reflecting the net present value of the lifetime cost of compensation and rehabilitation payments — also moves the focus of WHS concerns from the short term to the long term. The Campbell review acknowledged this point:

The Review recognises that the absence of an effective price signal [in the form of premiums] is a barrier to understanding the dollar cost of service-related deaths, injuries and illnesses in the ADF. ADF managers and commanders, while aware of the effects on individuals and on the capability of their units, are unaware of the dollar cost of poor OHS practices. (2011b, p. 251)

DVA argued that a premium was not needed to provide WHS information and a better approach would be to improve information sharing between Defence and DVA:

DVA believes that enhanced systematic information sharing between the two departments regarding the translation of service incidents into compensation claims provides a significant opportunity for Defence to proactively identify and manage occupational risk, in the absence of a price signal. (sub. 125, p. xiii)

However, while information sharing between Defence and DVA would no doubt allow Defence to better identify and manage WHS risks (the Commission has recommended this be pursued), the experience of the Electronic Information Exchange Strategy (many years in gestation) suggests that achieving this goal would be some years away.

6 Rehabilitation and wellness services

Key points

- The current arrangements for serving, discharging and former members of the Australian Defence Force (ADF) have a strong *formal* emphasis on rehabilitation and a focus on enhancing the wellbeing of ill and injured veterans.
- ADF members who need rehabilitation can access services through the ADF Rehabilitation Program and veterans can access services funded by the Department of Veterans' Affairs (DVA). Rehabilitation services are based on a multi-tiered, psychosocial approach, and have some good features.
- But the formal commitment to rehabilitation in legislation and service structures is not matched by what happens in practice. The focus of the veteran support system is on compensation, not rehabilitation and wellness.
- And there are some problems with the uptake of rehabilitation services:
 - There is reluctance among serving personnel to report an injury or illness when it occurs (in part because of concern that disclosure will affect deployability and career prospects). This can mean access to rehabilitation services is delayed.
 - There is an incentive for Defence to rehabilitate individuals with a high probability of redeployment or return to duty, but a weaker incentive to rehabilitate members who are likely to be transitioning out.
 - There is poor uptake of services, and a lack of emphasis on outcomes, within the DVA rehabilitation program.
- There is also an absence of good quality outcomes data or ex-post evaluation. Little is known about the effectiveness of rehabilitation services provided by Defence or DVA. To some degree, without this information, Defence and DVA struggle when it comes to establishing or improving the effectiveness of rehabilitation services for serving and ex-serving members of the ADF.
- The limited available evidence on outcomes from rehabilitation points to mixed results.
 - By any measure, and while acknowledging key differences between defence roles and other professions, return to work rates are comparatively low. Timeliness of access to rehabilitation is also different to other professions, particularly for ex-serving personnel.
- There is considerable scope to improve rehabilitation services for serving, and particularly ex-serving, members. Building on recent improvements, a more innovative and broad ranging conception is possible, matched by improved delivery structures, more rigorous evaluation of what works, and better safeguards to ensure genuine accountability and value for taxpayers' money.
 - Better accountability across the board is needed, with a strong emphasis on outcomes for individuals and for the system as a whole.
 - Significant changes are required to the way that Defence and DVA procures, organises and monitors rehabilitation services.
 - Changes are also needed to rehabilitation arrangements during the transition period to ensure continuity of care, including where a veteran relocates geographically.

This chapter is about rehabilitation for serving, discharging and former members of the Australian Defence Force (ADF). Section 6.1 looks at what rehabilitation is and why it is important. The rehabilitation services provided by the ADF and the Department of Veterans' Affairs (DVA) are then outlined in section 6.2. Section 6.3 looks at what we know about rehabilitation outcomes for serving and ex-serving members of the ADF. Options for improving the system of rehabilitation services are examined in section 6.4.

6.1 About rehabilitation

Why rehabilitation is important

Rehabilitation can mean that injured and ill people can recover more quickly and return to work sooner. With a higher incidence of injury (and death) in military service than in many other occupations (chapter 2), it is not surprising that modern military schemes, both in Australia and in many other countries, place a strong emphasis on in-service and post-service rehabilitation.

Rehabilitation is critical both for serving ADF members and for those who have served. For serving ADF members, it can return them to a state of readiness (for deployment on a military mission) as soon as is possible after an injury or illness, or assist them in their recovery as they are either reassigned to another role or discharged from the ADF. Rehabilitation is also essential to the wellbeing or quality of life of veterans. As the Department of Defence said:

Rehabilitation and attaining meaningful employment are fundamental to a successful life post ADF service. (sub. 127, p. 20)

The New Zealand Law Commission also said:

Rehabilitation has many benefits, including higher levels of self-esteem and confidence, a more stable and secure family life, improved social and life skills, better employment prospects, improved quality of life, retention or restoration of earning capacity, greater independence, and prevention of complications, deterioration or the development of other illnesses and conditions. (NZLC 2008, p. 17)

Early and effective rehabilitation can also reduce the overall cost of care, the number of medical discharges and the need for compensation (which ultimately means a lower premium for the employer and a more affordable system). SwissRe recently estimated that, for the broader Australian workforce, for every \$1 spent on rehabilitation services, insurers saved \$25 on income protection claims costs (SwissRe 2016, p. 4).

An independent review of forty DVA veteran claims across four defined groups — severely injured veterans, less-severely injured veterans at risk of life dependency, recently reported

claims and younger veterans with a mental injury — also found the potential for significant savings from improved return-to-work outcomes (EML, sub. 90).¹

A number of participants commented on the importance of a system of support that has a focus on rehabilitation and recovery. The Prime Ministerial Advisory Council on Veterans' Mental Health said:

Compensation must, of course, remain available ... however the **needs** of the individual in terms of treatment and rehabilitation in order that they can willingly, competently and confidently re-enter the workforce should be paramount. (sub. 99, p. 3)

And Mates4Mates said:

Within the context of rehabilitation for veterans with a service related injury or illness ... it should be about wrapping the necessary supports around them when needed but not undermining their rehabilitation and recovery by creating permanent dependency on services. (sub. 84, p. 1)

What is included in rehabilitation?

Rehabilitation is about restoring a person with an injury or disease to as productive and as independent a lifestyle as possible. It covers not only clinical treatment (such as physiotherapy), but also psychosocial and vocational services. Depending on the needs of the person, it can cover an array of services and include a significant number of providers and others providing support (box 6.1). The Australasian Faculty of Rehabilitation Medicine define rehabilitation as:

The combined and coordinated use of medical, psychological, social, educational and vocational measures to restore function or achieve the highest possible level of function of persons physically, psychologically, socially and economically; to maximise quality of life and to minimise the person's long term health care needs and community support needs. (DVA 2014a)

And Comcare state that the aim of rehabilitation:

... is to restore, as speedily and as far as is reasonably practicable, an injured employee to the same:

- physical and psychological state; and
- social and vocational status

as the injured employee had before suffering the injury. (2012, p. 2)

The rehabilitation process typically involves identifying a person's needs, defining rehabilitation goals, putting in place a rehabilitation plan, implementing interventions and assessing the effects of the interventions. Rehabilitation usually takes place for a specific period of time and is provided from the acute or initial phase after an injury or illness presents through to post-acute and maintenance phases. It should reflect the person's changing needs.

¹ At the time of writing, these estimates were not available publicly.

Box 6.1 **A suite of rehabilitation services and providers**

Rehabilitation is different for every individual and to maximise outcomes, requires input from a range of skilled health and social care professionals as well as the patient and family. At its core, rehabilitation is truly patient-centred care supported by the skills of an interdisciplinary healthcare team working with the patient and their family.

Rehabilitation multidisciplinary/interdisciplinary healthcare teams can include:

- client/patient and family
- occupational therapist
- psychologist
- physiotherapist
- rehabilitation medicine physician
- rehabilitation nurse
- speech pathologist
- social worker.

Healthcare and other professionals who may be included formally or informally in a team, dependant on patients' needs include:

- counsellor
- dietitian
- diversional therapist
- medical specialists such as surgeons, neurologists
- neuropsychologist
- podiatrist
- recreational therapist
- vocational rehabilitation providers.

Source: RACP, NZRA and AFRM (2014, pp. 7, 24).

In a military context, rehabilitation for serving personnel may be aimed at enabling an individual to return to duty (that is, the same or similar role they previously held) or a return to work (alternative duty) within a different part of the ADF (perhaps with a lesser level of physical or other requirements). Rehabilitation for those leaving the military, or who have already discharged, is about enabling the individual to gain and maintain employment, or if that is not possible, to reach a reasonable level of wellbeing, including meaningful participation in the community.

6.2 What rehabilitation services are available to serving and ex-serving ADF members?

Rehabilitation services have been a critical part of repatriation support for many years (box 6.2) and within both the ADF and DVA there continues to be a formal emphasis on rehabilitation.

An emphasis in legislation and policy on rehabilitation

The *Veterans' Entitlements Act 1986* (VEA) has little emphasis on rehabilitation. As Peter Sutherland said:

... the VEA has a very inadequate focus on rehabilitation and return to a fulfilled civilian life. Its pension-based structure encourages identification of illness and impairments to increase rate of pension ... (sub. 108, p. 1)

DVA also commented that:

It is notable that the older VEA, under which nearly 16 000 primary claims were made in 2017-18, has a focus on illness and lifetime compensation payments, which is not conducive to a 'wellness' model. (sub. 125, p. 18)

However, the introduction of the *Military Rehabilitation and Compensation Act 2004* (MRCA) marked a greater focus on rehabilitation and return-to-work outcomes. The MRCA has an emphasis on returning those who are injured to a pre-injury state wherever possible, and takes a whole-of-person approach (section 38). The Explanatory Memoranda for the MRCA stated that:

There is an increased focus on rehabilitation for ADF members and former members whose capacity for work is affected by conditions that have been accepted as related to their service. (Vale 2003, p. iv)

This formal emphasis on the importance of rehabilitation in the MRCA is also apparent in related policy documents and guidance material.

The policies of Defence and DVA mirror this emphasis on rehabilitation. For example, Defence states that:

The ADF Rehabilitation Program (ADFRP) has been developed to assist ADF members to return to a state of readiness as soon as is practicable after injury or illness, through the provision of occupational rehabilitation services. The ADFRP is a multi-disciplinary strategy aimed at maximising an individual's potential for restoration of their pre-injury physical, occupational, social, psychological and educational status. (DoD 2018n)

Box 6.2 The evolution of military rehabilitation policies

Rehabilitation services have been a critical part of repatriation support for many years, with programs in place from before the end of the First World War. Over time, there has been a gradual move away from a more piecemeal approach, involving largely charitable and non-government services, to a more modern legislated approach with government at front and centre of service organisation, and with growing involvement of the private sector in contracted service provision. The concept of rehabilitation has also broadened to include not just medical, but also social and vocational services.

A number of past reviews (Toose (1976), Baume, Bomball and Layton (1994) and Tanzer (1999)) are useful for tracking how the approach to rehabilitation developed. The Toose report, for example, noted that an administrative circular issued by the Repatriation Commission in 1946 was one of the earliest recognitions in the repatriation field of the benefits from rehabilitation. The circular said:

The Commission recognises that it is in the best interests of seriously disabled members, particularly those who have been granted special rate war pensions, for them to be engaged in some form of occupation to prevent physical or mental deterioration ... It has therefore been decided that an endeavour will be made to create such a state of mind in the member that part-time or even full-time work will be undertaken by him. (quoted in Toose 1976, p. 505)

On rehabilitation, the Toose report drew a distinction between medical and social rehabilitation, and vocational rehabilitation. It found that the approach as generally adopted was suitable, involving retaining disabled serving members of the Defence Force in service wherever possible. In cases where it was necessary to discharge a disabled member:

... the member concerned can be gravely disadvantaged by lack of co-ordinated supervision of his rehabilitation programme. Accordingly he should be referred on discharge to the Department which should undertake the oversight, co-ordination and follow-up of any subsequent rehabilitation or reestablishment programme. (Toose 1976, p. 520)

The later Baume report developed a list of principles to be met when providing any rehabilitation and health solution:

- DVA has a responsibility to ensure that the full spectrum of rehabilitation, health benefits and resettlement schemes are available to veterans
- rehabilitation should include social, medical and vocational rehabilitation schemes
- rehabilitation schemes should be complemented by appropriate resettlement schemes including, for example, assistance through home loans
- all rehabilitation and health provisions should be relevant and sufficiently flexible to meet the needs of each age group and the needs of various types of veterans
- the VEA scheme should encourage, not discourage, disability improvement, lifestyle adaptation and employment
- DVA should monitor the health and rehabilitation needs of specific groups of veterans, as well as the needs of individual veterans, and redress deficiencies
- the DoD and DVA should provide linked or complementary programs for rehabilitation and resettlement for personnel who leave the forces. (Baume, Bomball and Layton 1994, p. 96)

The Tanzer Review recommended that rehabilitation and return-to-work provisions of the *Safety, Rehabilitation and Compensation Act 1988* be adopted in any new military compensation scheme, with appropriate modification, to reflect the different requirements of the Australian Defence Force.

DVA also has a multi-faceted approach, with its whole-of-person approach containing elements of medical management, psychosocial and vocational support (sub. 125, p. 125). It adopts the MRCA rehabilitation philosophy for all DVA rehabilitation clients (DVA 2014a).

A multi-layered system of rehabilitation

The legislative framework and related policies result in a system where rehabilitation is provided across both Defence and DVA, involving an array of providers outside the ADF, Australian Public Service (APS) employees and enlisted specialists. Defence has the lead in caring for, and supporting, serving members, while DVA has the lead in caring for wounded, injured or ill ex-service members (figure 6.1).

Rehabilitation services provided by Defence

Rehabilitation (and health care) is provided to serving ADF members regardless of whether the injury or illness is workplace-related. The Joint Health Command (JHC) organises rehabilitation services across the ADF, and is a Comcare approved workplace rehabilitation provider in accordance with the relevant sections of the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and MRCA. The rehabilitation services delivered by JHC are provided through their *ADF Rehabilitation* and *Rehabilitation for Reservists* programs.

Individuals can be referred and assessed for rehabilitation through several avenues — self-referral, referral by commanding officers, or referral by treating medical staff (Porteous 2007, p. 15).

Rehabilitation in the ADF is focused on three goals, which in order of priority are:

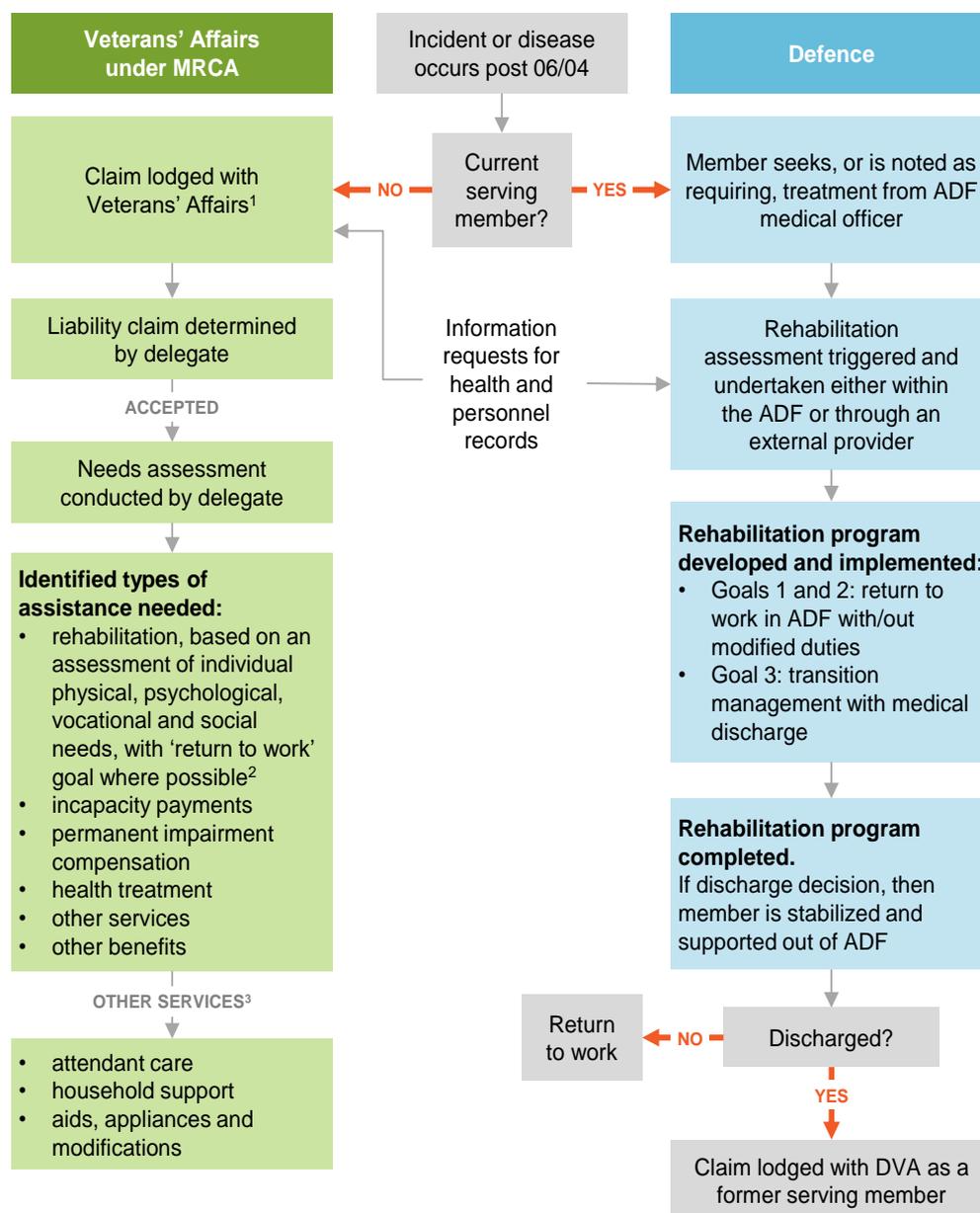
Goal 1: Fit for duty in pre-injury/illness work environment

Goal 2: Fit for alternative duty in the ADF

Goal 3: Transition out of the ADF (Defence Health Manual, vol. 1, Part 13, pp. 1–4).

Services, which include occupational and psychosocial rehabilitation, as well as medical rehabilitation, are provided by a mix of internal and external providers. Defence currently employs 50 APS rehabilitation consultants undertaking either rehabilitation case management or rehabilitation consultant duties. Under a contract with Medibank Health Solutions there are also currently 88.5 full time equivalent (FTE) rehabilitation consultants providing services to members on base, in or near Garrison Health Facilities. There are an additional 45 FTE rehabilitation consultants providing services to members off base, including ADF reservists (Joint Health Command 2017, p. 7; pers. comm., 23 July 2018).

Figure 6.1 Key rehabilitation processes under the MRCA



Notes: ¹ Both serving and former members are able to lodge a claim with DVA. ² For current serving members, Defence normally provides health and rehabilitation services. ³ Compensation payments and these other services are provided by DVA to serving and former members.

Source: ANAO (2016, p. 18).

In addition to the overarching rehabilitation support infrastructure provided by the ADF, each service has specific arrangements in place to support the rehabilitation of members. These include units that are set up for members on rehabilitation, together with facilities, such as Soldier Recovery Centres in the case of Army (box 6.3), designed to further assist individuals during their recovery.

Trends in the use of ADF rehabilitation

Trend information points to increased use of rehabilitation services by Defence personnel, and also shows that there is often a substantial period of time before individuals receiving rehabilitation services either return to work or transition out of the military. Service volume data shows that around 500 000 contracted service episodes were provided in 2016-17 (Joint Health Command 2017, p. 6).

In 2016-17, 9354 ADF members (or roughly 16 per cent of the total ADF workforce) received rehabilitation through the ADF Rehabilitation Program. The average duration:

- for Goal 1 and 2 cases (those returning to duty) was 25.7 weeks (a decrease of 20 per cent on the previous year)
- for Goal 3 cases (those transitioning out of service) was 59.5 weeks (an increase of 13 per cent on the previous year).

Members with open rehabilitation cases, who have limited or no ability to undertake suitable duties in their primary role, have access to psychosocial rehabilitation services in the form of Meaningful Engagement activities. In 2016-17, 217 applications for Meaningful Engagement were supported (Joint Health Command 2017, p. 7).

Box 6.3 About Army's Soldier Recovery Centres

Army's Soldier Recovery Centres (SRCs) provide commanders with additional resources to manage complex cases and/or members undertaking extended rehabilitation or transition. SRCs were established under Army's contribution to the Support to Wounded, Injured and Ill Program. The Centres are located in Townsville, Darwin and Brisbane.

SRCs aim to optimise recovery for soldiers with complex needs following wounding, injury or illness and to provide command, leadership and management of complex rehabilitation cases.

According to the Army, the majority of personnel health and welfare issues can be resolved through normal command and management processes. Additional resources and management are required to coordinate the support and services provided to personnel and their families with complex care requirements.

Army states that the SRCs aim to provide a positive recovery environment where personnel are engaged in meaningful activities and are enabled to focus on their recovery mission.

Source: Army (2016).

Rehabilitation organised and funded by DVA

For ex-ADF personnel, the main source of rehabilitation services is through DVA's rehabilitation program (box 6.4). As DVA said, its focus is not about arranging an employee's return to 'the same job, same employer, after a service-related injury or disease, as a return to service is not necessarily possible or desirable' (sub. 125, p. 125).

Box 6.4 **The Department of Veterans' Affairs' Rehabilitation Framework**

The Department of Veterans' Affairs (DVA) has a large amount of material on its approach to rehabilitation. This includes an extensive online Rehabilitation Policy Library and other resources.

As set out in these resources, DVA's rehabilitation best-practice principles are:

- care and respect for the client is paramount
- early intervention processes and practices must operate
- whole-of-person rehabilitation needs must be addressed
- the client, and their significant other, must be actively involved in the development of an appropriate rehabilitation plan/program with realistic goals
- all key stakeholders must be actively involved in an effectively coordinated plan/program of activities
- rehabilitation plans must be focused on whole-of-person goals and outcomes.

DVA states that it seeks to achieve this by:

- adopting the MRCA rehabilitation provisions to drive policy development for all DVA rehabilitation clients
- using the expertise of the Rehabilitation Advisory Committee as a consultation mechanism with industry to guide its best-practice decision making processes
- applying nationally consistent standards, practices and principles
- promoting excellence in service delivery and case coordination as the norm
- adopting the Goal Attainment Scaling method to rehabilitation
- challenging existing practices and reviewing and revising current approaches and policy
- adopting a robust structure to measure success for rehabilitation activities
- developing a supportive work environment which shares knowledge, experiences and expertise
- promoting the importance of rehabilitation and its outcomes in the lives of DVA clients
- acknowledging the role of family, friends and significant others in the client's life in achieving long-term positive outcomes in the rehabilitation process.

Source: DVA (2015a).

DVA provides services across three areas: vocational, psychosocial and medical rehabilitation. DVA describes its rehabilitation program as providing:

... broad support beyond the treatment services offered through health treatment cards, and beyond vocational assistance. It promotes veterans' wellbeing and quality of life through whole-of-person rehabilitation services to help them adapt to, and recover from, injury or illness related to their ADF service.

DVA's whole-of-person focus considers all aspects of a person's life in an effort to return a person to health and personal and vocational status similar to before they were injured or became ill. (sub. 125, pp. ix-x)

Referral for rehabilitation can be by self-referral, the DVA delegate, ex-service organisations, general practitioners (GPs) and treating specialists.

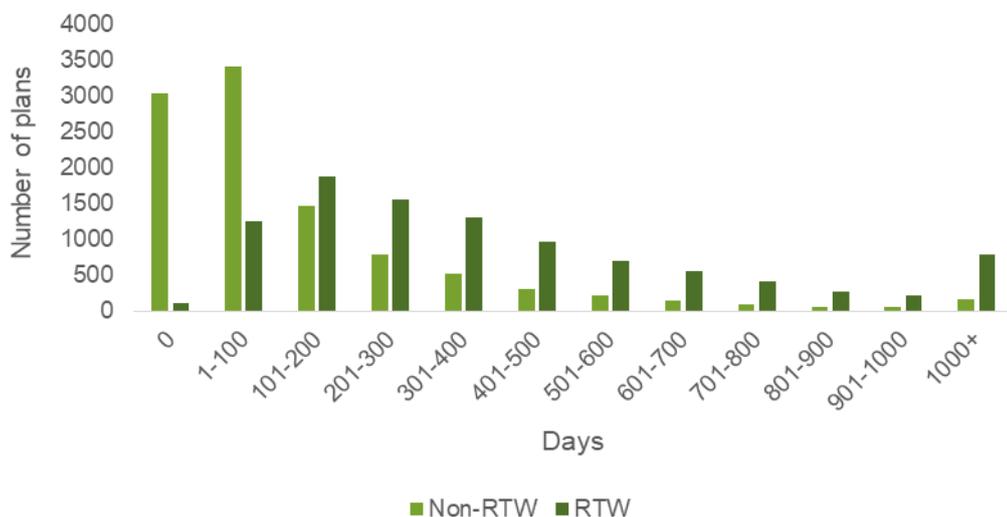
While there are significant differences in the legislative arrangements for rehabilitation across the VEA, DRCA and MRCA, according to DVA, in practice veterans could receive similar rehabilitation services regardless of which Acts they are covered by (DVA 2015a, p. 3). As will be discussed later, those under the VEA are less likely to access rehabilitation.

DVA also provides counselling services via Open Arms (previously the Veterans and Veterans Families Counselling Service (VVCS)) (chapter 15), online resources, and health and wellbeing programs.

Case plans

Central to DVA’s approach is the case plan and case management pathway. Individuals can have either a return to work (RTW) rehabilitation plan or a plan that does not contain the end goal of RTW. Around half of the 20 000 DVA cases receiving rehabilitation services between 2004-05 and 2016-17 had RTW plans (figure 6.2).

Figure 6.2 **Plan length, by rehabilitation program type**
2004–2016

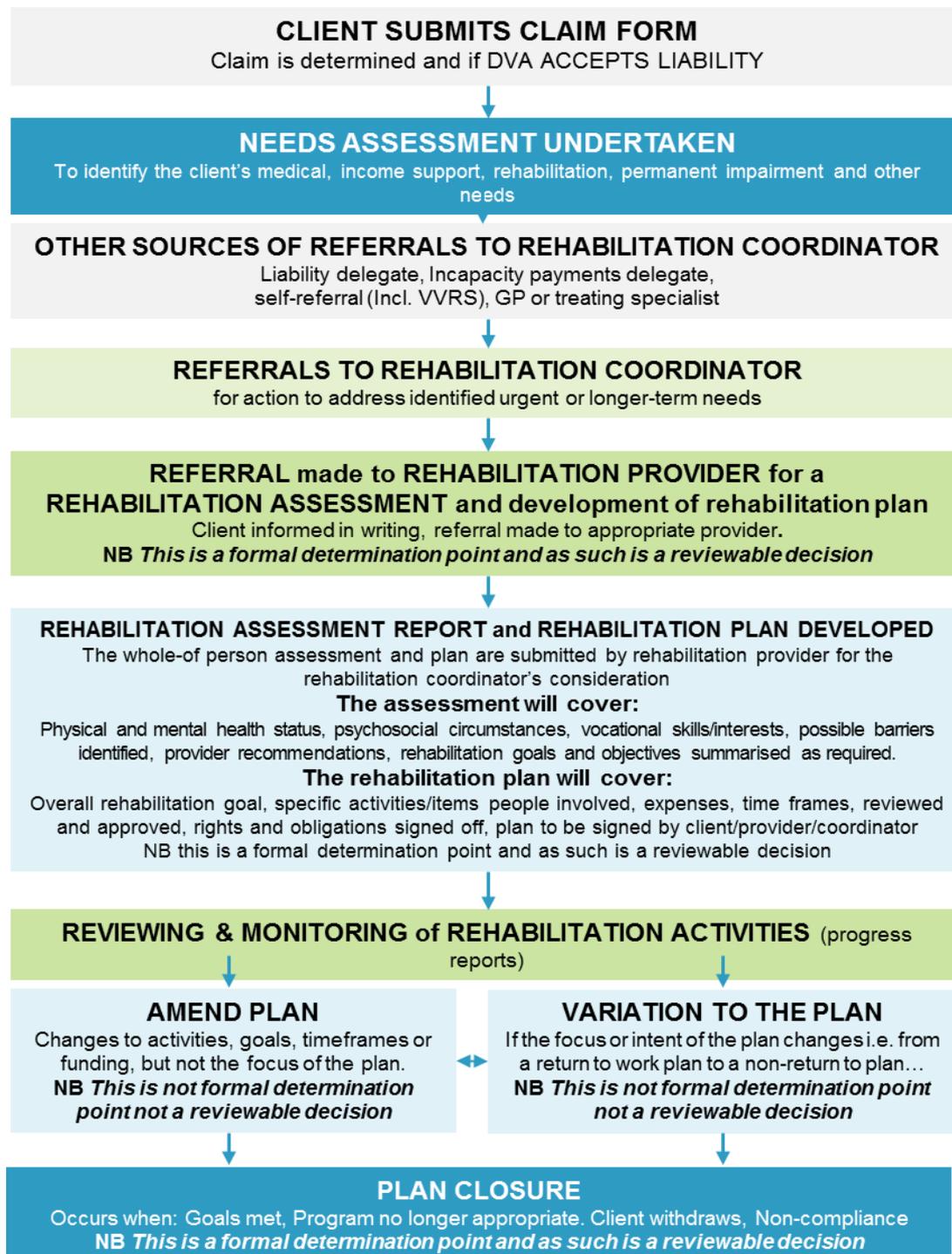


Data source: Productivity Commission estimates based on unpublished DVA data.

Many people are involved in coordinating or providing DVA rehabilitation services, including DVA rehabilitation coordinators, external rehabilitation providers and DVA delegates (dealing with individual claims).

Assessment and referral processes occur at several points throughout the DVA process (figure 6.3).

Figure 6.3 DVA’s rehabilitation case management pathway



Source: DVA (2017b, p. 1).

There are two main assessment points: the first one is very early on and is conducted by the DVA delegate dealing with the case; the second is a far more detailed assessment and report that takes place when a rehabilitation plan is developed.

Access to DVA-funded rehabilitation services is consequent upon DVA accepting liability for a claim involving rehabilitation. Given that assessing and deciding on claim eligibility can take considerable time, this can mean significant delays in personnel receiving rehabilitation services (this is discussed in more detail below).

Services provided

The types of rehabilitation services permitted under a person's plan as provided by rehabilitation consultants are set out in policy documents. The protocols of rehabilitation under the MRCA, first developed in 2004 and subject to regular updating, contain detailed requirements for eligible services and delivery costs (DVA 2017a).

Services funded by DVA are provided by external accredited providers (these are Comcare-accredited entities). There are currently 41 providers and around 700 rehabilitation consultants. In addition to Comcare accreditation, DVA has five service provider requirements, covering past experience working with DVA or similar clients, completion of DVA e-learning courses, and minimum experience periods for working with clients in medical management, vocational and/or psychosocial areas (DVA 2014a).

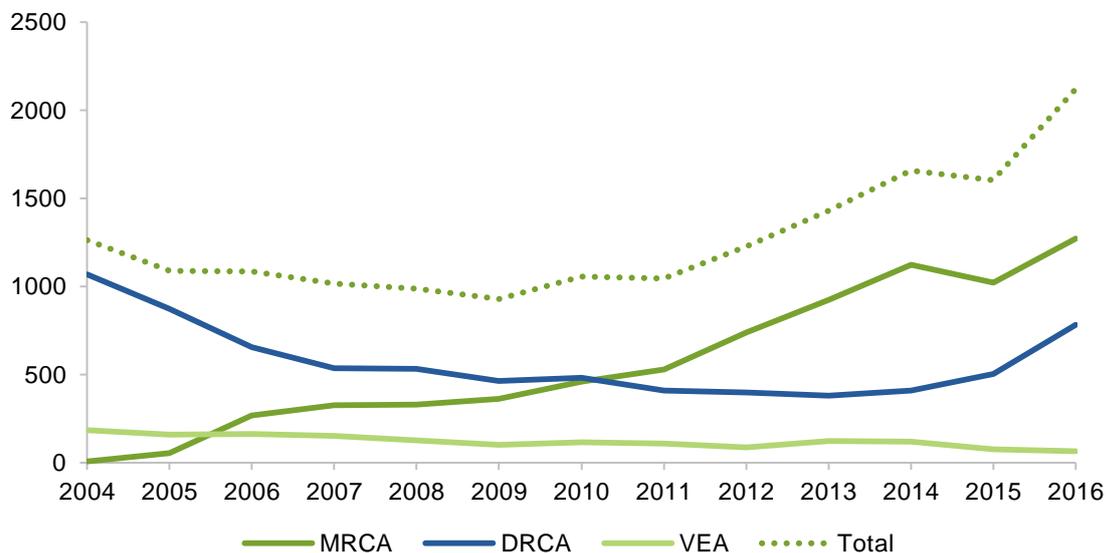
Trends in the use of DVA-funded rehabilitation

Rehabilitation data provided to the Commission by DVA shows that the number (figure 6.4) and cost of rehabilitation cases are increasing.

Recent work by the Australian Government Actuary also points to growing expenditure on rehabilitation under both the DRCA and MRCA (AGA 2017). Expenditure on rehabilitation is a relatively small part of DVA's overall expenditure (MRCA-related expenditure is currently around \$110 million, which includes medical and rehabilitation payments).

Increasing use and costs of rehabilitation point to a growing need for metrics on both treatment and cost effectiveness. (And as discussed below, such measures would also be expected to be in place given that it is roughly fifteen years since MRCA, with its emphasis on rehabilitation services, was introduced.)

Figure 6.4 Number of rehabilitation cases, by Act



Data source: Productivity Commission estimates based on unpublished DVA data

Others also provide rehabilitation services

While most rehabilitation services are funded and provided by Defence and DVA, rehabilitation services are also available to veterans from state and local governments, charitable organisations and ex-service organisations. The Rehabilitation Counselling Association of Australasia raised concerns about possible overlap and duplication with services provided by Defence and DVA:

Within the current system in Australia, there are a large number of services that veterans can access. For example, counselling and case management services can be accessed through rehabilitation providers, VVCS, Soldier On, Mates4Mates and RSL among others. Veterans could foreseeably access numerous services concurrently and be provided with quite varying levels of service and recommendations. Streamlining the approach as is evidenced by the [Veterans Affairs] system in USA could result in reduction of fragmented services. (sub. 74, p. 2)

Given the disparate nature of such services, and the fact that individuals may seek out services on a private basis, the full extent of demand for these forms of rehabilitation is not known. Mainstream health and other services are also at play here, but again, there are limited data on use by ADF or ex-ADF personnel.

The incentive structure for suppliers

The discussion above points (in theory) to a comprehensive system of rehabilitation supports provided to serving and ex-ADF personnel. (Transition support is discussed in chapter 7.)

Whether, in practice, the system delivers comprehensive and effective rehabilitation is another question.

However, prior to assessing the actual effectiveness of these supports, it is useful to think about the range of incentives faced by Defence and DVA, and community expectations, when it comes to military rehabilitation.

As discussed in chapter 4, the Australian Government has accepted responsibility for ensuring that, on leaving the military, ADF members are integrated successfully back into civilian life and any harm they incurred while serving is minimised (rehabilitation can reduce harm to the person and long-term costs to society).

However, Defence and DVA face different incentives. Defence has a strong incentive to rehabilitate members who can return to deployable status, but a weaker incentive for those who cannot. In the case where a person is unlikely to be deployed again, Defence could fast track them out of service and (where eligible and requiring it) into the DVA system of rehabilitation. As Stephan Rudzki put it:

Defence has no financial incentive to reduce or completely resolve injuries or illnesses prior to discharge. In many ways, once a member becomes injured or ill for a prolonged period they are on a one-way conveyor belt into the community requiring DVA assistance and support. (sub. 40, p. 4)

And because Defence does not pay a premium to cover the expected cost of claims, the incentive is to focus on the short-term impacts of spending decisions (and costs to ADF rather than the costs to the person and the overall costs to government).

DVA also has few incentives to focus on future demand and scheme sustainability (or long-term costs) which in turn means that timely and effective rehabilitation may not be a high priority. And both Defence and DVA face few incentives to ensure rehabilitation services are efficient and effective because there are limited constraints on spending and limited external oversight and accountability (chapter 11).

The mixed incentives exist in part because of the functional split between Defence, as employer and provider of rehabilitation to serving members, and DVA, as the effective administrator of the compensation and rehabilitation system for ex-ADF members.

DRAFT FINDING 6.1

Defence has a strong incentive to provide rehabilitation services to Australian Defence Force (ADF) members who have a high probability of redeployment or return to duty, but a weaker incentive to rehabilitate members who are likely to be transitioning out of the ADF. This is because ex-serving members become the responsibility of the Department of Veterans' Affairs (DVA) and Defence does not pay a premium to cover liabilities. Access to rehabilitation supports can also be disrupted during the transition period.

DVA pays limited attention to the long-term sustainability of the veteran support system (in part because the system is demand driven) and this reduces its focus on the lifetime costs of support, early intervention and effective rehabilitation.

The demand side and evidence of stigma

There are also incentives on the demand side that play an important part in how, when and where rehabilitation services are accessed by serving members of the ADF and by veterans. The Commission heard repeatedly that there is a widespread reluctance by serving personnel to report and seek treatment for physical injury and mental illness with the ADF. For serving personnel, this is driven largely by concerns for reputation, career prospects and deployment. Peter Reece, for example, said:

Concealment of injury is driven by the 'fitness for service' regime whereby allowances in particular are threatened ... The text book need to treat injury and provide rehabilitation immediately is effectively bypassed ... (sub. 49, p. 2)

The National Mental Health Commission (NMHC 2017, p. 44) discussed the stigma connected to reporting mental health problems while serving in the ADF. While some participants said the stigma has reduced in recent years, others said it remained a material concern for many people.

6.3 How effective are rehabilitation services?

Assessing the effectiveness of rehabilitation services provided by the ADF and DVA is difficult because there are such limited data and reporting on outcomes. Data on rehabilitation services collected by the ADF and DVA have either only been collected for a few years, or are not easily accessed. For example:

- DVA only began measuring outcomes using a Goal Attainment Scaling and a Life Satisfaction Index (box 6.5) in 2015.
- Data on rehabilitation outcomes from the ADF, or from its contracted providers, such as (until very recently) Medibank Health Services, was not provided to the Commission in a form that allowed a detailed evaluation of outcomes.

Box 6.5 Goal Attainment Scaling

DVA requires its contracted rehabilitation providers to use Goal Attainment Scaling to develop personal goals for clients during the development of their rehabilitation plan. As an added mechanism for assessing how clients rate their own life satisfaction before, during and after rehabilitation, each client is asked to provide Life Satisfaction Indicators.

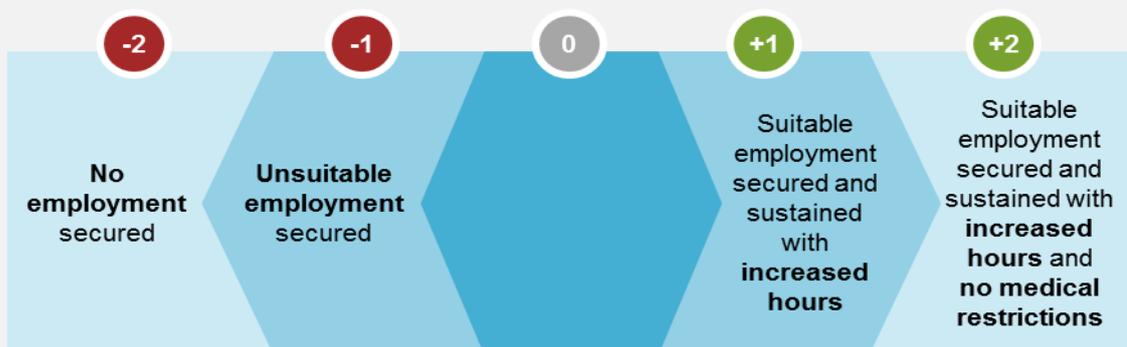
Providers work collaboratively with clients to tailor individual goals and to ensure they are appropriate and achievable. For each new goal, a scale is developed which describes specific outcomes.

Examples

If a client sets a goal to 'regain mobility outside of the home', the scale would identify the 'expected' outcome for that individual, such as to be able to walk non-stop around their suburban block three times a week. A 'more than expected' outcome would be to perform the walk five or six times a week. A 'less than expected' outcome would be to only complete the walk once a week, or not at all.

The example shown in the diagram below is for the goal to 'secure and sustain employment'.

GOAL: Secure and sustain employment



The importance of scaling to DVA and its clients

Goal Attainment Scaling is aligned with DVA's rehabilitation best practice philosophy and emphasises individualised services and maximum client involvement in the development of plans and goals. Scaling formalises the collaborative element of the assessment and plan development process between provider and client.

Scaling improves DVA's rehabilitation program by:

- ensuring all parties have the same understanding of the client's rehabilitation goals via collaborative development
- ensuring consistent expectations throughout the life of a rehabilitation plan by using well-developed formal documentation
- assessing and reporting on improvements and changes to life satisfaction and wellbeing.

Source: DVA (2014a).

Evaluation of services and comparisons of outcomes in this area is also complicated by the fact that rehabilitation cases in the military are often different from those in other workplace

contexts. For example, comparisons between rates of return to work in civilian workers compensation schemes and the DVA rehabilitation program require some caveating, as DVA clients may have left the workforce following the end of their military service. Rehabilitation services for veterans are not just about returning them to appropriate employment in a timely and cost efficient way, it can also be about returning them to ‘life’.

That said, despite the differences between military and non-military rehabilitation contexts, there are many lessons on scheme design and the effectiveness of rehabilitation approaches from the civilian world which *can*, and should, inform the approach to military rehabilitation. These include:

- approaches to rehabilitation of persons on claim
- claims management and case triage
- rehabilitation approaches with a focus on return to work
- data collection and analysis
- design and use of evaluation.

What is best-practice rehabilitation?

The first step to evaluating current arrangements for rehabilitation in the military context is to look at best practice in civilian workplaces.

Guidance on features of ‘good’ rehabilitation, and how best to translate such general principles into program delivery, is widely available. Examples include recent work by Safe Work Australia on rehabilitation in the area of psychological claims (Safe Work Australia 2017b), and more general guidelines by Comcare (2012), state-based workplace authorities and others (see, for example, Casey & Cameron (see, for example, Casey and Cameron 2014).

Common themes are that timeliness and durability of interventions are critical, as are a person-centred approach, processes that are joined up and efficient and evidence-based interventions (Casey and Cameron 2014; RACP nd; Safe Work Australia 2017b).

The evidence from the broader workplace literature suggests that intervening early is one of the most effective ways of reducing long-term dependence and average claim costs. Also, that a supportive initial response from employers after a claim has been lodged is very important (Safe Work Australia 2017b, p. 33). A number of experts also spoke to the Commission about the importance of timely rehabilitation. A prevailing view is that a failure to identify and meet rehabilitation needs early can cause adverse outcomes in regard to return to work and durability of treatment.

Box 6.6 Comcare’s Guidelines for Rehabilitation Authorities (Employers)***Suitable employment***

The key to achieving an early and successful return to work (or maintenance at work) of an injured employee lies in the employer’s willingness, ability and commitment to provide duties within the capacities of the injured employee. This is a significant responsibility and critical to maximising the potential for a successful return to work. Employee perceptions of organisational support also have a significant influence on return-to-work outcomes.

Identifying suitable employment is the key factor in the design and delivery of rehabilitation to maximise the employee’s capacity to undertake such employment. It requires a constructive and creative approach with commitment from senior managers and cooperation from line managers. Providing suitable employment increases the opportunity for an injured employee to remain at work or safely return to work sooner than would otherwise be possible.

Rehabilitation program

The purpose of a rehabilitation program (return-to-work plan) is to deliver structured activities and services that assist an employee to be maintained at or return to work and/or maintain or improve the performance of activities of daily living.

A rehabilitation program is based on the principle that the employer, using established rehabilitation management policies and procedures, can facilitate the employee achieving a return to work in a coordinated way.

The program is delivered having considered the medical advice with regard to medical fitness and, where necessary, the use of an approved rehabilitation provider.

Close communication and cooperation between the injured employee, case manager, supervisor, treating practitioner and approved rehabilitation provider assists in the development of an effective return-to-work plan as part of the rehabilitation program.

Source: Comcare (2012, pp. 7, 13).

The guidance material also emphasises a tailored or person-centred, flexible and holistic approach (box 6.7). For example, Safe Work Australia talk about the importance of a biopsychosocial approach to rehabilitation for the person on claim (or PoC):

A biopsychosocial approach is used to understand the PoC, identify barriers to desired outcomes and put in place the appropriate support, including treatment and rehabilitation, which are tailored to the PoC and take into account the nature of their injury. A biopsychosocial approach takes a holistic view of disability, understanding that social and environmental factors also influence disability alongside biological factors. (Safe Work Australia 2017b, p. 16)

There is also a related emphasis on effective processes for triaging claims. Good process in the context of rehabilitation services includes early intervention, early workplace-based rehabilitation, effective claims management, well-designed and properly targeted benefits and dispute resolution structures, and a focus on social inclusion and RTW or rehabilitation at work (Safe Work Australia 2017b, p. 15).

Box 6.7 **Insights from a survey of international best practice**

In 2016, Employers Mutual Limited (EML) commissioned the Institute for Safety, Compensation and Recovery Research at Monash University to look at the features of compensation schemes worldwide that contributed to successful transition of injured workers either out of schemes or into new systems. The report found that:

1. Successful programs for the long-term injured have a common element of quality. This is in terms of the people providing the program (experienced/talented), the levels of training provided (beyond basic resume building and computer training) and the outcomes targeted (meaningful roles).
2. Programs in this space need to be flexible to meet the individual's needs.
3. Empowerment via the development of generic skills (for example, communication with people in decision making roles) is an important element of support.
4. Peer support is an element that could be incorporated to achieve the above elements on the scale required.
5. Ongoing management of the condition/injury should form part of the transition.

Sources: EML (sub. 90, pp. 5–6); Iles (2017, p. 5).

Measuring, monitoring and reporting on key performance outcomes are also important features of good rehabilitation, and are critical for gaining insights into the effectiveness of rehabilitation services, including whether interventions improve outcomes for individuals and represent ‘value for money’ for taxpayers. As EML put it:

Constantly reviewing the quality of providers and the effectiveness of treatments being administered is essential. If this does not happen, DVA risks funding redundant treatments, which does not benefit either the veteran or DVA's bottom line. (sub. 90, p. 6)

How does the current system perform?

Efficient and timely processes?

Efficient case triage is particularly important for people receiving rehabilitation services as their injury or illness can make it difficult for them to self-manage aspects of their care.

DVA are working within the confines of existing legislation, and requirements within that legislation, such as the requirement for condition stabilisation in the MRCA (chapter 13), and the requirement that liability is accepted prior to full access to rehabilitation services. These legislative requirements make it challenging for DVA to provide timely rehabilitation services.

A *greatly* improved upfront assessment and triage process would improve outcomes. This point was highlighted in the Australian Public Service Commission (APSC) Capability Review of DVA in 2013:

A transformation in service approach from one-size-fits-all to a risk-based model that triages urgent and complex claims could help streamline processing to deliver more timely client

outcomes. This would be consistent with the objective driving most contemporary insurance operations — early intervention and expeditious reintegration of clients into the labour market and society. It is all the more important in DVA since claims assessment experience sets the tone for all future interactions between veterans and the department ... In short, the benevolent philosophy that has been much promulgated throughout the department, and actively looks to provide veterans with their entitlements, needs to be matched by benevolent design. (APSC 2013, p. 11)

Further details of a reformed approach to claims processing and assessment are discussed in the next section and in chapter 9.

The ADF has a rehabilitation case triage approach that, on paper, looks well designed and has formal lines of accountability. However, the effectiveness of services provided until very recently on contract by Medibank Health Solutions remains a black box (because of a lack of data).

A number of members (serving and ex-serving) told the Commission about their rehabilitation experiences and a common theme was that ADF's case triage fell well short of best practice.

Evidence on outcomes?

In the case of both Defence and DVA, the evidence base on the outcomes from rehabilitation is *very* limited (box 6.8). This is in stark contrast to many other workplace health and safety schemes, where there is comprehensive reporting of outcomes. This is also acknowledged — Defence and DVA are jointly working on developing the MRCA Rehabilitation Long-Term Study, which aims to look at effectiveness (but it has been deferred until 2019-20 due to a number of factors (DVA, sub. 125, p. 133)).

The history of the MRCA Rehabilitation Long-Term Study proposal is illustrative of broader concerns about value placed on evaluation. The study came about following a recommendation in the review of the MRCA in February 2011 (ANAO 2016, p. 29), but to date, all that has been produced is a proposed study design framework (dated November 2016, but not publicly available). While the framework contains useful elements, what is remarkable is that what is proposed is not already in place, some decade and a half after the commencement of the MRCA.

Box 6.8 'Evaluation vacuum' ... and little has changed

In 2016, the Australian National Audit Office commented that:

In managing rehabilitation programs, neither Defence nor Veterans' Affairs reliably measure, monitor or report on outcomes. Civilian rehabilitation schemes, for example, use critical measures of performance; namely the timeliness of rehabilitation following injury or illness, and the durability of return-to-work outcomes. Accrued liabilities under the MRCA are significant and growing. Robust performance information has not been sufficiently developed or used by Defence and Veterans' Affairs to manage the MRCA scheme overall, from assessing the risks of injury and illness in Defence through to considering the impact of rehabilitation on the overall performance and financial sustainability of the scheme.

In 2017, the National Mental Health Commission, in the context of rehabilitation services in the area of mental health, said:

... many of the programs and services delivered by the ADF and DVA have a sound evidence base, grounded in the literature about suicide and self-harm. The Commission also acknowledges that there have been some attempts by the ADF and DVA to evaluate some programs. However, this Review found insufficient information to empirically assess the effectiveness of services available to current and former serving members of the ADF, and their families, in relation to self-harm and suicide prevention.

- There are no direct measures of effectiveness (i.e. achievement of outcomes) for the services provided by the ADF and DVA. The only data that is available relates to outputs (e.g. the number of services provided, and the number of people attending training), which does not provide meaningful information about whether a service has achieved its intended outcome for its client (e.g. higher resilience) or client group (e.g. lower rates of mental illness or suicide attempts).
- ... while useful for the purposes of system-wide transparency, the rates of self-harm, suicide and suicide attempts are not appropriate metrics for assessing the effectiveness of individual services, given the complexity of these issues.
- A lack of evidence around effectiveness is not uncommon in relation to mental health and suicide prevention services more broadly, and an issue that is frequently commented on by mental health and suicide prevention reviews and inquiries. However, this is an issue that has previously been recognised in a military context, for example, with the 'Review of Mental Health Care in the ADF and Transition through Discharge' commissioned by the Minister for Defence Science and Personnel and the Minister for Veterans' Affairs in 2008, explicitly recommending rigorous evaluation of all programs.

Sources: ANAO (2016, pp. 8–9); NMHC (2017, p. 29).

The 2016 ANAO report on the administration of rehabilitation services under the MRCA (ANAO 2016) also made a number of recommendations on the need to improve measurement and reporting of rehabilitation effectiveness. Defence and DVA agreed to these recommendations, with qualification only regarding RTW measures. Despite this, many of the gaps identified by the ANAO still persist.

In light of these gaps in data and other information, the Commission looked at reported RTW rates; comparisons of RTW rates in other rehabilitation contexts; possible proxy measures such as changes in incapacity payments; and other sources of feedback, including feedback surveys.

Reported outcomes from ADF rehabilitation

The most comprehensive data on rehabilitation outcomes in the ADF comes from the Annual Report of the Defence Health Services Division (2006-07) and later reports from JHC (2007-08 to 2013-14). JHC has not published these reports in recent years, and gave the following explanation:

The intent is to publish the report annually, however there hasn't been one since FY13/14. This is because we rolled out the Defence e-health system (DeHS) in 2014 and when we attempted to migrate our rehab records across to DeHS we found we were unable to generate the required data. We have rectified these concerns and the 16/17 report is currently under development.

At this stage we are not going back and redoing the 2014-15 and 2015-16 reports due to the technical, difficult and time consuming nature of such a task. (Joint Health Command, pers. comm., 5 May 2018)

And while JHC have not yet produced a 2016-17 Annual Review report, it told the Commission that the RTW rate for 2016-17 was 71 per cent and that:

Defence is moving away from measuring rehabilitation outcomes by 'return to work'. Instead we are measuring durable outcomes by 'return to duty'. Defence has developed a military specific measure called a Return to Duty rate. This measure reflects the fact that a Defence member must be fit to perform all of their military duties before they fully return to work in Defence

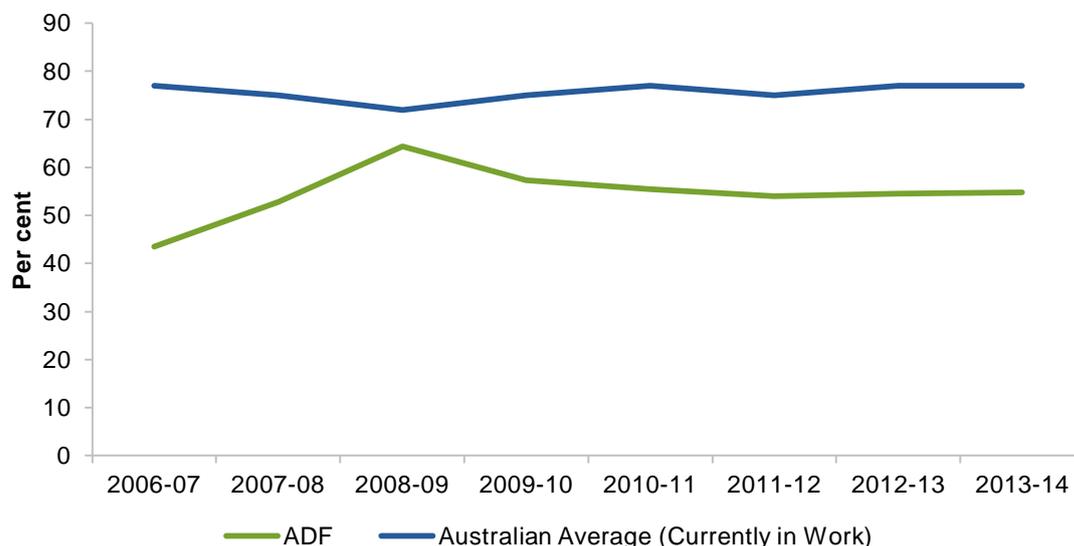
Return to work in some capacity is the first step in a successful rehabilitation outcome for an ADF member and forms the basis of the Return to Duty rate. Returning to Duty means that an ADF member can perform the full range of their ADF duties and so fully return to their pre-injury role in the ADF. (Joint Health Command, pers. comm., 11 September 2018)

While the ADF data are subject to structural breaks across time, gaps and changes in reporting methodology, the picture that emerges is consistent with that given by the ANAO in 2016 (ANAO 2016, pp. 26–31). The main results are that:

- RTW rates in the ADF that have been, at least until very recently, significantly below the Australian average (figure 6.5)
- Defence continue to not have a publicly available, reliable measure of treatment durability (although latest indications are that this is in development), and do not track longer-term outcomes for those receiving ADF rehabilitation
- over time (since 2006-07), there has been much less reporting, not only on outcomes, but also on process issues such as timeliness of intervention.

Some caution is needed when comparing RTW rates or other measures between the military context and other industries and sectors (discussed below).

Figure 6.5 Return to work rates in the ADF compared to the Australian average



Data sources: ADF rehabilitation program data; Social Research Centre (2016).

These results nevertheless point to a reporting framework that, despite some recent improvements, remains cursory at best. The ADF rehabilitation program is now a long running program, but one that struggles to demonstrate its outcomes relative to civilian programs in any comparable sense. Delays on further work on the long-term study of rehabilitation also means that reporting on outcomes (that happens as a matter of course in providing rehabilitation services in many other contexts) continues to be missing.

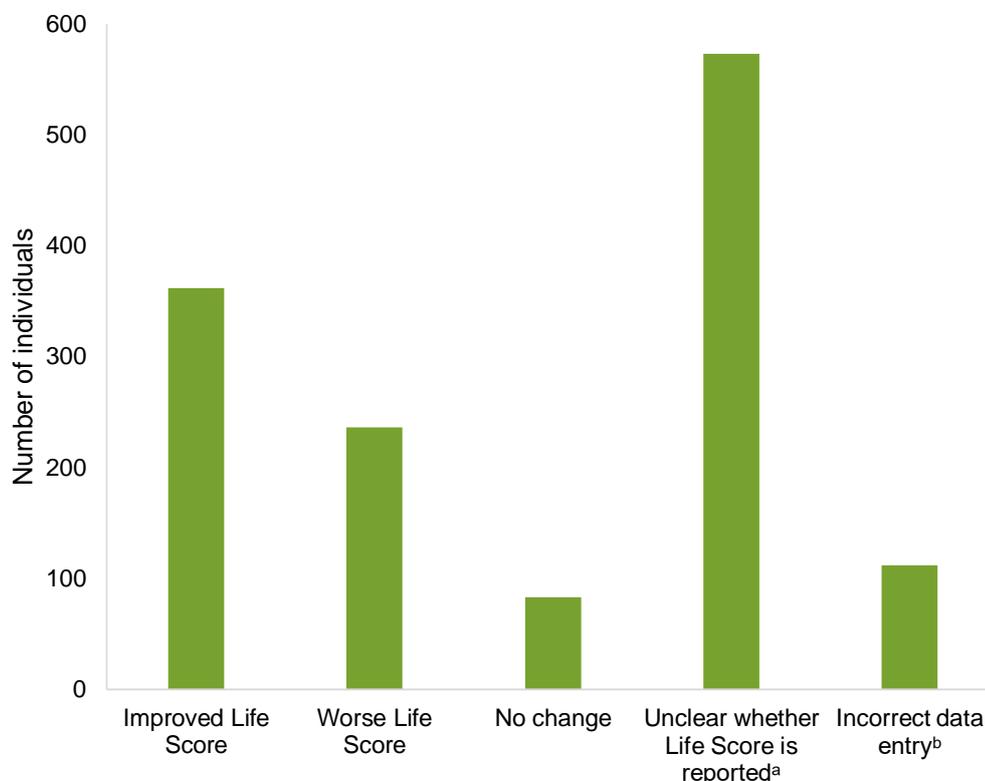
DRAFT RECOMMENDATION 6.1

The Australian Defence Force Joint Health Command should report more extensively on outcomes from the Australian Defence Force Rehabilitation Program in its Annual Review publication.

Reported outcomes from DVA rehabilitation

Data provided by DVA on their rehabilitation program (discussed in more detail in chapter 16), are also of very limited use in the context of assessing effectiveness of its approach (and, in many instances the data are of poor quality due to the presence of coding and integration errors, figure 6.6).

Figure 6.6 DVA life score results



^a This refers to cases where there is a 0 in two or more Life Score fields. As per DVA communication it is unclear whether this is the actual Life Score at each of these stages or if this represents that no Life Score was recorded by the rehab provider or delegate ^b This refers to instances where an 11 is put in as a Life Score. By definition a Life Score must be less than or equal to 10.

Data source: Productivity Commission estimates based on unpublished DVA data.

As with Defence, who are partners in the proposed long-term study on rehabilitation services under the MRCA, DVA appear to be making some attempts to improve data collection and use in this area. DVA data show:

- a rising number of rehabilitation cases, and costs, over recent years
- a large number of outsourced providers of rehabilitation services funded by DVA, but a small number of providers that account for a considerable number of service instances. In 2017-18, for example, ten companies provided 41 per cent of total rehabilitation services
- some information on the results from rehabilitation, but they contain numerous instances of ambiguous classification, and are difficult to interpret as a result (tables 6.2 and 6.3).

Table 6.2 Rehabilitation cases
Number of cases

	2013-2014	2014-2015	2015-2016	2016-2017
MRCA				
New cases:	925	1 125	1 023	1 271
• Return to work	606	834	697	1 064
• Non-return to work	276	260	219	283
Closed successful return to work	117	172	210	281
Closed successful non-return to work	94	145	139	324
DRCA				
New cases:	381	411	503	782
• Return to work	151	181	211	478
• Non-return to work ^a	195	202	257	301
Closed successful return to work	41	49	53	65
Closed successful non-return to work	227	197	312	635
VVRS				
New cases:	124	120	78	66
• Return to work ^a	122	121	76	64
Closed successful return to work	47	62	37	38

Notes: ^a Number of cases do not appear to add to total number of new cases.

Source: DVA data provided to the Commission.

Table 6.3 Rehabilitation outcomes, by program type
Per cent

<i>Reason for plan closure</i>	<i>Non-return to work</i>	<i>Return to work</i>
Successful return to work	N/A	36.4
Successful quality of life program	80.7	N/A
Further gains unlikely	4.9	15.2
Goals changed	2.4	4.1
Not accepted	4.7	14.3
Provider changed	2.3	13.4
Withdrawal by client	1.5	9.1
Other	3.5	7.6

Source: DVA data provided to the Commission.

Return to work: proxy measures?

As already discussed, the rehabilitation literature places a strong emphasis on the connection between wellbeing and employment (chapter 4). This is also reflected in DVA's statement that many of its own rehabilitation success stories:

... highlight how important employment has been in helping veterans get their life back on track after a service-related injury or disease. (sub. 125, p. 129)

Both Defence and DVA noted a number of special features that, in their view, limit comparisons between RTW outcomes that they achieve and those in other sectors.

- Defence stated that it is moving away from measuring rehabilitation outcomes by return to work, given the different requirements faced by ADF members in moving back to duty.
- DVA acknowledged that the exit rates from incapacity payments (indicating return to work and a positive outcome for rehabilitation) are much lower for their clients when compared to other Commonwealth and State-based worker and accident compensation schemes (box 6.9). However, it claims that these crude rates do not adjust for the potential systematic differences between DVA clients and other compensation clients such as degree of impairment, age, gender and difference in time between point of injury and commencement of rehabilitation.

While these points are noted, the Commission is of the view that return to work is a key measure of effectiveness.

Box 6.9 DVA's concerns with return-to-work benchmarks

In response to the Australian National Audit Office's (ANAO's) review of rehabilitation services, the Department of Veterans' Affairs (DVA) discussed the complex nature of return to work for its clients:

Achieving return-to-work outcomes for DVA rehabilitation clients is a more complex undertaking when compared to other jurisdictions. Because veterans are often unable to continue in or return to pre-injury employment and DVA seeks to assist them into new and or different occupations, national return-to-work benchmarks are not generally comparable.

This is further emphasised by the multiple injuries often suffered by members of the ADF, with mental health conditions forming a large part of injuries accepted by DVA as related to Defence service. In particular those returning from operational deployments and discharging medically, a group which has been increasing in recent years, are a particular group requiring a wide range of rehabilitation support to manage complex co-morbidities.

Shifts in the characteristics of DVA's rehabilitation population may be a factor in the reduced return-to-work rate in cases where return to work is a specific objective of the rehabilitation plans, and DVA will examine the reasons behind the ANAO findings.

It is also worth noting that success for DVA rehabilitation clients is not solely measured in return-to-work outcomes. For many clients, achieving better functionality, engagement and social participation is seen as a successful outcome ...

Source: ANAO (2016, pp. 55–56).

INFORMATION REQUEST 6.1

The Commission is seeking information (both quantitative and qualitative) on return-to-work outcomes from Australian Defence Force and Department of Veterans' Affairs rehabilitation programs. Areas of particular interest include the appropriateness of comparing return-to-work outcome measures in military and civilian contexts, and what approaches to return to work are effective both in-service and post-service.

Feedback surveys and results from other sources

In addition to the data sources discussed above, there are several other notable pieces of research that discuss indicators of rehabilitation effectiveness.

Recent research on *Pathways to Care* (Forbes, Van Hooff and Lawrence-Wood 2018) considered access to evidence-based treatment by serving and ex-serving individuals. It surveyed a sample from both groups, and found that more limited access to rehabilitation services was evident in the latter group. On satisfaction with services provided, it found better results for the currently serving cohort, and stated:

... satisfaction with services is higher in the 2015 Regular ADF. While effective treatment can and often should be episodic, these findings indicate that strategies need to be considered for improving engagement rates, retention and delivery of best-practice care at each contact point. (Forbes, Van Hooff and Lawrence-Wood 2018, p. iv)

These findings align with what the Commission heard in this inquiry — rehabilitation service effectiveness and access is better in service than out.

EML's recent review of forty DVA veteran claims, found significant room for improvement in the approach to rehabilitation. In particular, they found a lack of focus by DVA on effectiveness:

EML's review found that responsibility for returning veterans to work was often outsourced to rehabilitation providers rather than being coordinated and 'owned' by DVA and the veteran. While the majority of claims we reviewed did have a return-to-work opportunity identified, there was little measurement of the success rates of these opportunities being attained and no accountability on the primary parties of DVA and the veteran. (sub. 90, p. 5)

These findings are in line with the Commission's view that a serious deficiency in DVA's rehabilitation program is its lack of focus on outcomes.

Adopting more of an insurance-based approach with a lifetime approach to supporting veterans (chapter 11) will demand greater attention to data and evidence and the long-term financial sustainability of the veteran support system. It will also provide an incentive to focus efforts on early intervention, effective rehabilitation, independence and outcomes.

DRAFT RECOMMENDATION 6.2

The Department of Veterans' Affairs should make greater use of the rehabilitation data that it collects and of its reporting and evaluation framework for rehabilitation services. It should:

- evaluate the efficacy of its rehabilitation and medical services in improving client outcomes
- compare its rehabilitation service outcomes with other workers' compensation schemes (adjusting for variables such as degree of impairment, age, gender and difference in time between point of injury and commencement of rehabilitation) and other international military schemes.

Cost effectiveness

A number of participants to this inquiry raised concerns about DVA's oversight of rehabilitation providers and questions about whether DVA had the appropriate processes in place to ensure 'value for money' from rehabilitation services. EML, for example, said that it:

... did not observe any line of sight within DVA of its overall treatment expenditure. There is an inadequate focus on managing individual veteran treatments and scheme costs (i.e. a passive approach), resulting in over-servicing, as well as the regular administration of concurrent, ineffective and/or potentially harmful treatments. It was frequently unclear in individual cases who the treating GP or trusted medical advisor was, or what their view was of the veteran's return to work capacity and treatment goals. There was also no evidence of treatment expectation frameworks being provided to providers by DVA, or targeted selection of specialised providers for specific injury types. (sub. 90, p. 6)

Reporting of rehabilitation services in DVA's Annual Reports is also scant. Rehabilitation is also not mentioned in DVA's outcome and program structure (box 11.4).

The ANAO also said:

Veterans' Affairs does not have a basis to demonstrate that its rehabilitation services represent value for money. Veterans' Affairs has not completed market testing or established service level agreements with rehabilitation service providers to monitor and manage performance, and there is no documented rationale for selecting one provider over another when clients are referred to rehabilitation providers. (2016, p. 44)

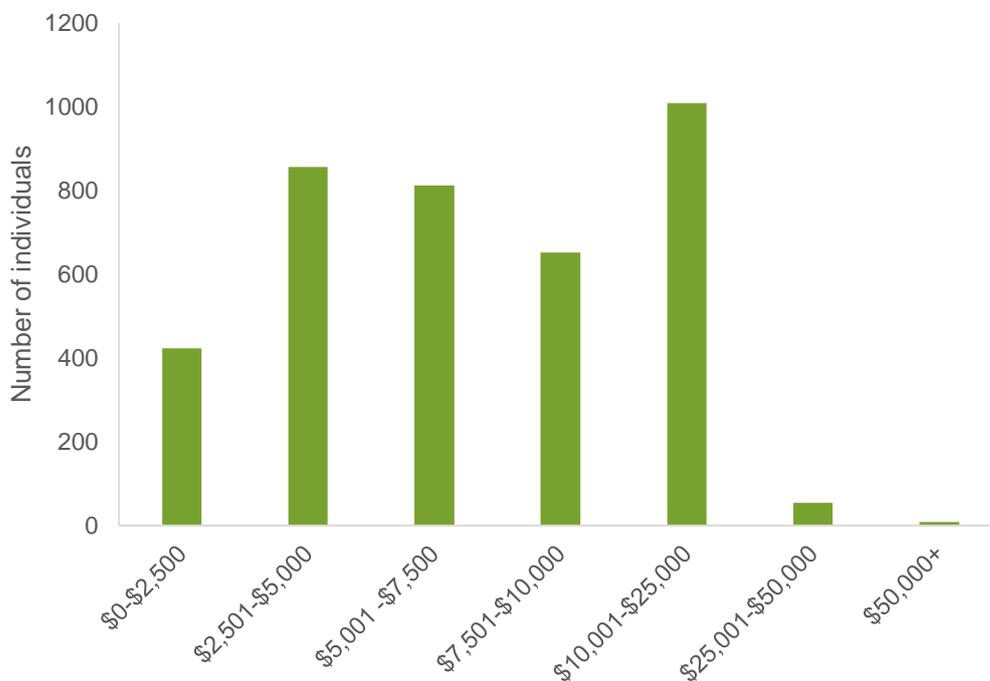
The Commission heard from a number of rehabilitation providers that DVA does not have set rehabilitation fees for providers but rather allows rehabilitation providers to set their own rates (providers noted that this is unique in the workers' compensation space).

The limited amount of data again means that it is difficult to assess the cost effectiveness of rehabilitation services.

As noted by the ANAO (2016, p. 30), Defence does not separately capture information on total rehabilitation expenditure within its health budget.

The DVA rehabilitation data provided to the Commission show that, when combining all the plans for individuals (from May 2017 onwards), the average cost of rehabilitation for an individual is \$8382, although the average masks a considerable range — the highest rehabilitation cost was \$363 496 and the lowest \$19.45. Figure 6.7 shows the cost of rehabilitation per person and the number of individuals in each range.

Figure 6.7 Costs of DVA rehabilitation plans



Data source: Productivity Commission estimates based on unpublished DVA data

Summing up

The formal emphasis on rehabilitation in the MRCA is not translated into a greater emphasis on rehabilitation on the ground or good rehabilitation outcomes (although it is difficult to know because of the lack of data).

Both Defence and DVA need to do more in the area of evaluation. This gap remains despite evidence of significant and growing expenditure on rehabilitation, and despite a plethora of formal policy documents, pilot programs and new initiatives pointing to the importance of effective rehabilitation.

The costs and outcomes for clients of rehabilitation (and health) services in the system need to be reported in far greater detail. Focusing effort and investment in services that are most cost effective is in the best interest of veterans (the objective being to recover at the earliest opportunity) and taxpayers (who want to know that the money government is spending on rehabilitation is making a difference to veterans' lives).

Shortcomings in this area are not new (many previous reviews have identified shortfalls). A further point worth making is that the MRCA and its emphasis on rehabilitation delivery has been in operation for the best part of a decade and a half.

Both DVA and Defence have work to do. Too much time has been taken to address the issues identified in past reviews. Priority must now be given to action in this area.

6.4 Ways to improve rehabilitation services

As well as better data collection and reporting, changes should be made in the following areas:

- the ADF and DVA's management of contracted rehabilitation services and market stewardship more generally
- the provision, oversight and funding of rehabilitation services immediately prior to, and following, discharge of personnel from the ADF.

Changes are needed to the way services are procured and the stewardship of the market

A common theme behind many of the observed deficiencies in the way rehabilitation services are provided is the absence of high-quality market engagement.

Despite some recent improvements, DVA continues to take a passive and transactional approach to rehabilitation services. Third party providers of DVA rehabilitation services are engaged and paid by DVA with very little scrutiny of the cost or quality of their services. As EML said, this is could be resulting in poorer outcomes for DVA clients:

By not adopting an active case management approach that recognises intervention opportunities, DVA could risk the delivery of sustainable, productive outcomes for veterans. (sub. 90, p. 3)

Entities such as the Transport Accident Commission in Victoria, and arrangements in place for police and emergency services in several State and Territory jurisdictions, provide examples of a more active model of claims management. And they appear to be streets ahead of DVA in terms of providing holistic and tailored rehabilitation services.

On the ADF side, the picture that emerges is that under the ADF Rehabilitation Program, services are more coordinated than is the case with DVA, and access to services is good.

However questions remain about efficacy, including around the mix of services provided in-house and by contractors.

The contract for Garrison Health Services is subject to renegotiation from late 2018. It is important that going forward there is better oversight of outcomes from rehabilitation (and health) services.

Fundamental change is needed

The bottom line is that there needs to be a fundamental change to the way rehabilitation services are commissioned, including more proactive engagement with providers (including requiring evidence-based approaches to rehabilitation) and better oversight of outcomes. Better coordination of Defence and DVA's commissioning of rehabilitation (and health) services could also mean making better use of purchasing power as well as addressing continuity-of-care issues (discussed below).

In the context of improving the commissioning of rehabilitation services, there are a number of options, including:

- The joint contracting or commissioning of rehabilitation services by Defence and DVA. Contracts could identify the differing requirements of Defence and DVA rehabilitation programs including services, reporting and monitoring aspects. This option does not necessarily mean one national contractor and, in fact, such an approach could reduce contestability and incentives to continuously drive improvements in practices and outcomes. (In this context, contestability is not simply a means to improve efficiency, but is also an important driver of service quality and innovation).
- The outsourcing of much of the rehabilitation management, coordination and provision to established service providers. This could be done on a state-by-state basis so that there may be only one (or two) providers per state or territory with the aim to have a small number (nationally) of high-quality and well-monitored providers, creating a competitive environment based on best practice approaches and outcomes.

The Commission welcomes comments on the best approaches to improved commissioning of rehabilitation services.

Structural changes for transitioning ADF members?

Many veterans spoke about the difficulties they experienced negotiating the rehabilitation systems within Defence and DVA. In particular, the structural disconnect between Defence and DVA is seen as a key reason for poor rehabilitation outcomes. Stephan Rudzki said:

There should be a separation of rehabilitation and compensation. The present system requires a successful compensation claim in order to access rehabilitation services. Defence provides medical care and rehabilitation to all its members without any requirement for compensation. If the system were truly 'seamless' then rehabilitation would be provided for all former ADF

members for conditions that they had treated for in Service, but not new conditions. A simple statement of injuries/illnesses incurred during service should provide access to care post discharge. (sub. 40, p. 1)

The Royal Australian and New Zealand College of Psychiatrists also said:

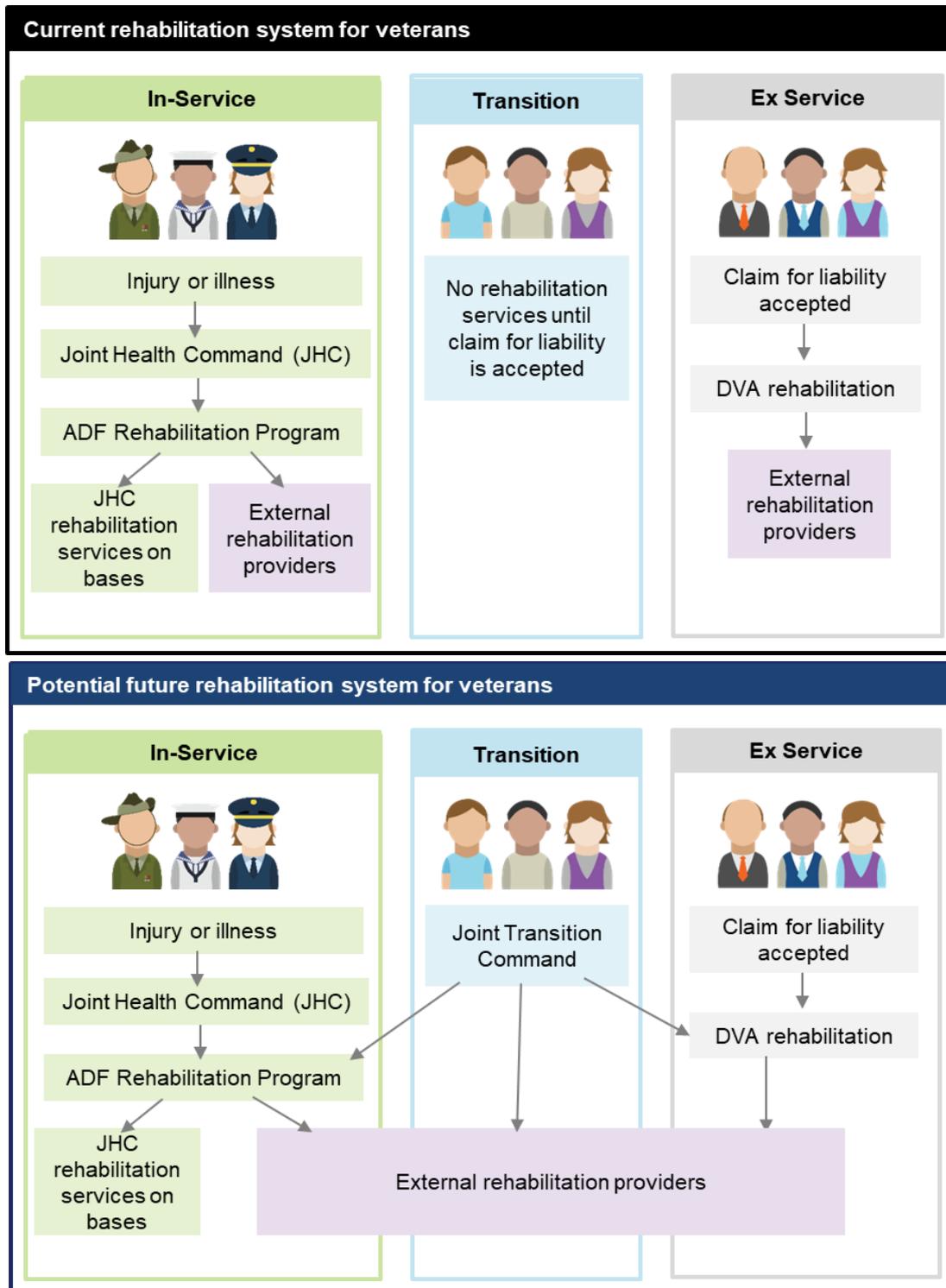
Consideration should be given to merging the rehabilitation and care services provided by the ADF and contracted by DVA, so veterans can be provided with seamless, ongoing care when they are discharged. This would involve merging and improving the administration, contracting and governance of the ADF and DVA health systems. This will remove a layer of bureaucracy and create efficiencies within the veteran care system. It will also increase the accountability of the ADF for the injuries that result from service, and will encourage greater responsibility for early intervention and injury prevention in the ADF. (sub. 58, p. 4)

As discussed in chapter 7, the proposed new Joint Transition Command would be responsible for preparing members to leave the ADF and supporting their transition to civilian life.

For transitioning personnel who require rehabilitation during transition, a more coordinated approach is required. The Commission's proposed new Joint Transition Command structure could organise (or ensure continuity of) rehabilitation services for transitioning personnel, at some point prior to their discharge, and, on a continuing basis after discharge until their initial claim is determined by DVA (figure 6.8). This Joint Transition Command would be tasked with 'bridging' the rehabilitation services provided or organised by JHC, while in service, and DVA-funded services provided following discharge.

The Commission is seeking further views on the role that the proposed Joint Transition Command should play in the coordination of rehabilitation services to ensure continuity of service to transitioning veterans and the accessing of new services for veterans who have not previously been assigned a rehabilitation provider.

Figure 6.8 An improved system of rehabilitation and wellness supports



There can also be eligibility issues for those requiring rehabilitation across the interval from service to post service. Delays in having compensation claims accepted can mean that access to rehabilitation is difficult over the period from lodgement to determination. One option is

for DVA (and subsequently the Veteran Services Commission (VSC)) to continue any rehabilitation programs for service-related injuries and illnesses set up by ADF (on the basis that lifetime costs of support could be higher if a rehabilitation program is disrupted). Given that rehabilitation programs are for limited periods of time, DVA (VSC) could then reassess the need for rehabilitation once the program has run its course. The Commission is seeking further views on the feasibility of this approach.

DRAFT RECOMMENDATION 6.3

Defence and the Department of Veterans' Affairs need to engage more with rehabilitation providers, including requiring them to provide evidence-based approaches to rehabilitation, and to monitor and report on treatment costs and client outcomes.

Changes are also required to the arrangements for providing and coordinating rehabilitation immediately prior to, and immediately post, discharge from the Australian Defence Force (ADF). Rehabilitation services for transitioning personnel across this interval should be coordinated by Joint Transition Command (draft recommendation 7.1). Consideration should also be given to providing rehabilitation on a non-liability basis across the interval from ADF service to determination of claims post-service.

The potential effects of an insurance-based approach

Levying an insurance premium on Defence and establishing an independent body to oversee the performance of the veteran support system (chapter 11) is also expected to have flow on benefits in the area of rehabilitation, including in the areas of data collection and evaluation and providing incentives for early intervention and effective rehabilitation.

Based on the experience in other sectors and industries, levying a premium on Defence will act to drive enhanced reporting frameworks, as inputs in to the premium-setting process are also subject to enhanced scrutiny. The data collection and analysis that goes into determining a premium and taking a focus on the lifetime costs of support will demand better data on outcomes from rehabilitation programs which in turn should influence the design and delivery of rehabilitation services. The Commission sees this as an important benefit of proposed governance arrangements discussed in chapter 11.

Adopting the best features of contemporary workers' compensation schemes to support veterans should also strengthen the incentives to provide early and effective rehabilitation. There should also be a greater emphasis on getting serving individuals to report problems and to seek treatment, for commanding officers to support this process. For its part, DVA or its equivalent in the new system should also continue to consider the incentives that are provided to individuals to be involved in both rehabilitation and, more broadly, in economic participation through employment. As recent research from the United States has borne out, changes in compensation arrangements can have significant effects on the incentives that

individuals face regarding work–leisure trade-offs and labour market participation (Autor et al. 2016; Autor and Duggan 2007).

A renewed focus on ability, as opposed to disability, points to a number of other elements required in any new approach to rehabilitation for veterans. A *tiered approach*, which classifies individuals according to whether they have low, medium or high rehabilitation needs, would assist in prioritising cases and providing more intensive resources to those most in need. And a genuinely *modular approach*, which focuses on the person, and wraps a range of rehabilitation supports around them as required, would also be more effective than the present approach. Finally, there exists a very well-developed body of evidence on the rehabilitation approaches that work — and those that do not. Greater use of this evidence base is needed, as part of an ongoing process of *treatment innovation and evaluation*.

A role for consumer-directed care?

As discussed in chapter 4, consumer-directed care (CDC) is one of the recent models of service delivery used in contemporary social insurance schemes to give users more choice and flexibility. It is increasingly being used in the areas of aged care and disability care. This model of service delivery involves individuals with assessed needs, and their carers and others, playing a more active role than has traditionally been the case in managing allocated care budgets and choosing service options and service providers.

A number of participants raised the idea of providing a CDC model of rehabilitation to military veterans. RSL NSW recommended DVA implementing a five year trial program of a CDC model for rehabilitation services to veterans with service covered by DRCA and MRCA (and, if successful, extended to VEA clients on an opt-in basis).

When a client claims for rehabilitation services, a DVA delegate or case manager should conduct an initial assessment to determine the client’s suitability for a consumer-directed care model of rehabilitation. Different clients can be offered individualised levels of control and flexibility along a continuum from a high level to a low level. (sub. 151, p. 33)

Any trial of CDC for veterans’ rehabilitation services would need to follow the principles of well-designed policy trials (box 16.4). The Commission is seeking further views on the practicality of CDC for rehabilitation services, or other alternatives for providing greater tailoring of rehabilitation service provision to the needs of veterans.

INFORMATION REQUEST 6.2

The Commission is seeking further views on the potential use of consumer-directed care for the rehabilitation services provided to veterans, or on alternatives for providing more tailored, person-centred rehabilitation services.

7 Transitioning to civilian life after military service

Key points

- Between 5500 and 6000 members of the Australian Defence Force (ADF) leave each year. Many are relatively young — they are typically in their mid-20s and have served for almost nine years. About 18 per cent of those who leave the ADF do so for medical reasons.
- Leaving the military can be challenging and the challenges are easily underestimated. They typically include simultaneously finding a new job, health care and social networks, as well as psychological changes in an individual's self-image. Many veterans also need to find new housing (often following an interstate move) or submit a claim to the Department of Veterans' Affairs (DVA) — a process that can be confusing and frustrating.
- Despite these challenges, most veterans make a relatively smooth and successful transition to civilian life, and go on to lead fulfilling and productive lives after their military service. About one quarter continue to serve in the Reserves, which may help to smooth their transition. But some find transition very difficult, and can go on to develop mental health or other problems. Family members of discharging veterans can also find transition difficult.
- While there are many initiatives to assist veterans in the transition process, the rhetoric around the importance of transition is not matched by effective action by either Defence or DVA, and neither department has clear responsibility for all aspects of veterans' transition. Little is known about what services work well (or not), and why and where extra supports should be targeted.
- Those who are younger, served in lower ranks and have skills that are not easily transferable to the civilian labour market tend to be most at risk when transitioning. But services are not targeted to this group (in fact this group can receive the least support) and navigating the available services can be confusing for all of those who need them.
- To improve military-to-civilian transition, two main changes are needed. First, responsibility for assisting members in their transition to civilian life should be centralised in a new body within Defence — the Joint Transition Command (JTC). Modelled on the existing Joint Health Command, it would consolidate transition support functions currently provided within Defence and DVA, and be staffed by ADF and DVA personnel. Its functions would include:
 - engaging veterans early in their careers, to help prepare them for their inevitable departure from the military and plan for their service and post-service careers
 - providing individualised support, advice and referrals to veterans and their families as they approach transition, and continued support after discharge (up to six months as needed)
 - ensuring that veterans have continuity of rehabilitation and other support services
 - reporting on transition outcomes to drive further improvement.Longer term transitional or reintegration supports will be through DVA.
- Second, an improved package of transition support is needed. The package should include the enhanced services provided by JTC, as well as support for veterans to gain skills and qualifications once they leave the ADF, by trialling a veteran education allowance for those undertaking full-time study.

Between 5500 and 6000 people leave the Australian Defence Force (ADF) each year (DVA and DoD 2018). Most make a relatively smooth and successful transition to civilian life, but some veterans and family members of discharging veterans can find transition difficult. An improved system of transition support is essential for achieving better outcomes for veterans and their families.

Section 7.1 considers the importance of the military-to-civilian transition experience for the future wellbeing of veterans and their families. Section 7.2 describes the characteristics of transitioning veterans. Sections 7.3 and 7.4 outline the services that are currently provided to transitioning veterans and recent initiatives to improve those services. Concerns about the adequacy, efficiency and equity of the support services available to veterans as they make the transition from military to civilian life are considered in section 7.5. Sections 7.6 to 7.9 describe the Commission's proposed reforms to transition services, and section 7.10 canvasses a range of other issues relevant to transition.

Transition in this report generally refers to transition from full-time military service, whether or not the person joins the Reserve forces. The issues associated with leaving the Reserves are dealt with briefly as a separate matter.

7.1 Why transitioning well matters

Leaving the military is a major life event

Everyone who joins the military will eventually leave the service. For the large majority, transition to civilian life is successful, but for a minority transition is particularly difficult. And a person's transition experience can shape their experiences for many years.

Veterans leave the military for many and varied reasons. For some it is planned, for others it is unexpected (which can mean there is little time for planning and preparation). As RSL Queensland pointed out:

Transition out is generally triggered by a 'change event'. This can include injury, birth of a child, unfavourable posting, job opportunity elsewhere, family stress, workplace harassment, dissatisfaction with current role or a combination of several factors. (sub. 73, p. 45)

Some will leave permanent full time service and join the Reserves, which may lessen some of the challenges of transition. Nevertheless, leaving permanent military life and adjusting to civilian life is one of the most profound transitions in the life course of ADF personnel (Van Hooff et al. 2018b, pp. 6–7). On this point, the RAAC Corporation said that:

... the discharge process is on any view and on any level, a fraught process for separating members and their families. It means a total severing of an involvement in a life in which career, rank, status, achievement, pride, camaraderie and being a part of the nation's defence and security, is no longer the case. Discharged members find themselves as just another civilian with no status. (sub. 29, p. 50)

The transition process can also trigger or exacerbate service-related conditions. As the recent *Mental Health Prevalence* report said:

Changes brought about by the transition process can lead to the development and/or exacerbation of existing service related mental and physical symptoms resulting in psycho-social adjustment issues ranging from employment difficulties and family/relationship conflict, to mental health and substance abuse problems. (Van Hooff et al. 2018a, p. 1)

What is a good transition?

The Forces In Mind Trust in the United Kingdom defined a good transition as one that:

... enables ex Service personnel to be sufficiently resilient to adapt successfully to civilian life, both now and in the future. This resilience includes financial, psychological, and emotional resilience, and encompasses the ex-Service person and their immediate families. (2013, p. 5)

Inherent in this definition is the idea that a good transition involves not only practical tasks — finding a job and housing, accessing civilian health care, potentially relocating or pursuing further education — but also a change in an individual’s view of themselves and their place in society.

The National Mental Health Commission (NMHC) recently emphasised the importance of this change in self-perception, noting that ‘psychological transition from being a “warrior” to becoming a civilian is an essential aspect of successful transition to civilian life’ (NMHC 2017, p. 21). Similarly, the United States Veterans’ Affairs Center for Innovation commented that:

[Military–civilian transition] is fundamentally a psychological and cultural evolution, in which veterans need to find a path to reorientation and self-redefinition, sometimes while acclimatizing to a new definition of wellness, but always while moving quite abruptly from a collectivist community to an individualist one. (VACI 2017, p. 2)

Transition experiences are more likely to be positive when members ‘own’ the decision to leave the military and have had time to prepare for the impending changes.

The move from a culture which prizes physical and emotional toughness, stoicism and self-reliance to a culture that places less value on those attributes is part of what makes veterans’ transition a unique challenge. This is compounded by the move from a collective to an individual mindset. After living and working within an institution that regulates their lives in ways that civilian employers do not, veterans can find themselves facing both practical and psychological challenges they are ill-equipped to handle. And unlike previous generations, who often put their civilian careers on hold when they volunteered or were conscripted to serve, contemporary veterans can have very limited experience of adult life outside the military. As one veteran put it:

[I] don’t feel that I am transitioning ‘back’ to civilian life but becoming a civilian for the first time. (OVOC 2017, p. 24)

This view is not uncommon.

Attached to the identity of ‘soldier’ was a level of institutionalisation. One of the most common difficulties experienced in the transition from soldier to civilian was adjusting to the lack of structure and routine in civilian life. (Wainwright et al. 2016, p. 750)

This institutionalisation can lead to veterans being unskilled in aspects of civilian life. As Phoenix Australia noted:

Many skills essential to life in the military (such as threat detection, rapid response, survival skills, unit cohesion, expectations of others) can make adjustment to civilian life difficult. A great deal of time and resources are spent developing these skills in the military, but while time is devoted to providing general discharge information, little time is spent re-training people for civilian life at the point of discharge. (2016, p. 5)

Many veterans are also surprised by how much they miss the social bonds and camaraderie of military life (Binks and Cambridge 2018).

The experience of leaving can have long-term consequences

While military service has unique characteristics (chapter 2), it also has features in common with other occupations, such as professional sport or opera singing, that require particular physical skills and have unusual timetables or schedules. These professionals can also struggle when they no longer work in their profession because it ‘becomes more than a means of earning a living, it becomes a way of life’ (Oakland, MacDonald and Flowers 2012, p. 1).

When a way of life comes to an end, grief is a normal reaction. As one veteran told the Commission at a roundtable, ‘on discharge I was lost, you need to belong’. Canadian research suggests that military–civilian transition is:

... associated with a sense of loss and characterized as worse than divorce by some. The stress can propel them along the mental health continuum toward more severe mental health problems. (Thompson and Lockhart 2015, p. 7)

A review of research on veterans’ reintegration found that they experience significant and multiple losses in three interrelated domains: loss of military culture and community; loss of identity; and loss of purpose (Romaniuk and Kidd 2018).

Veterans are not helped to deal with the grief and losses of transition by the commonly stated aim of ‘seamless transition’. The profound life change involved in transition means it can never be seamless. When the organisations involved in transition suggest that veterans should have a seamless transition (as opposed to striving to provide seamless transition support) this does veterans a disservice.

In the civilian world, the experience that most closely parallels the experience of leaving the military is that of job loss. Both can affect many other aspects of a person's life.

Loss of employment may entail multiple cascading losses. These include loss of income, financial security, social status, role in the family, and access to other potential reinforcements associated with employment, such as daily social contact and maintenance of a daily routine. Unsurprisingly, research indicates that job loss undermines well-being. (Papa and Maitoza 2013, p. 153)

If the risks to veterans' wellbeing inherent in transition are not dealt with properly, they can adversely affect veterans' success in living and working as a civilian, as well as their mental health (VACI 2017). And, because 'the commitment to serve is a whole-of-family commitment', veterans' families can also be affected by their transition (Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia, sub. 96, p. 9).

Effective transition support services are essential

To better equip veterans for the challenges of military-to-civilian transition, effective preparation and support are essential. There is also a sound economic case for good transition support, as smooth transitions contribute to veteran wellbeing and can reduce reliance on other forms of government support. As The Oasis Townsville put it:

Poor preparation for transition in part causes the elevated demand for compensation and rehabilitation services. (sub. 92, p. 1)

This has been clear for some time — a report commissioned by DVA in 2008 found that:

A smooth process which is sufficiently flexible to meet the needs of individual service members can have a huge positive impact both in terms of the veteran's long-term health outcomes, and ... reducing the likelihood of long-term dependency on compensation. (WestWood Spice 2008 cited in NZLC 2010, p. 220)

The potential for better transition support to reduce support needs over the long term is particularly important given the age profile of those who leave the ADF — most service leavers are relatively young, and potentially have decades of working life ahead of them. It would be expensive and wasteful for the community if these veterans did not find their place in civilian employment and society. And while each individual's capacity to adapt will vary, there is considerable potential to increase the wellbeing of even the most resilient veterans by better equipping them for productive post-service lives.

The changing nature of military operations — especially the increase in counter-insurgency (COIN) warfare — may be making the task of reintegrating into civilian life more difficult.

COIN warfare creates a 'bubble' environment for soldiers which is both a strength and a weakness. On operations, survival depends on close knitted camaraderie but in civilian life it can be problematic by keeping veterans in the bubble. Narrow boundaries of trust and anxiety about another's trustworthiness in civilian life are problematic, making normal social relations and

human social interaction difficult, which can increase feelings of isolation and withdrawal outside the army. (Brewer and Herron 2018, p. 2)

That is, an over-identification with the military predisposes veterans to an inability to cope in civilian life. And the special features of COIN warfare are intensifying over-identification, and could be worsening the management of the transition back to civilian life. As one participant put it, veterans also need to be prepared for the stresses of 21st century life.

Modern veterans are returning to society with much the same mental health issues as their predecessors of earlier conflicts however the modern veterans are returning to an inherently high stress society that is far more stressful than times experienced by veterans of earlier times. (David Watts, sub. 106, p. 3)

The changing needs of, and demands on, contemporary veterans means that transition support services need to evolve to meet those needs.

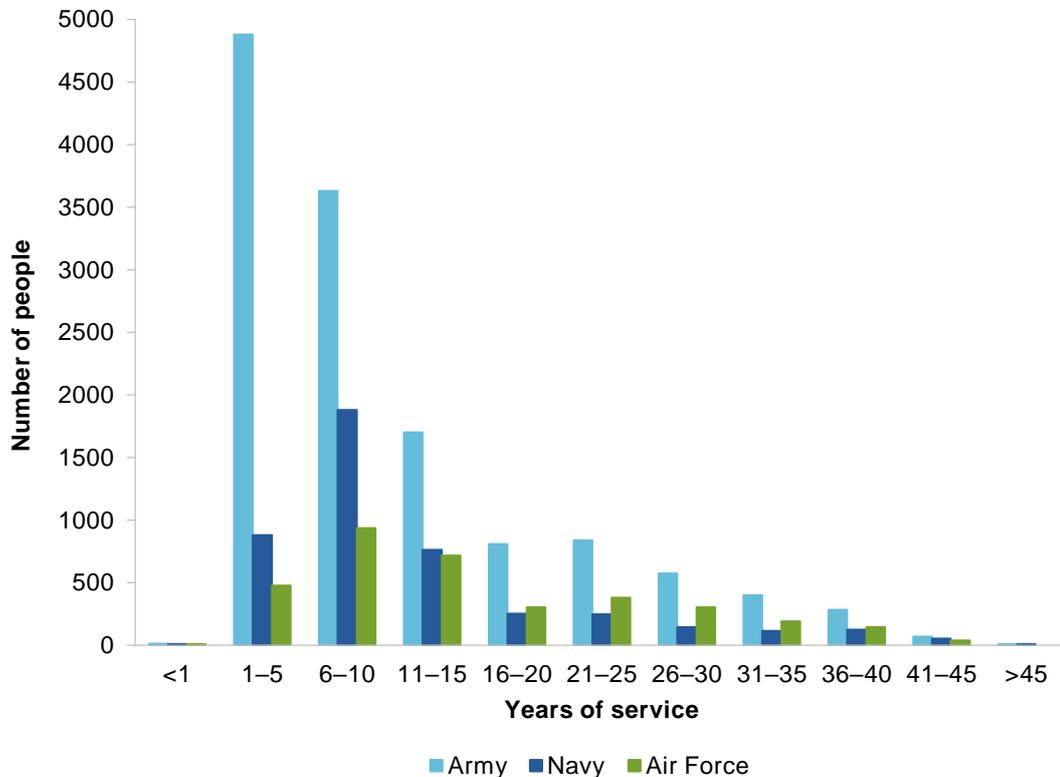
7.2 What do we know about those leaving the ADF?

Who is leaving the ADF?

Of the 21 000 people who left the permanent ADF over the period 2012–2016:

- about 62 per cent had served in the Army
- 21 per cent in the Navy
- 17 per cent in the Air Force
- over 60 per cent had served for 10 years or less when they left (figure 7.1).

Figure 7.1 **Length of service at separation from the ADF**
2012–2016

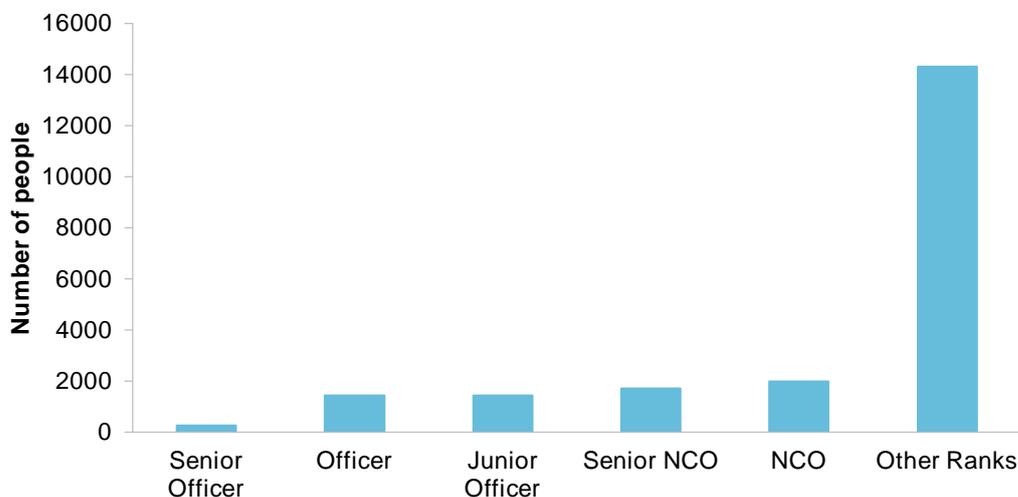


Source: Australian Government (2017a).

Of those ADF members who transitioned in 2015, 45 per cent had served four years or fewer (DVA 2016d) The median length of service of permanent ADF members is currently 8.7 years (DoD 2018m).

Just over two thirds of those leaving full-time service were serving in the ‘Other Ranks’ at the time of discharge, and less than 15 per cent were officers (figure 7.2).

Figure 7.2 Rank at separation from the ADF^a
2012–2016



^a Ranks are grouped into the following bands: Senior Officer — Colonel and above; Officer — Major and Lieutenant Colonel; Junior Officer — Second Lieutenant to Captain; Senior non-commissioned officer (NCO) — Warrant Officer Class 2 to Regimental Sergeant Major — Army; NCO — Sergeant to Staff Sergeant; Other Ranks — Private Proficient to Lance Corporal.

Source: Australian Government (2017a).

The Army accounted for around 62 per cent of separations over the period 2012–2016 while making up 52 per cent of ADF members (Australian Government 2017a; DoD 2017f). This is because the average length of service in the Army is shorter than that in the Navy or the Air Force. The median time in service upon separation was less for women than men across each of the services and rank groups (DoD 2017k).

Neither Defence nor DVA has a full picture of the demographic, health, employment and social characteristics of those transitioning. Defence quickly loses contact with most former members — four months after transition, less than a quarter of former members responded to Defence’s post-transition survey, and even fewer responded in subsequent months (DoD 2018h). And as noted in chapter 2, veterans who left the ADF prior to 1 July 2016 are not necessarily known to DVA — DVA only becomes aware of these veterans if and when they submit a claim.

Most of what is known about members transitioning from the ADF comes from a recent survey of those who left the ADF between 2010 and 2014 (Van Hooff et al. 2018b). While response rates to the survey were low (18 per cent of 25 000 transitioned members responded to the survey, with a higher response rate among officers and a lower rate for other ranks), its findings are one of the best sources of information on current and former ADF members. It found that:

- close to half of the transitioned ADF members met criteria for a mental disorder in the last 12 months

-
- one third of the transitioned ADF members reported high to very high psychological distress. Levels of psychological distress in the Transitioned ADF were nearly twice as high as those reported by the 2015 Regular ADF and three times those reported by the Australian community
 - one quarter of those leaving full time service stay on in the active Reserves, and another quarter in the inactive Reserves (Van Hooff et al. 2018b).

However, these data provide a partial snapshot. And because information on the age, qualifications, deployment history and reason for discharge are not routinely collected and published, data is not available to assist tailoring transition support to best meet the needs of those leaving the ADF.

How well do transitioning members fare?

Most ADF members make a relatively smooth and successful transition to civilian life, and go on to work in second careers and lead fulfilling and productive lives after their military service. For example:

- about half of transitioning veterans are in full-time employment 30 days after discharge (DoD 2018l)
- only about half of the 320 000 of those who have been deployed are clients of DVA (AIHW 2018b, p. 288). That is, about half of those who participated in warlike service or other similar actions have not needed (or wanted) support from DVA.

But the limited evidence suggests that a subset of veterans are faring poorly in a range of key areas (box 7.1). Veterans also face particular health risks upon transition, including the risk of social isolation and weight gain (DVA 2015e, p. 7). And, as discussed in chapter 2, there are high rates of mental health conditions and suicide in the ex-serving community. In particular, the suicide rate for ex-serving men aged 18–24 is twice that of Australian men of the same age (AIHW 2017b).

The limited evidence makes it very hard to establish the extent to which these problems have arisen as a result of military service. In the United Kingdom, Lord Ashcroft found that:

... problems among the minority who struggle are likely to be linked to a combination of pre-Service vulnerabilities such as difficult family relationships, or the advent of post-Service adversity such as social exclusion, substance abuse, homelessness and unemployment, rather than any Service-attributable condition. (Ashcroft 2014, p. 117)

This is not to discount that most veterans make a successful transition to civilian life — but for many this transition is harder than it needs to be. And for some, transition can exacerbate the effects of trauma experienced during military service, as discharge from the military can compound the sense of disconnection associated with trauma.

Box 7.1 **Some veterans may be faring poorly, but data are scarce**

There are few data on rates of unemployment, incarceration and homelessness experienced by veterans. And even if such data were available, it would not be possible to calculate rates of these outcomes for all veterans because there is no official estimate of the total number of veterans.

Unemployment

The United States and the United Kingdom collect and publish statistics on the employment status of veterans (or a subset of veterans), however Australia has no official statistics on veterans' employment.

Several inquiry participants suggested that veterans experience high rates of unemployment. For example, With You With Me has claimed that about 30 per cent of veterans are unemployed (Coady 2017). However, the methodology used to obtain these estimates was not published, so it is not clear whether they refer to all veterans or to those who have made contact with With You With Me (which, as a provider of employment programs, would be expected to see a higher proportion of unemployed veterans).

Other evidence suggests that veterans' unemployment rate is similar to that of the general community.

- A survey conducted as part of the Transition and Wellbeing Research Programme found that about 5 per cent of those who left the ADF between 2010 and 2014 were unemployed, and just over two thirds were employed (the remainder were retired, disabled or students) (Van Hooff et al. 2018b). But survey response rates were low, particularly among veterans from other ranks who are likely to be at greatest risk of unemployment.
- Surveys conducted by Defence of members who left the ADF since July 2017 suggest that 10 per cent were still looking for work 7 months after transition (DoD 2018I).
- The Minister for Veterans' Affairs recently stated that 'the rate of veteran unemployment currently sits about eight per cent 13 months after moving into civilian life' (Chester 2018c).

And research on vocational education and training outcomes found while veterans had more difficulties than their civilian counterparts finding a job, they had fewer difficulties overall due to their many other skills and attributes (Mavromaras, Mahuteau and Wei 2013).

Even if the veteran unemployment rate is higher than the general rate, this may not be problematic, as it is possible that 'veterans are more likely to be looking for work than non-veterans simply because they are more likely to have recently separated from a job, and finding a new job takes time regardless of veteran status' (Loughran 2014, p. 23). It could also be that veterans' job search takes longer as they are searching for 'a particular quality and type of work, with security, community and opportunity attached' (Rayner 2018, p. 63).

Incarceration

There are very few data to compare incarceration rates among Australian veterans and non-veterans (AIHW 2018d). One source of information is a study of the health of Gulf War veterans. This study found that Gulf War veterans were slightly more likely to have been convicted of a crime after their deployment than the comparison group, but no more likely to have been incarcerated (Sim et al. 2015, p. 234).

(continued next page)

Box 7.1 (continued)

International evidence is of limited use, as although male veterans in other countries have been found to be at greater risk of incarceration than non-veterans ‘these patterns were explained by different racial/ethnic groups and employment levels, rather than by combat trauma or other adverse military experiences’ (AIHW 2018d, p. 16).

Homelessness

The limited available evidence confirms that some veterans experience homelessness. For instance, a recent report on the state of homelessness in Australia’s cities recorded 457 homeless veterans, and close to two thirds of these were rough sleepers. One in six homeless veterans in this study identified as Indigenous, even though Indigenous Australians represented less than 2 per cent of the ADF (Flatau et al. 2018).

DVA has commissioned the Australian Housing and Urban Research Institute to ‘conduct research that will lead to a clearer understanding of homelessness among Australian veterans’ (DVA 2017d, p. 71), but the results of this research have not yet been published.

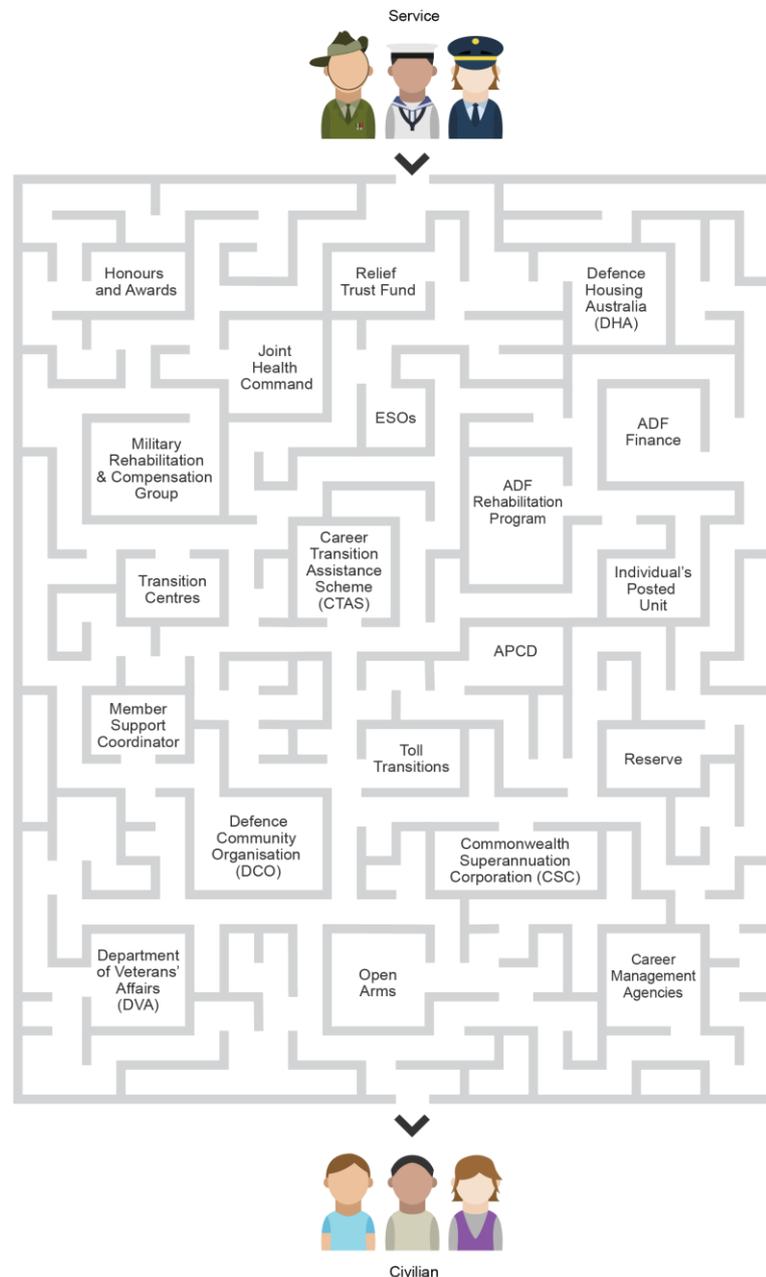
7.3 There are many disparate strands of transition support ...

The Departments of Defence and Veterans’ Affairs provide a range of transition support services for members leaving the ADF. These are complemented by services provided by ex-service organisations (ESOs) and the private sector. While State and Territory Governments have no formal responsibility for veterans’ transition, some support veterans, such as through initiatives encouraging veterans’ employment in the state public service (for example, NSW Government 2017; WA Public Sector Commission 2016).

The sheer number of Defence and DVA processes, requirements and programs can be confusing for those transitioning. One member of the Defence Force Welfare Association likened the ‘deficiencies and lack of co-ordination of a multitude of “Transition” initiatives’ to a ‘headless chook’ (DFWA 2017, p. 36).

At least 20 groups within or associated with Defence and DVA play some role providing transition assistance, or impose administrative requirements on transitioning members (figure 7.3). This figure closely resembles one produced by the Australian National Audit Office in 2004 (ANAO 2004a). Since that time, while the names of many of the groups listed have changed, the number of groups involved has not.

Figure 7.3 Groups within or associated with Defence and DVA that are involved in transition



Source: DoD (2017e).

Many ESOs also provide transition assistance to veterans, often in conjunction with welfare support and advocacy. For example, Mates 4 Mates said:

Coming out of a tightly-knit social unit, veterans often experience a sense of disconnection & isolation in civilian life and a distinct lack of community ... This is why ESO's such as ourselves,

and others, provide opportunities for veterans to access new ‘social villages’ or ‘tribes’ through various social connection activities. (sub. 84, p. 6)

A range of charitable, philanthropic and other non-government organisations also have transition support programs for veterans. For example, The Prince’s Trust Australia helps transitioning ADF members to start or grow their own business, through the Prince’s Lead Your Own Business program. Since 2015, 65 ADF personnel have participated in the program, and all but two are still in business (Prince’s Trust Australia 2017).

To attempt to make sense of the complex web of transition services, the following sections describe these transition activities in turn:

- procedures for discharge from the ADF
- transition support provided by Defence (including the Department of Defence and the Army, Navy and Air Force)
- transition support provided by DVA.

Participants’ views and other evidence on the accessibility and effectiveness of these services are considered in section 7.5.

Many veterans also submit a claim to DVA as part of their transition, a process many find complicated and confusing. Claims processes are considered in chapters 8 and 9.

Discharge from the ADF

When members leave permanent full-time service, they must complete many procedural and administrative requirements. These could include:

- submitting applications for separation and for transition clearance
- deciding on a transition date (for those discharging voluntarily)
- arranging to move to a new location and/or finding new housing
- finalising Defence personnel arrangements, including leave, finances, study assistance, security clearances and medals
- making arrangements for medical care, including undergoing one or more health examinations (box 7.2) and finding civilian healthcare providers.

Members may also choose to apply for, or participate in, transition support provided by Defence and/or DVA, to submit a claim for compensation to DVA and/or to seek invalidity benefits from the Commonwealth Superannuation Corporation (CSC).

Box 7.2 **Medical assessments of transitioning veterans**

Multiple medical assessments

Members of the Australian Defence Force (ADF) must undergo a Separation Health Examination (SHE) upon discharge. The Department of Defence said the SHE is 'a key component of the transition from military to civilian life' that:

- ensures that members are separated under the appropriate mode of separation;
- provides evidence for compensation and other claims;
- facilitates transfer of their health care to the civilian health sector; and
- provides a baseline against which future health assessments can be compared. (sub. 127, p. 24)

In addition to the SHE, DVA funds a one-off, comprehensive post-discharge medical examination for all former serving members of either the permanent or reserve forces, whether or not they are a DVA client. This examination is conducted by a veteran's General Practitioner and is known as the ADF Post-discharge GP Health Assessment. The purpose of the assessment is to identify and diagnose the early onset of physical and mental health problems among former serving members. It is unclear how many veterans choose to undergo an ADF Post-discharge GP Health Assessment, but budget estimates of the cost of expanding access to the assessment suggest that DVA expects no more than a third of eligible veterans to participate.

Veterans who submit claims for compensation to DVA or who are seeking invalidity benefits from the Commonwealth Superannuation Corporation (CSC) may also be required to undergo medical assessments as part of those claims processes (chapter 8).

Inquiry participants expressed concern about the 'multiple medical examinations of [the] same condition by ADF, CSC and DVA for different assessment purposes' (DFWA, sub. 118, p. 23).

Towards a single medical assessment?

A single 'transition health assessment' was piloted at Holsworthy Health Centre between October 2017 and May 2018. It was designed to:

- ... facilitate a streamlined transition for members, consolidating the requirements of Defence, DVA and CSC into a single medical assessment process undertaken before a member leaves the ADF. The aim of this pilot is to, wherever possible, reduce duplication within the system and provide greater certainty to members and their families regarding potential entitlements prior to separation. (DVA and DoD 2018, p. 62)

An evaluation of the transition health assessment was expected to be completed by 1 October 2018 but has not yet been released. The pilot is continuing at Holsworthy until this occurs.

However, despite the work towards a single medical assessment, DVA intends not only to continue to fund health assessments outside of that process, but to expand their availability.

- From 1 July 2019, transitioning ADF personnel ... will be able to receive a comprehensive health assessment in each of the first five years after leaving the ADF. This expands on the existing one-off comprehensive health assessment that has been available to transitioned members since 2013. (sub. 125, p. 136)

In the absence of published information on the uptake and effectiveness of the ADF Post-discharge GP Health Assessment, the rationale for such an expansion is unclear.

Medical discharge

While most transitions from the ADF are voluntary, the proportion of medical transitions has increased over the past decade — from less than 10 per cent of separations in 2007 to 18 per cent in 2017 (DVA and DoD 2018). Decisions about a member’s medical fitness are made in accordance with the Medical Employment Classification system (box 7.3).

Box 7.3 **The Medical Employment Classification system**

The Medical Employment Classification (MEC) system sets out medical fitness standards that apply across the Army, Navy and Air Force. Despite its name, a member’s medical employment classification is a career/personnel management decision made by the chair of the MEC Review Board, rather than a medical decision made by a doctor. The MEC has five levels:

- MEC 1: Fully Employable and Deployable
- MEC 2: Employable and Deployable with Restrictions
- MEC 3: Rehabilitation
- MEC 4: Employment Transition
- MEC 5: Separation.

Each level contains several sub-classifications. For example, MEC 3 includes MEC J33 for pregnancy and MEC J31 for medical conditions or injuries that are considered temporary and for which there is a reasonable expectation that the member will return to a deployable status within 12 months.

Members categorised as MEC 5 receive a termination notice on the basis that they are medically unfit — a ‘medical discharge’.

Under section 64 of the *Military Rehabilitation and Compensation Act 2004* (MRCA), there is a requirement for a case manager to be appointed for people who are likely to be discharged from the ADF for medical reasons. The role of the case manager is ‘to assist the person in the transition to civilian life, including by advising the person about entitlements and services for which the person may be eligible as a member or former member, and about how to obtain access to such entitlements and services’. Most members (but not all), who are on the path to medical discharge also receive services under the ADF rehabilitation program (chapter 6).

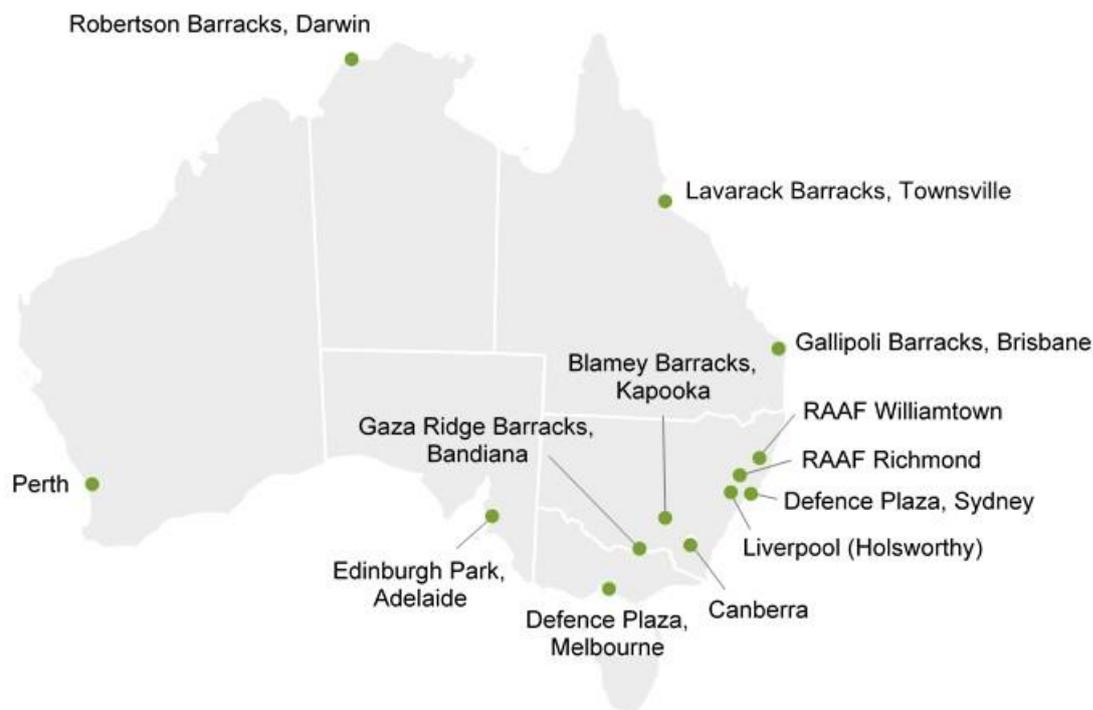
Transition support provided by Defence

Defence provides a range of services to support members as they transition from the military, including transition centres, transition seminars, the Career Transition Assistance Scheme and a range of other services.

Transition centres

The Defence Community Organisation (DCO) operates 13 transition centres around Australia (figure 7.4). Staff at the transition centres are civilian Department of Defence (DoD) employees, supplemented by contracted support where required (DoD 2018k).

Figure 7.4 Defence transition centres



Source: DoD (2018d).

Defence introduced a ‘new transition business model’ in July 2017, which ‘enhances the transition process by delivering, in addition to administrative elements, individualised career coaching and mentoring services’ (DoD, sub. 127, p. 22). Staff at the transition centres have undergone training to become ‘qualified career development practitioners’ (DoD 2018k, p. 1).

Transition seminars

Defence also runs transition seminars once or twice a year in major towns and cities. It describes the transition seminars as:

... two day seminars [that] help members and their family prepare for transition into civilian life and are available at any time during an ADF career. Seminars are held nationally throughout the year covering transition support and administration requirements, future employment, finance and superannuation, Department of Veterans’ Affairs, veteran and family support services and reserve employment. (DoD 2018l, p. 3)

Just over half of those who leave the ADF each year attend Defence transition seminars (section 7.5).

Career Transition Assistance Scheme

The Career Transition Assistance Scheme (CTAS) is designed to facilitate veterans' transition into civilian employment. The services provided under the CTAS depend on length of service and reason for discharge (table 7.1), with eligibility criteria prescribed under Defence Determination 2016–19 made under the *Defence Act 1903*.

To be eligible for the CTAS, the member must provide proof of their intention to separate from the ADF within 12 months (DoD 2017c, section 2.2.9). CTAS benefits must be accessed and completed within 12 months of termination (though extension may be granted for members whose service is terminated for medical reasons).

Defence spent close to \$3.3 million on the CTAS in 2016-17. In the *2016 Defence White Paper*, the Australian Government committed to 'enhance' the CTAS (DoD 2016a, p. 158), but did not provide details of those enhancements. Defence noted that it 'is currently reviewing the [CTAS] to make access to the program easier while redirecting resources more towards those members who are recognised as being at higher risk; even if a formal assessment has not been undertaken' (DoD, DoH and DVA 2017, p. 30).

Table 7.1 Eligibility for supports under the Career Transition Assistance Scheme

	CTAS Level	Job Search Preparation Workshop	Approved Absence	Career Transition Training (CTT)	Career Transition Management Coaching (CTMC)	CV Coaching	Financial Counselling
< 12 years of service	1	Yes	5 days	No	No	No	No
12 to 18 years of service	2	Yes	10 days	Yes, up to \$1100 if CTMC isn't undertaken	Yes, up to \$1100 if CTT isn't undertaken	Yes	No
Compulsory Retirement Age or > 18 years of service	3	No	23 days	Yes, up to \$5320 if CTMC isn't undertaken	Yes, up to \$2820 if CTT isn't undertaken	Yes	No
Medical Redundancy	3	No	23 days	Yes	Yes	Yes	Yes

Source: Defence Determination 2016–19.

Other services that contribute to transition support

A range of other services also assist ADF personnel to prepare for their transition to civilian life. For example, DoD has published the *ADF Member and Family Transition Guide* (DoD nd). Units to which members who are participating in rehabilitation are often posted, such as Army Personnel Coordination Detachments (APCDs), Soldier Recovery Centres and Member Support Units (chapter 6), can also play a key role in assisting those who are likely to be medically discharged in the near term.

Defence also operates the *Engage* portal, which provides information on not-for-profit services available to veterans and their families. *Engage* simplifies the process of accessing support, by allowing users to search for services based on relevant criteria, such as physical location or the type of support required (DoD 2017b).

In addition, Defence makes contact with former members by:

- phoning them 30 days after their departure to discuss their current situation and refer them to DVA or health services if required
- emailing them quarterly for the first year after discharge to ask them to participate in a survey on their transition experience (DoD, sub. 127, p. 22).

Despite the range of transition support formally offered by Defence, support for transitioning members remains variable, both between service branches and at the unit level (section 7.5).

Transition support provided by DVA

DVA also offers a range of transition support services.

- The *Stepping Out* program is a 2-day program delivered by Open Arms to ADF members and their partners who are about to, or have recently separated from the military. It is designed to help transitioning members and their partners ‘examine [the] transition process and what it means to go from military life to civilian life as an individual and as a family — in both practical and emotional terms’ (Open Arms 2018).
- The On Base Advisory Service (OBAS) provides a DVA presence on more than 40 ADF bases nationally. OBAS entails a DVA staff member visiting a base — typically fortnightly or monthly — to offer members information and advice about the support and entitlements that they might be able to receive through DVA. ADF members must make an appointment to visit the OBAS and, like many DVA processes, this can be confusing for veterans. For example, the DVA OBAS website lists seven different email addresses for making OBAS appointments, none of which can be used by members in Western Australia (who must book through the medical centre on base) (DVA 2018x).

DVA also:

- administers the Prime Ministers’ Veterans’ Employment Program (section 7.5)

-
- funds the ADF Post-discharge GP Health Assessment (box 7.2)
 - receives claims for liability from veterans and their advocates and makes determinations on those claims (chapter 8).

Once DVA has accepted a claim for liability, some veterans may also be supported in their transition by rehabilitation services funded by DVA (chapter 6).

7.4 ... and many initiatives to improve transition ...

There is an increasing recognition within Defence and DVA of the importance of an effective transition in determining the future wellbeing of veterans and their families. This has led to a range of recent initiatives designed to improve the transition experience. These include:

- the establishment of a Transition Taskforce (box 7.4)
- a ‘significant program of reform ... to improve transition support for ADF members and their families’ within the Department of Defence (DoD 2018l, p. 2)
- an internal Department of Defence Review of the CTAS (DoD 2018l, p. 4).

Box 7.4 Transition Taskforce

The Australian Government established a Transition Taskforce to examine the transition process from the perspective of Australian Defence Force (ADF) members and their families leaving the ADF and entering civilian life.

The taskforce was formed as a result of one of the Government's 2016 election commitments, and was asked ‘to identify the barriers to a successful transition, and develop recommendations to address those barriers’ (DVA and DoD 2018, p. 3). It is co-chaired by the Departments of Veterans’ Affairs (DVA) and Defence and is made up of current and former members of the ADF as well as representatives from key areas within DVA, Defence and the Commonwealth Superannuation Corporation.

The taskforce published its first report in July 2018. This report considered barriers and enablers to transition and made high-level recommendations. Promising directions suggested in the taskforce report include:

- the intention to focus transition-related processes, services and support on the needs of the person and their families
- the suggestion of trialling an integrated approach to service delivery that provides, where appropriate, proactive assistance to the person and their family
- the desire to investigate the intelligent use of data to track outcomes for separating members and allow the system to respond to emerging needs.

Source: DVA and DoD (2018).

New measures designed to improve transition outcomes include:

- the Early Engagement Model — under this model, ‘members who joined the ADF from 1 January 2016, and those who separated from the ADF after 27 July 2016 are now registered with DVA. Welcome emails have been sent to 11 095 newly enlisted ADF members, informing them of DVA’s services’ (DVA, sub. 125, p. 134)
- transition with documentation — as part of the ADF Transition Transformation program, Defence has implemented processes to ensure existing ADF members transition with their service and medical documentation. This documentation includes member service records, record of training and employment, and copies of medical records
- appointing a Military Transition Support Officer at each transition centre to provide a formalised military farewell and recognition of a member’s service as part of their transition (DoD and DVA 2018, p. 12)
- phone calls and surveys — as noted above, since July 2017 Defence has telephoned former members one month after discharge and sent them surveys at regular intervals.

The Commission heard that the efforts to improve transition support have started to bear fruit. For example, the Commonwealth Ombudsman said that it:

... acknowledges the beneficial and extensive work undertaken by DVA and Defence through the Defence Community Organisation (DCO) concerning the transition of members out of Defence. The work that has been undertaken in the last five years has been positive in assisting veterans into civilian life and ensuring continuity of healthcare. We have noted a reduction in the number of discharge related complaints to our Office, particularly where members with significant health issues were being administratively discharged. (sub. 62, p. 6)

And the Veterans’ and Veterans’ Families Counselling Service National Advisory Committee said:

Transition from the ADF to civilian life has improved, particularly for the medical discharge process. However, there are still areas to be addressed including a ‘warm handover’ of care and data sharing. (VVCS NAC, sub. 72, p. 4)

The RSL Veterans’ Centre East Sydney described transition as ‘patchy’, but noted that ‘in some instances, the DVA on base representative and the claim handlers have been very good and have really helped the member during complex and difficult times, especially where the discharge has been on medical grounds’ (sub. 114, p. 12). Soldier On provided a similarly mixed report card — it noted ‘significant improvement to the transition process ... over the past three–four years’ (2018, p. 2) but considered that ‘the [transition] space remains fractured and confusing for not only those transitioning and looking for work, but for the Departments who are looking to engage with veterans and families’ (2018, p. 8).

Others reported improvements that would appear to be rudimentary and long overdue. For example, the RAAC Corporation said that it is a ‘vast improvement’ that the Defence Transition Handbook can now be read by members in their own home, as it no longer contains hyperlinks to documents that can only be accessed from a Defence computer (sub. 29, att. 6, pp. 1–2). And compared to other countries, Australia is only just beginning

to direct substantial attention to its transition support system. For example, in the United Kingdom, a comprehensive review of veterans' transition was completed in 2014, and implementation of the review's recommendations is underway (box 7.5).

Box 7.5 The UK Veterans' Transition Review

In 2014, at the request of the UK Government, Lord Ashcroft completed a full review of veterans' transition in the United Kingdom. He found that:

- good transition is important for the Armed Forces and society as a whole, not just the individual, and leads to a better return on the investment the public has made in training and developing service personnel
- there is no shortage of service provision for those leaving military service, but coordination of those services could be improved
- however much provision is put in place, perhaps the most important factor in a successful transition is the mindset of the individual service leaver
- the service leavers most likely to struggle get the least help
- there is a widespread public perception that veterans are likely to be physically, mentally or emotionally damaged by their time in the Armed Forces, and that this in itself constitutes an unnecessary extra hurdle for service leavers, restricting their opportunities by lowering expectations of what they can do.

Some of the key recommendations of the Ashcroft Review were that:

- the Armed Forces should be more proactive in changing perceptions of service leavers
- all Armed Forces personnel should complete an online Personal Development Plan, beginning at the end of basic training
- all service leavers who have completed basic training should be eligible for the full transition support package
- a new work placement scheme should be created in partnership with industry, to give service leavers practical experience of civilian work
- a single 24/7 contact centre for, and a directory of, veterans welfare service and forces charities should be created.

These recommendations are being progressively implemented and, importantly, annual follow up reports have tracked the implementation of key recommendations.

Source: Ashcroft (2014).

7.5 ... but the path to civilian life remains hard to follow

Despite recent improvements, the Commission heard many concerns about the adequacy, efficiency and equity of the support services available to veterans as they make the transition from military to civilian life. For example, the Defence Force Welfare Association said that 'currently the perception is that Defence does not prepare its members very well for Transition' (DFWA, sub. 118, p. 65). And the NMHC said:

... the current transition processes are experienced as routine administrative ‘tick and flick’ exercises that suit the purposes of the ADF, but are not always in the best interests of the individual serving member, or their families. One reflection on this process heard during our Review was ‘they paid a million dollars to train me, and 20 cents to discharge me’. (sub. 107, p. 3)

RSL Queensland said that ‘from an ESO perspective there is no visibility of the progress that DVA is making in relation to collecting and analysing their data to achieve preferred transition support services’ (sub. 73, p. 60).

Many individual veterans also expressed their frustration at the slow pace of improvement.

There are still servicemen and women being discharged without DVA, [military superannuation] entitlements and any other entitlements in place. These poor individuals are finding themselves in financial difficulty, without medical and rehabilitation support, unable to cope and unsure how to seek the assistance that they and in some cases their family need! (John Burrows, sub. 27, p. 4)

The responsible Minister also considers that ‘more needs to be done to assist veterans and their families during the critical transition period to civilian life’ (Chester 2018d, p. 1). Another indication of ongoing concern is that the Defence Sub-Committee of the Joint Standing Committee on Foreign Affairs, Defence and Trade is currently inquiring into transition from the ADF and is due to report in late 2018.

One reason to be cautious about the tangible effects of recent improvement initiatives is that many of the recent changes appear very similar to previous initiatives. For example, the actions that were presented as recent progress in the 2011 review of the MRCA are very similar to those presented as progress in 2018. They include referring clients to DVA case coordinators, continuing the *Stepping Out* program, and Defence and DVA continuing to work collaboratively to improve transition services with the aim of providing a seamless transition for members (Campbell 2011b, p. 49). There is little clear evidence of the nature and scale of any improvements since 2011.

While the work of the Transition Taskforce is promising, progress has been slow — despite several years of work, there are still few practical improvements aimed at, or even clear plans for movement towards, those directions. For example, the taskforce identified the need to ‘address privacy based barriers to enable proactive engagement with family members’ (DVA and DoD 2018, p. 7). However it did not describe those barriers, consider the extent to which concerns about privacy barriers are justified (privacy is often incorrectly named as one of the primary barriers that prevents the sharing or accessing of personal information from and between government agencies (OAIC 2016, p. 2)) or provide any indication of how legitimate privacy barriers could be addressed.

Other concerns about transition include that few veterans access transition support, many transition programs do not deliver on their promises, veterans at greatest risk can easily miss out on support and there is little support for families in transition.

Few veterans access transition support

Low participation rates

As noted above, about half of those who leave the ADF each year attend Defence transition seminars — in 2017 just over 2700 separating veterans attended a transition seminar (5270 service men and women left the ADF in 2016-17) (DoD 2017f, 2018l). And about 12 per cent of those who attended transition seminars were parents and support people (such as spouses).

One reason for low attendance rates could be their relative infrequency. Transitioning members may not always be able to plan far enough in advance or wait for six or more months to access a seminar. For example, transition seminars were held in Townsville in March and October 2018, meaning there was a seven month gap between them (DoD 2018e). Transitioning members also expressed concern about commanders being unwilling to allow members to attend transition seminars, and about the relevance of the material presented in the seminars (see below).

Another reason why veterans may not participate in transition preparation is that doing so may be viewed unfavourably by their colleagues and commanders.

Veterans reported a stigma associated with accessing government-funded transition programs while they are still in the military, which for many means that they aren't accessing supports early on in the transition process. (VTAC 2017, p. 12)

Rates of participation in DVA transition services are even lower than those of Defence. For example:

- under its former name (Veterans and Veterans Families Counselling Service), Open Arms ran the *Stepping Out* program 14 times in 2016-17. Sessions were held in various locations around Australia with a total of 152 participants (DVA 2017d). This level of participation represents less than 3 per cent of those who left the ADF in 2016-17
- DVA does not publish data on the number of ADF members who accessed OBAS, but says that OBAS 'liaised with' more than 1300 Defence personnel (DVA 2017d). This equates to less than a quarter of discharging members (and just over 2 per cent of permanent ADF personnel).

Of course, the many veterans who have successfully found their place in civilian life would have no need to use DVA transition supports, and so low attendance rates could be an indicator of veterans' wellbeing. But the Commission heard about veterans' struggles with transition rather than their successes, which suggests that veterans who need guidance are missing out.

Veterans who need support are not always aware of available services

Some veterans do not use transition support services because they are unaware that the services are available. The Alliance of Defence Services Organisations said that there is ‘widespread unawareness of legislated entitlements and services’ (sub. 85, p. 51). The Defence Force Welfare Association, for example, said:

It is clear that Veterans, serving members and former members of the ADF are largely unaware of the services [that] are available to them. Many of those in receipt of payments from CSC and DVA are totally confused as to what the payments are and from which organisation they originate. It follows from this that Veterans are not getting access to services because they don’t know what services are available or what they may be eligible for. (sub. 118, p. 67)

Similarly, RSL Queensland said:

The majority of contemporary veterans who currently leave the military do so voluntarily. They may not seek assistance from DVA, or even be aware that assistance is available to them. Any difficulties they experience when transitioning to civilian life are often not visible to either DVA or Defence. DVA and Defence are both making significant efforts to ensure all veterans are aware of their potential entitlements; however, it is not apparent that this effort is translating to more informed ADF personnel. (sub. 73, p. 9)

The NMHC also expressed concern that ‘many people’ are unaware of the availability of DVA-funded treatment for mental health conditions through non-liability health care arrangements (sub. 107, p. 5). This issue would particularly affect transitioning veterans, given that the transition period is one of higher risk to mental health.

Many transition programs do not deliver on their promises

Misleading names

Dissatisfaction with transition support could also be because the programs do not deliver what they could reasonably be expected to, based on their names. For example, the Veterans’ Employment Assistance Initiative could reasonably be presumed to assist veterans to obtain suitable employment when they leave the ADF. However, the initiative only aims to ‘look at what support can be provided’ to 120 DVA clients in South Australia and Victoria and their employers over a six month period (DVA 2016f).

The Prime Minister’s Veterans’ Employment Program also does not directly support veterans’ employment (box 7.6). And Defence Families Australia (2018, p. 3) pointed out that while families are invited to transition seminars and are included in the title of the *ADF Member and Family Transition Guide*, their needs are not really addressed in the seminars or guide.

Box 7.6 The Prime Minister's Veterans' Employment Program

In November 2016 the Prime Minister announced the Prime Minister's Veterans' Employment Program. Despite its name, none of the program's six initiatives involve direct support for veterans' employment. Instead they include:

- an Industry Advisory Committee on Veterans' Employment
- the Prime Minister's Veterans' Employment Annual Awards
- an Ex-service Organisation Industry Partnership Register
- continued efforts by the Departments of Defence and Veterans' Affairs to improve the transition process for separating members of the ADF
- enhanced efforts to assist veterans to join the Australian Public Service (APS), including the addition of some dedicated information for veterans on the APS jobs website
- involvement of the Department of Jobs and Small Business in veterans' employment (DVA 2018ac).

The most visible aspect of the program is the inaugural Prime Minister's Veterans' Employment Awards, which were held in March 2018. While the awards may increase the profile of awardees' efforts, there is not yet any compelling evidence to suggest that awards programs lead to changes in behaviour at the individual level or the firm level. There has been limited progress on other initiatives.

- The Industry Advisory Committee on Veterans' Employment has a broad remit to 'develop practical measures to embed veterans' employment strategies into recruitment practices of Australian businesses', and 'to play a role in the broader promotion of skills and professional attributes that veterans have to offer employers' (DVA 2018t). One of the committee's initiatives is the Veterans Employment Commitment, which 'provides businesses with the opportunity to make a public commitment to support greater employment opportunities for veterans' (DVA 2018c). When it was launched, seven firms had signed the commitment (DVA 2018ai).
- The Departments of Defence and Veterans' Affairs have established a 'transition taskforce', which has produced one report containing high-level recommendations (box 7.4).
- The Australian Public Service Commission has developed a website designed to assist veterans to match their ADF rank with an APS classification (APSC 2017b).
- The Australian Government's jobactive website now includes an information page for veterans and an optional 'defence force experience desirable' flag that can be used by employers to. This was designed to make it easier for veterans seeking a job to use the jobactive website to search for suitable vacancies. However, uptake of the flag appears very low. For example, on 10 August 2018, there were 87 392 jobs advertised throughout Australia on the jobactive website but only 5 jobs were flagged as 'defence force experience desirable'. And on 16 November 2018, there were 116 295 jobs advertised, of which 7 were flagged.
- The Ex-service Organisation Industry Partnership Register is not proceeding, as a list of ex-service organisations is available through the Department of Defence's *Engage* portal (DVA 2018u).

The Prime Minister's Veterans' Employment Program also lacks links to other programs run by the Australian Government that could reasonably be expected to support veterans' employment but do not do so. For example, the 2018 Defence Industrial Capability Plan (DoD 2018a) does not mention veterans.

Poor content

Many participants told the Commission that information provided to veterans about transition fails to meet their needs. For example:

- the Defence Force Welfare Association said that the ADF does not adequately address the ‘role reversal’ and adaptation that is required as members shift from group responsibility to individual responsibility (sub. 118, p. 13)
- the NMHC found that veterans’ need for support in making a psychological transition from the ADF are not addressed in ADF transition processes (NMHC 2017, p. 21)
- the RAAC Corporation said that transition handbook is ‘silent on a number of important material particulars that detract from its effectiveness’ (sub. 29, att. 6, p. 4).

The Victorian Minister for Veterans noted that ‘veterans report feeling that the information offered to them in the transition phase is not sufficient or useful because the ADF does not want them to leave’ (Eren 2018, p. 2).

Participants in transition seminars gave them a poor rating — 81 per cent of those who responded to a survey conducted for RSL Queensland said that they did not find ADF transition programs useful (sub. 73, p. 49).

There are also a range of surprising omissions from the available information.

- There is no explicit explanation that the veteran support system is based on the Australian Government accepting liability for a service-related condition (chapter 8). It can come as a shock to veterans that many of the entitlements that they received while serving (such as convenient access to health care at no cost to them) are potentially no longer available to them free of charge when they leave the ADF.
- From a veteran’s perspective, it is unhelpful to become aware of a certain program (say, Open Arms’ *Stepping Out* transition seminars), without also being told how that seminar differs from the transition seminars offered by Defence.
- Despite a sense of loss being a known part of the military-to-civilian transition experience (and one that is consistent across countries and contexts (Romaniuk and Kidd 2018)), the *ADF Member and Family Guide Transition Guide* (DoD nd) does not raise it as an issue. It is therefore ineffective in helping members to deal with the multiple losses they will face as they reintegrate civilian life.

Taken together, these gaps suggest a strong need to make advice and information about the transition to civilian life more relevant to the needs of veterans and their families. Strategies for doing so are considered in subsequent sections.

Veterans at greatest risk can easily miss out on support

Risk factors for veterans' transition

Australian evidence is limited, but overseas research shows that those who are younger, served in lower ranks and have few skills that are easily transferable to the civilian labour market are most at risk during transition (see, for example, Ashcroft 2014; Morin 2011; OVOC 2017). Medical discharge can also be a risk factor for transition and was a source of particular concern to veterans (box 7.7).

Box 7.7 Medical discharge was a source of particular concern for veterans

Many inquiry participants told the Commission that being medically discharged was difficult.

... contemporary veterans regard medical discharge as a career or profession ending calamity. Transition to civilian employment was not their intention. Should it have been possible to retain them by rehabilitation within the ADF the idea of such rehabilitation might be more attractive. Many less 'sharp end' occupations, that might have been suitable for such members, have now become civilianised e.g. security, transport, cooks etc. A veteran discharged on medical grounds will seek compensation not only for his injury or illness, but for loss of an intended career path. (Robert Black, sub. 45, p. 2)

A veteran who was medically discharged following diagnosis of a progressive disease said:

I found the medical discharge process stressful and confusing. I found that once you are unable to do your job in the military, the entire system has little regard for the individual's needs and circumstances and everything that follows is mostly beyond their control. Most injured personnel are moved from their normal place of work. There is no concrete policy within the Defence Force Standard Instructions (DGIs) or Manuals (MILPERSMAN or HLTMAN) that gives a member any certainty of what will happen to them in the workplace. (sub. 70, p. 1)

And the Defence Force Welfare Association said that:

... when an ADF member has health issues that contribute to their leaning towards transition, some sections of the ADF appear to lose interest in the members concerned. (DFWA WA 2018, p. 2)

Similarly, a psychologist with experience treating veterans expressed concern about the lack of control they have during the medical discharge process.

This can be extremely detrimental as transitioning personnel often can become despondent and lose any sense of self-efficacy or belief that they can shape their own health and future, as a result of this process. In order to help those medically discharging take ownership of their future and life outside of the military, a sense of control over the discharge process is vital. (Romaniuk 2018, p. 2)

Concern about medical discharge may reflect that a greater proportion of veterans are leaving the ADF for medical reasons (section 7.3). This can lead those who are being medically discharged to feel cast aside.

There is a perceived perception that once the individual is no longer fully productive to defence the sooner they are out of the service the better for the service, it has been equated to an attitude 'replace a pair of worn out boots rather than repair them'. (VVAA 2018, p. 1)

Not only do medically discharging veterans need to address any ongoing effects of their illness or injury, they are also likely to have had less time to prepare for leaving the services. A Canadian study of veterans who self-identified as having successfully transitioned from

the military following medical discharge found that all veterans with less than 12 months to prepare for discharge felt unprepared (OVOC 2017, p. 23).

The age of many of those reintegrating into civilian life is also likely to increase the challenges they face, as ‘in general, outcomes are linked to age and, as a rule of thumb, the younger the leaver, the greater the risks of a difficult transition. Those leaving early will be in a weaker position in the labour market’ (Curry et al. 2017, p. 28). But current transition support arrangements provide the least support to those with the fewest years of service.

Slow claims processes

Many participants said that the time taken by DVA and CSC to process claims — and hence to start providing eligible veterans with income — was excessive, and had a significant adverse impact on veterans who needed to make claims during their transition. Slow claims processes can affect veterans’ income and can limit access to health care. RANZCP said:

Significantly greater coordination and engagement is required to support veterans when they are initially leaving the ADF. The discontinuity between the health care systems of the ADF to the DVA system is currently disruptive to care, administratively complex and daunting to veterans who are already facing significant social stressors associated with leaving the service, adjusting to civilian life or looking for new employment. (sub. 58, p. 4)

And slow claims processes will generally have the biggest effect on those veterans who need the most support.

Many suggested that the ADF should not discharge members who have submitted a claim to DVA and/or CSC until the claim is processed (box 7.8).

There are a number of initiatives in place to streamline claims processing, and these have achieved early successes in improving the accuracy of claims assessment and reducing claims processing times (chapter 9). If these initiatives continue to be successful, there will be less need to mandate that claims are processed prior to discharge, but should significant improvements not materialise nor be sustained then this approach may be warranted.

Box 7.8 Processing DVA and insurance claims before discharge

Many participants said that the Australian Defence Force (ADF) should not discharge members who have submitted a claim to DVA until that claim is processed. Some said that this should apply to veterans who are being involuntarily discharged.

Members who are being involuntarily separated have known and well documented case histories which could be transmitted to DVA before transition. At transition their condition could be accepted and compensation provided immediately, to ensure that the family is disadvantaged to a lesser degree. (Legacy sub. 100, p. 6)

All Defence members who have to discharge on medical grounds need to have their issues addressed prior to discharge. This includes all Defence members from Trainee to Officer. (TPI Federation, sub. 134, p. 23)

Injured ADF members, who are to be medically discharged, should not be discharged until a claim is accepted and compensation commenced. (Vietnam Veterans' Federation of Australia, sub. 34, p. 6)

Others considered that no veteran, whether separating voluntarily or involuntarily, should be discharged until their claim(s) are processed.

The member should be retained in the ADF until key decisions about superannuation and compensation entitlements have been determined. (Peter Sutherland, sub. 108, p. 6)

... a veteran's discharge should not be finalised until all of their paperwork has been completed and processed by the DVA and Military Super, if appropriate. (Maurice Blackburn Lawyers, sub. 82, p. 35)

... veterans (for the most part) should not be discharged from the ADF until their entitlements, if any, are determined by the DVA and DVA has all the necessary information it requires to assume the management of the individual. This is not to say that the individual abrogates responsibility for their own welfare. It is simply to ensure that the service person, separating from their service family, is embraced in a similar way by their post service family. (Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia, sub. 96, p. 4)

Permanent impairment assessments should happen automatically prior to discharge or when they are medically downgraded to MEC 4. Priority should be for members who are at risk of medical separation. (Petrina Fisher, sub. 75, p. 4)

Inequities arise when important factors are not taken into account

Participants also expressed concern about a lack of equity in transition support arrangements. A recurring theme was that those who are well placed to negotiate the transition to civilian life — by virtue of their high rank, previous life experience and ability to leverage civilian connections — are entitled to more transition support than those who are less well placed for the transition.

Presently, it is understood that star-ranked ADF retirees receive redeployment assistance and substantive post-Service job placement opportunities supported and managed through the Dept PM&C with the assistance of the HQADF Defence People Group. Such services should not be confined to a privileged few but broadened to include all retiring ADF personnel and managed by the DVA. (Peter Hayes, sub. 8, p. 1)

For those with longer careers the issue of transition to civilian work after service is often less difficult. They have time and some opportunities to plan the transition and gain the knowledge and support to translate their extensive experience into language that allows prospective employers to have confidence in their suitability. (Peter Alkemade, sub. 66, p. 2)

Often the Trainee is discarded as a mere ‘minion’ who does not deserve the compensation that they are due. If anything, they are more in need as it was so recent that they were strong healthy members on enlistment and then suddenly, shortly after enlistment, they are in need of a medical discharge. (TPI Federation, sub. 134, p. 23)

Similarly, veterans’ employment prospects are not consistently taken into account in the design of transition support (box 7.9).

Box 7.9 Veterans’ employment programs are not risk based: an example

Tom Moore, co-founder and CEO of WithYouWithMe, provided an example of the inequities in current transition support arrangements:

Let’s say I’m a 12-year systems engineer in the Navy with a mechanical background. I guarantee that person’s going to end up at one of the defence industry contractors very, very quickly on transition with a pay rise.

[Contrast] that scenario with one where an 11-year infantry corporal, who might be an exceptionally talented person as well as a very effective project manager in the construction industry, would be considered to present a much higher employment risk.

The person that’s leaving with 12 years is allocated \$2500 that’s not going to use it, and the person that’s done 11 years is allocated \$253 for a CV.

Source: Moore (2018).

Real world practicalities — such as the two-semester calendar typical of many tertiary institutions — can also mean veterans miss out on needed support. As one veteran explained:

During my discharge process I applied for CTAS to study at university ... [but] ... my detailed application was denied despite my appeals for considerations because my study was not starting until the academic year and therefore timing of my discharge meant that I couldn’t complete the course in the required 1 year. (sub. 70, p. 3)

Difficulties in accessing study support take on deeper resonance when coupled with the perception that the military has not lived up to its promise in relation to training during service. The promise is clear.

In addition to gaining military skills, you’ll be expected to acquire and maintain trade skills and professional qualifications that will help you excel in your job. Many of the roles on offer can be compared with civilian careers and the training often leads to nationally-recognised accreditation. (Defence Jobs nd)

But in practice, not all veterans receive recognised civilian qualifications. The Senate inquiry into suicide by veterans pointed to a ‘lack of recognition of skills and training [gained] while in uniform’ (SFADTRC 2017, p. 127), and participants to this inquiry, echoed that concern. For example, the Victims Of Abuse in the Australian Defence Force Association said that:

People join Defence to get qualifications be it blue collar e.g. driver, electronic or electrical etc. Indeed in its recruiting advertisements it promotes this as a benefit of joining ... Defence does not actually give them Civilian Qualifications. The reason is that they are afraid that they will

leave the Australian Defence Force upon expiration of their enlistment and not reenlist ... The only group who actually get their civilian qualifications are the officers who go through the Australian Defence Force Academy. (sub. 133, p. 27)

Giselle Fleming said that veterans often find that Defence qualifications are not transferable.

This is regardless of being told throughout their career, that they will receive relevant transferable Certificate or Diploma qualifications for their skills and trades that will be beneficial on transition. This is something you won't hear about in recruitment campaigns, is deceptive and misleading and vocationally detrimental to Veterans. (sub. 33, p. 15)

It is also the case that officers are more likely to the leave the ADF with recognised qualifications than are those who have served in other ranks. This difference exacerbates the lack of equity in transition arrangements, and makes transition more difficult than it needs to be for veterans from other ranks (who make up the majority of those leaving the ADF).

Families asked for more support during transition

Military life can affect veterans' family members in a range of ways. Family members may face changes in child care and schools, separation from their extended family, loss of social connections, and stress in adapting to new communities.

The Family Wellbeing Study conducted as part of the Transition and Wellbeing Research Programme found that a veteran's military service typically has positive effects on family relationships and on the financial situation of the veteran's spouse, but negative effects on the spouse's mental health, employment and career. And in some cases, such as the health, employment and wellbeing of the veteran's parents and adult children, military service has no effect at all (Daraganova, Smart and Romaniuk 2018, p. 7).

But even where military life has had positive effects for a veteran's family, the transition process can be difficult for them.

Transition can be a stressful and uncertain time for families, and some members reflected that their personal relationships were less stable during the transition period. Sometimes, family dynamics change during transition, as a result of changes to working arrangements, financial stability and relocating the family home. In these instances, families may require support in addition to the support available to the transitioning member. (DVA and DoD 2018, p. 47)

And veterans' service-related physical and mental health conditions can have a significant and lasting effect on their families. For example, RSL National said that:

... transition from the ADF to civilian life presents a significant challenge to ADF personnel ... These difficulties can affect all aspects of the veteran's life and the added stressors to the veteran can also significantly impact upon their families. (sub. 113, p. 29)

And RSL NSW said that more needs to be done to ensure 'adequate transition support for medically discharged veterans and their families, who often experience the sudden loss of support networks and housing due to a hastened departure from Defence' (sub. 151, p. 24).

These stresses can be compounded when transition triggers or exacerbates the veteran's health conditions, potentially leaving the family with additional caring responsibilities. For example, one participant to the Senate inquiry into veteran suicide said:

... one of the gaping holes in the system is lack of support for the family. We are given these broken people, people we barely recognise, and are not given any tools to help. We are the ones that have to support these wounded 24/7. (SFADTRC 2017, p. 123)

There are also gaps in family support for younger veterans, as a recent report on young people transitioning from military service found.

There is a lack of proactive family engagement both during the military career and the transition process. Parents and partners will often be an important source of support and they probably also had expectations about what the military career would provide for their family member, and this needs to be re-focused during transition. (Baker et al. 2017, p. 31)

Comments of this nature indicate a clear need to enhance transition support for veterans' families. Strategies for doing so are considered in subsequent sections.

Summing up

Defence and DVA have had decades to design and deliver transition services that meet the needs of veterans, to better coordinate their respective activities and to evaluate services to find out what achieves the best outcomes for veterans. However, neither has delivered. The rhetoric around the importance of transition is not matched by action to determine which services are working well, which are working poorly and where additional efforts should be targeted.

The respective roles played by DVA and Defence in supporting veterans as they transition from the ADF are not clear to veterans. And government silos and poor planning have led to gaps and duplication, services with rigid rules that inhibit the achievement of their objectives and both Defence and DVA losing sight of what is needed to deliver veterans' overall wellbeing. There is also unjustified variation in the availability of transition support across the country, and even between individual units.

The current system may be able to be improved but a more substantial change in approach and delivery is required to really provide the quality of transition support needed for future generations of veterans. The current system will not get us there.

DRAFT FINDING 7.1

The Departments of Defence and Veterans' Affairs offer a range of programs and services to support veterans with their transition to civilian life. Despite some improvements in recent years, these efforts remain fragmented and poorly targeted, with few demonstrated results. While many discharging members require only modest assistance, some require extensive support especially those who are younger, served in lower ranks, are being involuntarily discharged for medical or other reasons or who have skills that are not easily transferable to the civilian labour market.

7.6 A new Joint Transition Command

None of the concerns about transition presented to this inquiry are new. They are the same issues raised in past inquiries spanning many years (for example, ANAO 2004a, 2016; DoD 1997; Dunt 2009; SFADTRC 2016, 2017). Defence (with DVA and other agencies where relevant) has taken steps to address these concerns, but in order to achieve clear accountability for delivering the necessary improvements to veterans' transition, more fundamental changes are required.

The Commission's view is that responsibility for the policy and delivery of all military-to-civilian transition services belongs with Defence. Veterans are Defence personnel and Defence has an ongoing duty of care to ensure discharging members are prepared for and supported through transition, and not harmed in that process. Having considered the best way to give effect to this responsibility, the Commission is of the view that a new approach and structure are required. All aspects of transition preparation and support should be centralised in a new transition body in Defence to be known as the Joint Transition Command.

This is not to diminish that transition to civilian life is — and should remain — primarily the responsibility of individual veterans. But in order to successfully forge the next chapter in their lives, all veterans need support from an organisation that has clear, measurable goals and well-defined accountabilities.

Why a Joint Transition Command?

While the new transition body could be set up in several different ways, the option strongly preferred by the Commission is that the new body be placed within the broader Defence command structure. This would place responsibility for transition support with the organisation best placed to control both its content and its costs (box 7.10).

Box 7.10 Why preparing veterans to reintegrate into civilian life is core business for the military

As discussed in chapter 4, the Australian Government has accepted responsibility for ensuring that, on leaving the military, members of the Australian Defence Force (ADF) are integrated successfully back into civilian life and any physical or psychological harm they incurred while serving is minimised (transition preparation and support can reduce harm to the person and improve their wellbeing, as well as reducing costs to society over the longer term).

At the same time, many veterans — both serving and ex-serving — do not consider that transition should be a high priority for the ADF. Some contend that the ADF's mission is to defend Australia and its national interests and that preparing personnel for civilian life falls outside this mission, while others believe the function is properly the responsibility of DVA. As one participant put it:

... looking after former Members of the ADF is not the role of the ADF. The role of the ADF is to prepare for war. The Department of Veterans Affairs (DVA) is the organisation that should look after former Members of the ADF. (Charles Mollison, sub. 14, p. 1)

However, others see it as an integral part of the role of the military.

The mechanisms which the ADF use to train and develop military personnel can also contribute to their struggles post discharge. As such, few would argue that the ultimate responsibility for preparing ADF members for transition, both practically and psychologically lies with the ADF. (Mates4Mates 2018, p. 4)

The Chief of the Defence Force recognises that 'people are the Australian Defence Force's core capability' (DoD 2018c). Looking after people, both while they are serving and when they make the transition to civilian life, is an essential part of maintaining that capability.

The essential link between defence force capability and good transitions is also recognised in the United Kingdom.

Society and the state certainly have a responsibility to those who have served. But ensuring a good transition is more than a matter of meeting our obligations to a series of individuals. It can help to promote the core functions of our Armed Forces, and consequently should not be thought of as a fringe activity. This is because good transition can make a difference to what I term the four 'R's': Recruitment, Retention, Reputation and the Reserves. (Ashcroft 2014, p. 7)

But awareness that good transition preparation and support contribute to ADF outcomes in terms of recruitment, retention, reputation and reserve service is lagging. Addressing this deficit is a core part of the Commission's proposed approach to veterans' transition.

The new transition body should be a 'Joint Transition Command', modelled on the existing Joint Health Command (and staffed by military and non-military personnel — see below). We believe a command structure will have the appropriate level of recognition within the ADF and its members. The ADF trains and moulds its members into warriors and inculcates them into military institutions, and it should be the government agency that bears the costs of 'deinstitutionalising' them when their services are no longer required or they are no longer able to serve.

Such a command will improve coordination of transition (and continuity of rehabilitation) services and give greater prominence to transition, both among serving members and within the ADF hierarchy. And by providing a central and unified source of transition services, this model would reduce variation between members' experiences in different service branches

and units, and help to ensure a consistent quality offering across the ADF. It would also improve services, as the effectiveness of transition preparation and support depends on it being integrated into veterans' careers from the earliest stages.

Under this Joint Transition Command model, just as the Chief of Joint Health Command reports to the Chief of Joint Capabilities, the Chief of Joint Transition Command would also report to the Chief of Joint Capabilities, who operates out of Australian Defence Force Headquarters (ADFHQ). The Minister for Defence Personnel and Veterans (chapter 11) should have specific responsibility for transition issues.

Functions of the Joint Transition Command

The new Joint Transition Command will be responsible for all aspects of transition preparation and support. It will:

- begin to engage with veterans early in their careers by helping them to plan for their service and post-service career (section 7.7)
- provide more tailored information and support to veterans and reach out to families members as they get closer to transition, so that they can engage more actively in the process of transition
- assist veterans to access DVA claims processes and supports, including referrals to advocacy supports, where requested
- offer continued support to those who require it for a defined period after discharge — for up to (say) 6 months or until the end of an agreed rehabilitation plan where requested by the transitioning member. Some veterans will require no support after discharge
- engage staff, including from the ADF and DVA, with the skills to advise veterans and families on both the practical and psychological aspects of transition
- work closely with the Joint Health Command in the areas of rehabilitation support, medical examinations and medical records and DVA to facilitate access to claims processes and supports if needed
- reporting on transition outcomes to drive further improvement.

Joint Transition Command would take over all of the transition functions currently performed by DCO (leaving DCO to concentrate on the family and community aspects of its work), and the transition functions currently performed by individual services, and by other parts of Defence and DVA.

Individual services may choose to continue to have units where members who are participating in rehabilitation can be posted (such as Army Personnel Coordination Detachments (APCDs), Soldier Recovery Centres and Member Support Units (chapter 6)). But to the extent that these units play a role in transition support (and this varies between services and locations) they would transfer their transition support functions to Joint Transition Command.

Longer term supports and services for veterans — including the design and administration of the new veteran education allowance (section 7.9) — will be the responsibility of DVA (and then the Veteran Services Commission). DVA will also continue to support reintegration through its ongoing role in providing vocational and psychosocial rehabilitation to veterans whose service-connected conditions mean they require that support.

Tailored transition preparation and advice for every veteran

Providing personalised support services for transitioning veterans and families would be a core part of the role of Joint Transition Command. Often, tailored and responsive support services are called ‘case management’, particularly when provided to those at higher risk or those with multiple needs. But more recently, other terms have emerged for such services.

The United States and the United Kingdom have established a type of ‘Concierge Service’ within their defence departments that is available to assist medically releasing members and their families with the transition process. The concierge, who may be military or civilian, is trained in all aspects of the programs and services that are available during and after transition. The concierge becomes the single point of contact for members and their families for all administrative matters. In addition, the concierge navigates, on behalf of members, the bureaucratic jungle that has been created by many years of legislative, policy and program changes. (DND/CAF Ombudsman 2017, p. 11)

Regardless of whether they are framed as case managers, concierges or counsellors, the transition advisers would provide a single point of contact for reintegration questions, concerns and support needs. A veteran’s adviser would be an easily available and accessible expert support person to whom veterans and their families could reach out when required.

As noted above, transition advisers would come from a range of professional backgrounds, provided they have the skills to assist veterans in both the practical and psychological aspects of military-to-civilian transition. This could include, for example, assistance with the preparation of civilian resumés, interview coaching, mentoring and pre- and post-employment support services.

Importantly (and in contrast to some existing transition programs), access to Joint Transition Command services and advisers should not be limited to those who have committed to leave the ADF. One of the roles of the transition advisers will be to help veterans form realistic expectations about their future opportunities outside the military. (In this context, the Commission heard that under present arrangements some serving members choose to transition out earlier than might otherwise be the case if a certain, but second best opportunity, is in prospect.) This means that Joint Transition Command will need capacity to provide advice and support to those transitioning from full-time to reserve service, as well as those ending their reserve service commitments.

Holistic approach

To effectively respond to the needs of transitioning veterans and their families, a holistic approach is required. This is because ‘it is practically impossible to draw meaningful boundaries between mental health concerns, physical health concerns, and social concerns as they manifest in veterans’ lives’ (Zogas 2017, p. 8).

While the transition adviser would take a holistic approach to veterans and their families, they would coordinate, rather than substitute for, specialist providers. This means that:

- all veterans would receive tailored advice in order to obtain the services they and their families will need after transition (for example, health care, employment or education support)
- for veterans receiving rehabilitation services under the ADFRP, the transition adviser would work with the rehabilitation provider to ensure that the veteran continues to receive rehabilitation services (including after discharge until the end of an agreed rehabilitation plan)
- for veterans who need to submit compensation claims, the transition adviser would provide basic information and then, if necessary, direct them to advocates (chapter 8).

This needs to include assertive outreach for those who are likely to be at risk but are not making active use of transition services. This could mirror, and in some cases will need to liaise with, the assertive outreach services that have been shown to be effective for those in need of mental health care (chapter 15).

A robust handover process for those with mental health difficulties should be part of routine practice when a member discharges from the ADF. A case management approach, in which the discharging member is assigned a case manager who can facilitate coordination of mental health care between the ADF and DVA/civilian provider systems, would ensure facilitation of this process. (Romaniuk 2018, p. 3)

The Gallipoli Medical Research Foundation is currently trialling a psychometric assessment tool that measures psychological and cultural ‘readiness’ of military personnel transitioning into civilian life following military service (2018, p. 3). The idea is that this tool will allow individual needs to be identified and veterans at risk to be detected early. Such a tool could be very valuable to Joint Transition Command.

Transition support before and after discharge

Members of the ADF would interact with Joint Transition Command in the same way they currently interact with Joint Health Command — that is, they would obtain advice and services from specialist providers when required throughout their career, and those services would be provided within the military environment, supplemented by external specialists when required.

This implies an increasing level of interaction with Joint Transition Command as service members progress through their career. At first, this interaction may be limited to an annual or biennial session about long-term career options and the need to plan for a post-service career (section 7.7).

When it becomes clear that a service member could leave the ADF in the more immediate future — due to a MEC downgrade or for any other reason — Joint Transition Command would provide information and support to the veteran and their family and would step up their work with veterans on job-search skills. One of the initial tasks of Joint Transition Command would be to determine the trigger points for automatic engagement. In addition to a MEC downgrade, these triggers could include, for example, participating in the ADF Rehabilitation Program (chapter 6) or coming to the end of an initial minimum period of service.

The period over which veterans receive more intensive support services from Joint Transition Command would depend on their individual needs. The essential point is that it be a gradual transition. An example of one such gradual process was provided by inquiry participants (box 7.11).

Box 7.11 A staged and extended transition period?

Two veterans' advisory councils from South Australia provided a possible model for a gradual transition.

Numerous interviews with transitioning individuals of the ADF believe that the current three months transitioning period is too short for those with complex needs, or for those who have served for more than 15 years. Within the current three-month period [much] of the administration and planning is done under pressure, often whilst continuing their duties (even their duties in the field). Perhaps a more balanced approach would be to first assess if a member is likely to experience a simple or complex transition. If it is a simple transition, the first month may involve continuation in the role, at which time medical and DVA appointments can begin to be made, yet the member can continue to focus on the tasks of the ADF. This will also give the unit an opportunity [to] organise a replacement, if possible. The second month might involve continuing in the role part-time whilst conducting a handover. It is during this time that medical appointments and other critical administration be completed. The final month will enable the member to participate in activities more orientated to interview and employment skills, along with addressing issues of social connection. It is important that this final month be conducted in the discharge location, because it represents a critical period to create social and employment networks. For those with complex issues, this whole transition period may extend to six months.

Source: Veterans' Advisory Council South Australia and the Veterans' Health Advisory Council South Australia (2018, p. 12).

To ensure that the transition process is more gradual, Joint Transition Command should offer continued services and support to those who require it for a defined period after discharge — for up to (say) 6 months where requested by the transitioning member. Veterans who are participating in rehabilitation should be able to access support from Joint Transition Command until the end of their agreed rehabilitation plan (chapter 6).

Many veterans will require no support after discharge. Indeed, some will require few services and will have little or no involvement with the Joint Transition Command after discharge.

Others may access support early in the process and a small number may need significant support post discharge.

Beyond that time, veterans would rely on services available to the general community or those provided by DVA (noting that the Commission is also recommending many reforms to its services and the creation of a Veteran Services Commission — chapter 11). Longer term supports and services for veterans will be the responsibility of DVA (and then the Veteran Services Commission).

It is important for veterans that they are not in the transition phase indefinitely. As researchers from the United Kingdom highlighted:

Successful ‘transitioners’ are aware of the importance of in-house military support on first re-entering civilian life but then distance themselves from the military, preferring civilian support structures and engagements. Those transitioning badly want on-going military and civilian support. (Brewer and Herron 2018, p. 2)

Providing support to families

As discussed in section 7.5, family members can also be affected when veterans transition to civilian life. This is why ‘families are encouraged to participate in the transition process wherever possible’ (DoD, sub. 127, p. 22). But more needs to be done to support families that struggle with a veteran’s transition, and the Joint Transition Command will need to play a much larger role in reaching out to families.

Some families will need more support than others. The Forces in Mind Trust considered veterans’ families in two broad groups.

- ‘Proxy transitioners’ — family members who are also transitioning as a result of the veteran’s departure from the military and who are likely to be suffering similar disruptions as the veteran.
- ‘Civvy street hosts’ — family members who are indirectly affected because they already have their own civilian life, and who are likely to be the first to see signs of a difficult transition, and best equipped to provide practical guidance on civilian life-skills. (2013, p. 50)

These groups will have different concerns when it comes to transition, and so will need information from Joint Transition Command that is tailored to those particular concerns. Where the veteran is being medically or involuntarily discharged, families may also need tailored support. Legacy said that:

... the family should be involved in the transition process in all involuntary separations. Often in such circumstances the service member can be confused and in a stressful state, missing important information or required actions. The family will often become the carer in the most difficult circumstances and the advantage of the family being aware of services available and the circumstances around the separation will be better prepared for possible outcomes and take appropriate steps to avoid some situations. (sub. 100, p. 6)

Veterans' families can also experience mental health effects which may be related to the veteran's military service. A veterans' mental health problems can also affect their family. There are mental health services available to veterans' families, most notably Open Arms, and the improvement in mental health support for families recommended in chapter 15 will also assist during the transition period.

Families with children may also have particular needs. A range of excellent resources designed to support veterans' children during transition are available overseas (for example, Sesame Street 2016), and consideration could be given to making similar resources available for Australian families.

Defence Families Australia suggested that DCO's Partner Employment Assistance Program (PEAP) could be 'offered to partners during the transition process, especially in the case of a medical discharge where the partner needs to become the main breadwinner' (Defence Families Australia 2018, pp. 2–3). Under the PEAP, in each posting location, partners of ADF personnel can apply for up to \$1500 funding to access a range of professional employment and job-search support services, or to pay mandatory fees for professional re-registration (DoD 2018j). Joint Transition Command could consider extending this support to partners of transitioning members.

Joint Transition Command should also build on current efforts (section 7.3) to include, and to provide better tailored information to, families as veterans prepare to transition to civilian life. But it will also need to build on those efforts and assume a greater role in reaching out to families to prepare them for, and to support them through, transition.

And families will also benefit from any improvements in support services provided to veterans. For example, better preparation for the psychological and social aspect of transition will help veterans in their relationships with their families and communities.

More broadly, it will be important for Joint Transition Command to be mindful not only of the needs of families, but also the needs of veterans who do have family support (box 7.12).

Box 7.12 Not all veterans benefit from family support

While many families need support during a veteran's transition, the effect of families on a service member's transition is not clear. A literature review of family protective factors for members transitioning from Defence service found little evidence of family as either a protective or risk factor for transitioning or recently transitioned Defence members. There was also insufficient evidence to draw firm conclusions about what family factors, characteristics or behaviours might be risk or protective factors (DVA 2015f, p. 4).

That said, 'often the family will know when a veteran is struggling before the veteran might recognise it themselves' (DVA 2017s, p. 171).

But there is tension between respecting the privacy of the veteran and assisting them through involving their family (SFADTRC 2017). And the system needs to be designed not relying on family support, as some veterans do not have family members who can support them in transition. The Transition Taskforce noted that 'sometimes families cannot or do not support the member with their transition' and that 'people who do not have family support during their transition may need different forms of assistance from government' (DVA and DoD 2018, p. 47). But the form of this support remains unclear, and this gap could form an initial research priority for Joint Transition Command.

Resources for Joint Transition Command

The starting point for considering the resources required to provide better support for the military-to-civilian transition should be a detailed assessment of the current and future demand for transition support, and current gaps in service provision. The recent focus on transition — especially through the Transition Taskforce (DVA and DoD 2018) and the current parliamentary inquiry into transition from the ADF (JSCFADT 2018) — will provide a good foundation for this assessment.

Physical presence

The 13 transition centres operated by DCO should be transferred to Joint Transition Command, which could use them as an initial base for its service offering. It would then need to establish whether this is the appropriate geographic spread for its services, based on a thorough assessment of the needs of transitioning veterans.

Joint Transition Command could complement its centres by working in partnership with ESOs, including through the veteran hubs and veteran centres that some ESOs are establishing in various locations around Australia (for example, The Oasis Townsville (sub. 92) and the Partnerships Hub at the Jamie Larcombe Centre in Adelaide (SA Health 2017)). Veteran hubs have the potential to aid social integration, peer support and access to information for veterans and their families (chapter 9).

Staffing

As noted above, Joint Transition Command should be primarily staffed by transition advisers. The advisers would come from a range of professional backgrounds, both military and civilian, with most drawn from the ADF and DVA. Many would have qualifications and experience in career development, but others could have professional backgrounds in nursing, social work, psychology or other disciplines. The essential point is that veterans are able to access support from people who have the skills to assist them in both the practical and psychological aspects of military-to-civilian transition.

The advisers would also need to be familiar with the veterans compensation system, so they can assist veterans when they are initially considering preparing a claim. DVA should also provide staff members to work at all Joint Transition Command centres. The role of DVA staff should include an enhanced version of the On Base Advisory Service, modelled on the role of the Health Liaison Officer being trialled at Holsworthy Health Centre as part of the transition health assessment pilot (box 7.2).

Employment arrangements for the transition advisers should be determined with a focus on providing the highest calibre staff in a cost-effective manner. The model currently used by Joint Health Command — where health care is provided by a mix of uniformed ADF members from all three services, civilian Australian Public Service (APS) staff and contracted personnel with expert skills — provides a likely template.

Budget

The funding required for Joint Transition Command to provide transition support to veterans and their families will depend on:

- the extent of unmet demand, which should be assessed, as noted above
- the combination of services and support provided by Joint Transition Command
- the division of responsibilities between Joint Transition Command and other organisations (for example, the extent to which rehabilitation services remain within Joint Health Command — chapter 6).

But it is clear that to provide more services to the many veterans and their families who currently miss out on the transition support they need, the Joint Transition Command budget will need to be larger than Defence's current expenditure on transition. The Commission will seek to make more detailed estimates of the cost of enhanced transition support for the final report.

But regardless of their exact magnitude, these direct costs need to be considered against the potential for avoided costs in supporting veterans who struggle to make an effective transition from military to civilian life. Once the system is operating according to insurance principles with a focus on the lifetime wellbeing of veterans (chapter 4), it will be easier to see that the long-term benefits of intervening early to effectively support veterans' transition outweigh the costs of doing so. And while there are potential savings for governments from

this early intervention approach, improving veterans' wellbeing should be the primary driver of reform.

Reporting by Joint Transition Command

Reporting on transition outcomes will require Joint Transition Command to:

- establish an outcomes framework for transition support services. This should include describing what the activity will achieve to contribute to the wellbeing of transitioning veterans (contribution), the resources being use in the activity (inputs), a description of how the activity will be done (process), the tangible services delivered (outputs) and the outcome of those tangible services (outcome) (chapter 16)
- report publicly on the measures in the outcomes framework
- implement design and delivery changes in response to emerging trends and issues
- build on the evidence base about successful transitions, including through research.

On this latter point, the Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia said that there would be benefit in research on:

... the causal aspects/drivers behind why the majority of serving and former serving personnel are healthy and view their military service with fondness and positivity, including those exposed to significant stress and trauma during service. (sub. 96, p. 4)

But more generally, it will be important for Joint Transition Command to understand not just the effects of its programs, but also how and why many veterans adapt to civilian life without its support. In addition, good practice in accountability and stewardship requires Joint Transition Command to report publicly on its own operations. For example, its budget should be a clearly separate item within the overall Defence budget.

Summing up

The Commission is recommending substantial reforms designed to equip more veterans for the challenges of military-to-civilian transition. It is designed to meet the needs of those in military service today and future generations. If it is properly established, resourced and adopts a culture of continuous learning and improvement, the new system will deliver better transition outcomes for veterans and their families (figure 7.5).

Figure 7.5 Transition to civilian life: outcomes for veterans



DRAFT RECOMMENDATION 7.1

The Australian Government should recognise that Defence has primary responsibility for the wellbeing of discharging Australian Defence Force members, and this responsibility may extend beyond the date of discharge. It should formalise this recognition by creating a 'Joint Transition Command' within Defence. Joint Transition Command would consolidate existing transition services in one body, with responsibility for preparing members for, and assisting them with, their transition to civilian life. Functions of Joint Transition Command should include:

- preparing serving members and their families for the transition from military to civilian life
- providing individual support and advice to veterans as they approach transition
- ensuring that transitioning veterans receive holistic services that meet their individual needs, including information about, and access to, Department of Veterans' Affairs' processes and services, and maintaining continuity of rehabilitation supports
- remaining an accessible source of support for a defined period after discharge
- reporting on transition outcomes to drive further improvement.

INFORMATION REQUEST 7.1

The Commission is seeking feedback on the period of time that Joint Transition Command should have responsibility for providing support to members and former members of the Australian Defence Force who require that support.

7.7 Preparing for post-service careers

Early planning is a key component of successful transition

Early planning for a civilian career is an essential part of a successful military-to-civilian transition. In fact, career planning can be even more important for military personnel than others because of the risks involved in military service, and the greater likelihood of being required to make a sudden career change as a result of injury or illness (chapter 2).

It is important that veterans, including those just starting out in their careers, are aware that most service members will have second or subsequent careers after their military service, and that early planning can improve their transition and success in later careers. Early career planning should be about ensuring veterans have a mindset that will facilitate a successful transition.

The most important factor in a successful transition is the attitude and preparation of the individual. Those who realise they will need a second career, financial security and a home tend to prepare early and do well. Those who do not prepare early and lack the right mindset are more likely to struggle, even if they are offered all the support available. (Ashcroft 2014, p. 45)

Those veterans who struggle with transition are:

... those who do not look beyond Service life. They do not view their Service career as a ‘time-limited episode’. At best, their service career is likely to be a fixed number of years within their working lives; but even the initial fixed period for which they enlist may be cut unexpectedly short (for example, due to redundancy or medical discharge, amongst a number of other reasons). This group of Service leavers in particular find it difficult to transition as they have given little thought or preparation to life as a civilian. (FiMT 2014, p. 5)

But without systematic support at the highest levels of the military, unit commanders have little incentive to support members to devote the necessary time and effort to career planning. Peter Sutherland suggested that transition planning be expanded so that it ‘commences on the day that the member joins the ADF and is fully operational by the day that ADF service ceases’ (sub. 108, p. 6). Also, the Transition Taskforce said that:

... assisting ADF members to plan for life after service as early as possible in a member’s career will assist them to adjust to civilian life. (DVA and DoD 2018, p. 54)

That said, service members are unlikely to undertake the kind of thorough reflection, introspection and research that are necessary for effectively planning their post-service lives and careers. Service men and women are typically young and strong, and with this youth and strength comes a feeling of invincibility that can make them reluctant to plan for a different future.

Education sessions and encouragement are unlikely to be enough to overcome this reluctance, as there is little evidence that they can, on their own, inspire and equip people to make plans for a future they are reluctant to imagine. There is therefore a strong case for the ADF to require members to undertake systematic career planning, not only as they progress in their service careers but also for their likely post-service careers.

It is not enough that the Departments of Defence and Veteran’s Affairs are ‘investigating opportunities ... [for] having conversations early on in a member’s career about their personal goals’ (DoD and DVA 2018, p. 12). All members of the ADF would benefit from having these conversations in a routine and systematic way. This could take the form of a requirement for all non-deployed members of the ADF to participate in a career planning workshop and to draft a career plan on annual or biennial basis. This does not have to be an onerous requirement — an hour or two would be enough.

This type of career planning is happening in other countries. For example, from 2018, all members of the UK Armed Forces will be required to ‘[take] responsibility for their future and their preparation for it early on in their careers’ (Ashcroft 2017, p. 9) by completing an online personal development pathway — a portfolio of the individual’s education, skills and achievements (Ashcroft 2014).

Career planning need not be onerous, and should be tailored to the needs and receptiveness of members at different stages of their careers. The Ex-Defence Integration Team characterised veterans’ changing understanding of, and approaches to, transition as

comprising four stages (box 7.13). And such a model could be used to increase the focus on future career planning as members move closer to transition.

Box 7.13 Veterans' changing understanding of transition: a view from the Ex-Defence Integration Team

Veterans change their understanding, attitude and approach to transition at different times in their career:

Early in their Career — In the initial stages of their military career, veterans are told how good they are and how much better than civilians they are. All their training exercises and deployments confirm their understanding of this concept. They receive rugged military training which provides a tough exterior to do their job well and to handle tough situations. Telling them they need assistance to talk to someone about future employment at this stage is met with the attitude 'that's for those weak people'.

Mid-Career — At some point they will begin to think about re-joining the ranks of civilians and this concept of what a civilian is like then seems hard to reconcile. However, most approach it assuming they will go into the commercial workplace and prove themselves to be better than their civilian counterparts. Yet, at this point they still don't get it.

Approaching Transition — After deciding to discharge, there is little to help them remove the façade that they are better than civilians. Defence provide some theory of what it will take to effectively transition, however there is no de-militarisation training. They hear the transition disaster stories and believe they happen because others aren't as strong as they are.

Post Transition — Only once they have personally experienced the transition, do they then begin to realise that this 'transition thing' is more complex than they gave it credit for. But at this point, they have missed the transition training offered during their service. Or if they did undertake transition training, the trainers didn't relate the importance to what they were about to embark on and provide tools on how to address it.

Source: EDIT (2018, p. 1).

Components of effective career planning

Even if career planning requirements are tailored to the needs of veterans in different phases of their career, there is a risk that they will be treated as an administrative burden — a 'tick and flick' exercise. There are a number of strategies that could help to guard against this.

First, career sessions will need to encourage veterans to think more broadly than may be typical in a military context. The RSL Veterans' Centre East Sydney said that:

... unless the veteran was in a technical role, their transferable skills are seen as low by potential employers and even more so by young staff of recruitment agencies. [Look at] how many ex-infantry are only offered jobs as security guards, because recruiters don't take into account their training and experience; of working to plan and in teams (where their lives actually depended upon teamwork), also following orders but also that they are trained to use initiative, used to hard work and long hours. (sub. 114, p. 11)

Similarly, one veteran explained that, having spent years or decades operating in an occupation that they are not explicitly trained in, most members:

... think of their skills from a military perspective. They are a rifleman or submariner ... I was once a Tank Driver in Puckapunyal and a high school failure. Making a decision to leave defence

meant I believed I had limited options and was looking to just change uniforms, go into security or do some other menial role. (Arnould 2018, pp. 1–3)

Second, veterans need information to help them test the practicality of their plans. One way of doing this would be for ADF members to undertake work experience in civilian workplaces at earlier points in their career (box 7.14). Work experience may also be of particular benefit as part of a broader rehabilitation program (chapter 6) or to help veterans who are considering further education or training to make a fully informed decision (section 7.9).

Box 7.14 Work experience while serving in the ADF

Work experience is a common way of giving people a better basis for making career decisions. For veterans, it can also help them to understand the scale of change in culture and expectations between military and civilian workplaces.

The Senate inquiry into suicide by veterans recommended that serving ADF members have the opportunity to undertake a paid period of work experience with outside employers (SFADTRC 2017, p. 129). And in the Joint Committee inquiry into transition from the ADF, Dr Paula Dabovich suggested:

... a Commonwealth supported 12-month veteran internship across multiple industries or governmental departments. Ideally this might involve three to four rotations between different departments of a nominated industry, over 12 months. This would give veterans the opportunity to learn new skills, industry language, and to build relationships with others. Given that transition is a period of both decline and growth, such an internship would ideally allow for mistakes to be made without judgment (because people often find out *who they are*, through first finding out *who they are not*) and provide opportunities for creativity. (2018, p. 6)

While such a long period of work experience is unlikely to be practical or desirable for many, the idea that work experience should be truly experimental — in that it is as much about learning about which paths not to follow as those to follow — is an important one.

Work placements — Civilian Work Attachments (CWAs) — are part of the transition support system in the United Kingdom. The UK Armed Forces continue to pay veterans on CWAs, as well as providing allowances for travel and other costs.

A CWA can be taken at any time during your last two years of service. They can last from one day to several weeks. The length of a CWA will depend on whether you want a quick ‘taster day’ to see what a particular job is really like, or if you need to undertake a longer period of work experience to gain evidence for [recognition for prior experience or skills], or to gain experience or undertake some training with an employer prior to starting a job with them. (Career Transition Partnership 2015)

The CWA system could potentially provide a model for an ADF work experience program.

Another important aspect of testing the practicality of their plans will be for veterans to get a sound understanding of civilian wages and employment conditions. This is important as even if veterans have a clear career path in mind and the skills to pursue that career, they can struggle to adjust their salary expectations. Townsville Enterprise said that:

... not all veterans are conscious of award entitlements and conditions associated with civilian employment standards across various industry sectors. Accustomed to Defence payment standards; in association with, additional benefits/ allowances including rental assistance, health,

uniform and deployment bonuses can contribute to unrealistic expectations of civilian salary levels. (Townsville Enterprise 2018, p. 5)

The difference between military and civilian salaries can be large. One study found that service leavers experience a drop in weekly earnings of almost 30 per cent (Mavromaras, Mahuteau and Wei 2013).

Dispelling unrealistic salary expectations would reduce the potential for disappointment and dissatisfaction in civilian careers. Giving serving members more information on the salaries in their potential future occupations could have benefits — it may encourage them to pursue further study in order to qualify for a career that will match their salary expectations, or could provide impetus for continuing to serve in the military.

Third, as veterans are likely to have had less experience applying for jobs than civilians of similar age and experience level, veterans need explicit and expert training in job search and application skills to overcome this gap. Defence acknowledges that:

Civilians can have a competitive edge borne from their exposure and regular opportunity to apply for job roles, whereas veterans with equivalent skills lack experience in the application and interview process. (DoD, sub. 127, p. 7)

But as yet, most veterans do not have early access to advice about resumé writing, job-search strategies or interview skills. This lack of familiarity with some of the basic skills needed to gain civilian employment puts them at a disadvantage. Progressively building job search skills for veterans approaching transition will be one of the roles of the transition adviser.

However, even the best job-search skills will be of little assistance if veterans do not have relevant education and training for civilian careers. The Commission is also recommending enhanced support for veterans to gain qualifications and skills once they leave the ADF (draft recommendation 7.3).

7.8 Preparing veterans for other aspects of civilian life

For those who access them, existing transition resources can be effective instruction manuals for some of the practical aspects of civilian life. But they offer the veterans little guidance on the emotional and psychological aspects of transition, how to combine available services and supports to maximum effect, or how to develop a path towards a satisfied and productive post-military life. And these aspects of transition — together with the challenges of rebuilding social networks and developing previously unneeded life skills — can be just as large a challenge as that of finding sustainable employment.

Social connections

Social connections — both maintaining existing connections and building new ones — are an important part of veterans' transition. This can come as a surprise for people who have

spent years in the ADF, where service camaraderie is strong, and work and social networks are typically more closely intertwined than they are in the civilian world. Explaining this difference ahead of time would assist many veterans to understand that more pro-active action is required on their part, particularly if their transition involves leaving the city or town to which they had been posted.

Families can provide an important source of social support, both directly and through their links to the broader community. For instance, veterans' children may provide them with links into school communities, sporting groups and other parental networks. But not all veterans have these family connections or will be able to leverage them. Similarly, not all veterans will be able to rely on a network of their ex-service peers — most of those who transitioned since 2010 do not belong to an ex-service organisation (Van Hooff et al. 2018b).

International evidence shows that:

Cultural awareness training is necessary for return to civilian life ... Self-reliance and self-responsibility in the transitioning soldier must be taught as part of a broader process of cultural rehabilitation into civilian life and such training should involve transitioning soldiers going out and engaging with communities, employers and educational trainers. (Brewer and Herron 2018, p. 3)

There is therefore a need to encourage veterans to build their identity and social networks beyond ADF, as their hobbies, civilian friends, family, and passions are likely to help reduce the sense of loss they experience as they make the transition. Information about the importance of social connections, including the connections and camaraderie provided by ESOs, should form a key part of the transition preparation provided by Joint Transition Command. But at the same time, it is important that ESOs are not presented as the sole or best source of support for ex-serving members because, as noted above, an over-identification with the armed forces predisposes veterans to an inability to cope in civilian life.

Preparation for the psychological challenges of transition

A sense of loss is a known part of the military-to-civilian transition experience (section 7.1), and one that is consistent across countries and contexts (Romaniuk and Kidd 2018). That is why other countries prepare their veterans for the emotional challenges of reintegrating civilian life. For example, the first substantive chapter of the *New Zealand Defence Force Guide to Transitioning from Military to Civilian Life* covers emotional health (NZDF 2017).

When you transition, there is typically a sense of losing some part of you, or of no longer belonging. Some liken it to the grieving or change process where people can go through a period of shock and denial, before acceptance and adaptation. (NZDF 2017, p. 18)

The NZ guide also explicitly prepares veterans for the uncertainty, loss of confidence and change in status they may experience as part of their transition, and sets up realistic expectations about how long transition may take, by encouraging veterans to be patient and

to expect the process to take several years. Current transition advice for members of the ADF does none of these things.

By not preparing veterans for the psychological challenges facing them, ADF transition information also omits another important factor — an awareness that not all transitions go to plan. This is particularly problematic for veterans, who are trained to execute orders without question, not to change plans in response to unfolding events. This can leave veterans unsure of what to do if things do not work out, as Legacy highlighted.

The ADF transition process needs to place more emphasis and information available to exiting members so that if they do get into difficulties when plans don't work out they know where to go to get help/support and even mentoring/coaching. (2018, p. 2)

Preparing veterans for the changes of transition — rather than perpetuating the myth that transition could or should be seamless (section 7.1) — is the only way to ensure that as many veterans as possible succeed in moving smoothly to civilian life. And it will not be enough for the ADF to incorporate emotional preparation into all of its transition advice — it also needs to ensure that veterans take note of that advice.

Preparation for the social and psychological aspects of transition should be a key part of transition preparation, in the same way that career planning needs to be a routine and non-negotiable activity for all members of the ADF (section 7.7). The reasons for this are very similar — just as service members are reluctant to plan for their post service career, they are reluctant to imagine how hard transition will be. And at an individual level, their unit commanders have no incentive to encourage them to take transition planning seriously. This means that the impetus for social and psychological preparation must come at the system level.

While all military personnel should be required to prepare themselves for other aspects of civilian life, this does not necessarily need to involve attendance at transition seminars. Instead, the content of these seminars could be provided as online tutored learning packages that veterans and their families can use at any time during their career.

Increasing the number of veterans and families who participate in transition preparation — whether face-to-face or online — would also make it feasible for the information provided to be better tailored to the different needs of different groups. For example, while the current offerings provide the same information to experienced officers and to enlisted members finishing their initial minimum period of service, in the future this could be better targeted to the needs and aspirations of each group.

DRAFT RECOMMENDATION 7.2

Defence, through Joint Transition Command (draft recommendation 7.1), should:

- require Australian Defence Force members to prepare a career plan that covers both their service and post-service career, and to update that plan at least every two years
- prepare members for other aspects of civilian life, including the social and psychological aspects of transition
- reach out to families, so that they can engage more actively in the process of transition.

7.9 Education and training for post-service careers

Education and training are essential

For some veterans, putting their career plans into action and establishing themselves in a post-service occupation will require additional education or training. Some veterans will also have acquired skills in the military that need to be recognised through formal recognition of prior learning (RPL) processes. But at present, many veterans receive no support for education, training or RPL when they leave the ADF, while others can access partial assistance through the CTAS (section 7.3) or as part of a DVA rehabilitation plan (chapter 6). And for some, the military has not lived up to its promise that members will receive training that leads to recognised qualifications while they are serving (section 7.5).

The costs of education and training can be substantial, both in terms of direct costs such as course fees and textbooks, and indirect costs such as forgone income. Without support, some people will make short-term decisions relating to employment at the expense of employment and career outcomes that are sustainable and satisfying over the long term. This is why the Australian Government provides financial assistance for tertiary study, through the HECS-HELP and FEE-HELP schemes for higher education and VET student loans for vocational training. Veterans can access these schemes on the same basis, and under the same eligibility criteria, as other Australians. It is also why a number of other countries have education and training programs for veterans that cover the full cost of university or vocational courses (box 7.15).

Box 7.15 Overseas examples of higher education and training for veterans**United States**

The United States has supported veterans to obtain a college education since 1944. Under the Servicemen's Readjustment Act of 1944 — commonly known as the GI Bill of Rights — veterans receive financial support to undertake education or technical training after discharge. This includes both the cost of tuition up to certain limits and a monthly living allowance. Since 2008, veterans with active duty service on or after 11 September 2001 receive enhanced educational benefits that cover more educational expenses, provide a living allowance, money for books and the ability to transfer unused educational benefits to spouses or children (US Department of Veterans Affairs 2013).

United Kingdom

Veterans leaving the UK Armed Forces can access a range of services under the Career Transition Partnership (CTP), with CTP entitlements varying depending on length of service and reason for discharge. This can include vocational training courses in management, electrical engineering, building trades and IT, delivered both at the CTP's flagship Resettlement Training Centre and in CTP centres across the United Kingdom (UK Ministry of Defence 2015).

Canada

On 1 April 2018, Canada introduced an education and training benefit for veterans. The benefit covers college, university or technical education and may be spent on tuition, course materials, and some incidentals and living expenses. Veterans with six years of service may be eligible for an education and training benefit of up to C\$40 000, and veterans with at least 12 years of service can receive up to C\$80 000. Veterans who do not wish to attend college or university may spend up to C\$5000 on career and personal development courses such as small business boot camps and continuing education. All honourably released veterans have up to 10 years following their release date to use the benefit (VAC 2017).

Supporting veterans to participate in education and training

Trialling a veteran education allowance

There is a strong in-principle case for Australia to provide more support for veterans' higher education and vocational training to assist with employment outcomes, especially for those veterans affected by illness or injury. There are potential broader benefits for the Australian community, in terms of making better use of the skills veterans acquired in the ADF (skills already paid for by Australian taxpayers) and reducing veterans' future reliance on taxpayer-funded support.

The existing HECS-HELP, FEE-HELP and VET student loans programs could be used by veterans to obtain financial support to cover their course fees. These existing schemes already have a substantial subsidy component, and have been shown to be effective at reducing upfront cost barriers to study (Chapman 1996). Using these existing schemes rather

than creating a veteran-specific scheme allows the benefits to be obtained, while minimising duplication and administrative costs.

Any system of enhanced support for education and training needs to encourage full-time study. This is because full-time study has clear benefits in terms of course completion for mature-age students (most veterans are over 25 years when they leave the ADF and so are considered mature age).

If at least periods of full-time study are possible, mature-age students should seriously consider it. For students who cannot study full-time at all, any advice is partly a warning: the vast majority of people who study only part-time won't get a degree in the next eight years (Norton, Cherastidtham and Mackey 2018, p. 38)

But full-time study will only be possible for most veterans if they have an alternative source of income to support themselves. Full-time students can receive financial help from the Australian Government for everyday costs of living and some study expenses through either youth allowance (for people under 25) or Austudy (for 25 or older). But these payments are only available subject to income and assets tests, and those tests apply not only to an individual, but also to their partner and/or parents (DHS 2018). This means they are unlikely to provide the kind of encouragement for education and training that aligns with veterans' long-term wellbeing.

The Commission is therefore proposing that a veteran education allowance be introduced to provide financial support to veterans undertaking full-time education or training. The allowance would initially be provided as part of a policy trial conducted by DVA, with a view to the Veteran Services Commission (chapter 11) expanding it should the trial be successful.

Four key issues would need to be resolved in determining eligibility for the veteran education allowance during its trial phase. First, there is a need to determine whether eligibility for the allowance should be contingent on having completed a minimum period of service. Possible minimum periods include:

- completion of basic training
- completing an initial minimum period of service
- serving for a certain number of years (such as the six years of service required to access the Canadian veterans' education and training benefit).

The minimum period of service requirement could be waived for those being medically discharged. Each of these options has advantages and disadvantages, but broadly, the choice between them needs to strike a balance between promoting retention in the armed forces and providing adequate reintegration support to those whose future lies in the civilian sphere. The Commission is seeking participants' views on how this trade-off could best be made. Its initial view is that the veteran education allowance should only be available to those who have completed an initial minimum period of service or who are being medically discharged.

Second, there is a need to determine the rate at which the allowance would be paid. The key consideration here is the need to provide sufficient income to veterans to allow them to focus on their studies, while limiting the overall cost of the allowance to what is strictly necessary to achieve this.

- One option would be to set the veteran education allowance at the same rate as youth allowance. This would maintain consistency between various education allowances paid by the Australian Government. Youth allowance for a single adult with no children is \$445.80 per fortnight.
- Another option would be to set the veteran education allowance at the same rate as the veteran payment (which provides interim support to veterans who lodge a claim for a mental health condition — chapter 3). This would align payments that provide interim financial support to veterans. The basic rate of the veteran payment is \$923.20 per fortnight.

Alternatively, the veteran education allowance could be paid at a rate somewhere between the two, or at some other rate. The Commission is seeking further input from inquiry participants on the rate at which the veteran education allowance should be paid.

Third, there will need to be a limit on the time period over which the veteran education allowance can be claimed. The Commission's initial thinking is that the time limit should be set at four years, which is the length of a typical undergraduate degree. For courses that take less than four years of full-time study to complete, the allowance should only be available for the length of the course. Veterans should only be able to receive the allowance once.

Fourth, there needs to be systems for access to, and payment of, the veteran education allowance where a transition adviser in Joint Transition Command helps veterans to decide whether, and what, to study and assessing whether they meet the eligibility requirements for the veteran education allowance. Once this assessment is made, responsibility for paying the allowance would transfer to DVA (and then the VSC).

In practice, a scheme supporting veterans' education and training could involve veterans:

- working with their transition adviser to decide whether they would benefit from further education, and if so, on a preferred course of study
- enrolling in the chosen course and in the HECS-HELP, FEE-HELP and VET student loans programs (with support from their transition adviser if necessary)
- providing confirmation of their initial full-time enrolment to Joint Transition Command
- receiving the veteran education allowance once study commences (with administrative processes having been completed in the background between Joint Transition Command and DVA without any need for action on the part of the veteran)
- confirming their ongoing enrolment each semester with DVA, or notifying DVA if they cease study.

Like all policy trials, the success of the trial of the veteran education allowance will depend in large part on each of these elements being well designed. It is therefore essential that DVA follows good stewardship principles and designs a robust policy trial, as outlined in chapter 16.

DRAFT RECOMMENDATION 7.3

The Department of Veterans' Affairs should support veterans to participate in education and vocational training once they leave the Australian Defence Force. It should trial a veteran education allowance for veterans undertaking full-time education or training.

INFORMATION REQUEST 7.2

The Commission is seeking information to inform the design of the proposed veteran education allowance. In particular:

- *at what rate should the veteran education allowance be paid?*
 - *should eligibility for the veteran education allowance be contingent on having completed a minimum period of service? If so, what should that minimum period be?*
 - *should any other conditions be put on eligibility for the veteran education allowance?*
-

Recognition of skills and qualifications

Not all veterans will wish to undertake further education or training when they leave the ADF. And as noted in section 7.3, some will have acquired skills but not had them formally recognised with civilian qualifications. For those veterans, better recognition of prior learning (RPL) processes are needed. The need for improvement in RPL has been acknowledged by DoD, which said that it:

... has commenced collaboration with state and industry jurisdictions to map current Defence training to relevant civilian accreditation in order to provide accreditation and employment pathways that recognise the skills developed throughout Defence members' careers. (sub. 127, p. 27)

This mapping will be undertaken by the Australian Defence College (which includes the Defence Registered Training Organisation). It will develop a *Transferable Skills Recognition of Prior Learning Matrix and Strategy* in 2019 (DoD 2018g). Given the importance of skills recognition to transitioning veterans, Joint Transition Command should ensure that this mapping meets the needs of transitioning veterans.

7.10 Other transition issues

Encouraging employers to recognise the skills of veterans

Many firms around Australia recognise the value to their business of employing veterans and have recruited them. However, most people involved in recruitment have little connection with or experience of the military and may share some of the attitudes of the broader community — that is, that veterans have been damaged in some way by their service. This could lead some employers to overestimate the likelihood that veterans have some kind of physical, emotional or mental health problem that could adversely affect their capacity to be effective employees. There are no reliable estimates of these attitudes in Australia, but surveys undertaken in the UK and US found that about 90 per cent of the population considered that it was common for veterans to have physical, emotional or mental health problems as result of their service (Ashcroft 2014).

This suggests a general perception that military service causes harm. It is also possible that some ex-service members report experiencing discrimination in the form of negative perceptions of veterans as ‘a coping mechanism protecting veterans from acknowledging personal barriers, such as health or attitudinal, which impact employment’ (Keeling, Kintzle and Castro 2018, p. 67).

Current efforts by DVA to encourage private sector firms to employ veterans do not directly address concerns about the effect of veterans’ service on their physical, emotional and mental health. Instead, they focus on intangible factors like ‘core ADF values such as honesty, honour, initiative, integrity, respect and loyalty’ (DVA nd).

But even if some employers are unduly concerned about veterans’ physical, emotional and mental health, government programs are rarely going to be the best mechanism for addressing such barriers. Instead, such programs are likely to be more effective at supporting veterans to obtain employment in the public sector. This is demonstrated by the high rates of veteran employment in the APS — in 2017, close to 6 per cent of respondents to the census of APS employees identified as an ADF veteran (APSC 2017a), despite veterans comprising a much smaller share of the Australian population.

Government action to further encourage businesses to employ veterans is not likely to be successful unless there are veterans who have the skills and qualifications to be competitive for a position being overlooked in favour of non-veteran applicants. The additional support for veterans’ education and training recommended in section 7.9 will help here, as it will make it more likely that veterans have the skills and qualifications to be shortlisted for available positions. At that point, their intangible values — the honesty, honour, initiative, integrity, respect and loyalty instilled by the military — will stand them in good stead to succeed. The extent to which the Australian Government, and State and Territory Governments, should engage in more proactive employment assistance strategies or programs for veterans is not clear. A greater understanding of the needs of both veterans and employers is warranted. Any increase in government involvement should be carefully

evaluated, and should be based on evidence demonstrating significant veteran outcomes for the investment made.

Transition and Reserve service

As noted in section 7.2, about one quarter of those leaving full-time service continue active service in the Reserves (Van Hooff et al. 2018b). Others become members of the Reserves directly, and complete their military service without ever having been full-time members of the ADF. In both cases, when their period of Reserve service ends, members may experience some of the same issues and challenges as those transitioning from full-time service. For example, reservists may feel a loss of camaraderie and need to make a psychological transition away from their military identity.

The needs of reservists in transition are also likely to change, as the nature of Reserve service is transforming with the ADF's adoption of a new workforce model (box 7.16).

Box 7.16 The Total Workforce Model

Beginning in 2015-16, the Australian Defence Force (ADF) has progressively moved to increase the flexibility of its workforce, by adopting a new 'Total Workforce Model'. The Total Workforce Model is designed to 'draw on the skills and experience of its entire workforce in a more agile and integrated way' (DoD 2018c).

Rather than 'Permanent Force' or 'Reserves', the Total Workforce Model features a continuum of service categories that better reflect the type of service provided. (DoD 2017f)

The service arrangements are described in terms of service categories (SERCAT) and service options. There are seven SERCATs, ranging from permanent members working full time (SERCAT 7) to what was previously called the inactive reserve — members of the Reserves who do not render service and have no service obligation (SERCAT 2). Employees of the Defence Australian Public Service (APS) who are force assigned are SERCAT 1.

The number of days each ADF Reserve member works in a year can vary substantially, depending on their SERCAT, personal circumstances and organisational need.

The Defence Force Welfare Association said that the new workforce model has implications for those transitioning from full-time to Reserve service.

The employment arrangements for Reserve Service have changed markedly from the traditional attendance at weekly parades and annual camps. The different options for Reserve service, e.g. permanent part-time, short-term fulltime, plus the ease of returning to full-time service, has brought a new meaning to 'Transition'. (DFWA, sub. 118, p. 37)

To the extent that the total workforce model succeeds in removing the very notion of reservists (with ADF personnel instead being considered in relation to their current full-time or part-time service status), it could smooth the transition for many veterans leaving

permanent service. More evidence will be required to know this for certain, as there is currently limited evidence of the impact on transition of continuing to serve in the Reserves.

Currently we know little about how veterans who maintain connections with the armed forces through the active reserves differ psychologically in relation to their resilience for handling the difficulties involved in military-civilian transition (West 2018, p. 114)

There can also be a range of unique transition issues faced by members of the Reserves who deploy.

When deploying, reservists face the same challenges as regulars. In addition, reservists — and their families — face transitions from their civilian life to full-time service and back again. For regulars, deployment is a fundamental part of their employment, whereas, for reservists, deployment is a pronounced break from their civilian employment, as well as their family lives. (Orme and Kehoe 2011, p. 1223)

Not only do reservists face more transitions pre- and post-deployment, many return to their civilian lives very quickly. Some return home to their families within hours or days of returning from deployment, often dispersed as individual or small groups around the country. Thus, unlike members of the permanent forces, there is no assurance that reservists returning from deployment will have local or convenient support from their unit or service when they face reintegration challenges (and the return from deployment is a known time of stress and turbulence for veterans and families).

Reservists can also differ from the permanent forces in their motivations for, and experiences of, service and this can mean that their service has psychological effects. In particular, reservists have reported discrimination and bullying (West 2018, p. 113), but the effects of this on transition are not clear.

The Commission is seeking further information on the transition needs of members when they leave the Reserves to inform its final report.

INFORMATION REQUEST 7.3

The Commission is seeking further information on the transition needs of members when they leave the Reserves.

8 Initial liability assessment

Key points

- The first step to gaining access to most benefits in the veteran support system is establishing that a veteran's contemporary medical condition is causally related to their military service — that is, that the Australian Government has accepted liability for the condition.
 - Most claimants have liability accepted for their conditions. The overall acceptance rate in 2017-18 for individual conditions was around 56–79 per cent, depending on the relevant Act. As claimants often have multiple conditions, the probability of an individual having liability accepted under the *Military Rehabilitation and Compensation Act 2004* (MRCA) for at least one condition is nearly 91 per cent.
- The first steps to determining initial liability involve establishing a period of military service, a diagnosed medical condition and a date of clinical onset or worsening.
- The Department of Veterans' Affairs (DVA) uses Statements of Principles (SoPs), created by the Repatriation Medical Authority (RMA), to link a diagnosed condition to causal factors of service under the MRCA and *Veterans' Entitlements Act 1986* (VEA).
 - The existing SoP system is robust and effective. It promotes consistency, predictability and transparency, and draws a clear line between accepted and non-accepted conditions based on sound medical-scientific evidence and clinical experience.
 - Expanding the SoPs to claims under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* would enable a harmonised initial liability process across all three Acts, reducing complexity in the system.
- The SoPs are created at two different standards of proof for the underlying medical-scientific evidence — a beneficial 'reasonable hypothesis' standard for operational service under the MRCA and VEA, and a 'balance of probabilities' standard for all other types of service.
 - The Commission is proposing that only one standard should apply, but is seeking feedback on the systemic impacts (such as cost and acceptance rates) of moving to a single standard across all three Acts, and on which standard should be used.
- Some participants suggested that the SoPs system is slow to incorporate new or emerging evidence of causal links. To address these concerns, the Australian Government should:
 - increase resourcing for the RMA so that SoPs can be updated more quickly to reflect emerging evidence
 - allow the RMA to fund and guide research into unique veteran health issues
 - require the RMA to better explain the evidence relied on for decisions.
- The merits of a standalone Specialist Medical Review Council in the SoP review process are also uncertain, given its functions could be folded into the RMA.

For almost all claims for compensation, treatment and rehabilitation by veterans and their families under the *Veterans' Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA), the Government must accept initial liability for an injury, illness or death (hereafter a 'condition') before any support can be provided. In this sense, acceptance of initial liability is the gateway to the system of veteran support. There are a small number of circumstances or benefits that do not need such a test to be met.

This chapter sets out the steps involved in establishing initial liability (section 8.1), discusses some concerns raised by participants about the process (section 8.2) and looks at options for reform (section 8.3).

8.1 Steps involved in establishing initial liability

The successful determination of initial liability requires a claimant to make a case that links a veteran's condition to their military service. The claim is then investigated and assessed by a Department of Veterans' Affairs (DVA) delegate.

Establishing a link to service requires the DVA claims assessor to make the following three findings:

1. That the veteran has valid military service prior to the date of clinical onset or worsening.
2. That there is a valid medical diagnosis for the claimed condition.
3. That the onset or worsening of the claimed condition was caused by their military service.

Under the VEA and the MRCA, the Statements of Principles (SoPs) are the tools used to link a medical condition to service. DRCA claims are assessed on the evidence on a condition-by-condition basis.

The period and type of service

The first step in the initial liability claims process is for the claims assessor to establish the claimant's periods of military service and the type of service rendered. The period and type of service (for example warlike or peacetime service, chapter 3) will affect which Act (or Acts in the case of dual eligibility) the claim is assessed under, as well as the benefits the veteran is entitled to.

The Commission understands that claimants usually provide their own service records. This is relatively straightforward for current serving members. Otherwise, DVA can request records from Defence, similar to other data sharing arrangements (chapter 16). Since 1 July 2010, electronic service records have been obtained from Defence through the joint Defence and DVA Single Access Mechanism arrangement (box 8.1).

Box 8.1 The Single Access Mechanism

Defence's single access mechanism (SAM) 'provide[s] a single point of access between Defence and DVA for requests for information'. The Defence SAM team is responsible for coordinating information requests within the Department regarding serving and ex-serving members. During 2017-18, Defence SAM processed 27 124 requests from DVA. This was 'nearly 30 per cent greater than in previous financial years' (Defence, sub. 127, p. 11).

The types of records and information that DVA commonly requests from Defence include:

- service and medical records (operational service, dental, psychiatric and psychology)
- posting and leave records
- financial statements (including remuneration and allowances)
- incident and investigation reports (including exposure to hazardous materials)
- disciplinary records (including Boards of Inquiry reports).

The dispersed nature of Defence records can make the process of obtaining full service records challenging. This is particularly the case for veterans who discharged from the Australian Defence Force many decades ago and whose records may only be in paper form, in multiple locations around the country.

For these reasons, Defence's target timeframes for responding to SAM requests (table below) vary by the number of years since discharge and range from one working week for urgent requests to up to seven working weeks for routine requests (Defence, sub. 127, p. 12). For routine requests, this equates to between 29 and 65 per cent of DVA's target for the mean time taken to process initial liability claims — 75 days for VEA and 120 days for MRCA and DRCA (DVA 2017d).

Priority	Within 12 months of separation	1-3 years from separation	Over 3 years from separation
Urgent (general)	5 business days	10 business days	15 business days
Urgent (complex)	20 business days	20 business days	30 business days
Medium	15 business days	20 business days	25 business days
Routine	25 business days	30 business days	35 business days

The diagnosed condition

The next step of the initial liability assessment process involves the claims assessor confirming the veteran's current medical diagnosis, and:

- for claims of new conditions caused by service: the date of *clinical onset* of the condition
- for claims of pre-existing conditions aggravated by service: the date of *worsening* of the condition.

Diagnosis

Establishing the diagnosis for the claimed condition typically relies on the claimant's medical records from their treating general practitioner (GP) or specialist. To assist them in the interpretation of medical evidence, claims assessors, who typically do not have any medical training, can request a review of medical records by DVA's medical advisers (normally contractors to the Department).

Where medical records are not provided or where their quality is insufficient to establish a diagnosis, the claims assessors can ask that the client have an appointment with an external medical assessor (typically from medico-legal firms) in order to establish an accurate diagnosis (SFADTRC 2017, pp. 87–88).¹ DVA pays for these appointments. Issues with the use of external medical assessors are discussed in chapter 9.

Clinical onset or worsening

There are a number of ways to establish clinical onset or worsening of a condition. If the condition was caused by a particular incident during service (such as an accident), then ideally the claimant's service records would include a medical record or incident report that indicates a date of onset or worsening.

In practice, the use of incident reports in claims does not appear to be common. Available data suggests that under the MRCA:

- only around 2700 claimed conditions (2.4 per cent of the claimed conditions over the period 1 July 2004 to 30 June 2017) were linked to an incident report
- the links to incident reports were much lower for claimed conditions related to operational service (particularly for the nearly 15 000 conditions related to service in Afghanistan, at around 1.1 per cent)
- despite this, some periods of operational service had significantly higher rates of linkages to incident reports, particularly claimed conditions related to service in Fiji (nearly 16.9 per cent), the Solomon Islands (4.8 per cent), and general peacekeeping service (5.1 per cent) (Commission estimates based on unpublished DVA data).

In the vast majority of cases, where primary evidence is missing — because there was no incident report or, commonly, there was no particular incident that led to the condition — the date of clinical onset or worsening can be estimated by the treating or assessing medical specialist. For delayed onset illnesses, this will often be the date of diagnosis, while other conditions may have a date of clinical onset or worsening estimated retrospectively, based on discussion with the claimant around when symptoms arose (DVA 2018z, s. 3.4.4). This retrospective assessment is allowed because the veteran support system has less restrictive evidentiary standards than civilian workers compensation schemes (box 8.2), one of the

¹ External medical assessors can also be used for assessing the level of impairment once a condition has been accepted (chapter 12).

‘beneficial’ aspects of the veteran support system (noted in chapter 3) necessary to deal with the long time lag between relevant service and claims.

Box 8.2 Evidentiary standards in the veteran support system

Under the *Veterans’ Entitlements Act 1986* (s. 119) and the *Military Rehabilitation and Compensation Act 2004* (s. 334), Department of Veterans’ Affairs delegates are required to take into account the ‘absence of, or a deficiency in, relevant official records’ during service and the ‘effects of the passage of time’ since the relevant service when assessing the evidence for a claim.

- These provisions are intended to account for ‘the special problems of proof in the veterans’ entitlements system’, particularly the ‘length of time since service, the paucity of records and the frailty of human memory’ (Creyke and Sutherland 2016, p. 397).
- Although the provisions are very broad, they do not mean that all claims without supporting evidence will be accepted, as the provisions cannot be used to ‘provide evidence of facts if none exists’ — this is because an ‘assumption of facts may not be made if there are equally plausible facts to the contrary’ (p. 398).

Linking conditions with service

The final step in the initial liability process is to confirm that the condition is service-related. This is similar to civilian workers’ compensation schemes: there needs to be sufficient evidence of a link between employment — in this case the member’s service — and the medical condition.

What is a service-related condition under the MRCA and VEA?

There are several criteria (also known as ‘heads of liability’) under each of the Acts that define when a medical condition can be deemed to be service-related.

Under the MRCA (ss. 27-30) and VEA (ss. 8, 9 and 70), a condition can be deemed to be service-related if at least one of the heads of liability is met.² The main (but not only) heads of liability tests are that the condition:

- resulted from an ***occurrence*** that happened while the veteran was a member rendering defence service (a temporal link)
- ***arose out of***, or was attributable to, any defence service rendered by the veteran while a member (a causal link).

² The heads of liability under the VEA and MRCA are almost identical, an exception being that the restriction on the use of tobacco products only applies to the VEA after 31 December 1997.

For most VEA and MRCA claims, there is a two-step process for making a causal connection:

1. an assessment that the condition was caused by a factor in the relevant Statement of Principles (discussed below)
2. an assessment that the veteran's service made a 'material' (but not necessarily sole) contribution to the factor, under one of the heads of liability.

What is a service-related condition under the DRCA?

Under the DRCA (ss. 5A-7), diseases and injuries are assessed differently, as there are different heads of liability due to the Act's genesis in civilian workers' compensation schemes.

- For diseases, the claims assessor must decide whether service made a contribution (generally 'material' or 'to a significant degree', depending on the date of onset) to the disease.
- For injuries, the delegate must simply be satisfied that the injury 'arose out of or in the course of the employee's employment' before liability can be accepted.

Under all three Acts, a condition cannot be deemed to be service-related where the condition came about or arose from a self-inflicted act, an act of the veteran's own negligence (e.g. under the influence of alcohol or unauthorised drugs) or a serious breach of discipline.

The standards of proof

The nature of medical science means that the true underlying cause of a condition is never known with 100 per cent certainty.³ Initial liability claims assessors in DVA therefore need to make a judgment on the basis of the evidence before them about whether it is 'reasonable' to link a veteran's condition to their service.

In civilian workers' compensation schemes and elsewhere in civil law, evidence before an administrative decision maker is considered on the 'balance of probabilities'. What this means is that the weight of evidence must be more in favour of the claim being true than not. The balance of probabilities standard is also known as the 'reasonable satisfaction' test (because the assessors must be reasonably satisfied of a claim being true before an affirmative decision) or the 'civil standard' (to differentiate it from the much more onerous criminal standard, which involves only affirming a decision if convinced of the truth of a claim 'beyond a reasonable doubt').

³ For example, while exposure to a carcinogen during service may be strongly *correlated* with the development of a particular cancer, a person who develops that cancer may do so because of other unrelated reasons, such as genetic predispositions or accidental exposures in environments unrelated to ADF service.

In the veteran support system, all ‘findings of fact’ made by claims assessors are conducted on the balance of probabilities standard (DVA, sub. 125, p. 107). This applies throughout the entire claims process, including decisions under all three Acts about:

- whether a claimant has relevant service
- whether they have a diagnosable condition
- the date of clinical onset or worsening of their condition
- their level of impairment
- a multitude of other administrative decisions.

Some decisions about whether a veteran’s condition is related to their service (for initial liability purposes) are also made on the balance of probabilities. In particular, all claims under the DRCA are considered on the balance of probabilities, as are claims seeking to link a condition to MRCA peacetime service or equivalent VEA service (the different types of service are outlined in chapter 3).

However, the link between *operational* service and a condition can be considered on a more ‘beneficial’ standard of proof.⁴ The beneficial standard of proof for this type of service is referred to as the ‘reasonable hypothesis’ standard of proof — a hypothesis of a link between the condition and the service only has to be ‘reasonable’ (rather than more than likely) before it can be accepted.

The more beneficial standard of proof for claims related to operational service has a long history (box 8.3). At its core, it seems to be a result of political and community preferences for the veteran support system to avoid rejecting conditions that are actually related to service (a type II error), by accepting more conditions that may *not* be legitimately related (type I errors). As noted by Justice Heerey of the Federal Court,⁵ ‘a consistent theme in Australian repatriation legislation ... [is] a linkage between the risks undergone in service and the ease of proof of claims; the more dangerous the service, the less difficult it is to prove a connection between that service and death, injury or disease’.

It is important to note that the reasonable hypothesis standard is only operationalised via the reasonable hypothesis Statements of Principles (discussed below) — no findings of fact are made using this lower standard of proof.

⁴ This includes operational service under the MRCA or its equivalent under the VEA (such as warlike or peacekeeping service) — types of service are outlined in more detail in chapter 3.

⁵ In *Deledio v Repatriation Commission* (1997) 1047 FCA.

Box 8.3 **Some history on the beneficial standard of proof**

The original *Australian Soldiers' Repatriation Act 1920* required that a veteran's death or incapacity had to have resulted from their service before the Commonwealth had liability. Legislative amendments were introduced in 1929 to allow veterans to make a 'prima facie case' of the causation or aggravation of their condition by their service. Additional amendments in 1935 and 1943 allowed veterans further expanded benefits of the doubt.

In 1977, additional legislative amendments were intended to clarify the benefit of the doubt provisions by requiring the provision of a pension or entitlement to veterans with operational service unless the Department of Veterans' Affairs (DVA) was 'satisfied, beyond a reasonable doubt' that there were insufficient grounds to do so. Largely by accident, this fundamentally changed the system, as the High Court interpreted the new standard as the application of a 'reverse' criminal standard of proof to veteran support claims, rather than the previous civil standard (in *Repatriation Commission v Law* (1981) 147 CLR 635). A later case in 1985 (*Repatriation Commission v O'Brien*, 155 CLR 422) outlined the full ramifications of creating this new 'reverse' (as the onus was on DVA to prove a claim was *not* true) criminal standard: in practice, all claims by eligible veterans had to be accepted in the applicant's favour by default, unless DVA could present strong evidence that there were insufficient grounds for acceptance, which was an almost impossible task.

In 1985, the Acting Minister for Veterans' Affairs noted that this standard 'could require that a ... pension be paid even in a case where there is no evidence which points to there being a reasonable possibility or a connection between the veteran's incapacity or death and the veteran's war service'. As such, the standard's effect was 'to bring the determination of disability pension claims close to one of automatic acceptance for the vast majority of claims', because 'such an onus of disproof at the criminal standard is virtually impossible to satisfy in almost all cases' (Scholes 1985, pp. 2644–2645).

In 1985, the Government passed legislative amendments to tighten eligibility, based on an alternative interpretation offered by Justice Brennan's dissent to the *O'Brien* decision. This introduced the notion of the 'reasonable hypothesis' as a refinement to the standard. Whereas the reverse criminal standard on its own operated under the assumption of an adversarial claims process, adding a reasonable hypothesis test assumed an inquisitorial process, with all the facts about the case laid out before the assessor. If no 'reasonable hypothesis' of a link was then supported by the evidence, there would be insufficient grounds for granting the claim.

Sources: Baume, Bomball and Layton (1994); Creyke and Sutherland (2016); Lloyd and Rees (1994); Toose (1976).

The Statements of Principles

The Statements of Principles (SoPs) are legislative instruments that help claims assessors link a veteran's medical conditions to events during their service (box 8.4 provides a history of the SoPs). The SoPs are created by the Repatriation Medical Authority (RMA), based on the latest medical and scientific evidence (the process is discussed below).

Box 8.4 History of the Statements of Principles

After the introduction of the ‘reasonable hypothesis’ standard of proof in 1985, its operation was tested in two subsequent High Court decisions: *Bushell v Repatriation Commission* (1992) 175 CLR 408 and *Byrnes v Repatriation Commission* (1993) 177 CLR 564.

Both cases looked at whether the evidence of a single medical practitioner was sufficient to create a reasonable hypothesis between a condition and a veteran’s service. In both cases, the High Court sided with the veteran, noting in the *Bushell* decision that a ‘hypothesis may still be reasonable although it is unproved and opposed to the weight of informed opinion’.

Following these decisions, access to benefits under the VEA were opened much wider than originally intended by the legislation. Effectively, any veteran would be able to get their claim for liability accepted as a ‘reasonable hypothesis’ if they:

1. could prove that they had a medical condition and the relevant operational service
2. could then find a qualified doctor ‘eminent in the field’, who was willing to testify that there was a link between the condition and service.

As Baume, Bomball and Layton (1994, p. ix) noted, this was the case regardless of how spurious, ‘maverick’ or contrary to accepted medical opinion that doctor’s opinion might be. This inevitably led to allegations of rampant ‘doctor shopping’ in the veteran community.

In response, the Government commissioned the Baume Review (*A Fair Go*), to examine the system. This Review recommended a range of changes for determining initial liability, including:

- changing the standard of proof for operational service to the ‘balance of probabilities’ test, with a ‘benefit of the doubt’ provision if there was an approximate balance of evidence
- creating an expert medical committee to generate and oversee Statements of Principles (SoPs) to guide assessors in applying the standards of proof
- making SoPs binding on decisions under the VEA
- accounting for the effects of age-related factors on the causation and severity of any service-related conditions

The Government accepted some, but not all, of the review’s recommendations: it created the expert medical committee (the Repatriation Medical Authority) to oversee the formalised system of SoPs and made those SoPs binding on all VEA liability decisions.

Sources: Baume, Bomball and Layton (1994); Creyke and Sutherland (2016); Pearce and Holman (1997).

Each SoP defines a specific condition, typically with reference to common symptoms. They also outline a set of causal ‘factors’ for that condition, at least one of which must be linked to a veteran’s service to establish a causal connection. Each factor contains an event (such as ‘experiencing a significant physical force applied to or through the affected joint’ or ‘being bitten by a mosquito’) and a time period between that event and clinical onset or worsening of the condition (for example, ‘at the time of clinical onset/worsening’ or ‘within the two years before clinical onset/worsening’).

The SoPs are binding for decisions about liability for conditions made under the VEA and MRCA (but not DRCA) for all decision makers, from DVA through to the federal court

system. This means that a hypothesised link between the claimant's condition and service *must* be supported by at least one factor in the relevant SoP before it can be accepted.

Claims assessors are not able to accept a claim that makes a hypothesis linking a veteran's condition to their service through a factor that is not included in an *existing* SoP. As Creyke and Sutherland noted:

The decision-maker cannot use the evidence of an expert or others to contradict or provide alternate scientific or other facts to those in the relevant SoP. An hypothesis that does not fit within the template will not be 'reasonable' and the claim must fail. (2016, p. 433)

The RMA has created around 2500 SoPs, and over 300 injuries or diseases are included (RMA 2018f). The majority of claims to DVA are covered by SoPs — around 92 per cent of claims determined by DVA in 2017 and that had diagnosable conditions were covered by SoPs (RMA, sub. 111 attach., p. 17).

There is one major variation between the VEA and MRCA when using the SoPs:

- under the VEA a claimant has recognised rights under repealed SoPs
- the MRCA mandates (s. 341) that only the current SoP can be used for any primary claim or appeal (Creyke and Sutherland 2016, p. 434).

While claims under the DRCA are not bound by the SoPs, DRCA assessors and claimants can choose to use the relevant SoPs (at the balance of probabilities standard) as a guide when assessing or advocating for a claim. However, this is not required and may not be useful, particularly as the different heads of liability under DRCA mean some SoP factors are not relevant.

Double standards? Double statements

Due to the different standards of proof applicable to claims under the VEA and MRCA, there are two different SoPs for each condition — one listing causal factors that are medically related to the condition on the 'balance of probabilities' and one listing factors that must exist before a 'reasonable hypothesis' can be raised connecting the condition and the liability.

The two SoPs at the different standards of proof include many common factors of service because if a factor can be causally linked to a condition on a balance of probabilities, it can also be linked on a reasonable hypothesis basis. As an example, the SoP for tinnitus (ringing in the ears) includes 'being exposed to a peak sound pressure level at the tympanic membrane of at least 140 dB(C)' before clinical onset as a causal factor in both the balance of probabilities and the reasonable hypothesis versions (RMA 2012a, 2012b).

The SoPs differ for criteria such as the level or extent of exposure (the 'dose') necessary before a claim can be linked to service or the 'latency' of the time between exposure and clinical onset/worsening of the condition. Both SoPs for malignant melanoma of the skin

(skin cancer), for example, include having a sunburn in the period prior to clinical onset as a possible causal factor, but differ on the length of this period — the balance of probabilities requires the sunburn to be within the two years prior to clinical onset, while the reasonable hypothesis extends this period to five years (RMA 2015a, 2015b).

The reasonable hypothesis SoPs include more than 650 additional factors (around 16 per cent more) that are not in the balance of probabilities SoPs (table 8.1). These are the factors for which there is sufficient evidence of a causal link being a reasonable hypothesis, but not enough evidence to say there is a link on the balance of probabilities. One example is that various anti-malarial drugs (such as mefloquine or chloroquine) are included in the reasonable hypothesis SoPs for some mental health problems, but not in the balance of probabilities versions of those SoPs (RMA 2014a, 2014b).⁶

Table 8.1 Number of SoP factors

Reasonable hypothesis (RH) vs. balance of probabilities (BOP), at 28 May 2018

<i>SoP Factor</i>	<i>Number</i>	<i>Per cent of total</i>
Clinical Onset	4 879	
— RH factors	2 655	54.4
— BOP factors	2 224	45.6
Clinical Worsening	3 800	
— RH factors	2 014	53.0
— BOP factors	1 786	47.0
Total RH factors	4 669	53.8
Total BOP factors	4 010	46.2

Source: RMA (sub. 111, attach. 4)

Which SoP to use (reasonable hypothesis or balance of probabilities) for a given claim depends on whether the claimant:

- has relevant operational service that allows access to the reasonable hypothesis SoP and
- is hypothesising a link between that operational service and their condition.

For example, if a veteran with operational service is making a claim that their condition was caused by an accident that occurred during peacetime training in Australia, it will be assessed using the balance of probabilities SoP (because the causal connection is with the veteran's *peacetime* service, not their *operational* service). This means that a veteran with operational service under the MRCA or VEA will not automatically have access to the reasonable hypothesis SoP if the relevant factor of service did not occur during their operational service.

⁶ The Senate Foreign Affairs, Defence and Trade References Committee is currently conducting an inquiry into the links between these drugs and the long-term health effects of military personnel.

Assessment of non-SoP conditions

For some conditions, the RMA has not created a SoP. Claims for conditions without a SoP are treated in one of several different ways.

- If the RMA has given notice of its intention to create a SoP for that condition, DVA is not able to determine the claim for that condition until there is a registered SoP.
- If the RMA has given notice that it does *not* intend to create a SoP, the Repatriation Commission or Military Rehabilitation and Compensation Commission can make a determination of compensation coverage for particular conditions. This is a rare outcome, but creates, in effect, a ‘substitute SoP’ (Creyke and Sutherland 2016, p. 448). If the Commissions decline to make such a determination, then the condition is either considered to not be an injury or disease for the purposes of the VEA or MRCA or not able to be related to service. As a result, claims for such conditions cannot be accepted by DVA. Examples of non-SoP conditions that are unable to be related to service include obesity and Gulf War syndrome (RMA 2018a).
- If the RMA has not given notice of *either* its intent to create a SoP or to not create a SoP for a given condition, DVA is not restrained from considering the claim and it is subsequently assessed on pre-SoP basis (that is, on its merits without reference to a SoP, as occurred prior to 1994) (Creyke and Sutherland 2016; DVA sub. 125, p. 108; RMA 2018a).

The role of the RMA and the SMRC

The SoP system is overseen by the RMA and the Specialist Medical Review Council (SMRC) — the RMA creates and updates the SoPs and the SMRC reviews SoP decisions made by the RMA (box 8.5). Both agencies are independent statutory authorities that are responsible to the Minister for Veterans’ Affairs.

Box 8.5 About the RMA and SMRC

The Repatriation Medical Authority (RMA)

The RMA is made up of a panel of five medical practitioners ‘eminent in fields of medical science’ whose primary function is to determine SoPs for any condition that could be related to military service, based on ‘sound medical-scientific evidence’ (RMA 2017b). The VEA specifies (s. 196L) that at least one of the RMA members must have at least 5 years of experience in the field of epidemiology, while current members also have experience in psychiatry, oncology and musculoskeletal diseases.

The RMA members meet six times a year. Prior to each meeting, the RMA also holds an informal meeting with Department of Veterans’ Affairs staff, current service personnel and representatives from ex-service organisations, in order to consult on operational issues relevant to the SoPs, such as how they are worded, their ease of use and whether they are relevant to military service.

In 2017-18, there were around 10 staff in the RMA Secretariat assisting the members in their functions, including with medical research.

The Specialist Medical Review Council (SMRC)

The SMRC reviews the contents of a SoP or any decisions by the RMA not to make or amend a SoP for a specific condition or to carry out an investigation.

Like the RMA, the SMRC is made up of medical practitioners and scientists. Unlike the RMA, however, there is no standing board of members. Instead, the Minister appoints Councillors as part-time officers to the SMRC. There are currently 35 appointed Councillors in the SMRC, in addition to the Convener as the head of the SMRC. Each review is conducted by between three and five Councillors.

Sources: RMA (2018f, 2018d), SMRC (2018a, 2018c).

The process for determining SoPs

The key function of the RMA is to create and review the SoPs (figure 8.1). In 2017-18, the RMA made determinations on 93 different SoPs, including 60 revoked and re-issued SoPs, 22 SoPs for new conditions and 9 amended SoPs (RMA 2018f).

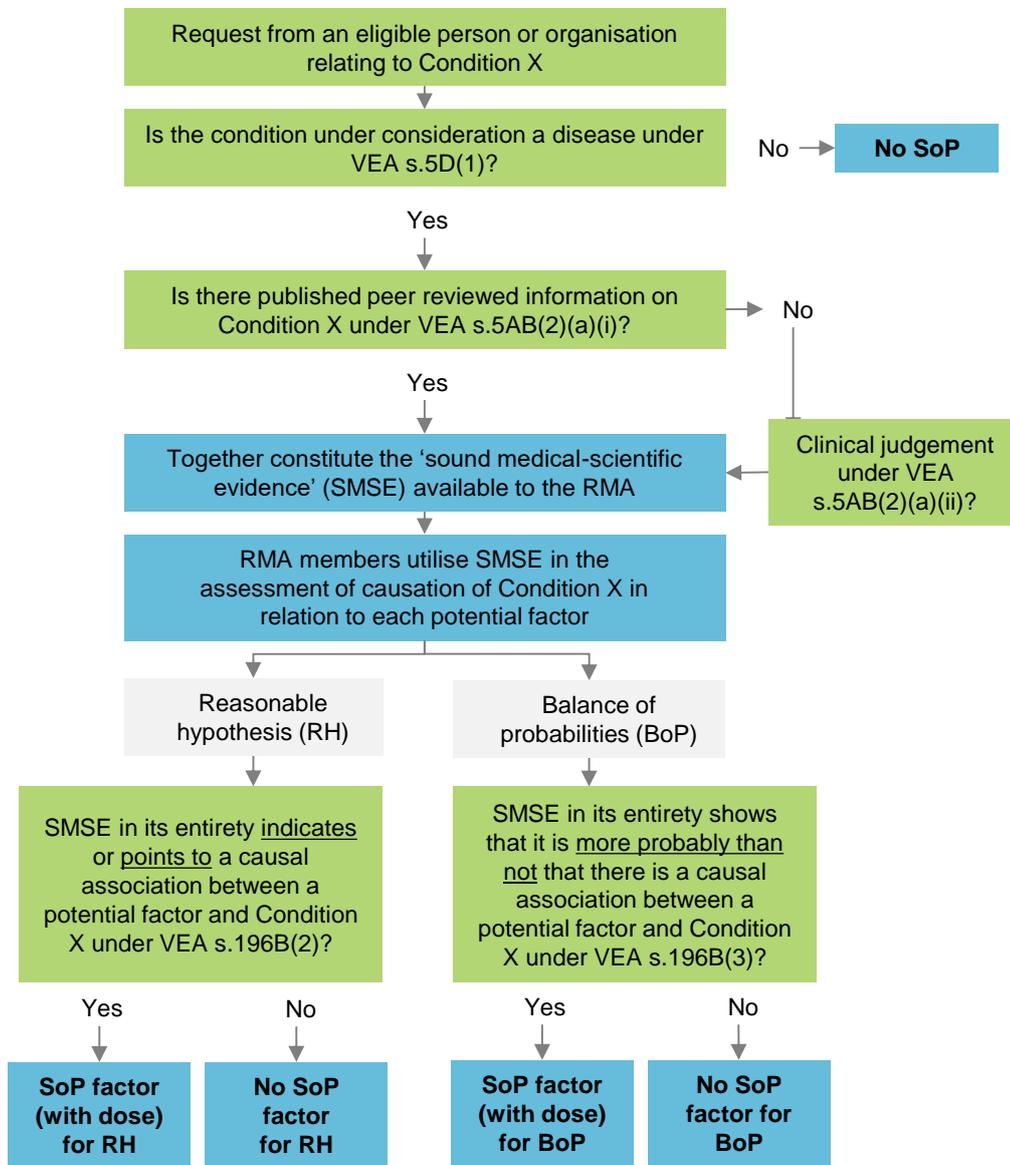
Crucial to this role is the determination of whether there is ‘sound medical-scientific evidence’ relating a particular kind of injury, illness or death to relevant military service. The VEA defines ‘sound medical-scientific evidence’ — in s. 5AB(2)(a) — as information that is:

- (i) consistent with material relating to medical science that has been published in a medical or scientific publication and has been, in the opinion of the RMA, subjected to a peer-review process or
- (ii) in accordance with generally accepted medical practice, would serve as the basis for the diagnosis and management of a medical condition.

The RMA’s decisions on SoPs are guided by the results of the sound medical-scientific evidence for each condition. RMA researchers prepare briefing papers that identify the evidence for that condition from peer-reviewed medical-scientific journals, as well as from reputable research organisations. The totality of this evidence and any relationship it shows between the condition and causal factors is then weighed, with different pieces of evidence given different weights. Evidence of a higher quality (such as well-conducted randomised controlled trials) is weighted more heavily by the RMA than weaker evidence (such as individual case reports). For each potential factor, the strength of all the evidence is categorised into grades:

- Grade 1 (Convincing) — strong evidence of a causal relationship, such as a large number of consistent, high-quality studies that find a statistically significant relationship.
- Grade 2 (Suggestive) — strong evidence that suggests a causal relationship, but chance, bias or confounding reasons cannot be ruled out with reasonable confidence.
- Grade 3 (Limited) — evidence suggests a possible causal relationship, but is limited in quality or quantity.
- Grade 4 (Very limited) — evidence is too limited to support a causal relationship, such as inconsistent results from low quality/quantity studies.
- Grade 5a (Inadequate) — evidence sufficiently limited that no firm conclusion can be made.
- Grade 5b (Evidence suggesting no causal relationship) — evidence is strongly suggestive that there is unlikely to be a causal relationship, such as several good quality studies that show no statistically significant relationship (RMA 2018d, pp. 13–15).

Figure 8.1 The RMA’s process for determining SoPs



Source: RMA (2018d).

The required strength of evidence before a causal factor can be included (and at what dosage level or latency period) varies between the two different standards of proof — the reasonable hypothesis standard needs much weaker evidence of a causal link than the balance of probabilities standard before a factor can be considered for inclusion in a SoP (table 8.2).

Table 8.2 Usual strength of evidence before a factor can be considered

<i>Assigned grading</i>	<i>Balance of probabilities</i>	<i>Reasonable hypothesis</i>
Grade 1	Yes	Yes
Grade 2	Maybe	Yes
Grade 3	No	Yes
Grade 4	No	Maybe
Grade 5a	No	No
Grade 5b	No	No

Source: RMA (2018d, pp. 15–16).

The strength of the different standards of proof can also be quantified as the *minimum* probability that an accepted claim under that standard is *actually* causally related to the veteran’s service.

- For the balance of probabilities, the minimum standard is generally accepted to be near, but less than, a 50 per cent probability that the successful claim’s condition is actually related to service (Pearce and Holman 1997, pp. 95–96; Sutherland, sub. 108, p. 4).
- The strength of the reasonable hypothesis standard is generally quantified as at least a 5 to 10 per cent probability that the successful claim’s condition is actually related to service (Pearce and Holman 1997, pp. 95–96), or around a ‘20 to 1 shot’ (Donald 2008).

SoP reviews

Eligible individuals who want to dispute the contents of a SoP can request a review of the SoP by the RMA. When conducting these reviews, ‘the RMA takes as its starting point the information that was available to it at the most recent review, and focusses on new material’ using the same process as above (RMA 2018d, p. 7). Under the VEA, the RMA is not required to undertake a requested review if there has already been a review in the past 12 months (s. 196C) or the request is ‘vexatious or frivolous’ or does not identify grounds for a review (s. 196CA).

When requests for a review only relate to a particular part of a SoP, the RMA can also conduct a ‘focused investigation’ that only reviews the relevant part of the SoP. For example, in August 2018 the RMA concluded focused investigations into whether the SoPs for some mental health conditions — such as anxiety disorder and post-traumatic stress disorder (PTSD) — should include exposure to a ‘corpse’ (singular) as a causal stressor, rather than ‘corpses’ (plural). This specific wording issue was raised by participants to this inquiry — including Legal Aid NSW (sub. 109, p. 19) — and the RMA has now updated most of the relevant SoPs to refer to ‘corpse’ in the singular (RMA 2018c, 2018e).

The SoPs are also reviewed periodically by the RMA, regardless of whether anyone has requested a review. Under the *Legislation Act 2003*, legislative instruments like the SoPs have to be reviewed and reissued (‘sunset’) every ten years. The RMA regards this

requirement as ‘a maximum period within which to review medical-science to ensure that it is up-to-date’ (RMA 2018d, p. 7). On average, the RMA reviews each SoP every 7 to 8 years (SFADTRC 2017, p. 63).

Where an eligible individual is still dissatisfied with the results of the RMA’s review (or the RMA declines to carry out an investigation), they can then request that the SoP be reviewed by the SMRC. Reviews are conducted by three to five members of the SMRC, chosen on the basis of their expertise in the relevant condition (the Convener may or may not be part of this ‘Review Council’). When conducting its review, the Review Council is only able to consider ‘available’ information — sound medical-scientific evidence that was used by the RMA at the time of their decision. Individuals with ‘new’ information (information the RMA advises was not available to it) are generally directed to the RMA instead.⁷

The SMRC cannot make or amend SoPs itself. Instead, if the Review Council believes that the SoPs require amendment, it can either direct the RMA to make the amendment, or remit the matter back to the RMA for their reconsideration (SMRC 2018b). Recent SMRC reviews have taken an average of 16 months to conduct (from receipt of the application), while nearly 70 per cent of the 19 SMRC reviews since 2009 confirmed the RMA’s original decision (SMRC, pers. comm. 22 October 2018).

Recent reviews by the SMRC (during 2016-17) included:

- chronic multisymptom illness — ongoing since August 2014
- malignant neoplasm of the prostate — resulted in suggested changes in August 2016 that the RMA subsequently implemented, to remove some of the causal linkages with tobacco use
- lyme disease — commenced in June 2016 but did not proceed after February 2017, as it was found to be an invalid request (RMA 2017d).

Although the legislation underpinning the SoP system is able to be reviewed by the federal court system, the courts do not have jurisdiction to dispute the contents of an individual SoP. Instead, federal court appeals have only been upheld on the grounds of an error in the application of the law, such as misinterpretation of the standards of proof (Creyke and Sutherland 2016, p. 436).

Favourable outcomes for most veterans

The initial liability system results in favourable outcomes for most veterans. In 2017-18, DVA accepted:

- 61 per cent of over 14 000 liability determinations for VEA disability pensions

⁷ However, the SMRC can consider ‘new’ information if the RMA has refused to conduct an investigation and there seems to be SMSE not previously considered by the RMA that might justify a fresh investigation (SMRC 2018b).

- 68 per cent of the 1100 claims for a VEA war widow(er)'s pension
- 56 per cent of nearly 7000 conditions seeking liability under the DRCA
- 79 per cent of the 23 000 conditions assessed for liability under the MRCA (DVA 2018f, pp. 223–226).

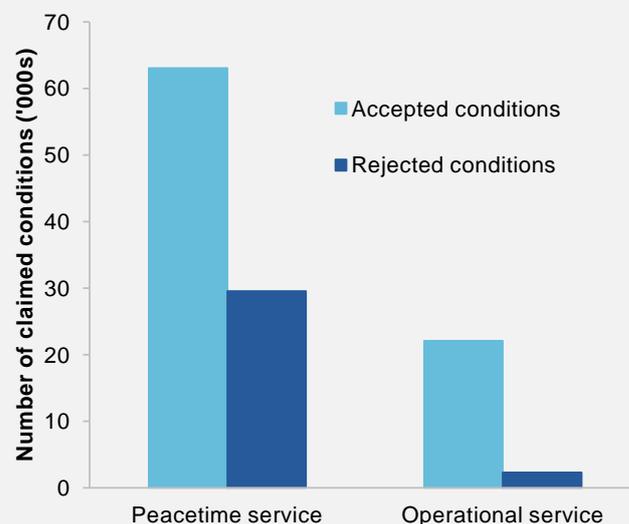
The Commission's own analysis of DVA client data for all conditions claimed under MRCA (from 1 July 2004 to 30 June 2017) suggests that around 91 per cent of MRCA clients have liability accepted for at least one condition, although acceptance rates vary considerably between different conditions and depending on what type of service it is related to (box 8.6).

Box 8.6 Rates of acceptance

From the commencement of the MRCA scheme on 1 July 2004 to 30 June 2017, nearly 29 200 individual claimants had lodged claims for liability for over 117 000 determined conditions.

Around 24 400 of these conditions (21 per cent) were reported as related to operational service, including service in Afghanistan, Iraq, East Timor and various peacekeeping missions. Over 89 200 other conditions (76 per cent) were related to peacetime service, while another 3400 conditions (3 per cent) were reported as relating to both peacetime and operational service.

For any single condition, the probability of liability being accepted under the MRCA was around 73 per cent. For conditions related to operational service only, the acceptance rate jumped to over 90 per cent. For conditions related to peacetime service (including those related to both peacetime and other types of service), the acceptance rate declined to around 68 per cent.



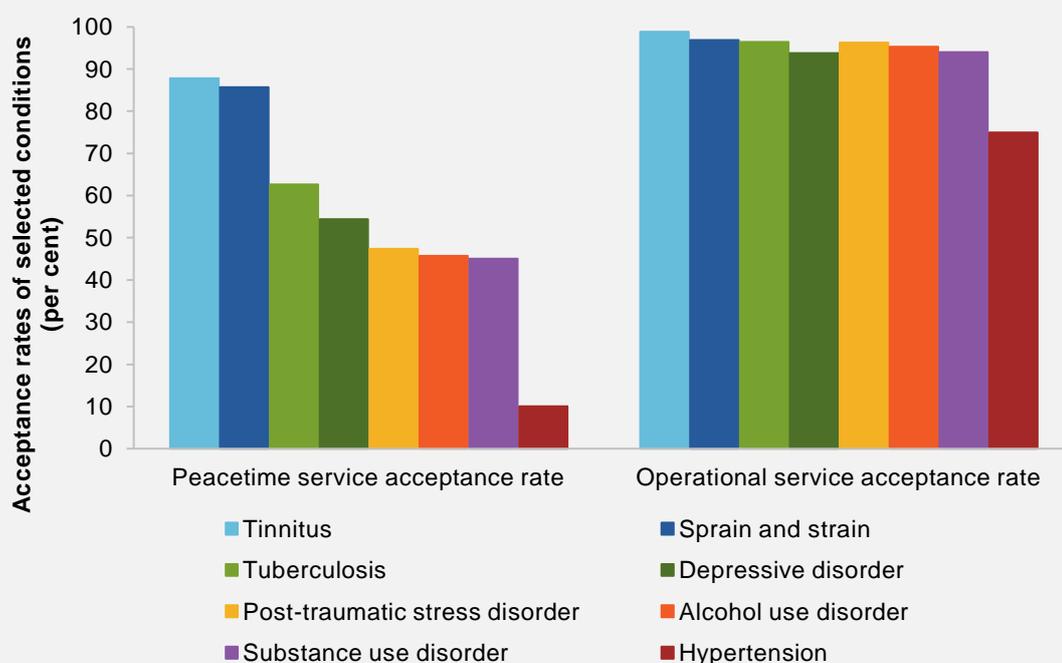
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Box 8.6 (continued)

Of the 29 200 claimants, around 26 500 (91 per cent) had liability for at least one condition accepted. The remaining 2700 (9 per cent) had all of their claims rejected.

Acceptance rates varied considerably across conditions (as categorised by the relevant SoP).^a

- Common conditions (with more than 200 claims) had acceptance rates which varied from less than 21 per cent (sleep apnoea and hypertension), through to over 91 per cent (shin splints, tinnitus and non-melanotic skin cancer).
- Some claimed conditions were significantly more likely to be accepted if related to operational service than peacetime service (including hypertension, gastro-oesophageal reflux disease, alcohol and substance use disorders, post-traumatic stress disorder and panic disorder).
- Some conditions that were not frequently the subject of a claim had very low acceptance rates. For instance, of the 12 claims for asbestosis (lung disease from exposure to asbestos) that have been made under the MRCA, none have ever been accepted. Similarly, none of the 48 claims for presbyopia (a degenerative eye disease) have ever been accepted.



^a Limitations in the client data mean that the most common claimed condition (at 17 per cent) was 'non-SoP'.

Source: Productivity Commission estimates based on unpublished DVA data.

8.2 Some concerns about the SoPs and standards

Many participants to this inquiry supported the SoPs (box 8.7). DVA, commenting on the SoPs, said:

... SoPs are robust and ... their use supports more transparent and consistent decision making. Further, the design of the system of SoPs was carefully considered to require the development or

amendment of each SoP to be based on an extensive review of international medical literature, rather than allowing consideration of a medical condition to rely on the views of particular medical practitioners, as had previously been the case. (sub. 125, p. 104)

The SoPs provide a transparent and predictable framework for considering service factors related to a given condition. They have reduced doctor shopping, and facilitated faster, more consistent and more predictable claims processing for the overwhelming majority of claims. This sentiment is summarised by the Returned and Services League (RSL) Queensland:

There is no doubt that the Statements of Principle (SoPs) have helped to create a more equitable, efficient and consistent system. Prior to the introduction of the SoPs, a successful liability decision was achieved in a case-by-case, ‘my medical specialist trumps your medical specialist’ approach. The process was expensive, time consuming, inconsistent and highly litigious. (sub. 73, p. 23)

Box 8.7 Support from many participants for the use of the SoPs

In support of the continued use of the SoPs, the Vietnam Veterans Association of Australia said that it:

... considers that many advantages have flowed from the use of the Statements of Principles and supports their continued use. We do not support the view that the SOPs are insufficiently flexible. (sub. 78, p. 7)

The Alliance of Defence Service Organisations noted that:

Anecdotally, the introduction of SoP did bring — and, logically, would have to have brought — consistency to determinations:

- In the absence of SoP, Delegates had no legislated connection between service and condition.
- Again, logically, if Delegates have a legislated instrument to refer to, their determinations would have to have become more efficient and equitable. (sub. 85, p. 36)

And the Air Force Association said:

There is general support for the Statement of Principles (SoP) as a very useful tool in the claims processes under Veterans’ Entitlement Act and Military Rehabilitation and Compensation Act. However, their usefulness would be improved if their existence is better promulgated and readily available. Moreover, the consensus is that they have helped create a more equitable, efficient and consistent system of support for veterans. (sub. 93, p. 4)

Warren Harrex agreed, although noted some difficulties applying the SoPs to military service:

The RMA Statements of Principles have been a welcome addition to the compensation determination, providing an independent authoritative body of scientific evidence of the factors leading to illness and injury. The major difficulty is applying these factors to [Australian Defence Force] military service. In many cases, the appropriate assessment of a claim requires a detailed knowledge of military service. (sub. 89, p. 4)

The Defence Force Welfare Association (DFWA) ACT branch contended that the SoPs ‘provide the necessary certainty in the determination of claims, compared with the pre-SoP experiences’, and recommended that ‘[SoPs] be introduced into DRCA’ (sub. 13, pp. 1–2).

In a vote of confidence for the SoP system, Veterans' Affairs New Zealand has also adopted the RMA's SoPs for determinations of liability under their veteran support system.⁸ Indeed, a recent review of New Zealand's veteran support system noted that, because the RMA's process 'relies on extensive research into medical-scientific evidence and epidemiological expertise' it is difficult for the New Zealand Veterans' Health Advisory Panel (which is tasked with reviewing and advising on the adoption of the RMA's SoPs) 'to add any appreciable value to the Authority's findings' (Paterson 2018, p. 94).

Some stakeholders, however, raised concerns about the SoPs and the standards of proof (both in this inquiry and in past reviews and other forums). DVA is cognisant of this, noting that:

... perhaps because their use is non-discretionary, SoPs are perceived by some in the veteran community to be too rigid and inflexible. This largely reflects the intended operation of this system, in that the development or amendment of each SoP is based on an extensive review of world-wide expert medical literature. (sub. 125, p. x)

'Decision-ready' conditions and the prescriptive nature of SoPs

One complaint about the SoPs is that the evidentiary burdens to prove select factors of service are too onerous, making it difficult for veterans to map the details of their individual service record to a specific factor of service, even where they know they have met that factor. The Royal Australian Armoured Corps Corporation (RAACC), for instance, said that:

... the difficulty in quantifying the effect of service on a claimed disability was enormous, forcing veterans to quantify by level of exposure to sunlight or noise, pack years, alcohol consumption and weights for example, over a (lengthy) given period of time ... (sub. 29, p. 15)

DVA has introduced 'streamlined' and 'straight-through' processing (box 8.8) to simplify the administration of liability claims and reduce the time it takes to process claims. Effectively, the rollout of these 'decision-ready' conditions allows DVA to short-circuit most of the administrative complexity of the SoPs, while still meeting the legal requirement to establish a link between the claimant's condition and their service. Combined with the rollout of the MyService portal (chapter 9), veterans can have a claim accepted within minutes, rather than days or weeks.

Working with Defence and RMA, DVA intends to continue to expand the number of decision-ready conditions. DVA notes that 'basing "decision-ready" conditions on certain occupational-defined exposures would make claims simpler where there is an automatic link between certain military occupations and impairments' (sub. 125, p. 104).

⁸ The reasonable hypothesis SoPs are used for any conditions due to qualifying operational service (covering New Zealand's deployments since the First World War), while the balance of probabilities SoPs are used for qualifying routine service (all other service in the New Zealand Armed Forces prior to 1 April 1974).

Box 8.8 Streamlined and straight-through processing

Streamlined processing involves DVA identifying commonly-claimed conditions with very high acceptance rates, reflecting the fact that most veterans can meet the requirements of at least one of the SoP factors because of the inherent nature of military service. There is only a low risk that claims for these conditions are not actually related to service, so the investigation of liability claims can be streamlined. This generally involves acceptance of liability (once the condition has been established) if the veteran's service records point to at least one relevant SoP factor and there is no countervailing evidence suggested by the material in the case.

Streamlined processing initially began with five commonly claimed medical conditions identified by DVA in 2007 (sensorineural hearing loss, tinnitus, non-melanotic malignant neoplasm of the skin, solar keratosis and acquired cataracts). Since then, another 27 conditions have been added to DVA's list of conditions for streamlined processing.

Straight-through processing — DVA and Defence have worked together to establish when the conditions of Australian Defence Force (ADF) training and service mean that a veteran has already met a specific SoP factor. This means that an eligible member's profile and details of service can be used as evidence of meeting specific SoP factors for their condition without needing further investigation (including avoiding the need for the claimant to complete onerous physical or service exposure questionnaires).

Generally, straight-through processing focuses on SoP factors that have quantifiable exposure elements (such as lifting or load-bearing factors). For example, the balance of probabilities SoP for lumbar spondylosis (a degenerative disorder of the spinal vertebrae) includes as a factor 'lifting loads of at least 20 kilograms while bearing weight through the lumbar spine to a cumulative total of at least 150 000 kilograms' in a ten year period prior to clinical onset (RMA 2014c).

Before straight-through processing, claimants with lumbar spondylosis had to fill out questionnaires detailing all the individual instances when they lifted loads of at least 20 kilograms. Because veterans could be putting in claims for liability decades after the instances occurred, this requirement created significant difficulties for many claimants. Straight-through processing allows DVA to accept that service in a given employment category or arm of service (as an Army Officer with 12 months service, for example) resulted in the relevant service factor (150 000 kilograms lifted) being automatically met.

Sources: DVA (2018z, s. 3.4.5; pers. comm. 20-26 June 2018).

Plain English SoPs

Another criticism of the SoPs is around how they are written. The RAACC, for example, said the 'language is bewildering to say the least, and creates a formidable obstacle to the ordinary veteran reader in trying to make sense of what the document is all about'. The RAACC suggested the SoPs be rewritten in plain English (sub. 29, p. 16). The *Review of the RMA and SMRC* (Pearce and Holman 1997) also noted that there is 'no doubt that the SoPs contain terminology that is obscure to persons who are not medically trained and in some cases even to those who are' (p. 47).

As a legislative instrument that outlines the latest medical-scientific evidence on the causal factors of particular conditions, the SoPs are, by their nature, complex. They include highly

technical medical terminology, and are written as an enforceable legal instrument, thus using a lot of ‘legalese’ in their drafting. Rather than rewriting the SoPs, there could be improved guidance for claimants on what the SoPs mean and how they are operationalised, such as through the MyService platform (chapter 9).

Flexibility in the application of SoP factors

Another concern of participants is that the SoP factors are applied by DVA claims assessors without any discretion or flexibility to account for the circumstances of an individual case (Kenneth Park, sub. 2; Slater + Gordon, sub. 68; Legal Aid NSW, sub. 109). As at least one factor within a SoP must be met before liability can be accepted under the VEA and MRCA, evidence of a causal link outside of the strict bounds of the SoPs will not be sufficient to have a claim accepted.

The strictness of the SoP regime can result in claimants feeling that their legitimate claim has been declined without due consideration, leaving them aggrieved by the process. As examples, several participants to this inquiry submitted complaints about specific SoPs that do not cover certain factors or have overly restrictive latency periods. For instance, Maurice Blackburn (sub. 82, p. 27) recommended that the ‘time periods for stressors set out in SoPs concerning psychiatric injuries be removed’. Similarly, Peter Nelms (sub. 6) contended that the asthma-related SoPs were unreasonably restrictive, requiring diagnosis within 24 hours of exposure to an asthmatic agent, while William Gore (sub. 97) argued that exposure to trichloroethylene should be a causal factor for Parkinson’s Disease.

In comparison to the veteran support system, civilian workers’ compensation schemes do not have an equivalent to the SoPs, meaning that individuals must put forward their claim for liability for consideration on its individual merits (on the civil standard, the ‘balance of probabilities’), first by the claims assessor and then, on appeal, the courts. This is also the system used for a veteran’s claim under the DRCA (although claimants and assessors can use the SoPs as guidelines).

As a result, claimants reliant on factors not included in the SoPs or on exposure levels or latency periods beyond the limits specified in those SoPs may find their application rejected under the MRCA or VEA, whereas claims assessors are freer to take a more expansive view of causality under the DRCA. This can result in a compensation system that appears to be *less* beneficial to veterans and their families than what is available in civilian workers compensation schemes. As the RAACC stated in their submission, ‘the strictness and inflexibility of the application of the Risk Factor component operated to neutralise the beneficial intent of the VEA and later the MRCA’ (sub. 29, p. 15).

However, concerns about the strictness of the SoP regime seem to misunderstand the nature of the RMA’s role and how evidence of a causal link between service and the condition should be considered. While the SoP regime deliberately limits acceptable claims to those where the totality of sound medical-scientific evidence suggests a causal link (at one of two different standards of proof) between the factor and the condition, there is a potential for

assessors under the DRCA to take a view of causality that is not necessarily consistent with the prevailing medical-scientific evidence. As the Baume Review explained:

Determining authorities sometimes appear to have a poor understanding of the scientific place of epidemiology in determining causality. It seems that decision makers at any level can be satisfied on matters relevant to a causal link, even when a medical specialist advances a view based on a single small study. In such a case the decision maker raises a possible risk factor to the status of an aetiological cause of a condition. Sometimes there appears to be a blurring of the distinction between a mere association, a risk factor and a causal factor ... Tribunals and Courts must decide the question of causation for themselves on a basis far less stringent than scientific proof demands. (Baume, Bomball and Layton 1994, p. 42)

The distinctions between sufficient evidence for a merits process and for a medical-scientific process were noted by the Government at the time the SoP system was introduced:

In this regard it has become apparent that lay tribunals do not deal with medical-scientific issues consistently and, while nominally inquisitorial, appear to adopt an approach that is inappropriate for determining medical-scientific issues that call for detailed technical knowledge. (Beazley 1994)

Further, those claimants who believe they *do* have legitimate grounds for consideration outside a current SoP on the basis of sound medical-scientific evidence can provide their supporting evidence to the RMA and request a SoP review. Although the transparency of the RMA's investigations could be improved (section 8.3), if the evidence supplied by the claimant genuinely supports a new or different causal link, the RMA is obliged by the legislation to change the SoP.

At the end of the day, a line will always have to be drawn between liability claims that are accepted and rejected. Regardless of where that line is drawn, it will inevitably mean there are some aggrieved claimants who feel that their legitimate case has been declined. As RSL Queensland noted, there will 'always be cases which do not meet SoP criteria and concerns will legitimately be raised, however in most cases the system appears both fair and cost-effective' (sub. 73, p. 23).

The dual standards of proof

The application of the SoPs in the veteran support system is made more complicated by the fact that there are two SoPs for each condition — one at each standard of proof. These dual standards of proof are a source of additional complexity in the system, which is not replicated in any other similar workers' compensation system. Much of the complexity of the dual standards of proof stems from working out when each standard applies for an individual claimant with multiple types of service or dual eligibility across several Acts.

Aside from introducing complexity into the veteran support system, a lower standard of proof for veterans with operational service also creates strong incentives for historical

operations and other military actions to be retrospectively upgraded.⁹ In particular, upgrading an operation from peacetime service to non-warlike service enables affected personnel to access the lower causal standard of proof for some of their conditions, if those conditions can be linked to that service.

As the Clarke Review noted, similar incentives to retrospectively upgrade military actions are created by the provision of the Gold Card and other additional benefits to those with warlike service (as qualifying service):

Over many years, there have been calls by particular groups of service personnel ... who have argued that their service or employment should be recognised as eligible war or defence service and/or qualifying service under the VEA. Some of these groups are not currently covered by the VEA, while some already have VEA entitlements but not qualifying service, and so are seeking the extension of qualifying service to enable access to the service pension and Gold Card. (Clarke, Riding and Rosalky 2003, pp. 233–234)

During the course of this inquiry, we heard a range of views from participants both in favour of and against maintaining the different standards of proof between operational and peacetime service (box 8.9).

As discussed in chapter 4, the Commission is of the view that the existing divides between operational and peacetime service are not justified. This is on the basis that ‘an injury is an injury’, regardless of where it occurred. Personnel in peacetime service can be subject to very high intensity and ‘high-fidelity’ training, particularly when preparing for deployment (a ‘train hard to fight easy’ approach). It is also linked to the ongoing professionalisation of the Australian Defence Force (ADF) as a career, not a calling (in war) or a requirement (under national service), with deployments now an anticipated and sought-after objective of modern service.

Moreover, there is nothing about operational service that justifies a lower strength of epidemiological medical evidence before a condition can be said to be related to a causal factor of service. Personnel who go on operational service are unlikely to be biologically or demographically different to those who do not. While personnel on operational service can be exposed to more (or less controlled) risks than individuals on peacetime service, this would affect the frequency and severity of any resulting conditions, not the underlying issue of whether they were caused by their service.

Historically, a single standard of proof also applied for all operational and non-operational service from the genesis of the *Repatriation Act 1920* until the legislative amendments in 1977 (Baume, Bomball and Layton 1994, p. 26).

⁹ For example, on 26 March 2006, service on Operation Tamar as part of the United Nations Assistance Mission for Rwanda between July 1994 to January 1996 was reclassified from ‘hazardous’ service to ‘warlike’ service under the VEA. Similarly, the service of RAAF crew during the Berlin Airlift in 1948 and 1949 was reclassified as ‘non-warlike’ service on 6 July 2004, following a recommendation of the Clarke Review (Clarke, Riding and Rosalky 2003; DVA 2014e).

Some stakeholders may point to the difficulty of keeping and maintaining accurate service records during operational service as a justification for two standards of proof. However, this point is more relevant to the evidentiary standards used in the VEA and MRCA (which are already ‘beneficial’, as discussed in box 8.2), rather than the standards of underlying medical-scientific proof used in the SoPs.

As such, we believe that a single test of causality (which test is considered in section 8.3) should apply to all claims. The current dual standards create unnecessary complexity and have a weak rationale. Dual standards should not form part of a reformed system that is designed to remove complexity (where possible) and introduce greater equity between categories of veterans going forward.

Box 8.9 Divided views on applying different standards of proof

Some were not in favour of different standards between types of service

Royal Australian Armoured Corps Corporation:

The nature of military service is in many ways, regardless of the Government’s beneficial intention towards veterans who render operational service overseas, demands that equity of treatment of veterans *per se*, must be paramount ... The dichotomy that presents with the [reasonable hypothesis] test and the [balance of probabilities] (civil) standard of proof has operated to create an evidentiary imbalance in the equitable application of the SoPs. As such, it is contended that consideration should be given to establishing a standard of proof or test that could apply to both operational service and eligible Defence service. (sub. 29, p. 19)

Vietnam Veterans Federation of Australia:

... the different standards of proof applying to SOPs should be abolished. The ADF trains for operational deployment in ways as close as possible to operational situations. Distinguishing between, say, the Black Hawk helicopter incident in Queensland and a similar incident in an operational deployment lacks an appreciation of the intensity of ADF training. Operational SOPs should be used. (sub. 34, pp. 24–25)

Slater + Gordon:

... this arbitrary discrepancy should be abolished; there can be no good basis to discriminate against Veterans and serving members who did not render operational service. (sub. 68, p. 33)

But others were in favour

Hilton Lenard and Keith Russell ‘believe that the distinction between Qualifying Service and Peacetime Service in ... the SoPs is fair and appropriate recognition of the levels of service provided by veterans within the ADF’ (sub. 13, p. 2).

The Alliance of Defence Service Organisations (ADSO) said:

From one perspective: the more beneficial standard of proof for operational service reflected long-standing societal values and legislative practice ... From another: deployed personnel whose service did not put them in immediate danger should be subject to the same standard of proof as another who did not deploy but was prepared to do so ... ADSO notes that some advocates and veterans see inequity in different types of service attracting different standards of proof. We understand that some see this as contrary to the notion of a ‘fair go’ in an egalitarian society, while others argue that they were prepared to deploy but were not for reasons out of their control, and should not therefore be disadvantaged. While we understand such views, on balance, we do not support them. (sub. 85, pp. 37-38)

The timeliness of RMA reviews and investigations

Some inquiry participants criticised the time taken by the RMA to create and update SoPs to reflect newly discovered medical science and for not making its determinations in a timely and efficient manner. Slater + Gordon, for example, observed that the ‘fundamental issue with SoPs is that they are premised on constantly evolving medical science, yet, despite endeavours by the RMA, they are not updated soon enough to reflect these changes’ (sub. 68, p. 37).

The data suggests that the RMA does take a considerable amount of time in its deliberations. In 2017-18, the average time the RMA took to complete a full investigation or review of a SoP was 451 days — this was longer than the average of 401 days in 2016-17, but was down from an average of 815 days in 2015-16 and 1036 days in 2014-15.¹⁰ The reduced time to investigate in recent years was possibly a result of a decreased workload, with 93 total SoP determinations for 2017-18, up from 77 in 2016-17, but still down from 129 in 2014-15 (RMA 2017d, pp. 15–16, 2018f, pp. 15–16). It is also an average of 7 to 8 years before the RMA reviews and updates a SoP, further adding to the length of time before emerging medical-scientific evidence can be included.

Delays in updating or investigating a SoP create costs for DVA claimants. Slater + Gordon said that the delay to create or amend SoPs ‘is causing significant distress to claimants’ (sub. 68, p. 30), while SoPs that are out of date or out of line with medical advancements have ‘an unfair impact on veterans, for whom evidence would be sufficient if the SoPs were up-to-date’ (p. 34). Also, delays in updating a SoP to include new medical evidence can result in the final resolution of a legitimate claim being prolonged, generating unnecessary or even harmful obstructions for veterans seeking treatment, rehabilitation or compensation.

However, the counterfactual possibility to explain the RMA’s long time periods for investigating and updating a SoP is that the hypothesised link between the condition and military service does not exist (Grade 5a or 5b evidence), despite claims to the contrary. In this case, the RMA’s slow and careful consideration of the evidence serves to filter out spurious or nonexistent links between conditions and service, so should not be discouraged.

Sound medical-scientific evidence

A more fundamental problem with the RMA’s role is the nature of their task.

In theory, the requirement (under s.5AB(2)(a) of the VEA) for the RMA to consider both peer-reviewed literature and clinical judgment (section 8.1) means that the standard of proof could be similar to the system that was in place prior to the introduction of the SoPs.

¹⁰ Figures exclude focused reviews — if included, the average time to complete an investigation was 414 days, 365 days, 642 days and 939 days for 2017-18, 2016-17, 2015-16 and 2014-15, respectively (RMA 2017d, p. 16, 2018f, p. 16).

Conceivably, the testimony of only a few specialists may be sufficient to provide ‘sound medical-scientific evidence’ of a reasonable hypothesis under the clinical judgment clause.

In practice, however, the RMA seldom relies on the clinical judgment clause in isolation, using it only when there is no sufficient epidemiological evidence in the literature (Donald 2008). Although this reliance on peer-reviewed literature is reasonable, participants to this inquiry identified two broad areas of concern:

- where the medical-scientific evidence is new or only just emerging, such that there has not yet been extensive peer-reviewed research
- where the veteran population diverges from the civilian population, such that a reliance on civilian peer-reviewed literature can lead to different outcomes.

The treatment of emerging medical-scientific evidence

The RMA is bound by legislation to only incorporate existing evidence into the SoPs. For novel diseases or causal links, there may be no, or only poor quality, peer-reviewed medical evidence. As William Gore questioned, ‘the RMA requires the rigour of scientific evidence before it can promulgate a factor, however, if the science is not available, what then?’ (sub. 97, p. 1).

Without adequate sound medical-scientific evidence, the RMA will not include a hypothesised link between the condition and the service in the relevant SoP. The RMA treats strong evidence that there is no causal link (Grade 5b) the same as an *absence* of solid evidence that there is a causal link (Grade 5a), both of which are insufficient for including a factor in the relevant SoP under either standard of proof (section 8.1).

One reason for equating inadequate evidence of any link with strong evidence of no link is that the lack of sufficient evidence (whether peer-reviewed scientific literature or even indicative case reports) is a result of the causal link being spurious or unsound — there may not be a lot of peer-reviewed research into the direct causal relationship between head trauma and developing frostbite, for example, because such a relationship is highly unlikely to exist. As such, a lack of high-quality studies can be indicative of no causal relationship existing.

However, an alternative is that the hypothesised link between the service and the condition *is* legitimate, but as yet, is simply unsupported by any research — after all, an absence of evidence is not the same as evidence of an absence.

Do the SoPs encapsulate unique veteran issues?

Another argument made is that the RMA does not consider unique veteran issues when setting the SoP factors. While the RMA seeks out emerging peer-reviewed research on medical causality from Australia and around the world, almost all of this research is based on civilian populations, rather than populations of veterans, due to the relative scarcity of studies based on the latter (Donald 2008; RMA 2017a). Participants argued that without

consideration of unique veteran issues in the underlying evidence, the SoP factors may be inappropriate to apply to veterans in some cases. This line of argument was noted and discussed in the 1997 *Review of the RMA and SMRC*:

The view is strongly put by the ESOs [ex-service organisations] that basing SoPs on information obtained about the incidence and causes of disease in the civilian population does not reflect the special conditions of services ... the RMA is generally obliged to base the SoPs on information that has been acquired by studies of civilians because there is insufficient service based information available. (Pearce and Holman 1997, p. 46)

Stakeholders pointed to three areas where veteran issues are unique:

- The effects of military culture on issues of diagnosis and clinical onset — as noted by Pearce and Holman (1997, p. 53), military culture ‘does not concede that injury or illness has been suffered’, while ‘practical concerns ... led to service personnel hiding injuries’.¹¹ However, these effects of military culture are generally an issue with the standard of evidence used to support a case, not with the SoPs or the RMA’s processes. In particular, not reporting an injury or illness does not mean that the injury or illness did not occur, only that there is no record of it, so it is harder to present relevant evidence to support the claim. The ‘beneficial’ (but not indulgent) evidentiary standards used to assess claims are discussed in section 8.1.
- Differences between the levels and types of exposures that civilian populations and service personnel are subject to — for instance, the nature of military service can involve exposure to a range of situations and substances unlikely to occur (or occur at such levels) in the civilian world. Examples include brain injuries from shoulder-fired weapons (Simkins 2018) or high exposure levels to toxic chemicals such as polychlorinated biphenyl (William Brown, sub. 110). As these exposures (or exposure levels) do not generally occur in the civilian population, the sparse research into veteran issues may inhibit discovery of a causal link for many years or decades (if ever).
- Different profiles of veteran and civilian populations — varying levels of fitness or susceptibility to mental health problems between civilians and veterans could result in different medical outcomes that are not exhibited in medical-scientific evidence based on civilian studies. It is worth noting, however, that the RMA’s limited consideration of unique veteran evidence works both ways — if the RMA did consider service-related differences for SoP factors, this could actually reduce or restrict the available SoP factors in some areas. For example, Pearce and Holman (1997, p. 46) observed that not considering veteran-specific evidence ‘does not necessarily disadvantage veterans as service personnel are required to reach a level of fitness that is much superior to that of the civilian population’.
 - Similarly, the SoPs generally do not take into account other demographic differences on causality, such as the effects of ageing and gender. Instead, ‘the RMA determines

¹¹ Similar issues were raised by participants to this inquiry, such as Peter Nelms (sub. 6, p. 1), who contended that his claim ‘was rejected because [the SoP] states that you must be diagnosed as having asthma within 24 hours of being exposed to the agent’, but that ‘this stipulation is based on a culture of “running to the doctor every time something happens” and is contrary to the culture within the Services’.

doses that are the lowest possible while being consistent with the evidence. This means that SoP factors make allowance for populations that may be more vulnerable, including females’ (RMA 2017c, p. 4).

8.3 Options for reform

Several options for reforming the initial liability arrangements were put forward by stakeholders. The merits of some of the most prominent ideas are discussed below.

Introducing flexibility to the SoPs

A number of participants said that the SoPs should be applied more flexibly — that is, claimants should be able to present evidence of a hypothesis that is outside of the strict bounds of the relevant SoP factors. This includes hypothesising new causal factors that are not included in the SoP, as well as allowing more flexibility on the exposure levels or latency time periods between exposure and onset that are currently within the SoPs. Some said that the SoPs should only be a ‘guide’ for assessors, rather than a strict checklist (Kenneth Park, sub. 2; Slater + Gordon, sub. 68; Maurice Blackburn, sub. 82; Legacy Australia, sub. 100; Legal Aid NSW, sub. 109; DFWA, sub. 118).

The Senate inquiry into suicide by veterans (*The Constant Battle*) also suggested that ‘a better system’ might involve DVA delegates being ‘primarily guided by the SoPs prepared by the RMA’, but they ‘should not be completely bound by the SoPs’ and ‘should have within their discretion the capacity to determine claims provided there is a reasonable link to a person’s service’ (SFADTRC 2017, p. 69). Similarly, the Joint Standing Committee on Foreign Affairs, Defence and Trade recommended in its report on *Care of ADF Personnel Wounded and Injured on Operations* in 2013 that DVA should:

Review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted. (2013, p. 147)

Turning the SoPs into ‘guidelines’ is not without considerable risks. As in most other areas of administrative law, the initial liability system needs to balance flexibility with consistency. While too little flexibility for individual decision-makers can mean an overly prescriptive system that does not take into account individual circumstances, too much discretion (or flexibility) can lead to inconsistent and unpredictable outcomes that defeat the purpose of determining liability in the first place.

Changing the SoPs into guidelines at *the reasonable hypothesis standard* would undermine the original rationale for the SoPs, by allowing any ‘reasonable’ theory of a causal link between conditions and service to be put forward, without being substantiated by medical evidence. This would revert the claims determination system back to the pre-1994 system where the opinion of any qualified medical professional ‘eminent’ in a given field is enough

to create a reasonable hypothesis. Veterans in this system had strong incentives to engage in ‘doctor shopping’, while the claims system became bogged down as DVA had to investigate all these new hypotheses.

The introduction of flexibility in the application of the SoPs is more feasible at *the balance of probabilities standard*, as this is the basis that most other aspects of administrative law function on and there are reduced incentives to engage in doctor shopping, as the evidence of a single eminent medical specialist is generally not sufficient for a claim to succeed.

Introducing flexibility to the interpretation of the SoPs would be very similar to the current DRCA system, where the SoPs are effectively already treated as guidelines on the balance of probabilities. As in most civilian workers’ compensation schemes, claimants under DRCA can put forward their hypothesis of a link between their condition and their service, which is then judged on its individual merits. The balance of probabilities SoPs can be used in DRCA as guides to assist DVA decision-makers in expediting their determination, but evidence does not need to conform to the SoP in order to be accepted.

This treatment of the SoPs under DRCA was used by some participants as a rationale for introducing flexibility at the balance of probabilities in the application of the SoPs to MRCA and VEA claims. RSL National (sub. 113, pp. 11–12) said that the DRCA method ‘is much more open and flexible’ as it ‘allows conditions to be accepted that may not meet a factor within the [SoPs] in some circumstances if the evidence is strong’ unlike the treatment of such evidence under the VEA and MRCA. Similarly, Slater + Gordon argued that ‘a Commonwealth public servant covered by the SRCA [now DRCA for military personnel] can more easily prove liability for the same condition using the more lenient tests under the SRCA’ (sub. 68, p. 40).

However, there are risks that extending the DRCA treatment to VEA and MRCA claims could still encourage additional doctor shopping. In turn, this may result in claimants with more resources (to engage in doctor shopping) or better representation (to direct them to amenable doctors) getting a more beneficial outcome than veterans without similar advantages. As RSL Queensland noted, the system prior to 1994 ‘was very beneficial for solicitors and certainly kept the [Administrative Appeals Tribunal] busy, however veterans were the losers’ (sub. 73, p. 23). Making the SoPs binding on all claims encourages a level playing field among veterans, particularly by creating consistent and predictable decisions.

The SoP system also works well for the vast majority of cases, creating decisions based on an expert analysis of the latest sound medical-scientific evidence. Some individual cases will not succeed, but this is because there is a necessary line drawn between liable and non-liable claims, not because of any underlying issue with the system. The Commission is not convinced that there should be more flexibility in the SoP regime, as allowing it is likely to undermine the system.

Applying the SoPs to DRCA decisions

An alternative reform is to make the SoPs binding on DRCA claims, not just VEA and MRCA claims, as supported by RSL Queensland (sub. 73, p. 24). The advantages of applying the SoPs to DRCA are that it would:

- make initial liability decisions under the DRCA faster, by opening up opportunities to extend streamlined and straight-through processing to DRCA claims
- make DRCA decisions more consistent and predictable, as well as ensuring that they are in line with the latest sound medical-scientific evidence
- reduce complexity in the veteran support system, by allowing a single harmonised initial liability process across all three Acts.

Due to the different heads of liability under DRCA and VEA/MRCA though, the current SoPs can be inappropriate for some DRCA decisions. As a result, a prerequisite for making the SoPs binding on DRCA claims is to change the DRCA heads of liability, ensuring they are aligned across all three Acts. As DVA put it, ‘the liability construct under DRCA would also need to be altered’ as part of a broader harmonisation strategy between the Acts, because ‘there are no equivalent “heads of liability” as exist in sections 27-30 of the MRCA’ (sub. 125, p. 103).

Moving to a single standard of proof

Although we favour moving to a single standard of proof (discussed in section 8.2), the outstanding question is *which* standard of proof?

An obvious choice would be to choose one of the existing standards. But both choices have downsides.

- A move to the ‘balance of probabilities’ standard would only affect claims under the VEA and MRCA. The resulting system would be less generous to some veterans, decreasing their chances of success for a claim. This reduced generosity would reduce costs, as the decreased number of accepted conditions would inevitably lead to fewer payments.
 - Moving the standards of proof under all three Acts to a uniform balance of probabilities standard would also have the added benefit of aligning the veteran system with the civilian workers’ compensation system. This would significantly reduce complexity in the system, as the tried and tested rules in civilian systems could be applied to veteran support, removing the ongoing legal confusion caused by interpreting the ‘beneficial’ standard in practice.
- By contrast, a move to the ‘reasonable hypothesis’ standard would require changes to all three Acts (including DRCA) for uniformity in treatment regardless of service type. The inevitable outcome of such a move would be that many claims under these Acts by

members with peacetime service would be newly accepted, resulting in a significant increase in Australian Government expenditure as a consequence.

- Although the reasonable hypothesis standard is contrary to most other areas of administrative decision-making, it also serves as the manifestation of a ‘beneficial’ veteran support system. To the extent that this is desirable, there is nothing inherently problematic with moving to the reasonable hypothesis standard under the existing SoP system.

Calculating how the proportion of accepted claims would be affected by moving to either standard of proof is difficult. Any estimate is reliant on understanding the individual circumstances of each liability claim that is approved or denied and what the counterfactual result would have been under a different standard of proof. Current limitations in the data collected by DVA (discussed further in chapter 16) reduce the scope for such analysis, especially under the VEA. And simple comparisons of acceptance rates between the DRCA and the other Acts are not instructive, as there are different profiles of claims between Acts and over time.

Nevertheless, a comparison of acceptance rates under the MRCA for individuals with different types of service can be illustrative of the size of expected changes (box 8.10), although there may be hidden confounding factors that are influencing the acceptance rate between different types of service. For example, DVA delegates may take a more ‘beneficial’ interpretation of the provisions on standards of acceptable evidence for conditions related to operational service (due to the ‘absence of, or a deficiency in, relevant official records’, discussed in box 8.2).

Due to the issues with determining the number of affected claims, the financial impact from moving to either standard of proof is also difficult to calculate. The cost is reliant on the marginal change in the resulting compensation, treatment, income support and rehabilitation from the claims with changed liability.

As most clients have multiple claims (some accepted, some rejected), there may also be a minimal financial impact from more claims being accepted or rejected, as the client could already be accessing DVA benefits for other accepted conditions. For example, under the MRCA 80 per cent of clients who had liability for a claimed condition rejected had other conditions that were accepted. This rises to 88 per cent for those whose rejected condition related to operational service (Commission estimates based on unpublished DVA data).

Box 8.10 A ballpark estimate for MRCA claims

Assuming that claimed conditions related to operational service had access to the reasonable hypothesis standard while those related to peacetime service only had access to the balance of probabilities, a simple analysis of acceptance rates by service type can provide a ballpark estimate of the number of claims that would be affected by moving from one standard to another.

As discussed in box 8.6, conditions related to operational service had an acceptance rate of over 90 per cent under the MRCA. By comparison, conditions related to peacetime service (including those related to both peacetime and other types of service), had an acceptance rate of around 68 per cent. However the type and incidence of claimed conditions are not identical under each type of service. For example, while 21 per cent of *all* claimed conditions are related to operational service, over 70 per cent of claims for tuberculosis and PTSD are related to operational service, as well as around 60 per cent of claims for erectile dysfunction and alcohol and substance use disorders. As different conditions have vastly different acceptance rates, differences in the underlying condition incidence between operational and peacetime service can skew the results.

The Commission analysed two counterfactual scenarios based on replacing the acceptance rate for each of the 287 conditions claimed over the life of the MRCA with the condition-specific acceptance rate for each type of service:

1. **Move to the reasonable hypothesis** — if all claimed conditions related to peacetime service had the same acceptance rates as those related to operational service, then the acceptance rate across *all* claimed conditions would have been 87.5 per cent (14 percentage points higher), equivalent to an additional 17 000 accepted conditions between 2004 and 2017.
2. **Move to the balance of probabilities** — if each claimed condition related to operational service had the same acceptance rates as those related to peacetime service, then the acceptance rate across *all* claimed conditions would have been 67.5 per cent (5 percentage points lower), equivalent to an additional 6000 rejected conditions between 2004 and 2017.

Source: Productivity Commission estimates based on unpublished DVA data.

The compromise — a middle ground standard

An alternative is to find a ‘middle ground’ standard of proof.

The 1994 Baume Review suggested the use of a balance of probabilities standard but with a ‘benefit of doubt’ for veterans with operational service where the evidence is approximately evenly balanced. The rationale for this recommendation was ‘its ultimate fairness, its legal simplicity, and the ease of its application for decision makers at all levels’, and that it ‘more closely resembles the way in which veterans have been treated over the lifetime of the legislation’ (Baume, Bomball and Layton 1994, p. 28).

Baume’s proposed standard was similar to the standard of proof that existed prior to legislative amendments in 1977. Between 1929 and 1977, the underlying civil standard of proof in veteran entitlements was successively modified to include provisions allowing veterans the ‘benefit of *the* doubt’, the ‘benefit of *any reasonable* doubt’ and then the ‘benefit of *any* doubt’. According to Baume, none of these tests were ‘criticised as being ungenerous’ at the time (Baume, Bomball and Layton 1994, pp. 15–16, 25).

While a ‘benefit of the doubt’ provision on top of a balance of probabilities standard could be achievable, it is not clear how this would be different to the existing system. As noted in section 8.1, the minimum acceptable strength of the existing balance of probabilities standard (under the RMA’s SoPs) is already estimated to be less than 50 per cent (‘far less’, according to Peter Sutherland, sub. 108, p. 4). As a strict balance of probabilities standard would have a minimal acceptable strength of close to 50 per cent (by definition), the existing standard may already include some informal notion of a ‘benefit of the doubt’.

Although the reasonable hypothesis only exists because the failed attempt to introduce a variation of a ‘benefit of the doubt’ provision in 1977 generated unintended legal consequences, introducing similar new provisions in the current legislation need not be as difficult. As the RMA’s operationalisation of the standards of proof through the SoPs relies on specific (numerical) risk factors, the legislation could simply specify a new risk factor between the existing standards. Legislating a specific number to represent the minimum probability for a factor being causally related to a condition could reduce the ambiguity created by poorly worded legislation, open to different interpretations.

However, moving to a new compromise standard of proof between the two existing standards would also require the creation of a whole new set of SoPs at that standard, creating significant transitional costs for the RMA, particularly through disruption to current practices and time to implement.

DRAFT RECOMMENDATION 8.1

The Australian Government should harmonise the initial liability process across the three veteran support Acts. The amendments should include:

- making the heads of liability and the broader liability provisions identical under the *Veterans’ Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- applying the Statements of Principles to all DRCA claims and making them binding, as under the MRCA and VEA
- adopting a single standard of proof for determining causality between a veteran’s condition and their service under the VEA, DRCA and MRCA.

INFORMATION REQUEST 8.1

The Statements of Principles are created on two different standards of proof for the underlying medical-scientific evidence — a ‘reasonable hypothesis standard’ and a ‘balance of probabilities’ standard.

The Commission is seeking participants’ views on which standard of proof the veteran support system should use going forward. What would be the impacts of that choice on future claims and government expenditure, and how could they be quantified?

RMA reform

As the gatekeeper of the SoP system, the performance of the RMA is of vital importance to the entire system. One avenue for reforming the SoP system is to make changes to the role, functions and resources of the RMA, to reduce the frequency or severity of many of the issues identified in section 8.2.

Reducing the time taken to conduct investigations

Reducing the length of time it takes for the RMA to conduct reviews and investigations into SoPs would help to improve outcomes for many veterans dependent on those SoPs for their initial liability claim to be finalised. As DVA said:

There are opportunities to improve the use of SoPs ... [by] improving the speed and responsiveness by which SoPs incorporate emerging science. (sub. 125, p. 104)

The timeliness of the RMA's reviews and investigations could be improved if the Authority had more resources. More staff and resources would mean that the RMA could conduct reviews and investigations into SoPs quicker and more frequently, ensuring that they remain up to date with the latest medical-scientific evidence.

The RMA is a relatively small agency — in 2017-18, the secretariat consisted of around ten full-time equivalent staff supporting the five RMA members, and an annual expenditure of just over \$2 million (RMA 2018f). From a whole-of-government perspective, a comparatively small increase in resourcing (both financial and staffing) would translate to a significant boost to the RMA's capabilities and would potentially result in substantial benefits to many of the most vulnerable veterans with complex needs.

However, there are limitations on how quickly the RMA can conduct an investigation into a SoP. Aside from the time needed to conduct the research and gather relevant sound medical-scientific evidence, the Authority also undertakes consultation with interested stakeholders when investigating and amending a SoP. For example, the RMA provides a minimum period of at least two months for submissions from ex-service organisations (ESOs) and other interested parties when it is intending to remove a factor in a SoP (RMA 2018b). This consultation process can delay the addition of new factors or the expansion of old factors if they are being added in the same review as another factor is being removed.

Discussions with RMA staff suggest that, even with unlimited resources, the minimum time period required to conduct an investigation into a SoP and make changes would probably be up to six months, largely due to current notification requirements and these consultation practices (RMA, pers. comm. 11 October 2018). Although there is a need for transparency and accountability through a consultation process, these needs must be weighed against the costs to veterans who are waiting for a SoP to be updated.

The RMA cannot conduct its own research

Although the Authority seeks out emerging scientific peer-reviewed research on medical causality from around the world, it does not actively fund, guide or conduct any research into specific veteran issues. Under its enabling provisions in the VEA (s. 196C(1)), the RMA is prohibited from carrying out any new research work, including tests or experiments. This prohibition exists because there was a view at the time of the RMA's creation that if it could conduct its own research, it would be too strongly influenced by that research, rather than the entire weight of sound medical-scientific evidence (Donald 2008).

Instead, the RMA has the power to request that DVA carry out research on its behalf (s. 196C(2)). However, this power has only been used on two occasions in 24 years and on each occasion DVA has declined to undertake the requested research (RMA, pers. comm. 11 October 2018). There is also very little research into veteran health issues that is self-initiated by Defence or DVA. As the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted 'the Department of Defence and DVA often suffer from funding limitations which may impact their capacity to translate reports and data into peer-reviewed literature' (sub. 58, p. 6).

That is not to say that there is no research done on veteran-specific medical issues in Australia — see, for example, the recent reports by the Australian Institute of Health and Welfare (AIHW 2017b) and the National Mental Health Commission (2017) into the incidence of veteran suicide. However, this research tends to be ad hoc and reactive to major issues, rather than informed by early, emerging issues that the RMA has become aware of. There is also a difference between the health studies regularly conducted by the AIHW and the epidemiological research into medical causality that the RMA relies on for its role (Donald 2008; RMA 2017a).

Without the ability to conduct new research into veteran-specific areas of medicine, the RMA relies on a relatively passive approach to discovering emerging medical-scientific evidence — it is forced to wait until a third-party conducts the relevant research of their own volition, using their own resources. For example, while emerging medical evidence may not show a strong link between a particular chemical and long-term health problems, Australia's veterans may have been exposed to that chemical at much higher doses than otherwise researched and the RMA is not able to fund or conduct research to investigate this issue.

Some participants suggested expanding the RMA's powers to allow it to conduct its own research. The RANZCP, for example, noted that 'Australia has made substantial contributions to the research and treatment of veterans' mental health issues and deserves a national policy to coordinate future research to better inform care' (sub. 58, p. 6). Similarly, William Gore recommended that the veteran 'legislation be changed to allow the RMA to commission and fund research' (sub. 97, p. 2), explaining that the current restriction:

... causes the Commonwealth not to recognise the impact of product and process on veterans health, making it negligent and failing in its responsibilities and not meeting the needs of veterans with VEA or MRCA coverage. (p. 1)

The New Zealand equivalent to the RMA (the Veterans' Health Advisory Panel) contributes to research into veteran-related health issues by distributing the income of the Veterans' Medical Research Trust Fund to 'fields of medicine that may benefit [New Zealand] veterans', through research grants and awards (VANZ 2018a, 2018b).

It is our view that there is value in having similar arrangements in Australia. The risk of the RMA overweighting their own evidence is comparatively small compared to the potential gains for veterans from a system that better understands their needs and unique circumstances. These risks can be further minimised by the RMA only funding and guiding medical and epidemiological research, not conducting the research itself. The RMA could even work with their counterparts in New Zealand to maximise the effectiveness of limited research funds.¹²

Transparency for investigations

The contention of many participants to this inquiry appears to be that the RMA did not adequately consider the results of a particular piece of medical-scientific literature, or failed to give it sufficient weighting (William Brown, sub. 110; Julie Anderson, sub. 152). For example, David Watts states that the RMA 'has never been empowered by the Act to dismiss the expert opinions, works or published peer reviewed scientific material of experts other than themselves with greater experience in different areas than the members of the Authority, yet time and again the Authority has done just this' (sub. 106, p. 4).

In part, some of this contention seems to stem from a misunderstanding of the RMA's role, which is to weigh the *totality* of evidence, not refer to particular pieces of literature.

Public understanding of how the RMA has weighed the evidence is not helped by an opaque process. Following an investigation, the RMA does not routinely publish a list of the 'sound medical-scientific evidence' (generally peer-reviewed literature) it relied on to reach its conclusions, although such a list is available to the public on request (under s. 196I of the VEA). Under the VEA, the RMA is not required to either publish or make available any information that explains to the public how the literature was interpreted and given relative weighting by RMA researchers, nor which factors in a SoP are relevant to which piece of literature.

Without greater transparency, some veterans, their families and their advocates will continue to be unsatisfied with the results of RMA's review processes, which may appear to ignore the evidence they presented and reach conclusions they do not understand or accept. In 1997, the Administrative Appeals Tribunal (AAT) criticised the RMA's lack of transparency in a submission to the *Review of the RMA and the SMRC*, noting that 'there are no assurances that the intention of the legislation is being fulfilled' and that an opaque process 'serves to undermine the legitimacy of the system' (Pearce and Holman 1997, p. 36).

¹² A collaborative approach between the RMA and New Zealand could also align with the recommended changes to the NZ veterans' support system in the 2018 Paterson Review (Paterson 2018, pp. 93–95).

In their conclusions, Pearce and Holman stated that ‘it would be desirable if the RMA could spell out in detail the basis on which it had arrived at a conclusion’, but ultimately declined to recommend changes, as this ‘would require a massive increase in the time spent by the RMA on the production of SoPs and would assuredly delay their production’ (1997, p. 37).

Although there would be additional time and cost involved in putting together relevant documents for publication, much of the necessary work already takes place. As part of the investigation and review process, RMA researchers are already required to put together briefing papers that ‘systematically describe and analyse the available [sound medical-scientific evidence] ... for the condition under investigation’ and ‘categorise the strength of the evidence’ (RMA 2018d, p. 8). The Commission also understands that this material, alongside the sound medical-scientific evidence itself, is routinely provided to applicants that have requested a review at the SMRC (SMRC, pers. comm. 22 October 2018).

Another potential limitation (discussed by Pearce and Holman 1997) of publishing information about how different pieces of evidence were considered during an investigation is that it may undermine the Authority’s ability to carry out its functions due to concerns about public reaction. For instance, if the RMA were worried that a particular decision would be seen as controversial, the members may err towards a more ‘acceptable’ conclusion. Although this is a valid concern, the controversial aspect of the RMA’s investigations (the decision whether or not to include a SoP factor and at what dosage or latency period) is *already* public. Improved transparency about the underlying rationale used to reach those contested decisions is likely to make the RMA’s position *less* controversial, not more.

DRAFT RECOMMENDATION 8.2

The Australian Government should amend the *Veterans’ Entitlements Act 1986* (VEA) to allow the Repatriation Medical Authority (RMA) the legal and financial capacity to fund and guide medical and epidemiological research into unique veteran health issues, such as through a research trust fund.

Following any investigation, the RMA should be required to publish the list of peer-reviewed literature or other sound medical-scientific evidence used, as well as outline how different pieces of evidence were assessed and weighed against each other. This may require legislative amendments to the VEA.

Additional resources should also be given to the RMA, so that the time taken to conduct reviews and investigations can be reduced to around six months.

The merits of a standalone SMRC

Although the Baume Review in 1994 was the primary driver behind the creation of the SoP system and the RMA, the Review did not recommend the creation of the SMRC. Instead, it recommended that the RMA (referred to in the report as the Expert Medical Committee) include a mechanism such that if:

... an interested party makes a submission regarding the making, amending or revoking of a Statement and is dissatisfied with the outcome, it could request reconsideration by the Expert Medical Committee and the matter would be considered by the Expert Medical Committee augmented by additional specialists relevant to the medical or scientific concern. (Baume, Bomball and Layton 1994, p. 27)

There is substantial merit in the Baume Review's recommendation. Bringing in the skills and knowledge of experts in relevant medical fields can help to augment the RMA's 'clinical judgment' (part of the definition of 'sound medical-scientific evidence' in the VEA) with that of specialists for particularly contentious matters.

However, this 'augmentation' of the RMA's permanent members through the inclusion of experts in the relevant field of medicine was not supported by the then Government.

Instead, during Parliamentary consideration of the legislation to create the SoP system, several ESOs expressed concerns 'that the new SoP process would remove most opportunities for an appeal from a decision of the Repatriation Commission' (Creyke and Sutherland 2016, p. 534). As one Senator stated during the Senate debate:

The proposal to bind the Repatriation Commission and the various appeal tribunals associated with veterans' claims ... would remove most opportunities for a veteran to appeal the original departmental decision ... In fact, a legal opinion obtained by a veterans' organisation claims the proposed process would effectively negate the right of appeal on the grounds of medical causation. (Kemp 1994, p. 2166)

In response, the SMRC was established to 'create an appeal mechanism for individual veterans who believe that the established principles either ignore their medical circumstances or are incorrect in establishing their causation' (Kemp 1994, p. 2179).

While the SMRC has similar functions to those recommended by the Baume Review, the creation of the SMRC duplicated many of the administrative costs of the RMA by creating a new organisation. Although the SMRC does not report separately to DVA, its annual expenditures in the past two financial years have been around \$400 000 per annum (SMRC, pers. comm. 11 September 2018).

The SMRC's structure is also cumbersome. A new Review Council is convened for each investigation, often with newly appointed councillors if no existing councillors have relevant skillsets, creating delays as new councillors must be identified and selected. The SMRC's structure also results in a considerable loss of institutional knowledge between reviews, which in turn further delays the process (as new councillors have to learn about their role and the SoP system) and may lead to inconsistent or unpredictable decision-making (if new councillors take a different approach to applying the standards of proof than the RMA or previous Review Councils).

The functions and future of the SMRC were questioned in the 1997 *Review of the RMA and SMRC*. The authors agreed with the notion that the SMRC's role 'is simply pitting the views of one set of medical specialists against another' and noted that an appeals mechanism 'fits

ill' with the SoPs, as they are legislative instruments, already subject to review by Parliament. However, the review also acknowledged that the SMRC's primary function is to build public confidence in the SoP system, by 'ensuring that an aberrant RMA can be called to account by its peers' (Pearce and Holman 1997, pp. 62–63).

INFORMATION REQUEST 8.2

The Commission is seeking participants' views on whether there is merit in the Specialist Medical Review Council remaining as a standalone organisation, or whether its role should be folded into an augmented Repatriation Medical Authority review process that brings in additional medical specialists.

9 Claims administration and processing

Key points

- Most claims submitted to the Department of Veterans' Affairs (DVA) are successfully determined in favour of the claimant. However, DVA's processes for administering claims are inefficient, unnecessarily complicated and stressful for both claimants and assessors.
- In 2016 DVA launched a major transformation program known as Veteran Centric Reform (VCR). The aim of this program was to improve client outcomes by updating and better incorporating information and communication technology (ICT) into DVA's claims administration processes.
- A key early success is the online claims processing platform, MyService. It is 'veteran centric', flexible and was developed in collaboration with veterans.
 - MyService has been rolled out for initial liability decisions and early results are positive — error rates are below target and claims processing times are significantly lower.
 - When fully rolled out across the claims process, MyService, in combination with Defence's Early Engagement Model (which is designed to facilitate the automatic flow of service and medical information about serving members to DVA throughout their careers), has the potential to automate the claims process for the overwhelming majority of clients.
 - To ensure the continuing success of MyService, DVA needs to resolve problems involving the shared ICT relationship with the Department of Human Services.
- While VCR has had some early successes, its rollout will need to be carefully managed and closely supervised to ensure that success is consolidated and DVA's history of poor change management is not repeated. Notable ongoing areas of concern in the claims administration process that the Commission observed and participants raised include:
 - a general lack of training and guidance for assessment staff, including how to effectively deal with trauma-affected clients
 - slow claims assessment
 - consistently high error rates
 - inappropriate use of external medical assessors.
- Ex-service organisations play many important roles in the veteran support system, including assisting veterans to lodge claims. Given the Australian Government has commissioned a Veterans' Advocacy and Support Services Scoping Study (due to report in December), the Commission will give detailed consideration to ex-service organisations in the final report.

The Department of Veterans' Affairs (DVA) approves the majority of claims submitted by veterans and their families (and has done so for decades). For example, the proportion of conditions¹ accepted for initial liability by DVA in 2017-18 was:

- 79 per cent under the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- 56 per cent under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA)
- 62 per cent under the *Veterans' Entitlements Act 1986* (VEA)² (DVA 2018f).

But there are significant and ongoing problems with the way DVA administers claims. One participant to this inquiry described getting assistance from DVA as 'like going through a minefield' (Owen Bartrop, sub. 20, p. 2). As recent reviews have found, these problems appear less to do with DVA staff per se, who by and large are well-intentioned, dedicated professionals, and more to do with outdated information and communication technology (ICT) infrastructure, as well as inefficient, and poorly planned and executed administrative processes (section 9.1).

DVA is attempting to fix these problems under the banner of its Veteran Centric Reform (VCR) program, which began in 2016 (section 9.2). VCR has had a number of successes — most notably, the introduction of an online claims system (MyService) and progress towards automating claims lodgement (section 9.3). But much remains to be done. Client communication, the timeliness and quality of claims assessment, and the use of external medical assessors remain problematic (section 9.4). Although the prospects for success for VCR appear positively balanced at present, DVA has some history of not completing reform programs, so close supervision is required (section 9.5).

Ex-service organisations (ESOs) play a number of important welfare and advocacy roles in the veteran support system (section 9.6). Because there is a major review into ESO advocacy services currently underway, the Commission has not made any recommendations on ESOs, but will give detailed consideration to broader ESO matters in its final report.

9.1 Good intentions but poor execution

DVA's service charter outlines what their clients can expect when dealing with the Department. Their commitments include, among others, that DVA will:

- be courteous, considerate and respectful
- listen to you
- be fair and ethical in our dealings

¹ The average claim tends to include more than one condition.

² VEA claims do not include a separate initial liability assessment. The acceptance rate refers to the number of determinations for VEA disability pensions.

-
- deliver our services in a timely and prompt manner
 - make it easy for you to use online services and find information
 - resolve any concerns, problems, enquiries and complaints quickly
 - provide accurate, clear and consistent information
 - recognise that you have varying and changing needs
 - develop and equip our staff so they can provide you with quality service, and
 - increase awareness in the community about issues facing veterans, war widows and widowers, and serving and former members of the Australian Defence Force. (DVA 2014c)

In our dealings with DVA, the Commission observed a positive mindset and attitude among most staff. Other reviews made similar observations. The Australian Public Service Commission (APSC), for example, said:

There is a palpable, sincere and passionate sense of mission among client-facing, administrative and policy staff within DVA; namely, to support those who serve, or have served... (2013, p. 5)

And more recently a 2017 independent Gateway Review of the First Stage of the VCR program said:

The Review team was impressed by the commitment and enthusiasm of DVA generally, and the VCR program specifically, to deliver improved support and services for veterans. (2017a, p. 9)

However, a combination of inefficient and ineffective administrative processes, insufficient training for staff, and (until recently) outdated ICT systems undermines the ability of DVA employees to consistently provide a high level of service to veterans and their families. As one participant put it:

I must state that I am not complaining about any individual within the department as they are simply applying practices and procedures as documented, it is the actual practice/regulation or process that is deeply flawed. (Raymond Wombold, sub. 16, p. 1)

RSL NSW also said:

Despite working within a byzantine, sluggish and at-times adversarial system, it is worth noting that in the experience of RSL NSW, DVA staff have been well-meaning and responsive. Contact between RSL NSW and the Department is frequent (multiple times every day) and the professional advocates and claims advisors of RSL NSW feel they are able to work with DVA delegates to overcome any issues that arise in order to achieve a fair outcome. (sub. 151, p. 10)

Poor administration has undermined DVA's reputation

As was well documented in the Senate Foreign Affairs, Defence and Trade References Committee report titled *The Constant Battle: Suicide by Veterans* (SFADTRC 2017, p. xxi), poor administration of claims places unnecessary stress on veterans and their families and,

because those claiming can be particularly vulnerable, when processes do not go well the outcome can be disastrous. Administrative failures during the claims process on DVA's behalf are known factors in both the Martin Rollins case and Jesse Bird's suicide in 2016 (Vincent 2018).

Feedback provided to DVA from their own clients indicates that there is considerable dissatisfaction with the Department's administrative processes (box 9.1). Clients said that:

- DVA's processes and attitude are too adversarial, with interrogative investigation of claims
- veterans are not trusted to provide accurate information and there is too much reliance on medical evidence and supporting evidence from Defence
- DVA is process driven and the processes are too slow; when DVA does eventually accept liability for a condition, there is a further slow process to assess the claim
- DVA also tends not to proactively engage with its veterans and their families. (sub. 125, p. 15)

Box 9.1 Experience with DVA administration

[DVA has] a culture lacking in transparency, openness, honesty and veteran centric support. (Brendan Dwyer, sub. 15, p. 3)

DVA is seen as a monster and has thrown significant frustration at me that defies logic and evidence ... The frustration and labouring momentum of having to deal with and conform to such profound inconsistency does have lasting and telling impacts on individuals ... (Neil Robson, sub. 146, p. 1)

DVA 'doctor shopped' until they found someone to diagnose me with a non-compensable condition, ignored all previous diagnosis, spent many tens of thousands of dollars at the [Administrative Appeals Tribunal], completely mismanaged the re instatement of my compensation payments, then paid me only slightly more than half my legal expenses; whilst managing to put myself and my young family through a two year emotional and financial wringer. (Daniel Foley, sub. 19, p. 5)

It is the DVA administrative procedures of the three Acts that is directly affecting and hindering some veterans, in the processing of their claims ... assessment of claims for compensation have been far from ideal and have resulted in unnecessary stress for the veteran and resulted in additional cost and resource implications for DVA. There is also a reputational cost associated with such cases. (Hilton Lennard and Keith Russell, sub. 13, pp. 3,8)

Nothing in the DVA process at times is easy and the treatment of veterans at times applying for a claim is nothing short of contempt for their service of their country. (Richard Coathup, sub. 124, p. 2)

The reason some of the injuries have not been submitted to DVA purely relates to the lack of desire to be further exposed to the 'DVA red tape machine'. The bureaucracy of the DVA appears to thrive on admitting liability to the least number of claims possible, almost as if this were a Key Performance Indication for the department. (Hugh Baldwin, sub. 10, p. 1)

Dissatisfaction is particularly high among younger veterans who are more likely to be going through the claims process. DVA's 2016 client satisfaction survey found that just 49 per cent of DVA clients under the age of 45 were satisfied, compared to 92 per cent of clients over the age of 65 (DVA & Orima 2017).

The Commission heard that even people who had not yet interacted with DVA, such as current serving members, had concerns about the administration of claims — suggesting that DVA’s reputation precedes it. As the Royal Australian Armoured Corps Corporation (RAACC) said:

... an ongoing continual almost universal opinion, most particularly in the veterans’ community, that a wide range of organisational, cultural and systemic failings over a considerable period of time have impacted significantly on the capacity of the Department of Veterans’ Affairs to provide effective service delivery to its stakeholder base to the detriment of that stakeholder base. (RAACC, sub. 29, p. 3)

Administrative shortcomings are well documented

There have been numerous reviews of the veteran support system over the past few years (chapters 1 and 11) with more planned or currently underway.³ Recent reviews, including by the Senate Foreign Affairs, Defence and Trade References Committee in 2017 (SFADTRC 2017), and the Australian National Audit Office (ANAO) and the Commonwealth Ombudsman in 2018 were strongly focused on DVA’s administrative shortcomings.

DVA’s administrative practices were ‘the overwhelming concern of the majority of submissions’ to the 2017 Senate Committee inquiry into suicide by veterans (SFADTRC 2017, p. xxi). Submissions to the Senate Committee inquiry raised concerns about staffing issues, delays in determining claims, incorrect payments, communication issues and a general adversarial approach to claims assessment. The inquiry noted that poor administration of claims places unnecessary stress on veterans and their families and that there was also a perception that ‘problems with the compensation claims process were ... contributing factors to suicide by some veterans’ (SFADTRC 2017, p. 42).

A 2018 ANAO report into the time taken to process claims by DVA concluded that inefficient handling processes mean that some claims ‘take an excessively long period to process’ with significant impacts for affected veterans and potentially, for DVA’s reputation (2018b, p. 8). The ANAO audit identified the following issues in DVA’s business systems and processes:

- the purpose built workflow management system, the Rehabilitation and Compensation Integrated Support Hub (R&C ISH), was not being used effectively. Rather individual spreadsheets are being used to manage workflow
- R&C ISH also lacks key functionality such as controls to ensure integrity over manual records placed in the system. Dates associated with registration of claims and referral for medical consultations were inconsistent and key client documentation was being kept

³ With the release of its 2017-18 annual report, DVA announced four more reviews as part of its response to the 2017 Senate Committee inquiry into suicide by veterans. In November it announced another review into the Department’s response to Jesse Bird’s suicide.

manually by staff. There were also inconsistencies in naming conventions for records across ICT systems

- the claims process, particularly for DRCA and MRCA claims, was unnecessarily segmented, leading to delays and inefficiencies and claims becoming lost at handover points. And there was too much focus on monitoring the median and the average time taken to process with insufficient attention given to the complete population of claims.

The ANAO (2018b) audit also identified issues with DVA's delivery of services:

- The longest delays in claims processing came from waiting for medical specialists, who are not subject to time monitoring procedures. These were ten times longer than the delays for requests for information from Defence
- The second most common delay — indicative of a lack of transparency — was inactivity, where claims were simply lost or where delegates failed to act despite having sufficient information to do so
- Reports containing key metrics on claims operations did not identify emerging risks or reasons for change in performance and are largely ignored by team leaders.

A particularly egregious case of DVA maladministration — which also involved the Commonwealth Superannuation Commission (CSC) and the Navy — prompted a 2018 report by the Commonwealth Ombudsman. The Ombudsman found that due to DVA's deficient record keeping, quality assurance and internal review processes, a relatively minor oversight was able to 'snowball' over a period of more than 10 years, resulting in underpayments of more than \$500 000 (Commonwealth Ombudsman 2018).

The Ombudsman stated that 'while cases involving this level of accumulated administrative errors are rare, the individual errors are not isolated incidents' (2018. p. 1). The subsequent impacts on individual veterans can be severe:

The negative impact on the life of this veteran cannot be overstated. He expressed to my Office that he lives in constant fear that tomorrow there may be no payment in his account, or that payments may be recovered in the future and he may not be able to meet his basic needs. His health has suffered and his relationships have been strained. (2018. p. 1)

It is critical that DVA implements the recommendations aimed at addressing administrative shortcomings from these recent reviews.

DRAFT RECOMMENDATION 9.1

The Department of Veterans' Affairs should report publicly on its progress in implementing recommendations from recent reviews (including the 2018 reports by the Australian National Audit Office and the Commonwealth Ombudsman) by December 2019.

9.2 Veteran Centric Reform — a vehicle for change

DVA began its latest major transformation program — known as Veteran Centric Reform — in 2016 in response to a ‘high risk of catastrophic failure’ of its ageing ICT infrastructure (ANAO 2018b, p. 22) and a growing dissatisfaction, particularly among its younger clients, with DVA’s impersonal, transactional and slow service:

DVA’s client demographics are changing, and our younger clients have different needs and expectations. DVA’s outdated ICT systems and business processes are not suited to the needs of these younger clients and need to be replaced to provide the best possible service to veterans and their families. (DVA 2017d, p. 6)

Expected to take six years to implement, VCR is a means to achieving DVA’s broader transformation goals of becoming a service commissioning, stakeholder engagement and policy development agency, with a fundamentally transformed culture that places ‘the veteran and their family at the centre of DVA’s service delivery orientation and philosophy’ (DVA, sub. 125, p. vi).

Funding for the first phase of the transformation program will go towards improving the client-facing elements of the Department including by building new online systems, replacing outdated ICT infrastructure and software and overhauling existing business and administrative processes (box 9.2).

Box 9.2 About the Veteran Centric Reform program

Veteran Centric Reform (VCR) was first funded in the 2016-17 Budget with \$24.8 million to ‘simplify and streamline the Department of Veterans’ Affairs (DVA’s) business processes and replace legacy Information and Communication Technology [ICT] systems’ (Australian Government 2016a, p. 154). Subsequent Budgets allocated an additional \$279 million to VCR, with approximately one half allocated to the Department of Human Services to provide ICT services to DVA as part of a broader whole-of-government shift towards centralising ICT delivery arrangements (Australian Government 2017b, 2018a).

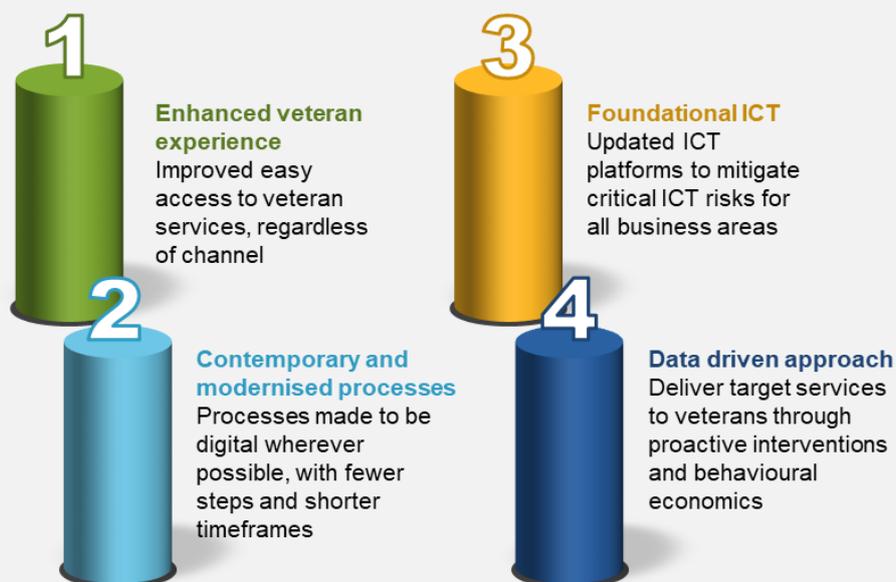
Organised around four strategic pillars (figure below, DoD, DoH and DVA 2017, p. 32), the end point of the VCR will see DVA transformed into a department that:

- utilises modern ICT systems, leveraging off synergies in whole-of-government projects to achieve economies of scale (such as in payment platforms)
- has an easy-to-use, largely online customer interface, making services for veterans and their families simpler and faster to access, while also freeing up staff to focus on those veterans with complex and multiple needs
- embeds the use of data and data analytics in day-to-day functions, in order to:
 - adopt a proactive approach to engaging veterans, reaching out to offer services and support earlier in order to reduce longer-term demand on the system from later interventions

(continued next page)

Box 9.2 (continued)

- monitor service delivery performance and support ‘a culture of continuous improvement’
- reduce the time taken to conduct claims assessments, by using existing information and data (DVA 2017c, sub. 125; Lewis 2018).



9.3 Some early signs of success

The large number of initiatives introduced under the VCR banner are already having a positive impact on the claims administration process and on the way that veterans and their families interact with DVA (box 9.3). A key early success and one that embodies well the VCR’s aspiration of simplifying the client experience by leveraging ICT functionality is the online claims processing platform, MyService.

MyService — a case study in how to deal with complexity

Simplifying the claims process

MyService is an online claims platform that can be accessed via the MyGov⁴ website. Originally only for MRCA claimants, since July 2018 claimants under all three Acts can register as a DVA client and submit initial liability claims online. MyService also allows veterans and their families to access non-liability health care based on eligible service (that is, without the need to claim).

⁴ Launched in 2013, the myGov web portal allows centralised access to a range of Government services provided by, among other agencies, Centrelink, Medicare, the Australian Taxation Office and (now) DVA.

Box 9.3 A summary of VCR progress to date

Specific initiatives and programs introduced as part of Veteran Centric Reform include:

- **Straight-through processing** — using Defence training and service data to identify where the service-related requirements of certain conditions have been automatically satisfied, reducing the information about service activities and exposures that needs to be collected from claimants (discussed further in chapter 8).
- **Digitisation of records** — this has significantly reduced the costly, inefficient and time-consuming movement of paper files between locations during claims processing and other administrative activities. By July 2018, about 33 million pages of client files had been digitised (DVA, sub. 125, p. 80).
- **Rollout of MyService** — providing a way to lodge initial liability claims online, as well as free mental health treatment claims, needs assessments and access to an electronic health card that specifies the conditions it covers (discussed further below). As at June 2018 over 5000 users had lodged claims through MyService, while a link to myGov (the whole-of-government online platform) from 30 July 2018 enables access by many more (p. 79).
- **Client segmentation** — providing DVA with data-driven analyses of veteran characteristics, needs and preferences, including a detailed profile of each client segment.
- **Student Pilot** — piloting a digital channel for veterans and their families to register for, and claim education allowances from July 2018, leveraging off the Department of Human Services' (DHS) Welfare Payment Infrastructure Transformation program.

DVA's priorities for the remainder of 2018-19 include:

- expanding MyService to include permanent impairment and incapacity claims
- expanding the Student Pilot (in partnership with DHS) into other income support payments to 170 000 veterans and their families
- improving DVA's website, letters and factsheets to make access easier
- continuing to embed cultural reform and business process redesign within the department
- streamlining more conditions to improve the timeliness of decisions
- beginning to use data analytics to anticipate veterans' needs and provide help
- providing a single phone number — 1800VETERAN — for access to DVA services, with quicker response times and improved call quality
- reaching out to veterans and their families who are not currently in contact with DVA, such as through Australia Post and mobile service centres (DVA, sub. 125, p. 54).

Source: DVA (sub. 125).

MyService replaces the existing MyAccount online claims platform, which allowed claimants or their representatives to fill in a paper claim online. In contrast to MyAccount, MyService automates the initial liability claims process using a set of 'rules' designed to satisfy the legislative requirements for making a legal determination under each of the three Acts. That is, the rules ensure that determinations are legally defensible, in this case, for the Government to except initial liability. Again, in contrast to MyAccount, MyService 'filters

the appropriate eligibility requirements and conditions based on each veteran's circumstances' (DVA, sub. 125, p. 80). It takes a tailored approach to the claims process.

MyService is designed to allow a determination to be made *in real time*, and depending on the type of claim, potentially without any input from a claims assessor. For example, for claims that are 'decision ready' (such as tinnitus and lumbar spondylosis, chapter 8), a determination is literally instantaneous. Decision ready claims now cover about 50 per cent of all claims received. Where there are no decision ready rules in place, a claim will be forwarded on to a claims delegate to make a determination under the relevant Act.

MyService was created by DVA (and subsequently DHS staff following the introduction of the shared services arrangements in late 2017, box 9.4) in 2016 in close and ongoing collaboration with a representative group of veterans guided by the Digital Transformation Agency's (DTA) digital service standard. Based on the UK Government's *Digital by Default* Service Standard, the DTA digital service standard is designed to help teams create 'government services that are simple, clear and fast' (DTA 2017).

DVA is aiming to expand MyService to incapacity and permanent impairment claims by the end of 2018-19 using a similar rules-based approach.

Box 9.4 Shared services: paired or pared services?

Shared services arrangements between the Department of Veterans' Affairs (DVA) and the Department of Human Services (DHS) were introduced in November 2017. By piggy backing on DHS ICT infrastructure, the shared service arrangement should allow DVA to provide faster and more comprehensive client services, particularly payments services, in the long run. However, the Commission understands that service protocols to formalise ICT arrangements between the Departments remain in draft form.

The Commission heard that in the immediate term, management and procurement of ICT resources (such as ICT staff from DHS for discrete projects) under the shared service arrangements is not running smoothly and is adversely affecting key Veteran Centric Reform (VCR) projects. For example, there have been project delays and a reduction in the pace of development of MyService. These teething problems around the shift to shared services need to be resolved as they risk stalling momentum and undermining the significant progress made so far under VCR.

MyService — outcomes so far

Approximately 6 000 claims have been lodged so far through MyService (DVA 2018f, p. 42). And feedback from users is positive.

MyService and culture change are ongoing improvements that have been particularly effective. (Alliance of Defence Service Organisations, sub. 85, p. 28)

The ease of operation for veterans both current and former, to access the data base and lodge a claim is on any view, the most important ground-breaking achievement by DVA in the veterans' claims and support continuum to date. The ease of using an online claim form that is applied

across all three Acts administered by DVA is simply astounding. This [is] important, because enabling veterans to be able to complete an online claim form in the safety, security and comfort of their own home, is a hugely pleasing aspect of this process. (RAACC, sub. 29, p. 9)

As the RAACC alludes to, MyService also offers an effective way to deal with a number of common complaints experienced by veterans when making claims.

- On timeliness — the average time taken to process a MyService initial liability claim is 33 days, compared to an average across all MRCA initial liability claims of 84 days in 2017-18 (DVA, pers. comm. 29 November 2018; Commission estimates based on unpublished DVA data).
- On accuracy, although MyService is yet to be subject to a formal quality assurance assessment, informal analysis by DVA showed assessment error rates well within the Department's internal targets.
- By using a rules-based approach, MyService asks the right questions to arrive at a lawful determination. In this way it effectively acts as a guide for both claimants and assessors and is a highly effective way of dealing with the complexity of the Acts.
- It minimises the amount of data that a claimant must source by 'pulling' information automatically from existing government databases (such as Defence PmKeys) including for identity checks and determining periods of service.

Automating the claims process — completing the Early Engagement Model

The Early Engagement Model is designed to alert DVA to potential future clients by providing information (sent from Defence) about Australian Defence Force (ADF) members throughout their career in response to various triggers or events. There are currently five triggers. When a member:

1. enlists in or is appointed to an ADF service branch (after 1 January 2016)
2. is involved in a serious incident or where a Defence member's service is to be terminated administratively (either on medical grounds, or for any other reason that involves the use of prohibited substances or the misuse of alcohol, as soon as practical after the event or the decision to terminate)
3. commences transition from the permanent force or continuous full-time service (CFTS) in the ADF
4. completes transition from the permanent force or CFTS in the ADF
5. renders service which attracts eligibility as 'qualifying service' under the VEA.

There are, however, some missing triggers⁵, including a trigger for when a member is injured (particularly if it is a service-related injury). To the extent that the transfer of information

⁵ There are different modes of information transfer across these triggers. For example some information is provided via email, and some via direct access by DVA into Defence platforms.

can be combined with MyService functionality, this could mean an automatic claim without the service member having to file a claim. Defence (within the Veterans Support Branch) in collaboration with ADF (via Joint Health Command) and DVA are working on such an outcome. An amendment to the MRCA that would allow the Chief of the Defence Force to lodge a claim on behalf of a member, with the member's consent, was lodged for consideration by Parliament in 2018 (DVA 2018h). The Commission also understands that a pilot program is scheduled to commence in early 2019 using a subset of ADF members who are undergoing medical rehabilitation.

But the complexities of rolling out such a change more broadly, particularly in Defence, should not be underestimated. The ADF needs to modify the way medical staff and contracted specialists collect information about diagnoses — potentially by recording whether a Statement of Principle (SoP) has been satisfied at the time of diagnosis. It would also need to modify the software used to document injuries and illnesses and coordinate processes across the service branches.

A somewhat analogous cautionary tale is the introduction of the 'condition onset flag' in International Statistical Classification of Diseases and Related Health Problems (ICD) coded hospital data. The flag indicates whether a patient's diagnosis was present on admission or arose during the hospital stay. First trialled in Victoria in 1992, it was not adopted throughout Australia until 2008. And by 2011-12, only 80 per cent of public hospitals were using the supposedly mandatory flag (Australian Commission on Safety 2013, p. i).

DRAFT FINDING 9.1

MyService, in combination with a completed Early Engagement Model, has the potential to radically simplify the way Australian Defence Force members, veterans and their families interact with the Department of Veterans' Affairs (DVA), particularly by automating the claims process.

But achieving such an outcome will be a complex, multi-year process. To maximise the probability of success, Defence, DVA and the Department of Human Services will need to:

- continue to work closely in a collegiate and coordinated fashion
- retain experienced personnel
- allocate sufficient funding commensurate with the potential long-term benefits.

9.4 But there is still room for improvement

Four notable areas of concern (all of which have been targeted as part of VCR or are currently under review) where there is clear room for improvement are discussed below:

- client communication and looking after people with complex needs
- time taken to process claims

-
- quality assurance for claims
 - the use of external medical assessors.

Client communication and supporting clients with complex needs

While online services such as MyService have the potential to automate the claims process and largely act as a one-stop-shop for claimants, they do not eliminate the need for DVA staff to interact with veterans and their families. For example, medical conditions that are not ‘decision ready’ require a claims delegate within DVA to manually assess a claim for initial liability under the SoPs. And MyService is still to be rolled out to the subsequent steps in the claims process — of which there are many (figure 9.1 provides a *simplified* representation of the MRCA claims process for primary determinations).

It is typically failures during the claims process involving human-to-human interactions that create pain points for clients. The Commission heard numerous times during its consultation about situations where a simple phone call to a client asking for information, explanation or clarification about the client’s circumstances could have helped the claims process run quicker and potentially led to a different, possibly favourable outcome (similarly in the review process, chapter 10).

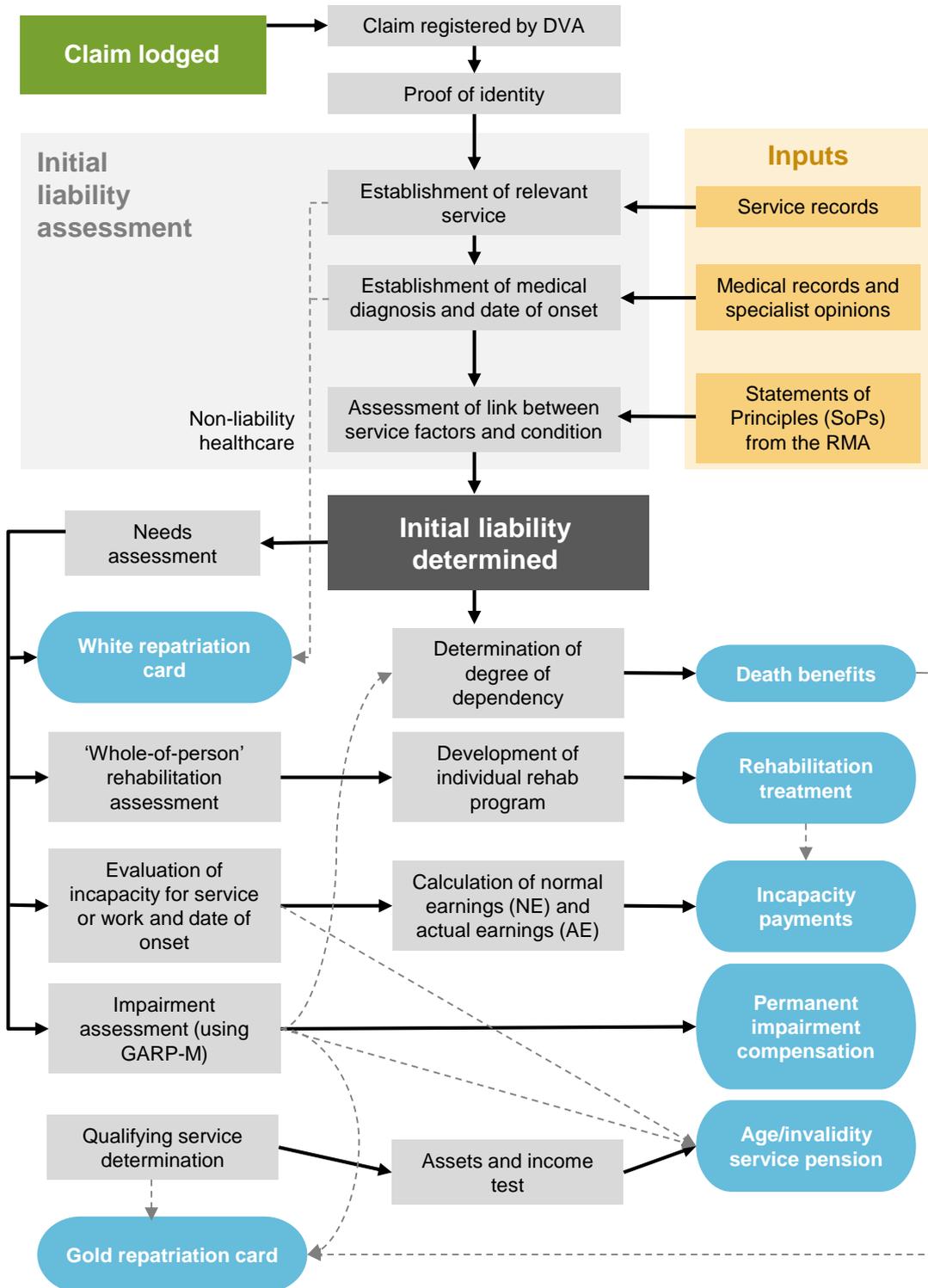
The Commission also heard that empathy — conveying a sense of understanding — during conversations was important for clients. It is not clear that DVA staff are appropriately trained to deal with potentially vulnerable clients, such as veterans who *could* become distressed during a call. DVA’s *Open Door* policy from 2013 notes that training will be offered as required:

Keeping the phone call professional, short and targeted can be difficult to achieve. Lifeline/Comcare run a course called the ‘Accidental Counsellor’ and one of the skills is about learning to manage time on phone calls. It is proposed that this course will be offered to delegates as required. (DVA 2013a)

In its consultations with DVA, the Commission heard that this type of training remains, at best, optional for delegates (the cost of training is a few hundred dollars per person). It is clear that getting these communications right can make a real difference to clients, an issue covered at various points in the Senate Committee inquiry into suicide by veterans (SFADTRC 2017) and tragically brought home in the case of Jesse Bird.

Figure 9.1 The DVA claims process^{a,b}

For MRCA claims



^a Dashed lines signify a step that can be available under certain circumstances, but is not a requirement.

^b Appeal and review processes are not included.

Source: Productivity Commission analysis.

Supporting clients with complex needs

In lieu of comprehensive training for *all* staff who interact with clients, DVA has in place a suite of programs and protocols that set out how to interact with claimants classified as having complex or multiple needs (box 9.5) while they navigate the claims process. It does this by directing clients towards specially trained staff or diverting them into external services — such as counselling.

Box 9.5 Who are complex clients?

Clients with complex and multiple needs could include those who:

- have been designated as ‘priority’ by Defence as part of the Early Engagement Model
- are making mental health claims
- are in financial hardship
- have severe or life threatening injuries
- have been sexually or physically assaulted.

Source: DVA (pers. comm. 9 October 2018).

The following three programs have operated since 2007: the Client Liaison Unit, Case Coordination Program and the Service Coordination Program. Commencing in February 2016, these three services were consolidated into the Coordinated Client Support Service model (CCS). In addition to the CCS there are a number of other ad hoc initiatives designed to assist clients with complex needs, including the use of social workers under the Early Intervention Model.

Moving clients into the complex needs program is invoked at various points in the claims process when triggers are identified. For example, a social worker will make contact with a client when a claim is registered for a mental health condition. The social worker will contact the client in the first instance to determine their wellbeing (make sure ‘they are ok’) and to make them aware of the services that are available, such as the Open Arms counselling service (formerly the Veterans and Veterans Families Counselling Service or VVCS) and access to non-liability treatment. The social worker does not act as an intermediary between the client and claims assessors (the claims process proceeds in the background).

Access to CCS is slightly different. Again, transition into CCS can occur at any point in the claims process starting with a referral by DVA staff who, in their dealings with the client, identify certain triggers on the list of CCS referral indicators (external parties, such as advocates, medical practitioners or other Government agencies can also request that DVA refer a client to the CCS). Following referral, the subsequent access to CCS and the type and duration of the intervention depends on a risk assessment of the client by CCS staff (box 9.6). Unlike social workers, CCS staff do act as intermediaries between the client (or their representative) and the claims assessors. However similar to social workers, the claims process continues in the background and CCS staff do not ‘undertake any processing role or

investigate or determine a client's entitlements/claims, nor does participation provide prioritisation of claims' (DVA 2018i).

Box 9.6 **The Coordinated Client Support service model**

Coordinated Client Support (CCS) provides clients with a point of contact who can act as an intermediary between claims assessors and clients to help them navigate the claims process.

Identified clients are assessed by CCS intake coordinators at three different levels of risk.

- Level 1: Self-manage (low risk) — no specific CCS support provided.
- Level 2: Guided support (higher risk) — provided by a client support coordinator, who provides short term intervention with a view to building capacity to return a client to self-management.
- Level 3: Comprehensive support (highest risk) — provided by a case coordinator who provides a single point of contact and works with a range of stakeholders to assist the client to navigate the claims process and access essential entitlements and supports.

In March 2018, there were 13 client support coordinators and 28 case coordinators (DVA, pers. comm. 20 March 2018).

Sources: DVA (2016c, 2018i).

Should case coordination be the default?

Some participants were complimentary of the CCS and DVA's attempt to identify and manage vulnerable clients (such as the Alliance of Defence Service Organisations, sub. 85). For instance:

[Case coordination] ... is an excellent facility and has the effect of significantly lowering the stress associated with the claims and compensation determination process ... Clearly experienced case coordinators have the ability and authority to prioritise work within DVA to assist veterans. (Hilton Lenard and Keith Russell, sub. 13, p. 7)

EML, a commercial claims manager, commented on the importance of a personal approach:

... case management can often benefit exponentially from a human element — a phone call, direct interaction or tailored personal support. It is EML's view that the DVA model must be improved to first and foremost engage with veterans by introducing a new framework of management and a capability uplift on the importance of active management with a personal approach. (sub. 90, p. 6)

Some suggested that all clients, not just those with complex and multiple needs should be provided with a case coordinator by default, instead of referral, and that the case coordinator should *determine* claims. For example, Maurice Blackburn, citing a SafeWork Australia

report, suggested that something akin to CCS comprehensive case management (level 3) is ‘optimum’ and should be the default for all claims:

... every veteran who lodges a claim with DVA should be provided with a case manager who is responsible for the oversight and determination of all claims and entitlements. (Maurice Blackburn, sub. 82, p. 13)

Under the DVA’s current segmented approach to processing DRCA and MRCA claims, separate assessors undertake each step of the claims process (and potentially each injury under the DRCA). As such, it would be difficult for a single case manager to determine an entire claim from beginning to end, except in the simplest of cases (such as non-liability healthcare applications). The ‘super delegates’ who can do this — DVA staff members familiar with the length and breadth of the entire claims process and with decades of experience across the agency — do not exist in sufficient numbers to handle all cases.

However, it is conceivable that a single claims assessor could remain the main point of contact for a claimant and still do the simpler aspects of the claims process, while outsourcing the more difficult steps (particularly the interpretation of complex medical or legal evidence) to those with specialised skillsets. This could be facilitated by removing unnecessary segmentation in the claims process, an issue that the ANAO recommended that DVA address in their June 2018 report (ANAO 2018b). DVA agreed and has committed to at least investigate the possibility to ‘prospectively manage the claim and client through a single point of contact for all initial liability claims’ (ANAO 2018b, p. 35).

More broadly, increasing the number of CCS staff to enable them to act as claims coordinators for all claimants could potentially result in a reduction or redirection of resources (particularly well-trained staff) away from crucial functions elsewhere in DVA. To the extent that expanding the CCS was aimed at preventing claimants with complex needs from being inadvertently nudged into a worse psychological position by claims assessors, a more cost-effective approach might be to provide claims assessors with adequate training to help them interact with vulnerable clients (such as Lifeline’s ‘Accidental Counsellor’ course).⁶ The provision of this type of trauma-informed training for claims assessors was an outcome supported by the RSL NSW, which said:

The Department would benefit from additional training and support for staff dealing with vulnerable clients, including awareness training for the initial identification of vulnerable and at-risk clients. (sub 151, p. 10)

DRAFT RECOMMENDATION 9.2

The Department of Veterans’ Affairs should ensure that staff, who are required to interact with veterans and their families, undertake specific training to deal with vulnerable people and in particular those experiencing the impacts of trauma.

⁶ It is important however, that CCS is adequately resourced to meet the demands of claimants with complex needs (as currently defined by the CCS).

Time taken to process

The Senate Committee inquiry into suicide by veterans commented on the severe toll that claims delays can have on veterans and their families, hearing evidence from participants that ‘delayed claim processes leave the individuals “in a form of limbo which directly and negatively affects mental health” and can also cause “severe financial distress to individuals, which is a causative factor for suicide”’ (SFADTRC 2017, p. 84).

The Commission heard similar claims. For example, Maurice Blackburn said:

... our clients have reported that it has taken years for DVA to process their claim ... The financial difficulties caused by these delays resulted in some veterans almost losing their homes. (sub. 82, p. 10)

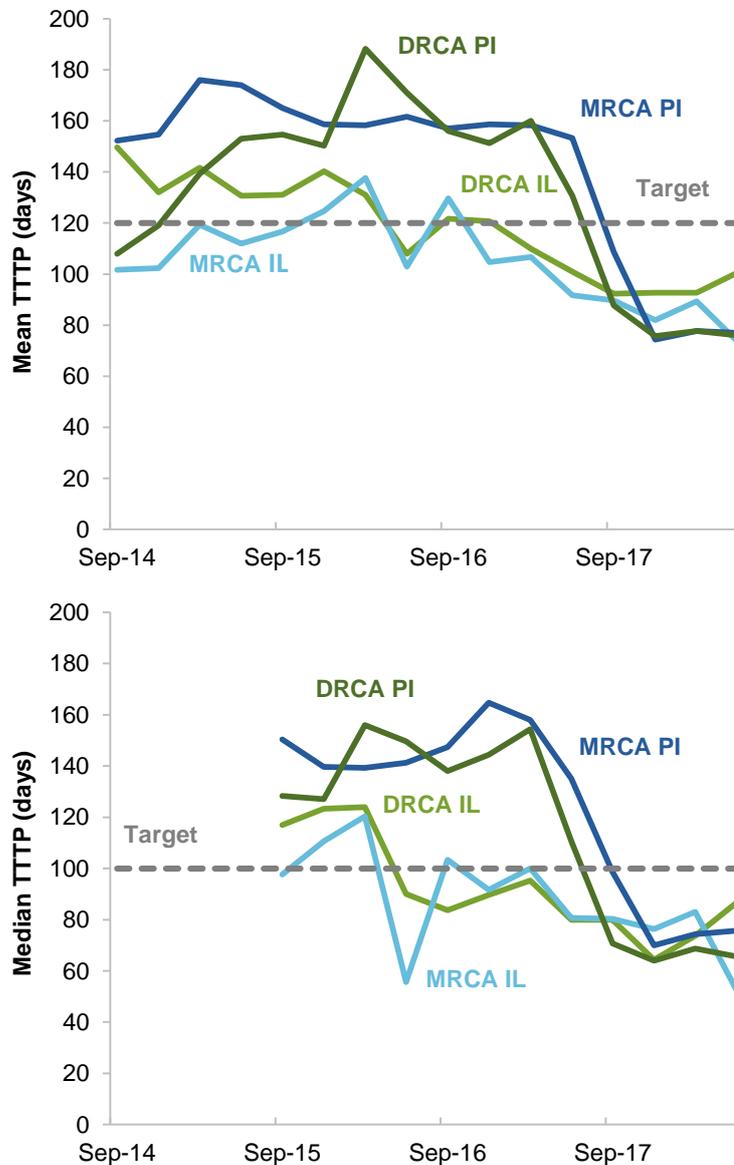
Since VCR was implemented in mid-2016 there has been a consistent and significant reduction in the time taken to process initial liability and permanent impairment claims under the newer, more complex Acts (DRCA and MRCA). Permanent impairment processing times have been cut by more than 50 per cent, while all DRCA and MRCA claims processing areas are currently sitting comfortably within DVA’s internal targets (figure 9.2).⁷ However, some of the decrease in time taken to process performance may have come at the expense of the quality of claims assessment (discussed below).

Consistent with these outcomes, the Commonwealth Ombudsman told this inquiry:

While our Office still receives complaints about claim processing timeframes, this issue has been significantly reduced with the commencement of the Veteran Centric Reform program. (sub. 62, p. 6)

⁷ Targets for processing times are set by the Department annually and reported in DVA’s Portfolio Budget Statement. There are no statutory requirements that claims processing be completed within a certain time frame. The SRCA contains provisions to impose statutory time limits via regulations, but these have never been implemented.

Figure 9.2 Time taken to process (TTTP) claims^a
 By Act, for initial liability (IL) and permanent impairment (PI)

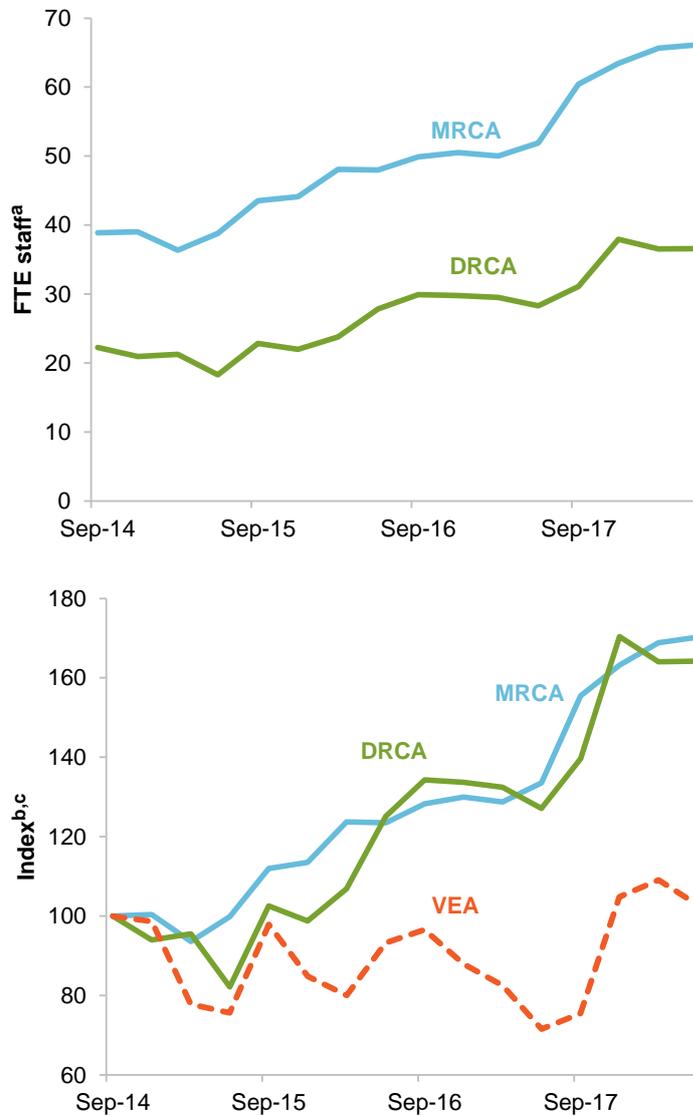


^a Three month moving average.

Source: Productivity Commission estimates based on unpublished DVA data.

The drivers of the improvement in time taken to process include VCR initiatives such as MyService — which is processing claims well within DVA’s internal targets. However, there has also been a significant increase in staffing resources allocated to DRCA and MRCA claims assessment areas, paid for by additional ad hoc departmental funding over the last two Budgets (figure 9.3 — VEA included for reference).

Figure 9.3 Full time equivalent (FTE) staff
By Act, for both initial liability (IL) and permanent impairment (PI)



a Three month moving average. **b** September 2014 = 100. **c** VEA includes the entire assessment process (not just IL and PI).

Source: Productivity Commission estimates based on unpublished DVA data.

Departmental funding base: clients or claims?

According to DVA, adjustments to departmental Budget funding, which were based on the number of *clients* it services, has adversely affected processing times in the claims assessment areas over the past 5-6 years. This is because a client focus, relative to a claims focus, ignores the front-loaded nature of DVA's business (and thus allocates insufficient funding). That is, claims assessment is complex, but once the claim is accepted, client

maintenance in terms of full-time equivalent (FTE) staff per client is relatively low. This is particularly the case for older veterans — a shrinking share of DVA’s client base — who are largely covered by the VEA, a relatively simple, low cost to assess, ‘set and forget’ pension scheme. But compared to the older VEA clients, newer and younger DVA clients under the MRCA and DRCA — a workers’ compensation scheme — tend to be more complex and time consuming to assess (both initially and subsequently), given their legislation’s greater focus on rehabilitation and a return to work.

Budget funding for claims assessment purposes needs to adequately take account of the average new claim, not just the average existing client. Over the past two years, DVA has obtained additional funding based largely on this rationale. However, funding proposals have been ad hoc.

DRAFT FINDING 9.2

The Department of Veterans’ Affairs needs to negotiate a sustainable and predictable funding model with the Department of Finance based on expected claims and existing clients.

This should incorporate the likely efficiency savings from the Veteran Centric Reform program via initiatives such as MyService.

Should statutory time limits be introduced?

One way to incentivise timely claims processing suggested by a number of participants to this inquiry — including Maurice Blackburn (sub. 82), Slater + Gordon (sub. 68) and the Royal Australian Armoured Corps Corporation (sub. 29) — is to introduce statutory time limits for initial liability claims and allow claims to be ‘deemed’ to be accepted after the time elapses. These issues were also canvassed by the Senate Committee inquiry into suicide by veterans (SFADTRC 2017, p. 86) and were the subject of a 2014 review conducted by the Military Rehabilitation and Compensation Commission (MRCC).

A number of civilian workers’ compensation schemes include statutory timeframes. For example, under Victoria’s *Workplace Injury Rehabilitation and Compensation Act 2013* if a claim for weekly incapacity payments is not decided within 28 days from receiving a valid medical certificate, the claim is deemed to have been accepted (s. 75). Similarly, the *Workers’ Compensation and Rehabilitation Act 2003* (Qld) requires a decision ‘within 20 business days after the application is made’ or the claimant can have their application reviewed (s. 134).

However, DVA claims are not directly comparable to civilian claims. They tend to be more complex, involve overlapping entitlements, uncommon medical conditions, and there can be limited evidence that the condition either exists or is related to service. Relatively longer processing times could also reflect some of the ‘beneficial’ aspects of the veteran support legislation.

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- No time limits on claims — claims to DVA are typically made many years or decades after the initial injury or exposure occurred, compared, for example, to 110 days for civilian workers' compensation claims submitted to Comcare (ANAO 2018b, p. 55). The delay can mean evidence and relevant records are harder to obtain and this can make it more difficult for claims assessors to make quick determinations.
 - Requirement to investigate — claims to DVA are required to be thoroughly investigated by claims assessors, regardless of the quality of the applications. By contrast, civilian workers' compensation schemes generally only accept complete claims (MRCC 2014). Shorter time limits could come at the expense of DVA being able to conduct an exhaustive investigation into each claim.

Introducing deemed liability could also create adverse incentives for claimants and assessors.

- Claimants would have an incentive to delay or complicate a claim, such as by providing inadequate evidence or delaying their input (although a 'stop-the-clock' mechanism where the time that a claim is reliant on the claimant for further documents or evidence is not counted toward the statutory time limit would be an effective counter).
- Assessors would have an incentive to deny a claim if it were complex or required significant investigation that might take longer than the statutory time limit, and the Commission heard that DVA delegates are risk averse (chapter 11).

DRAFT FINDING 9.3

The Commission does not support deeming initial liability claims at this stage. Progress on the Veteran Centric Reform program in the Department of Veterans' Affairs should continue to significantly improve the efficiency of claims processing and management. Should these reforms fail to deliver further significant improvements in the timely handling of claims, then the need for statutory time limits should be reconsidered.

Quality assurance

DVA has a post-determination quality assurance (QA) process (box 9.7) in place, which is designed to achieve the following outcomes:

- provide assurance about the correctness of decisions made by delegates on client entitlements in rehabilitation, compensation and income support under the legislation
- provide analysis on error trends (financial and non-financial)
- share good practice to improve work procedures
- identify potential training needs
- provide a credible reporting and feedback process that is used by managers and staff for improving the quality of assessment

-
- contribute to fraud control arrangements
 - satisfy internal and external scrutiny (DVA, pers. comm. 25 June 2018).

Box 9.7 About DVA's Quality Assurance process

The Department of Veterans' Affairs' (DVA) Quality Assurance (QA) processing area is currently made up of 13 full-time equivalent staff members, operating across the claims hierarchy. QA Officers (QAOs) are typically experienced claims assessors, whose job it is to assess cases selected for quality assurance. QAOs are not to have been involved in any way with the original decision.

The QA process is run monthly based on a random sample drawn from the total pool of determined claims (including at each point in the claims process) with the sample size determined using a statistical sampling technique called the Sawyer Methodology. In 2016-17:

- 108 MRCA initial liability cases (claims) were checked, out of an intake of 9316 — a sample rate of 1.16 per cent
- 363 VEA cases were checked out of an intake of 16 004 — a sample rate of 2.27 per cent.

The QAOs assess 'whether the conclusions and decisions that the delegate reached were open to him/her, given all the material that was available at the time of the decision ... If this has not occurred, an error has occurred'. QAOs subsequently report their findings to the original decision maker. That person then has appeal rights against the finding.

Errors in assessment can work against or in favour of veterans. When liability is incorrectly accepted by the government, leading to payments that should not have been made, DVA can initiate debt recovery action against claimants if the mistake is identified. Conversely, where liability is incorrectly denied, payments can be backdated if the mistake is identified. Information about how often errors work against or in favour of veterans is not available.

Sources: DVA (internal manuals and pers. comm.).

The results of the QA process are reported to management monthly and quarterly. Annual figures are also published in DVA's annual report. The headline numbers — or the key performance indicators — are the correctness rates with reference to high (critical) and low impact errors.

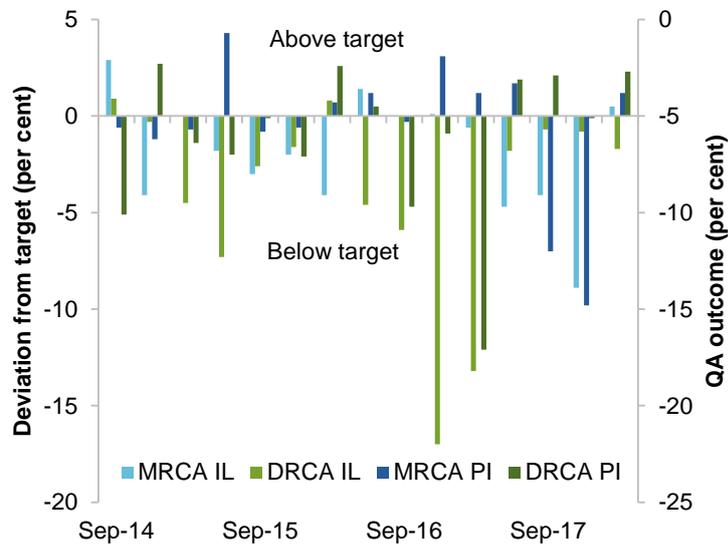
- A 'high-impact error' occurs where action or non-action by the Department results in significant deviation from the entitlements a client should have received.
- A 'low-impact error' is an error in the decision-making process which has not resulted in significant deviation from the entitlements a client should have received.

A correctness rate of greater than 95 per cent (an error rate of less than 5 per cent) is considered acceptable for high-impact errors, while a correctness rate of greater than 90 per cent (an error rate of less than 10 per cent) is considered acceptable for low-impact errors.

The QA system shows that DVA consistently makes mistakes

Over the past four years, MRCA and DRCA initial liability and permanent impairment claims assessors have failed, on average, to meet high-impact error targets in two out of every three quarters (figure 9.4). Outcomes for DRCA initial liability assessment are particularly poor, missing the 5 per cent target in 13 out of 15 quarters — or 87 per cent of the time — and in every quarter over the two years to March 2018.

Figure 9.4 Quality assurance outcomes for MRCA and DRCA
Percentage point deviation from DVA’s internal 5 per cent critical error target for initial liability (IL) and permanent impairment (PI) assessments

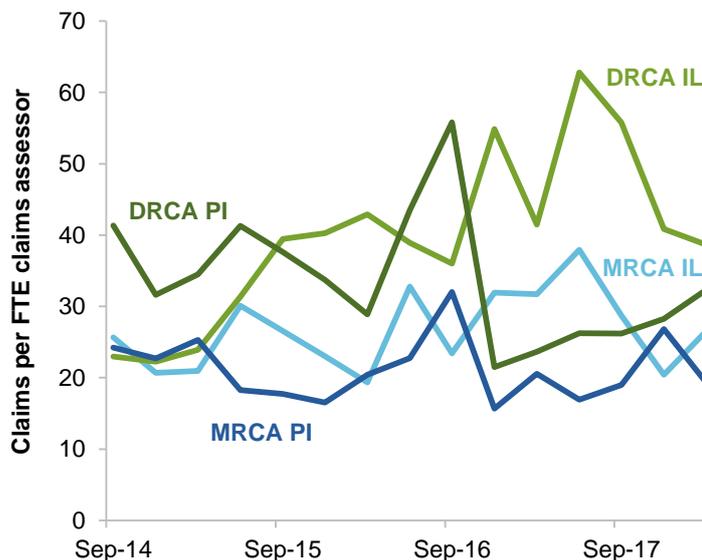


Source: Productivity Commission estimates based on unpublished DVA data.

Why these high error rates have persisted is not clear. Increased workload could be one explanation. Over the past four years the intake of claims per FTE staff within each of the assessment areas has not exhibited an obvious rising trend (figure 9.5). However the intake per FTE has been highly volatile, fluctuating by as much as a factor of three compared to the beginning of the period. The claims area which experienced the largest and most volatile increase in claims per FTE — DRCA initial liability assessments — also exceeded the error target most frequently, suggesting these two measures may be correlated. This would support the suggestion made by some participants that within DVA, ‘... the compensation system is severely understaffed and under resourced’ (confidential, sub 9, p. 1).

However, the correlation between claims per FTE and the quality of claims assessment is relatively weak in the other claims areas. Inadequate training and guidance for DVA staff is another possible explanatory factor (box 9.8).

Figure 9.5 **Claims intake per full-time equivalent (FTE) claims assessor**
By Act for initial liability (IL) and permanent impairment (PI)



Source: Productivity Commission estimates based on unpublished DVA data.

Box 9.8 **DVA claims assessment staff: sufficient guidance?**

The Commission heard that staff retention is a persistent challenge in the claims assessment areas. Combined with Government imposed caps that limit Australian Public Service staff numbers and strong growth in MRCA and DRCA claims, this has led to heavy reliance within DVA on contract staff, who now account for about 40 per cent of the 2900 employees on DVA's payroll (this includes approximately 1800 DVA APS staff and as many as 1100 non-APS staff such as consultants and contractors and a number of non-DVA APS staff from other agencies).

Some participants suggested that this was eroding institutional knowledge within DVA and undermining effective claims assessment.

... Compensation is filled with non-ongoing temporary staff; who have very little understanding of the system, nor the understanding of the need to support clients. (confidential, sub 9, p. 1)

... the CPSU notes that the Commonwealth has continued to apply an Average Staffing Level cap which is driving outsourcing and the use of labour hire staff within the Department of Veterans' Affairs. The increase of non-ongoing and casual staff in the Department has resulted in fewer ongoing staff with knowledge of, and experience in, the application of legislation and related decision-making processes.) (CPSU, sub. 94, p. 2)

(continued next page)

Box 9.8 (continued)

Staff also appear to be acting with insufficient, outdated and non-comprehensive written guidance to assess claims, particularly with respect to the interpretation of the Statements of Principles (SoPs). This is potentially problematic given the nature of decision making under the veterans legislation, where claims assessors are required to use their discretion to make administrative decisions on the balance of probabilities (chapter 8). Without clear guidance, claims assessors may be more likely to reject claims that were not clear cut, which, on the balance of probabilities, they perhaps should have accepted.

Rather than acting in the best interests of the veteran; DVA staff often do not seem to accept the convention (indeed, expressly written into the various Acts) that where there is uncertainty or the validity of the case is finely balanced, a decision should favour the veteran. (Vietnam Veterans and Veterans Federation Australian Capital Territory and Belconnen RSL Sub Branch, sub. 42, p. 10)

Individuals were reluctant to make decisions that might be incorrect or unwittingly set precedents, or that could be interpreted as over generous or an unwarranted demand on the public purse. (Payton 2018, p. 101)

Claims assessors are also not adequately trained in how to communicate lawful decisions. This is contributing to confusion amongst veterans, their advocates and presumably internal and external reviewers when considering the correctness of primary determinations made by DVA delegates.

... the initial claims delegate chose to use an unqualified five-word answer to a standard question in a previous claim as the grounds to reject both claims. The veteran and his advocate remained unaware of the 'real' reason of rejection (the misinterpretation of a five-word answer to an earlier claim) until we were at the [Alternative Dispute Resolution] phase of the [Veterans' Review Board]. The correct result for this claim could have been achieved several years earlier. The anguish caused to the veteran and the physical cost to DVA could have been averted. (Hilton Lenard and Keith Russell, sub. 13, pp. 4–5)

Legal Aid NSW made the following related suggestion:

DVA should be required to explain the actual path of reasoning in its determinations in sufficient detail so that veterans and the tribunals may ascertain whether its determinations contain an error of fact or law. (sub. 109, p. 11)

It is not obvious who is responsible for maintaining the currency of claims assessment manuals or for maintaining the consistency between internal manuals used by assessment staff and the external manuals — the CLIK manuals — that are publically accessible online to assist claimants. Indeed, the CLIK manuals are accompanied by a disclaimer stating amongst other things that the information is potentially not accurate, not timely and not complete:

While we make every effort to ensure that the information on this site is accurate and up to date we accept no responsibility whether expressed or implied for the accuracy, currency and completeness of the information ... For reasons of succinctness and presentation, the information provided on this website may be in the form of summaries and generalisations, and may omit detail that could be significant in a particular context, or to particular persons. (DVA 2014a)

It is also not clear why there are two sets of manuals — internal and external — and the practice of keeping the internal versions private is problematic for veterans and delegates.

There are clearly DVA issued guidelines issued from time to time to their delegates ... in many years of exposure to DVA determinations, never have we been able to obtain these directives. We discover these changing circumstances (directives) through exposure to many determinations ... Advocates ensure veterans submit with their claims the evidence required to meet the requirements of the appropriate SoP(s). The procedure of keeping advocates in the dark regarding these internal changes in policy appears counterproductive and annoying to the experienced advocates. (Hilton Lenard and Keith Russell, sub. 13, p. 5)

Could the QA system be used more effectively?

The QA system is clearly identifying quarter after quarter (and year after year) that claims assessors are not achieving targets for the accuracy of their decisions. And the QA quarterly reports include a section on *learnings, trends and strategies*. Indeed, QA staff are required to monitor these outcomes as part of their duties:

Be aware — QA need to escalate any trends or inconsistent practices. Should you identify a recurring error, an inconsistent practice (either between or within locations) or a delegate who consistently appears with incorrect or inconsistent work please refer the information to the ... coordinator. A QA Bulletin may be issued to remind delegates of the correct procedures. (DVA, pers. comm. 25 June 2018)

What is not clear is how senior managers in the assessment areas are acting on this information. The Commission understands that, consistent with the VCR's cultural change initiatives, the QA area is attempting to improve what has historically been a reportedly somewhat adversarial and uncooperative relationship with the assessment areas. A broader issue is whether the QA area itself is appropriately staffed to undertake adequate QA assessments and outreach.

A recall trigger?

When DVA's QA process routinely identifies excessively high error rates, consideration should be given to recalling the entire batch of claims that was sampled, in order to reassess them all. For example, in December 2016 more than 20 per cent of DRCA initial liability claims were identified by the QA process as containing a high-impact error. Extrapolating to the entire intake that quarter, this would correspond to around 150 claims being incorrectly assessed during December. Similarly, in March 2017 almost 20 per cent of DRCA permanent impairment claims were identified as containing high-impact errors.

When errors are so high, and the affected claims can be clearly identified to within a month, there is a strong case for those claims to be reassessed en masse. It is possible that under such a regime, the case of Mr A, investigated by the Commonwealth Ombudsman (2018), could have been identified, and fixed, earlier. But at present there is no contingency for such an outcome, nor, given DVA's response to recommendation one in the Ombudsman's report, does it appear to be in consideration:

Mr [A]'s case was not selected for QA review otherwise the errors may have been discovered earlier. (2018, p. 24)

Remediating incorrectly assessed claims that can cause 'significant financial, health and personal detriment' to DVA clients should not necessarily be confined to those claims identified via random sampling. Where the QA process identifies error rates of significant

magnitude, all claims in the batch that was sampled should be recalled for reassessment. As the Commonwealth Ombudsman said:

[Veterans] put their trust in the hands of the Commonwealth and have every right to expect that the Commonwealth will, in turn, provide best practice service. (Commonwealth Ombudsman 2018, p. 1)

DRAFT RECOMMENDATION 9.3

If the Department of Veterans' Affairs' quality assurance process identifies excessive error rates (for example, greater than the Department's internal targets), all claims in the batch from which the sample was obtained should be recalled for reassessment.

Assessing the external assessors

Another frequent cause of concern for DVA's claimants is the use of external medical assessors during the claims process.

Although DVA's guidelines state that a report from a treating specialist is preferred, claims assessors can request (at DVA's expense) that claimants have an appointment with an external medical assessor (typically from a medico-legal firm) to obtain an independent report of the claimant's medical condition. These assessments can be requested at different points throughout the claims process, including:

- where medical records are not provided or there is no treating specialist
- if the quality of the provided record is insufficient to establish a diagnosis for initial liability (chapter 8)
- to assess the level, stability and permanency of a condition once it has been accepted (chapters 12 and 13)
- where the DVA delegate is dissatisfied with any provided reports (SFADTRC 2017, pp. 87–88).

The Senate Committee inquiry into suicide by veterans raised a number of issues with DVA's use of external medical assessors.

- Allegations of inconsistent, adversarial or unexplained use of external assessors by DVA delegates, particularly when the claimant's treating doctor appeared to have provided sufficient information.
 - Feedback from veterans, their families and ESOs to DVA has also included a view that 'veterans are not trusted to provide accurate information' (DVA, sub. 125, p. 15).
- External medical assessments may be inappropriate for some patients, particularly those with mental health conditions who may not be comfortable speaking to a new doctor, or

reliving traumatic experiences, or who require an ongoing relationship to establish an accurate diagnosis.

- Difficulties for some clients to attend strict appointment times with specified doctors, particularly rural or regional veterans who live far from metropolitan medical centres (SFADTRC 2017, pp. 87–90).

A number of participants, including the Vietnam Veterans' Federation of Australia (sub. 34), David Melandri (sub. 61), Slater + Gordon (sub. 68), Legacy Australia (sub. 100) and the Defence Force Welfare Association (sub. 118), raised many of the same concerns.⁸

Slater + Gordon suggested that DVA is using external medical assessors 'when the delegate is dissatisfied with the treating doctor's response', in order to "doctor shop" to seek the best outcome for DVA, and not for the very people they are supposed to be assisting'. Slater + Gordon also drew parallels to the life insurance industry, where the fees paid to some of the same external medical assessor firms have been alleged to create a conflict of interest, where the assessors 'are incentivised to make findings which are agreeable to the interests of the insurance company' (sub. 68, pp. 58–59).

In response to the issues raised in the Senate Committee inquiry into suicide by veterans, the Senate Committee recommended (Recommendation 10) a review into the use of medico-legal firms, with a focus on assessments (particularly where information is available from treating specialists) and whether the medical assessors have adequate training on treating veterans (SFADTRC 2017). As at 30 September 2018, DVA's progress update on the implementation of the Senate Committee's recommendations stated that:

... an internal review of the issues associated with the collection of medical evidence has been underway. Options to streamline the processes associated with accessing specialist medical advice, and to improve the service experience when dealing with medico-legal firms, are being considered. The review is expected to be completed by the end of 2018. (DVA 2018ah, p. 5)

DRAFT FINDING 9.4

External medical assessors provide useful diagnostic information about veterans' conditions and are a necessary part of the claims process for the veteran support system. However, they should only be called upon when strictly necessary and staff should be provided with clear guidance to that effect.

The Department of Veterans' Affairs needs to ensure that the current review into external medical assessors fully considers all aspects of Recommendation 10 of the Senate committee inquiry into veteran suicide.

⁸ Issues related to veterans having to undertake multiple external medical assessments (for Defence, DVA and the Commonwealth Superannuation Corporation) at the time of discharge are discussed in chapter 12.

9.5 Will Veteran Centric Reform succeed?

The idea that DVA needs to be more ‘veteran centric’ is not new. It appears that the idea was first floated by former DVA Secretary Ian Campbell in 2008. As part of the Department’s plan to prepare for the 2015 centenary of the Gallipoli landings, the then Secretary envisioned a more ‘veteran centric’ DVA as:

1. getting the right client services as close as possible to clients with consolidated ‘back office’ functions to get more efficient processing
2. integration of VEA, *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and MRCA claims processing
3. bringing client-related information together (virtually and/or physically) for a whole-of-client view. (DVA 2008, p. 4)

These three outcomes are not dissimilar to those of the VCR program. And many initiatives under the VCR program build on existing work — such as the 2010 Defence-led Support For Wounded, Injured Or Ill Program that laid the foundations for the Early Engagement Model⁹ — or are rebadged (previously suspended) reforms from the past — such as the ‘Veterans First’ initiative from the 2010s which preceded the R&C ISH.

When the APSC commented on why earlier DVA reform initiatives had failed (for example, the ‘Veterans First’ initiative), it pointed to ‘poor articulation of goals’ and ‘inadequate scope management and project management skills’ (APSC 2013, p. 18).

It is fair to conclude that change has not been managed well within DVA, and multiple incomplete or poorly implemented projects and frequent structural change have led to a level of cynicism ... Without a significant improvement in change management skills and a collective willingness to overcome resistance where it raises its head, DVA will likely be unsuccessful in implementing new major projects or any type of large transformational change. (APSC 2013, p. 18)

And there are some signs that these problems remain. A case in point is the 2018 ANAO audit which was critical of initiatives implemented over the previous two years. In particular, the ANAO (2018b) made a number of findings and recommendations (summarised in section 9.1) concerning the R&C ISH. The creation of the R&C ISH, under a \$23.9 million 2016-17 Budget measure, was supposed to ‘ensure critical compensation and rehabilitation processing systems operate effectively’ (DVA 2016g, p. 2). The audit findings clearly suggest that R&C ISH *is not* being used effectively, or at least to its full potential — a fact acknowledged by DVA when it accepted all of the audit’s findings and recommendations.

The 2017 Australian Government Assurance Reviews (also known as Gateway Reviews) into the VCR program, initiated by the Department of Finance and conducted by an independent panel, also said that while success was ‘probable’, ‘constant attention will be

⁹ Under this model, members who joined the ADF from 1 January 2016 and those who separated from the ADF after 27 July 2016 are registered with DVA (chapter 8).

needed to ensure risks do not become major issues threatening delivery’ (Department of Finance 2017a, p. 3).

Gaining assurance

Assurance Reviews, which are mandatory for programs with a total estimated cost of over \$50 million, could be particularly useful for DVA in light of the shortcomings identified by the APSC in 2013 and more recently by the ANAO. The Reviews will continue throughout the life of the VCR program, typically on an annual basis, assuming that funding continues.

Led by independent experts (three appointees external to government and one from within government) in project implementation, Assurance Reviews are designed to provide commissioning agencies with ‘independent assurance and advice to improve the delivery and implementation of ... policies, programmes, projects, and services, as well as providing an early identification of areas requiring corrective action’ (Department of Finance 2017b).

While these Reviews are not usually made public, they will also provide insights on progress to government agencies such as Finance, Treasury and Prime Minister & Cabinet who are responsible for overseeing the implementation of the VCR program.

DRAFT FINDING 9.5

Under the Department of Veterans’ Affairs’ (DVA’s) stewardship, the Veteran Centric Reform (VCR) program has produced a number of early successes. However, given DVA’s poor history of change management, close supervision and guidance will be required to ensure VCR continues to be successfully rolled out. Regular progress reporting and ongoing assurance reviews will facilitate this outcome.

9.6 ESOs and advocacy

The many roles of ESOs

ESOs play an important role in the veteran support system, undertaking a wide range of activities and often volunteering thousands of hours of time to aid veterans in almost all aspects of their post-service lives. These include:

- welfare and mentoring services for veterans and their families
- commemoration and recognition activities and other social events
- transition support for members leaving the ADF
- employment services
- education and training services

-
- advocacy services
 - assistance with filing and presenting legal or administrative challenges/appeals to DVA decisions.

DVA meets often with ESOs via an array of formal consultative forums under the National Consultative Framework, including the ESO Round Table (ESORT), which is the main forum for dialogue between DVA and ESOs (chapter 11).

The many ESOs

There is no definitive list of existing ESOs. The Commission heard estimates that the number of ESOs is currently as high as 5500 (DoD, pers. comm. 25 October 2018). A study by the Aspen Foundation in 2015 found that 3474 registered charities had nominated ‘veterans and/or their families’ as a beneficiary (although only 519 of those charities nominate ‘veterans and/or their families’ as the sole beneficiary) and that there were 2780 ESO locations across Australia (Aspen Foundation 2015). DVA estimated the number of ESOs to be at least 1339 (sub. 125, p. 69).

Very few ESOs have a national footprint, with the exception of the RSL and Legacy, which have national and state branches and hundreds of sub-branches and provide the full gamut of services. Others, such as WithYouWithMe and Soldier On, focus on a much smaller subset, or even single issues.

Despite calls for self-regulation and coordination of activities, including by the then Minister Tehan in 2017, to overcome ‘rivalry between organisations ... duplication of effort, misalignment in strategic priorities and ... poor management and service delivery’ (DVA, sub. 125, p. 69), there is no peak body that provides a unified position for ESOs. The idea of creating a peak body was strongly supported by the RSL NSW who said ‘DVA should commit to funding a peak body of ESO service providers tasked with accrediting ESOs as eligible for DVA funding, taking the international aid sector as a model’ (sub. 151, p. 1).

Some participants told the Commission that a lack of organisation amongst ESOs could be diluting their effectiveness.

... unless ESOs return to the purpose for which they started a century ago, none of the advances being made through VCR, ADR [Alternative Dispute Resolution] and [the Advocates Training and Development Program] will achieve their full potential ... Highly federated structures, robustly protected autonomy at the state and (especially) local levels, and poor information flow between the various organisational levels are issues that many ESO have yet to resolve. (ADSO, sub. 85, p. 35)

One potential solution to this issue is community veteran services hubs. The Oasis Townsville envisioned ‘a “Supported Veteran” (“Smart Cities”-like) collaboration between Federal, State and Local government for the benefit of veterans and their families’ (sub. 92, p. 1). These hubs would not try to replicate existing ESOs, rather they would act as

a ‘relaxing veteran and family friendly community space’ that would provide referral services connecting veterans and their families with relevant ESOs whose services best suit their needs (The Oasis Townsville 2018).

DRAFT FINDING 9.6

Ex-service organisations play an important role in the veteran support system. However, the lack of coordination among them may be diluting their effectiveness.

ESO advocacy

Of particular interest to this inquiry is the advocacy role that ESOs play, specifically in the compensation space, helping veterans navigate the compensation and rehabilitation system. Some advocates are paid, although the majority volunteer their time, often with support from Australian Government grants (box 9.9).

Volunteers are engaged in supporting ex-service officers in a variety of ways, and can play a critical role in their rehabilitation. Advocates play a crucial role in the compensation process, offering advice on what supports and services are available to veterans, and assisting with lodging claims and appeals. (Volunteering Australia, sub. 142, p. 3)

... over the period 1992 to 2016, [the Training and Information Program] trained as many as 10 000 ex-ADF personnel as volunteer pension or welfare officers and [reviews] advocates. Many of these volunteers have given long and faithful service to veterans, war widow(er)s and families. Their contribution to veteran advocacy is ongoing testimony to the tradition of ‘Mates helping Mates’. Neither its effect nor its importance can be over-estimated. (ADSO, sub. 85, p. 32)

Compensation advocacy services provided by ESOs are broad and include:

- information and general advice on the full range of entitlements
- claims lodgement assistance, such as ensuring that the forms are correctly filled out and all relevant information is present
- claims advocacy, in the strictest sense of arguing the claim on behalf of the veteran
- case coordination, to progress the claims process as rapidly as possible through DVA in line with the wishes of the veteran.

Box 9.9 Funding for ESO advocacy services

The Australian Government will provide about \$7 million in grant funding in 2018-19 to ex-service organisations (ESOs) to provide a range of different services.

Grants targeted at ESOs to provide advocacy services include:

- Building Excellence in Support and Training — \$3.8 million in 2018-19 to support ESOs to provide compensation and welfare assistance to the veteran community. Funding is distributed to ESOs based on their advocacy workload as a percentage of the national workload. Funding can be used to pay advocates and to cover associated equipment and administrative expenses (Community Grants Hub 2018a).
- Grants-In-Aid (GIA) — \$145 000 in 2018-19 to national ESOs for projects and activities that encourage cooperation and communication between veterans, ESOs and the Government, as well as support the provision of advocacy services to veterans. GIA funding cannot be used for salary assistance or normal ongoing costs (Community Grants Hub 2018b; DVA 2018p).

General grants targeted at ESOs include:

- Supporting Younger Veterans — \$4.25 million over five years (\$1 million in 2018-19) to ESOs or other organisations that assist younger veterans with service post-1999 to assist transition back into civilian life. Funding can be used to deliver projects and activities that:
 - develop the capability to service the unique needs of younger veterans
 - support the development of tailored services for younger veterans
 - fund organisations that deliver services to younger veterans now and into the future
 - increase collaboration among organisations to expand services and harness existing expertise
 - increase awareness of younger veteran issues and services, where doing so would benefit younger veterans (DVA 2017r, 2018aj).
- Veteran and Community Grants — \$2.17 million in 2018-19 (up to \$50 000 per grant) to ESOs to improve veteran health and wellbeing, for example through projects that promote a healthy lifestyle, help veterans continue to live independently in their own home, reduce social isolation, support carers and improve access to community services (Community Grants Hub 2018c; DVA 2018ao).

The number of advocates is falling

Advocate ranks are shrinking due to ageing and difficulty recruiting.

A particular concern is the falling numbers of advocates, pension and welfare officers and the corresponding reduction in support to veterans, their families and dependents ... ESO succession plans aren't being as fruitful as they have been in the past. Furthermore and very sadly some of the well intentioned replacements aren't coping with the complications and associated difficulties of the current system so they are not staying. (John Burrows, sub. 27, p. 1)

Younger volunteers just are not coming forward with a result that ESO's are struggling to maintain numbers of advocates. For example, the advocate base at a Canberra based [Veterans Support Centre] has dwindled in the space of five years from a high of 25 Advocates/Pension

Officers to 13 currently. (Vietnam Veterans and Veterans Federation Australian Capital Territory and Belconnen RSL Sub Branch, sub. 42, p. 6)

RSL NSW reported that 72 per cent of its volunteer pensions officers are older than 65 years and 10 per cent are 50 years or younger (sub. 151, p. 4).

Difficulty recruiting may be part of a broader disinclination amongst younger veterans to join the older, established ESOs (which tend to provide the majority of advocacy services).

[There is a] marked reluctance by contemporary veterans to have anything to do with mainstream ESOs in particular in respect of a new Advocate training programme which is perceived rightly or wrongly, to be underwritten by DVA. [They have also] lost a significant level of trust and faith in mainstream ESOs due to the recent scandals surrounding the nation's leading ESO, the RSL. (RAACC, sub. 29, p. 23)

A corollary to the attrition problem is that there are too few advocates knowledgeable in the MRCA and SRCA/DRCA legislation.

Anecdotal evidence indicates many older generation [Training and Information Program]-trained advocates mainly focus on the Veterans' Entitlements Act and tend to avoid matters involving the Safety, Rehabilitation and Compensation Act and Military Rehabilitation and Compensation Act. (Air Force Association, sub. 93, p. 3)

I consider there has been a particular problem arising from advocates' knowledge of, and preference for, the VEA rather than the SRCA. (Peter Sutherland, sub. 108, p. 4)

The Commission also heard that the quality of advocacy services can be 'very variable, ranging from knowledgeable and effective to adverse to client interests' (Peter Sutherland, sub. 108, p. 4). RSL Queensland said:

Advocates who are well trained and competent are a very valuable and important aspect of the claims process. Some credibility has been lost because of the number of inadequately prepared advocates who were lodging claims and dealing with DVA. (sub. 73, p. 22)

However, Legacy disputed the extent of this problem: 'the variation has been greatly exaggerated by those who have a political agenda or have a vested interest in a particular viewpoint' (sub. 100, p. 4).

The move to online claiming services, such as MyService will not remove the need for advocates.

Whilst there is much to be said for on-line claiming systems, there are also many benefits in having well-trained advocates to guide claimants through the process. (RSL Queensland, sub. 73, p. 11)

On-line claiming does not fill the gap. There is still a need for injured and ill members and former members to get expert personalised assistance to work through the claims process and to understand where it is appropriate to request the review of a decision. (Slater + Gordon, sub. 68, pp. 80–81)

Advocacy training is contentious

The Commission heard mixed, but passionate, views on the new advocacy training program, the Advocacy Training and Development Program (ATDP) (box 9.10). While there is general support for the concept of a professional, competency-based system, there were concerns about a lack of support by DVA (including funding). Others raised concerns about an undue focus on filing claims and insufficient focus on wellness and rehabilitation, while the time requirements — including on mentors — were criticised as excessive and driving existing and potential advocates away.

[ATDP] is just starting to be implemented and should improve the knowledge and experience of those advocates assisting with both claims and appeals. As it is competency based it will require those advocating to reach an accepted level and be mentored by suitably qualified mentors. This in turn will result in a better outcome for claimants. (name withheld, sub. 36, p. 5)

[The Alliance of Defence Service Organisations] strongly supports the advent of ATDP and accredited advocacy. It is ... the start of a process of progressive professionalisation of Military Advocacy. (ADSO, sub. 4, p. 1)

[ATDP] has its issues, but the underlying concept of having a competency-based training program is to be commended. However, this program is still predominantly following the [Training and Information Program] training modules and is focussed on Compensation and Welfare. There is very little clear direction or training for potential advocates regarding the importance of rehabilitation and having veterans seeking to achieve a high level of wellness. (RSL Queensland, sub. 73, p. 6)

The new ATDP initiative is excellent as a concept but it is failing due to lack of appropriate funding and a serious lack of direction. ATDP is placing a huge burden on volunteers to manage a very complex process and it is running the risk of losing the support of all ESOs. (Slater + Gordon, sub. 68, p. 80)

... the ATDP has become bureaucratised and process driven and many of the current, long term advocates have expressed the opinion that it will be very difficult for volunteer advocates to achieve accreditation under the current arrangement. (Legacy, sub. 100, p. 4)

The introduction of the ATDP concept was rushed, it failed to adhere to the original model ... and is particularly onerous upon the unpaid volunteer advocates. The previously [Training and Information Program] trained advocates will continue to drop out as the requirement for on-going mentoring, training and bureaucratic interference continues. (David Melandri, sub. 61, p. 3)

Box 9.10 **Advocacy training programs**

The Training and Information Program (TIP) was a 20-year partnership between ex-service organisations (ESOs) and the Department of Veterans' Affairs (DVA) to provide compensation and welfare training to new and existing advocates.

TIP officially commenced in 1994 and was a solution designed for a point in time. TIP served those needs well when it was introduced. Volunteers from ... ESOs willingly gave up their time to support the huge number of [World War II] veterans who had reached, or were reaching, the retirement age. These veterans needed support and guidance with the compensation process and DVA did not have the reach or the resources to address that need. When compared to the existing complexities of the three applicable legislations that now must be considered, the system was simple. The aim was to achieve the highest pension level possible for aging veterans (RSL Queensland, sub. 73, p. 6).

In March 2014, the Advocacy Training Review commissioned by DVA (led by Brigadier Bill Rolfe) found that the TIP framework was outdated and needed to evolve. A working party developed a blueprint for a new program, which was subsequently endorsed by ESOs and the Government.

The Advocacy Training and Development Program (ATDP)

The ATDP vision is to 'train and develop selected practitioners to provide high quality advocacy services to current and former ADF members and their dependents, covering rehabilitation, compensation, appeals and welfare' (DVA 2018d).

At the core of the new ATDP is skills accreditation. In April 2017, the ATDP Course in Military Advocacy was formally accredited as a vocational education course by the Australian Skills Quality Authority. A registered training organisation (Major Training Services Pty Ltd) issues statements of attainment to trainees for each of the six units of competency (covering compensation, appeals and welfare topics) that are completed and audits all ATDP training and development activities.

Although there are no specific knowledge pre-requisites, new advocates must be assessed by a sponsoring ESO to determine their suitability. After this, the trainee must complete on-the-job training (under a mentor) and online training, before undertaking face-to-face training, and then being tested and accredited. As of October 2018, there had been 687 units of competency awarded to 534 advocates through the ATDP (DVA 2018g).

Recognition of Prior Learning is available for existing advocates, allowing them to demonstrate their existing knowledge and skills to achieve accreditation. Accredited advocates are also required to complete learning and development activities (including questionnaires, essays and seminars) to keep their skills and knowledge current. This occurs through a points-based 'Continuing Professional Development' program, which was due to be launched on 1 July 2018.

Sources: Australian Government (2018b); DVA (2015b, 2016j, 2018d, 2018g).

The Australian Government has commissioned a Veterans' Advocacy and Support Services Scoping Study led by Robert Cornall. This scoping study is investigating how veterans and their families are assisted to access entitlements and services. The advocacy study is expected to recommend a model to the Australian Government in December 2018. As such, the Commission has not made any recommendations on advocacy services in this report, but will in the final report.

10 Reviews

Key points

- Most decisions by the Department of Veterans' Affairs (DVA) to provide (or not provide) compensation or support to claimants can be challenged in an administrative review. The *Veterans' Entitlements Act 1986*, *Military Rehabilitation and Compensation Act 2004* and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* each have separate review processes.
- After an internal review or reconsideration, reviews progress to either the Veterans' Review Board (VRB) or the Administrative Appeals Tribunal (AAT). For some decisions, the AAT is the first point of review, while for others, the AAT only reviews the case after the VRB. In both the VRB and AAT, cases are initially dealt with via alternative dispute resolution (ADR). The ADR process helps the claimant and DVA to discuss the case at hand, and may allow them to gather new information. This new information may allow an otherwise unjustified claim to be approved. If an error is identified, a case can be resolved without a hearing. If the case remains unresolved, it moves to a full hearing.
- Although more cases are being resolved in a timely manner through the ADR process, there are several problems with the current arrangements.
 - Internal review processes are not effective in identifying recurring errors in either DVA's decision making, or the underlying processes that cause these errors. The majority of cases that reach the VRB lead to changes to DVA's decision, even after an internal review.
 - The necessary information to support an accurate determination is not always collected prior to a case being referred to external merits review.
 - There is no clear process to harness review findings to improve the administration of original decision making.
 - Different review processes across the Acts are unjustified and cause unnecessary complexity.
 - Having two external merits review bodies would be unnecessary in a better performing system.
- The review process is perceived by many as a 'backstop' relied upon by DVA to avoid being more thorough and accurate in their initial decision-making processes. Instead, the review process should support DVA in making accurate initial decisions and seeking earliest resolution of disputed matters.
- There should be a single pathway for all reviews, regardless of legislation, comprising reconsideration, dispute resolution, formal merits review, and judicial review.
 - Reconsideration: DVA could use the VRB's current 'outreach' process to clarify the issues with claims when it first reconsiders a claim and clarify matters of disagreement with the claimant.
 - Dispute resolution: The VRB's role should be modified to specialise in resolving cases through ADR processes, but not to have determinative powers (nor conduct hearings).
 - Formal merits review: The AAT would be the only determinative merits review body to deal with complex cases that require a decision-making hearing. It would offer guidance on interpretation of the law and clarify how DVA can better adjudicate on those issues in the future.
 - Judicial review: Appeals to the courts on matters of law would be dealt with in the current manner.

This chapter looks at the current arrangements for reviewing decisions made in the veteran support system and considers the case for reforming these arrangements.

- Section 10.1 describes the purpose of review processes and the distinction between internal review, merits review and judicial review.
- Section 10.2 looks at the current review processes under each Act.
- Section 10.3 considers the high rate at which decisions under the veteran support system are varied upon review, and proposes reforms to reduce this rate.
- Section 10.4 considers the complexity and duplication across the multiple review paths and proposes the creation of a single review pathway.
- Section 10.5 looks at perceptions of adversarial conduct by the Department of Veterans' Affairs (DVA) in assessing claims and reviews.
- Section 10.6 considers how proposed changes to the review process can interact with other reforms to the system to improve decision making by DVA.
- Section 10.7 considers the remaining issues of whether review is available for all decisions that affect veterans' interests (and those of their families), and whether the reasons currently provided for decisions are adequate.

10.1 Why do review processes matter?

When a veteran submits a claim to DVA for compensation under the veterans' compensation and rehabilitation Acts,¹ DVA can approve or deny the claim. When making any sort of administrative decision there are effectively two types of errors that might be made by a government agency decision maker:

- a 'false positive', where a claim that should be rejected under the legislation is accepted
- a 'false negative', where a claim that should be accepted under the legislation is rejected.

A false positive (in the case of an entitlement or compensation) represents an avoidable cost to government. In the case of the veterans' compensation and rehabilitation system, false positives will only be corrected if DVA, through its own quality assurance processes, reviews and redetermines the claim. This leads to DVA recovering the overpaid amount.

A false negative, on the other hand, denies an entitlement to someone who should receive it. If a valid claim is rejected by DVA, a veteran could suffer significant and unjustified

¹ *Veterans' Entitlements Act 1986; Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988; and Military Compensation and Rehabilitation Act 2004.*

hardship. And to receive the support they are entitled to, the veteran needs to go through a review process that would not otherwise be necessary. As one veteran put it:

It is unfair that veterans are currently paying the price for the mistakes of DVA staff and/or their highly paid contract Doctors plus their internal and external Lawyers. Justice delayed is justice denied. (Alan Ashmore, sub. 95, p. 2)

Acknowledging that not all initial decisions by government will be correct, the review process exists to support fair, high-quality, efficient and effective decision making (ARC 1999). As well as providing oversight of individual decisions, the review process helps to assess the effectiveness of the broader decision-making process within an agency. Where initial decision-making practices are deficient, external reviews can provide guidance on issues of merit or legal interpretation to improve those initial administrative practices. To this end, government decision making is subject to a variety of review processes (box 10.1).

Box 10.1 Appeal and review: what's the difference?

The terms 'appeal' and 'review' are, somewhat confusingly, used interchangeably in the Department of Veterans' Affairs' documentation. In a technical legal sense, 'appeal' refers to a higher court examining a decision made by a lower court, while 'review' refers to a tribunal or court examining a decision of an executive government agency. The further consideration of claims in the veterans' context falls into this latter category.

Internal review processes can be requested as a first step by an individual dissatisfied with a government decision. A decision does not need to be entirely adverse to the affected individual for the claimant to seek review. For example, a person may have been accepted as receiving an entitlement, but seek review if they believe they are entitled to a greater level of payment.

Internal reviews can also be initiated within an agency, through (for example) quality assurance protocols (discussed in chapter 9). These processes aim to identify and fix mistakes in administration by assessing a set of applications.

Internal processes can act as an indicator of the consistency and effectiveness of decision making, especially when paired with the right data collection and analysis tools.

External review processes include merits review and judicial review. Any person whose interests are affected by a decision can apply for review.

- Merits reviews — which are provided for by legislation, and are undertaken by merits review bodies such as the Veterans Review Board (VRB) and the Administrative Appeals Tribunal (AAT) — involve a reassessment of the evidence to determine whether the correct and preferable decision was made by the original decision maker with the outcome being a new or upheld decision. The AAT reviews matters in the first instance in some cases (first-tier review) and reviews matters arising from decisions of the VRB (second-tier review).
- Judicial reviews — which are provided for both under legislation and in the Australian constitution, and are undertaken by courts — ensure that the determination was made lawfully. If it was not, a determination may be thrown out and sent back to the decision maker.

In this chapter, 'review' is used to describe the processes available for veteran support claims to be re-examined (primarily internal review and merits review processes).

Source: Cane (2010, pp. 7–8).

10.2 How the review processes work

Veterans can seek review of decisions made by DVA through a number of processes. The process for review depends on which Act the decision was made under — the *Veterans' Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) or the *Military Rehabilitation and Compensation Act 2004* (MRCA). However, all Acts have in common some kind of internal reconsideration or review, followed by an external merits review process with the Veterans' Review Board (VRB) or the Administrative Appeals Tribunal (AAT).

At each stage of the process, there are several possible courses of action by the reviewer, DVA and the claimant:

- if the reviewer thinks that the original decision was correct, they may *affirm* it
- if the reviewer finds an issue with the original decision, they may *vary* the decision (replacing the decision with the correct decision), or merely *set aside* the decision (leaving it up to the original decision maker to make a new decision)
- DVA and the claimant may *resolve the dispute by consent* before the VRB reviews it (with DVA potentially agreeing to provide some but not all of the entitlements claimed by the veteran)
- the veteran may *withdraw* their application for review, leaving the original decision intact.

If a merits review does not provide a satisfactory response, the claimant may pursue an independent judicial review process in the courts. Courts cannot replace a government decision themselves on review — they generally will set the decision aside if it is deemed unlawful, so that DVA can make an alternative decision. The merits and judicial review processes are subject to different time limitations, varying from between 30 days and 12 months of the applicant being given notice of a decision by DVA.

Internal review

Two statutory authorities are responsible for veteran support claims decisions under the three Acts. The Repatriation Commission is responsible for deciding claims under the VEA, while the Military Rehabilitation and Compensation Commission is responsible for deciding claims under the DRCA and MRCA. In practice, the powers of these agencies are delegated to DVA staff (chapter 11). Staff in each of these Commissions are responsible for examining decisions on review.

If a claimant is unsatisfied with a determination under any of the Acts, they can request an internal review by DVA. DVA also initiates internal reviews for all applications to the VRB as a matter of policy. Under the VEA and MRCA, these reviews are examinations by DVA review officers of the original determination — they are not fresh determinations, but rather focus on whether errors are obvious from the final determination itself. Under the DRCA,

the decision maker looks at the information to make a new decision — an internal reconsideration rather than a review.

Some veterans view the internal review processes as more of an administrative exercise than a proper, serious review:

... largely it is considered S31 reviews are a pointless waste of time, and little more than a procedural or administrative tick in the box. (Geoff Shafran, sub. 144, p. 2)

External merits review: the VRB and AAT

If DVA conducts an internal review and the claimant remains unsatisfied, the claimant may seek a formal merits review. This is at the VRB for most decisions made under the VEA and MRCA, and at the AAT for some VEA decisions and most decisions under the DRCA.

The VRB: alternative dispute resolution and hearings

The VRB aims to conduct merits review in a manner that is fair, just, economical, informal and quick (within 12 months).

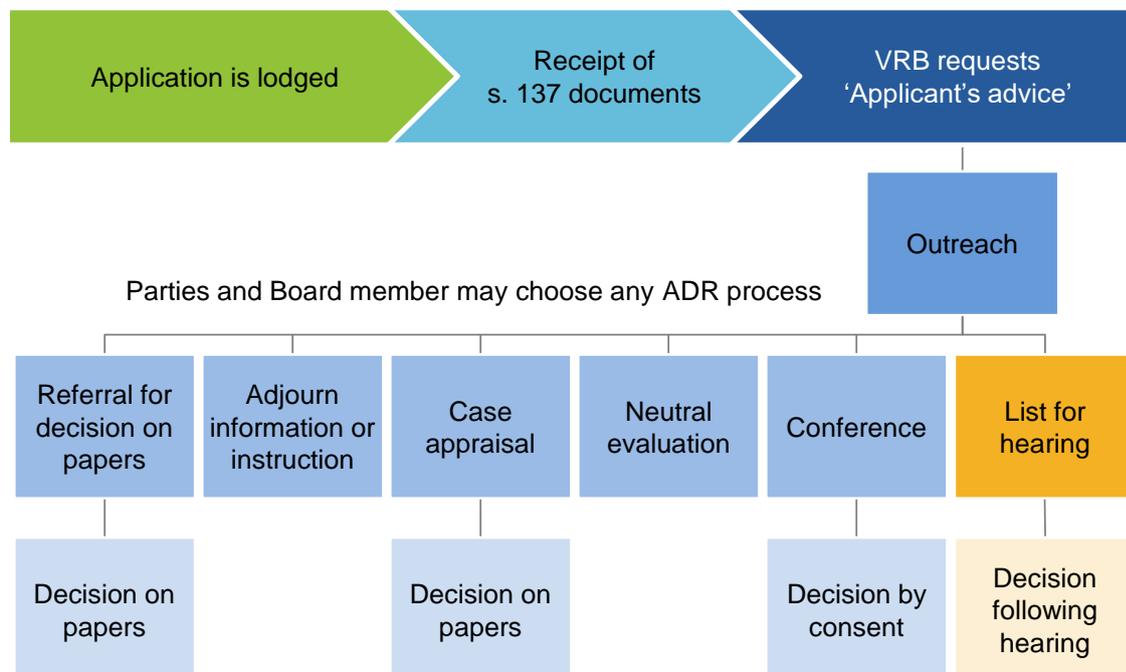
The VRB makes a decision that it considers to be correct and preferable in all of the circumstances — not necessarily with reference to faults in the original decision. In doing so, the VRB exercises the same statutory powers, and is subject to the same limitations, as the DVA decision maker whose decision it is reviewing.

Under the VEA, veterans may seek a review of a DVA decision by the VRB under s. 135, with or without an internal review. For MRCA decisions made prior to 1 January 2017, veterans applying for review were required to decide between having DVA (internally) reconsider their case, or the VRB reviewing it. This process was adjusted for newer claims to more closely mirror the VEA pathway, with both internal review and external review at the VRB being available. Under the DRCA, the first point of external merits review is at the AAT rather than the VRB. This arises as a consequence of the DRCA's origins in the broader Australian Government civilian workers' compensation system.

The VRB process is illustrated in figure 10.1. Importantly, the VRB uses an alternative dispute resolution (ADR) process to resolve most cases. If DVA and the applicant cannot resolve the claim through the ADR process, then the VRB will hold a formal hearing.

ADR processes aim to resolve disputes between two or more parties outside of formal court and tribunal proceedings. Traditional legal processes involve both parties preparing submissions on their position in a dispute, and appearing for a formal hearing in front of a judge or tribunal member. By contrast, the ADR process is intended to be facilitative — that is, centred on reaching a solution, rather than on deciding who is 'right' or 'wrong'.

Figure 10.1 What happens to a case in the VRB?



Source: Adapted from VRB (2018b).

After receiving an application for a review by the VRB, DVA is required to prepare a s. 137 report containing the evidence used to make their original decision. This might include service records, internal documents, or medical evidence.

A conference registrar then has an outreach conversation with the applicant, ensuring that they understand the issues of the case and the broader ADR process.

The VRB has a number of ADR processes at its disposal, which can be used at any time and in any sequence.

- If the s. 137 report and the outreach show that a review can quickly be resolved in the applicant's favour, then the registrar may decide the case **'on the papers'** without a hearing.
- The conference registrar may **request further information** from DVA or the applicant.
- If the applicant needs guidance on what the key issues in their case are, or if the case appears complex, a member of the VRB will conduct a **case appraisal**. They read all of the written materials (including any further evidence obtained). They may clarify the points in issue between the parties. They can reach a conclusion on the *factual* issues between the parties.
- The VRB member may use the similar process of **neutral evaluation**. However, unlike a case appraisal, the member provides an opinion on the probable outcome on the case

as a whole (examining both facts and law). This offers an opportunity for the applicant to reconsider before proceeding to a hearing, and can be used by both parties as an objective basis of their likelihood of success, as a starting point for further negotiation.

- The VRB member may order further **conferences** between parties to discuss the issues in dispute, any further evidence that may help, and identify opportunities to resolve the dispute by agreement between the parties without a hearing.

At the conclusion of any of these processes, another ADR process may be selected, a decision may be made, or a date for a formal hearing may be set. The VRB first trialled ADR processes in 2015. Today, ADR is the first step in all VRB cases except in Queensland, where the process will be rolled out later in 2018. In 2017-18, 83 per cent of cases referred to an ADR process were finalised without the need for a hearing. ADR cases were finalised, on average, around four and a half months from lodgements, while the average VRB case took just over a year (VRB 2018a, p. 2).

Participants indicated that the transition to ADR had improved the way reviews were dealt with at the VRB:

The Alternative Dispute Resolution programme has been highly effective in boosting the efficiency of appeals before the Veterans' Review Board, leveraging its non-adversarial nature to maximum advantage. The informal, conversational setting significantly lessens the stress on veterans and their families, while empowering them by restoring a measure of agency. (RSL NSW, sub. 151, p. 14)

When cases in the VRB reach a hearing, those hearings are generally conducted informally and in private. Veterans may seek legal advice prior to the hearing, and make written legal submissions to the board, but lawyers cannot present a case at hearing (though they can appear at ADR). DVA does not ordinarily have a representative at the hearings (VRB 2018a, p. 40), but rather the VRB member effectively acts as the decision maker under the VEA or MRCA. Decisions by the VRB are provided to the claimant and DVA (VRB 2018a, p. 24). Cases are decided by a panel of three VRB members — including at least one who is legally qualified, and one who has served in the Australian Defence Force. Lawyers cannot attend VRB hearings as representatives of a claimant seeking review, although non-lawyer advocates can (this continues to be a point of contention — section 10.5).

Role of the AAT

The AAT can review decisions made by the VRB, as well as decisions made by DVA on internal review under the DRCA. It hears applications for review in its Veterans' Appeals division. Review in two separate bodies is a unique feature of veterans' entitlement law. Most merits review processes for other Australian Government decisions are heard in the AAT only (box 10.2).

Box 10.2 All together now: amalgamation in the Administrative Appeals Tribunal

Since its establishment there have been a number of efforts to bring many of the decisions made by other merits review tribunals into the remit of the Administrative Appeals Tribunal (AAT) — a process known as ‘amalgamation’. This was first proposed by the Administrative Review Council (1995) in its Better Decisions report. Most recently, the Migration Review Tribunal, Refugee Review Tribunal and Social Security Appeals Tribunal were amalgamated with the AAT (from 1 July 2015).

However, the Veterans’ Review Board (VRB) was excluded from amalgamation attempts in 2000 (under the *Administrative Review Tribunal Bill 2000*) and in 2015 (under the *Tribunals Amalgamation Act 2015*). Successive reviews of the issue cited ‘the need for a specialised review mechanism for veterans’ (Williams 2000, p. 21 408) and ‘[its] focus on defence-related matters’ (National Commission of Audit 2014, p. 212) as a justification for retaining a separate VRB.

In 2017-18, the average cost to government per finalised VRB case was \$2169 (VRB 2018a, p. 11). For comparison, AAT cases cost \$3848 on average (AAT 2018, p. 24). However, many cases in the AAT are likely to involve commercial parties with legal representation — this does not show that the AAT costs more than the VRB to resolve similar cases. There are no application fees at the VRB or AAT for veterans’ decisions, meaning applicants for review do not contribute to this cost.

Tribunal amalgamation, in theory, allows government to reduce the costs of both back office functions and maintaining multiple leases for functionally-similar tribunal buildings. In practice, the most recent series of tribunal amalgamations resulted only in ‘modest’ cost savings, as governments incur a number of up-front costs in amalgamation, such as relocating offices, updating tribunal material and changing IT systems (Creyke 2016, pp. 61–62). As such, a decision to amalgamate the VRB should not be made with a view to cost reductions in the short term. As Creyke said:

The evidence suggests that it is unlikely that amalgamation of tribunals will lead to a reduction in calls on the revenue, at least in the short to medium term. Those seeking to identify the financial benefits of the amalgamation need to take a long-term view, and focusing exclusively on financial benefits is misplaced. Achievement of this goal should be replaced with others such as greater efficiency or better public satisfaction and even these will take time to materialise. (Creyke 2016, p. 62)

Like the VRB, the AAT relies on ADR practices as well. The main ADR processes available to the AAT are:

- conferences between parties, case appraisal and neutral evaluation (which operate in a similar manner to the VRB)
- conciliation (where a conciliator helps both parties to solve their dispute together and suggests options for settlement agreements)
- mediation (where a mediator facilitates discussion and agreement between the parties on the issues in the case, but does not actively suggest the content of a settlement agreement).

The AAT also has the power to adjust its procedures and proceedings in formal hearings to meet the needs of the parties — so, for instance, an unrepresented party may be offered

greater assistance by the tribunal member than a represented party would be. Unlike the VRB, veterans' decisions in the AAT are generally published (AAT 2018, p. 51).

Judicial review

If a client believes errors in law have been made by the merits review bodies, they can also pursue judicial review in the Federal Court or High Court of Australia.² Technically, an applicant can seek judicial review without seeking merits review first. However, courts are reluctant to interfere with the processes of other decision-making bodies until other procedures have been exhausted, and may choose to use their discretion not to grant judicial review if merits review opportunities have not been used.³

This pathway exists for all decisions under the veterans' legislation. Unlike in merits review, where the applicant can argue that the decision maker has made an error of fact in determining their case, applicants for judicial review must prove that there was an error of law. To prove an error of law, an applicant must argue that the decision maker:

- went beyond the powers granted to them by the statute under which the decision was made
- failed to ensure fair procedure in making the decision (for example, by failing to give an applicant a fair hearing, or by coming into the decision with bias) or
- made a decision without rational justification.

In 2017-18 there were six decisions of the Federal Court for claims under the Acts (DVA 2018f, p. 96). The High Court last considered an appeal for a veteran's claim under the predecessor to the DRCA (the *Safety, Rehabilitation and Compensation Act 1988*) in 2016⁴ and under the VEA in 2005.⁵ To date, no claims under the DRCA or MRCA have reached the High Court.

Other avenues of review can address administrative errors

Claimants dissatisfied with the outcome or process of their claims have additional avenues of review. In particular, the Australian Government can review whether a government agency has failed to perform its function properly, even where there is no breach of legislation, under the banner of maladministration or defective administration.

² If an applicant is unsuccessful in the AAT, they may apply for judicial review with a single judge of the Federal Court or Federal Circuit Court under the *Administrative Decisions (Judicial Review) Act 1977* ss. 55-56 (ADJR Act). Applicants may also seek judicial review in the High Court under the *Australian Constitution* s. 75(v), though the case can be remitted to the Federal Court: *Judiciary Act 1903* s. 44. If a single judge of the Federal Court makes an adverse decision, then the applicant may seek special leave to appeal their decision to the Full Court of the Federal Court (with three judges), then to the High Court.

³ See, for example, ADJR Act s. 10(2)(b)(ii).

⁴ *Military Rehabilitation and Compensation Commission v May* (2016) 257 CLR 468.

⁵ *Roncevich v Repatriation Commission* (2005) 222 CLR 115.

Maladministration

In cases of maladministration, where the complainant has been unfairly or unreasonably treated, rather than merely an error in the application of policy to their claim, applicants can complain to the Commonwealth Ombudsman, who will consult and negotiate with the agency on their behalf (Commonwealth Ombudsman 2017b).

The Ombudsman has no power to direct an agency to reconsider a decision, but will make formal submissions to government to improve outcomes and may publish a report. In July 2018, the Ombudsman conducted an investigation into the case of ‘Mr A’, a Navy veteran who faced both overpayments of some benefits and omission of others, making several recommendations of both specific application to Mr A’s case and general application to the work of DVA (Commonwealth Ombudsman 2018).

Defective administration

The Department of Finance operates a scheme for compensation for detriment caused by defective administration (CDDA). The scheme allows Australian Government agencies to provide compensation where there is a moral rather than a legal obligation to do so, in cases of ‘defective administration’ — that is, ‘an agency’s unreasonable failure to comply with its own administrative procedures, institute appropriate administrative procedures, or give proper advice’ (Commonwealth Ombudsman n.d., p. 1) DVA is reported to have paid out \$2.4 million in compensation under this scheme between 2008 and 2018 (Baines 2018). However, no central or public record of CDDA payments is made. In part, this is because payments under the CDDA scheme are often confidential and can require a claimant to release their right to make other claims against the agency. This approach, by reducing the likelihood of significant media exposure of any individual instance of defective administration, could limit the potential for the CDDA scheme to act as an effective accountability mechanism for government agencies generally.

10.3 Why is there a high rate of variation on review?

The available data suggest that, when DVA decisions make it to the AAT or VRB, they are more likely than not to be changed.

DVA and the VRB currently collect high-level data on the number of claims that reach each stage of the review pathway. In 2016-17, 8–10 per cent of the total number of decisions were reviewed.⁶ Table 10.1 breaks down the number of determinations and reviews for claims under each Act.

⁶ This does not strictly mean that between 8 and 10 per cent of determinations were reviewed, as many of the reviews considered in 2016-17 were made from determinations that were made in earlier years.

Table 10.1 Number of determinations and reviews under veteran support legislation
2016-17

<i>Act</i>	<i>Number of primary determinations</i>	<i>Total % of cases where review is sought^a</i>	<i>Number of internal reviews sought</i>	<i>Number of VRB cases</i>	<i>Number of AAT cases</i>
VEA	18 656	8.8% - 14.2% ^b	996	1 646	191
MRCA	25 437	4.9%	528	710	43
DRCA	11 974	12.6%	1 507	n/a	77
Total	56 067	7.8% - 9.6%^b	3 031	2 356	311

^a The total number of cases where the first level of review is sought, as a proportion of determinations under each Act in 2016-17. ^b In the case of claims under the VEA, VRB cases which are reviews from internal reviews by DVA are not recorded separately from those VRB cases which are reviews from DVA's original decision. As a result, the exact number of first-instance reviews cannot be determined.

Source: DVA (pers. comm., 25 June 2018).

Figure 10.2 shows decisions at each stage of the review process in 2016-17, from an initial determination by DVA to the external merits review stage.

- Significant numbers of claims were not accepted (between 29 and 56 per cent across each Act). However, most of these determinations were not reviewed.
- Where decisions were subject to internal review, most DVA decisions (between 74 and 79 per cent) were confirmed, or the applicant withdrew their case (leaving DVA's original decision intact).
- Of the total number of cases that reached the VRB across both the VEA and MRCA, more than half of DVA's original decisions were set aside (figure 10.3 shows the relevant data for 2017-18).
 - 48 per cent of DVA decisions taken to the VRB under the VEA, and 66 per cent of decisions under the MRCA, were altered.
 - For first-tier reviews under the DRCA in the AAT, 32 per cent of DVA's decisions were set aside.
 - The number of cases set aside also varied between case type, with initial liability in death cases being set aside most frequently and initial liability in impairment cases being set aside least often.
- At the AAT, the majority of reviews of the VRB or of internal reviews by DVA (under the DRCA and MRCA, where available) affirmed those bodies' decisions. However, a considerable share (between 26 and 40 per cent) of AAT reviews led to another change to the decision.

By comparison, in 2017-18, around 81 per cent of Comcare claims taken to the AAT in the same period for civilian workers' compensation led to the original determination being

affirmed (SRCC 2018, p. 20). Less than 1 per cent of nearly 37 million tax returns lodged faced objections from taxpayers; just 478 of these cases proceeded to courts or tribunals (Commissioner of Taxation 2018, p. 183).

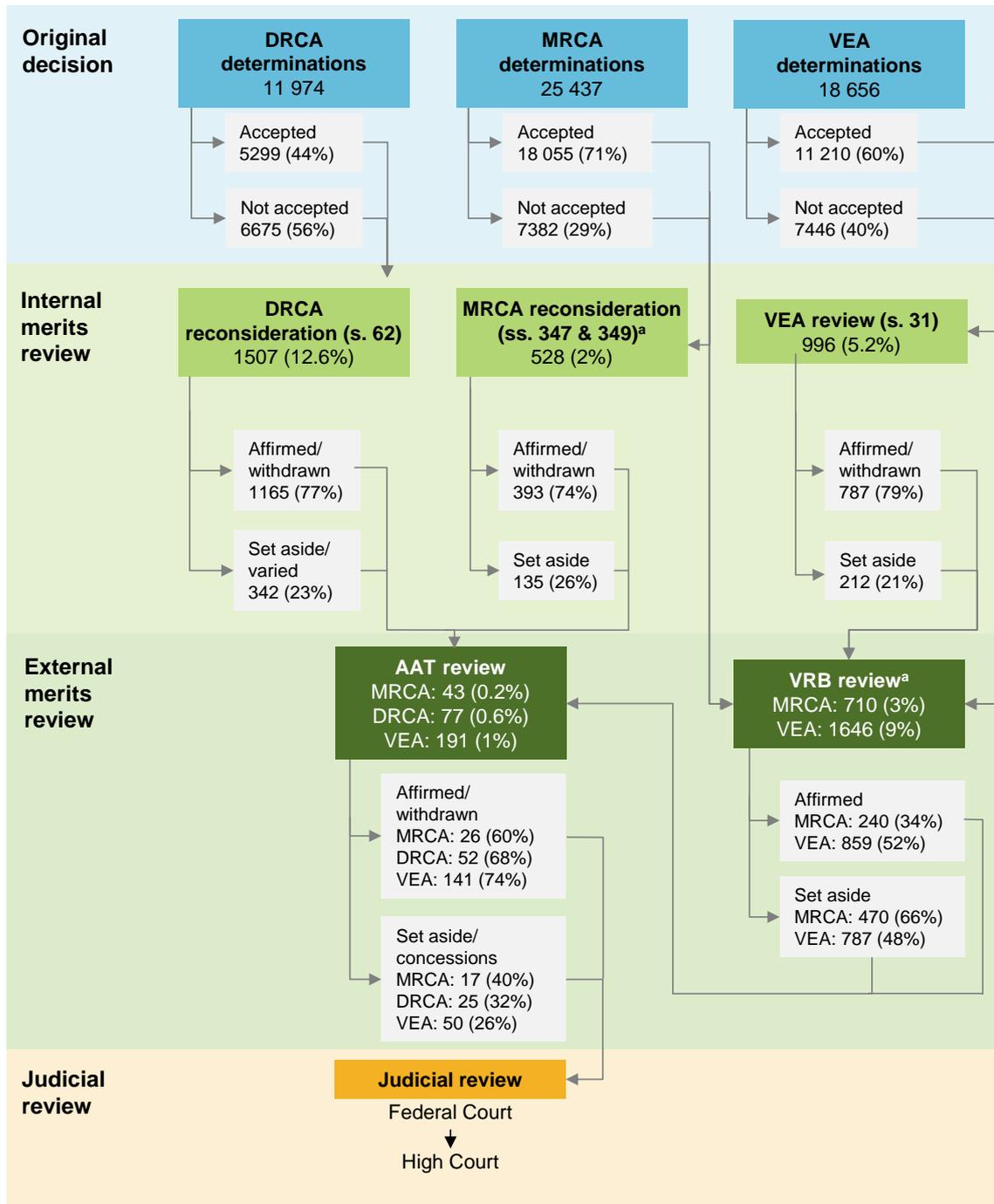
It should be noted that DVA decision makers are granted more discretion by the veteran support Acts than exists in either Comcare or taxation legislation. There is no time limit on bringing veterans' claims, and DVA delegates are required to take into account the likely deficiencies of records and the effect of the passage of time.

This requirement is intended to be beneficial to veterans. Having said that, this can allow considerable scope to validly make different decisions in similar cases. This is reflected in the high variation rates at the AAT level, where a new decision is sometimes reached even though several reviewers may have already considered the case. Further, discretion (and consequently, demand for review of decisions) is likely to be greater for decisions based on complex medical evidence (SFPARC 2003, p. 34).

Most decisions by DVA are accepted by the individuals affected. However, when a veteran seeks external review, the VRB more often than not changes DVA's decision. This suggests that the review process is playing a useful role in properly examining the rights of veterans.

However, the high rate of variation on review raises questions around the integrity of the original decision-making process, and around the ability of the system to build in improvements based on feedback from the review process.

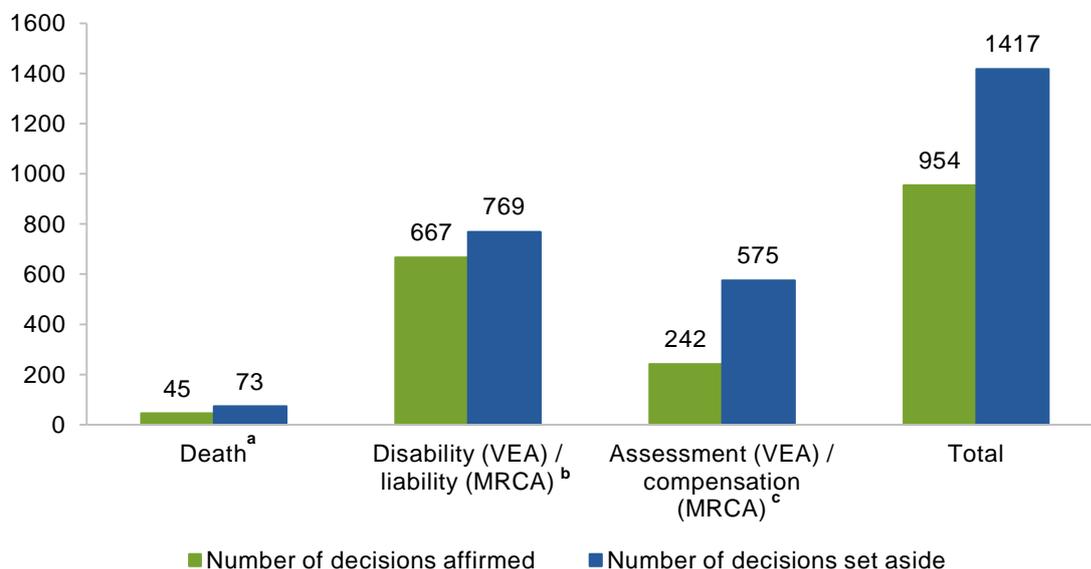
Figure 10.2 **Claim acceptance rates through the review pathway**
2016-17



^a MRCA claimants prior to 1 January 2017 were required to choose between internal or VRB review.

Source: DVA (pers. comm., 25 June 2018).

Figure 10.3 **DVA decisions set aside or affirmed by the VRB in its decisions**
2017-18



^a Determinations of whether the Commonwealth is liable for claims where the veteran died in service under the VEA or MRCA. ^b Determinations of whether the Commonwealth is liable for non-death claims under the VEA or MRCA. ^c Decisions other than initial liability claims under the VEA; claims other than liability (such as permanent impairment, treatment and rehabilitation) under the MRCA.

Source: Veterans' Review Board (2018a, pp. 25–26).

Are claims rejected out of hand?

A number of participants argued that initial decision making was focused on DVA's interests, rather than on accurate assessment of entitlements against the legislation. Stakeholders also raised concerns that DVA would reject any ambiguous claims without giving the veteran the opportunity to clarify their circumstances. Some participants suggested that this was done with the aim of reducing the key performance indicators measured by DVA or in the hope that claimants would not pursue the relatively complex pathways for review. And DVA is failing to meet five out of six of its targets for correct decision making under the MRCA and DRCA (DVA 2018f, p. 77).⁷

Participants suggested that DVA could be resolving claims in a more timely manner but instead look for reasons to reject claims (box 10.3).

⁷ Accuracy in original decision making is covered further in section 9.4.

Box 10.3 A culture of denying claims?

A number of participants questioned the Department of Veterans' Affairs' (DVA's) approach to initial decision making.

Far too often, decisions are made in the best interest of the Department, where these are overturned on review (internally or via external agencies, such as [the] AAT). ... decisions are being released earlier than previously. However, quite often that decision under review has been overturned as there was several factors missed, or the blind following of policy by less experienced staff creates mistakes or decisions made without considering all factors (not merit based). Delegates look for reasons to decline; instead of using merit based decision processes. (confidential, sub. 9, p. 1)

... DVA rejected my claim which left me very despondent and confused, noting that my case was well documented and had already been accepted under the SRCA [*Safety, Rehabilitation and Compensation Act 1988*]. The RSL advocate then informed me that this was the 'normal' first response from DVA and that all I had to do was get a lawyer to draft a letter to DVA pretty well saying exactly what I had said in my application and in all likelihood I would be granted [total and permanent impairment] status. I spent under 10 minutes with an RSL recommended lawyer, paid my fees and was given a letter to take to DVA. Within a much shorter time frame than the original application took to be processed I was granted [total and permanent impairment] status. (Daniel Foley, sub. 19, p. 4)

There is and has been a culture within DVA to deny and do this until the person gives up claiming or cannot afford to fight the claim ... (Timothy Chesterfield, sub. 24, p. 1)

The department has ... an established practice of denying any claims, forcing the veteran into a three part appeal process which can take anywhere up to three years (personal experience) ... (Garry Ridge, sub. 25, p. 2)

... when I rang the delegate, she said her team leader said reject it as it will be overturned at Section 31 review, which it was ... when I rang and challenged [a DVA delegate] she told me 'tough, you will have to go to VRB' ... (Raymond Kemp, sub. 37, p. 12)

... the approach seems to be one of finding every possible way to deny a claim, which results in further expense in appeals that should have been determined very much earlier and in a far more timely manner. (Adrian d'Hagé, sub. 54, p. 1)

On the 21st August 2014 I submitted claims to VEA and SRCA both of which were rejected in September 2014. My advocate said it will get rejected as all claims do, so he started working on the appeal as soon as we submitted claim. I appealed both decisions and [DVA] accepted my condition on 11 February 2015. (William Sim, sub. 148, attachment p. 4)

The VRB noted in its annual report, 'the fact that a decision is set aside by the Board is not necessarily a reflection on the quality of the primary decision' (VRB 2018a, p. 24). The Commission understands that, more often than not, when DVA's original determination is changed by the VRB, new information has been provided by the applicant or existing information is clarified or further explained (VRB, pers. comm., 23 October 2018). This may reflect the approach taken by the VRB — in particular, its investigative and outreach processes, which help to clarify the issues in an applicant's claim and seek the information required to prove an entitlement (box 10.4). Further, the Senate Finance and Public Administration References Committee observed that applicants may withhold information in order to reach the VRB, where decisions appear to be made in veterans' favour more often (SFPARC 2003, pp. 33–34). The VRB (2018a, p. 24) likewise observes that the 'approach taken by applicants and representatives' can change the outcomes for cases on review.

Box 10.4 **Successful Veterans' Review Board outreach — an example**

A veteran submitted claims in 2015 for conditions relating to back injuries. The Department of Veterans' Affairs accepted liability in two claims, but rejected a claim for a third condition. The veteran resubmitted his claim in 2017 with further medical opinion and witness statements, but was again rejected. An internal review under s. 31 of the *Veterans' Entitlements Act 1986* was also rejected.

The application was reviewed by the Veterans' Review Board (VRB), and the application was referred to a VRB member for alternative dispute resolution. The member asked the veteran to clarify an answer given in his original 2015 claim. Neither the veteran nor his advocate were aware this was the barrier to his claim being accepted. The veteran addressed the issues in a short reply email.

Rather than asking for further information back in 2015, the Department of Veterans' Affairs officer rejected the claim, meaning that the veteran was denied a valid entitlement. By explaining the primary issue with the claim, and the additional evidence required, the VRB was able to rectify the error.

Source: Hilton Lenard and Keith Russell (sub. 13, p. 4).

However, if a large number of rejected claims succeed when more information is provided, this suggests that that information should have been sought by DVA when the original claim was made. A lack of clarity within DVA, or for advocates, of what is required when making an original claim, can result in more cases than necessary reaching the review stage.

Integrity of the review process

The fact that a large number of decisions are varied upon review raises the prospect that there is also a significant number of false positives: cases where DVA (or the VRB) have granted a claim that should not have been granted under the legislation. DVA does monitor VRB decisions with a view to identifying cases where further review may be necessary 'to clarify a legal issue or protect the integrity of the legislation'. However, DVA rarely does this — indeed, it took just one matter to the Federal Court in 2017-18 (DVA 2018f, p. 96). Further, for the small number of VRB matters that are reviewed in the AAT, the VRB's decision is varied more often than not. The VRB notes that, as with its own assessments of DVA's decisions, 'in the majority of these cases, there appears to have been evidence before the AAT that was not before the VRB' (VRB 2018a, p. 28). Nonetheless, it raises questions about whether laws are currently clear enough for DVA decision makers and tribunal members alike to make consistent decisions.

This may allow a persistent claimant to succeed, in spite of ambiguity in interpretation of the legislation at a single point of the review, and DVA will not seek to clarify the ambiguous point for future reference. DVA, to the contrary, might decide that the VRB's decision is an incorrect interpretation of the legislation and continue to apply policies in another manner. This does not provide veterans and advocates with a transparent and principled guide to how their claims will be determined.

Nonetheless, DVA's practice of not seeking reviews of VRB decisions could have the counterintuitive result of increasing the number of incorrect (false positive) decisions.

DRAFT FINDING 10.1

Current review processes are ensuring that many veterans receive the compensation or support that they are entitled to under the law, albeit sometimes with significant delays. The majority of cases that are reviewed externally result in a change to the original decision made by the Department of Veterans' Affairs.

Missing: a feedback loop and follow-up

Ultimately, the greatest improvement that can be made to the experience of veterans is to improve the accuracy of initial decisions by DVA. However, current arrangements do not provide effective feedback on deficiencies in DVA decisions and processes identified in VRB reviews and on how those deficiencies might be avoided. The VRB provides its written decisions to DVA, can remit decisions back to DVA (allowing it a further opportunity to review the VRB's reasoning in making decisions) and 'actively engages and liaises with [DVA] in a variety of fora to assist in optimising primary decision-making' (VRB, sub. 117, p. 12). However, this communication does not appear to be systematic, regular, or driven by data.

This lack of formal arrangements to incorporate feedback from administrative review into original decision-making considerations is not necessarily unique to DVA. It is not always clear that tribunals achieve their goal of influencing and improving primary decision making (box 10.5). However, this issue is not new: the Australian National Audit Office (ANAO) wrote in its report on DVA's compensation pension system:

The trends set by appeal bodies through their decisions have not appeared to have influenced the primary level in such a way as to lead to a fall in primary decisions being appealed. Although there are a number of other reasons for this, the ANAO believes that inadequate feedback from the appeals level to primary decision makers is a contributory factor ... There is little feedback by the appeals bodies to the DVA on undesirable trends they may consider exist in primary decisions being appealed. (1992, p. 86)

And the Senate Finance and Public Administration References Committee found:

Settling cases without the need for external review has the advantage of resolving cases in the shortest possible time frame and in a cost effective manner. All stakeholders from DVA, [ex-service organisations] and the legal profession agree that an expeditious claims and appeals process — 'getting it right the first time' — should be a priority of the review system. (2003, p. 35)

Box 10.5 The impact of administrative review on decision making

The review process is one of several influences on administrative decision making. Public servants and others making government decisions are also influenced by resources, policies, politics, and cultural factors of the environment they are working in (Pearson 2008, p. 59). Likewise, decisions are not altered only because of administrative errors. A whole number of reasons may allow tribunals to make fewer errors (Pearson 2008, p. 60).

- Tribunals can consider new evidence, which may change the outcome of the decision.
- Applicants may approach the process more seriously having already faced a rejection.
- Tribunals also bring more attention, experience and resources to an individual case than are typically brought at the stage of the initial decision.
- Tribunal members often have judicial or legal experience, so they are more likely to be familiar with the legal qualities of decision-making processes.

Tribunal decisions are also not binding legal precedent, meaning that original decision makers do not need to make decisions in line with their rulings. There is always room for an executive agency to seek further review of a tribunal decision, arguing that the tribunal has made an error in interpreting a statutory power. There is a risk that, if every tribunal decision is treated in isolation, agencies may fail to recognise systemic errors that may unnecessarily force applicants into review processes (Fleming 2000, p. 62).

That said, insofar as tribunal decisions reflect the proper application of legislation, administrative decision makers should apply the same reasoning when dealing with similar decisions. The Administrative Review Council recommended this as a best practice approach:

It is important that [administrative agencies] have in place processes for:

- receiving review tribunal decisions and analysing their potential effects on agency decision making (including determining whether further review should be sought of, or an appeal made against, particular review tribunal decisions);
- effective and timely distribution of relevant review tribunal decisions (or a synopsis of decisions where that is sufficient), and identification of changes to legislation, guidelines and policies which should arise from those decisions; and
- training staff (particularly primary decision makers) in appropriate aspects of administrative law, including the role of external merits review.

... The broader effects of review tribunal decisions will not be felt within agencies unless agencies have in place effective channels for distributing information about review tribunal decisions, and any policy or legislative changes flowing from such decisions. (1995, pp. 113, 115)

Anecdotally, many departments report processes to review tribunal decisions at a central level and to share this information with primary decision makers. However, there are no detailed evaluations of the impact on tribunal decisions on decision making.

The most immediate and necessary form of feedback is implementing the tribunal's decision for the individual seeking review. However, some veterans reported that, even where an external merits review decision had been made in their favour, DVA did not immediately implement the decision, requiring the veteran to contact DVA to ensure their compliance with tribunal rulings:

DVA seemed to know nothing of the AAT decision to reinstate my compensation when I phoned them ... around three weeks after the AAT decision was made. (Daniel Foley, sub. 19, p. 5)

Further, the sample of VRB decisions made available to the Commission did not focus on issues with the original decision. Rather, the VRB member determining the case merely decided, based on the material presented to them, whether a claim should or should not be granted. This is not a legal requirement, as merits review tribunals are responsible for reviewing the correctness of the decision itself, rather than the reasons for the decision. However, unless the differences in the reasoning process are clear, VRB decisions may not assist DVA to identify the points at which they made errors or failed to seek further information during the claims process. As a result, VRB decisions should be supplemented by a separate and robust feedback process from the VRB to DVA (detailed below).

DRAFT FINDING 10.2

The Veterans' Review Board and Administrative Appeals Tribunal are not providing sufficient feedback from their review processes to the Department of Veterans' Affairs to better inform decision-making practice. Further, the Department is not incorporating the limited available feedback into its decision-making processes. This means that opportunities for process improvement are being missed.

An effective review process can improve original decision making

There are no system-wide data on the types of issues that are most widely reviewed (and where there may be strong justification to change the way DVA collects information in the initial claim). The review process can correct issues with individual decisions, but can only lead to changes with systemic issues if there are processes to identify and share common issues with the original decision makers.

With data on information deficiencies (or other oversights) that lead to improper rejection of claims, current application processes and paperwork can be altered to ensure more robust and accurate decisions are made on claims under each Act. The VRB does not need to observe an error in the original decision to reach a conclusion that another decision is correct and preferable. However, where it does observe such an error, it should explicitly detail the issue (or issues) with the original determination, within its decision. If the VRB merely substitutes its new decision for the old decision without pointing out errors in the original decision, then it will be more difficult for DVA to identify and eliminate systemic problems in their determinations.

Data are collected on the total number of DVA determinations that are set aside or affirmed in broad categories of claim (death, disability/liability, and assessment/compensation). Future data collection should retain these broad categories but also identify the particular section of legislation, and any relevant regulatory instruments (including the Statement of Principles (SoP) under which a person is claiming). This will allow DVA to identify which areas of legislation are most likely to give rise to poor DVA decisions on claims, and to assist it in developing approaches to improve how it deals with such claims.

This type of aggregated statistical data should be reported to the DVA senior management and staff responsible for determining veteran support claims on a regular basis — given the high volume of cases resolved by DVA, quarterly reports might be appropriate. These statistical data should also be informed by reports from members of the VRB, identifying trends they have seen in their cases and factors that merited a variation of DVA’s decision.

Such reporting should be required by legislation, not treated as something to be discussed through informal liaison processes between the VRB and DVA. It should highlight areas where more reviews are succeeding than would be expected. This should go alongside data from DVA’s internal quality assurance process (chapter 15) to ensure that accountability for making correct decisions becomes part of the culture of claims assessment.

DRAFT RECOMMENDATION 10.1

The Department of Veterans’ Affairs (DVA) should ensure that successful reviews of veteran support decisions are brought to the attention of senior management for compensation and rehabilitation claims assessors, and that accuracy of decision making is a focus for senior management in reviewing the performance of staff.

Where the Veterans’ Review Board (VRB) identifies an error in the original decision of DVA, it should clearly state that error in its reasons for varying or setting aside the decision on review.

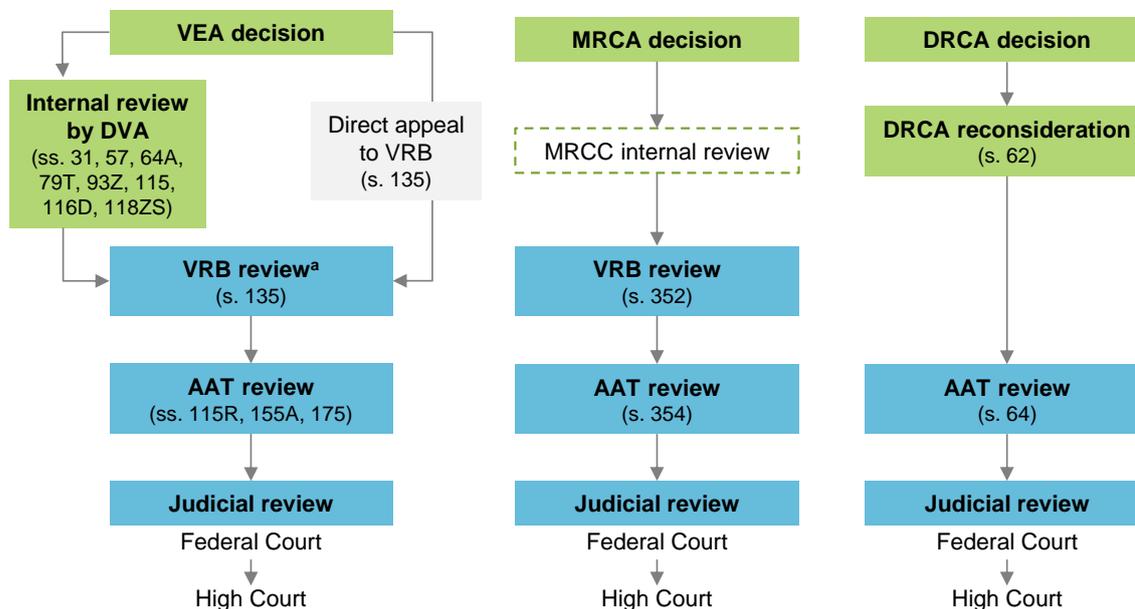
The Australian Government should amend the *Veterans’ Entitlements Act 1986* to require the VRB to report aggregated statistical and thematic information on claims where DVA’s decisions are varied through hearings or alternative dispute resolution processes. This reporting should cover decisions of the Board, as well as variations made with the consent of the parties through an alternative dispute resolution process. This should be collected and provided to DVA on a quarterly basis and published in the VRB’s annual report.

DVA should consider this reporting and respond by making appropriate changes to its decision-making processes.

10.4 Unnecessary complexity and duplication

There is unnecessary complexity and duplication in the review process because of differences between the Acts. Each Act has a different review process (figure 10.4).

Figure 10.4 **Review processes under the Acts**
2018



^a Only for decisions under ss. 14, 15 and 98, and for s. 31 reviews from decisions under those sections.
Source: DVA (pers. comm., 25 June 2018).

Whether a decision can be reviewed or not depends on which Act the decision was made under (figure 10.5). And there are differences between the Acts.

- For example, decisions on rehabilitation or medical treatment under the VEA cannot be reviewed by the VRB, while those under the MRCA can.
- Some VEA decisions can be reviewed by the AAT immediately. Most of these decisions are themselves from internal reviews.
- Internal review is available for some decisions where external merits review is not, and judicial review is available as an option for all decisions under the legislation (though not for decisions under policy schemes — section 10.7). Such a review considers the narrower grounds of errors of law, rather than errors on the merits of the case.
- SoPs are policy documents that are not subject to merits review. However, the Repatriation Medical Authority and the Specialist Medical Review Council can review them on a claimant’s request (chapter 8).

Figure 10.5 What decisions can be reviewed?

VEA, MRCA and DRCA, 2018

VEA decisions Review in the VRB (s. 135)		MRCA decisions Review in the VRB (s.352)	
Disability pension (s. 14)	War widow's or orphan's pension (s. 14)	Initial liability (chapter 2)	Rehabilitation (chapter 3)
Increase in disability pension (s. 15)	Application for attendant allowance (ss. 98, 111)	Compensation (chapters 4, 5)	Medical treatment (chapter 6)
Review in the AAT (s. 175)		Claims (chapter 7)	Miscellaneous (chapters 10, 11)
Verification of reinstated pensioner (s. 13AG)	Qualifying service (s. 57)	DRCA decisions Review in the AAT (s.64)	
Clean energy payments (s. 64C)	Pharmaceutical benefits card (s. 93Z)	Initial liability (s. 14)	Compensation (ss. 15, 16, 17, 18, 19, 20, 21, 21A, 22, 24, 25, 27, 29, 29A, 30, 31)
Allowances and other benefits (s. 115)	Veterans' Children Education Scheme eligibility (s. 116C)	Rehabilitation (ss. 36, 37, 39)	Determination of overpayments (s. 114B(5)(a))
Seniors health card (s. 118Y)		Transitional (part X, div. 3)	

Sources: *Military Rehabilitation and Compensation Act 2004*; *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*; *Veterans' Entitlements Act 1986*; VRB (2018a, pp. 7–9).

The administrative complexity of the review process is multiplied for individuals with claims under multiple Acts. A person with claims under multiple Acts could be required to submit

one review application in the VRB and one in the AAT, even though each entitlement is derived from the same service and circumstances (for example, Brian Fuller, sub. 11, p. 2).

Each Act also differs in its approach to internal review: the DRCA provides (and the MRCA previously provided) for full reconsideration of the original decision on request of the applicant. Under the VEA and MRCA (for claims after 1 January 2017), a reviewer will examine the original decision for errors, rather than considering all of the information available to the original decision maker and reaching their own conclusion.

These differences appear to be based not on any meaningful reasons related to policy, but rather on historical differences in the patchwork development of each Act. For example, the VRB does not play a role in the DRCA review pathway because the Act was originally part of the same compensation scheme as civilian public servants. This is inconsistent now that veterans' claims are in separate legislation. In addition, some participants felt that it was more difficult for veterans to put their case to the AAT:

The expenses associated with appealing a decision to the AAT represent an insurmountable barrier for many veterans. (RSL NSW, sub. 151, p. 14)

These differences are, in turn, likely to cause confusion for claimants — who may have to pursue multiple proceedings for the same injury — and increased complexity for DVA in administering the scheme. DVA is already making progress to address discrepancies between the Acts in the initial claim process, the recent rollout of MyService (chapter 9) helps to remove this confusion, by providing a single entry point for all initial liability claims regardless of the legislation the claim is under. Without reform to the review level, this confusion will remain in spite of DVA's best efforts to streamline processes.

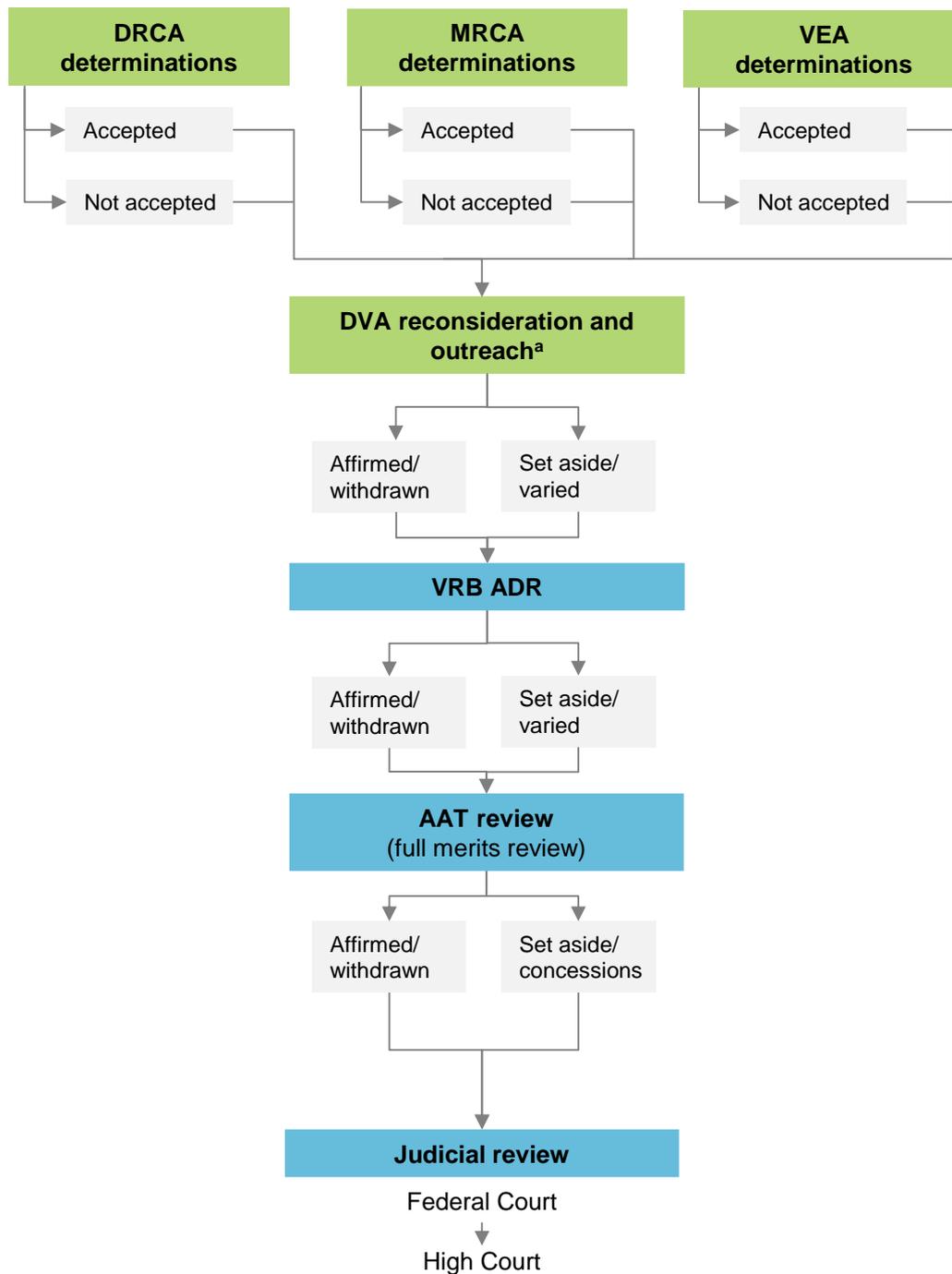
DRAFT FINDING 10.3

While many veterans are managing to negotiate the current pathways for reviews of decisions made under the various veteran support Acts, there are unjustified differences and complexities in the rights of review available to claimants under each Act.

A single review pathway

In the Commission's view, there should be a single review pathway for decisions across all three Acts. This will make it easier for veterans, their families and their advocates to navigate the system and know their rights to appeals and reviews. DVA (or any body that absorbs its functions in the future) could also simplify its notifications of decisions for reviews under each Act to a single document, reducing back-end complexity. The proposed single pathway is outlined in figure 10.6.

Figure 10.6 Less complexity: a single review pathway



^a Upon the establishment of the proposed Veteran Services Commission (draft recommendation 11.2), this function would move from DVA to the Commission.

Bringing the outreach in: effective internal reconsideration

This single pathway should start with internal reconsideration and outreach by the agency responsible for the veteran support system.

The Commission favours the use of a ‘reconsideration’ process, not a ‘review’ process, at this step. ‘Reconsideration’ involves a claims assessor reconsidering the entire claim afresh, including conducting a new investigation and seeking out additional evidence from the claimant or other sources. DVA internal reviews, by comparison, focus on only the evidence used to reach the original decision, checking for any egregious errors.

Although it is difficult to measure, reconsideration seems to be more effective at catching errors, as proportionately fewer reconsidered claims under the DRCA (and MRCA prior to 1 January 2017) resulted in second-tier review at the AAT (section 10.3). Participants raised other favourable features of reconsideration as a first stage:

The [MRCA] reconsideration method on the other hand has proven itself to being a faster appeal method without the requirement for an applicant’s case to be restated due to its internal nature. This results in the latter method being unquestionably more cost efficient, less time consuming and less stressful for an applicant. (Slater + Gordon Lawyers, sub. 68, p. 52)

Internal reconsideration can help to catch egregious mistakes early and fix them without involving external agencies. This can help to shorten the feedback loop if the original decision maker has erred — they are more likely to find out the nature of their error faster and learn from it.

The corrective impact of reconsideration on decision making can be bolstered by giving the claimant an opportunity to provide information at this stage. The VRB’s outreach function — which allows it to identify key issues in a case to the claimant and request information — appears to be succeeding in helping veterans to bring the information needed to prove their case. Many claims are varied on the basis of new information.

If a claim is being denied in the first instance due to a failure to provide relevant information (for example, failing to provide evidence in relation to a condition in an SoP), or is being reviewed internally, then DVA’s first step should be to clarify this information rather than deny the claim. An outreach call, modelled on the VRB’s current ADR processes and made by the delegate responsible for reviewing the claim, would explicitly discuss the main issues with a fully or partially rejected claim with a claimant, and make clear any information that could be provided that would allow DVA to grant the claim. Claims could also be resolved by mutual agreement between the claimant and DVA at this stage. Such an outreach call may also help to elaborate on the reasons provided for the decision.

There is precedent for this approach in other agencies. The Australian Taxation Office, another high-volume administrative body, offers taxpayers a similar procedure to resolve cases before they reach the AAT (box 10.6).

Box 10.6 In-house facilitation at the Australian Taxation Office

Since 2015, individuals or small businesses who object to an Australian Taxation Office (ATO) tax or superannuation decision have had the option to use in-house facilitation. Much like an ordinary mediation process, in-house facilitation involves a facilitator meeting with the claimant and the case officers to:

- identify the issues in dispute
- develop options
- consider alternatives
- attempt to reach a resolution.

Unlike a traditional alternative dispute resolution process, however, the facilitator is employed by the ATO. Although they are not truly independent, they are employed as a specialist facilitator, rather than a case manager. They do not face immediate incentives in their position to resolve cases in the ATO's favour.

Facilitation conferences are usually held face-to-face, but may be held by phone or video link. All parties agree to participate in good faith and be willing to negotiate an outcome. Information disclosed in the course of a facilitation remains confidential and cannot be used to make further changes to the taxpayer's return without their permission. The taxpayer must seek the in-house facilitation voluntarily, and using the facilitation process does not prevent them from seeking further review at the Administrative Appeals Tribunal.

Source: Australian Taxation Office (2017).

Bringing the outreach procedure 'in-house' to DVA is likely to have a number of benefits, including:

- avoiding the time spent making a formal application to the VRB
- making the outcomes of reviews more visible to original decision makers
- permitting clearer communication of systemic issues within DVA.

It also sets dispute resolution as the guiding principle for DVA in dealing with reconsideration processes.

The Commission understands that the current number of staff in DVA's review teams would not enable this type of detailed review to take place for every application. Any change to the review pathway should come with resourcing that allows thorough consideration at each stage. Additional costs at this reconsideration stage are likely to reduce the number of cases that reach higher levels of review. As each individual case is given more time on review, cases that unnecessarily reach review at the VRB or AAT are more expensive both to the claimant and government. Accordingly, it is sensible, based on a holistic view of cost, to properly resource the accurate processing at this earlier stage of reconsideration by ensuring that reconsideration teams are adequately supported.

A clearer role for the VRB: resolving disputes

As noted earlier, almost all of the remaining first-tier merits review tribunals were amalgamated into the AAT in 2015, which means that the VRB is an anomaly among merits review bodies in Australia today.

Past proposals to amalgamate the VRB were rejected. This is partly because of a perception on the part of veterans that the special expertise of the VRB could be lost if it were no longer a separate tribunal (Creyke 2016, pp. 55–56). However, the AAT already deals both with veterans' claims (in its Veterans' Appeal Division) and with workers' compensation (for claims by Commonwealth civilian public servants).

The VRB is also highly regarded in the veteran community:

The VRB is an excellent means of getting claims that have been refused accepted. The ADR system is a great system that saves the veteran a large amount of stress. The system works well. (Raymond Kemp, sub. 37, p. 13)

As a statutory body, the VRB is independent from DVA. In practice, however, it has been described as operating 'essentially ... as a division of the Department of Veterans' Affairs' (National Commission of Audit 2014, p. 212). Its funding comes from DVA's budget and its staff are employed by DVA and made available by the DVA Secretary to the VRB as requested.

In some ways, the governance arrangements for the VRB make it more likely to be treated as a 'backstop' for DVA decisions. There are few other government departments with a specialised merits review body devoted to reviewing their parent department's decisions. Those that do have highly specialised and low-volume jurisdictions. For example, the Classification Review Board, which reviews film, television and game classification decisions made by the Classification Board, considered just two decisions in 2017-18.

In the Commission's view, the VRB's relationship with DVA has potential to encourage DVA officers and veterans alike to treat the VRB as an opportunity for contentious claims to eventually succeed, and an opportunity for other claimants to abandon their case. This shifts the resolution of problems further away from their source, rather than addressing them at the point where they first occur.

In this way, the VRB has overlapping functions with both DVA's internal review processes and the AAT's review process. Applicants are likely to have to go through very similar processes at all three levels: being asked to provide information to a decision maker, some communication between the parties about the particulars of the case, and a decision being rendered. Each extra review means unnecessary costs and added stress for veterans and their families.

DRAFT FINDING 10.4

The Veterans' Review Board, while highly regarded by veterans, has functions that overlap with those of the Administrative Appeals Tribunal. Rather than being used occasionally to resolve difficult or exceptionally difficult cases, the Department of Veterans' Affairs is relying on the Board's external merits review as a standard part of the process for addressing many claims.

If the VRB is to continue, there should be a sensible rationale and a clearer role for it to play in the review pathway. This role itself should be subject to review to make sure that the VRB is providing assistance that cannot be better provided from within the AAT or DVA.

There are several options for reform of the role of the VRB.

- **Status quo:** The VRB would retain all of its current ADR powers, as well as the power to conduct itself as a tribunal and hold formal hearings.
- **Amalgamation:** The VRB would cease to exist and its current jurisdiction over first-tier external merits review would be made part of a new Veterans' Division of the AAT (with appeals to the existing Veterans' Appeals Division). Current VRB members could lead such a division. The Veterans' Division of the AAT would be subject to the same procedural rules as other parts of the AAT, including the right to have legal representation.
- **ADR-only:** The VRB would continue to exist as a separate entity, but would only use ADR processes. Its procedural rules would be adjusted such that all proceedings were completed using methods other than formal hearings such as outreach, mediation, conciliation or case appraisal. These outcomes would be reached with the consent of the claimant, who would retain their right to appeal further to the AAT for full merits review. The VRB could also refer complex cases requiring a formal hearing to the AAT. If there is no consent (that is, no resolution is agreed upon by the parties) the original decision will stand but the claimant will have the right to seek a full merits review by the AAT. The VRB could also refer complex cases requiring a formal merits review to the AAT where a VRB member has deemed the matter unsuitable for resolution by ADR, if consented to by the claimant.

Although the VRB is not truly independent of DVA, amalgamating the VRB into the AAT runs the risk of damaging the trust placed in the VRB by claimants. Amalgamation of the VRB into the AAT may also encourage veterans (and perhaps government) to obtain legal representation, potentially making external review less accessible and more complex for claimants.

There is also a risk that amalgamation would remove a trusted institution in the review pathway, while increasing costs for all parties. This is not an improvement at a time when many cases considered by the VRB result in a change to DVA's decision, and while the VRB is providing a relatively low-cost forum for review to veterans and to government.

It is the Commission's view that the VRB should remain in place but focus on facilitating ADR, and leave the task of resolving ambiguous cases through more formal hearings to the AAT. Already, only a minority of VRB cases (less than 40 per cent) are resolved by hearings, with the remaining proportion resolved by ADR or by the applicant withdrawing their case.

Following internal reconsideration, the single review pathway across the Acts should then allow claimants to proceed to the VRB as an independent review and resolution body. (ALRC 2016).

This would involve a shift in the legal role and powers of the VRB. The VRB would no longer be a determinative body. Instead, it would essentially play a facilitative role assisting DVA and the claimant to resolve the dispute between themselves. Different ADR processes can achieve this goal, including those used by the VRB currently, depending on what the issues between DVA and the veteran are. Expanding the range of ADR processes available at the VRB to include conciliation and mediation would give the VRB member or conference registrar as many options as possible to help resolve disputes. Through these processes, claims that ought to succeed will have their deficient aspects corrected, while claims that should be denied will have sufficient light thrown upon them to encourage a withdrawal (or for DVA to feel more confident in its legal position if it chooses to seek further review).

In effect the substantive change would be to remove VRB as a decision maker and thus there would be no hearings. VRB members would facilitate resolution of matters, including being able to recommend outcomes to the parties, through their current and extended array of ADR approaches. The VRB could also refer complex cases requiring a formal merits review to the AAT where a VRB member has deemed the matter unsuitable for resolution by ADR subject to the claimant's consent.

Does this change the role of the AAT?

If the VRB's ADR process cannot resolve a dispute between the DVA and the claimant, the claimant should then be allowed to seek review by the AAT for a full merits review in its existing Veterans' Appeals Division.

There are likely to remain some complex cases: genuine ambiguities in the law that may not be resolved by the VRB in a case appraisal, or circumstances where the relationship between DVA and the claimant is so impaired that ADR processes cannot help.

There would still be overlap between the roles of the VRB and the AAT. In particular, the AAT has a suite of ADR processes it can use to resolve cases before holding a hearing. Indeed, the VRB's ADR processes were based on those in the AAT. However, the AAT's ADR process is not a legislative requirement. Although pre-hearing conferences are standard practice, 'there is no expectation on the part of the Tribunal that every application will be referred to another form of ADR' (Downes 2008, p. 3). Effectively, different aspects of the AAT's ADR process are implemented for different types of reviews as the tribunal member sees fit. For example, the AAT does not use ADR processes in its migration and refugee

divisions. If the AAT has a high degree of confidence in the VRB's ADR process, they would have the option to expedite the full merits review hearing.

If claimants were eager to proceed to the AAT and be able to obtain legal representation funded by legal aid services, then they might be advised to frustrate the VRB's ADR process so that the case can progress to a hearing more quickly. As a result, the VEA (which established the VRB in legislation) should require that participants engage with the proposed ADR process in good faith in the VRB.

The removal of the full merits review stage at the VRB may at least in the earlier stages result in more cases being heard by the AAT. Claimants could face the additional cost of appearing in that venue; AAT review is also generally more expensive (per case resolved) to government.

An increase in matters going to the AAT is not necessarily a poor outcome, as long as the AAT's resources in the Veterans' Appeal Division remain sufficient to cope with the increase. Around 480 cases were decided in the Veterans' Appeal Division in 2017-18 — representing just 1.2 per cent of review applications finalised by the AAT in 2016-17. Even if all 1108 of the decided cases where a hearing is held in the VRB were instead heard in the AAT, the tribunal's caseload relating to veterans would still be dwarfed by their caseload in home affairs (47 per cent) and social services (45 per cent) (AAT 2018, pp. 127–128). In practice, ADR processes are likely to help the parties in a more timely manner, obviating the need for a hearing in any forum. Many members of the AAT are appointed to multiple divisions, so further resources are available to respond to an increased caseload. Another option would be to redirect some of the resources of the VRB (particularly some of the experienced VRB members) into the AAT.

Ultimately, the number of matters to be heard at the AAT should decline if the proposed reconsideration and ADR approaches work as intended.

Legislating changes to the review pathway

Moving from the existing three pathways for review to the proposed single review pathway would require amendments across all three Acts. These changes are proposed as options for short-term changes to the legislation; in the longer term, the Acts should change to achieve a number of other goals of streamlining (chapter 17).

Reconsideration rather than review

All powers for DVA to review its decisions should be clearly described as reconsideration processes. In such a process, all of the information (and new information) could be considered by DVA in reaching a decision on review. The simultaneous outreach process should be implemented as a matter of policy rather than of legislation, as there is a risk of

being too prescriptive and constraining the procedure through which DVA makes meaningful contact with the veteran.

Establishing the VRB as a review and resolution body

The VRB is constituted under part IX of the VEA so amendments would be required to adjust its role to provide only ADR procedures. In the present review process, the VRB makes the decision as if it were DVA (s. 139(3)).

As a body that exclusively performs ADR, the optional referral of VRB cases to dispute resolution processes (set out in division 4A of the VEA) would become the basis of procedure for the VRB.

The VRB would assist claimants to reach a satisfactory agreement with DVA on their entitlements. It would do this by:

- facilitating conferences, mediations or conciliations between the veteran and DVA, or
- a single VRB member appraising/evaluating the key issues of the case to make a recommendation about the appropriate entitlement of the claimant under the legislation.

This recommendation would then be actioned by consent of the parties (under s. 145C of the VRB's legislation). Either party would be entitled to disagree with the outcome and take the case to the AAT.

The power of the VRB to make binding decisions under s. 139(3) would be removed (and corresponding amendments would be made to the ancillary sections 140, 140A, 156 and 157).

Division 5 of the VEA (which sets out the procedures of the VRB) would also need to be amended so that the VRB no longer holds full board hearings. However, in order to ensure it can meaningfully assist parties, the VRB should retain its powers to compel DVA or a veteran to provide information.

The MRCA and DRCA

The VRB can review decisions under the MRCA as if they were decisions under the VEA. Section 353 of the MRCA effectively adjusts the VEA's sections about the VRB so that references are to MRCA rather than VEA decisions. Amendments would be required to ensure that the new procedure set out above carries through to decisions under the MRCA. Similar deeming provisions can be amended in the DRCA to allow the VRB to hear cases under that Act.

What would the AAT review?

In this new review pathway, the VRB does not make binding decisions under any of the legislation.

As a result, references to reviews of VRB decisions (for instance, in s. 175 of the VEA and s. 354 of the MRCA) should be replaced with references to ‘DVA decisions that have been through an ADR process at the VRB.’ There is no reason to require parties to complete all of the ADR processes beyond an initial conference: in some cases, the breakdown of the relationship between DVA and the claimant means that the case will require a formal hearing. Presently, claimants may accept a decision from a VRB ADR process and still seek review of that decision at the AAT.

The Commission does not anticipate any amendments being immediately necessary to the *Administrative Appeals Tribunal Act 1975*, which gives the AAT sufficient flexibility to change its procedures to suit particular cases. In particular, given that VRB ADR processes may have been extensive prior to the case reaching the AAT, tribunal members may choose not to require the parties to proceed with further ADR within the Tribunal.

DRAFT RECOMMENDATION 10.2

The Australian Government should introduce a single review pathway for all veterans compensation and rehabilitation decisions. The pathway should include:

- internal reconsideration by the Department of Veterans’ Affairs. In this process, a different and more senior officer would clarify the reasons why a claim was not accepted (partially or fully); request any further information the applicant could provide to fix deficiencies in the claim, then make a new decision with all of the available information
- review and resolution by the Veterans’ Review Board, in a modified role providing alternative dispute resolution services only (draft recommendation 10.3)
- merits review by the Administrative Appeals Tribunal
- judicial review in the Federal Court of Australia and High Court of Australia.

DRAFT RECOMMENDATION 10.3

The Australian Government should amend the role and procedures of the Veterans' Review Board (VRB).

Rather than making decisions under the legislation, it would serve as a review and resolution body to resolve claims for veterans. All current VRB alternative dispute resolution processes would be available (including party conferencing, case appraisal, neutral evaluation and information-gathering processes) together with other mediation and conciliation processes. A single board member could recommend the correct and preferable decision to be made under the legislation, and the Department of Veterans' Affairs and the claimant could consent to that decision being applied in law.

Cases that would require a full board hearing under the current process, or where parties fail to agree on an appropriate alternative dispute resolution process or its outcomes, could be referred to the Administrative Appeals Tribunal.

Parties to the VRB resolution processes should be required to act in good faith.

10.5 An 'adversarial approach'?

The following discussion is largely in relation to both the VRB and the AAT as currently constituted and with their existing functions, unless otherwise specifically noted.

Some veterans told the Commission that DVA has an 'adversarial approach to veterans' (Garry Ridge, sub. 25, p. 2) and a 'culture of suspicion — that the veterans are trying to rip the system off' (Adrian d'Hagé, sub. 54, p. 1). Others said it depends on who receives the claim.

It is a lottery of which DVA department in which city you get to deal with as to how your claim gets dealt with. (Slater + Gordon Lawyers, sub. 68, p. 63)

It can sometimes be a bit of a lottery when you submit a claim or a request; it depends on which staff member receives it. Sometimes it is simple, sometimes it seems obstructive. (David Harrison, sub. 129, p. 2)

Past reviews also raised the prospect that DVA delegates are approaching interactions with clients in a confrontational manner (for example, Dunt 2009, pp. 84–85; SFADTRC 2017, pp. 94–95).

The Australian Government and its agencies (including DVA) are obligated to behave as model litigants in the conduct of litigation.⁸ Governments administrate legislative programs that are intended to assist the public (and in DVA's case, veterans). This obligation to behave

⁸ This obligation is set out in appendix B of the Legal Services Direction 2017, determined by the Attorney-General through directions that apply to all Australian Government legal work under the Judiciary Act 1903 part VIIC.

as model litigants should be the priority in resolving claims, and should override any departmental or government interest. In dealing with disputed claims, DVA is required to:

- act promptly and not cause unnecessary delay
- pay legitimate claims without litigation
- act consistently in the handling of claims and litigation.

These concerns were sometimes amplified in relation to review processes. Legal Aid NSW (sub. 109, p. 18) reported a case where a DVA officer instructed a veteran that their claim would not succeed at the VRB, and that he should withdraw his application. This took place despite the veteran retaining legal representation from Legal Aid NSW; his representative was not contacted by DVA about the claim.

Veterans attest that some DVA delegates are providing useful and constructive service to clients, including through the internal and external review processes. That said, viewing the review process as an ‘us against them’ proposition does not serve veterans or DVA. The focus should be on fairly determining the entitlements of the claimant. The findings and recommendations on claims administration (chapter 9) go towards this goal.

Having said that, some claimants will not receive entitlements that they apply for — and DVA is entitled to defend the integrity of the support system by seeking further review of ambiguous or complex cases to the AAT or the courts.

Legal representation at the VRB: advantages and disadvantages

In this section we are primarily dealing with the VRB as currently constituted.

The perception of adversarial conduct can compound the sense of difficulty that veterans may have in making claims, particularly if they need to seek review. Lawyers are not permitted to appear with individuals making applications in formal hearings of the VRB (though they may appear at ADR processes). Advocates from ex-service organisations (ESOs) provide the primary support available to veterans navigating the review. These advocates are trained by DVA under the Advocacy Training and Development Program, which aims to provide the training necessary to assist veterans in making DVA entitlement, liability and other claims (section 9.6).

Traditionally, legal aid services would play a role in supporting disadvantaged claimants through merits review processes. However, the role of legal aid services and community legal centres differs between states (box 10.7).

Box 10.7 **The role of legal aid services**

Legal Aid NSW runs a Veterans Advocacy Service, providing advice to clients claiming under the veteran support system. They also represent veterans in applications for merits review to the Veterans' Review Board (VRB) and Administrative Appeals Tribunal (AAT). Representation is provided by an advocate for cases in the VRB, or a lawyer in the AAT. Funding is also provided for disbursements (such as expert medical reports). In this way, its advice services mirror the advocacy services provided by ex-service organisations (Legal Aid NSW, sub. 109).

Legal aid services in other states only provide assistance for veterans seeking review at the AAT from a decision of the VRB, funded by the Attorney-General's Department under the National Partnership Agreement on Legal Assistance Services. This service is not means-tested (COAG 2017, pp. B-2, B-3).

It should be noted that Legal Aid NSW is, overall, funded at a higher rate than its interstate counterparts. In 2016-17, its operating revenue was around \$300 million. For comparison, Victoria Legal Aid had an operating revenue of around \$180 million — about half that of Legal Aid NSW — even though the overall population of Victoria is only 20 per cent smaller than New South Wales (ABS 2018b; Legal Aid NSW 2017, p. 6; Victoria Legal Aid 2017, p. 98).

In principle, the VRB is a tribunal without the full formality of other legal proceedings — this is the historical justification for lawyers being excluded from its proceedings. However, several stakeholders raised that this placed further pressure on veterans navigating a complex system. Although veterans entitlements are widely recognised as a relatively complex area of law, the first and primary actors in the review process are volunteers without a legal background. There are benefits and costs to these types of tribunals permitting legal representation (box 10.8).

Box 10.8 **The benefits and costs of representation**

There are benefits and costs associated with allowing legal representation in tribunals. Representation can assist parties who:

- cannot adequately promote their own interests
- are facing an opponent who is a lawyer
- are dealing with complex legal issues.

However, high rates of representation can create unintended consequences such as increased formality and complexity of proceedings. Legal representation is also usually only available to those who can afford it, creating inequity between users of the tribunal. As a result, permitting legal representation may only increase the level of unnecessary legalism in tribunals that are intended to make the involvement of lawyers unnecessary.

Legal costs can also substantially reduce the potential gains from litigation. Where both parties are equally capable of handling the dispute themselves, both parties may well be better off if they both elect to self-represent. But where one party chooses to engage a lawyer, it creates an incentive for the other party to do the same.

Source: PC (2014, pp. 368–373).

In the veterans' space, applicants are generally not required to self-represent, as 80 per cent of applicants at the VRB are represented by an advocate, typically from an ex-service organisation (ESO) (VRB 2018a, p. 37). However, there remains concerns around the extent to which volunteer advocacy services are meeting the substantial task of providing effective assistance to veterans during the claim and review processes. However, the Australian Government has already commissioned a scoping study (by Robert Cornall) on this issue. As a result the Commission has not made any findings or recommendations regarding ESO advocacy services at this stage (section 9.6).

It must be noted that advocates do not (and must not) have formal legal training. Slater + Gordon Lawyers (sub. 68, p. 14) described the veteran support system as 'one of the most complex legislative compensation schemes in Australia'; the Federal Court commented in a decision under the legislation '[the] complexity [provisions of the VEA], to say nothing of the wider labyrinth, presents considerable challenges of comprehension as to its application'.⁹ Nothing prevents individuals seeking legal advice before going to the VRB, however, it would not be funded by legal aid services (except in New South Wales — box 10.7).

At the same time, DVA does not have an advocate for their interests in the VRB. In effect, the VRB member determining the claim acts as a substitute decision maker on behalf of DVA. At the same time, the tribunal members themselves may be lawyers or judges. Veterans may feel that they are at a disadvantage having an advocate without formal legal training:

Veterans should be allowed lawyer representation at the VRB. The Senior Member is one so why not. (Rodney Parnell, sub. 48, p. 1)

The complexity of the Acts is no surprise to both veterans and DVA with DVA staff being trained in specific veteran's legislation, on the other hand DVA encourages veterans to seek guidance and representation from advocates that must know everything. This becomes even more detrimental when veterans have their case escalated to the VRB and have no rights to qualified legal representation and only by an advocate which is a case example of David vs Goliath. (name withheld, sub. 119, p. 2)

Compared to the AAT or a court hearing, the VRB is better characterised as an inquisitorial tribunal: the board member carries the responsibility of investigating the circumstances of the case, and can request more information from the applicant or DVA if required to reach a correct decision. In this environment, the applicant should not be 'fighting' DVA, and a board member can adjust the complexity of proceedings to suit the needs of the applicant.

VRB hearings are held without an adversarial representative from DVA, and the board member has a responsibility to reach a correct decision on the merits of the case regardless of the arguments advanced by the veteran or their advocate.

⁹ *McDermid v Repatriation Commission* [2016] FCA 372 (15 April 2016) at [5].

If the introduction of legal representation at the VRB level were to encourage DVA to represent itself at more hearings, VRB hearings could become more adversarial, potentially undoing the progress made through the introduction of ADR processes.

The opportunity to engage legal representation is provided at the AAT stage of an appeal, for those veterans and families who desire it. AAT cases require significantly more preparation by advocates, and the possibility of facing a lawyer at the VRB would unnecessarily add this workload to all VRB cases, significantly compromising efficiency ... The right to legal representation, even if allowed only under special conditions decided on a case-by-case basis by the principal member, would risk complicating an effective process for little practical benefit. (RSL NSW, sub. 151, p. 15)

As a result, the Commission does not see clear benefits that would come from allowing formal legal representation in the VRB. This would also be the Commission's view under the proposed modification to the VRB's role. A final position will be determined after reviewing the upcoming Cornall study of the role of advocates.

Are veterans at a disadvantage in the AAT?

Submissions also raised issues about going to the AAT given that DVA is often legally represented. Most of DVA's legal matters were dealt with by external lawyers: in 2017-18, it briefed 72 barristers at a total cost of \$487 000; its total external legal costs were \$9.4 million (DVA 2018f, p. 100). In this environment, expecting all veterans to be adequately served by volunteer advocates may be a hard ask.

This means that if a veteran seeks a review by the AAT, they may face the prospect of paying legal fees. Legal aid funding (without means testing) is available, but is subject to competition with the many other demands on these services from other areas of the law.

If a veteran does retain a lawyer and succeeds on review in the AAT they can obtain up to 75 per cent of their costs from DVA, but only if their case is under the MRCA or DRCA (MRCA s. 357; DRCA s. 67; AAT 2015, p. 2). It is not clear why no such costs arrangement is in place under the VEA. In any case, costs orders are made at the discretion of the AAT member deciding the case, meaning it is not guaranteed that plaintiffs will recover costs. As with all matters in the AAT, costs are measured using the Federal Court costs scale, rather than the actual amount charged by the solicitor. This means that generally, the veteran remains out of pocket — sometimes by as much as 50 per cent of their total costs incurred in pursuing the review (Maurice Blackburn, sub. 82, p. 19).

Although this current approach is likely to leave veterans out of pocket, it reflects standard practice in the AAT. The Commission is concerned that this part of the review process has potential to deny access to justice for veterans. If the AAT holds more hearings for veterans than it currently does under the system proposed in this chapter, then there is a risk that more veterans could be denied access to justice if they cannot receive a costs order in support of their application. The Attorney General's Department (which has policy responsibility for

the broader administrative review system) should consider the implications of the AAT approach to costs on veterans.

10.6 A best-practice system

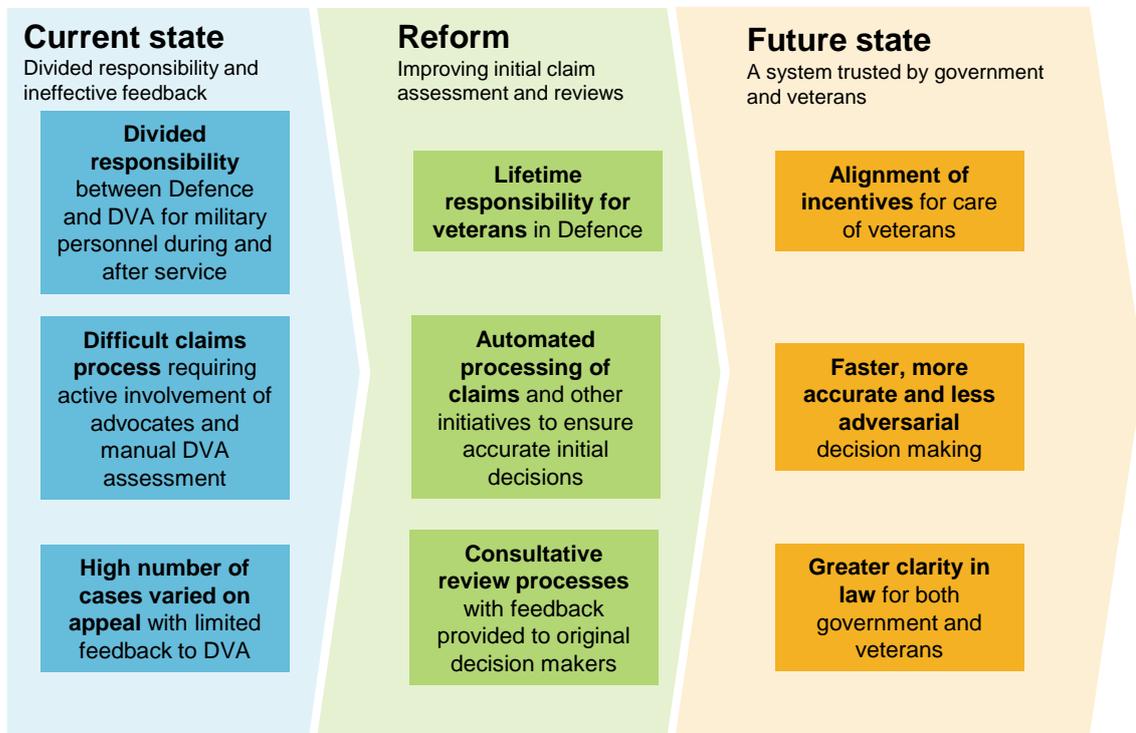
Reforms to the review process work hand-in-hand with the initial claims process (chapter 9) and governance of the veteran support system (chapter 11) (figure 10.7). Together with proposals in this chapter, there should be positive effects on the system as a whole.

- Placing the ultimate responsibility for supporting veterans in the hands of Defence would provide incentives to minimise unnecessary injuries and illnesses, reducing the number of initial claims.
- The ongoing efforts to streamline and improve the initial claims process will allow many initial liability decisions to be made without claims assessors. The effective use of data to identify and accept valid claims will help to reduce the number of errors made.
- Where errors are made, the review process should be established to correct the error as soon as possible, and feedback should be made available to the original decision maker, helping to further reduce error rates. Bringing the impact of the review process to the attention of original decision makers makes the costs of improper decision making more obvious, reducing the incentive for claims officers to treat the VRB as an internal backstop.
- Giving a clear focus and attention to ADR in the VRB should lead to greater resolution and ultimately fewer appeals to the AAT.
- As the veteran support system improves in its ability to consistently make correct decisions, it can make strategic use of test cases in the AAT (or judicial review) to obtain clarification on genuine ambiguities in the system. This will improve the overall integrity of the system.

The combined aim of these changes across the system is to increase accuracy at the first level of decision making. The end goal is a transparent and open system where both veterans and DVA know the likely outcome of most cases and only dispute the ones that matter.

If the proposed sequence of change outlined in figure 10.7 is adopted, then original decisions in the veteran support system will improve. Simpler cases will be resolved by the new agency responsible for veteran support through its reconsideration and outreach process. Once this happens as standard practice, it may be possible to move the greater suite of ADR functions at the VRB into DVA. The smaller number of complex cases requiring a more technical and legalistic process could then be heard at the AAT.

Figure 10.7 A sequence for improving the veteran support system



Given the early positive signs of the Veteran Centric Reform program and the changes recommended in this chapter, improved decision making will enhance trust and confidence in the process over time. The experience in other government settings (for example, the Australian Taxation Office and Comcare) show that this is possible: the AAT largely agrees with their decisions when it reviews them.

As a result, the Commission proposes that the role and necessity of the VRB be re-examined once the impact of a reformed veteran support system is fully realised — likely between five and seven years after the passage of reform legislation. At this stage, rather than amalgamating the VRB and AAT, its remaining ADR functions could be brought into DVA or any body that performs its functions in future.

DRAFT RECOMMENDATION 10.4

The Australian Government should conduct a further review in 2025 on the value of the continuing role of the Veterans' Review Board, once significant reforms to the initial claim process for veterans are established. In particular, the review should consider whether reforms have reduced the rate at which initial decisions in the veteran support system are varied on review. If the review finds that the Board is no longer playing a substantial role in the claims process, the Australian Government should bring the alternative dispute resolution functions of the Board into the Department of Veterans' Affairs or its successor agency.

10.7 Other issues

Is review available for the right decisions?

The proposed reforms to the review process will not affect decisions where review is unavailable under the current legislation. However, if a decision is not a formal determination — that is, it is not the exercise of a power under the Acts — it is not subject to review at all. This appears to be the case with the inclusion of vocational or educational training on a veteran's rehabilitation program. DVA policy on the issue confirms this:

When a rehabilitation coordinator has considered all relevant evidence and has made a decision that study is not an appropriate activity to fund through a rehabilitation program, there are no avenues of appeal for the client. This is because a *formal determination* has not been made, and is not made as part of the process. Rather, the rehabilitation coordinator has considered all available evidence, and has made a decision that study is not an appropriate activity to be included on a client's rehabilitation program. (DVA 2018b) (emphasis in original).

In principle, review should be available for any decision where government can materially affect the interests of a person (box 10.9). To introduce external merits review for decisions that are currently matters of policy, some decisions may need to be put into the legislation specifically. However, this change reduces the flexibility of government to adjust these schemes to suit changing circumstances.

Box 10.9 What decisions should be subject to merits review?

The Administrative Review Council (1999) set out guiding principles for the Attorney-General to be used in 'deciding the appropriate jurisdiction of ... persons or bodies who engage in independent or external merits review'. The Australian Government continues to rely on these principles as its formal policy for determining what decisions should be subject to merits review (AGD 2011, pp. 14–15). The general rule is clear:

If an administrative decision is **likely to have an effect on the interests of any person, in the absence of good reason, that decision should ordinarily be open to be reviewed on the merits**. If a more restrictive approach is adopted, there is a risk of denying an opportunity for review to someone whose interests have been adversely affected by a decision. Further, there is a risk of losing the broader and beneficial effects that merits review is intended to have on the overall quality of government decision making. (ARC 1999) (emphasis added)

The council sets out categories of decision that may be unsuitable for merits review including 'legislation-like decisions' that are not directed towards the interests of any individual, but apply generally to the community; 'automatic decisions', where there is not scope for dispute about whether or not particular facts have occurred; preliminary or procedural decisions; and decisions to allocate finite resources (such as a fixed pool of grant money).

On the other hand, some factors are not generally sufficient to exclude merits review, including a lack of structure for the decision (that is, if the legislation provides only general criteria or no criteria at all to be used in making the decision); decisions made by reference to government policy; and the availability of judicial review for the decision.

There were no submissions indicating that these types of non-reviewable decisions were causing issues for veterans. The Commission is seeking further information on this issue.

INFORMATION REQUEST 10.1

The Commission is seeking further information on whether there are any decisions that are not reviewable, that should be reviewable.

Reasons given for decision

DVA is required to provide written reasons for its decisions under the veteran support legislation (VEA s. 34; MRCA s. 346(1); DRCA s. 61(1)). Although they are not expected to provide the same level of detail as a court considering the same legislation, there are guidelines about what information should be provided by decision makers (box 10.10). Some participants (including other government agencies) submitted that the reasons currently provided did not properly explain how a decision was reached.

We sometimes find that the record of decision provided to the veteran does not include an adequate explanation as to why the claim was not linked to service. In these cases, we may request that DVA provide the veteran with either a reconsideration of the decision, or a better explanation of the original decision. Without an adequate explanation as to the reasons why the claim was

rejected, veterans are unable to address these issues on review. (Commonwealth Ombudsman, sub. 62, p. 3)

Legal Aid NSW in particular argued that DVA's written reasons for its determination on claims did not consistently provide:

- the actual path of reasoning used to reach a determination
- the specific calculations of any entitlements under formulas
- copies of all of the evidence used to reach a decision.

This created issues for claimants and advocates:

As a result, veterans and their legal representative or advocate often find it difficult to understand how the decision-maker arrived at the decision, and whether mandatory relevant considerations have been taken into account. (Legal Aid NSW, sub. 109, pp. 9–10)

One advocate highlighted a number of obvious inconsistencies in the reasons provided for decisions for his veteran clients, such as references to old versions of SoPs (William Forsbey, sub. 3, pp. 4–5).

Multiple submissions noted, in particular, that obtaining reports from medical advisers hired by DVA required the claimant to make a freedom of information (FOI) request (for example, Slater + Gordon Lawyers, sub. 68, pp. 62–4; Legal Aid NSW, sub. 109, p. 10). DVA is likely to rely on these reports when deciding a claim.

Box 10.10 Being reasonable: obligations to give reasons in the decision and review process

There is no general legal requirement for government decision makers to give reasons for their decisions to an applicant. However, the Act under which a decision is made might require that reasons be provided (either with the notice of the original decision, or on the request of the applicant). There is not a single standard for the detail of reasons required to satisfy a statutory requirement to give reasons — rather, it depends on the scope and purpose of the legislation and the role to be performed by the particular decision maker.

Tribunals, on the other hand, are quasi-judicial — they resolve disputes between parties. As a result, there is a greater reason in principle for them to be required to provide more detailed reasons for their decisions. A tribunal still does not need to give a full formal judgment as a court would. However, their statutes tend to require them to give reasons (for example, s. 43(2) of the *Administrative Appeals Tribunal Act 1975* requires the tribunal to give reasons for its decisions).

A failure by a tribunal to give adequate reasons has been considered an error of law by the Federal Court, permitting a claimant to seek judicial review: *Muralidharan v Minister for Immigration* (1996) 62 FCR 402 at 414.

The Administrative Review Council wrote that, as a matter of best practice, ‘reasons for a decision’ should include:

- the legislation under which the decision is being made, and that gives the decision maker power to make the decision
- the findings on the facts that can affect the outcome of the decision (material facts)
- the evidence on which the findings were based (and, if there is conflicting evidence, which evidence was preferred and why)
- the steps in the reasoning process leading to the ultimate decision
- any review rights.

There is nothing wrong with using a ‘pro forma’ for decisions of a particular type — particularly if it promotes consistency of decision making by providing a ready check list of relevant factors. However, each individual decision should be made on its merits.

Sources: Administrative Review Council (2007); Wilson (2001).

The Commission was provided with samples of letters for reasons of decisions to reject or accept a number of initial liability claims. The letters follow a pro-forma structure detailing:

- the criteria that must be met to accept a claim (though not with reference to specific sections of the legislation or SoPs)
- the eligibility of the claimant for coverage under the particular Act (depending on the type of service they provided in the Australian Defence Force)
- the evidence considered (including the claim form and any medical records)
- dates of diagnosis and effect of a claimed illness or injury
- the DVA delegate’s restatement of their understanding of the facts (that is, the event that happened during the veteran’s service that led to an injury or illness)

-
- a determination of whether all of the criteria have been met.

Not all letters provided similarly detailed reasons. Some, but not all, aimed to show the rational link made between the facts of the case (as the DVA delegate understands them), and the issues that determine the case. This is particularly true of demonstrating a connection to service. Some letters simply outline the claimant's version of events then state that the delegate is either satisfied or not satisfied to the relevant standard of proof, while others make specific reference to the evidence that persuaded the delegate that a claim was or was not valid.

Reports by contracted medical advisers (CMAs) commissioned by DVA would sometimes disagree with a veteran's claim, or their diagnosis by another doctor. However, these reports are not made available to rejected claimants as a matter of standard practice – they can be requested through FOI processes, or will be made available at the stage of VRB review. This has potential to delay cases even further as indicated by Slater + Gordon Lawyers:

One of the first things we do is FOI entire DVA files, pension files and medical records. One of the problems we find is that DVA are issuing decisions referring to medical reports and they do not give you the medical reports. So then we have to FOI DVA, and if you do not get in fast enough they shunt the file off. It is like, 'Oh, we have done our bit, so we will close that file down.' We are told we have to FOI to get a copy of a medical report that has a direct bearing on the decision. You can imagine there is a further delay. It will take a month or two months to get those medical reports so that we can actually look at them and say, 'Well, why have you denied this claim?' (sub. 68, p. 62)

The decision notices provided to claimants sometimes provided little detail on the content of these reports, or on the reasons why a CMA's diagnosis was more appropriate than the one suggested by the claimant. This may mean that it is not always obvious to the veteran why their claim was not accepted. However, it is not always appropriate to immediately provide the report of the CMA to the veteran, particularly if they are already in a vulnerable state having faced the immediate rejection of their claim.

In any case, it is not apparent whether these letters meet the legal standard for reasons provided for initial decisions. DVA has outlined improving its letters as a priority in 2018-19 (DVA 2018f, p. 46). The Commission will consider this issue further for its final report.

11 Governance and funding

Key points

- Good governance arrangements are critical to achieving good outcomes for veterans and their families, as well as for the broader community.
- Under the current governance arrangements, responsibility for the wellbeing of military personnel is split between Defence and the Department of Veterans' Affairs (DVA). They have very different (often competing) objectives — Defence trains and equips members to defend Australia's interests; DVA subsequently restores and compensates members.
 - This policy split is problematic as it means no single agency has responsibility for the *lifetime* wellbeing of Australians with military service. And the conflicting objectives can create an incentive for Defence to shift costs and responsibility for care and support of veterans onto DVA (resulting in worse outcomes for injured or ill personnel and for the broader community). The policy split also creates problems around the exchange of information on veterans, which can affect the processing of claims.
- Strategic policy in the veteran support system appears to be largely reactive and driven by external events (often making the system more complex and expensive). Much of this is due to the emotive nature of policy related to veteran supports, which can work against good policy. Another contributing factor is an out-of-date governance structure, which is made up of two statutory Commissions with shared members and overlapping responsibilities.
- The governance arrangements need to change. Better arrangements will result in better service delivery, more effective supports and better outcomes for veterans and their families.
 - A single Ministry for Defence Personnel and Veterans should be permanently established.
 - To better align Defence's 'duty to prepare' with the Government's broader 'duty to care' for service personnel, policy and strategic planning for veterans' affairs should be moved to a new dedicated Veteran Policy Group in Defence.
 - Similar to civilian workers' compensation schemes, an independent statutory agency (the Veteran Services Commission) should be established to administer the veteran support system. The Commission should have an independent board and the power to autonomously manage the system. It would replace the Repatriation Commission, the Military Rehabilitation and Compensation Commission, and DVA.
 - A new Veterans' Advisory Council to the Minister for Defence Personnel and Veterans should be established.
 - The Australian War Memorial should take responsibility for all commemoration and war graves functions.
- The veteran support system going forward should be funded using annual premiums (levied on Defence) set to fully-fund future liabilities. A premium would provide information to Defence and the Government about the long-term impacts of policy changes, improve public accountability and provide a stable and predictable funding base.

This chapter examines the governance arrangements of the veteran compensation and rehabilitation system, including the relationship between, and the functions of, the Departments of Veterans' Affairs and Defence.

- Section 11.1 discusses why institutional governance arrangements matter, and provides an overview of current governance arrangements in the veteran support system and the functions of the key institutional bodies operating within it.
- The relationship between the Departments of Veterans' Affairs and Defence (and the adverse incentives and inefficient administrative practices that the divide in functions may be creating) is explored in section 11.2.
- Section 11.3 looks at why veteran support policy is not resulting in good outcomes for veterans and their families, including the challenges around strategic policymaking in the veteran support system.
- A proposed reform pathway for governance arrangements in the veteran support system is presented in section 11.4.
- Section 11.5 discusses an alternative funding arrangement for the veteran support system going forward, based on collecting an insurance premium from Defence to fully fund the system.

11.1 An overview of the governance arrangements

Governance arrangements: why they matter, how they are determined

Governance and institutional arrangements matter because they influence whether public administration is effective and efficient.

Good governance arrangements (box 11.1) include accountability structures and reporting mechanisms that provide the community with confidence, by showing that an agency or system is well-run, that it is achieving what it is set up to achieve and that it is doing so efficiently and at least cost. As the *International Framework: Good Governance in the Public Sector* states:

Good governance in the public sector encourages better informed and longer-term decision making as well as the efficient use of resources. It strengthens accountability for the stewardship of those resources ... Good governance can improve organizational leadership, management, and oversight, resulting in more effective interventions and, ultimately, better outcomes. People's lives are thereby improved. (CIPFA and IFAC 2014, p. 6)

The Department of Finance (2015a) also has its own principles of good governance in the public sector. They include:

- clarity of purpose
- accountability to the Parliament
- transparency to the public

-
- optimisation of efficiency and performance.

Box 11.1 Some principles of good governance

The *International Framework: Good Governance in the Public Sector* states that acting in the public interest requires the following principles:

- behaving with integrity, demonstrating some commitment to ethical values and respecting the rule of law
- ensuring openness and comprehensive stakeholder engagement.

And achieving good governance requires effective arrangements for:

- defining outcomes in terms of sustainable economic, social and environmental benefits
- determining the interventions necessary to optimize the achievement of the intended outcomes
- developing the entity's capacity, including the capability of its leadership and the individuals within it
- managing risks and performance through robust internal control and strong public financial management
- implementing good practices in transparency, reporting, and audit, to deliver effective accountability.

The Organisation for Economic Co-operation and Development's (OECD's) list of principal elements of good governance includes: accountability, transparency, efficiency, effectiveness, responsiveness and rule of law.

Sources: CIPFA and IFAC (2014); OECD (2011).

The Department of Finance also highlighted the importance of ensuring that governance arrangements are 'fit for purpose' within any area of the public sector, to ensure that 'the body undertaking the activity can operate efficiently and to a high standard' (Department of Finance 2017c).

Institutional governance arrangements for public sector entities in Australia are set out (at the broadest level) by the Administrative Arrangements Orders (AAOs), which establish policy portfolios and departments of state (box 11.2) within each portfolio, while also outlining the legislation and 'matters' administered in each portfolio (DPM&C 2018). Specific legislation subsequently sets out some 'day-to-day' functions and can potentially establish other bodies (statutory agencies) responsible for undertaking those functions.

Although a range of different bodies are potentially capable of guiding the development and implementation of public policy within government, the Department of Finance suggested that:

To optimise efficiency, the governance policy requires new activities to be undertaken by existing Australian Government bodies or non-government bodies unless there is a clear case for approving a new body. This reduces unnecessary duplication of administrative effort and

inefficient use of resources, particularly where the new body is seeking to be established as a new ... entity. (Department of Finance 2015a)

In the veteran support system, there are a number of agencies directly involved in governance under the current AAOs (from April 2018) and associated administered legislation. There are two departments, Defence (DoD) and Veterans' Affairs (DVA), as well as the Australian Defence Force (ADF). Collectively, DoD and ADF are known as the Australian Defence Organisation or just 'Defence' (figure 11.1).

Box 11.2 Departments of state

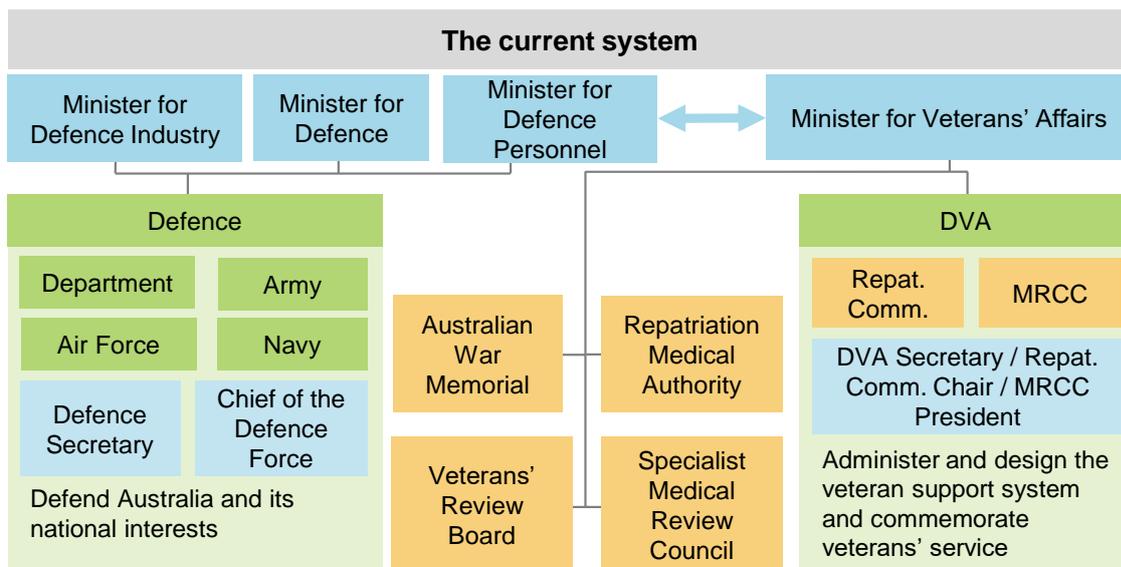
Under the *Public Governance, Performance and Accountability (PGPA) Act 2013* 'departments of state' are non-corporate Commonwealth entities. Empowered under section 64 of the Australian Constitution, departments of state are formed as part of ministerial portfolios to administer and help develop Australian Government policies.

Status as a department of state 'works well for functions of government that require close ministerial involvement, direction and responsibility. These include primary functions such as Budget implementation, defence and policy formulation generally'.

Compared to bodies created by statute, whose purpose and structure can only be amended through legislation, 'departmental structures are more flexible [given they] can be created and abolished ... on advice of the Prime Minister' (2005, p. 18).

Sources: Department of Finance (2005, 2017d).

Figure 11.1 Governance in the veteran support system



Defence

Under the AAOs, Defence is responsible for:

- international defence relations and defence co-operation
- defence scientific research and development
- defence procurement and purchasing
- defence industry development and co-operation (DPM&C 2018).

Defence is also responsible for administering 28 pieces of legislation, including the *Defence Act 1903* under which the ADF is constituted.

The role of Defence is:

... to defend Australia and its national interests, to play an active role in contributing to regional security and stability, and to contribute to coalition operations around the world where our interests are engaged. (DoD 2017f, p. 10)

Under the ‘One Defence’ operational model, the day-to-day administration of Defence is shared between the Secretary of the DoD and the Chief of the Defence Force (CDF, the head of the ADF) (figure 11.2) in what is described as a ‘diarchy’ (box 11.3).¹

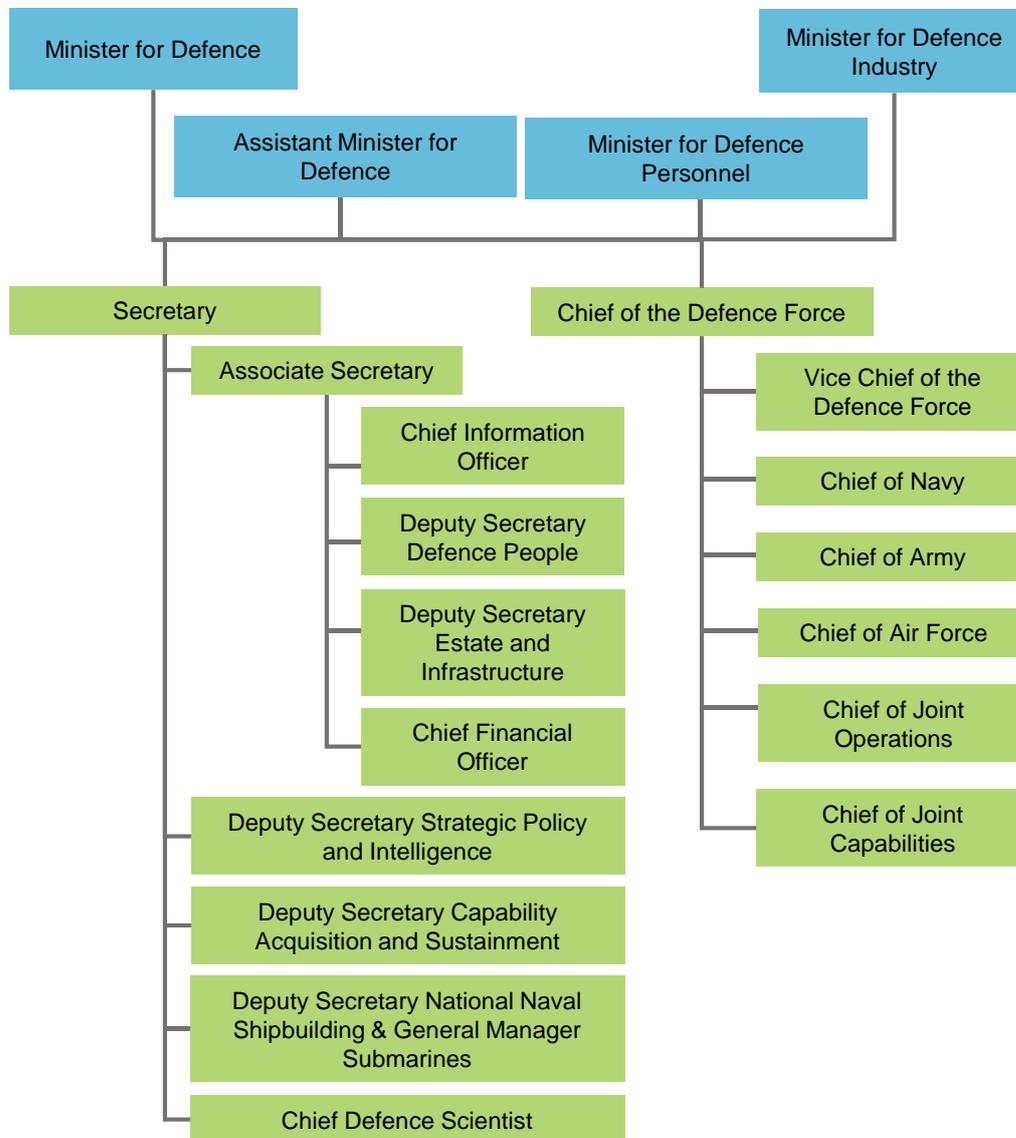
Within Defence, the DoD has no direct command functions over the ADF branches (Army, Navy and Air Force), although around 4000 ADF members work in ‘non-service groups’ within the DoD (Peever et al. 2015, p. 57). As a department of state, DoD has traditional departmental responsibilities and advises the Minister on Australia’s defence policy, resources, organisation and finance (Horner 2007, p. 150). The public servants in the DoD have also occasionally been referred to as ‘the fourth service’ of the ADF under the One Defence model (Dennett 2018).

Under the joint ADF structure, each service branch (through the Chiefs of the Army, Navy and Air Force) is responsible for raising, training and sustaining combat forces. All military operations and exercises are controlled by Joint Operations Command directly, using personnel and equipment from all three service branches as needed. The integration of the three service branches and their different capabilities in joint operations has been described by the ADF as a ‘key warfare’ concept, ‘that produces a synergy in the conduct of operations’ (The Australian Approach to Warfare, quoted in Horner 2007).

¹ The diarchy is unique among Australian Government departments, and ‘encompasses the individual and joint responsibilities and accountabilities of the Secretary and the [CDF]’ (DoD 2017f, p. ii). It has been criticised in the past for a ‘duplication of effort between the public service and military functions of Defence and consequent opacity around accountability at all levels in the organisation’ (Peever et al. 2015, p. 20).

Figure 11.2 **Defence's organisational structure**

As at 17 October 2018



Source: DoD (2018b).

Box 11.3 **A brief history of Defence's governance arrangements**

After Federation, the Australian Government assumed responsibility for defence matters. This was in line with its powers under the Constitution (s. 51) to create laws with respect to 'the naval and military defence of the Commonwealth'. The military forces of the colonies were unified in the *Defence Act 1903*, creating a single armed force (renamed the Australian Army in 1980).

The Royal Australian Navy was created as a separate service branch in July 1911, following panic within the British Empire when it was revealed that Germany was building dreadnoughts to challenge the supremacy of Britain's Royal Navy. The Royal Australian Air Force was formed in 1921 out of the experience of the Australian Flying Corps, which had served as part of the Army in France and the Middle East during the First World War.

Prior to the Vietnam War, coordination between the service branches (Army, Navy and Air Force) was weak. For most of this period, each service branch had its own department with the 'Defence group', alongside additional departments for Supply, Production and Defence, while there were often separate Ministers responsible for each branch.

During World War I, Australia's Army and Navy units are said to have effectively fought separately, operating under British command. Little changed during World War II, although some notional joint command arrangements existed under United States control in the Pacific theatre.

The expansion of Australia's involvement in Vietnam from 1966 led to a rearrangement of the operational command structure. The Army and Air Force commitments to the Vietnam War were controlled through a single headquarters — the Australian Force Vietnam — with a single commander. Although the new command structure came with challenges (particularly from a lack of clear strategic direction), this set a precedent for later ADF operations:

The government realised that, for overseas operations, there was great value in appointing a national commander who could ensure that Australian policy was followed. Further, if more than one service was deployed, there was advantage in having one national joint service commander deal with allied commanders-in-chief and host governments. (Horner 2007, p. 147)

In 1967, Lieutenant General Sir John Wilton (then Chairman of the Chiefs of Staff Committee), proposed reorganising Australia's Armed Services, with a unified Department of Defence and service branches amalgamated into an integrated Australian Defence Force (ADF), with this 'diarchy' responsible to a single Minister for Defence. This model included retaining the separate identities of the service branches to 'preserve morale and operational efficiency', but as most operations would be joint, there should be a 'single clear chain of operational control' (Horner 2007, p. 148). This reorganisation was carried out incrementally over the ensuing years, and was finally completed (following the Tange Review) on 9 February 1976, when the role of Chief of Defence Force Staff (now Chief of the Defence Force) was created and given ultimate command of the ADF.

Sources: AWM (2018c); Grey (2008); Horner (2001, 2007); Khosa (2010); Tange (1973).

The Department of Veterans' Affairs and statutory commissions

Under the current AAOs, DVA is responsible for the following matters:

- repatriation income support, compensation and health programs for veterans, members of the Defence Force, certain mariners and their dependants

-
- commemorations
 - war graves (DPM&C 2018).

DVA is also responsible for administering 23 pieces of legislation, including the three that are of key interest to this inquiry:

- the *Veterans' Entitlements Act 1986* (VEA)
- the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- the *Safety, Rehabilitation and Compensation (Defence Related Claims) Act 1988* (DRCA).

These three Acts establish the Repatriation Commission (RC) and the Military Rehabilitation and Compensation Commission (MRCC), which delegate to DVA certain functions, including the administering of payments and services for eligible veterans and their families, as well as the conduct of commemorative programs (box 11.4).

Box 11.4 DVA's purpose and reporting framework

The Department of Veterans' Affairs' stated purpose is to 'support those who serve or have served in the defence of our nation and commemorate their service and sacrifice' (DVA 2018f, p. 12). The Department reports on its responsibilities in three outcomes:

- Outcome 1: Compensation and support — maintaining and enhancing the financial wellbeing and self-sufficiency of clients through access to income support, compensation, and other support services.
- Outcome 2: Health — maintaining and enhancing the quality of life of clients through health and other care services that promote early intervention, prevention and treatment.
- Outcome 3: Commemorations — acknowledging and commemorating veterans' service, through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage and official commemorations.

The Repatriation Commission

The RC is a statutory body under the VEA empowered to provide treatment and grant pensions and other benefits to veterans and their dependants. It also advises the Minister for Veterans' Affairs on the operation and administration of the VEA (box 11.5).

Membership of the RC is made on appointment by the Governor-General, and consists of a President, a Deputy President and a Repatriation Commissioner (also known as the Services Member, as they are appointed from a list of names provided by ex-service organisations). All three members also have senior executive management roles within DVA.

- Under the VEA (s. 184), the Secretary of the DVA also holds the office of President. The Deputy President and the Repatriation Commissioner are also members of the Department, holding roles equivalent to a Deputy Secretary and directly managing several key functions

of the Department, including the DVA's claims operations and Open Arms counselling (formerly the Veterans and Veterans Families Counselling Service).

The stated rationale for the overlapping membership of the RC and the senior management of the Department is 'to ensure alignment of the functions and objectives of the Commissions and the Department' (DVA 2017d, p. 13).

Box 11.5 **A brief history of the Repatriation Commission**

The Commission and the Department

In April 1918, the newly formed Repatriation Commission (RC) and the separate Department of Repatriation began operations, implementing the *Australian Soldiers' Repatriation Act 1917*, which established an initial framework for a repatriation system.

The RC was made up of six voluntary members (plus the Minister for Repatriation) and its functions were to oversee and implement policy (through drafting regulations for assistance and benefits — giving the scheme 'flesh'), and to hear appeals on decisions made under those regulations (Lloyd and Rees 1994, p. 82; Payton 2018, p. 14).

The then Department of Repatriation, by contrast, was a department of state responsible for the day-to-day administration of repatriation policy under the supervision of State Boards, operating on the delegated authority of the RC (Lloyd and Rees 1994; Repatriation Department 1919). The Department's activities covered employment services and vocational training for discharged soldiers, medical and general assistance to re-establish returned soldiers in the community, and more general housing and financial support for totally and permanently incapacitated soldiers or the dependents of deceased or incapacitated soldiers (Repatriation Department 1918, 1920).

The Commission becomes the Department

In 1920, the structure of the RC and the Department were altered with the *Australian Soldiers' Repatriation Act 1920*. The RC became a paid, full-time commission of three members with guaranteed returned soldier representation (the Services Member). Control of the Department also passed to the RC at this time, generating additional administrative functions for the RC, not just advisory functions, and the State Boards were also changed to full-time paid Boards of three members. Administration of war pensions was transferred from the Treasury to the Repatriation Department (Repatriation Department 1920).

As noted by Lloyd and Rees (1994, p. 208), this post-1920 arrangement was cumbersome and raised 'problems of duplication and overlap in the presence of the two administrative bodies'. However, it ultimately 'provided the administrative continuity which ensured repatriation's survival as an important element of Australia's public policy and administration' during the inter-war years, even as the repatriation function 'disappeared intermittently' from the Cabinet Ministry.

(continued next page)

Box 11.5 (continued)

Following the changes in 1920, the repatriation system was characterised by increasingly blurred dividing lines between the Department and the RC. During the inter-war years there was uncertainty about whether the RC was a statutory commission or a governmental department — labels of ‘Commission’ and ‘Department’ were often used interchangeably. Partial clarification came in 1923, when the High Court held (in *Repatriation Commission v Kirkland*) that the RC was a ‘very special [Commonwealth] department for a very special purpose’ (Lloyd and Rees 1994, pp. 309, 312). However, according to Payton, ‘the [RC] was thought to be a hybrid temporary creation, not quite a “commission” in the way the term was often understood, and not exactly a department in its own right either’ (2018, p. 65).

The Repatriation Department and RC, while set up as temporary organisations, were still operating in the late 1930s. The expectation was that they would ‘fade away’ after repatriating soldiers returned from the First World War, but repatriation proved to be an unexpectedly complex and lengthy task. Following the outbreak of the Second World War and an entirely new client base with an expanded range of needs, it became evident that the Department would remain, so it was incorporated into the public service in 1947 (Lloyd and Rees 1994; Payton 2018).

A Joint Public Accounts Committee report in 1954 suggested that the status and functions of both the Department and the RC should be reviewed, as the administrative functions of the Department had taken precedence over the initial quasi-judicial functions of the RC (JPAC 1954; Lloyd and Rees 1994). This meant that by the early 1950s the RC had ‘become in effect the senior executive arm of the Repatriation Department and was best understood in that light’ (Payton 2018, p. 66)(Payton 2018, p. 66)(Payton 2018, p. 66)(Payton 2018, p. 66).

In the early 1970s, the Secretary of the Repatriation Department was also appointed as Chairman of the RC, creating ‘a formal recognition of a de facto situation that had existed for many years’ (Lloyd and Rees 1994, p. 342). Following the recommendations of the Toose Report (1976), the Repatriation Department acquired the administration of the Defence Service Homes Scheme and the War Graves Commission on 5 October 1976 and was renamed the Department of Veterans’ Affairs (DVA) to more ‘accurately set out the range of functions performed by the Department’ (Lloyd and Rees 1994, p. 354). The RC retained its existing name, ‘but its relationship with DVA remained unchanged’ (Payton 2018, p. 71).

The Military Rehabilitation and Compensation Commission

The MRCC is a statutory body (box 11.6) under the MRCA and the DRCA, empowered to accept liability and provide rehabilitation, compensation and other benefits to veterans and their dependants.

The MRCC currently has six members made on appointment by the Governor-General. Three of these are the same three members of the RC (with the President of the RC also the Chair of the MRCC). The other three members are:

- a person nominated by the Minister for Jobs who either administers the Commonwealth’s workers’ compensation scheme or is a public servant working in the Department of Jobs and Small Business (currently the CEO of Comcare)

-
- two people nominated by the Minister for Defence who are either permanent members of the ADF or public servants working in the Department of Defence (currently the Joint Health Commander and the Head of the People Capability Division).

An MRCC subcommittee (made up of the three members of the RC) can also consider routine administrative matters independently, although its decisions have no legal effect until ratified by the full MRCC (DVA 2017d).

Box 11.6 **A brief history of the Military Rehabilitation and Compensation Commission**

The Military Rehabilitation and Compensation Commission (MRCC) was established under section 361 of the *Military Rehabilitation and Compensation Act 2004* (MRCA). The MRCC was to be ‘a new, five-person commission responsible for strategic monitoring and management of the scheme’s performance’ (Campbell 2011b, p. 254).

The MRCC’s functions under the MRCA (s. 362) are to:

- make determinations — ‘accurately and quickly’ under s. 142 of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* — on the acceptance of liability for service-related conditions, the payment of compensation and the provision of treatment and rehabilitation
- minimise the duration and severity of service-related conditions by ‘arranging quickly’ for rehabilitation
- promoting the return to suitable (civilian or military) work
- promote research into the health of members and former members, the prevention of injury and disease, and rehabilitation
- provide advice and information to the ministers and departmental secretaries of Veterans’ Affairs and Defence and the Chief of the Defence Force, either on request or on own initiative (DVA 2017d).

Prior to the introduction of the MRCA, the Tanzer Review had recommended (in 1999) that a new regulatory authority for the proposed MRCA be located within the Defence portfolio, with some common members from other existing regulatory agencies — such as the Safety Rehabilitation and Compensation Commission (SRCC) and National Occupational Health and Safety Commission. This structure (which was partly adopted) aimed to ‘reverse engineer’ the structure of the SRCC (Tanzer 1999, pp. 83–84), which at that time was the primary policy agency advising the Employment Minister on the operation of the *Safety, Rehabilitation and Compensation Act 1988*.

In 2011, the MRCA (Campbell) Review recommended that the MRCC be expanded from five members to six, with the additional member drawn from Defence to improve effective information sharing between the Department of Veterans’ Affairs and Defence. The impetus for this change came from Defence — ‘Defence believes that current Defence representation on the MRCC is inadequate’ (Campbell 2011b, p. 255).²

² It is not clear why only one Defence member on the MRCC was an obstacle to effective information sharing or whether the adoption of an additional Defence member since then has made any difference to this.

Other veterans' affairs agencies

There are also two medical authorities, an appeals review body and the War Memorial within the veterans' affairs sub-portfolio:

- the Repatriation Medical Authority (RMA) is an independent statutory authority. Its role is to determine the Statements of Principles (SoPs) for any disease, injury or death that could be related to military service
- the Specialist Medical Review Council (SMRC) reviews the RMA's decisions on SoPs and directs or recommends that the RMA amend the SoPs
- the Veterans' Review Board (VRB) reviews certain decisions made under the VEA and the MRCA.
- the Australian War Memorial (AWM) maintains and develops the national memorial to Australians who have died in wars or warlike operations, while also maintaining and exhibiting a national collection of historical material and conducting research into Australian military history.

The roles of the RMA and the SMRC are discussed in more detail in the initial liability chapter (chapter 8). The reviews chapter (chapter 10) looks at the role of the VRB (and the Administrative Appeals Tribunal). The AWM is discussed further in section 11.4.

External oversight: Ministers and other agencies

Oversight bodies can be split roughly into those that provide ongoing or regular oversight and report directly to Ministers (the central departments of state — Prime Minister and Cabinet, Finance and Treasury), and those that provide ad hoc or reactive oversight (either independently or on the direction of a Minister) in response to a complaint or a referral. This latter group includes the Commonwealth Ombudsman, the Australian National Audit Office (ANAO) and the Inspector-General of Defence.

As in all other areas of public policy, ultimate responsibility for Defence and DVA (including the underlying policy and its day-to-day administration) rests with the relevant Ministers. More specifically, under the *Defence Act 1903*, the Minister for Defence has overarching control and administration of Defence, while DVA is subject to the Minister for Veterans' Affairs and is a sub-portfolio of Defence under the AAOs. Both Ministers are held accountable by Parliament, the main legislative body.

11.2 Institutional separation — Defence and DVA

An arbitrary functional split

Defence and DVA have different and often competing objectives (section 11.1). There are also some overlapping policy responsibilities at certain times for Australians with military service.

- Defence has responsibility for training and equipping current serving members to maintain the capability to defend Australia’s interests around the world. Defence also has (some) responsibility for helping current serving members transition into civilian life (chapter 7).
- DVA has responsibility for assisting those members who have had liability for a service-related condition accepted by the Australian Government or who satisfy the criteria for non-liability care. This includes providing them with rehabilitation, treatment and compensation that is consistent with the provisions in the veteran support legislation.

But a formal shared purpose that could help unify and coordinate action across these responsibilities in favour of veteran wellbeing is lacking. Instead, there is a set of somewhat arbitrary (from the point of view of the serving and ex-serving member) functional splits and institutional separations between DVA and Defence that create adverse incentives for the respective agencies, policy and implementation gaps, duplicated services and generally inefficient administration.

The adverse incentives faced by Defence

The cost of post-service care for ADF members is the responsibility of DVA. This is an unusual arrangement compared to most civilian employers, a fact noted by Defence:

... the unique aspect of the current system of veterans’ support is that Defence as the employer is *not financially responsible* [its emphasis] for the compensation of its personnel for the impact of their service. (sub. 127, p. 18)

This ‘unique aspect’ creates an incentive for Defence to shift the cost of long-term injuries and illnesses onto DVA. This *could* result in service personnel undertaking unnecessarily risky actions (incurring relatively more injuries and illnesses) or being prematurely discharged without adequate support (such as the opportunity to rehabilitate in service).

In its consultation for this inquiry the Commission heard about cases that suggested that in the past, commitment to preventing excessive casualties in the ADF has not been all-pervasive across all services and all activities (chapter 5).

As noted in the rehabilitation chapter (chapter 6), one participant claimed that ‘once a member becomes injured or ill for a prolonged period they are on a one-way conveyor belt into the community requiring DVA assistance and support’ (Stephan Rudzki, sub. 40, p. 4).

The Defence Force Welfare Association (DFWA) claimed that:

... the ADF has no further responsibilities for those medically discharged and [in] fact, is quite enthusiastic in removing members who adversely impact on ADF operational readiness and effectiveness. (sub. 118, p. 27)

But the ADF's contemporary approach to workplace health and safety appears to have improved in recent years (chapter 5). And a disregard for the long-term costs of injuries and illnesses on service personnel would be inconsistent with Defence's capability objectives, as many long-term conditions will have short-term impacts on the effectiveness of serving members. As the 2016 Defence White Paper said, 'the quality of our people is the foundation of Defence's capability, effectiveness and reputation' (DoD 2016a, p. 145).

That said, the underlying incentives for Defence still remain, and are likely to be most pronounced where the impacts on members only occur after discharge (so do not affect Defence capabilities). The potential benefits from better aligning the incentives of Defence and DVA to focus on the long-term wellbeing of serving members are likely to be substantial, given that DVA spent \$5.3 billion on health care and rehabilitation in 2017-18 (DVA 2018f).

Inefficient and ineffective administration

The separation between DVA and Defence also leads to less efficient and effective administration of supports for current and ex-serving personnel. For example:

- data and information exchange between the two departments is historically poor, cumbersome and bureaucratic, and relies on voluntary memorandums of understanding for critical information about the medical, health and service records of veterans (chapters 8 and 16).
- Defence and DVA need to better coordinate the provision and commissioning of many services (such as rehabilitation and health care services) to avoid duplication and create a continuum of care and generate cost efficiencies through economies of scale.

Defence acknowledges that its functional separation with DVA (and, to a lesser extent, the Commonwealth Superannuation Corporation) in the veteran support system creates a 'risk of confusion, gaps, overlaps and less accessible services, reducing the effectiveness of the system' (sub. 127, p. 4).

Defence has identified several areas for improvement that are 'under active consideration by the departments and the MRCC' (p. 15), including the alignment between agencies and the exchange of information between them. Likewise, the flow of information back from DVA to Defence could also serve to 'assist Defence to better understand occupational risks and to identify opportunities to proactively manage those risks' (DVA, sub. 125, p. ix).

11.3 Where is the strategic policy?

DVA is the principal policy maker in the veteran support system. It is responsible for both making policy, as a department of state, and implementing policy under its administered legislation. DVA's focus, both historically and currently, has been on the day-to-day administration of the existing veteran support system — assessing claims, paying pensions and managing stakeholders — with limited attention given to strategic policy to ensure that the system is fit for purpose.

A 2013 capability review by the Australian Public Service Commission (APSC) highlighted DVA's lack of attention to strategic policy:

... what strategic thinking and policy development occurs within DVA seems often ad hoc and silo bound. Insights are not usually shared or actively sought across the department and subsequent service offerings are seen as disjointed and at times appear to overlap or allow for gaps. It is notable that the functional area responsible for defining the strategic framework and bringing the client's perspective to bear in service design is comparatively under-resourced given the imperative for major reform. (APSC 2013, p. 10)

The APSC also noted that DVA's governance arrangements:

... tend to work against the conduct of vital strategic conversations ... Across the governance framework more generally, it is unclear where strategic discourse is being conducted. (2013, p. 7)

Lack of strategic thinking leads to poor policy outcomes

A predictable outcome in a system lacking strategic direction is that, rather than policy change that is proactive, anticipating crises before they occur and making changes in the long term interest of veterans, policy change tends to be reactive in nature and driven by external events. This results in 'political pressure on "the system" to do something ... or be seen to be doing something' (DFWA, sub. 118, p. 33).

DVA's current reform program, Veteran Centric Reform (VCR), came about in response to a perception that 'problems with the compensation claims process were ... contributing factors to suicide by some veterans', while outdated information and communications technology (ICT) infrastructure faced potentially catastrophic failures (ANAO 2018b; SFADTRC 2017, p. 42).

There is also some history of DVA not completing reforms. Examples include the 'Veterans First' initiative from the early 2010s (chapter 9) and the lack of sustained action around the veterans long-term rehabilitation study which came about from the 2011 MRCA (Campbell) Review (chapter 6).

DVA acknowledges that decision making is often reactive and that this reactive policymaking:

... adds to complexity and can ignore the needs of the whole veteran community, or can overlook the circumstances faced by other cohorts of veterans and their families in otherwise similar situations. (sub. 125, p. 29)

DVA also observed that reactive changes can lead to cycles of ever-increasing benefits, as they ‘introduce relatively minor but nevertheless compounding amendments to legislation’ that can lead to ‘new differences that may then lead to calls for further extensions’ (p. 29). DVA also noted that:

Such responses are also likely to be based on particular historical or current circumstances, without considering all veterans’ future needs and without prioritising improvements. (sub. 125, p. 29)

There are several notable examples of such outcomes, where an ad hoc policy response is the genesis of a future policy problem.

- The June 1996 Black Hawk accident that killed 18 soldiers (chapter 3) shone a light on the problem of dual eligibility, particularly the inequities in payouts between the VEA and the then *Safety, Rehabilitation and Compensation Act 1988* (SRCA, now DRCA) for soldiers (or their dependants) with the same condition (in this case, death). The variation in payouts were as high as \$300 000 (DoD 1997). The inequities caused by having two compensation Acts had been known for some time, but were only addressed following this high-profile accident. The accident led to an additional SRCA payment through the *Defence Act 1903* — which sought to top up the SRCA payments to the level of VEA payments — and ultimately, via the Tanzer Review, to the creation of the MRCA — which was meant to (but did not) solve the dual eligibility problem.
- The expansion of non-liability mental health treatment in successive Budgets between 2016 and 2018 (Australian Government 2016a, 2017b, 2018a) and the introduction of the Veteran Payment for claimants with pending mental health claims was a response to several veteran suicides and recommendations from the resulting Senate inquiry into veteran suicide (Atkin 2017; DVA 2018s; DVA and DoD 2017; Maurice Blackburn, sub. 82; Tehan 2017a; Thompson, sub. 116). But there was no consideration of the broader implications of introducing non-liability financial support (the Veteran Payment) to the veteran support system, which is fundamentally based on the Government accepting liability for a service-related condition *before* compensation is provided. The National Mental Health Commission’s review into suicide and mental health (NMHC 2017) asked that this exact type of broader strategic consideration be undertaken when it recommended that the Government ‘consider whether there are superior models for supporting optimal health and wellbeing of current and former members and their families, including models that separate compensation, liability and health care provision’ (recommendation 3). The Government’s response was that ‘the proposed economic study would have limited value’ (DoD, DoH and DVA 2017, p. 65).

The strategic thinking and policy development that does take place in the veteran support system appears to be mostly outsourced to other parties, such as Senate inquiries and ‘independent’ reviews. Over the past decade alone there have been at least 12 reviews into

various aspects of the veteran support system (figure 11.3), as well as numerous health studies into veteran outcomes. DFWA claimed that:

There are probably well over 50 government projects, studies, inquiries, task forces, and new organisations that had their genesis in the public alarm and political pressure concerning veteran suicides, mental health and transition. (sub. 118, p. 33)

The following parts of this section discuss the factors that appear to be consistently contributing to ad hoc policy making and poor policy outcomes in the veteran support system, including the:

- sacrosanct nature of veterans policy
- lack of effective oversight for spending and strategic planning
- lack of clarity around the roles of the RC and MRCC, whose functions overlap and duplicate each other.

Veterans' affairs policy is sacrosanct

The community expects veterans to be looked after

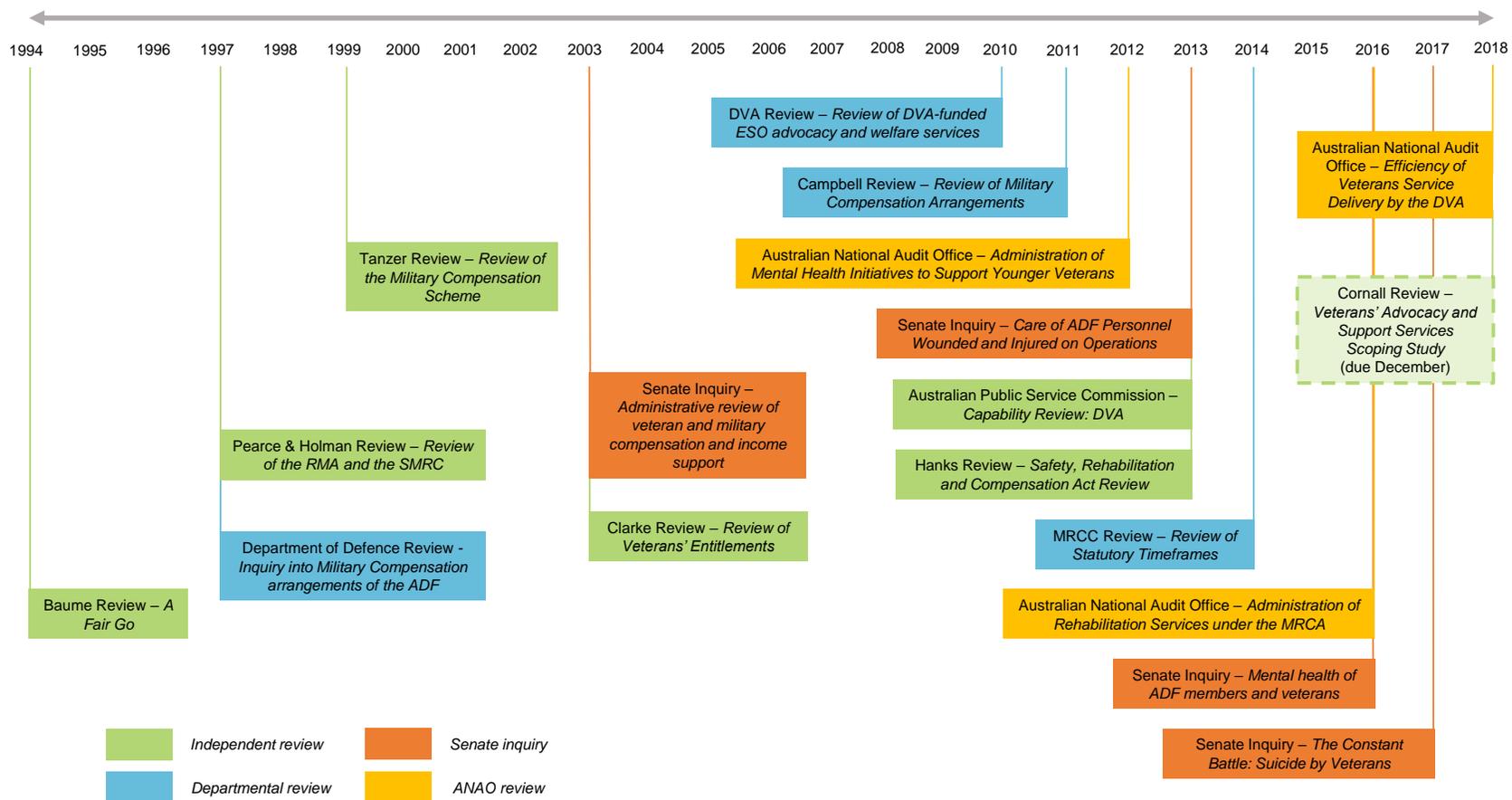
Over the past two decades there has been a resurgence in interest within the Australian community about the country's military history. This is exemplified by the large numbers of Australians travelling overseas to attend ANZAC day ceremonies. In 2015, DVA had to hold a ballot to ration attendance at the centenary Dawn service at ANZAC Cove and Lone Pine in Gallipoli — almost 8000 Australians attended this ceremony more than 15 000 km from the Australian capital (Payton 2018, p. 95).

How this interest in commemorating the service of Australian soldiers extends to expectations about government support for veterans is unclear. If you ask Australians for their opinion — which this inquiry did through submissions and consultations — there are few calls for supports to be wound back (although there are calls for changes to the focus of the system, chapter 4).³ What you do hear is statements like 'veterans deserve everything they get'. This sentiment, first enunciated by former Prime Minister Billy Hughes in 1917 (that 'when you come back we will look after you'; Lloyd and Rees 1994, p. 69), is reflected in the actions of contemporary Australian governments and the Parliament more broadly.

³ This may also partly reflect widespread unfamiliarity with the level and number of benefits that veterans currently receive.

Figure 11.3 Reviews and more reviews, but still little strategic policy

Reviews and inquiries into the veteran support system, 1994-2018



Source: Commission analysis.

And according to the Air Force Association, this is as it should be:

The ‘best interests’ of veterans and their families described initially in 1920 legislation prevails today. This time-honoured commitment needs to be maintained. The demands on our servicemen and women and their families have not diminished. Societal expectations are that veterans and their families are a national asset and any diminution of support would be viewed seriously. (sub. 93, pp. 3-4)

Such expectations can make reform difficult. As noted above, benefits and payments tend to accrete bit by bit, adding complexity, but with little regard to whether each marginal addition actually improves veteran outcomes or represents value for taxpayer money (chapter 14). Often the perception that benefits (particularly financial benefits) may be taken away from some veterans can be enough to stop or seriously compromise efforts at reform.

This risk-averse approach — which manifests in avoiding major policy changes — can result in poorer outcomes for veterans and their families. The attempt to solve dual eligibility when the MRCA was created is instructive. It was originally envisioned that new claims under the existing Acts (VEA and SRCA) would cease with the introduction of the MRCA. But this option was rejected by ex-service organisation (ESO) representatives at the time, with DVA taking the view that VEA provisions, ‘most particularly the Above General Rate Pensions ... were untouchable’ (RSL Queensland, sub. 73, p. 18). The possibility that the MRCA legislation would present a better overall package for veterans, with its increased emphasis on wellness, rehabilitation and restoring veterans ‘to at least the same physical and psychological state ... as he or she had before the injury or disease’ (s. 38 of the MRCA) compared to the VEA (with its focus on pensions for life), carried too little weight. As one former DVA employee said of the VEA:

... I quickly came to appreciate the complexity of compensation legislation, and especially the anachronistic nature of the VEA in a political climate where it was (and still is) treated as a sacred cow, stymying any serious reform. Sadly I fear that is still the case. (Peter Reece, sub. 49, p. 1)

Ex-service organisations are highly influential, but have no unified position

As organised representatives of veterans and their families, ESOs are important stakeholders in the policy development process. ESOs, due to their advocacy and welfare role, are uniquely placed to see the shortcomings in the system and can provide feedback about how the system is functioning and if it is fulfilling its aims and objectives. To this end, and consistent with principles of good governance, DVA frequently meets with ESOs, including through an array of formal consultative forums under the National Consultative Framework (box 11.7).

However, with as many as 5500 ESOs and no peak body (chapter 9), engaging meaningfully and productively with such a large and disparate group is difficult. Managing stakeholders in this situation can become an end in itself, rather than the means to inform potentially difficult policy decisions. Indeed it was suggested by some participants, including the Alliance of Defence Service Organisations (ADSO, sub. 85) — which itself is an alliance of

ESOs — and DFWA (sub. 118, p. 55) that there is a ‘never-ending problem of trying to get a unified voice from the ESO community’. This might be handicapping policy development and undermining the effectiveness of existing initiatives, including the VCR program.

And ESOs appear to be an important driver of policy change, perhaps unduly influencing outcomes at the expense of broader public policy considerations or even other (future) veteran cohorts. DVA acknowledged this problem:

To date, veterans’ military compensation policy has often been developed in reaction to requests advocated by individual veterans or by ESOs ... (DVA, sub. 125, p. 29)

To some extent this deferential behaviour (generating an unwillingness within Government and the public service to say ‘no’ to representations for change from affected groups) appears to be driven by fear of bad publicity. As the APSC said:

Departmental staff have described DVA as being ‘terrified’ of the risk of adverse media attention, particularly in relation to its rehabilitation and compensation functions, and how the department works hard to avoid risk at all costs rather than proactively managing it. (2013, p. 41)

Box 11.7 DVA consultative forums

- ESO Round Table (ESORT) — the main forum for dialogue between the DVA and ESO leadership, ESORT addresses issues of strategic importance to the veteran community in the medium to long term, including in the context of ageing members, declining membership and multiplying ESOs. ESORT also serves as the main body for consultation on the development of legislative instruments under the VEA, MRCA and DRCA (DVA 2018n).
 - DVA also organises a consultative forum in each state and territory to ensure that it engages with the sub-national branches of the major ESO organisations (DVA 2014f).
- Younger Veterans Contemporary Needs Forum (YVF) — designed to increase engagement and information sharing between DVA and younger veterans outside of existing ESOs, YVF deals with emerging issues in the areas of mental and social health including how they vary by veteran cohort and location, as well as to recommend improvements in DVA’s operational policy to promote quality and accountability in service delivery (DVA 2018aq).
- Operational Working Party (OWP) — a forum for ESOs to discuss concerns about DVA’s delivery of services and identify and provide recommendations for improvements in operational policy (DVA 2018ak).
- Female Veterans’ and Families Forum — to provide an annual platform for female veterans and veterans’ families to raise issues directly with the Government and DVA (DVA 2017f).
- National Aged and Community Care Forum (NACCF) — a forum for ESOs, aged care providers and the DVA to discuss current and future health, aged and community care policy and mental and social health policy, including how DVA can better support people at home via community support (DVA 2018w).
- DVA Health Providers Partnership Forum — to promote and support collaboration between the DVA and peak health sector bodies to improve policy and service delivery (DVA 2018l).

Accountability has not achieved lasting change

In line with principles of good governance, oversight bodies for DVA and Defence should ensure accountability for, and transparency of, policy and administrative decision making (there is also a merit and judicial review process — chapter 10). However, it is difficult for the accountability bodies to effectively influence change. In addition to the issues raised in the previous section, this is because these agencies do not have formal responsibility to pursue these types of strategic changes, nor an ability to compel change when it is identified.

Ongoing oversight bodies

Ongoing oversight of DVA is provided by the three central departments — Finance, Prime Minister and Cabinet (DPM&C) and Treasury (the central agencies) — as part of the normal Budget and Cabinet process. Central agencies are in frequent contact with line departments such as DVA and Defence and will typically set up small ‘shadow’ teams (such as the Agency Advice Units in Finance) who work closely with agencies to ensure that their policy proposals and outcomes are consistent with the Government’s broader Budget and policy priorities, as well as specific Cabinet decisions.

Because the day-to-day deliberations between central agencies and DVA (and Defence) are not public, assessing their effectiveness as oversight agents is difficult. However, we do know that Finance has taken a stewardship role overseeing the VCR program, in line with its Budget accountability responsibilities (including commissioning annual assurance reviews as the responsible agency for Gateway Reviews — chapter 9). This is designed to assist with implementing the VCR program, ensuring it keeps to its budget and aligns with whole-of-government ICT and service delivery systems, including the Department of Human Services’ Welfare Payment Infrastructure Transformation (WPIT).

And while the central agencies are not directly responsible for veteran policy, because veteran support policy is politically sensitive, there is no reason to believe these agencies (or the recipients of their advice) will be any less risk averse than DVA.

One example of this risk aversion is illustrated in the conclusions of an attempt to deal with dual eligibility — the 2011 MRCA (Campbell) Review’s consideration of transitioning SRCA claimants into MRCA. The steering committee, led by the secretary of DVA, and including representatives from Treasury and Finance, presented similar findings to those used to justify the original MRCA legislation:

- ‘transitioning future SRCA claims to the MRCA would reduce complexity, confusion among stakeholders and some administration’
- most claimants ‘would receive a higher benefit under the MRCA’ which could increase the call on the Budget
- but MRCA ‘can lessen the amount of compensation’ payable overall, thus offsetting concerns about increasing the Australian Government’s likely financial liability (Campbell 2011b, p. 273).

Despite presenting this compelling evidence for action, the committee recommended ‘no action be taken’ (p. 280).

Independent (and quasi-independent) oversight bodies

Independent oversight bodies also have a vital role to play in the veteran support system. These bodies (the most prominent are outlined in box 11.8) do not report directly to a Minister, but release public reports and are relatively free of the types of public pressures discussed above.

However, these bodies tend only to respond to individual incidents (such as the Commonwealth Ombudsman’s investigation into ‘Mr A’ — chapter 9) or referrals to investigate specific issues (such as the ANAO investigation into the efficiency of service delivery by DVA) rather than broader veteran support policies and the underlying legislation.

Box 11.8 Independent oversight bodies

- The *Commonwealth Ombudsman* (as the Defence Force Ombudsman) has the power to ‘consider and investigate complaints from people who believe they have been treated unfairly or unreasonably’ by DVA’s administrative practices, with the aim of effecting ‘significant improvements in the quality of government administration’ (Commonwealth Ombudsman 2017a). Under the *Ombudsman Act 1976*, these functions include special investigative powers (including self-initiating an investigation), as well as the capacity to recommend changes to individual decisions or to broader departmental rules and procedures. In 2017-18, the Ombudsman received around 170 complaints about DVA’s administration (Commonwealth Ombudsman, sub. 62, p. 2).
- The purpose of the *Australian National Audit Office* (ANAO) is ‘to improve public sector performance and support accountability and transparency in the Australian Government sector through independent reporting’. More specifically, the Auditor-General, as an independent officer of the Parliament, provides independent assurance of the executive branch and holds it accountable for ‘its use of public resources and the administration of legislation passed by the Parliament’ (ANAO 2018a, p. 11).
- Led by the Public Service Commissioner, the *Australian Public Service Commission* (APSC) is a statutory agency within the DPM&C portfolio, whose purpose is ‘to create a high-performing Australian Public Service [APS] that delivers quality results for government, business and the community and to make genuine and enduring changes to the way the APS operates’. The APSC has responsibility (under the *Public Service Act 1999*) for increasing ‘awareness and adoption of best-practice public administration by the APS through leadership, promotion, advice and professional development’ (APSC 2018, p. 7).

In the veteran support system, these broader strategic issues tend to be considered by quasi-independent (as they often include DVA staff in their membership or use a secretariat in DVA), ad hoc review bodies, such as the Toose (1976), Baume (1994) and Tanzer (1999) Reviews. Agencies with a broader remit to investigate policy (such as the Productivity

Commission) are unusual, and rely on a formal reference before any investigation or inquiry can be undertaken.

Both of these sets of oversight bodies — those with a specific remit and a broader policy remit — can only make recommendations. Their power is one of disclosure — they have no ability to compel policy change or administrative action by a Department or a responsible Minister and, as discussed above, the latter are averse to making significant, transformational changes to the veteran support system.

DVA's internal governance arrangements

DVA's internal governance structures are characterised by duplicated functions and forms, confused dividing lines between institutions, and a lack of clarity about their purpose and rationale. In particular, the RC and MRCC sitting alongside the normal structure of a department of state creates confusion and complexity without any identifiable benefits. As the APSC in their capability review said: '[t]he number of committees, duplicated membership and confused accountabilities inhibit decision making' (2013, p. 7).

Effective governance requires clear objectives and clarity of purpose. As Department of Finance guidelines state:

A lack of clarity about an activity's purpose can result in ineffective governance structures that inhibit the efficiency and performance of the body tasked with undertaking the activity. In particular, it can make it difficult for the accountable authority to set a clear direction for the body to achieve the scope and objectives set for it by the Parliament or the Government ... Put simply, form follows function. (2015a)

The overlap between the Commissions means it is not clear 'who' (one of the Commissions or the Department) is doing what. And much of this confusion is a function of the legislation. Within their guiding legislation, the dividing line between the Commissions and the Department is unclear — the RC (in s. 179A of the VEA) and MRCC (in s. 363 of the MRCA) are both 'taken to be part of the Department' for the purposes of the *Public Governance, Performance and Accountability (PGPA) Act 2013*.

This confused accountability structure permeates into interactions between the Commissions and the Department. For example, DVA on occasion refers to the RC and MRCC as entirely separate entities (without common membership). The Department's 2017-18 annual report, for instance, states that 'DVA reports to the Repatriation Commission on the administration of major programs and the progress and outcome of all major reviews', implying that DVA's senior executives report to themselves, given both organisations are headed by the same individuals (DVA 2018f, p. 28).

The reality seems to be that the RC *is* the Department, and effectively has been since 1920. For example, the Secretary of DVA is the President of the RC and the RC has a significant overlap in functions and purpose with the Department. But with no independent staff of its

own, the RC is not able to function without the Department, so it seems unnecessary to define it as a statutory body independent of the Department.

Given the overlapping membership between the RC and MRCC, there is a similar case that the MRCC is also just the Department under a different title, particularly as the RC (acting as the ‘MRCC subcommittee’) can make decisions on behalf of the full MRCC. Indeed, DVA noted that the two Commissions ‘often consider the same issues and hold joint meetings’ (sub. 125, p. 4).

The functions of both Commissions are also not unique roles that can justify their existence separate from the Department. For instance, the RC and MRCC both have as a legislated function the provision of advice to the Minister for Veterans’ Affairs (and the Minister for Defence for the MRCC). But providing advice to Ministers is a normal and foundational function of any department of state, such as DVA (box 11.2). It is unclear why this function needs to be duplicated, particularly as neither Commission is providing advice to the Minister that is truly independent from DVA.

The key difference between the RC and the MRCC is the inclusion of the three non-DVA members on the MRCC (one from Employment, two from Defence). In theory, this allows the MRCC to create value in the veteran support system where the RC (and even the DVA) cannot, particularly by injecting new, external views into the policy and administration process. Given the governance and administrative problems documented throughout this report, and notwithstanding that the deliberations of the MRCC are not public,¹ the effectiveness of these additional members seems unclear at best. Regardless, there are more effective ways to inject diverse views into policy development (section 11.4).

11.4 The Commission’s proposed path forward

Given the problems with the institutional governance arrangements discussed above, there is a strong case for major reform. Modelled on contemporary workers compensation schemes, the reforms would include simplified institutional arrangements — a single unified portfolio department and an independent agency for administration — and a changed system focus.

Changes to the focus of the system will:

- better incorporate the long-term wellbeing of veterans and their families
- provide efficient and effective administration of early, cost-effective interventions
- ensure that Defence and the Government are cognisant of the long-term costs of its actions on serving personnel.

¹ It is also worth noting that any three-three vote splits between DVA members and non-DVA members would be resolved in the DVA members’ favour due to the Chair having a casting vote. However, it is unclear how often these splits occur, given the MRCC reportedly ‘tends to make decisions by reaching consensus’ (DVA 2011b, p. 256).

Changes to the institutional arrangements will:

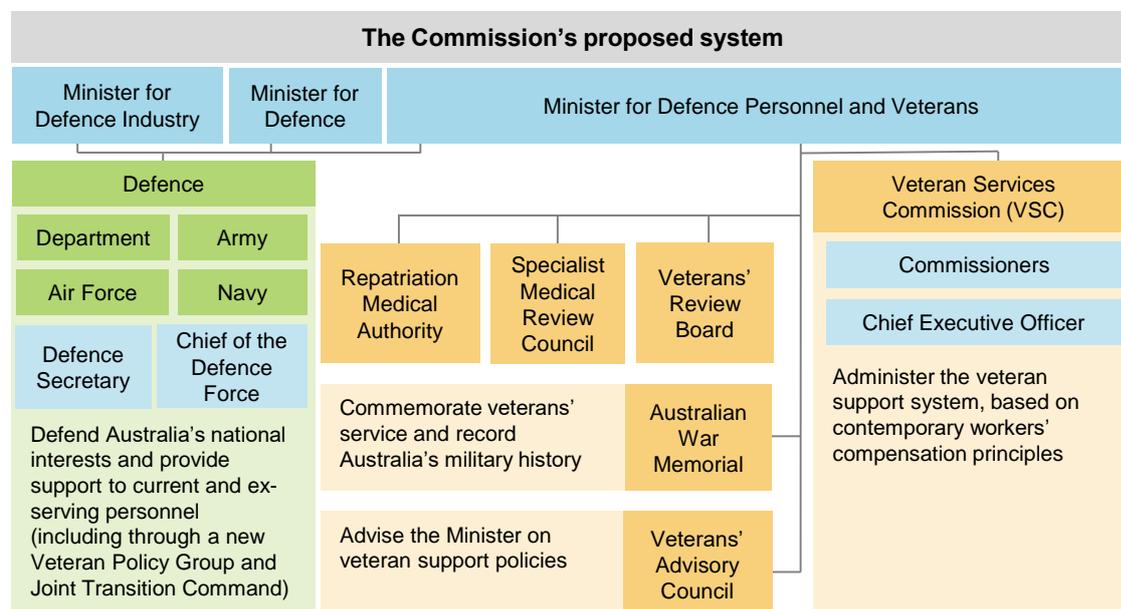
- simplify the existing arrangements and create clear lines of responsibility
- improve strategic direction in the veteran support system by balancing Defence's objectives with its duty of care to members.

These reforms are consistent with the APSC's recommendation from 2013 that 'structural [governance] change ... should endeavour to simplify these arrangements and create an environment where strategic discussions and the making of tough decisions are encouraged' (APSC 2013, p. 7).

The Commission's proposed pathway of reform to achieve this goal is outlined below (transition arrangements are discussed in chapter 17). These reforms are aimed at bringing about a greater clarity in roles and responsibilities, improved governance and accountability, a separation of policy from administration, and enhanced avenues for strategic advice to the Government. The reforms would lead to new administrative and governance arrangements (figure 11.4) comprising:

- a single Ministry for Defence Personnel and Veterans
- veteran support policy and strategic planning being moved into a new Veteran Policy Group within the Department of Defence, headed by a Deputy Secretary
- the creation of a new statutory agency — the Veteran Services Commission — within the Defence portfolio (but not within the Department) that will take responsibility for the administration and operation of the veteran support system
 - With the establishment of the Veteran Services Commission, the RC, MRCC and DVA would cease to exist.
- responsibility for all commemorations and war graves activities being consolidated into the Australian War Memorial
- the establishment of a new Veterans' Advisory Council to the Minister for Defence Personnel and Veterans.

Figure 11.4 The Commission's proposed new governance arrangements



Removing institutional separation for policy and planning — merging Defence and DVA

The arbitrary functional split between Defence and DVA (section 11.2) should be removed. To this end, the Commission is recommending merging the functions, responsibilities and objectives of DVA and Defence into a single, unified portfolio.

This reform will involve changing the AAOs, to move all of the legislation and policy matters of the veterans' affairs sub-portfolio into Defence.² In practice, the changes could be achieved by creating a new 'Veteran Policy Group' in the Department of Defence, led by a Deputy Secretary.

This Veteran Policy Group would be dedicated to ensuring that the legislation and policy settings that makeup the veteran support system are considered in the context of broader Defence policy, ensuring that the latter incorporates the long-term wellbeing of all current and ex-serving personnel. This more unified arrangement would facilitate a better balance between Defence and DVA's competing objectives.

Removing the arbitrary split between Defence and DVA would make it easier for the Department of Defence to develop holistic, integrated and long-term policies for enhancing

² The Commission also considered other portfolios that could take policy responsibility for the veteran support system. Although some were potentially viable — including Jobs, to create synergies with civilian workers' compensation systems — those options are not discussed further, as they would fail to bridge the structural divide with Defence.

the wellbeing of serving and ex-serving military personnel and their families throughout the whole of their lives. It tangibly recognises that Defence's duty of care to ADF members goes beyond their time in service. In practice, it should enable Defence (and the proposed Veteran Services Commission in the Defence portfolio, discussed below) to:

- provide continuity of care around the point of discharge
- realise administrative efficiencies, such as by generating economies of scale from service commissioning across serving and ex-serving member supports, where appropriate (such as for rehabilitation services)
- share data and information.

This reform would bring the institutional arrangements in line with the current ministerial arrangements, which, since 2016, have included a single Cabinet member as both the Minister for Veterans' Affairs and the Minister for Defence Personnel (Australian Parliament 2016, 2017). A single ministry for Defence Personnel and Veterans should be permanently established, with the Minister having responsibility for veteran support policy.

Broadly similar arrangements exist in New Zealand, where responsibility for veteran support policy sits within Defence, while a separate agency (Veterans' Affairs New Zealand) administers the scheme (New Zealand Government 2018; Paterson 2018; VANZ 2017).

DRAFT RECOMMENDATION 11.1

A new 'Veteran Policy Group', headed by a Deputy Secretary, should be created in Defence with responsibility for veteran support policies and strategic planning.

Ministerial responsibility for veterans' affairs should be vested in a single Minister for Defence Personnel and Veterans within the Defence portfolio.

A new Veteran Services Commission to administer the system

Under current arrangements, little (if any) attention is given to the performance and long-term sustainability of the veteran support system. This is in part because a real budget constraint is missing (the veteran support system is demand driven) which means there is little pressure on DVA to operate the system efficiently and effectively and, as discussed above, there is also limited oversight or accountability of the system.

The underlying governance arrangements have also not been reformed since the move away from a pension-based welfare system (the VEA) to a more contemporary compensation and rehabilitation scheme (the MRCA). A department structure is not suited to operating a modern worker's compensation scheme, and is without precedent elsewhere in government.

Best-practice workers' compensation schemes place a strong emphasis on scheme sustainability, and this in turn means they focus on the lifetime costs of supporting clients.

(And a focus on lifetime costs of support means better outcomes for clients because there is an incentive to intervene early and find cost effective rehabilitation, transition support and health care). In the interest of getting better outcomes for veterans, the management of the veteran support system needs to more closely reflect contemporary workers' compensation schemes, and while the driver in the case of the veteran support system is not a financial one, focusing on scheme sustainability is the way to get better outcomes for veterans (and the wider community).

As such, the Commission is recommending that an independent statutory agency — the Veteran Services Commission (VSC) — should be created to administer the veteran support system.³ This is in line with institutional arrangements for contemporary civilian workers' compensation schemes, which generally feature independent agencies to administer the system separate from the government department that has responsibility for the underlying policy. For example, claims for workers compensation by Australian Government employees are determined and administered by Comcare as an independent statutory agency, and the Minister for Jobs under advice from the Department of Jobs and Small Business has responsibility for the enabling SRCA legislation. Other examples include the Victorian Transport and Accident Commission and New South Wales' *icare* agency.

A policy and administration divide is also consistent with institutional arrangements elsewhere in government:

- Claims for pensions and other forms of social security payments are considered, administered and paid by the Department of Human Services (through Centrelink), while the Minister for Social Services (with advice from the Department of Social Services) has responsibility for the Government's policy on pension eligibility.
- The tax system is administered by the Australian Taxation Office (ATO), but the Treasurer, with advice from Treasury, has responsibility for the relevant tax legislation.

Functions of the VSC

The new VSC would replace many of the functions of DVA and the RC and MRCC, including managing claims, engaging with stakeholders and providing or commissioning services. However, a critical function of the VSC should be the management of the veteran support system, adopting the model and management of a workers' compensation scheme, including a strong reliance on data collection and actuarial analysis — it is this approach that will get better outcomes for veterans and their families.

The VSC's functions (likely legislated in the MRCA) should include powers to:

³ The Commission also gave consideration to whether the Department of Human Services (DHS) could administer the veteran support system, particularly given it is already providing some back-office functions to DVA. However, as DHS primarily administers income support pensions, it would be ill-suited to the administration of a contemporary workers' compensation scheme, so is not discussed further.

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- achieve the legislated objectives of the veteran support system (draft recommendation 4.1), particularly:
 - restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in work and civilian life
 - providing adequate and appropriate compensation for veterans (or if the veteran dies, their family) for pain and suffering and lost income from service related harm
 - enabling opportunities for social integration.
 - manage, advise and report on the outcomes of the veteran support system, including the financial sustainability of the MRCA scheme as a compensation insurance scheme
 - make claims determinations under all three Acts (and delegate this power to VSC staff, computer programs or other entities)
 - fund, commission or provide services to eligible veterans, including health, mental health and community services
 - collect, analyse and exchange data about veterans and veteran supports (including early intervention)
 - conduct or commission research into veteran issues (although the RMA would do some of this separately, as discussed in chapter 8).

The VSC would also be expected to:

- provide advice to the Minister in relation to its functions and powers
- work closely with Defence by providing feedback on the workings and outcomes of the current system with the aim of improving policy design
- calculate, collect and administer a Defence premium for ADF members under a fully-funded system (discussed in section 11.5).

Internal governance of the VSC

The VSC would be set up with a corporate model of governance. The VSC should be led by a Commission of part-time members, appointed by the responsible Minister. They would act similarly to a corporate board of directors and would:

- be empowered to decide how to carry out the functions of the VSC in the most appropriate manner
- independently appoint a CEO, responsible for the day-to-day administration of the VSC
- develop appropriate means by which the Commission receives input and feedback from veterans and other stakeholders
- number around five in total
- consist mostly of members with experience in civilian workers' compensation schemes to ensure that the veteran support system keeps up with industry best-practice for claims

management, although some members should have experience of military life or veterans issues.

In line with chapter 12, the VSC could also be the body responsible for administering invalidity claims under the military superannuation system. This would mean administering compensation payments for incapacity or death under the *Australian Defence Force Cover Act 2015*, the *Military Superannuation and Benefits Act 1991* and *Defence Force Retirement and Death Benefits Act 1973*, while policy responsibility remains in the Defence portfolio. As noted in draft recommendation 12.2, further consideration of this option is needed, once the VSC has been created.

DRAFT RECOMMENDATION 11.2

The Australian Government should establish a new independent Commonwealth statutory authority, the Veteran Services Commission (VSC), to administer the veteran support system. It should report to the Minister for Defence Personnel and Veterans and sit within the Defence portfolio (but not within the Department of Defence).

An independent board should oversee the VSC. The board should be made up of part-time Commissioners appointed by the Minister who have a mixture of skills in relevant civilian fields, such as insurance, civilian workers' compensation and project management, as well as some with an understanding of military life and veteran issues. The board should have the power to appoint the Chief Executive Officer (responsible for the day-to-day administration).

The functions of the VSC should be to:

- achieve the objectives of the veteran support system (draft recommendation 4.1) through the efficient and effective administration of all aspects of that system
- manage, advise and report on outcomes and the financial sustainability of the system, in particular, the compensation and rehabilitation schemes
- make claims determinations under all veteran support legislation
- enable opportunities for social integration
- fund, commission or provide services to veterans and their families.

The Australian Government should amend the *Veterans' Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004* to abolish the Repatriation Commission and Military Rehabilitation and Compensation Commission upon the commencement of the VSC.

Create a standing Ministerial advisory body

To improve strategic direction in veteran support policy (section 11.3) and overcome a heavy reliance on ad-hoc policy review processes, the Commission is recommending the creation of an independent Veterans' Advisory Council that reports to the Minister for Defence Personnel and Veterans. The goal of the Council would be to provide advice to the Minister

on veteran issues, particularly on the policies and performance of the veteran support system to ensure it remains fit for purpose going forward.

The advisory body would be entirely separate to the VSC's proposed board of Commissioners (draft recommendation 11.2) and could be established immediately, in order to provide advice during the transition to the VSC and the implementation of several reform initiatives.

Independent policy advisory boards are common in other highly complex policy areas. One example is the Board of Taxation, which provides expert advice to the Government on taxation issues (box 11.9). Other jurisdictions also have similar veteran advisory bodies. For example, a Veterans' Advisory Board provides advice to the New Zealand Minister for Veterans (box 11.10). And in Australia, the ESO roundtables run by DVA (box 11.7) currently provide advice and feedback to the Department.

Box 11.9 The Board of Taxation

Consisting of 11 members (eight from the non-government sector, plus the Secretary of the Treasury, the Commissioner of Taxation and the First Parliamentary Counsel), the Board of Taxation (BoT) is a non-statutory advisory body charged with 'contributing a business and broader community perspective to improving the design of taxation laws and their operation'. More specifically, the BoT provides advice on tax policy to the Treasurer, undertakes in-depth reviews when requested and offers real-time input on law design and administrative matters. The Board is assisted in its functions by a voluntary advisory panel with over 60 members sourced from business, professional and community organisations, as well as a secretariat based within Treasury (BoT 2018).

The creation of the BoT was first recommended by the 1999 Review of Business Taxation (the Ralph Review) as a way to achieve 'a more open, consultative, accountable and systematic approach to business taxation' (Ralph, Allert and Joss 1999, p. 120). Formed by the Treasurer the following year, the overarching objective of the BoT is 'to achieve better legislative and implementation outcomes, ensuring they correctly reflect the Government's policy intent, are compatible with commercial realities and the circumstances of individuals, minimise complexities and associated compliance costs, and avoiding unintended consequences' (Treasury 2001, p. 61). As noted by the current Chair of the BoT, the key to the Board's quality 'is in the background, experience and independence of our Board members, supported by the frank input of the business and tax community, the Treasury and the ATO' (Andrew, M., quoted in BoT 2017, p. vii).

The BoT 'does not have responsibility, but nor is it accountable, for taxation policy, which ... remains with the Treasurer and the Government'. Similarly, the Board 'has no authority or powers to direct the Commissioner of Taxation on how to run the ATO' as the Commissioner is an independent statutory role (Treasury 2001, p. 60).

The BoT cost around \$2.5 million in 2016-17, including remuneration for non-government members (BoT 2017).

Membership of the Council

The membership of the Council needs to include veterans and civilians with skills and experience in workers' compensation systems, insurance, project management, legal fields and public policy. Expertise from non-veterans with relevant skillsets will generate new perspectives on how to improve the system and can complement the views and input of veterans (provided via the various consultative forums discussed above).

The Council should report directly and publicly to the Minister for Defence Personnel and Veterans. The existing consultative forums are DVA initiatives under the National Consultative Forum without any direct line to the Minister. This undermines the transparency and accountability of the views of each forum.

The Council should also be adequately funded to effectively undertake its roles and responsibilities.

Box 11.10 The New Zealand Veterans' Advisory Board

Under the *Veterans' Support Act 2014* (NZ), the Veterans' Advisory Board (NZVAB) operates in New Zealand 'to provide advice to the Minister on its own motion or on request, including advice on policies to be applied in respect of veterans' entitlement' (s. 247). Membership of the NZVAB is limited to seven members appointed by the Minister and 'who are representative of the veteran community', as well as one serving veteran nominated by the Chief of the New Zealand Defence Force (s. 248). Resources and administrative support for the NZVAB are provided by Veterans Affairs New Zealand (s. 251).

The genesis for the NZVAB was a 2010 Law Commission report on the previous veteran system, which envisaged the NZVAB as providing 'a mechanism through which veterans can have a direct voice to the Minister' (NZLC 2010, p. 121).

A 2018 review of New Zealand's new veteran support system found that the NZVAB lacked sufficient transparency in its advice to the Minister and a defined work program, making its operations 'ad hoc'. The breadth of experience among its members was also limited, as 'skills and experience in public service policy and in contributing to governance and advisory bodies would also be useful' (Paterson 2018, pp. 91–92). The review concluded that the NZVAB should be merged with the Veterans' Health Advisory Panel into a single body.

DRAFT RECOMMENDATION 11.3

The Australian Government should establish a Veterans' Advisory Council to advise the Minister for Defence Personnel and Veterans on veteran issues, including the veteran support system.

The Council should consist of part-time members from a diverse range of experiences, including civilians and veterans with experience in insurance, workers' compensation, public policy and legal fields.

Consolidate commemoration activities within the AWM

The governance changes discussed so far mean changes will need to be made to the institutional arrangements governing the commemoration and war graves activities undertaken by DVA.

As discussed in chapter 4, commemoration activities are a ‘relatively small but enormously significant part’ of DVA’s broader functions (DVA, sub. 125, p. 12) and serve a vital role in the veteran support system by providing veterans and their families with community recognition and validation of their service and sacrifices.

However, DVA’s current commemoration activities do not align with the proposed functions of the VSC, while Defence having primary responsibility for commemoration and war graves functions may not be considered appropriate by some veterans groups.

There are a range of other organisations currently involved in providing commemoration activities in Australia (box 11.11). The most prominent of these is the Australian War Memorial (AWM) and the Commission is recommending that all of DVA’s commemoration functions be consolidated in that organisation. This would:

- consolidate the number of entities involved in commemorative activities, reducing duplicated administrative costs and the need for coordination
- invest responsibility for commemoration to the highly-respected and independent AWM, as a logical extension of the AWM’s growing role in commemoration activities and its mission to ‘assist Australians to remember, interpret and understand the Australian experience of war and its enduring impact on Australian society’ (AWM 2018a).

Administering the commemorative activities currently undertaken by DVA would be a significant change for the AWM, given the AWM’s current activities are based largely in and around the War Memorial in Canberra. An expanded remit for all commemorative activities would involve a much broader geographic focus, covering activities across Australia and at memorial sites around the world. This change in focus may present some transitional challenges, but would be surmountable over time with capable leadership and using existing expertise and systems within DVA.

Consolidation of all commemorative and war graves functions into the AWM could potentially leverage off the AWM’s recently announced \$498 million expansion and redevelopment (Morrison and Chester 2018a).

Policy regarding the AWM and its expanded functions would remain located within DVA, and then the Veteran Policy Group within Defence (draft recommendation 11.1) and would report to the Minister for Defence Personnel and Veterans.

DRAFT RECOMMENDATION 11.4

The Australian War Memorial (AWM) already plays a significant and successful role in commemoration activities. As a consequence of the proposed governance and administrative reforms, the Australian Government should transfer primary responsibility for all commemoration functions to the AWM, including responsibility for the Office of Australian War Graves.

Box 11.11 Existing commemoration and war graves organisations

Department of Veterans' Affairs (DVA)

In 2017-18, DVA spent around \$92 million on commemorative activities (up from \$75 million in 2016-17), including staffing and other departmental expenses, and had around 87 staff working on commemorative activities (down from 154 in 2016-17) (DVA 2017d, 2018f).

The largest commemorative expense for DVA is for the Office of Australian War Graves (approximately \$55 million in 2017-18) under the *War Graves Act 1980*.

The role of the Office of Australian War Graves is to:

- maintain war cemeteries and individual war graves within Australia and the immediate region, as agents of the Commonwealth War Graves Commission
- officially commemorate eligible veterans who have died post-war and whose deaths are accepted as being caused by war service
- provide and maintain national memorials overseas.

The Australian War Memorial

The Australian Government contribution to the Australian War Memorial's (AWM's) operating costs was \$53 million in 2017-18 (total expenses were \$69 million).

The AWM was initially founded after the First World War, although the AWM building in Canberra was only completed and opened to the public on Remembrance Day 11 November 1941. The AWM was formally established as a corporation under the *Australian War Memorial Act 1980*, operating within the Veterans' Affairs portfolio as an independent statutory agency.

The purpose of the AWM is to maintain and develop the national memorial to Australians who have died as a result of active service. It also maintains and exhibits a national collection of historical material about Australia's conflicts, and conducts and arranges for research into Australian military history. The day-to-day administration of the AWM is managed by a Director, responsible to the AWM Council.

(continued next page)

Box 11.11 (continued)

Commonwealth War Graves Commission

The then Imperial War Grave Commission was established by Royal Charter in 1917 with the purpose of acquiring, maintaining and documenting all military graves belonging to the forces of the British Empire as a result of the First (and then Second) World War. By 1918, nearly 600 000 graves had been identified and a further 550 000 casualties were registered as having no known grave. In 1964, its name was changed to the Commonwealth War Graves Commission (CWGC).

The Commission is led by the United Kingdom and members include representatives of the Australian, Canadian, New Zealand, South African, Indian (since 1964) and Pakistan (since 1964) governments. Commission members from these countries are generally the High Commissioners to the UK. The current President of the CWGC is Prince Edward, the Duke of Kent.

Sources: AWM (2018a, 2018b); CWGC (2018b, 2018a); DVA (2016k, 2016a).

11.5 Funding the new veteran support system

The Commission is recommending the veteran support system be redesigned based on the best-practice features of contemporary workers' compensation and social insurance schemes (chapter 4). Consistent with this, the funding model for the veterans' support system going forward should be based on setting premiums that:

- achieve full funding (as opposed to the current pay-as-you-go arrangements) of the scheme
- do not distort price signals to Defence about the importance of preventing workplace fatality, injury and illness
- promote cost effective rehabilitation and return to work.

Such an approach would make transparent the lifetime cost — both financially and in terms of health impacts on veterans — of changes to veteran support policy and broader defence policy at the time policy decisions are made. This information is missing under current institutional arrangements, obscuring policy costs to Defence, the Government and the public.

Existing pay-as-you-go funding arrangements send the wrong signals

The veteran support system is currently funded on a pay-as-you-go (PAYG) basis, similar to Australia's age pension system. PAYG funding meets the immediate cash requirements of the system, such as payments for compensation, rehabilitation and treatment. No assets are accumulated to meet future entitlements or management expenses in respect of incidents that have already occurred (PC 2004, p. 279).

Compared to a fully-funded approach, a PAYG approach leads to:

- Unfunded liabilities, where a scheme's liabilities are not covered by its assets. In the veteran support system, contingent liabilities are large and there is no specific source of financial capital to fund annual liabilities — funding comes from the Australian Government's general revenue.
- Cross-subsidisation over different generations. In the veteran support system, past generations of ADF members make claims and current and future generations pay the bill.
- Dampened incentives to improve workplace health and safety. In the veteran support system, there is no institutional price signal providing information about the lifetime costs of injury and illness (PC 2004).
- A short term focus, as PAYG schemes with large contingent liabilities (such as the veteran support system) encourage scheme managers to 'focus on the next 12 months and then the next three years, and not beyond that' (PC 2011, p. 669).

PAYG funding models also fail to provide the Government, Defence and DVA with useful information about the long-term financial costs of contemporary policy decisions. Under PAYG, even with the governance arrangements recommended above, the current leadership of Defence and the Government would not be accountable for policy decisions they make today because the liabilities (injuries or illnesses for ADF members) would not mature until many years or even decades later — the average MRCA and DRCA claimant does not submit a claim until 16 years after the injury occurred (ANAO 2018b, p. 55).

Premiums that sustain a fully-funded system are preferred

The veteran support system going forward should be funded using annual premiums set to sustain a fully-funded scheme. A fully-funded scheme (detailed in box 11.12) is one where:

... sufficient assets are accumulated in the scheme to meet all expected entitlements to compensation, regardless of when they may be paid, and all costs associated with managing claims that have occurred. It is expected that investment income earned on the funds set aside to meet future claims will also be available to meet emerging costs. (PC 2004, p. 279)

For the veteran support system, the employer would be Defence, paying premiums for uniformed ADF personnel (those covered by the veteran support system) to the VSC (the insurer), who would then manage the pool similar to any civilian workers' compensation scheme.⁴

⁴ These premiums would be in addition to those that Defence already pays to Comcare each year for the workers' compensation scheme covering Defence public servants (SRCA), which was approximately \$22 million in 2017-18 (DoD 2018f, p. 165). Although this would result in Defence paying two premiums each year, they would cover mutually exclusive sectors of its workforce (public servants or uniformed ADF personnel).

Box 11.12 How a fully-funded workers' compensation system operates

In a fully-funded scheme, workers' compensation benefits are paid from an 'insurance pool', a capital asset which is built up over time by the collection of annual insurance premiums. In contrast to pay-as-you-go (PAYG), full-funding means that existing claimants do not rely on future contributions — the liability associated with their injury is covered by the insurance pool.

The annual insurance premium is calculated, using actuarial models (chapter 16), to cover the long-run expected costs of the scheme. For a not-for-profit scheme (like the veteran support system) the annual premium would be equivalent to the net present value of expected future entitlements from liabilities created from injuries or illnesses suffered by service members during the year (plus an allowance for the insurer's costs of administration) (Gallagher Bassett 2018; IC 1994; PC 2004). For the veteran support system, the annual premium should be set to cover the costs of funding the activities of the VSC (draft recommendation 11.2) including:

- the medical and income payments made to injured or ill veterans
- the cost of rehabilitating and facilitating the return to work of injured or ill veterans
- compensation for the pain and suffering of injured and ill veterans
- the cost of managing the premium pool.

Differences in the magnitude of the premium from year to year will reflect discrepancies between modelled outcomes and actual outcomes. These discrepancies could be a result of:

- changes in behaviour (such as a higher or lower rate of injury)
- changes in policy (such as higher or lower payment rates)
- changes in scheme administration (such as the claims process becoming easier or harder)
- exogenous economic events (such as higher or lower returns on insurance pool investments) — these exogenous factors are common to all insurance schemes, and can be accounted for in the premium and managed on a business-as-usual basis by the insurer.

Premiums provide information about the cost of injuries and illnesses

One of the primary benefits of premiums is that they send a strong information signal to the employer about how changes in working conditions (such as an organisation's workplace health and safety performance), benefit structures and other underlying factors (such as deployment activity) are linked to quantifiable change in the premium.

Premiums can therefore provide a powerful signal to employers about the *costs* of injuries and illnesses occurring under their watch, which enhances or complements existing data about workplace health and safety (chapter 5). In Defence's case, a premium acts as a price signal about the cost of achieving long-term wellbeing of serving personnel.

A premium can act as a powerful mechanism for accountability and transparency

Defence does not have strong incentives to improve the long-term wellbeing of ADF members (section 11.2). The recommended governance changes (section 11.4) improve

those incentives by bringing responsibility for all relevant policy levers under the control of Defence (and the Defence Ministers). This includes day-to-day ADF policies (such as workplace health and safety guidelines), policies affecting compensation and benefits for current and ex-serving members (through the new Veteran Policy Group in Defence)⁵ and Australia’s defence policy.

With Defence being responsible for the relevant policies, it follows that Defence should be the accountable body for explaining and justifying the related Budget costs of those policies. An effective way to achieve this is by levying an *actual* premium on Defence — as opposed to a *notional* premium (box 11.13) — and making Defence accountable during the Budget process for the size and annual change in the premium caused by policy outcomes or changes to policy. For example, the size, frequency and tempo of overseas deployments is a policy decision informed by Defence, with direct effects on the risks borne by ADF personnel. It follows that changes in the level of the premium, which reflect the long-term costs of deployments, can and should be made clear in the Budget.

Box 11.13 A notional premium is not enough

As discussed in chapter 5, the Australian Government Actuary (AGA) — on behalf of the Department of Veterans’ Affairs (DVA) — already estimates the size of an annual notional premium needed to meet the cost of compensation and rehabilitation claims under the MRCA (table 5.6), as well as estimated existing liabilities under the DRCA and MRCA. This information is published in an abridged form in DVA’s annual report.

Making the actual AGA report public (as under draft recommendation 5.3) would shine further light on the economic cost of service related injuries and illnesses among ADF members about the impact of Defence activities on serving members.

However, the report lacks sufficient detail to meaningfully inform Government deliberations around Budget expenditure — for example, because it provides only limited information about which factors are driving changes in the premium. This is largely due to a lack of high quality data (including any data from Defence) about injuries, such as their cause or cost of treatment.

As discussed in chapter 5, Defence argued that the ‘high-risk nature’ of its operations means a premium is not suitable (sub. 127, p. 18). The very nature of military service is one involving elevated risk and there will be injury and even death. But making clear the cost of engaging in high-risk behaviour, military or otherwise, is the point of a premium. It is another piece of information that should be considered — and weighted appropriately — amongst the broader suite of information that informs departmental and Cabinet deliberations about national security. Defence is best placed to account for these costs.

⁵ This includes programs, supports or initiatives provided by the VSC that might not normally be considered part of a workers’ compensation scheme.

Levying a premium creates financial pressure for change

Premiums also affect behaviour because employers tend to be budget constrained — that is, the premium has financial ‘bite’. Where the employer controls the policies affecting the premium, they can take direct action to improve outcomes or behaviours (such as by minimising workplace risks) and reduce their premium (other things equal). As the Commission previously said:

If [workplace] risks are high, this should feed through into premiums, which in turn should signal to employers the need to invest in workplace safety and rehabilitation. Where there are improvements in safety and rehabilitation, and workplace risks are accordingly lowered, this should be reflected in reduced premiums. (PC 2004, p. 282)

For the veteran support system, Defence could reduce the size of the premium by:

- intervening early to treat and rehabilitate injuries or illnesses (preventing costly exacerbation)
- encouraging a smooth transition to civilian life (improving long-term wellbeing and reducing any future draw on benefits from veterans with poor transition outcomes)
- ensuring benefits and services provided to ex-service personnel are both effective and efficient
- changing the capital-labour mix in the make-up and operations of the ADF.

But would a premium bite?

Defence is not a normal employer for the purposes of a workers’ compensation premium. It is responsible for the defence of the nation and, as such, political realities around the prioritisation of national security suggest that Defence will not be budget constrained in the same way as other government organisations might be. As a result, the Commission anticipates that future Governments would provide some increases in Defence funding to cover rises in the premium after it is imposed.⁶

To avoid undermining the premium’s financial incentives, any supplementation to the Defence budget would need to be carefully designed. The Government should, in line with existing Budget rules, require Defence to request and justify additional funding each year. Any changes in the premium and the effects on the estimated liabilities should be transparent and accountable.

The Commission does not believe that the consequential effects of the application of a well-designed premium will adversely impact on the operational requirements for a highly-trained, combat-ready, deployable force of men and women. It will continue to

⁶ While additional funding to Defence may be viewed as an added imposition on the Government, the premium only reflects future compensation expenditure that would have been incurred by the Government anyway. Thus, it does not represent new expenditure (on a whole-of-government basis), just a movement of expected expenditures forward in time.

encourage good practice in risk management, injury prevention and early responses where injury does occur.

Levying an insurance premium incentivises better data collection and use

As discussed in chapter 16, understanding the cost drivers and emerging risks in the veteran support system to inform the calculation of an insurance premium requires good quality data about injury and illness risks, outcomes and costs of treatment in the veteran support system. Significant data gaps will need to be filled and systems created or modified to collect, share and analyse that data for use by scheme actuaries.

Many of Defence's objections to a premium are based on general data issues that affect all workers' compensation systems. Defence-specific issues include:

- difficulties ascertaining under what circumstances a member suffered a medical condition (operational or non-operational, service-related or not?)
- how spending on treating a condition, or conditions, is attributed (specific treatment or care under a Gold Card, which covers all conditions?) (Defence, sub. 127, p. 18).

The fact that Defence and DVA's current data holdings do not satisfy the requirements of an insurance system based on actuarial modelling is not surprising, given that their current institutional arrangements do not require or encourage the collection, maintenance and sharing of data to serve that purpose.

The recommended governance changes, combined with a levied premium, would create the necessary incentive to pursue improvements in data collection and capability (guided by the VSC). Under a fully-funded risk-based insurance model, poor quality or insufficient data leads to a poor understanding of risk and is likely to put upward pressure on premiums.

DRAFT RECOMMENDATION 11.5

Once the new governance arrangements in draft recommendations 11.1 and 11.2 have commenced, the Australian Government should make the veteran support system a fully-funded compensation system going forward. This would involve levying an annual premium on Defence to enable the Veteran Services Commission to fund the expected future costs of the veteran support system due to service-related injuries and illnesses incurred during the year.

Transitioning to a premium model

In moving to a fully-funded premium model, the Government would need to decide how to deal with prospective *and* retrospective liabilities.

Future liabilities would be covered by a premium

On its own, the premium is prospective only and would apply to new liabilities created from conditions related to service after the first year it is imposed. For example, if it commenced in 2021-22, the premium paid that year would cover the expected liabilities (lifetime costs of the veteran support system) for ADF members created during 2021-22, with future premiums covering subsequent years.

As the growing liabilities from service-related injuries after the first year would be matched by the VSC's growing assets from collecting and investing successive premiums, the veteran support system would be 'fully-funded' going forward (prospective coverage).⁷

Capitalising the existing liabilities would make the cost of policy change clear

While past injuries and illnesses cannot be affected by policy changes today, the range of benefits provided to veterans with an existing liability can be affected. Indeed, governments regularly make policy changes that affect these benefits — a recent example being the expansion of non-liability mental health care (this and another example, the Gold Card, are discussed in chapter 15). These policy changes impact the size of the financial liabilities in the veteran support system. However, as discussed above, the lifetime costs of these changes are largely hidden under a short-term PAYG approach.

Under a fully-funded system that also covered these existing liabilities (retrospective coverage), any policy change that altered the size of the liabilities would need to consider whether the VSC's existing asset pool was sufficient to continue to meet all expected entitlements. If not, a policy that was expected to increase liabilities would require a fresh injection of capital ('recapitalisation'), in line with the expected cost of the changes.

This requirement for recapitalisation would make the financial implications of policy changes obvious and immediate to both Defence and the Government, instead of occurring years or decades later. As such, there would be considerable merit in covering as many existing liabilities as possible.

But existing liabilities are large and could make capitalisation prohibitively expensive

There is a large existing stock of veteran liabilities. These include:

- 166 000 DVA veteran clients
- 117 000 dependent clients (chapter 2)

⁷ The Government might also consider some amount of starting capital, in order to mitigate small pool risks (such as highly volatile investment returns) that could result in higher premiums than otherwise.

-
- an unknown number of other veterans who will develop a condition related to their past service.

To fully-fund all existing liabilities in the *entire* veteran support system (under all relevant Acts), the VSC's assets would have to match the size of these existing liabilities. This could be achieved by an equivalently sized injection of initial capital into the VSC.⁸

As at June 2018, DVA reported (based on estimates by the Australian Government Actuary) that the combined size of existing MRCA (from 1 July 2004 to 30 June 2017) and DRCA liabilities was between \$10 billion and \$13 billion (DVA 2018f, pp. 157, 158). No estimates are available for existing liabilities under the VEA, but *annual* PAYG expenditure as of June 2018 was approximately \$9.8 billion (DVA 2018f).

In practice, it is likely to be prohibitively expensive to capitalise all three schemes, particularly the VEA. However, it may be feasible to capitalise the existing MRCA and DRCA liabilities.

The Commission is seeking input on this issue.

INFORMATION REQUEST 11.1

The Commission is seeking feedback on the extent and design of the veteran support system funding model, particularly whether the fully-funded system should cover future liabilities only, or whether existing liabilities (including the Veterans' Entitlements Act 1986) should be capitalised into the insurance pool.

⁸ Depending on its structure, the initial VSC capitalisation may be able to be considered a Budget neutral capital expenditure, rather than an administered expense from Defence.

12 The compensation package

Key points

- Veterans and their families can be entitled to a range of payments across the three veteran compensation Acts. There is compensation for: pain and suffering ('impairment') and loss of income ('incapacity'); dependants (including when a veteran dies from a service-related injury or illness); the cost of health care and other services. There are also various supplements and allowances, superannuation invalidity compensation, and the service pension.
- When considered as a package, compensation for veterans and their families is relatively beneficial compared to other workers' compensation schemes.
 - A veteran with warlike service and an impairment rated at about 20 impairment points would receive lifetime compensation of over \$100 000 under the *Military Rehabilitation and Compensation Act 2004* (MRCA). This is about double what a civilian worker with a similar impairment point rating would receive under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA).
 - A veteran who is totally and permanently incapacitated would receive lifetime compensation of between \$1.5 and \$3.9 million under the MRCA, depending on their age and need for services such as attendant care. The same person would receive between \$1.2 and \$2.8 million under the SRCA.
- The veteran compensation system is complex, in part because of the three Acts and the many different payments available under the Acts. The system can be difficult for veterans to access and for the Department of Veterans' Affairs to administer (and can mean that veterans can wait a long time before they receive payments).
- Aligning the compensation provisions of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) with those in the MRCA could reduce complexity and improve equity across claimants, but it will mean an additional cost for taxpayers.
 - Aligning the two Acts is likely to result in a small increase in compensation for most veterans with potential claims under the DRCA — that said, a small number of veterans could receive less because of the age-based lump sum approach in the MRCA. Given the number of claims under the DRCA and the existing similarities between the Acts, the fiscal effect of reform is expected to be relatively small.
 - Current recipients would not see a reduction in benefits as a result of these changes.
 - However, eligibility for the Gold Card would not be extended to veterans with current DRCA coverage. They would continue to receive the White Card.
- Veterans can currently receive two forms of lost income ('economic loss') compensation — superannuation invalidity payments and payments through the veteran compensation system. The two payments are offset against each other.
 - This causes unnecessary complexity. The administration of these two schemes should be streamlined.

In 2017-18, the Department of Veterans' Affairs (DVA) spent over \$7 billion on compensation and income support for veterans, and over \$5 billion on health care (DVA 2018f). This chapter outlines:

- the support veterans and their families may be entitled to (section 12.1)
- the effectiveness of the compensation package as a whole (section 12.2)
- ways to improve the compensation system (section 12.3).

Chapters 13 to 15 explore options for improving various aspects of the compensation system.

12.1 Compensation for veterans and their families

Compensation is one of the key aspects of veteran support. It covers:

- financial payments to veterans and their families to compensate for the pain and suffering associated with an impairment (or death)
- financial payments to compensate veterans for a reduced earning capacity due to an impairment
- healthcare (and other) costs resulting from an impairment
- benefits not linked to an impairment, such as the service pension.

Many of the compensation payments for veterans align with payments in other workers' compensation schemes (impairment compensation, income replacement and healthcare costs). However, there are additional payments and allowances which are unique to the veteran support system (figure 12.1).

As there are many interacting parts of compensation, it needs to be considered as a package. Changes to one aspect of compensation can have implications for other aspects.

Impairment compensation

Impairment compensation is a payment for the 'non-economic' effects of a service-related injury or illness on a veteran's life. That is, the compensation is for the impairment itself, rather than secondary effects such as loss of income. As the explanatory memorandum for the *Military Rehabilitation and Compensation Bill 2003* states, these payments are for 'functional loss, pain and suffering and the effect of the injury or disease on the person's lifestyle' (Vale 2003, p. iv).

Figure 12.1 **Veteran compensation — the range of payments**

	VEA	DRCA	MRCA
 Impairment compensation	General rate disability pensions Additional payments for specific disabilities	Permanent impairment payments Eligible young person lump sum	Permanent impairment payments Eligible young person lump sum
 Income replacement	Above general rate disability pensions Superannuation invalidity pensions	Incapacity payments Superannuation invalidity pensions (offset)	Incapacity payments Superannuation invalidity pensions (offset) Special Rate Disability Pension
 Dependant benefits	Widow(er)'s pension Orphan's pension Funeral allowance Bereavement payment Income support supplement Education allowance Superannuation compensation	Lump sum divisible between dependants Additional death benefit Payments for eligible children Funeral allowance Superannuation compensation	Wholly dependant partner payments Payments for eligible children Payments to 'other' dependants Funeral allowance Bereavement payment Income support supplement Education allowance Superannuation compensation
 Health care	Gold Card White Card Attendant care allowance	White Card Attendant care Household services	Gold Card White Card Attendant care Household services
 Other allowances	Energy supplement Veterans' supplement Clothing allowance Decoration allowance Recreation transport allowance Vehicle assistance scheme Service pension	DRCA supplement Service pension Veteran payment Legal and financial advice	Energy supplement MRCA supplement Service pension Veteran payment Motor Vehicle Compensation Scheme Legal and financial advice

Impairment compensation is available under all three Acts.

- Permanent impairment payments are provided under the *Military Rehabilitation and Compensation Act 2004* (MRCA) and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA).
- General rate disability pensions are provided under the *Veterans' Entitlements Act 1986* (VEA). While disability pensions are not explicitly considered pain and suffering (non-economic loss) compensation, their value is estimated in a similar way to permanent impairment payments under the MRCA.

Impairment compensation is calculated in a similar way under all three Acts — it is based on the level of impairment (the 'impairment rating') and effect of the impairment on the veterans' lifestyle (the 'lifestyle factor') (box 12.1).

Box 12.1 Measuring the level of impairment

Military Rehabilitation and Compensation Act (MRCA)

The MRCA uses the Guide to Determining Impairment and Compensation (GARP-M) to assess the level of impairment of a veteran and the amount of compensation. A veteran's impairment is rated from 0–100, based on the level of functional loss suffered by the veteran. For example:

- five impairment points is associated with conditions such as a lower level speech impairment, severe skin disorder or amputation of multiple toes (aside from the great toe)
- twenty impairment points are assigned to conditions such as those that result in a moderately reduced walking pace and inability to manage stairs without rails
- a person who is blind in one eye would receive a rating of 25 impairment points, while a person who is blind in both eyes would receive a rating of 85 impairment points.

The ratings can be adjusted based on the veteran's age — younger veterans can, in some cases, receive higher impairment points for the same impairment.

Impairment ratings for each body part are combined to form the whole of person impairment rating, using a table in the GARP-M (rather than adding impairment points for each injury together).

The veteran is also assigned a lifestyle factor of between 0 and 7, depending on how the impairment affects their lifestyle. A veteran that previously had a more sedentary lifestyle may have a lower lifestyle rating than a veteran with a more active lifestyle.

The impairment rating and lifestyle factor are combined together to determine the compensation factor — which is the percentage of the maximum rate of compensation the veteran is entitled to. For example, a veteran with warlike service, an impairment rating of 20 and a lifestyle factor of 2 would have a compensation factor of 0.222. That is, they would receive 22.2 per cent of the maximum rate of compensation available under the MRCA.

Veterans' Entitlements Act (VEA)

The VEA uses the Guide to the Assessment of Rates of Veterans' Pensions (GARP) to assess a veteran's level of impairment. The process under the VEA is similar to the process under the MRCA, with one key difference. Impairment ratings and lifestyle factors are combined together to determine the veteran's level of incapacity — a number between 0 and 100 which reflects the general rate pension that the veteran can receive.

Safety, Rehabilitation and Compensation Act (Defence-related Claims) (DRCA)

The DRCA uses the Comcare Guide to the Assessment of the Degree of Permanent Impairment to estimate the level of compensation available to the veteran. There are some key differences between the approaches used under the VEA and MRCA, and that under the DRCA.

- The DRCA does not use a whole of person impairment approach. Impairment ratings and compensation are calculated for each injury separately, and are not combined together.
- Lifestyle factors under the DRCA are on a 0–100 scale. These are not combined with the impairment ratings using a table. Rather, there are three components to the DRCA permanent impairment compensation — two of these are estimated using the impairment rating, and the third is estimated using the lifestyle factor.

Sources: Australian Government (2016b); Comcare (2014); MRCC (2016).

Who is entitled to impairment compensation?

A veteran does not automatically receive permanent impairment compensation under the MRCA or DRCA when DVA accepts liability for a condition.

- The injury or illness must be considered ‘permanent and stable’ to receive permanent impairment compensation — that is, if a condition is expected to improve, either naturally or with rehabilitation, DVA cannot grant permanent impairment compensation at that time. Veterans can receive ‘interim’ permanent impairment compensation while DVA is waiting for a condition to stabilise (box 12.2).
- A veteran must have a minimum level of impairment to receive impairment compensation (5–10 impairment points, depending on the impairment).

Impairments do not have to be permanent and stable for a veteran to receive a disability pension under the VEA.

Box 12.2 What is interim permanent impairment compensation?

Interim permanent impairment compensation is available to veterans under the *Military Rehabilitation and Compensation Act 2004* where an impairment is deemed to be permanent, not yet stable, but it is anticipated that the condition will stabilise in the future. The degree of impairment upon the stabilisation of the condition must be able to be estimated, and it must meet the minimum impairment threshold for payment.

The amount of interim compensation payable is based on the estimate of the final permanent impairment rating that the veteran is likely to have once the condition is stabilised.

Once the condition has stabilised, final compensation is paid. However, interim compensation can only be adjusted upwards — the amount of compensation the veteran receives cannot be reduced at the final assessment stage.

Similar provisions apply under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

Source: Military Rehabilitation and Compensation Act 2004.

Impairment compensation — how much is paid?

The permanent impairment compensation amount increases based on the level of impairment up to a maximum amount (figure 12.2). Under all three Acts, additional compensation is also available for severely impaired veterans (table 12.1). In all cases, impairment compensation is not taxable, and does not count as income for the purposes of receiving the service pension. Impairment compensation may be available as a periodic payment (VEA), a lump sum (DRCA) or both (MRCA).

Table 12.1 Impairment compensation

As at June 2018

	VEA	DRCA	MRCA
Maximum amount	\$500.60 per fortnight ^{a,b}	\$260 302 lump sum	\$347.24 per week (can be converted to a lump sum)
Level of impairment for the maximum amount	About 40–65 impairment points. ^c	100 impairment points	80 impairment points
Additional compensation for severe impairments	Additional compensation of between \$34.20 per fortnight (amputees below the knee or elbow) and \$681.50 per fortnight (most double amputees).	Severely impaired veterans (generally those with an impairment of at least 80 impairment points) can receive: <ul style="list-style-type: none"> • the maximum compensation • an additional \$80 918 • an additional \$89 302 for each eligible young person in their care.^d 	Veterans receiving the maximum rate of compensation can receive an additional \$89 393 for each eligible young person in their care.

^a 100 per cent of the general rate pension. ^b Rate includes the energy supplement. ^c Can be reached at a higher or lower level of impairment, depending on the lifestyle factor. ^d DRCA severely impaired provisions are included under the *Defence Act 1903*.

How many veterans are receiving impairment compensation?

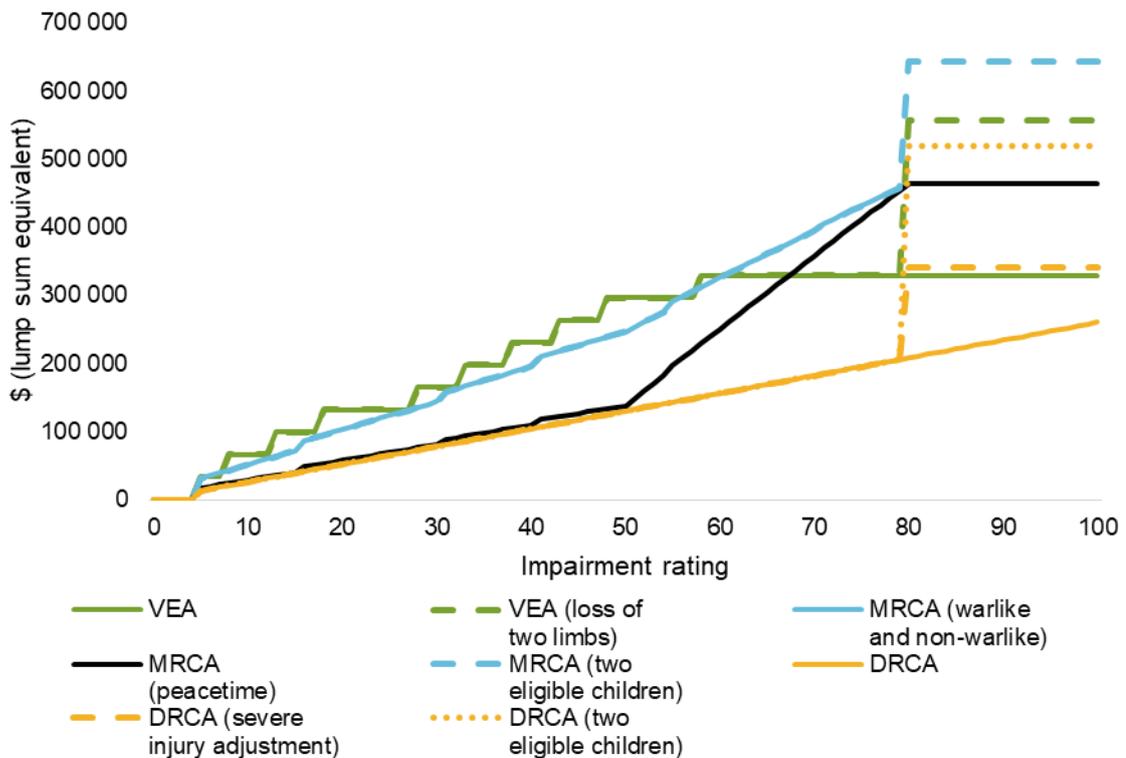
Of the veterans that were receiving impairment compensation (or had received an impairment lump sum) in June 2018:

- about 86 000 veterans were receiving a VEA disability pension (including those receiving a pension above the general rate)
- about 14 000 a DRCA permanent impairment payment
- about 12 000 a MRCA permanent impairment payment (DVA 2018f, p. 22).

Most veterans receiving permanent impairment payments under the MRCA have relatively low rates of impairment (compared to the VEA) — about two-thirds have an impairment rating of 30 points or lower, and about 70 per cent of veterans are paid a lump sum equivalent payment of less than \$100 000. Under the VEA, about half of the veterans received a pension of 100 per cent of the general rate or higher (figure 12.3).

Figure 12.2 Impairment compensation by level of impairment^{a,b,c}

Rates as at May 2018



Sources: Productivity Commission estimates based on Australian Government (2016b); MRCC (2016); *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

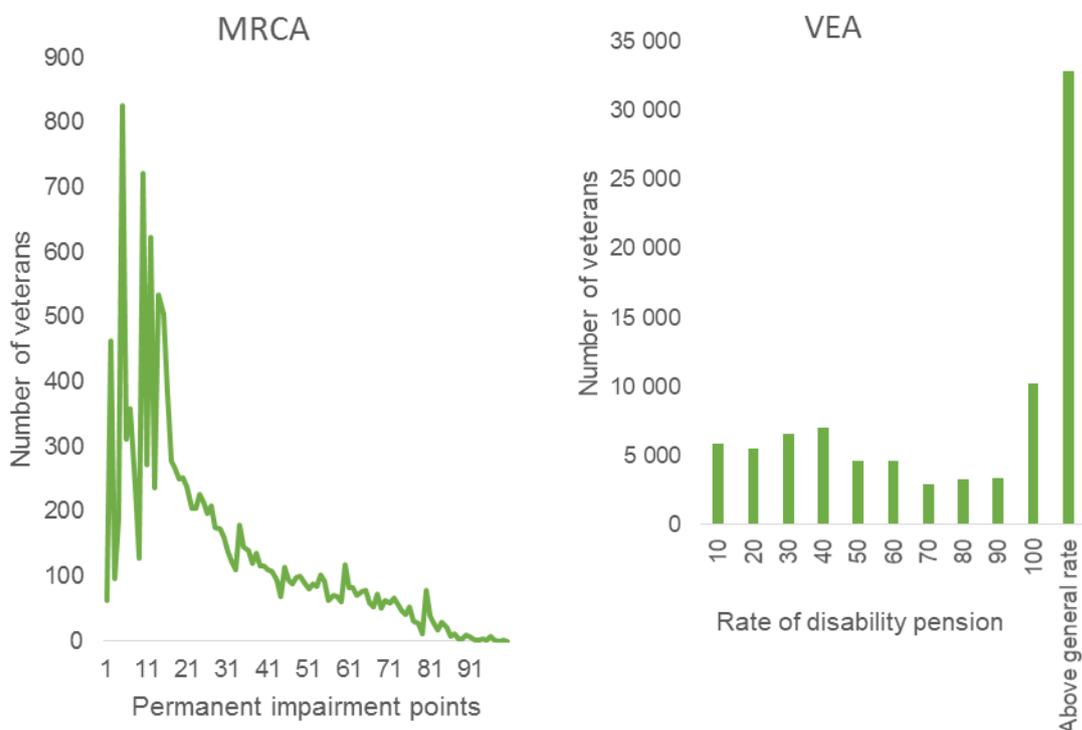
^a VEA specific injury payments are only available for veterans on less than the special rate of disability pension. In this example, it is assumed that the veteran receives the specific injury payment once they are over 80 impairment points. ^b For the VEA and MRCA, lifestyle factors reflect the factors most commonly assigned for a given level of impairment. For the DRCA, the lifestyle rating is assumed to be the same as the impairment rating. ^c Periodic payments have been adjusted to lump sums based on the MRCA conversion rates for a 30 year old.

Very few veterans receive the additional payments provided above the base impairment compensation for severely impaired veterans. In December 2017 about:

- 300 veterans were receiving additional disability pension payments for specific injuries under the VEA
- 171 veterans had accessed additional payments for eligible young people under the MRCA
- 56 veterans had accessed the DRCA severe injury adjustment (Productivity Commission estimates based on unpublished DVA data).

Figure 12.3 Level of impairment for veterans claiming impairment compensation^a

As at December 2017



^a Based on the veteran's current disability pension or their impairment rating at the time of their most recent claim.

Source: Productivity Commission estimates based on unpublished DVA data.

Compensation for economic loss (income replacement)

Veterans who cannot work or have reduced capacity to work because of a service-related injury, disease or illness can receive compensation (income replacement) for their resulting economic loss.

Under both the MRCA and DRCA, incapacity payments are based on the difference between a veteran's actual earnings, and what they were earning in the military (or sometimes, civilian work) when they were incapacitated for service or work.

Compensation for lost income under the VEA is provided in the form of disability pensions set at a rate above the general rate. These include:

- the special rate of disability pension (SRDP) for those who are totally and permanently incapacitated or totally and temporarily incapacitated

-
- the intermediate rate disability pension for veterans capable of part time or intermittent work
 - the extreme disablement adjustment (EDA) for veterans over 65.

A version of the SRDP is also available under the MRCA — veterans can elect to receive this payment in lieu of receiving incapacity payments if they meet certain criteria.

Who is eligible?

A veteran may be eligible to receive incapacity payments under the MRCA or DRCA if they are assessed as having incapacity for work or service, and face a loss of income, as a result of their service-related impairment.

Incapacity for work or service is broad. At one extreme, it could mean that the person is unable to work at all. At the other extreme, the person may still be able to work full time, but be restricted in the type of work they are able to undertake, and consequently be forced to work in a lower paying job. In both cases a veteran would be eligible for incapacity payments, although the level of payment received would vary.

A veteran is eligible to receive the SRDP under the VEA if:

- they are receiving a disability pension of at least 70 per cent of the general rate (usually met at 40–50 impairment points)
- they are totally and permanently incapacitated (although a temporary SRDP is available for those with temporary conditions)
- they are prevented from undertaking their normal work or other substantive work in their work history for more than 8 hours a week solely because of VEA accepted conditions
- they are suffering a loss of earnings as a result.

For veterans over 65, they must have been working for a continuous period of at least 10 years which continued past them turning 65 to start receiving the SRDP. Veterans over 65 who are severely incapacitated but not eligible for the SRDP can receive the EDA.

The criteria for the intermediate rate disability pension are the same as those for the SRDP, except there is a lower threshold for hours worked (20 hours, or 50 per cent of hours normally worked) and the condition does not have to be permanent.

The criteria for the SRDP under the MRCA are similar to, but not exactly the same as, those under the VEA. Veterans are eligible to receive this payment if they:

- have conditions assessed at more than 50 impairment points
- are receiving incapacity payments
- are unable to work for more than 10 hours a week (and cannot be assisted by rehabilitation to do so).

How much compensation?

The amount of compensation payable to veterans receiving income replacement compensation is set out in table 12.2. VEA payments are provided instead of general rate disability pensions, while MRCA and DRCA incapacity payments are provided in addition to permanent impairment compensation.

Table 12.2 Economic loss payments

	<i>VEA disability pensions</i>	<i>MRCA incapacity payments</i>	<i>DRCA incapacity payments</i>
Rate of payment	\$1 408 per fortnight (special rate) \$956 per fortnight (intermediate rate) \$777.90 per fortnight (extreme disablement adjustment)	For the first 45 weeks of payments, veterans receive the difference between normal earnings and the amount they are currently earning. After 45 weeks, normal earnings are reduced to 75 per cent if the veteran is not working, with smaller step downs if they are engaging in some work.	Based on the difference between normal earnings and the amount they are currently earning. After 45 weeks, normal earnings are reduced to 75 per cent if the veterans is not working, with smaller step downs if they are engaging in some work. Payments are reduced by a further 5 per cent for veterans receiving superannuation to reflect a notional superannuation contribution
Remuneration loading	na	Normal earnings are increased by \$165 per week to reflect the non-monetary benefits of military service	No
Are payments taxed and count towards welfare income tests?	No ^a	Yes	Yes
For how long can payments be received?	Pensions are for life	Until age 65	Until age 65
Minimum payment?	na	Normal earnings must be at least minimum wage	\$478.01 per week (higher with dependants)
Maximum payment?	na	No	150 per cent of average weekly ordinary time earnings of full time adults (currently \$2 379 per week)

^a Payments do count towards Centrelink income tests, but reductions in payments as a result of this test are reimbursed to the veteran through the Defence Force Income Support Allowance. **na** Not applicable.

How much compensation are veterans receiving?

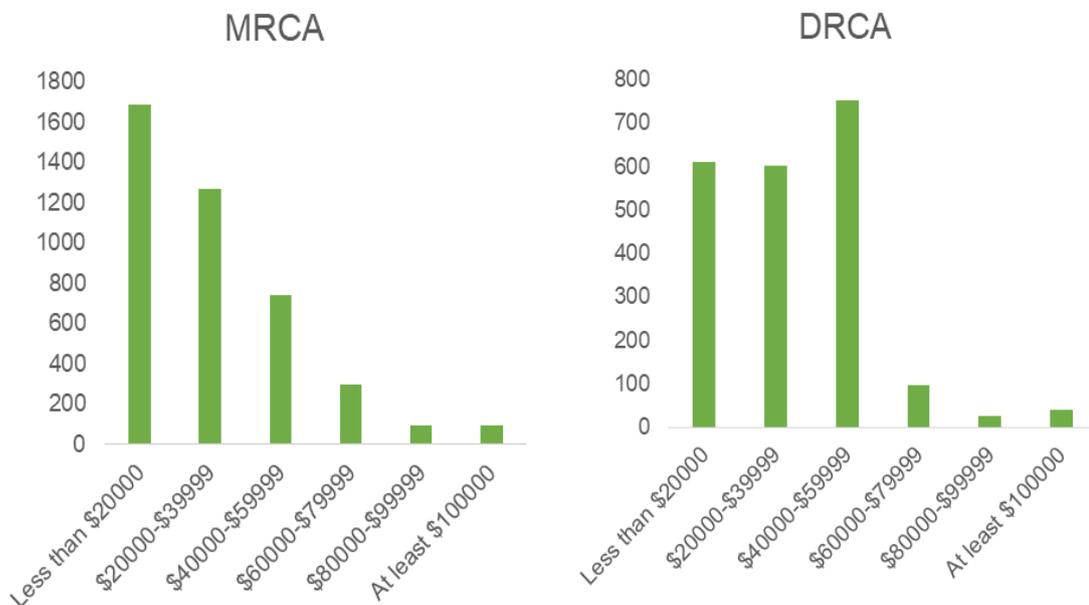
In 2017-18, 4910 veterans received a MRCA incapacity payment, and 2185 a DRCA incapacity payment (DVA 2018f). This represents the total number of veterans who received incapacity payments over the year, and at a point in time, the number of incapacity payment recipients will be lower — on 30 June 2018, 3893 veterans were receiving MRCA incapacity payments, and 1874 veterans DRCA incapacity payments (DVA 2018f, p. 22). The level of incapacity payments received can vary markedly between veterans, depending on their normal earnings, actual earnings, and length of time on incapacity payments (figure 12.4). For example, the Australian Government Actuary (2018a, pp. 46, 54) found that:

- the average fortnightly incapacity payment varies from \$1700 to \$2700, depending on the veteran's age profile, length of time on the payments and Act they are covered by
- over half of the veterans are not on the payments 12 months after they first receive the payment.

There were close to 33 000 veterans on above general rate pensions under the VEA as at December 2017. Most of these (about 27 000) were on the SRDP. About 5000 were receiving the EDA, and about 700 were on the intermediate rate (Productivity Commission estimates based on unpublished DVA data).

Figure 12.4 Value of incapacity payments

Incapacity payments received in 2016-17 by veterans on incapacity payments



Source: Productivity Commission estimates based on unpublished DVA data.

Superannuation benefits

Current ADF members can receive superannuation benefits from one of three funds (chapter 3). The newest scheme — ADF Super — commenced in 2016, although veterans can still be receiving benefits under the older schemes.

All three schemes offer government-funded invalidity and death insurance. Members of these schemes who are medically discharged from the military may be entitled to a lifetime pension, based on their years of service, salary in the military, and incapacity for civilian work (box 12.3). Under the three schemes, the impairment resulting in discharge does *not* need to be related to service for veterans to receive invalidity or death compensation.

Box 12.3 Superannuation invalidity pensions

The three military superannuation schemes each have their own method for estimating the amount of invalidity pension to be paid (but the approaches are similar). This box explains the arrangements under ADF Cover.

A veteran who is medically discharged from service and classed as Class A (at least 60 per cent incapacitated for work) or Class B (30–59 per cent incapacitated from work) can receive an invalidity pension. Eligible veterans receive two types of pension.

- The basic rate of pension is payable for life. The pension is calculated as: salary at discharge, times prospective years of service to age 60, multiplied by an incapacity factor (0.011 for Class B, and 0.022 for Class A).
- A top up pension is payable until age 60. This pension is calculated based on years of service in the military times salary at discharge multiplied by an incapacity factor.

Example

Frank joined the military at age 20, and was medically discharged at age 25. Frank was severely impaired and incapable of working, and was classed as Class A.

Frank receives a pension for life of \$46 200 each year (35 prospective years of service X \$60 000 X the 0.022 incapacity factor). He will also receive a top up pension until age 60 of \$6600 annually because of his 5 years of service.

Offsetting arrangements

It is Australian Government policy, established under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA), that it should not pay two sources of income maintenance to the same person (Campbell 2011b). That means that if a person is receiving Australian Government-funded superannuation and incapacity payments under the MRCA or DRCA, their incapacity payments are reduced dollar for dollar by the amount of government-funded superannuation they are receiving. The SRDP under the MRCA is also offset by 60 cents for every dollar of Australian Government-funded superannuation. There is no offsetting under the VEA, nor is there offsetting for the benefits received by dependants.

Offsetting only applies for Australian Government-funded superannuation — this includes the invalidity insurance provided through military superannuation, as well as defined benefit superannuation payments. Benefits arising from private contributions to superannuation, such as employee contributions to ADF Super, are *not* offset.

Additional allowances and payments for veterans

Veterans can also receive a range of other benefits. There are four broad categories of benefits.

- Benefits to cover the financial costs of an impairment
- Payments that supplement impairment compensation
- Benefits provided as a recognition for service
- Payments to help veterans through the compensation system.

Benefits to cover the financial costs of an impairment

Veterans who suffer an impairment can face additional financial costs, including healthcare costs and costs related to helping them maintain their independence.

Under all Acts, the White Card covers the costs of all clinically necessary health care related to impairments that DVA has accepted liability. It also covers healthcare costs for cancer, pulmonary tuberculosis and mental health conditions, whether related to service or not.

Other costs that veterans can be assisted with under the MRCA and DRCA include:

- attendant care services, such as assistance with hygiene, grooming, dressing and feeding
- household services, such as meal preparation, cooking and cleaning.

Eligible veterans are reimbursed for the costs they face, up to a maximum of \$491.67 each week for attendant care and the same amount for household services under the MRCA, and \$473.25 each week per service under the DRCA.

A range of allowances are also available under the VEA. Unlike the allowances provided under the MRCA and DRCA (which are provided as reimbursements), veterans who meet certain criteria are usually given a set rate allowance to meet their costs.

- Veterans with certain impairments that restrict their mobility (for example, amputees) can be entitled to several allowances to meet their travel expenses.
 - a maximum of \$91 each fortnight to meet the costs of travel for recreational activities
 - \$2371 each year to meet the costs of maintaining a motor vehicle
 - financial assistance to purchase a new (or modify a) vehicle (a similar program is available under the MRCA that applies for vehicle modifications only)

-
- Goods and Services Tax exemptions for motorcycles.
 - Veterans with certain impairments (such as amputees or those who are blind) are entitled to a maximum of \$341 each fortnight to meet the costs of attendant care.
 - Veterans with impairments that damage their clothing can receive a clothing allowance of a maximum of \$14.30 a fortnight.
 - Veterans who suffer a loss of earnings as a result of undergoing treatment for a service-related impairment can receive compensation to cover this loss of earnings.

Compensation supplements

Veterans receiving impairment compensation or with DVA healthcare cards are automatically eligible for payments that supplement their compensation. There are two main payments.

- The energy supplement (introduced to provide financial assistance to cover the cost of the carbon tax), is available for people on MRCA permanent impairment payments, the MRCA SRDP or a VEA disability pension. This is in addition to an energy supplement that can be received for having a Gold Card or being on the service pension. The level of energy supplement varies depending on the type of payment received, but can be up to \$10.75 each week (the energy supplement is usually included in the compensation rate for the other payments).
- The MRCA, DRCA and veterans' supplements replaced the pharmaceutical allowance, and are available to people eligible for the SRDP (MRCA and VEA) and certain other above general rate pensions (VEA), those with more than 80 impairment points (MRCA) or those with a DVA health care card (all Acts). It is paid at either \$6.20 or \$12.40 per fortnight, depending on the veteran's eligibility. This supplement is only payable if the veteran is not receiving a pension supplement under the *Social Security Act 1991* (as it includes a pharmaceutical allowance) or through the service pension.

Eligible veterans under the VEA can also receive additional payments if they have certain decorations. The rate of this payment is \$2.10 each fortnight, plus an additional \$4541 each year for Victoria Cross recipients. Prisoners of war can also receive an additional \$569.10 per fortnight.

Benefits as a recognition for service

Veterans with qualifying service (chapter 3) can also be entitled to the service pension and the Gold Card.

The service pension is similar to the age and disability pensions provided to the general population, and is an income support payment for eligible veterans and eligible partners. The main difference between the service pension and generally available pensions is that the age service pension is available at 60 years old (this is the mandatory military retirement age).

DVA paid about \$1.7 billion in service pensions in 2016-17 (DVA unpublished data).

The Gold Card covers the cost of a range of public and private health care services, irrespective of whether the impairment treated was related to service or not. All veterans with qualifying service are eligible for the Gold Card once they reach 70 years of age. Severely impaired veterans under the MRCA and VEA (60 impairment points or access to the SRDP) can also access the Gold Card, as well as various other groups of veterans. The Gold Card is discussed in detail in chapter 15.

The Australian Government also recently announced a new Australian Veteran Card, which will provide a range of discounts for veterans at participating businesses (Morrison and Chester 2018b).

Payments to support veterans through the system

In 2018, the Australian Government introduced the Veteran Payment to support veterans with a mental health condition who are waiting for their DVA claim under the MRCA or DRCA to be processed. Eligible veterans can receive this payment if they are incapable of working for more than eight hours per week, and the payment is subject to an income test. This payment is set at \$991 per fortnight for singles and \$771.90 per fortnight (each) for couples.

The Veteran Payment ceases six weeks after a decision has been made on the veteran's claim.

In addition, veterans or their dependants can receive compensation for legal or financial advice in certain circumstances under the MRCA. This includes advice to help the veteran make a choice between receiving a lump sum or weekly permanent impairment if they have more than 50 impairment points, advice on whether to choose the SRDP if they are eligible for it, and advice for dependants where they receive a wholly dependent partner payment.

Veterans or their dependants can also receive compensation for financial advice under the DRCA where they are eligible for a payment payable under the *Defence Act 1903*.

Dependant benefits

If a veteran dies as a result of a service-related impairment (or, in some cases, if they had a severe service-related impairment upon their death), their dependent family members ('dependants') are eligible for compensation, either in the form of a pension or a lump sum payment. However, who is a dependant, and the compensation they are entitled to, differs across the three Acts.

Who is eligible for dependant benefits?

Three types of dependants can be eligible to receive compensation.

- Under all three Acts there is compensation available for the veteran’s partner.
- Under all three Acts ‘eligible children’ can receive compensation. Eligible children include children under the age of 16, and those between 16 and 25 who are undertaking full-time education.
- Both the DRCA and MRCA include provisions for other dependants — such as extended family and partly dependent partners — to receive compensation.

Dependants are entitled to compensation where a veteran’s death is linked to their service. In addition:

- compensation under the VEA is automatically paid if the deceased veteran was receiving a pension at or above 100 per cent of the general rate, or if they were an ex-prisoner of war
- compensation is automatically payable to dependants under the MRCA if the deceased veteran was eligible for the SRDP at some period of their life, or they suffered impairments of at least 80 impairment points.

How much compensation for dependants?

The level of compensation for dependants varies across the three Acts (table 12.3). Payments are tax free. Widow(er)s receiving VEA or MRCA compensation are not eligible for Centrelink income support payments, but can receive a DVA income support payment (discussed below).

Table 12.3 Compensation for dependants

<i>Dependant type</i>	<i>VEA</i>	<i>MRCA</i>	<i>DRCA</i>
Wholly dependent partner	\$931.50 per fortnight	\$465.75 per week (can be converted to a lump sum) Additional age-adjusted lump sum of up to \$148 988 ^a	A lump sum of \$550 321.42 to be divided across all dependants based on their level of loss An additional death benefit of \$60 756.25 is payable to the spouse ^b
Eligible child	Double orphan: \$204 per fortnight Single orphan: \$102.10 per fortnight	\$148.68 per week Additional lump sum of \$89 393	Additional compensation of \$89 301.98 is payable for eligible children ^b A weekly payment of \$151.34 is payable to eligible children.
‘Other’ dependant	na	Lump sum of \$89 393	

^a This lump sum is only available where the veteran’s death has been linked to service. ^b These payments are included in the *Defence Act 1903*. **na** Not applicable.

Additional allowances for dependants

Dependants can also be entitled to many of the additional benefits and supplements outlined above. Partners and children receiving benefits as a result of a veteran's death under the VEA or MRCA are entitled to a Gold Card. Dependants receiving certain payments can also receive the energy and the MRCA/veterans' supplement.

Eligible partners (or the veteran's estate) can receive a 'bereavement payment' under the VEA and MRCA.

- Under the MRCA, this payment is equal to 12 weeks of the incapacity payments, periodic permanent impairment payments or SRDP the veteran was receiving (or entitled to receive) at the time of their death.
- Under the VEA, the partner receives a lump sum equal to six instalments of the disability pension the veteran was receiving at the time of their death. If the veteran was receiving income support, a lump sum based on this payment may also be paid.

Widow(er)s with limited means can receive the Income Support Supplement under the VEA and MRCA. This is an income and assets tested payment of a maximum of \$275.40 per fortnight.

There is a funeral allowance to assist with the funeral costs of veterans (provided under all three Acts) where they died as a result of service. And as with other dependant benefits, it can also be paid out under the VEA and MRCA in other circumstances, such as if the veteran was receiving the SRDP, or died in needy circumstances. A maximum of \$2000 is available under the VEA, while just over \$12 000 is available under the MRCA and DRCA.

Eligible children of deceased or severely impaired veterans can also receive education allowances under the VEA and MRCA, and additional education support such as tuition. The rate of payment can be up to \$550.30 a fortnight, depending on the age of the child and their living situation. This payment has complex interactions with family tax benefit and youth allowance (chapter 14).

What compensation are dependants receiving?

In 2017-18, there were 59 000 war widow(er) pensioners under the VEA, and 124 wholly dependent partners receiving a pension under the MRCA (or who had received a lump sum payout). In addition, there were 155 dependent children receiving an orphan's pension under VEA and 128 receiving an eligible young person payment under MRCA (DVA 2018f, p. 22).

In 2017-18, \$35 million was paid to 165 dependants under the MRCA, and \$15 million was paid to 72 dependants under the DRCA (DVA 2018f, p. 225).

12.2 Evaluating the package of compensation

The adequacy, complexity and timeliness of payments and whether the payments are targeted at the right people are examined in this section. The following sections and chapters outline reforms to improve the effectiveness of the compensation package. This section uses hypothetical case studies to highlight the compensation package that veterans can be entitled to (box 12.4).

Box 12.4 Estimating lifetime compensation

The case studies in this section include a lifetime value of compensation available to the veteran based on reasonable assumptions. Where payments are provided as periodic payments over time, they are converted to a lump sum based on the formula used in the MRCA.

- Where compensation is available for the veteran or dependant's lifetime, compensation is converted to a discounted lump sum based on the actuarial tables used to convert permanent impairment payments to lump sums in the MRCA.
- If payments are only available for a specified period of time (such as incapacity payments), compensation is converted to a discounted lump sum using the formula to convert incapacity payments to lump sums in the MRCA.

Payments that are taxed, such as incapacity payments, are converted to an after-tax value based on current taxation arrangements.

Superannuation payments are based on the ADF Cover arrangements.

Where estimates include the Gold Card, this is based on the value of the Gold Card being about \$18 500 per year (the value estimated by the Parliamentary Budget Office as the value of the Gold Card to a person who already had a White Card (chapter 15)).

How does the compensation package compare with other schemes?

Compensation for veterans

Whether a compensation package is 'adequate' or 'fair' is a difficult judgment to make. It requires calls about the value of a person's pain and suffering and the potential effect of an impairment on their lives. As noted by the Canadian Veterans' Ombudsman, in many cases 'no amount of money can provide full restitution' (2016, p. 2).

That said, only a few participants raised concerns about the adequacy of the compensation package as a whole (primarily in relation to the SRDP, discussed below). And in fact, many noted the beneficial nature of the supports for veterans. For example:

- Returned and Services League of Australia (RSL) National Office said 'with regard to compensation in the broader sense, the range of entitlements and benefits offered to Australian veterans compares favourably to those offered to Canadian veterans and New Zealand veterans and superior to those of the US and UK' (sub. 113, p. 26).

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- Alexander McFarlane said that the schemes run by DVA ‘are more supportive and beneficial to the recipients and more equitably administered’ (sub. 69, p. 6) than state-based workers’ compensation schemes.
 - EML described the benefits to Australian veterans as ‘well-resourced and largely generous’ (sub. 90, p. 3).

Most ESOs also agreed that, once access to the payments has been granted, the benefits are fair and reasonable.¹

One approach to assess adequacy is comparisons with other workers’ compensation schemes. When compared with the workers’ compensation package applying to Commonwealth employees (the SRCA), the veteran compensation package is generous.

- For veterans with a low level of impairment and no incapacity for work, compensation is relatively straightforward — it includes a permanent impairment payment or disability pension, and the energy and veterans’ supplements. For veterans with warlike or non-warlike service, permanent impairment compensation is more generous than a civilian worker covered by the Commonwealth workers’ compensation legislation (box 12.5).
- For veterans with higher needs, the system is more complex. Veterans can receive transport allowances, various supplements, household and attendant care, incapacity payments, special rate pensions, welfare payments, superannuation invalidity pensions and the Gold Card, as well as various other allowances.
 - The MRCA and the DRCA offer payments that are generally in addition to, or more generous than, the standard Commonwealth workers’ compensation. Under the MRCA, veterans can be entitled to lifetime compensation in excess of \$3.9 million (box 12.6). Under the SRCA, the equivalent amount is likely to be about \$2.8 million.
 - Determining the generosity of the VEA is less straightforward — as the VEA provides set rate pensions, its relative generosity depends on the veteran’s pre-impairment earnings, as well as access to superannuation benefits and various allowances (boxes 12.6 and 12.7). However, in general the level of payments in the VEA is relatively comparable to those provided through the MRCA and DRCA. Some participants suggested that there is a case for an increase in the VEA SRDP, on the basis of comparisons with the minimum wage. This issue is considered in chapter 13 — but it is important to look at the whole package of compensation when making judgements about adequacy, rather than the individual components.

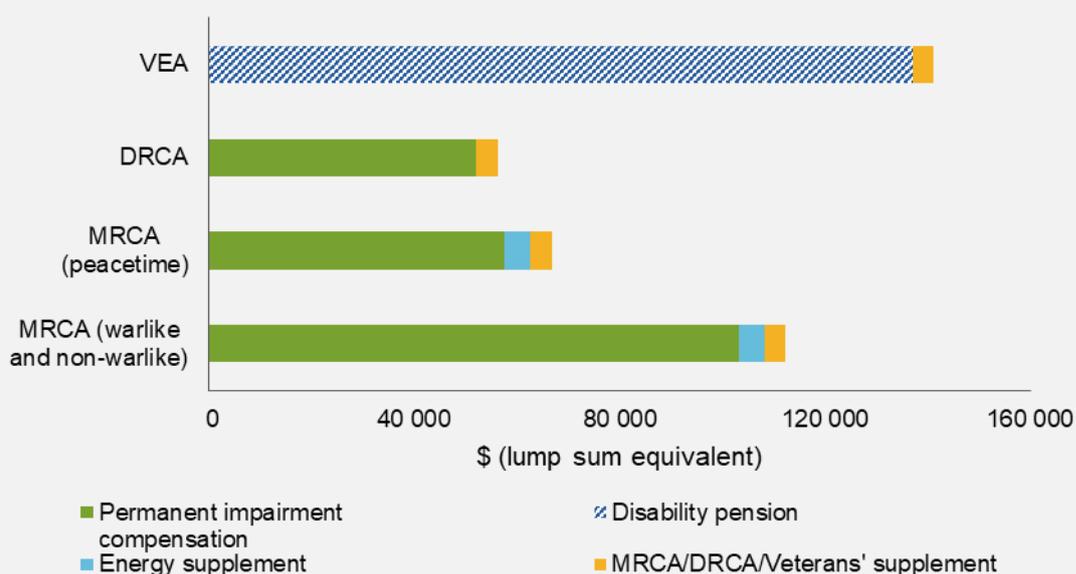
¹ Based on discussions in roundtables and meetings.

Box 12.5 Example — low level of impairment

Jane is a 30 year old veteran who has suffered a shoulder impairment graded at about 20 impairment points. While the amount and type of compensation will vary based on which Act she is covered by and the type of service under which the impairment was suffered, she will be entitled to:

- either a permanent impairment payment or a pension to compensate for the pain and suffering from the impairment. (Because Jane’s ability to work is not affected by her impairment, she will not be entitled to an income replacement payment.)
- various supplements.

Jane could expect to receive \$56 000 — \$140 000 in lifetime financial compensation (with the VEA being the most generous).



Jane will also receive treatment for the shoulder impairment through the White Card, and, if she has qualifying service, will receive the Gold Card at age 70 and the service pension at age 60.

Source: Productivity Commission estimates.

Other comparisons are more difficult. For example, when compared to state and territory workers’ compensation schemes, MRCA (and DRCA) incapacity payments step down to the lowest level in the country, but this is offset by not having a maximum payment rate, a maximum length of time for which payments can be granted and the additional remuneration loading (table 12.4). Permanent impairment payments vary in level across the states and territories, although eligibility for permanent impairment payments can be more restrictive — for example, some states have higher impairment thresholds to be able to claim permanent impairment compensation. That said, the veteran compensation schemes are likely to be more generous in most instances, as workers in state and territory schemes are not paid the range of allowances and benefits available to veterans and their families, such as education payments and the Gold Card.

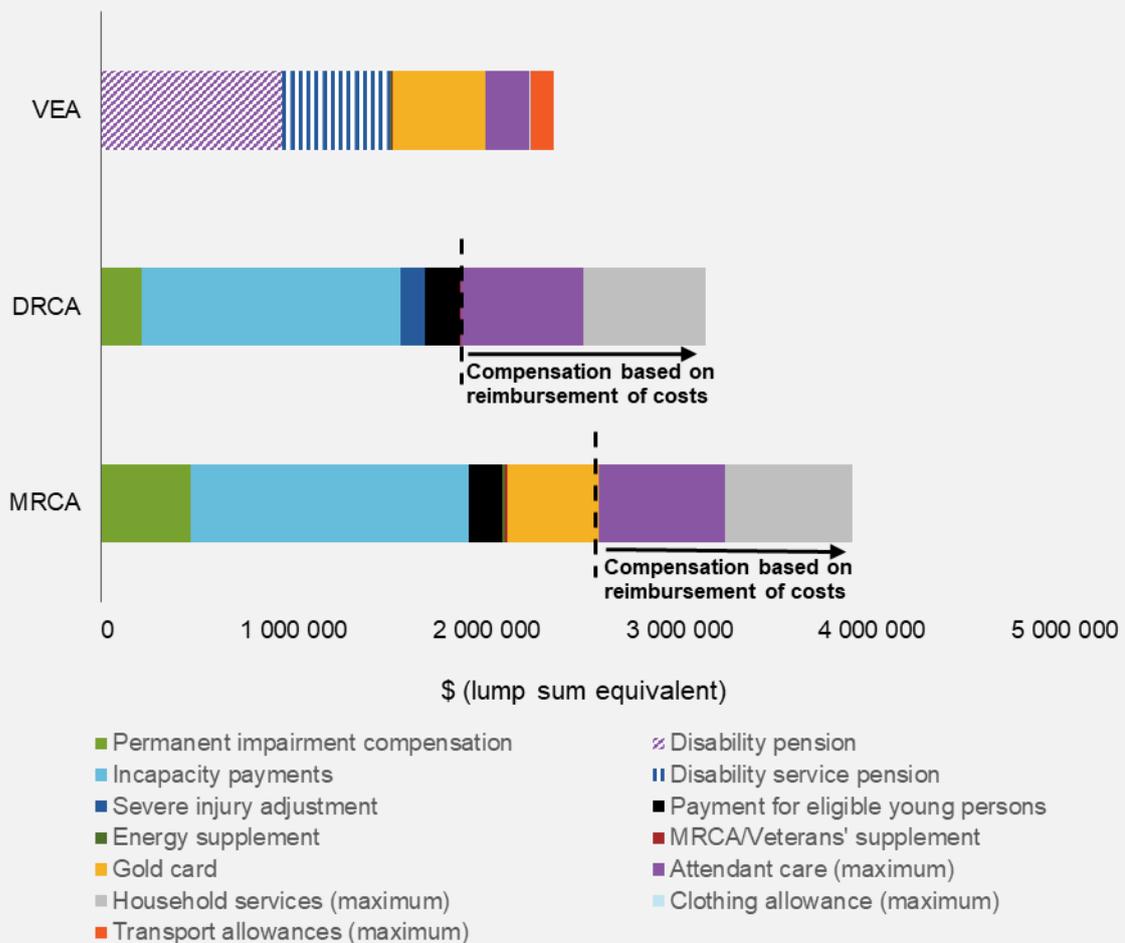
Box 12.6 Example — totally and permanently incapacitated veteran

Bill is a 30 year old veteran that has suffered a severe impairment graded at 80 impairment points. Bill is left unable to work as a result of the impairment resulting in him unable to earn his previous salary of \$100 000. Bill is not eligible for compensation from his military superannuation.

Under the MRCA and DRCA, Bill would receive incapacity payments until age 65 as well as a permanent impairment payment. Bill has two children, and will receive an additional lump sum for having eligible young children under the MRCA and DRCA. Under the VEA, Bill would receive the special rate of disability pension for life as well as the invalidity service pension.

Bill's impairment has left him with high needs, and as a result he also claims the maximum rate of attendant and household care service available. Bill receives immediate access to the Gold Card under the VEA and MRCA.

The total lifetime value of the compensation provided to Bill would be \$2.5–4 million under the MRCA (depending on the level of household and attendant services claimed) and over \$2 million under the VEA.

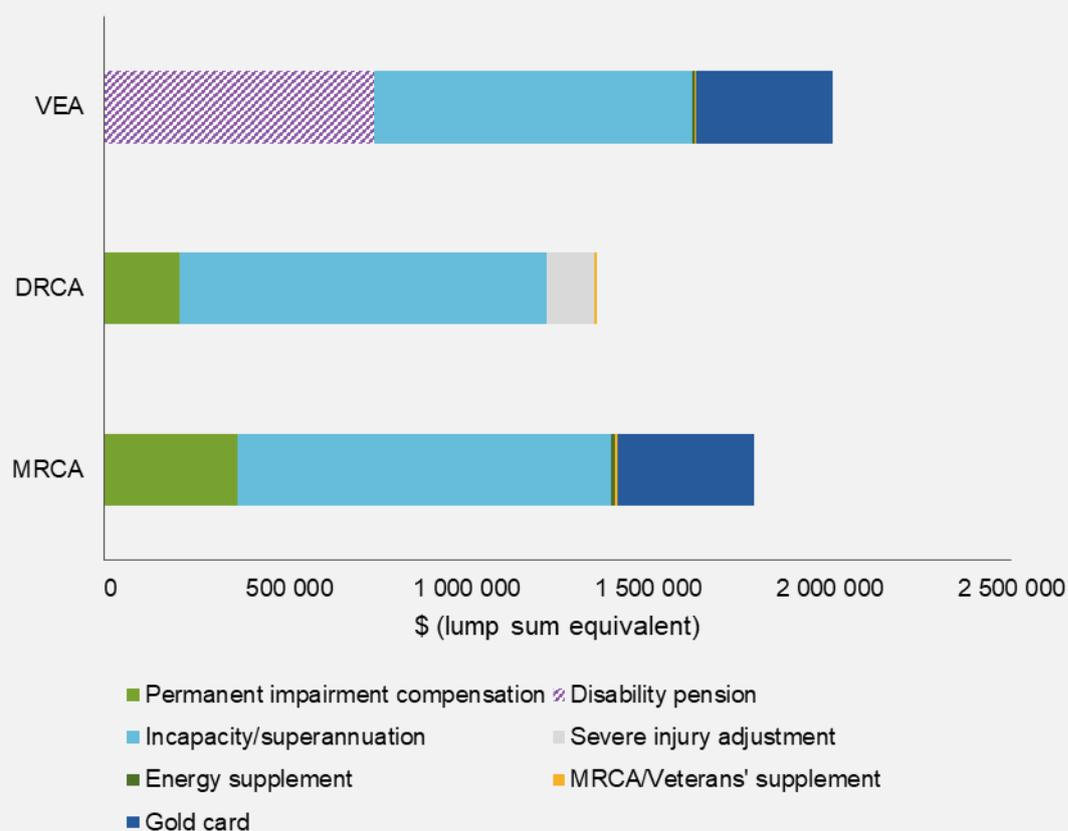


Source: Productivity Commission estimates.

Box 12.7 Example 2 — totally and permanently incapacitated veteran

Joe is a veteran facing the same circumstances as Bill (box 12.6), with some key differences. Joe is older (50 years of age), has no children and does not have a need for attendant and household services, or the other VEA allowances. Joe is also eligible for compensation from his military superannuation (Class A).

Unlike Bill, for Joe the VEA is likely to be the more generous compensation scheme, providing just over \$2 million in lifetime compensation.



Source: Productivity Commission estimates.

Internationally, the level of veteran compensation available is often quite different from the Australian compensation schemes, and comparisons are difficult.

- The Canadian New Veterans' Charter is most akin to the MRCA, and provides a disability award (akin to permanent impairment payments), an earnings loss benefit (akin to incapacity payments) and various other allowances. Lifetime support available for a totally impaired veteran ranges from C\$1.5–\$3.5 million (about A\$1.5–3.5 million) — consistent with the Commission's estimates for the Australian schemes (Canadian Veterans Ombudsman 2017).
- The UK offers a much higher threshold for permanent impairment compensation — a maximum of £570 000 (just over A\$1 million). However, this is often the only compensation veterans receive — while income replacement is available, only 2 per cent

of veterans receiving compensation received the income replacement payment (Brooke-Holland 2017).

- Under New Zealand’s scheme 2 (the more modern of New Zealand’s two schemes), the level of permanent impairment compensation available is lower than in Australia — a maximum of about NZ\$200 000 (about A\$183 000). New Zealand also offers income replacement, stepping down to 85 per cent of the veteran’s pre-injury income after one year.

Table 12.4 Incapacity payments in other workers’ compensation schemes — examples

As at December 2017

	<i>MRCA</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>
Maximum step down	75 per cent from 45 weeks	80 per cent from 14 weeks	80 per cent from 14 weeks	75 per cent after 26 weeks	85 per cent from 14 weeks	80 per cent after 1 year.
Maximum length of time on incapacity payments	No maximum	Five years, except for high needs workers	No maximum (with some conditions)	Five years	No maximum	2 years if not seriously injured (above 30 per cent whole of person impairment)
Maximum weekly payment	No maximum	\$2 043	\$2 150	Maximum total compensation of \$314 920	\$2 667	\$2 946

Source: Safe Work Australia (2017a).

While comparisons can be instructive, they need to be placed into the context of the broader support available in each country, including both veteran-specific and widely available support. As noted by the Canadian Veterans’ Ombudsman:

Assessing the sufficiency of the Disability Award should not be based on a comparison of how other countries compensate for the non-economic effects of disability. For example, the fact that the UK Compensation for Injury benefit is a maximum of £570,000 (CDN\$1,175,277) does not mean that the Disability Award maximum of \$360,000 is insufficient. It simply means that the amounts are different because the UK and Canada decided to support their Veterans in different ways, through a different suite of benefits that address unique needs, national imperatives and economic realities. (2016, pp. 29–30)

Overall, it is the Commission’s view that the payments to veterans are beneficial, reflecting the intent of the veteran compensation system.

Compensation for dependants

As with benefits for veterans, there is little guidance about what compensation a spouse should receive upon the work-related death of their husband or wife, or what a child should

receive upon the death of their parent. There is no generally accepted amount of compensation, and across Australia, the benefits received vary widely.

- In New South Wales, the compensation most reflects the veteran schemes — lump sum compensation of \$760 000 is available, plus a periodic payment for children and funeral expenses. At the other end of the spectrum, in the ACT the available lump sum compensation is about \$210 000, with weekly payments of \$70 available per child.
- In some states, such as South Australia and Victoria, payment based on the amount the worker was earning before they died is available for a period of time (Safe Work Australia 2017a).

The base level of support available for dependants is reasonably consistent with the most beneficial state and territory schemes. However, other benefits, including insurance available through the veteran's superannuation and the Gold Card can push the package of benefits available to in excess of \$1 million (box 12.8).

The easier access to dependant benefits, rather than the level of compensation, is the most beneficial aspect of the dependant benefits. The access to dependant benefits available under the MRCA and VEA for dependants of veterans who died while on certain payments is unique to the veteran's system in Australia. This allows a portion of dependants to receive compensation where the veteran's death was not related to service (chapter 13). These provisions mean that more dependants are able to access compensation than in other schemes.

The complexity of compensation

A key concern of participants is the complexity of the system. Veterans claim that it leads to confusion around entitlements and DVA points to the difficulties administering the scheme. The three Acts are seen as a major contributor to the complexity of the scheme. However, having invalidity pensions through superannuation alongside the compensation system also adds to complexity. This leads to a system of compensation offsetting between the Acts, which can be complex and confusing for veterans to understand. Proposals to consolidate and streamline the three Acts are considered in chapter 17.

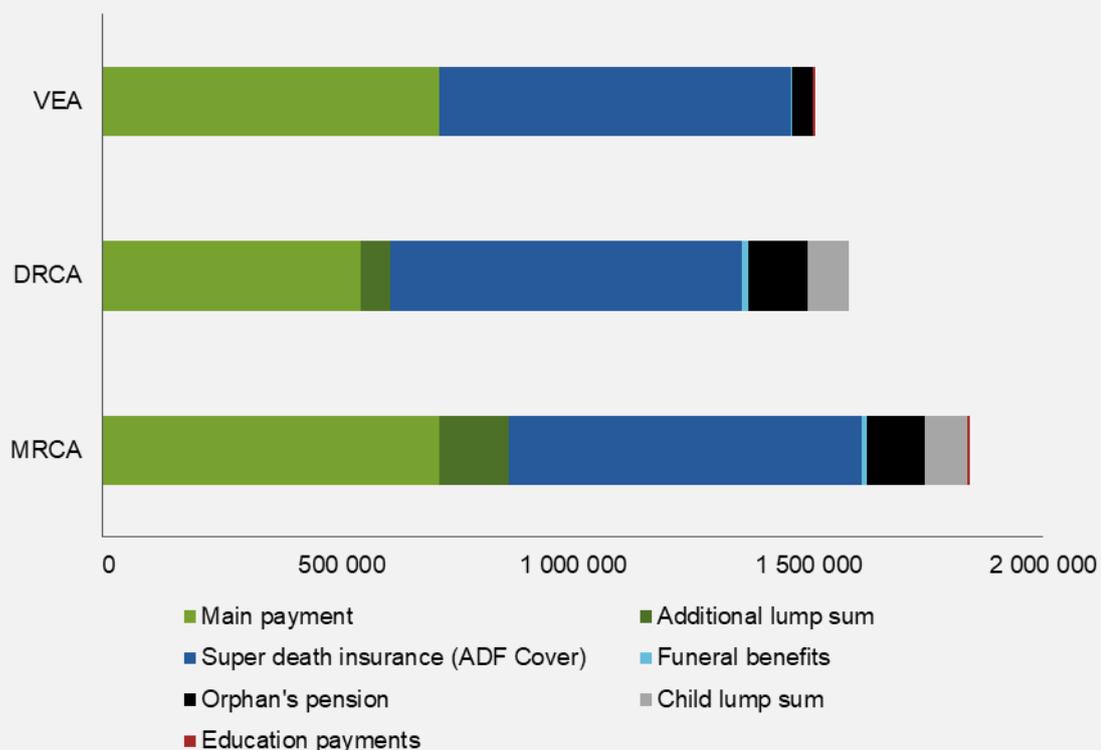
While much of the focus is on the number of Acts, the complexity of the individual Acts themselves should not be ignored. Most workers' compensation schemes have a limited number of payments — they typically focus on lost income (economic loss), pain and suffering (non-economic loss), and healthcare coverage. However, the veteran compensation schemes extends beyond this: for example, there are payments for damaged clothing, vehicle allowances, education payments, additional payments for specific disabilities, additional payments if the veteran has eligible children, payments for having particular decorations, payment supplements, the service pension and the Gold Card. Some payments are lump sum, some are weekly; some are taxed, some are untaxed. Some benefits are in the form of health care, rather than cash payments. This complexity makes it difficult to determine what compensation package veterans are entitled to.

Box 12.8 Dependant benefits — example

Mark was a veteran who was killed during service, leaving behind a 30 year old spouse and one child. Mark was previously earning \$100 000 in the military.

Under all Acts, Mark's spouse would receive a main lump sum or pension payment, as well as a payment through superannuation. The spouse would also receive a small funeral allowance as well as various other allowances and supplements. The total lifetime support for the spouse is likely to be in the region of \$1.5 million across all three Acts.

Support is also available for Mark's child. This would be in the form of an orphan's pension, a further lump sum (in the MRCA and DRCA) and education payments (in the figure, only education payments up to age 16 are considered).



Veterans may access payments under multiple Acts, sometimes for the same impairment, further increasing the complexity of compensation arrangements. They may also access other broader payments, such as Centrelink social security payments and superannuation compensation. RSL Queensland highlighted the complexity caused by the range of payments on offer:

A key shortcoming is the variety of benefits available across the three Acts and the complexity of ensuring the most beneficial legislation is being applied. It is the view of RSL Queensland that the range of benefits is extensive and not necessarily well understood ... Acknowledging the complexity of the range of benefits, it remains difficult for a veteran or his family to feel confident that they have accessed all of their entitlements. (sub. 73, p. 29)

This complex system of payments has emerged over time, as payments have been added to the system in response to perceived needs (chapter 3). For example:

- benefits were added under the DRCA (and continued on to the MRCA) following the 1996 Black Hawk incident
- payments, such as the veteran payment, were added in response to the difficulties people with mental health conditions were facing navigating the system.

Eligibility for certain benefits has also become more beneficial over time in response to veterans' concerns (chapter 3). For example, eligibility for the Gold Card has been progressively increased over time, despite governments stating the increases in eligibility would not be considered (chapter 15). And more people have become eligible for automatic access to dependant benefits upon the death of a veteran (chapter 13).

However, it is rare that payments are examined on the basis of whether they are fit for purpose in light of changes in other payments veterans are eligible for — including those available to the general public — and in general societal changes. The result is a long list of potential payments for veterans (figure 12.1), some of which are poorly targeted and have little rationale.

Delays in accessing payments cause distress

The time taken to process compensation claims can be lengthy, although there have been improvements (chapter 9). While the length of time to process claims can vary, times taken to process, for example, permanent impairment claims can be over a year (ANAO 2018b). These types of delays can take its toll on veterans' wellbeing.

Many participants to this inquiry commented on the effect delays in receiving compensation can have on veterans — including an overreliance on Centrelink (Peter Alkemade, sub. 66) and a disenchantment with the system (Warren Harrex, sub. 89). Maurice Blackburn (sub. 82) noted that delays in receiving compensation have almost resulted in several of their clients losing their homes, and the RSL (2015) said that the effect of delays can be more pronounced for veterans who were not medically discharged, but find themselves unable to work for an extended period of time. The Australian Psychological Society also highlighted the issues faced by veterans who are discharged with mental health issues and no reliable source of income.

[Australian Psychological Society] members who provide mental health services to veterans report that it can often take from six weeks to six months for some veterans to access income from their superannuation or pension. This creates clear barriers for veterans in obtaining accommodation, other important capital expenditure decisions and creates barriers for essential functions of daily living. This interruption in having access to essential funds is a serious issue along with the significant cost of living upon discharge. (APS 2015, p. 13)

There are many reasons why there can be delays in receiving compensation. The ANAO (2018b) noted that the two leading causes of delays are due to inactivity during the claims

process, and the time taken to receive medical information from specialists. These delays may reflect the complexity of cases — claims may involve multiple impairments covering multiple Acts, all of which need to be processed for the claim to be finalised. They may also reflect the legislative requirements placed on specialists — for example, the Royal Australian and New Zealand College of Psychiatrists noted that ‘... it is challenging to meet the requirement of having a “permanent and stable” condition. Often substantial support and treatment will be required before stability is achieved in the field of mental illness ...’ (sub. 58, p. 8). The ANAO report included several recommendations for DVA, including contracts that prescribe timeliness and quality for medical specialists engaged by DVA. These recommendations were accepted by DVA — it remains to be seen what effect they will have on decision making.

The targeting of compensation is important

It is also important to consider how compensation is targeted. While the quantum of compensation is important, if the people with the greatest needs are not receiving adequate compensation or necessary services, the compensation system will not be effective.

Some payments and services in the veteran compensation system are not targeted effectively. For example, while the veteran compensation system will pay for health care, there is less of a focus on ensuring that services are available, and veterans are not always able to access the health support that they need. Health services are provided to a wide range of veterans, whereas a tighter focus on high-needs veterans may be desirable (chapter 15). Some payments are provided to all veterans, where higher levels of support to a more targeted group of veterans may be more beneficial (chapter 14).

12.3 Reforming the compensation package

Based on the problems identified above, the focus of reforms should be on reducing the complexity of compensation, improving the timeliness of compensation and ensuring that the right people are targeted by the compensation package.

Reform in this area is not possible without affecting some veterans’ potential entitlements. And in fact, it is the reluctance to remove payments and the grandfathering of compensation benefits that is, at least in part, the root cause of the complexity of the current system. This was noted by DVA:

In previous decades, the avoidance of apparent or actual loss of benefits to any group of existing veterans has meant that reforms to legislation have built on existing entitlements, rather than revoking or altering them to align with new arrangements. (sub. 125, p. vii)

Some reductions or increases in future entitlements is the byproduct of reform in this area — nonetheless, the Commission’s reform package has been designed such that, with the

exception of some very small payments, veterans currently receiving benefits will not lose access to these benefits.

The individual payments that make up the veteran compensation system are assessed in the following chapters, based on the contribution of these payments to the overall compensation package. Some whole-of-package reforms are needed to improve the system — these are considered below.

Harmonising DRCA compensation with the MRCA

The compensation received through the DRCA is consistent in structure with that in the MRCA, and there appears scope to harmonise, and then merge, the compensation received through the two Acts (the reasons for this are outlined further in chapter 17). The following sections illustrate the fiscal costs of change in this area, how veterans may be affected, and some of the transitional arrangements that would be required. Details on changes needed to the MRCA to accommodate harmonisation are included in chapters 13 and 14.

Permanent impairment payments

There are differences in the way MRCA and DRCA permanent impairment payments are estimated — including different payment rates, periodic payments in the MRCA, and the use of whole-of-person impairment in the MRCA (section 12.1). These differences mean that harmonising the MRCA and DRCA payments would not be straightforward.

The Commission sees some advantages in the MRCA approach to assessing permanent impairment. Aside from the level of payment received (section 12.1), there are two key differences between the MRCA and DRCA approaches.

First, the MRCA uses periodic payments (that can be converted to an age-based lump sum). The use of periodic payments in the MRCA provides veterans with more choice about how payments are received and provides relatively more compensation to veterans who are impaired early in life — this is fairer and consistent with the principle of providing impairment compensation on the basis of the pain and suffering the person will experience over their lifetime. It should be noted, however, that age-based lump sums under the MRCA will mean that some older veterans may receive less compensation under the MRCA than they would have under the DRCA.

The second key difference is that MRCA uses a whole-of-person impairment methodology and the DRCA uses an injury-based approach. Some veterans may be disadvantaged by the MRCA approach. For example:

- a veteran with two impairments rated at 20 points would receive compensation based on 40 impairment points under the DRCA (or, more accurately, two sets of compensation based on 20 impairment points would be provided)

-
- under the MRCA the two impairment ratings would be combined using the GARP-M to a rating of 36 points
 - where two injuries lead to an impairment to the same functional system, under the DRCA the person may be compensated twice for the same impairment — this would not be the case under the whole-of-person methodology.

On the other hand, some veterans would be advantaged by the whole-of-person methodology — veterans who have several impairments below 5 impairment points would receive no compensation under the DRCA, but can combine these impairments to receive compensation under the MRCA.

It is the Commission’s view that the whole-of-person methodology is more reasonable. In particular, it means that veterans cannot receive compensation above 100 impairment points — the maximum compensation intended to be payable. The Commission also considers it reasonable that people are not compensated twice for different injuries that lead to the same functional loss. This would bring DRCA cases back to the methodology that applied before the High Court found that each condition must be assessed separately.

The DRCA should be amended to apply the MRCA permanent impairment approach for future claimants. Current recipients of DRCA permanent impairment compensation would not have their existing compensation recalculated (although if the impairment deteriorated over time, additional compensation could be sought through the MRCA). Given the compensation under the DRCA is provided as a lump sum, any change in entitlements would be complex, and it would be difficult and stressful for veterans if an attempt was made to claw back a lump-sum payment. Alternatively, veterans who would be better off under the DRCA could receive large windfall gains. Existing payments would be grandfathered, and offsetting applied where needed.

The fiscal cost of harmonising permanent impairment payments is relatively small — if veterans making a claim under the DRCA in 2017 had instead received compensation under the MRCA based on the warlike rate, total compensation would be about \$17 million higher (Commission estimates based on unpublished DVA data). About three quarters of veterans would have received more compensation under the MRCA, while about a quarter would have received less compensation due to the use of age-based lump sums. These estimates take into account the different rate of compensation and age based lump sums under the MRCA — they do not take into account the whole-of-person methodology used under the MRCA.

If compensation were based on the peacetime rate, compensation would have been reduced by about \$13 million. The Commission is seeking feedback on whether compensation in the MRCA should be based on the warlike rate or the peacetime rate (chapter 13).

Incapacity payments

There are also several differences between the MRCA and the DRCA incapacity payments (section 12.1). Ultimately, these differences mean that the MRCA incapacity payments will provide for a higher level of payment than the DRCA.

Unlike permanent impairment payments, incapacity payments are generally paid as a periodic payment. The Commission considers that it is feasible for all recipients of incapacity payments to move to one system of incapacity payments, including existing recipients. This would be based on the more generous MRCA model — meaning that DRCA veterans would receive a higher level of incapacity payments — although the Commission has considered whether some features of the DRCA approach should be adopted (chapter 13).

The Commission estimates that the effect of introducing the remuneration loading into the DRCA and removing the 5 per cent superannuation step down would have increased the costs of incapacity payments in 2017 by \$16–20 million (Commission estimates based on unpublished DVA data). It is difficult to estimate the effect of other differences between the incapacity payments, including the indexation and maximum payment threshold, but these are unlikely to have large cost effects in practice.

Dependant benefits

The dependant benefits in the MRCA and DRCA are similar in total compensation, but have some structural differences. Under the DRCA, payments to dependent partners are lump sums that are not age adjusted. The MRCA offers similar compensation either through periodic payments, the option of an age-adjusted lump sum, or some combination of the two. The age adjustment means that those under 60 would likely receive more compensation under MRCA than DRCA and vice-versa for those over 60. It is the Commission's view that an age-adjusted lump sum payment is sensible, particularly when calculating an equivalent periodic payment. This offers dependants additional choice in how they receive their payments.

The MRCA extends automatic eligibility to some groups that do not require liability for death due to service to be accepted, whereas under the DRCA the death must be proven to be service related. This results in considerably fewer people being eligible for dependant benefits. The Commission does not recommend extending this eligibility to the DRCA cohort as there is little rationale for this under the MRCA (this issue is considered further in relation to the MRCA in chapter 13).

Families with children have benefits that are almost identical under the DRCA and MRCA, with the exception that education payments are only available under MRCA — these should be extended to DRCA recipients (the Commission recommends some modification to education payments in chapter 14 — these would also apply to DRCA recipients).

DRCA dependants with low means currently access mainstream income support payments and benefits through Centrelink. MRCA dependants are excluded from receiving income support through Centrelink and instead are eligible for the Income Support Supplement (ISS) and Rent Assistance through DVA. As the ISS is designed to replace income support from Centrelink and the Commission has heard no issues in submissions with the rate of ISS, it is assumed that these benefits are adequate.

Overall, the cost to government for dependant benefits would be minimal as there are few people who qualify for these benefits each year under the DRCA. For those dependants of veterans with service-caused death there would be some extra benefits (such as age adjusted compensation and education payments) and some changes in overall compensation based on age.

Other benefits

As a result of the streamlining of compensation, the DRCA should be amended to provide access to the range of allowances under the MRCA. These include:

- access to the MRCA education and training scheme
- the slightly higher payment ceilings for household and attendant services
- the motor vehicle compensation scheme.

These payments are relatively small, and increasing their eligibility would not lead to a large fiscal cost on the scheme, but there are benefits in a harmonised approach to these payments. If these payments were modified as recommended in chapter 14, they would also have benefits for veterans and their families and not lead to a substantial increase in scheme complexity.

However, the Commission does not consider that access to the Gold Card should be extended to veterans and their families that would have been eligible for compensation under the DRCA. The reasons for this are outlined further in chapter 15, but in sum, there is no compelling rationale for extending coverage of the Gold Card.

DRAFT RECOMMENDATION 12.1

The Australian Government should harmonise the compensation available through the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) with that available through the *Military Rehabilitation and Compensation Act 2004*. This would include harmonising the processes for assessing permanent impairment, incapacity and dependant benefits, as well as the range of allowances and supplements.

Existing recipients of DRCA permanent impairment compensation and dependant benefits should not have their permanent impairment entitlements recalculated. Access to the Gold Card should not be extended to those eligible for benefits under the DRCA.

Military superannuation

Superannuation offsetting

Currently veterans who are medically discharged from service due to a service-related condition can receive two sources of income replacement compensation — incapacity payments or above general rate pensions under the VEA, DRCA and MRCA, and invalidity pensions through military superannuation arrangements. Under the MRCA and DRCA invalidity pensions are offset dollar for dollar against incapacity payments. Often this can result in the veteran losing most or all of their incapacity payment (box 12.9).

Veterans receiving a defined benefit superannuation pension or lump sum under the Defence Force Retirements and Death Benefits scheme and the Military Superannuation and Benefits Scheme can also be subject to the offsetting of this payment against incapacity payments.

Box 12.9 Superannuation offsetting — example

Using the example from box 12.3, Frank is a fully incapacitated veteran receiving an invalidity pension of \$52 800 (about \$1015 per week). He was previously earning \$60 000 annually in the military.

If he was not receiving an invalidity pension, Frank would be entitled to an incapacity payment of about \$1294 per week for the first 45 weeks after discharge. This amount is reduced dollar for dollar by his invalidity pension, such that Frank would receive a \$279 a week incapacity payment on top of his invalidity pension.

After 45 weeks, Frank's incapacity payments would reduce to 75 per cent of his previous income — equal to \$971 per week. As this is less than his invalidity pension, his incapacity payments would be fully offset by the pension — he would not receive an incapacity payment.

The offsetting of invalidity pensions has caused angst and confusion amongst the veteran community. The Vietnam Veterans' Association of Australia (sub. 78, p. 10) stated that superannuation offsetting was 'unreasonable'. The TPI Federation stated that it 'is criminal that a veteran and the veteran's family is put in the position where they receive no compensation because of a superannuation income protection payment ...' (sub. 134, p. 14). Similar views were put to the 2011 Review of the MRCA (Campbell 2011b).

It is important to note that the offsetting arrangements only apply to government-funded superannuation arrangements. Invalidity insurance is provided free of charge to members of the military, in large part because members of the military are likely to find it difficult to obtain cover at a reasonable cost under standard insurance arrangements (Robert 2015). Offsetting arrangements are in place to prevent the Australian Government from paying two sources of income replacement to the same person. If offsetting was not in place, a person could receive income replacement far in excess of their previous income — which would be overly generous.

Offsetting arrangements should remain between government-funded superannuation and the veteran compensation schemes.

DRAFT FINDING 12.1

The principle of not providing two sources of income replacement to the same veteran is sound. There is no case for changing the current offsetting arrangements between government-funded superannuation payments and incapacity payments.

Superannuation arrangements add to the complexity of the system

Currently, decisions about veteran compensation are made by DVA, while decisions about invalidity pensions are made by the Commonwealth Superannuation Corporation (CSC). Several participants commented on the complexity caused by these arrangements. For example:

- the interaction between superannuation and DVA payments can lead to administrative failures, such as overpayments which are later recovered by DVA (with tax implications), placing stress on the veteran and their family (RSL National Office, sub. 113; AVA, sub. 81; DFWA, sub. 118)
- there can be inconsistencies between decisions made by CSC and DVA — for example, Rod Thompson (sub. 116) highlighted a case where DVA decisions have differed from those made by CSC
- uncertainty and delays in the invalidity assessment made by CSC can cause further uncertainty and stress for veterans (DFWA, sub. 118)
- having three agencies, including the Department of Defence, DVA and CSC, responsible for delivering services for veterans ‘creates risk of confusion, gaps, overlaps and less accessible services’ (Department of Defence, sub. 127, p. 4).

The complexities that can arise from the interaction of the superannuation system and the veteran compensation system were also highlighted in a recent Defence Ombudsman report (box 12.10).

While the Department of Veterans’ Affairs (sub. 125) noted that recent initiatives (including information sharing) between itself and CSC have had positive outcomes, a system that relies on the goodwill and information sharing between two agencies has the potential for communication breakdowns, which can have significant implications for affected veterans.

Box 12.10 2018 Commonwealth Ombudsman report — superannuation

In 2018, the Commonwealth Ombudsman released a report relating to 'Mr A', a veteran who served between the 1970s until 1997 and 2002 to 2007. Following his retirement in 2007, Mr A transferred to reserve service.

Mr A was eligible for invalidity compensation under the Defence Force Retirement and Death Benefits scheme (DFRDB) and received a lump sum payment and pension following his initial discharge in 1997, and his discharge in 2007.

Mr A applied to the Department of Veterans' Affairs (DVA) for incapacity payments in 2007. DVA were advised by CSC of the DFRDB lump sum paid in 2007, but not the lump sum payment in 1997. Mr A began receiving incapacity payments in 2008, with offsetting applied for the 2007 DFRDB lump sum.

In 2013, CSC reported the 1997 DFRDB lump sum payment to DVA following a review of Mr A's entitlements. In 2015, DVA sent Mr A an overpayment debt notice for over \$50 000 — reflecting the amount that Mr A had been overpaid as a result of offsetting not being applied for the 1997 lump sum.

Following a complaint to the ombudsman, DVA advised that it had incorrectly applied offsetting. At the time, current members of the defence force (including reservists) did not have offsetting applied to DVA payments as a result of their superannuation payments (this was changed in 2013). As a result, DVA determined that Mr A was in fact owed an additional \$500 000 in back payments — with this new lump sum placing Mr A in the highest tax bracket and leading to a tax liability of over \$200 000.

Source: Commonwealth Ombudsman (2018).

Scope to better integrate the superannuation and veteran compensation systems

Several participants called for the responsibility of the assessment of invalidity pensions to be taken from CSC and given to the body responsible for governing veteran compensation (Robert Shortridge, sub. 76; DFWA, sub. 118; RSL Queensland, sub. 73). For example, the Defence Force Welfare Association stated that 'there is a case for responsibility for military superannuation to be transferred to the [Minister for Veterans' Affairs] ... This would assist the addressing of the governance issue with an initial focus on compensation, inefficiencies regarding medical administration, offsetting payment problems and support timely sharing of information' (sub. 118, p. 29).

Previous reviews of veteran compensation and military superannuation have gone further, recommending greater integration between the military superannuation and veteran compensation system. The 2011 Review of the MRCA stated:

It is questionable why there are two legislative arrangements and two Australian Government agencies to administer unique invalidity benefits for former ADF members ...

The complexity of a former member receiving military superannuation benefits in full for life and top-up benefits from the [Military Rehabilitation and Compensation Commission] until age 65 under a rehabilitation regime would be reduced if the legislation was more integrated and a single agency held responsible. (Campbell 2011b, p. 171)

The 2007 Podger Review of Military Superannuation recommended that arrangements for disability benefits should be merged under the auspices of DVA. It noted that there would be benefits in building upon the incapacity arrangements under the MRCA for superannuation invalidity insurance — conditions for which liability is accepted by DVA should be compensated by incapacity payments only, with a reduced version of incapacity payments available for non-liability impairments (Podger, Knox and Roberts 2007).

The Australian Government accepted a recommendation of the MRCA Review to explore options to streamline the administration of veteran compensation and invalidity and death pensions. It noted:

The legislative and administrative responsibilities of both ComSuper and DVA are unique and complex and there are interactions between the benefits paid by both agencies. This consideration, across government, provides the mechanism to scope opportunities for streamlining the administration of superannuation and compensation invalidity and death benefits by aligning legislative definitions and consolidating service delivery. (Australian Government 2011)

There has been some progress — although the administration of compensation and invalidity pensions remains separated. A pilot program commenced at Holsworthy Barracks in 2017 to introduce a single medical assessment for DVA, CSC and Defence. There are also steps being taken to facilitate greater information sharing between DVA and CSC, and amendments in 2017 sought to make it easier for CSC to obtain information from DVA.

Nonetheless, the current arrangements of two sets of income replacement for veterans managed by two different agencies and offset against each other appears nonsensical, and has potential for communication breakdowns with implications for veterans. While the veterans receiving these payments do not perfectly overlap, many veterans are receiving both payments — currently, over half of veterans receiving incapacity payments had offsetting applied for superannuation (Productivity Commission estimates based on unpublished DVA data). The Commission is not aware of any other system that operates in this way.

The current system also leads to adverse outcomes for veterans. Veterans need to go through two different bodies, and have two different medical assessment processes, which potentially lead to different outcomes. As noted above, there have been attempts to introduce a single medical assessment process for DVA, CSC and Defence, but these are still in their infancy. The potential for errors and overpayments is a serious concern for veterans, as highlighted by the case of Mr A.

Nonetheless, integrating the system is not without its costs and complications. There would be transitional costs involved with developing new information technology systems and processes. There would also be governance issues — if DVA took over responsibility for invalidity pensions it would be responsible to the Military Rehabilitation and Compensation Commission for part of its operations, and to CSC for another. Finally, there may be issues in having the administration of invalidity pensions separate from the administration of the other parts of military superannuation. (This is particularly the case for the older military

superannuation schemes, where the line between invalidity pensions and defined benefits superannuation is blurred. The distinction is much clearer in the ADF Super arrangements.)

The Commission does not consider these issues to be insurmountable. Consolidation of the administration should be the long-term goal, but it will take time. In the short term, there are several steps that could be taken that would improve the process for veterans.

- A single ‘front door’ for invalidity pensions and veteran compensation would reduce confusion for veterans, and streamline the process.
- Continuing the process of introducing a single medical assessment process for invalidity pensions and veteran compensation would reduce the burden on veterans, and improve the consistency of decision making.
- Continuing steps to facilitate greater sharing of information between DVA and CSC — such as automatic notifications to DVA when a veteran’s invalidity pension is altered — would reduce the scope for errors resulting in under- or over-payments.

These changes would lay the foundation for potential consolidation of the administration in the future. And when the Veteran Services Commission (chapter 11) is established this would be an opportunity to consider further consolidation.

DRAFT RECOMMENDATION 12.2

The Department of Veterans’ Affairs (DVA) and the Commonwealth Superannuation Corporation (CSC) should work together to streamline the administration of superannuation invalidity pensions and veteran compensation, including by:

- moving to a single ‘front door’ for invalidity pensions and veteran compensation
- moving to a single medical assessment process for invalidity pensions and veteran compensation
- developing information technology systems to facilitate more automatic sharing of information between DVA and CSC.

With the establishment of the proposed Veteran Services Commission (draft recommendation 11.2), consideration should be given to whether it should administer the CSC invalidity pensions.

In an ideal world, there would be one system of income replacement for veterans, rather than the current two overlapping systems. This is not only for reasons of simplicity, but because the existence of the parallel superannuation system could undermine some of the objectives of a modern, return to work focused, compensation scheme (box 12.11).

Box 12.11 Military superannuation insurance: some potential issues

A potential issue with insurance provided through military superannuation is a lack of a rehabilitation and return-to-work focus. Superannuation invalidity pensions — which are typically applied for before or slightly after discharge — have no rehabilitation requirement while the Department of Veterans' Affairs' incapacity payments — which are often applied for years after discharge — require rehabilitation to be undertaken. These issues were noted in the Campbell review:

While this Review has not examined the superannuation legislation or operations in any depth, there does appear to be a fundamental gap, in that there is no rehabilitation component after discharge from the ADF. The invalidity benefit level increases with higher incapacity levels. There is little incentive for improving the quality of life through participation in the workforce. (Campbell 2011b, p. 171)

The limited incentives to rehabilitate and return to work can have both a detrimental effect on the wellbeing of veterans, as well as increase the cost of the compensation system.

In addition to the absence of rehabilitation, invalidity pensions could also distort work incentives in other ways. If a veteran is reclassified to a lower level of incapacity as a result of returning to work, this can dramatically affect the pension they receive. On the other hand, incapacity payments through the Department of Veterans' Affairs have mechanisms to encourage a return to work through payment step downs.

There are also some questions about the equity implications of the superannuation insurance — particularly for dependants (and for veterans under the VEA scheme) where there is no offsetting. Dependants of veterans who die while in service can receive substantially more compensation than those where the veteran dies as a result of a service-caused condition that materialises after service.

The Commission is exploring options for aligning the legislative arrangements for superannuation insurance with those in the MRCA for future claimants, such as the option proposed by the Podger Review. It is seeking further information from participants on the costs and benefits of such an approach.

INFORMATION REQUEST 12.1

What are the costs and benefits of further integration between superannuation insurance benefits and the veteran compensation scheme, and how might this integration be achieved?

13 Compensation for an impairment

Key points

- There are a number of changes that could be made to permanent impairment payments under the *Military Rehabilitation and Compensation Act 2004* (MRCA) that would simplify the payments, and improve access and equity.
 - The difference between compensation for warlike and non-warlike service, and peacetime service should be removed — it adds complexity, requires evidence that a veteran's injury was suffered as a result of operational service and creates inequities between veterans. But the question then is what rate for a single rate? Participants' views are being sought on what the single level of compensation should be.
 - While interim compensation payments have reduced concerns about the requirement that impairments are permanent and stable before compensation is paid, the provisions could be improved by limiting the length of time an impairment is considered unstable. Because interim compensation payments are 'interim', they should only be given as periodic payments, and on the basis that they could be reduced (or increased) if the impairment stabilises at a level lower (or higher) than what was expected.
 - There is little rationale for additional permanent impairment payments for having eligible young people, and the payments add complexity and create inequalities between veterans. They should be removed.
- Incapacity payments under the MRCA are generally consistent with those under other workers' compensation schemes. The *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* should adopt the MRCA incapacity payments.
 - There is a case for some veterans to receive superannuation contributions as part of their incapacity payments, to ensure that these veterans are not disadvantaged in retirement. This provision could replace the remuneration loading — which appears to have little solid rationale.
- The option to take the special rate disability pension under the MRCA is counter to its rehabilitation focus — it provides little incentive for veterans to rehabilitate and return to work. It is also rarely used. The option of taking this pension under the MRCA should be removed.
- The rationale for providing benefits to widows of veterans whose death was not related to service (if the veteran had a threshold number of impairment points before their death) is questionable. This eligibility should be removed from the MRCA, and not expanded to other groups under the *Veterans' Entitlements Act 1986*.

As a way to simplify the current complex legislative arrangements for veteran support, the Commission recommends that the compensation aspects of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) be aligned with the *Military Rehabilitation and Compensation Act 2004* (MRCA) (chapter 12). In this context, this

chapter looks at some of the more detailed issues that participants raised about the MRCA in the areas of permanent impairment payments (section 13.1), incapacity payments (section 13.2) and benefits for dependants (section 13.3). The chapter also considers issues raised about the *Veterans' Entitlements Act 1986* (VEA).

13.1 Impairment compensation

Veterans under the MRCA can receive permanent impairment payments to compensate them for the pain and suffering associated with a service-related impairment (chapter 12). This section addresses a number of issues about permanent impairment payments.

Different rates of compensation in the MRCA

Veterans eligible for permanent impairment compensation under the MRCA can receive a different rate of compensation depending on whether their impairment was suffered during operational (warlike or non-warlike), or peacetime service (figure 12.1). The rates for warlike and non-warlike service are about 80 per cent higher than those for peacetime service up to 50 impairment points, and it narrows to zero per cent at 80 impairment points. At its largest point, the difference can be over \$100 000 in lump sum terms.

This difference is a result of the way permanent impairment compensation is estimated in the Guide to Determining Impairment and Compensation (GARP-M).

- Table 23.1 of the Guide specifies a set of compensation factors that apply to veterans with operational service.
- Table 23.2 specifies a different set of compensation factors for those with peacetime service (MRCC 2016).
- Section 67 of the MRCA requires that the guide specify different methods of compensation for these groups.

As discussed in chapter 4, the reason for the different rate of compensation is that operational service is more demanding and risky, and veterans injured in such service should be granted special compensation. For example, the 2011 MRCA Review stated that:

The retention of higher compensation payments for operational service is in recognition of those who are intentionally exposed to harm from belligerent enemy or dissident elements. This policy objective is as relevant today as it was following the Second World War. (Campbell 2011b, p. 73)

At least in part, the different rates for warlike and non-warlike, and peacetime service reflect the historical genesis of the MRCA — that it was an amalgamation of the VEA and the DRCA. The different rates of compensation between these two Acts form the basis of the compensation in the MRCA. The explanatory memorandum for the MRCA stated that:

The outcomes in terms of compensation for those whose injury or disease results from warlike or non-warlike service and is up to 50 impairment points will approximate those under the VEA.

For peacetime service the results will approximate those under the SRCA [*Safety, Rehabilitation and Compensation Act 1988*]. (Vale 2003, p. 35)

Participants' views on the differences between those with and without qualifying service, and hence the need for different rates of compensation, were mixed (chapter 4).

It is unclear why the same impairment should be treated differently depending on where the impairment was suffered. The current approach to compensation also raises questions about why a compensation differential is justified at low levels of impairment, but not at 80 impairment points and above (Campbell 2011b). The different rates of compensation also:

- add to the complexity of the system
- require veterans to demonstrate whether their injury was suffered as a result of operational service or not
- create inequities between different groups of veterans.

The difference should be removed from the MRCA and replaced with a single level of compensation across all types of service.

If a single rate, what rate?

Selecting a single rate of permanent impairment compensation for all veterans covered by the MRCA is not straightforward. Moving to the warlike and non-warlike rate would mean that no veteran was disadvantaged, but it would have budgetary implications for the scheme. Back-of-the-envelope estimates suggest that moving all veterans to the warlike and non-warlike rate would increase permanent impairment compensation by about 28 per cent — which would have increased compensation by about \$60 million in 2016-17 (Productivity Commission estimates based on unpublished DVA data). And this will increase substantially over time as the MRCA becomes the predominant compensation scheme.

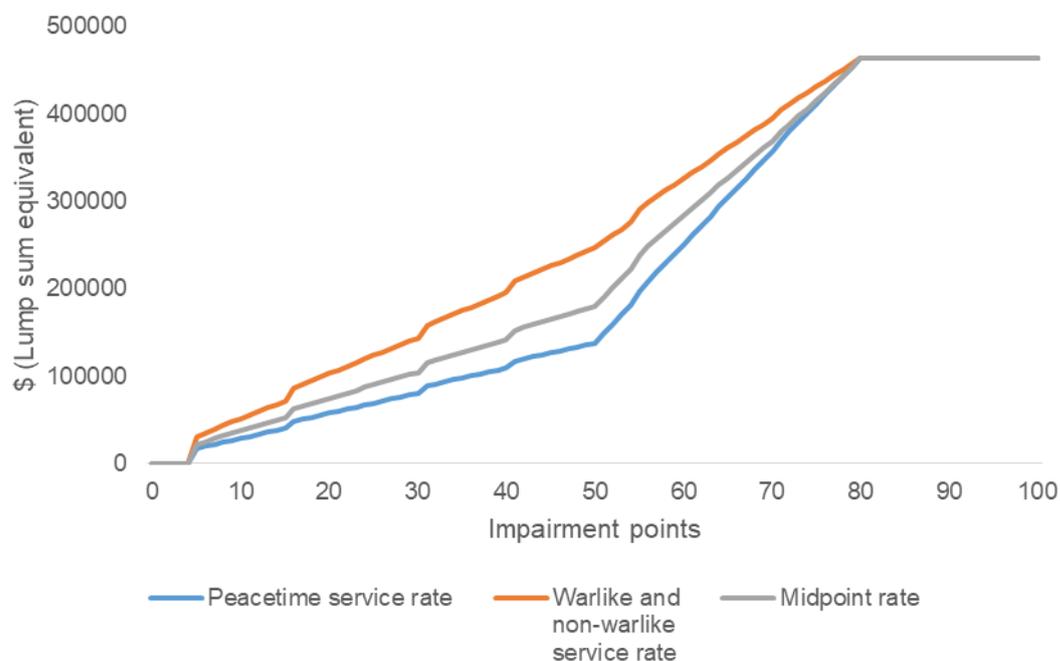
However, moving to the peacetime rate, while reducing costs for taxpayers — by about 13 per cent, or about \$30 million if applied in 2016-17 (Productivity Commission estimates based on unpublished DVA data) — could disadvantage a large group of veterans who have not as yet put in impairment claims.

An alternative is to select a compensation rate in between the current permanent impairment rates — a rate that maintains the current budgetary cost of the scheme. This option maintains the current generosity of the scheme, but changes how the compensation is distributed — those with operational service would receive slightly less compensation, while those with peacetime service would receive more.

The Commission estimates that the budget-neutral point would be set at about 30 per cent above the current peacetime rate. However, while existing entitlements would be preserved, this would change the benefits for veterans who have yet to put in a claim — some would be better off, and some would be worse off.

The three options are highlighted in figure 13.1. The Commission is seeking comments from participants on what rate of compensation is reasonable.

Figure 13.1 Options for reform to permanent impairment rates



Source: Productivity Commission estimates.

DRAFT RECOMMENDATION 13.1

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the requirement that veterans with impairments relating to warlike and non-warlike service receive different rates of permanent impairment compensation from those with peacetime service.

The Department of Veterans' Affairs should amend tables 23.1 and 23.2 of the Guide to Determining Impairment and Compensation to specify one rate of compensation to apply to veterans with warlike, non-warlike and peacetime service.

INFORMATION REQUEST 13.1

The Commission is seeking information on the new level of permanent impairment compensation that would be reasonable, taking into account the costs, benefits and equity implications to veterans, governments and the broader community.

Impairments must be permanent and stable under the MRCA

Under the MRCA (and the DRCA), impairments must be considered permanent and stable for permanent impairment compensation to be granted. Veterans with impairments that are not considered stable are eligible for interim compensation based on what their condition is expected to stabilise to (chapter 12). Interim compensation cannot be clawed back if the assessment is found to be too generous.

Because under the MRCA permanent impairment compensation can be taken as a lump sum, permanent and stable provisions prevent veterans receiving compensation for impairments that are likely to improve naturally or with rehabilitation. For example, a veteran could have an impairment to their shoulder of 50 impairment points, but with rehabilitation it could improve to 20 impairment points. Without permanent and stable provisions, the veteran could receive lump sum compensation based on 50 impairment points.

Issues raised about the permanent and stable provisions

Several participants to this inquiry said that the permanent and stable provisions are unfair, and they add to the time taken for a veteran to receive compensation. The Vietnam Veterans' Federation of Australia (sub. 34) stated that the provisions cause delays and should be removed, while the Vietnam Veterans' Association of Australia (sub. 78, p. 9) said the provisions were 'unreasonable'. In its submission to the Senate inquiry into veterans suicide, the Alliance of Defence Service Organisations (2016) also noted that the provisions are known to frustrate veterans awaiting determinations.

The provisions are of particular concern for veterans with conditions that can fluctuate with time, such as mental health conditions. DVA (sub. 125) noted that many conditions will have a fluctuation in symptoms as part of their normal manifestation. The Royal Australian and New Zealand College of Psychiatrists also noted that it can be challenging to meet the permanent and stable provisions for people with a mental illness.

The episodic nature of mental illness, whereby consumers can have periods of wellness and periods with severe symptoms, means that it is challenging to meet the requirement of having a 'permanent and stable' condition. Often substantial support and treatment will be required before stability is achieved in the field of mental illness, and veterans should not be left without compensation during this period if their mental health issues are related to service. (sub. 58, p. 8)

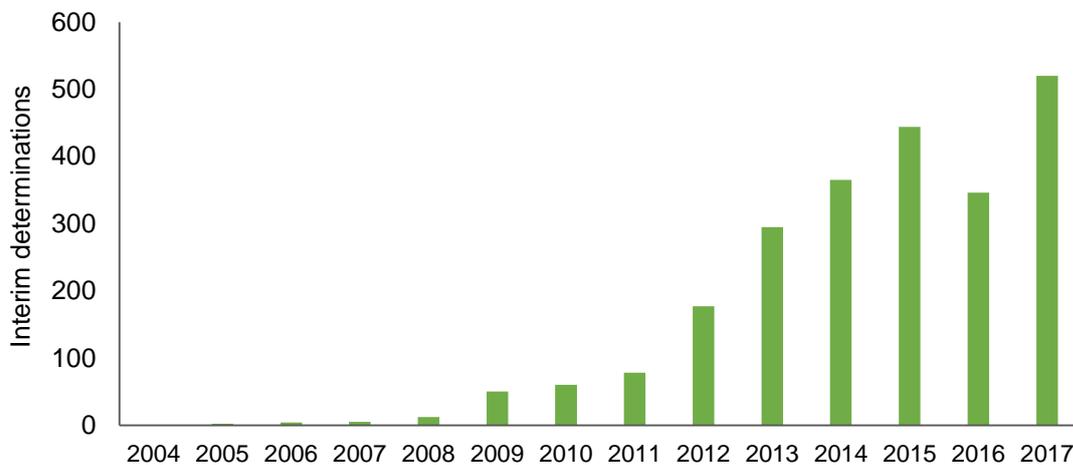
Similarly, the TPI Federation noted that 'a number, if not all, psychological conditions along with a number of physical conditions will never be stabilised but yet the Veteran and their families need to wait until the Claim Delegate decides that they are ready to finalise the claim' (sub. 134, p. 23).

Other participants, however, were of the view that the issues around permanent and stable had been resolved. Peter Sutherland (sub. 108, p. 5), for example, said that the issue had been 'overblown', and mainly arose from a failure to apply interim compensation arrangements effectively. The Returned and Service League (RSL) National (sub. 113) also

said that the issue had been resolved by recent amendments and improvements in interim compensation payments.

The 2011 review of the MRCA noted issues with the permanent and stable provisions, and considered that more frequent use of the interim compensation provisions would address the issue (Campbell 2011b). While DVA has always been able to offer interim compensation under the MRCA, it was rarely granted in the initial years (figure 13.2). It has been used more frequently since 2009. In 2017, over 500 MRCA cases led to interim compensation determinations.

Figure 13.2 Interim compensation determinations (MRCA), 2004-2017



Source: Productivity Commission estimates based on unpublished DVA data.

What are veterans entitled to while they wait for a condition to stabilise?

It is important to point out that the provisions around stability only relate to permanent impairment compensation. Veterans can still be eligible for other forms of compensation, including incapacity payments, while waiting for a condition to stabilise. And as noted above, veterans can also receive interim permanent impairment compensation while waiting for their condition to stabilise — and the use of this form of compensation has increased over time.

As a result of recent policy changes, veterans submitting a claim for a mental health impairment may be eligible for two additional forms of compensation.

- First, they can receive the Veteran Payment while waiting for a claim to be determined and six weeks after the claim has been determined. This provides an income stream for a veteran while waiting for their payment to be processed.

-
- Second, DVA will provide interim compensation to people with mental health conditions at a minimum of 10 impairment points, even if the condition is expected to stabilise to less than 10 impairment points (DVA 2018a).

The permanent and stable provisions should remain

The permanent and stable provisions should remain in place. A person should not receive a final permanent impairment lump sum on the basis of a level of impairment that is expected to improve over time.

DRAFT FINDING 13.1

The requirements that a condition be permanent and stable before final permanent impairment compensation is granted, under the *Military Rehabilitation and Compensation Act 2004*, are needed to prevent veterans from being overcompensated for impairments that are likely to improve.

And while many of the concerns about the permanent and stable provisions have been addressed by the improved access to interim compensation since 2009, this is not to say that the permanent and stable provisions cannot be further improved.

Interim compensation — weekly compensation or lump sum payments?

The Commission heard that there is a culture of risk aversion during the claims process in DVA, particularly regarding the payment of interim compensation. While the use of interim compensation has improved, given uncertainty around what impairments may stabilise to, there is likely to remain a bias towards not paying interim compensation, or paying interim compensation at a low level. For example, as discussed below, lifestyle ratings under the MRCA for interim assessments are generally more conservative for a given impairment rating than those for final permanent impairment assessments.

One reason for this may be that interim permanent impairment compensation is not truly interim in nature. Veterans can take interim compensation as a lump sum, which cannot be reduced — even if the condition stabilises at a level lower than expected. Lump sum payments can be increased following stabilisation of the impairment, and underpayments can be corrected later in the process.

A consequence of this arrangement is that veterans can be overpaid if they have conditions that improve more than expected. This may be exacerbated by the recent policy decision to grant interim compensation of at least 10 impairment points for those with mental health conditions — even if the condition is expected to stabilise below 10 impairment points.

The Commission supports recent moves to increase the availability of interim permanent impairment compensation, particularly for those with mental health issues. Recommendations

following the suicide of Jesse Bird note that more needs to be done to ensure that veterans eligible for interim compensation are actually paid it (DVA and DoD 2017). These efforts should continue. However, interim permanent impairment compensation should be interim in nature — that is, compensation should be provided as a periodic payment that can be increased or decreased at a later date depending on the final permanent impairment assessment (compensation already granted should not be ‘clawed back’).

These changes should be combined with a change toward paying interim compensation at the level that best reflects where the impairment is likely to stabilise to, including the lifestyle rating. That is, there should be less risk adverse assessments of interim compensation. Veterans on interim compensation should be required to undertake reasonable rehabilitation. Once the condition has stabilised, the level of compensation should be reviewed and veterans would then have the option of taking a lump sum.

RSL Queensland (sub. 73) argued that interim permanent impairment payments should be weekly, but be based on the current level of impairment, rather than the level that the impairment is expected to stabilise to. This would simplify the process, however, it could reduce incentives for veterans to participate in rehabilitation. Given the importance of rehabilitation for recovery and veterans’ wellbeing, the Commission does not support this proposal.

DRAFT RECOMMENDATION 13.2

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the option of taking interim permanent impairment compensation as a lump-sum payment. The Act should be amended to allow interim compensation to be adjusted if the impairment stabilises at a lower or higher level of impairment than what is expected within the determination period.

A time limit for stability?

A key source of concern for veterans is the length of time it can take for an impairment to be determined to be stable. For example, in 2009, the Commonwealth Ombudsman noted that:

The time frame for potential stabilisation can be many years, and clients are understandably frustrated that their claim for their illness cannot be resolved sooner. This is particularly so when they have psychologically adjusted themselves to a serious and permanent health condition. (2009, p. 3)

Requiring that an injury become stable will lead to some delays. As noted by Hanks in relation to the Victorian Accident Compensation Act:

Some delay due to the instability of a worker’s injury or illness is unavoidable. It is important that an injury has stabilised to ensure that the ‘permanent’ impairment resulting from the injury is appropriately assessed and the entitlement to compensation accurately calculated. (2008, p. 270)

Nonetheless, delays should be minimised. Even with access to interim compensation, delays stretching several years can cause unnecessary angst for veterans, particularly where the veteran is suffering from a mental health condition.

The Commission considers that DVA should have the discretion to offer final permanent impairment compensation in cases where the condition is not stable, but:

- the impairment is permanent — that is, it is likely to have a lasting effect
- a significant length of time has passed since the veteran lodged their claim — at least two years
- the veteran has undertaken all reasonable rehabilitation and healthcare.

At this point, the veteran would receive compensation based on their current level of impairment, which could be taken as a lump sum.

A similar approach is used under the New Zealand *Accident Compensation Act 2001* — compensation can be paid if two years have passed, and a medical practitioner determines that an impairment is likely to lead to a lasting effect, but is not yet fully stable.

For the majority of cases, this provision is unlikely to have a significant effect, as the veteran's impairment is likely to become stable within two years. However, it would remove outlier cases, particularly veterans with mental health issues, where the impairment can take many years to be considered stable.

DRAFT RECOMMENDATION 13.3

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to allow the Department of Veterans' Affairs the discretion to offer veterans final permanent impairment compensation if two years have passed since the date of the permanent impairment claim, but the impairment is expected to lead to a permanent effect, even if the impairment is considered unstable at that time. This should be subject to the veteran undertaking all reasonable rehabilitation and treatment for the impairment.

Payments for eligible young dependants

Following the Black Hawk disaster in 1996, the 1997 Inquiry into Military Compensation Arrangements recommended that the maximum permanent impairment compensation under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) be increased by \$150 000. This was to take into account:

- the need to acquire suitable housing and a vehicle
- the additional financial costs incurred by families who forego careers to provide care
- an inability to re-enter the workforce

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- the drop in income brought about by the loss of financial support, such as housing, provided to members of the Australian Defence Force (ADF) (DoD 1997).

In response to the recommendation, the Australian Government increased the maximum compensation under the SRCA by \$49 000, with an additional \$50 750 for each child dependant if the veteran was severely impaired. This payment is retained in the MRCA — with indexation, a severely impaired veteran can receive \$89 393 for each child dependent on them (chapter 12).

Based on the Commission’s research, the MRCA is the only compensation scheme that links the maximum permanent impairment compensation to the number of children the person has, and it is unclear what the rationale is for the payment. Linking a non-economic loss payment to the number of children appears tenuous at best. The economic costs of raising children are met through other payments — including income maintenance through incapacity payments. There are also separate payments available to assist with, for example, the cost of the child’s education (chapter 12). Generally available welfare payments, such as the family tax benefit, also assist with the costs of raising children.

The payment can also lead to perverse incentives for veterans. For example, the Commission heard that there can be an incentive for veterans to delay submitting claims that would lead to them exceeding 80 impairment points until they have children, and become entitled to the additional compensation. On the other hand, if an impairment stabilises after a child ceases to be an eligible young person, the veteran can miss out on a substantial amount of compensation.

There are also questions of equity between veterans raised by the payment. A veteran with two children can receive about \$180 000 more in compensation than one without — even if that veteran is likely to have children in the future. Similarly, a veteran with two children but with impairments rated at 79 impairment points will receive over \$180 000 less than a veteran in the same situation but with 80 impairment points.

The introduction of the MRCA resulted in a large increase in the maximum rate of permanent impairment compensation — the maximum rate of lump sum compensation is about \$200 000 higher than the SRCA rate — but the eligible young person payment has been retained. A severely impaired veteran under the MRCA with two dependent children could receive close to two and a half times the amount of permanent impairment compensation a civilian worker in the same situation would receive under the SRCA.

DRAFT FINDING 13.2

There is little rationale for providing additional non-economic loss compensation to veterans for having children, and the current payment leads to inequities and complexities. This payment is unique to the veteran compensation system.

It is inequitable that veterans with children get a substantially higher amount of permanent impairment compensation than those without. The need for an eligible young person lump sum has been superseded by the substantially higher level of permanent impairment compensation available under the MRCA relative to the DRCA. The reduction in costs would be minimal — in 2016-17 about \$5 million in eligible young person compensation was paid under the MRCA (Productivity Commission estimates based on unpublished DVA data) — but removing it would simplify the system, improve equity between veterans, and remove the current perverse incentives.

DRAFT RECOMMENDATION 13.4

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the permanent impairment lump-sum payments to the veteran for dependent children and other eligible young persons.

Guides to assessing impairment

As noted in chapter 12, each Act has its own guide to assess rates of permanent impairment. This is an area of potential simplification. The use of different guides means that the same impairment can be given a different impairment rating, depending on the Act the impairment falls under. This makes comparisons across the Acts more difficult, increases the complexity of assessing claims, and increases the difficulty of offsetting between the Acts. The Department of Veterans' Affairs noted that:

The guides used by DVA are not necessarily the latest assessment guides, and there can be significant differences in the assessment of benefits across each of DVA's Acts depending on which condition is being assessed and under which guide. (sub. 125, p. 104)

The guide used under the DRCA is the most distinct from the other two guides in terms of the impairment ratings assigned to each condition. Simplification would be achieved by assessing future claims that would have been assessed under the DRCA under the GARP-M. While it is not possible to align the Guide to the Assessment of Rates of Veterans' Pensions (GARP) and the GARP-M entirely, given the differences in processes across the VEA and MRCA, where possible these manuals should be aligned to ensure that the same impairment is assigned the same impairment rating across the remaining Acts.

Lifestyle ratings

Under all three Acts, an impairment will be allocated a lifestyle rating depending on its effect on the veteran's lifestyle, which affects the level of compensation that a veteran may receive (chapter 12). Lifestyle ratings are from 0–7 under the MRCA and VEA, and from 0–100 under the DRCA. Slater and Gordon (sub. 68) questioned the use of lifestyle ratings, noting that:

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- in the GARP and GARP-M each impairment rating has a range of 1–2 lifestyle ratings associated with it (this range is referred to as ‘the shaded area’). Allocated lifestyle ratings rarely fall outside this range
 - the factors that affect lifestyle ratings are out of date, and were predominantly developed for World War II veterans
 - veterans often do not adequately identify the limitations on their lifestyle, or will over exaggerate the effects
 - if claimants seek a lifestyle factor outside the shaded area, this can result in a long, drawn out process
 - increases in lifestyle ratings often result in little gain for the claimant.

It is clear that, at least for the MRCA, most lifestyle ratings fall inside the shaded area for the impairment rating. As of June 2017, about 96 per cent of people who had received a permanent impairment payment had been allocated a lifestyle rating within the shaded area — 73 per cent of people had received a rating at the top end of the shaded area. Of the remaining 4 per cent of veterans, roughly half received a lifestyle rating below the shaded area, while the other half received a rating above the top of the shaded area (Productivity Commission estimates based on unpublished DVA data).

The tendency for veterans to be allocated a lifestyle rating within the shaded area reflects the fact that veterans can opt not to submit a lifestyle questionnaire, which will usually result in a lifestyle rating at the top of the shaded area, or at the bottom of the shaded area for interim permanent impairment assessments. It may also reflect an administrative bias towards granting veterans lifestyle ratings within the shaded area.

It is also the case that changes in lifestyle ratings often do not have a large financial effect in practice, particularly under the MRCA. For veterans with warlike or non-warlike service under the MRCA, a one point change in lifestyle rating will affect their compensation factor by 0.01–0.02 — a difference of \$4–\$8 per week. Under the VEA, an increase in lifestyle factor may put veterans onto the next highest general rate pension (which can lead to an increase in compensation of \$25 per week), or alternatively not affect the veteran’s compensation at all.

Hilton Lenard and Keith Russell (sub. 13) highlighted the complexity that can occur as a result of the assessment of lifestyle ratings. It noted an example of a veteran who had been assigned a lifestyle of rating of two, when they were seeking a lifestyle rating of four (a rating consistent with the top of the shaded area for the veteran’s level of impairment). While after lodging an appeal to the Veterans’ Review Board the veteran received a lifestyle rating of four, the Association noted that: ‘after several years, this veteran received what he was entitled to from the beginning but initially denied and forced into the appeals system due to bad administration’ (sub. 13, p. 3).

There is an in-principle case for retaining lifestyle ratings. Veterans whose impairment leads to a greater effect on their lifestyle should, all else equal, receive a higher amount of

compensation. That said, the way they are currently used suggests that they are a ‘tick and flick’ exercise of the compensation process — with little variation in the lifestyle ratings assigned and difficulties for veterans in obtaining a rating that differs from the shaded area. If lifestyle ratings are to remain, they should be treated by veterans and DVA as a more integral part of the process.

DVA should assess whether the administration of lifestyle ratings could be improved. If it cannot, there is a case for removing the lifestyle ratings from the MRCA.

DRAFT RECOMMENDATION 13.5

The Department of Veterans’ Affairs should review its administration of lifestyle ratings in the *Military Rehabilitation and Compensation Act 2004* (MRCA), to assess whether the use of lifestyle ratings could be improved.

If the use of lifestyle ratings cannot be improved, the Australian Government should amend the MRCA and the Guide to Determining Impairment and Compensation to remove the use of lifestyle ratings and provide veterans permanent impairment compensation consistent with the lifestyle ratings that are currently usually assigned for a given level of impairment. Existing recipients of permanent impairment compensation should not have their compensation reassessed.

13.2 Compensation for economic loss

Incapacity payments

This section considers some of the issues raised about incapacity payments in the MRCA and DRCA. The incapacity payment provisions in these Act are relatively consistent (with some exceptions) to the provisions that apply in most workers’ compensation schemes, and few issues were raised about these payments.

In general, there is a balancing act between the generosity of compensation and incentives to return to work and rehabilitate. The step downs in compensation in the MRCA and DRCA are designed to pay a reasonable level of income replacement, while still maintaining an incentive to return to work (PC 2004).

Remuneration loading

Veterans on MRCA incapacity payments can receive a remuneration loading — a top up to their normal earnings reflecting the non-monetary benefits of military service (chapter 12). The explanatory memorandum to the MRCA stated that the payment was ‘to reflect and compensate for the lost non-financial components that make up the entire ADF remuneration package, such as free medical and dental and subsidised housing’ (Vale 2003, p. 50).

Peter Sutherland raised concerns about the generosity of the remuneration loading, noting that:

[The remuneration loading] now amounts to more than \$160 pw and has the effect that a junior private will receive about \$50 000 pa in incapacity payments, an amount which they are unlikely to be able to earn in civilian employment. I think the add-on was probably a necessary compromise to get the MRCA Bill passed into law, however its logic is doubtful: the service allowance is already built into normal earnings for discharged veterans (without the inconveniences compensated for by the service allowance) and many of the non-pay issues are no longer relevant after discharge. (sub. 108, p. 5)

Incapacity payments are designed to cover the economic loss associated with an impairment, and where a person has suffered genuine economic loss, they should be compensated for it. The veteran scheme appears to be the only workers' compensation scheme in Australia to add a remuneration loading type allowance on to normal earnings. Although this is not the norm, it could be justified where the veteran faces a genuine economic loss as a result of a losing access to the services they have available in the military.

Nonetheless, the rationale for introducing the remuneration loading appears weak. Many veterans can receive partial or full health coverage after leaving the military through the DVA healthcare cards system. Veterans can also get access to subsidised home loans to assist with their housing costs through schemes such as the Defence Home Ownership Assistance Scheme. It is unclear what the other intangible benefits included in the allowance are, and there appears little science behind why the loading was initially set at \$100 per week.

Superannuation contributions

Under the MRCA and the DRCA, employer superannuation contributions are not taken into account when estimating the veteran's normal earning for incapacity payment purposes, nor is a superannuation contribution paid when the veteran is receiving incapacity payments. Peter Sutherland argued that:

In the current environment of retirement savings through accumulation superannuation funds, it is inequitable that veterans on incapacity payments cannot access compulsory superannuation to help them after age 67 when their incapacity payments cease. (sub. 108, p. 5)

Superannuation contributions are not made due to Australian Taxation Office guidance that notes that compensation for workers not working are not salary or wages, and thus no superannuation contribution needs to be made. It is also consistent with all state and territory workers' compensation schemes, with one exception: in Victoria, superannuation contributions can be paid if the worker has been on incapacity payments for at least a year.

The issue of whether superannuation contributions should be made where a person is on workers' compensation payments has been considered for many years.

- In 1994, the Industry Commission recommended that superannuation contributions should continue while workers are on weekly incapacity benefits, otherwise they would be disadvantaged relative to other workers upon retirement (IC 1994).

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- In 2004, the Productivity Commission noted that ‘inclusion of superannuation contributions could provide for some of the needs of injured workers after the cessation of benefits’ (2004, p. 261).
 - And the Hanks review of the SRCA recommended that consideration be given to amending the Superannuation Guarantee Act so that workers’ compensation payments would be considered ordinary time earnings, and be subject to superannuation contributions (Hanks 2013).

Not paying superannuation is likely to lead to cost shifting from the veteran compensation system to the welfare system, which masks the costs of impairments and may reduce the incentive to minimise injuries. As noted by the Department of Family and Community Services in its submission to the Commission’s workplace relations inquiry:

Long-term unemployment can have significant implications on superannuation for both workers and their families. As injured workers that have not returned to work have a decreased amount of superannuation, many will have increased reliance on age pension in retirement and lower overall income, as age pension only provides a basic level of support. (Cited in PC 2004, p. 270)

However, for many current veterans, the lack of a superannuation contribution may not be a significant concern. Until 2016, military superannuation was mostly in the form of defined benefits funds, and veterans who are incapacitated while serving would be entitled to invalidity pensions for life through their superannuation. However, going forward, ADF members on the ADF Super accumulation fund may find themselves disadvantaged as a result of their incapacity to work (if they are not receiving an invalidity pension through ADF Cover).

Better targeting the compensation package?

Incapacity payments should be targeted at the economic loss actually faced by veterans. The compensation package would be better targeted if the remuneration loading was removed, and replaced with superannuation contribution for veterans on incapacity payments who:

- have been on incapacity payments for at least a year
- are not eligible to receive a defined benefit superannuation payment
- are not receiving an invalidity pension through their military superannuation.

Not only would this better target the economic loss faced by veterans, it would also target support towards those veterans who most need it — those who are facing long-term disadvantage as a result of their impairment.

There are, however, some practical issues that may limit DVA paying superannuation, and reform will require legislative changes beyond the veteran support Acts. The Commission is seeking further information on the costs and benefits of these reforms.

INFORMATION REQUEST 13.2

The Commission is seeking further information on the costs and benefits of removing the remuneration loading and replacing it with superannuation contributions for veterans with long-term incapacity. What are the barriers to providing superannuation to veterans on incapacity payments, and how could these be overcome?

Other differences between the MRCA and the DRCA

There are a number of other differences between the MRCA and DRCA incapacity payments, including that:

- the DRCA increases incapacity payments based on indexation, while the MRCA increases payments based on actual movements in ADF pay
- the DRCA reduces payments by an additional 5 per cent based on a notional superannuation contribution.

The Commission considers that aligning the DRCA with the MRCA approach in these cases is reasonable. Adjusting payments based on actual movements in ADF pay more accurately reflects the economic loss faced by the veteran as a result of their incapacity. The superannuation contribution is outdated. The Hanks review noted that:

That deduction is intended to represent the contribution that the employee would have been making to her or his superannuation scheme if still employed. However, very few superannuation funds now require an employee to contribute to her or his own superannuation. Because most employees are not required to contribute to their superannuation funds, it is inequitable to reduce their incapacity payments in lieu of this assumed contribution. (Hanks 2013, p. 99)

The MRCA approach in these areas should be retained, and applied for veterans currently receiving incapacity payments under the DRCA.

The special rate disability pensions

The MRCA special rate disability pension

Under the MRCA, veterans that meet certain eligibility criteria can opt to take a special rate disability pension (SRDP) — largely equivalent to the special rate of disability pension under the VEA — instead of incapacity payments (chapter 12). This payment is rarely used — in large part because incapacity payments are more generous than the SRDP for most younger veterans. Only about 15 veterans received more than \$10 000 through the SRDP over the lifetime of the MRCA as of July 2017 (Commission estimates based on unpublished DVA data).

There are several issues with this payment.

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- The criteria for the payment runs counter to the rehabilitation focus of the MRCA. Unlike incapacity payments — which provide incentives for veterans to return to work — veterans lose access to their payment entirely if they return to work for more than 10 hours per week. In effect, veterans receiving the payment are labelling themselves as totally incapacitated for life.
 - And while the payment is rarely used, the choice between incapacity payments and the SRDP can create confusion for veterans. Veterans can receive financial advice to make this choice, but this is costly. As of June 2017, the cumulative cost of providing financial advice to choose between the SRDP and incapacity payments was about 25 per cent of the cumulative cost of providing the SRDP over the lifetime of the MRCA (Commission estimates based on unpublished DVA data).

DVA also noted that the SRDP ‘is complex to administer and can act as a barrier to employment’ (sub. 125, p. 32).

The SRDP was originally introduced into the MRCA to provide a safety net to ensure that no one would be made worse off in the transition from the VEA to the MRCA — in particular, people in junior ranks in the military (Campbell 2011b; Vale 2003). It may not even be effective in achieving this objective — some participants to this inquiry noted that the MRCA SRDP was less generous than the VEA SRDP, in large part because the MRCA is subject to superannuation offsetting, while the VEA is not (TPI Federation, sub. 134).

Irrespective of the above, given the substantial increase in wages in the military in recent years it is unlikely that a veteran would be better off on a SRDP than on incapacity payments. And the evidence is in the low take-up of the SRDP.

One exception is for veterans approaching retirement age. Because the SRDP continues beyond 65, while incapacity payments cease, a veteran close to 65 may be better off on the SRDP. This is a deliberate design feature of incapacity payments — there is no rationale for providing economic loss compensation for a veteran who is at retirement age, and has had a full career.

On the whole, there is no rationale for the retention of the MRCA SRDP, and it can create costs, cause confusion and reduce incentives to return to work. The option of taking this payment should be closed.

DRAFT RECOMMENDATION 13.6

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the option of taking the special rate disability pension. Veterans that have already elected to receive the special rate disability pension should continue to receive the payment.

The level of the VEA special rate disability pension

Several participants raised concerns about the level of the SRDP under the VEA. For example, the TPI Federation (sub. 134; sub. 145) used comparisons with the minimum wage and average weekly earnings to state that the level of the SRDP has decreased over time. The Federation noted that the level of the SRDP has declined from 80 per cent of average weekly earnings in the 1950s to about 43 per cent of average weekly earnings. The Federation called for an increase in the SRDP of about \$400 a fortnight — several other participants supported the assertion that the SRDP was too low (Max Ball, sub. 140; John Reeves, sub. 26).

Such comparisons ignore the other benefits that veterans on the SRDP can receive, including the Gold Card and various allowances and supplements. Veterans on the SRDP can also receive the service pension (or equivalent Centrelink payment) — the SRDP does not count towards the income test for these payments. As noted by Clarke et al. (2003), the amount that special rate pensioners were able to receive increased from about 70 per cent of male average weekly earnings to 90–120 per cent throughout the 1970s, as the SRDP was progressively excluded as income from welfare tests. It remained at this level throughout the period considered by the Clarke Review.

The additional payments received by special rate pensioners cannot be ignored, as most special rate pensioners are receiving some form of additional welfare payment. As of December 2017, over 70 per cent of veterans on the SRDP were also receiving some level of the service pension and a further 6 per cent were receiving a Defence Force Income Support Allowance payment (indicating that they were receiving a Centrelink payment). And, as noted by Clarke et al. (2003), this is the minimum income a veteran on the SRDP should receive — any not receiving the maximum amount of welfare would be receiving a different income source, including potentially an invalidity pension through their superannuation. Thus veterans are not required to survive on the SRDP alone.

When both the SRDP and service pension are considered, a totally and permanently incapacitated veteran would be receiving about \$2300 per fortnight (not considering benefits such as access to the Gold Card). This is consistent with the figure estimated in the Clarke Review of about 90 per cent of average weekly (after tax) earnings — there does not appear to have been an erosion in the adequacy of the SRDP since the Clarke Review. As noted above, prior to the 1970s, veterans on the SRDP could not access the service pension, and the changes to the service pension access increased the relative generosity of the SRDP.

There is no compelling case for an increase in the SRDP.

DRAFT FINDING 13.3

Changes to eligibility for the service pension and other welfare payments means that the package of compensation received by veterans on the special rate of disability pension is reasonable. Despite strong veterans' representation on this issue, there is no compelling case for increasing the rate of the pension.

13.3 Benefits for dependants

There were few issues raised about benefits for dependants — ESOs representing dependants generally considered the benefits available to be reasonable. However, benefits for dependants in the MRCA are an amalgamation of the SRCA and the VEA, and this has led to some discrepancies and areas where the payments available may no longer be fit-for-purpose.

Benefits for dependant for non-service-related deaths

Under both the VEA and the MRCA, dependants of veterans can receive compensation even if the death was not service related. Dependants of veterans on certain payments, including the SRDP, intermediate rate pension and extreme disablement adjustment, and dependants of veterans eligible for the MRCA SRDP, or above 80 impairment points can automatically receive dependant benefits upon the death of the veteran, irrespective of whether liability for the death was accepted by DVA.

As of June 2018, about 30 per cent of people receiving the war widow(er)s' pension under the VEA were receiving it as a result of the automatic eligibility (DVA unpublished data). It is unknown how many of these would be eligible for the pension in the absence of the automatic eligibility. Most people receiving wholly dependent partner payments under the MRCA were as a result of service-caused deaths — this may be due to the relatively young age of veterans covered by the MRCA, and would be expected to change in the future.

The rationale for the automatic eligibility for benefits for dependants is unclear. The original intent of war widow(er) provisions was to compensate dependants for the service-related death of a veteran. In 1936, automatic eligibility for the war widow(er)s' pension was introduced for dependants of veterans who died while on the SRDP. The Government noted that this was 'a big departure from the generally accepted principles of war pensioning and any additional departures cannot be countenanced' (McLachlan 1935, p. 2415). In 1991, the automatic eligibility was extended to cover the extreme disablement adjustment and widows of prisoners of war (Clarke, Riding and Rosalky 2003). It was later extended to cover the intermediate rate pension.

The New Zealand Law Commission (2010) considered this issue in the context of the two schemes operating there.

- For scheme one (applying to veterans serving prior to 1974) it recommended that dependants of veterans receiving a disability pension at the time of their death should receive some compensation, but at a reduced rate (50 per cent of the pension the veteran was receiving). This was on the basis that the role the spouse had played during the veteran's life should be acknowledged, but that, because scheme one was for veterans who had served prior to 1974, there was less rationale for a generous payment — the veterans covered by this scheme had not had their life cut significantly short by service.
- For scheme two, it recommended narrower eligibility — dependants would receive benefits only if veterans died during qualifying service, within 10 years of service from a condition that was attributable to service, or more than 10 years from an accepted late onset condition. This is more generous than similar provisions in the United Kingdom system of 5 years and in the case of Canada, 30 days. There is no automatic eligibility under this approach — death needs to be closely related to service. The Law Commission noted 'when non-veterans are dying at a similar age of the same condition, the provision of entitlements, such as compensation, to a surviving spouse does not seem justifiable. Elderly surviving spouses are financially provided for by the Government's income support and disability services' (NZLC 2010, p. 227).

Automatic access to benefits for dependants had a stronger rationale at the time they were introduced. At the time, the welfare and health systems were not as well established, and veterans (almost exclusively men) were often the sole income providers. There is also some evidence to suggest that veterans had a shorter life expectancy than non-veterans (chapter 15). These rationales no longer hold.

The Commission is not proposing removing automatic access to benefits for dependants under the VEA. Under the VEA, benefits are provided almost exclusively as pensions, and the benefits available provide for an extension of (some) pension to a spouse upon the death of their partner. While the rationale for this compensation is weak, the Commission does not see a strong case for its removal. This means that the dependants of the close to 30 000 veterans on the SRDP will become eligible for benefits in the future.

However, the provision of automatic compensation is difficult to justify under the MRCA. Veterans can receive a lump sum permanent impairment compensation payment, which is intended to cover their pain and suffering over their entire life expectancy. There is no solid grounds for providing an additional lump sum payment to dependants upon the veteran's death, if it is not related to service. Doing so is very beneficial, and results in inequities — for example, less compensation could be provided for a veteran who is killed in service than a veteran with the same circumstances who is impaired in service, and later dies in an unconnected, non-service-related incident.

The automatic eligibility for benefits for dependants should be removed from the MRCA — dependants should only receive benefits if DVA accepts liability for the veteran's death.

Some support would still be available to other widow(er)s, including bereavement payments, the funeral allowance, and potentially superannuation reversionary pensions or lump sums.

This reform would be designed to target payments towards those most in need of support. The effect of the reform is likely to be minimal in the short term — as noted above, the majority of dependants under the MRCA are receiving benefits due to service-related deaths. The effect would be higher in the long-term, as MRCA veterans begin to die from age-related diseases.

DRAFT RECOMMENDATION 13.7

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* (MRCA) to remove automatic eligibility for benefits for those dependants whose partner died while they had permanent impairments of more than 80 points or who were eligible for the MRCA Special Rate Disability Pension.

The additional death benefit

The benefit received by wholly dependent partners upon the service-related death of a veteran (or the death of a veteran on certain benefits) under the MRCA has two components.

- First, the partner can receive a weekly payment based on the VEA war widow(er)s' pension, which can be converted to a lump sum.
- Second, partners can receive an additional lump sum if the veteran died due to a service-related death. This MRCA lump sum is age adjusted if the partner is over 40.

The MRCA Review considered the rationale for these two separate payments, and recommended that they be combined, noting that:

The Committee recognises the beneficial nature of the MRCA's death benefit package when compared with other statutory compensation schemes. However, the complicated nature of the package means its value is not always readily apparent or easily understood. The Committee believes that a single lump sum payment to wholly dependent partners would be more easily understood than the existing, complicated arrangement. (Campbell 2011b, p. 96)

The Commission agrees. Having two separate payments adds needless complexity to the system, and obscures the true value of the benefits for dependants available under the MRCA. Combining the payments would also provide greater flexibility for veterans — it would allow them the option of taking the whole package as either a weekly benefit or a lump sum, rather than being required to take a component of the package as a lump sum.

The current additional lump sum is equivalent to between \$90 and \$130 per week, depending on the age and gender of the partner — likely to be about \$115 per week for most people. The wholly dependent partner payment where DVA has accepted liability for the death of the veteran should be increased by this amount to compensate for the removal of the additional payment.

DRAFT RECOMMENDATION 13.8

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to remove the additional lump sum payable to wholly dependent partners of veterans who died as a result of their service. The Australian Government should increase the wholly dependent partner compensation by the equivalent value of the lump-sum payment (currently about \$115 per week) for partners of veterans where the Department of Veterans' Affairs has accepted liability for the veteran's death.

14 Streamlining and simplifying additional payments

Key points

- There is scope to streamline and simplify additional compensation payments to better target benefits (so they are based on need) and remove inefficiencies.
- Payments that are in addition to general compensation, should have a good rationale and they should achieve their stated objectives without giving rise to unnecessary complexities.
- Some payments add unnecessary costs and needless complexity to the support system. These payments should be removed or consolidated with underlying payments.
 - The Defence Force Income Support Allowance (a payment made by the Department of Veterans' Affairs to people whose social security payments are reduced or not payable because of disability/permanent impairment pensions) moves costs between government departments, generates administrative burden and creates confusion for veterans. This allowance should be removed and the Department of Social Services should exempt qualifying compensation payments from income tests for welfare payments.
 - The education schemes should be extended to those students currently covered by the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* and consolidated with their equivalent youth allowance after the age of 16.
 - The pension supplement subsidiary payments (replacement of the pharmaceutical allowance that is not covered by the Pension Supplement) should be consolidated with permanent impairment payments, disability pensions and dependant benefits through a proportional increase.
- Some of the additional payments made to veterans and their families lack a clear objective and/or the coverage is wider than what is necessary to achieve its objective.
 - The energy supplement for compensation payments should be removed. It was put in place to cover the additional cost of the carbon tax (that is no longer in place) for income support recipients.
 - The vehicle modification scheme under the *Veterans' Entitlements Act 1986* is overly generous (eligible veterans can purchase a new car every two years) and it is not needs-based. It should be aligned with the modern *Military Rehabilitation and Compensation Act 2004* equivalent which is needs-based.
- Some payments are poorly targeted and inconsistent — these should be changed to improve their effectiveness and equity through harmonisation across Acts. For example, the *Military Rehabilitation and Compensation Act 2004* attendant and household services should replace the outdated *Veterans' Entitlements Act 1986* attendant allowance.
- Going forward, the veteran support system should not have additional payments added unless there is a clear objective that cannot be met by general compensation payments.

Veterans and their families can be entitled to ‘additional’ payments — that is, payments that go beyond the main income replacement (economic loss), impairment compensation (non-economic loss) and dependant compensation. As outlined in chapter 12, additional payments can cover educational costs for children, allowances for damaged clothing and vehicle modifications. This chapter looks at the benefits and costs of the range of additional payments, and ways to simplify and better target these payments.

14.1 The benefits and costs of additional payments

Additional payments are typically provided to cover extra costs that some veterans and their families face that are not covered by general compensation. Some people in particular circumstances can require different levels of support and face additional costs. Amputees, for example, can have additional care and assistance needs (their vehicles may need to be adapted and they could require assistance with cooking and cleaning) that are not covered by general compensation (box 14.1). As the Pension Review Report background paper of 2009 said:

Supplementary payments provide a way of ensuring that people with additional costs achieve a similar standard of living.

Supplements recognise specific costs faced by particular groups which have not otherwise been met through direct services and which cannot reasonably be met out of the basic payment alone. (Harmer 2009, p. 10)

As discussed in chapter 12, there are a range of payments that make up the compensation package for veterans. Across the three Acts there are additional payments that are paid at different amounts, at different times, and have different eligibility criteria.

While additional payments can help people meet the costs of additional supports, these payments can also increase complexity and costs, including administrative costs, and can make the system more difficult for veterans and their families to navigate. As the Returned & Services League of Australia (RSL) National Office said:

When looked at in their totality, the range of entitlements and support available to veterans is overwhelming and confusing ... (sub. 113, page 30)

The RSL’s observation underscores the point that the system can be so difficult to navigate that veterans and their families need a trained advocate to help them manage a claim.

Additional payments also have budget implications. It is therefore important that the benefits of any additional payments outweigh the costs (including the cost of complexity) and that any compensation is paid in the most efficient way (figure 14.1).

Box 14.1 Additional needs of amputees

Amputees are a cohort of permanently impaired veterans who can have specific needs. And while anyone who is permanently impaired can face additional costs because of their impairment, amputees can face several big-ticket items because of their impairment that go beyond incidental living costs.

Modifying vehicles

Amputees can face additional costs to modify their vehicles so they can drive themselves (steering aids, hand controls and pedal adjustments that need to be fitted by an approved engineer and endorsed on their driver's license) or be transported by family and friends (lowered floored minivans and equipment to secure a wheelchair). These modifications can be a large expense.

Attendant care and household services

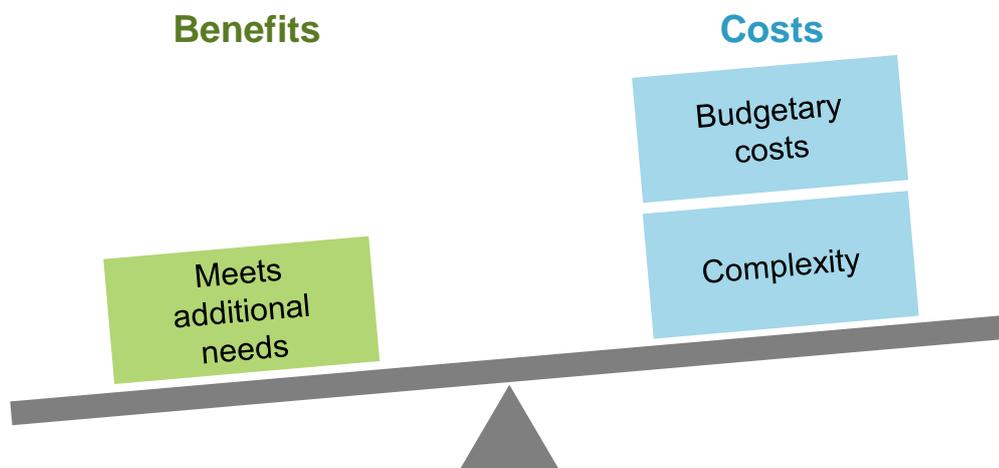
Amputees may need additional assistance to manage their own personal care. This can be simple and short term assistance — such as recovering after minor surgery — or more complex and ongoing assistance that can vary with the individual's circumstances. It can include assistance with personal hygiene, grooming, dressing, feeding and general assistance for living with a severe injury.

They may also require help with the running and maintenance of their household. This can include meal preparation, cleaning, laundry and shopping. Again, these services may be required for a short period or ongoing.

These services are highly variable in both needs and costs and so require a highly-targeted approach.

Figure 14.1 **Weighing up the costs and benefits**

The benefits should be substantial enough to outweigh the costs



Some participants called for the additional allowances to be rationalised. For example, RSL Queensland, noting that ‘the range of benefits is extensive and not necessarily well understood’, said:

The various allowances available under the VEA [*Veterans’ Entitlements Act 1986*] should be reviewed and rationalised using a ‘better off overall’ methodology. (sub. 73, p. 29)

Many of the payments available to veterans are outdated (often having remained unchanged since the 1920s), do not meet their intended objectives, and result in another layer of complexity in the veteran compensation system. These payments are in need of reform through simplification, streamlining or updating to better meet their objectives.

Questions the Commission asked when assessing additional payments

The Commission’s assessment of the range of additional compensation payments available to veterans and their families, involved asking the following questions:

1. What is the rationale for the payment (and is it still relevant)?
2. Does the payment achieve its objectives?
3. Could the costs of the payment (including the costs of complexity) be reduced or the benefits increased (including by improving targeting, figure 14.2)?

Based on the answers to these three questions, the Commission identified eight additional payments (from the full list of additional payments) that should be reformed (table 14.1).

Figure 14.2 A framework for assessing additional payments

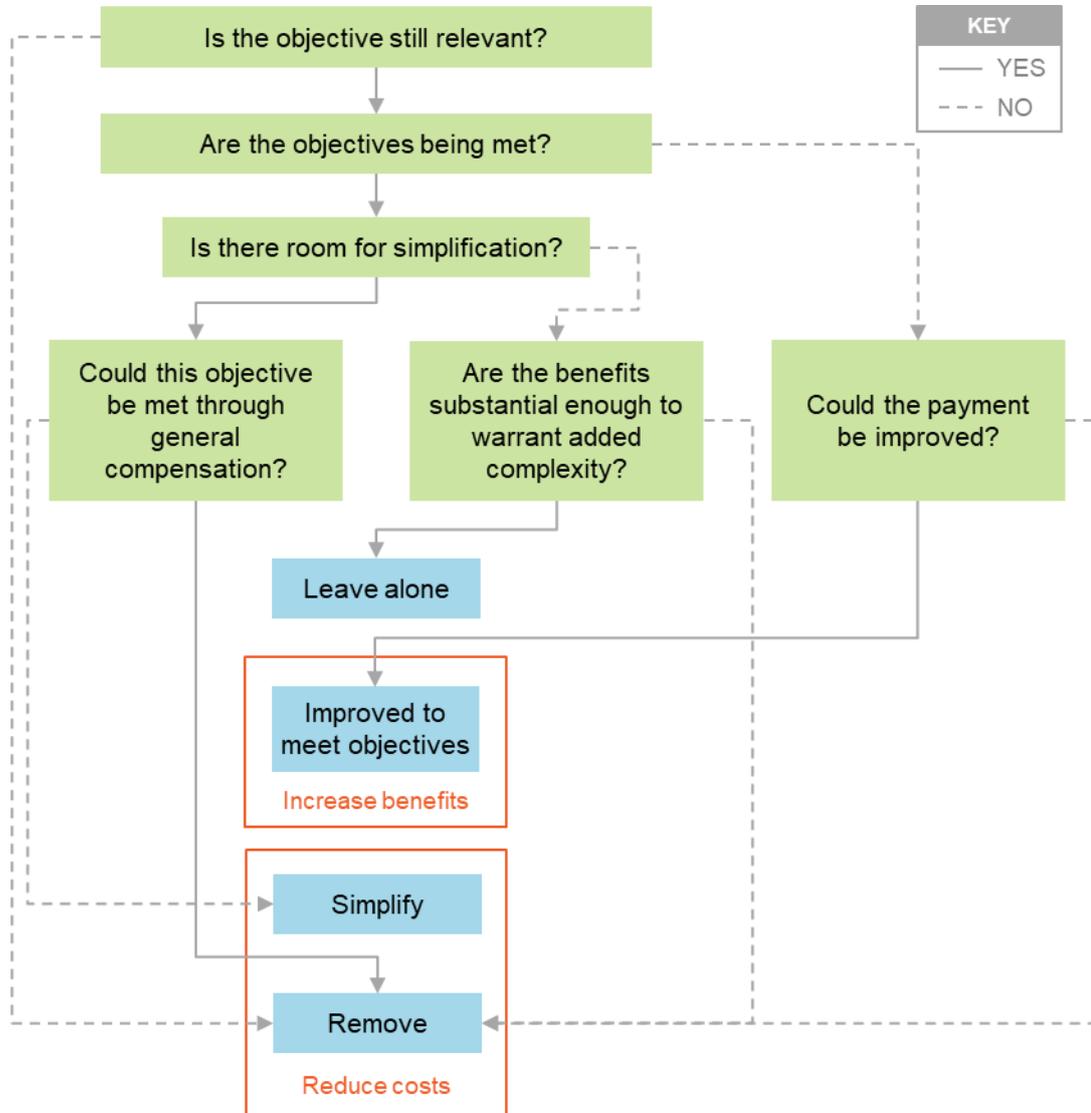


Table 14.1 Summary of additional payments assessment

<i>Payments</i>	<i>Needs simplifying</i>	<i>There is justification for removal or consolidation</i>	<i>Needs better targeting</i>	<i>Increases harmonisation across Acts</i>
Defence Force Income Support Allowance	✓			
Education payments	✓			✓
Supplements	✓	✓	✓	
Decoration allowances		✓		✓
Clothing allowance		✓		✓
Recreation transport allowance		✓		✓
Attendant and household care			✓	✓
Vehicle modification			✓	✓

14.2 Options for reform

There are two broad reform options for additional payments:

- simplifying and streamlining payments (and removing payments that no longer have a strong rationale)
- better targeting of payments based on need.

Simplifying payments

The Defence Force Income Support Allowance (DFISA), DFISA Bonus, and DFISA-like payments

The Department of Social Services (DSS) treats Department of Veterans' Affairs (DVA) payments as income and can reduce a person's income support payments if they are also receiving these DVA payments. For economic loss payments (replacement of income), this

is the end of the process. However, impairment compensation has a more complex arrangement with how it interacts with DSS payments.

Veterans' Entitlements Act 1986 (VEA) and *Military Rehabilitation and Compensation Act 2004* (MRCA) disability pensions, and MRCA permanent impairment payments ('adjusted disability pensions') attract reimbursement through DFISA (box 14.2). This is essentially a roundabout way of exempting adjusted disability pensions from DSS income tests (figure 14.3). The service pension income test directly exempts adjusted disability payments.

Box 14.2 An example of how DFISA works in practice

A veteran receiving the age pension

A 65 year old veteran is receiving a special rate disability pension of \$1408 a fortnight under the *Veterans' Entitlements Act 1986* and does not have any other income. He does not have qualifying service and therefore cannot apply for the service pension (which exempts adjusted disability pensions from its income test), but instead, is eligible for the age pension (which includes adjusted disability pensions in its income test).

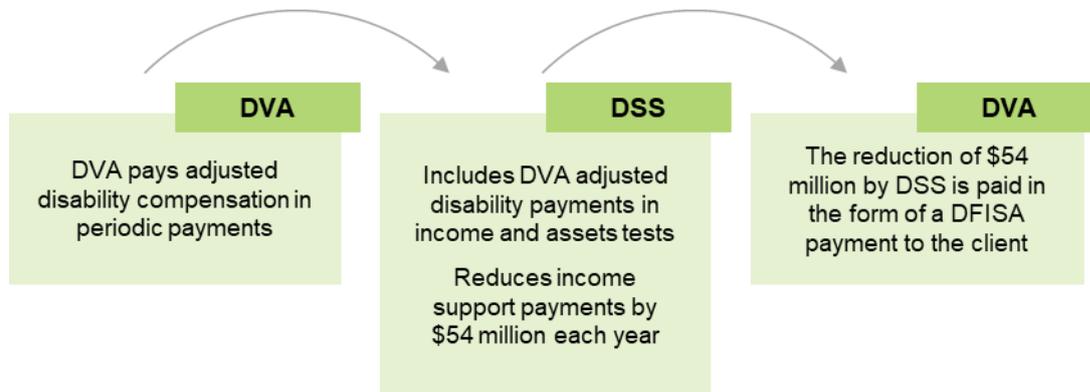
His special rate pension is included in the income test for the age pension which reduces the maximum rate for a single person from \$916 to \$415 a fortnight. The difference of \$501 is then calculated by the Department of Social Services and the figure sent to the Department of Veterans' Affairs. The Department of Veterans' Affairs then pays this amount out in the form of a DFISA payment along with the special rate pension. The Department of Social Services, usually on a different day, will pay the reduced age pension of \$501 to the veteran.

There are similar payments for veterans claiming the age pension bonus under DSS, called the DFISA Bonus. And a DFISA-like payment, which covers payments in a similar way that are not technically under DSS legislation. For example, ABSTUDY is administered by the Department of Agriculture, rather than DSS and is excluded from DFISA, but is covered instead by DFISA-like payments.

DFISA also allows those who have their payment under DSS reduced to nil, but are paid greater than nil through DFISA, to receive fringe benefits such as concession cards and supplements.

Currently about \$54 million is being offset by DSS and then paid out by DVA every year. There are about 14 000 people who receive periodic DFISA payments a year (Productivity Commission estimates based on unpublished DVA data).

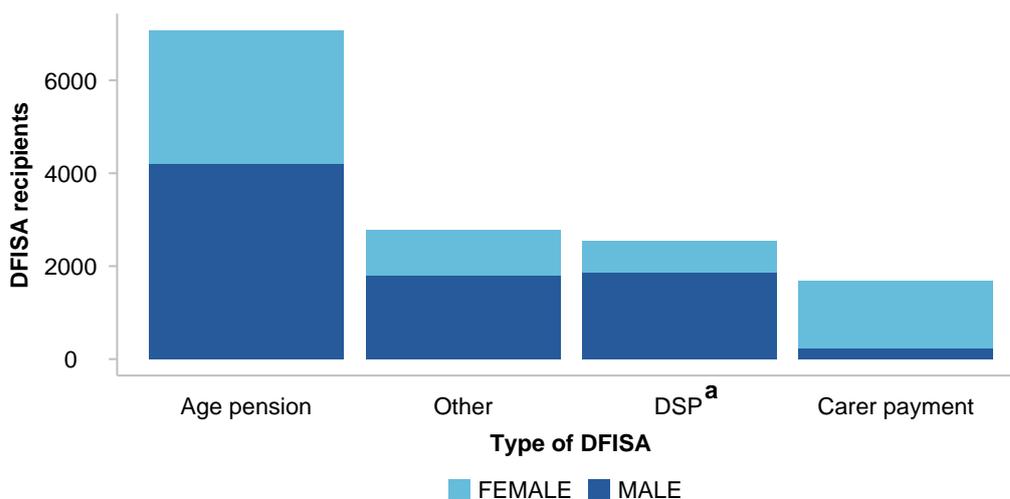
Figure 14.3 The DFISA process



Most income support payments, including the age pension, the disability support pension and carer payments, attract DFISA (figure 14.4). Recipients of the age pension are by far the largest group of DFISA recipients. A large percentage of this group are women who receive no other payments from DVA except the DFISA payment (because their partner is receiving an adjusted disability pension). They would also be receiving a reduced age pension from DSS.

Figure 14.4 Who receives DFISA payments?

The most common income support payments that attract DFISA



^a Disability support pension

Source: Productivity Commission estimates based on unpublished DVA data.

What is the rationale for DFISA payments?

The DFISA payments have their genesis in the treatment of war pensions (the precursor to disability pensions) in income tests for the service pension. While initially war pensions were regarded as income for the purpose of receiving a service pension, this was relaxed progressively over time. In 1973, the service pension exempted 25 per cent of the war pension from income assessment. This was increased to 50 per cent in 1975, and then to 100 per cent in 1982 following a recommendation of the Toose Report (1975). This recommendation reflected the fact that compensation payments were not regarded as income for taxation purposes and therefore should not qualify as income for the purpose of a means tests (Toose 1975, p. 404). However, war pensions were still considered as income for the purposes of Commonwealth rent assistance payments paid by DVA.

The exemption created an anomaly because disability pensions were not considered as income for the purpose of the service pension, but were considered as income for the purpose of DSS payments, such as the almost identical age pension. In 2003, the Clarke Review recommended extending the exemption of disability compensation from income tests to all income support payments.

In the Committee's view, disability compensation payments under either scheme should not be assessed as income in any means tests applied under the VEA or the social security system. (Clarke, Riding and Rosalky 2003, p. 629)

The Australian Government accepted this recommendation and created the DFISA to effectively exempt this compensation. However, although the Clarke Review explicitly recommended rent assistance be included, it was not adopted, and rent assistance is currently not covered by DFISA. The rationale for excluding rent assistance but including other forms of income support is unclear and appears to be inconsistent with the principles of DFISA.

While exempting workers' compensation payments from welfare income tests is unique to the veterans' compensation scheme, there is some rationale for DFISA.

- First, there is an argument that impairment compensation should not be considered as income because it is for pain and suffering, rather than economic loss. This is similar to the argument made by Toose and the Australian Government at the time to exclude this compensation from the service pension income test.
- Second, it is unique to the veterans' compensation scheme that impairment compensation is paid as a periodic payment, rather than a lump sum. Lump sum payments would only be considered in the asset test, which is considerably higher than the equivalent income test, especially when used to purchase a family home. Veterans taking a periodic payment could be substantially worse off without DFISA because of their reduced income support payments compared to those who take a lump sum.

However, there are also arguments against the full exemption of adjusted disability pensions from income tests. First, unlike MRCA, the special rate disability pension under the VEA does not explicitly distinguish between permanent impairment and incapacity payments

(chapter 12). There is some justification for the exemption from income tests for this payment (the permanent impairment part), but not all (the incapacity part). As the special rate disability pension is presumed to be a mix of these two payments, it is hard to decipher how much of it is permanent impairment compensation that should be excluded from income tests, and how much is income replacement that should be included. The MRCA and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) explicitly distinguish between these forms of payments. The Commission is not proposing a change in this area.

Second, there may be cases where someone who takes a lump-sum payment could be left worse off than someone who takes a periodic payment under the current arrangements. This would be the case where the level of the lump sum results in a person exceeding the assets tests for income support payments, or where the person invests the lump sum to generate a periodic income stream, which would then be considered in the income test. Again, the Commission is not proposing a change in this area.

DFISA achieves its objectives, but the costs of administering it could be reduced

While DFISA achieves its objectives, the way it is implemented creates a layer of confusion and adds unnecessary administrative burden. The current arrangements mean that costs are simply passing from one government agency to another. As RSL Queensland (sub. 73, p. 33) said, DFISA is ‘confusing and apparently difficult to administer’.

TPI Federation Australia went further and described some of the complications that can arise from an inefficient exemption system:

There is also an issue where a non-operational DVA client who HAS to deal with Centrelink is advised by them that there is an overpayment. This needs to be repaid via the Centrelink Disability Pension. Because there was an overpayment with this payment then the DFISA from DVA also has an overpayment. This has to be recovered from the DFISA payment. If a DVA client wants to query this overpayment, then Centrelink advise that DVA should be contacted and then DVA advise that Centrelink should be contacted. There is never a resolution. (sub. 134, att., p. 4)

Similarly, RSL Queensland said that:

... the importance of not requiring a veteran to deal with two separate Government Departments in order to obtain basic benefits should be foremost in the focus of those responsible for veterans’ wellbeing. (sub. 73, p. 33)

Veterans may also not know which department to talk to about their DFISA payments as different departments handle different parts of the processes (including debt recovery from overpayments that need to be made to both departments) depending on the circumstances.

People receiving income support from DSS can receive their income support payment on any of the 10 working days in a fortnight. DVA’s payments, however, are only paid on one of those days. This can mean someone receives their reduced age pension one week and their

DFISA payment another week. This can create a confusing payment situation and could make it more difficult for recipients to plan ahead (because of uncertainty about when they will receive their payments) and to repay overpayment debt.

Options for reform

There is room to simplify the system for veterans, their families, the advocates and for DVA administration by removing a layer of complexity that does not add any benefits — DFISA should be removed.

The first option is to remove DFISA without adding any exemptions. However, as noted above, there are some rationales for exempting adjusted disability pensions from means testing. This option would also see many veterans worse off — and in the case of veterans currently receiving the special rate of disability pension and a welfare payment, substantially so. It would also create inequities and an inconsistency with the service pension, which currently exempts adjusted disability pensions from its income test — the mostly equivalent age pension includes adjusted disability pensions in its income test.

The second option is for DSS to exempt all income support payments currently covered by DFISA directly. This would achieve the same result as the DFISA payment without the added complexities. The main difference would be that the payments would be made by DSS in full rather than DVA paying the difference.

Rent assistance eligibility will not be affected much as, although eligibility for rent assistance would be expanded due to direct access to income support payments through DSS, adjusted disability pensions would still be included in the rate of reduction in rent assistance due to income. The Commission is not recommending a change in this area.

DFISA is a complicated way of exempting periodic adjusted disability pensions from income tests by DSS. DSS should add an explicit exemption for these payments to help streamline the existing system.

DRAFT RECOMMENDATION 14.1

The Australian Government should amend the *Social Security Act 1991* and relevant arrangements to exempt Department of Veterans' Affairs adjusted disability pensions from income tests for income-support payments that are currently covered by the Defence Force Income Support Allowance (DFISA), DFISA Bonus and DFISA-like payments. The Australian Government should remove the DFISA, DFISA Bonus and DFISA-like payments from the *Veterans' Entitlements Act 1986*.

Education schemes

Financial assistance, student support services, and guidance and counselling services are available for eligible students (dependent children of veterans who are either permanently impaired or who have died as a result of service). These are available through the Veterans' Children Education Scheme (VCES) under the VEA and the Military Rehabilitation and Compensation Act Education and Training Scheme (MRCAETS) under the MRCA.

There are different rates of payment for students in primary school, secondary school, and tertiary education. Education payments are not income tested, unlike youth allowance under DSS (although MRCAETS requires that the student is not working full time). The rates for tertiary education students are equivalent to those of the income-tested youth allowance under DSS — students of veterans covered by DRCA have to apply for youth allowance.

There are currently about 2600 dependants receiving payments under VCES and MRCAETS at a cost of about \$20 million each year (DVA 2018f, pp. 22, 217).

Do the education payments achieve their objectives?

VCES replaced the Soldiers' Education Scheme in 1986 and rates were aligned with youth allowance in 1989 for students 16–25 years old (the current arrangement). The income test for students over 16 years was abolished in 1993 as the scheme was seen as compensation rather than income support for those studying. While initially straightforward, the Australian Government extended family tax benefit (FTB) in 2012 to those aged 16–19 and still in full-time study, which complicated the arrangements.

For dependants under 16 years old, the education schemes provide additional support in a relatively straightforward manner. These dependants can receive education payments in addition to other income support, such as FTB. For these dependants, the scheme appears to be meeting its objectives.

However, this is not the case for dependants over 16 years old. The only additional benefit that eligible students can receive is not being subject to the income test. Therefore, this payment is only benefiting high income families that would not qualify because of the income test under youth allowance (youth allowance is covered by DFISA).

When a dependant turns 16, the education payment is considered as income for the purposes of the income-tested FTB payment — essentially, dependants can only access one payment or the other, but not both. This means that families are faced with a complex choice between an education payment or the FTB once the eligible young person turns 16 years old (box 14.3).

Participants to this inquiry said the arrangements were confusing and that people are switching to FTB when dependants reach 16 years of age then switching back to education payments

when FTB eligibility ends at 19 years of age or the dependant begins tertiary education (figure 14.5). The Partners of Veterans Association of Australia, for example, said:

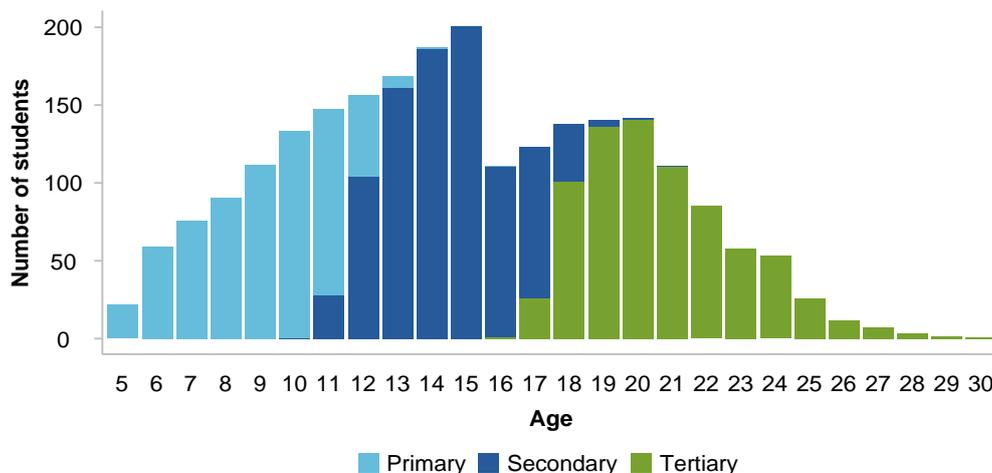
There are an additional unknown number of high school students in this age group who have opted for Centrelink’s Family Tax benefits instead of DVA’s education allowances. It is thought there are probably another 250-280 students who might return to the Scheme as tertiary students once they finish year 12 and the Family Tax Benefit cuts out. (sub. 77, p. 2)

Box 14.3 Example of complex pathways

John, a dependant of a permanently impaired veteran on the special rate under the *Veterans’ Entitlements Act 1986* (VEA), has just turned 16 years old. He currently lives at home and is enrolled in secondary school. Up until this point, John’s family had been receiving an education payment of \$56 each fortnight under VEA Veterans’ Children Education Scheme (VCES) and the maximum rate under the Family Tax Benefit (FTB) Part A of \$238 each fortnight.

Once John turns 16 years old, he must be studying full time to be eligible for VCES. In addition, the FTB and education payments cannot be paid together so the family must make a choice. This choice is a difficult one to make. John would likely remain at home while in secondary school and the family would opt for the FTB, as it can be more beneficial (because of other benefits such as rent assistance). When the FTB cuts out at 19 years old, if John goes to tertiary education he is able to collect the education payment from the Department of Veterans’ Affairs. This would be the better option as there is no income testing, but it would mean that John and his family have to go back and forth between agencies depending on their circumstances for no clear benefit (except if John’s family has a higher income, then it would be beneficial to have the exempted payment).

Figure 14.5 Eligible young people receiving education payments^a
Three year average — December 2015–17



^a Education payments can continue for those over 25 if their course has not yet been completed.

Source: Productivity Commission estimates based on unpublished DVA data.

Because after the recipient reaches 16 years of age, the education schemes mirror youth allowance with the exception of income testing, the additional support would be going to those families who are relatively better off. Youth allowance also offers additional support for those under 22 and looking for work that the DVA education schemes do not. Given the complexities involved, it is not clear that these schemes are well targeted, or have net benefits.

The confusion for veterans and their families is amplified when dependants receive an orphan's pension under the VEA or equivalent under MRCA. Before 16 years of age they can receive education, FTB and orphan's payments all at the same time. After 16 years of age, it becomes more complex. A dependant can receive the education and orphan's pension at the same time under the MRCA, but not under the VEA. The DRCA adds more complexity with all three Acts paying different rates of orphan's pensions at different times and with different eligibility rules.

Options for reform

Providing an over-16 years education payment that is almost identical to youth allowance is needlessly complex, especially when the FTB is also available. Removing payments for over-16 year old students in favour of youth allowance would better target those in need of education assistance and simplify the process.

If this was the case, then education assistance, like counselling and tuition, would still be available to these same students. This is currently the case for students not receiving an education payment under the VCES or MRCAETS but who are eligible — they can still receive additional assistance such as tutoring and counselling services. These services are also currently available to students of veterans covered by DRCA, who would have to apply for youth allowance.

While removing this payment would reduce access to education payments for some (higher-income) families, this could be offset by an increase in compensation to some other families. Currently, dependants of veterans covered under DRCA do not get access to education payments. There are reasons — such as equity and harmonisation across the Acts — to allow access to education payments for these students (if they are under 16 years of age).

The trade-off between reducing access to higher income families after 16 years of age and introducing payments for DRCA families under 16 years of age would remove complexities, harmonise benefits between Acts, and better target those in need.

DRAFT RECOMMENDATION 14.2

To align education payments across the veteran support system, the Australian Government should amend the *Veterans' Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004* to remove education payments for those older than 16 years of age. Those who pass a means test will still be eligible for the same payment rates under the Youth Allowance.

To extend education payments for those under 16 years of age, the Australian Government should amend the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to adopt the Military Rehabilitation and Compensation Act Education and Training Scheme.

Supplements

The two main supplements available to veterans and their families are the energy supplement and the various pension supplements (chapter 12).

The energy supplement (formerly the Clean Energy Supplement), was introduced in 2013 (when the carbon tax was introduced with the Clean Energy Act 2011) to assist income support recipients with the increased energy costs. The rates have been frozen since 2014 (since the repeal of the carbon tax with the *Clean Energy Legislation (Carbon Tax Repeal) Act 2014*). In September 2016, the Government closed the energy supplement to new recipients of Family Tax Benefit Part A and Family Tax Benefit Part B; and to new recipients of the Commonwealth Seniors Health Card.

There are different rates of the energy supplement that are attached to a number of DVA payments and benefits — namely income support payments and impairment compensation (disability and permanent impairment payments). DVA clients can only receive more than one energy supplement if they are receiving an income support payment and a DVA impairment compensation payment.

The pension supplements have a different genesis. In September 2009, DSS payments were changed to consolidate the pension supplement (intended in 2000 to account for the effects of the GST) with other smaller payments to help simplify the system. It combined the former telephone, internet, utility and pharmaceutical supplements into the pension supplement. And while the process simplified DSS payments, it added complexity to the veteran support system. This is because some DVA clients were not eligible for the pension supplement who were previously entitled to the pharmaceutical allowance. To account for this discrepancy there were three additional supplements, one for each Act, put in place: the MRCA Supplement, DRCA Supplement and Veteran Supplement. These essentially replaced the pharmaceutical allowance to help cover the cost of co-payments for medication for those who cannot receive the pension supplement.

The rationale for supplements

The energy supplement was put in place to help clients with higher energy costs as a result of the carbon tax. The carbon tax, however, is no longer in place.

The pension supplement, and the subsequent additional supplements, were designed to consolidate a range of supplements designed to help with the cost of living expenses.

The rationale for extending supplements to veteran payments is weak.

- First, if supplements are needed to assist with the cost of certain expenses, it is unclear why this could not be achieved through an increase in the underlying payment, rather than as a separate payment.
- Second, while there is some rationale for attaching cost of living compensation to income support payments — such as the service pension — there is no rationale for attaching such supplements to impairment compensation. These payments are not designed to cover living expenses — rather, they are compensation for pain and suffering.

Separate supplements add to administrative burden without benefiting veterans and their families. For example, someone who receives a permanent impairment lump sum under MRCA will continue to have their fortnightly MRCA supplement paid at the low rate of \$6.20 or the high rate of \$12.40 for the rest of their lives — this makes little sense. Similarly, those who access the White Card for non-liability health care and do not receive any other payment are also entitled to this supplement of \$6.20 a fortnight.

The supplements are needlessly complex.

- The supplements are sometimes included in the underlying payment and sometimes not.
- Supplements can be subject to different levels of indexation than their underlying payments that can result in extra complications when trying to remove or roll-in the payment.

In 2015, the report of the Reference Group on Welfare Reform to the Minister for Social Services summed up the current state of supplements in the Australian welfare system:

Some supplements have a strong rationale while others have remained in the system long after the rationale has passed. In some cases, more than one supplement is performing equivalent roles. In many cases, there is no reason why the supplement cannot be rolled into the primary payment. (2015, p. 48)

The Commission agrees with this analysis and finds little or no rationale for the structure of the payments that adds to confusion and the complexity of the system with no additional benefits to doing so.

Options for reform

These payments should be rolled into their underlying payments or removed. This would:

- address the issue of different indexation and supplements being paid on their own
- make the compensation arrangements simpler for veterans to use and for DVA to administer.

The Reference Group on Welfare Reform to the Minister for Social Services noted on the broader welfare system:

In the current system, it is not clear why some costs or activities are supported through supplements and others are supported through the payment system or through services. In some cases, the costs of certain goods or services are covered in part by both payments and supplements.

For example, some supplements cover general costs of living such as telephones or utilities. In moving to a simpler and more coherent system, it would make sense for the main payments rather than supplements to cover general costs of living.

Other supplements that go to the majority of income support recipients such as the Energy Supplement should be rolled into the five main payments. (2015, p. 92)

The Commission agrees. This logic should be followed in the veteran support system going forward. As the Reference Group points out, this is a broader system issue that needs to be addressed. However, there are some specific changes that can be made within the veteran support system:

- the various pension supplements should be consolidated with the underlying payments
- the energy supplement should be removed from impairment compensation payments.

First, the pension supplements should be rolled into their underlying payments. There is little justification for having a complex array of supplements that cover general living costs and even less rationale for having them attached to impairment compensation. The DRCA, MRCA, and veteran supplements should be removed and the underlying payments increased by their relevant amounts. This would simplify the system for veterans and their families, and for DVA to administer. It should be noted that those with non-liability health care cards that do not meet the threshold for compensation would miss out on this payment as there is no underlying payment to attach it to. This would leave this group worse off by a small amount. Those with any claim above non-liability coverage would have it included in their underlying payment and some groups would be receiving an extra supplement, as this amount is already included in the main Pension Supplement.

Second, there is little rationale for an energy supplement for impairment compensation (non-economic loss payments) which are not designed to help with the cost of living. This should be confined to income support payments, which *are* designed to help with the cost of living. Those who are receiving an impairment compensation payment and are eligible for income support would be able to access this payment, just not twice. Those who do not

qualify for income support but receive impairment compensation would no longer receive this supplement.

Going forward, supplements should be carefully considered along with their complexities. The Australian Government should follow the recommendation by the Reference Group on Welfare Reform to the Minister for Social Services that ‘supplements ... should be for clearly defined purposes and specific extra costs’ (2015, p. 93).

DRAFT RECOMMENDATION 14.3

To help simplify the system, smaller payments should be consolidated where possible or removed where there is no clear rationale.

The Australian Government should remove the DRCA Supplement, MRCA Supplement and Veteran Supplement, and increase clients’ payments by the equivalent amount of the supplement.

The Australian Government should remove the Energy Supplement attached to Department of Veterans’ Affairs’ impairment compensation, but other payments should remain consistent with broader Energy Supplement eligibility.

Consolidation of small and outdated VEA payments

There are a number of outdated payments under the VEA that have a long history dating back to the 1920s. They include the decoration allowance, the recreation transport allowance and the clothing allowance. Some of these payments are small — for example, the decoration allowance is \$2.10 each fortnight and has only been indexed once since its inception. And some of these payments require additional individual applications (where many eligible may not apply).

These allowances no longer have a clear rationale and should be removed to facilitate a simpler system and one that is closer aligned with the modern principles of the MRCA.

Although not a significant source of complexity by themselves, they do add another layer to the system and inconsistency across the Acts. As RSL Queensland said:

Consideration should be given to making lump sum payments available if requested by the veteran for allowances such as Decoration Allowance, Victoria Cross Allowance and Recreational Transport Allowance. (sub. 73, p. 29)

And the added complexity is for little benefit, as the payments are poorly targeted and outdated. As a result, they were not retained under the MRCA. While the budgetary impost is low — the Commission estimates, using unpublished DVA data, that the cost of payments is \$1.5 million each year — there is little case for their retention.

That said, current recipients of these payments should not be made worse off. The Commission considers that these recipients should receive a one-off, age-adjusted,

lump-sum payment instead of receiving the periodic allowances. The payments would be closed for new recipients.

DRAFT RECOMMENDATION 14.4

To streamline and simplify outdated payments made to only a few clients, they should be paid out and removed. The Australian Government should amend the *Veterans' Entitlements Act 1986* to remove the recreation transport allowance, the clothing allowance and the decoration allowance and pay out those currently on the allowances with an age-adjusted lump sum.

Targeting and streamlining services

There are payments and services under the veteran support system that require improvements in the targeting of compensation to better meet their objectives, rather than simplification. This section outlines how a better targeted approach can help meet the complex requirements of veterans with extra needs.

VEA attendant and household care

Under the VEA, attendant and household care is provided through an attendant allowance and a program offering home care services.

- The attendant allowance is paid to eligible veterans to assist them with the cost of attendant care (feeding, bathing, dressing and other activities of daily living). Under the VEA, there is a higher rate of \$341 and a lower rate of \$170.30 each fortnight for incapacity from war- or defence-caused conditions arising from service before 2004. The lower rate is paid for blindness, certain amputations, or for injuries or diseases that affect the brain and/or spinal system. The higher rate is paid to a veteran who is both totally blind together with loss of speech or total deafness, or has both arms amputated. The attendant allowance is paid fortnightly once eligibility has been determined, with no follow-ups for assessing changes in needs. In 2017-18, 273 people received an attendant allowance (DVA 2018f, p. 22). The Commission's estimates (based on unpublished DVA data) are that the cost of the attendant allowance was about \$1.4 million in 2016-17.
- The Veterans' Home Care (VHC) program provides a range of household and attendant services for veterans who have a White or Gold Card. The service is not intended for complex care needs, but rather to assist with smaller duties so that ageing veterans can remain at home rather than be moved into care. The veteran does not need a service-related impairment to receive access to these services. Co-payments can be required for these services.
- There are no household services available for VEA clients beyond what is covered under the VHC program, which are limited to basic household needs.

The MRCA and DRCA approach is different — household services and attendant care are provided to veterans with service connected injuries on a needs basis through reimbursement.

- Household services: maximum of \$491.67 (\$473.67) each week under MRCA (DRCA).
- Attendant care: maximum of \$491.67 (\$473.67) each week under MRCA (DRCA).

The DRCA rates are similar (but not the same due to indexation) and both caps are far higher than under the VEA, which does not offer household services. Veterans under the MRCA and DRCA can also access the VHC program, but cannot access specific services under the VHC program if they are receiving a reimbursement for household services or attendant care to avoid overlap in services. In general, the range of services that can be accessed through the MRCA and DRCA attendant care and household services are much broader than those offered through the VHC program and far more suitable for those with complex needs. These needs are assessed by a suitably qualified professional, most often an occupational therapist. When determining the reasonable requirements for care the following issues are among those considered:

- the nature of the injury, disease or illness
- the ability for the veteran to care for themselves and their household
- the need to avoid disruption to employment and other activities
- the extent to which other services are already providing support
- the extent to which a relative may be able to help.

These requirements are regularly reviewed and DVA makes a decision based on how many hours of care are appropriate. The household and attendant care services are generally paid through reimbursement and they encourage the use of professionally qualified service providers. This allows choice and control for those claiming the services to seek out their desired services with reimbursements made on a needs basis.

Household and attendant care services can be provided through either DVA or through the National Disability Insurance Scheme (NDIS) with an individual care plan, but not both.

Does the attendant allowance achieve its objectives?

The attendant allowance is designed for those who have additional care needs such as amputees (box 14.1). People with more complex needs require a targeted and flexible approach that cannot be met by general compensation. That is, increasing general disability payments would not reach those with attendant needs as effectively as possible without raising all disability payments up to the rate of the most complex case. Therefore, targeted attendant and household care services are appropriate and consistent with other schemes (such as the NDIS).

The attendant allowance was created in 1922 for certain veterans who were double amputees, blind or who had spinal injuries. These conditions were gradually expanded over time with little change since the allowance's inception. The modern day approach to attendant care has evolved since then with needs-based assessments, individualised care and consumer-directed markets (chapter 4). This type of care is most prominent in the NDIS principles.

The NDIS promoted the need for consumer choice and control, rather than an allocated amount that is intended to cover the entire cohort who all have individual and differing needs. The Commission in the 2011 Disability Care and Support inquiry said:

Even small degrees of decision-making power can lead to large improvements to a person's quality of life. Increasing the degree of choice available to people may not even require more funding – in some cases, it can lead to more efficient choices which can reduce costs. (2011, p. 151)

The evidence strongly suggests a wide range of positive wellbeing outcomes from self-directed funding for people with disabilities and their carers, including higher satisfaction with life, more independent living, better continuity of care and lower levels of abuse and neglect. (2011, p. 343)

The current VEA attendant allowance allows for choice in provider and spending, but only at two fixed rates (a low and a high rate). These rates are far below the maximum allowances under the MRCA and DRCA (which also include household services of a near equal upper limit). The MRCA and DRCA services allow for a needs-based approach as well as allowing the veteran to have choice and control of the service providers they use. These allow greater flexibility of funding allocations without the constraint of an arbitrary allowance amount. Therefore, although the attendant allowance achieves some of its objectives (giving choice and control through cash payments) it does not allow for funding levels to adjust to the needs of veterans — which would allow a better-targeted approach.

Options for reform

Alignment of the outdated VEA attendant allowance with the MRCA (the DRCA is already aligned with the MRCA except for slightly different rates due to indexation — these should be harmonised) would simplify the system through harmonisation and make a more equitable system by providing greater access for those with higher needs.

The budgetary effect of this change is likely to be small. The average payment per person for the attendant care allowance under the VEA is \$83 a week for a total cost of \$1.4 million in 2016-17 (DVA 2017d, p. 17). In comparison, under the MRCA and the DRCA, the average payment for attendant care services is \$90 a week and \$25 a week for household services.¹ If the same people applied for these services under the MRCA who are currently receiving the VEA attendant care allowance, it would be a yearly budgetary increase of about

¹ These payments are not periodic cash payments, but reimbursements and therefore not directly comparable. The estimates are also biased by people dropping in and out of the schemes during the observed period, but averages over the year can be used to give a rough estimate of the financial costs.

\$450 000. While there may be an increase in the number of people accessing the payments, barring a very large increase, the budgetary effect would likely remain small.

The change would mean that those on the attendant allowance under the VEA would have to change programs. This could be done in two ways:

- grandfathering those currently on the attendant allowance with new claims being made through the new MRCA equivalent. This would be a simple approach but would allow the payment with few people to remain for years to come
- alternatively, those on the old attendant allowance could be automatically transferred to the same level of payment (rounded to the nearest beneficial hourly rate) on the new MRCA model. This would create harmonisation immediately but would lead to a small amount of disruption for those receiving the VEA allowance. Some of these people may be able to access a higher level of payment, if they have higher needs. As there are only about 300 veterans on this payment, disruption is likely to be minimal, and this is the Commission's preferred option.

DRAFT RECOMMENDATION 14.5

The Australian Government should amend the *Veterans' Entitlements Act 1986* (VEA) to remove the attendant allowance and provide the same household and attendant services that are available under the *Military Rehabilitation and Compensation Act 2004* (MRCA).

Current recipients of the VEA allowance should be automatically put on the same rate under the new attendant services program. Any further changes or claims would follow the same needs-based assessment and review as under the MRCA.

Vehicle modifications

Vehicle modifications can be required to enable a veteran with a severe impairment to access or operate a vehicle. These can include additional requirements for wheelchair entry, exit and being able to be transported safely. They can also include specialised controls to allow operation of a vehicle.

There is a different, but similar, vehicle modification assistance scheme operating under each of the VEA, DRCA and MRCA. In addition, there is a similar assistance program under the NDIS — these are all mutually exclusive (and cannot be accessed by those receiving a recreation transport allowance).

The Vehicle Assistance Scheme (VAS) is a VEA-only scheme intended to help veterans with severe impairments (including having both legs amputated or having one leg and both arms amputated):

- purchase a motor vehicle (and a replacement vehicle every two years)

-
- running and maintenance costs
 - make driving modifications to that vehicle.

At the end of June 2018, there were 43 people receiving the VAS (DVA 2018f, p. 22).

There are similar programs under both the MRCA and the DRCA, but with some key differences. The Motor Vehicle Compensation Scheme (MVCS) that covers the MRCA does not include running costs or the purchase of a motor vehicle (or a replacement vehicle) unless there are special circumstances. The DRCA program is mostly aligned with the MRCA program.

The NDIS motor vehicle modification scheme, like the MRCA and DRCA schemes, does not provide funds for the purchase of the motor vehicle itself or the running costs, but does provide funding for the necessary modifications of the vehicle. The exception to this is when it is necessary or more cost effective to purchase a vehicle outright that has been modified rather than modifying an existing vehicle.

What is the rationale for covering the cost of vehicle modifications?

There is a strong rationale for using a targeted approach to cover the additional cost of modifying a motor vehicle. Modifying a motor vehicle is a significant additional cost to those who cannot drive or be transported in an unmodified vehicle. It does not make sense to cover this cost in general compensation as only a small number of veterans need their vehicles modified, and to varying degrees.

However, the cost of the unmodified vehicle and the normal running costs should be incurred by the veteran. These are costs that are incurred by the broader cohort of veterans and economic compensation and/or income support are designed to cover general living expenses. Eligible veterans, and those with certain types of disability of the general community, already have access to cheaper motor vehicles and parts through the GST exemption provided by the Australian Taxation Office.

Options for reform

The differences between the schemes adds extra and unnecessary complexity to the veteran support system. This could be easily solved by harmonising the schemes. The Military Rehabilitation and Compensation Commission has already agreed in-principle to align the assistance for motor vehicle modifications under all three Acts.

The MVCS under the MRCA provides similar services to other schemes, but with a more sensible and needs-based approach than the VEA. Unlike the VEA scheme, it only funds the purchase of a vehicle if an existing vehicle cannot be modified. This system removes the incentive to claim the purchase of a new car every two years while still providing

compensation based on the additional individual needs. The DRCA has a very similar program to the MRCA and could be aligned easily.

DRAFT RECOMMENDATION 14.6

The Australian Government should amend the *Veterans' Entitlements Act 1986* Vehicle Assistance Scheme and section 39(1)(d) (the relevant vehicle modification section) in the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* so that they reflect the *Military Rehabilitation and Compensation Act 2004* Motor Vehicle Compensation Scheme.

Additional payments going forward — what needs to be considered

There should be good processes in place for considering any additional compensation payments going forward. Questions that should be addressed before making any changes are:

- What is the problem being addressed or why are additional payments required?
- Why are existing compensation payments inadequate to deal with the problem?

Where there is a clear case for an additional payment, the costs and benefits of alternatives (including costs of complexity and administration) should then be assessed.

Additional payments should not be added to the system unless there is a clear rationale, and the benefits of the payments clearly exceed the costs to the community as a whole.

15 Health care

Key points

- The Department of Veterans' Affairs (DVA) fully funds health care for eligible veterans and dependants at public and private providers, including private specialists and hospitals. Access to health care is via the Gold and White health care cards. In 2017-18, about 191 000 DVA clients were eligible for treatment via a Gold or a White Card, at a cost of \$5.3 billion.
 - The Gold Card gives access to a broad range of services. It is highly valuable (to veterans), and costly (to taxpayers): the average cost is about \$23 000 per cardholder each year. And it is uncapped.
 - The White Card funds treatment for service-related conditions (as well as treatment for mental health, cancer and tuberculosis without needing to prove a link to service). It is generally well-targeted and the best vehicle for funding veterans' health care needs.
- Over time, the overriding rationale for the Gold Card appears to have become more one of compensation — providing the Gold Card as gratitude for service — than health care. The veteran community has continually sought greater access to Gold Cards, and eligibility for Gold Cards has slowly expanded up over time.
- Yet the context for health care has radically changed since the Gold Card was introduced. Australia's Medicare regime has significantly changed access to quality health care for all Australians. And the introduction and extension of the White Card provides better targeted health care supports for most veterans.
- The Gold Card is inequitable, inefficient and not needs-based or wellness-focused when provided as a form of compensation. It does not fit with the key principles that should underpin a future system. Eligibility for the Gold Card should not be extended to any *new* categories of recipients (this will not affect any current Gold Card holder or person who is entitled to a Gold Card under current legislation).
- Mental health care and suicide prevention are key areas of need. Expanding non-liability coverage to mental health care was a positive step, but DVA needs a new mental health and suicide prevention strategy to build on recent work and maintain momentum. DVA should also evaluate the effectiveness of its own mental health service, Open Arms, to ensure that its services are adequate, accessible and high-quality.
- The Coordinated Veterans' Care program, which funds coordinated care for Gold Card holders at risk of hospitalisation, is a good initiative which could be improved by better targeting and measuring of outcomes.
- Some (not all) of the fees that DVA pays health providers are below market rates and below those paid by other workers' compensation schemes. DVA has to find the right balance between paying fees that support provider participation, contain overall costs and ensure quality services. The Commission is seeking views on how to achieve the optimal balance.

In 2017-18, the Department of Veterans' Affairs (DVA) spent \$5.3 billion on health services for about 191 000 clients (DVA 2018f). About one in eight Australians aged over 85 is eligible for DVA-funded health care (DVA 2017t).

Eligible veterans, war widows and widowers and their dependants can access a wide range of DVA-funded healthcare services, pharmaceuticals and other benefits, services and appliances to assist with independent living at home, transport to medical appointments and residential aged care.

This chapter looks at:

- who gets DVA-funded health care (section 15.1) and what services DVA funds (15.2)
- the eligibility criteria for DVA-funded health care (15.3)
- the quality of DVA-funded health care (15.4).

15.1 Health care — an original feature of veterans' support

DVA issues health cards to eligible veterans, war widows and widowers and their dependants. The health cards identify eligible people and the type of health care coverage they are entitled to. There are two main health cards — the Gold Card and the White Card (there is also a third card, the Orange Card, box 15.1).

Box 15.1 Health care cards, some history

The health care card system began in 1979. It allowed eligible people to visit dentists and general practitioners of their choice, without first needing approval from the Department of Veterans' Affairs (called the Repatriation Department at the time).

In 1987, a four coloured card system was introduced:

- the yellow card was for treatment for all conditions
- the white card was for treatment for specific conditions
- the lilac card was for widows and children
- the red card was for service pensioners.

The lilac and red cards did not allow access to the same travel or pharmaceutical benefits as the yellow card.

In 1996, the yellow card became the Gold Card and those with the lilac and red cards were given Gold Cards. The White Card remained the same.

The Orange Card was created in 2002 to give access to pharmaceuticals for Commonwealth and other allied veterans living in Australia.

Sources: Bell (2002); Clarke et al (2003); Repatriation Commission (1979).

About the Gold Card

The Gold Card entitles the card holder to DVA funding for all clinically necessary health care needs for all conditions, irrespective of whether they are related to military service. (Section 15.2 covers the types of treatment a Gold Card holder can receive.)

Gold Cards are issued to:

- veterans aged over 70 with qualifying service (chapter 3) (about 7000 cardholders¹)
- veterans receiving the service pension who satisfy a means test (about 11 000 cardholders¹)
- veterans receiving a *Veterans' Entitlements Act 1986* (VEA) disability pension paid at 100 per cent of the general rate or higher — 50 per cent or above if they are also receiving a service pension (at any amount) (about 49 000 cardholders)
- veterans with conditions accepted under the *Military Rehabilitation and Compensation Act 2004* (MRCA) at above 60 impairment points — above 30 points if they are also receiving a service pension (about 1500 cardholders)
- dependants of deceased veterans who qualify for a war widow(er)'s pension, orphan's pension, or wholly dependent partner or child payment (about 62 000 cardholders)
- ex-prisoners of war (140 cardholders), British nuclear test participants and members of the British Commonwealth Occupation Force (650 cardholders).

Gold Cards are not available for impairments covered under the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA).

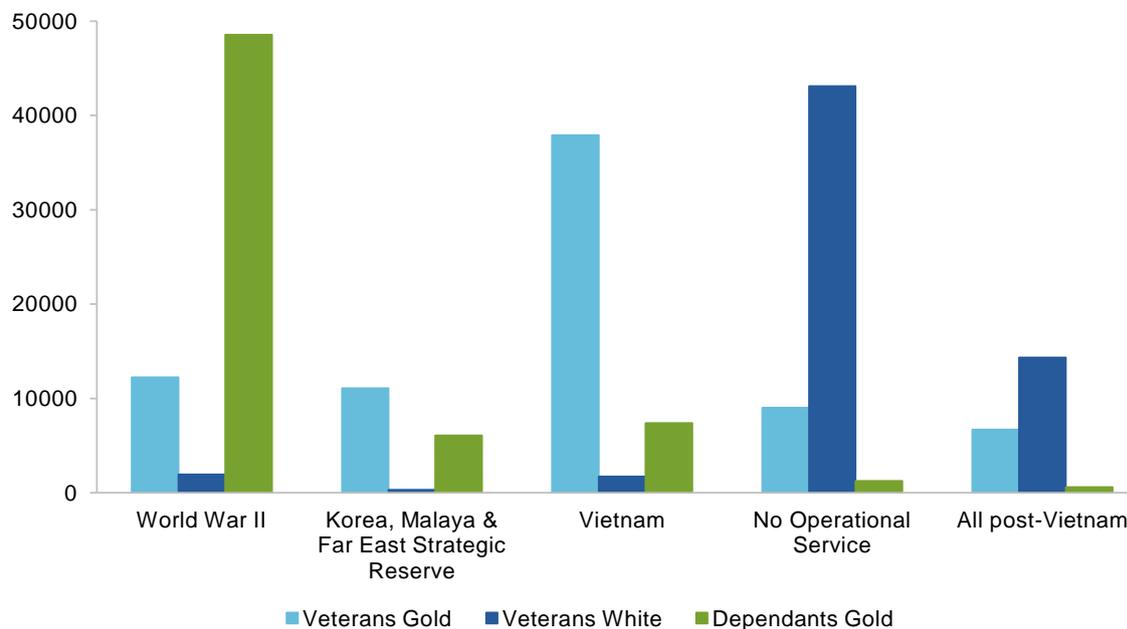
About 130 000 DVA clients have a Gold Card (DVA 2018a). More than half of these are over 80 years of age and 39 000 (or 30 per cent) are over 90 years of age. The largest cohorts are:

- dependants of World War II veterans (about 48 000 women)
- Vietnam War veterans (about 38 000 men)
- World War II veterans (about 12 000 men and 500 women) (figure 15.1).

¹ These estimates exclude veterans who would qualify for the Gold Card through any other means.

Figure 15.1 Gold and White Card holders by conflict^{a,b}

March 2018

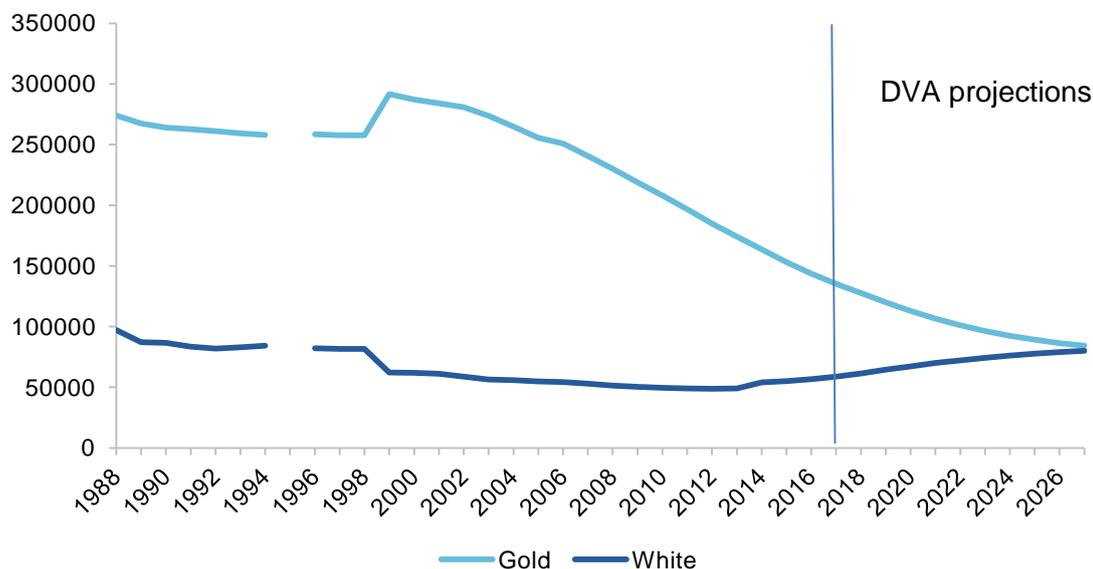


^a There are also 66 World War I dependants with Gold Cards. ^b Peace-keeping forces are included in the post-Vietnam bars.

Source: DVA treatment population statistics.

The number of DVA clients with a Gold Card peaked in 1999, following a spike in eligibility because of the Government’s decision to provide the Gold Card to all World War II veterans over 70 (figure 15.2). Since then, the number of Gold Card holders has halved, reflecting a decline in the number of living veterans from the World Wars. The share of Gold Card holders (or, before 1997, those holding a card which would become the Gold Card, as outlined in box 15.1) aged over 85 increased from 5.6 per cent in 1994 to 48.4 per cent in 2016. Over the next decade (to 2027), DVA projects the number of Gold Card holders to continue to fall.

Figure 15.2 **Gold and White Card holders^{a,b}**
1988 – 2027



^a Prior to 1997 Gold Cards include Personal Treatment Entitlement Card, Service Pensioner Benefits Card and Dependant Treatment Entitlement Card and White Cards include the Specific Treatment Entitlement Card. ^b The data for 1995 are not available.

Source: DVA Treatment Population Statistics, various years.

About the White Card

A DVA Health Card — Specific Conditions, commonly known as the White Card, is issued to:

- veterans with an accepted service-caused injury or disease under the VEA, DRCA or MRCA
- any veterans seeking non-liability mental health care
- veterans with certain types of service (war, operational, warlike, non-warlike, peacekeeping or hazardous, and others) for non-liability treatment of malignant cancer and pulmonary tuberculosis.

Commonwealth and other allied veterans living in Australia can also be issued a White Card.

About 61 000 people hold a White Card — 43 000 of these have no operational service and about 3000 are issued to Commonwealth and other allied veterans living in Australia (DVA 2018an). The average age of a White Card holder is 55 years old.

The number of DVA clients with a White Card fell from 1988 until 2013 but has risen since then (figure 15.2). DVA projects the number of White Card holders to increase strongly over the next 10 years.

15.2 What does the veteran health system cover?

DVA funds a wide range of health and other care services. Most of the funding pays for DVA clients to access mainstream services, like public and private hospitals, but there are also veteran-specific programs and entitlements.

The biggest areas of expenditure are residential aged care, medical consultations and services, and hospital stays (table 15.1). DVA also spends about \$110 million administering its health care programs (DVA 2018aa).

Table 15.1 Health expenditure
2017-18

<i>Area of expenditure^a</i>	<i>Amount (\$ million)</i>
Residential aged care	1014
General medical consultations and services including GP, specialist and dental visits	791
Private hospitals	795
Public hospitals	658
Pharmaceuticals	336
Veterans counselling and other health services	319
Community care and support	255
Travel for treatment	170
Rehabilitation appliances	145
MRCA/DRCA medical services	178
Total	4661

^a Excluding program support.

Source: DVA (2018aa).

DVA cardholders are able to access many services — private hospitals, private specialists, dental services and travel for treatment — that are not available to other Australians without a charge. Gold Card holders are also exempt from paying the Medicare levy.

In 2017-18, DVA funded just over 30 million health services, equivalent to 162 health services per cardholder (DVA 2018f). By way of comparison, Medicare funded about 17 services per person in 2017-18 and about 45 services per person aged 75 to 84 years (DoH 2018).

In 2016-17, the average cost per Gold Card was \$23 400 and \$2900 per White Card (DVA 2017q). That said, many of the services funded by these cards are funded by governments for the general population — such as public hospitals and pharmaceuticals (box 15.2).

Box 15.2 **The cost of the health care cards**

There are several estimates of the net additional cost of the Gold Card, that is, the cost of the Gold Card taking into account services funded by the public health system.

One estimate of the net additional cost of the Gold Card comes from the Australian Institute of Health and Welfare (AIHW). The AIHW calculated that the Department of Veterans' Affairs' (DVA's) expenditure per cardholder in 2015-16, excluding residential aged care, was \$15 612. This was more than double the \$6671 spent per person for the total Australian population (all sources of funds) (AIHW 2018e).

The Parliamentary Budget Office (PBO) also costed a proposal by Senator Jacqui Lambie to extend Gold Card eligibility to all veterans with qualifying service (discussed in section 15.3). The PBO estimated that the proposal would increase the average annual cost by \$21 000 for each veteran who previously did not have a health card, and by \$18 500 for veterans who previously had a White Card (PBO 2016).

The much higher average age of the cardholding population compared to the general population may explain some of the apparent additional cost of the Gold Card. Various sources show that older people have higher health expenditure.

- For example, in 2012-13, the AIHW found that hospital expenditure per person for men aged 75–79 was more than six times higher than for men aged 40–44, and expenditure for women aged 75–79 was about five times higher than women aged 40–44 (AIHW 2017a). Expenditure per person aged 85–89 was 50 per cent higher than for people aged 75–79.
- Medicare statistics also show higher expenditure for older people. Medicare expenditure per person aged over 85 was 2.6 times higher than the average for all age groups (DoH 2018).

GPs and specialists

DVA will pay for almost any clinically necessary health service for conditions covered by the Gold and White Cards. General Practitioners (GPs) coordinate health care for cardholders and decide what is 'clinically necessary'. GPs maintain a written care plan that sets out the planned treatment regime and its expected outcomes. Cardholders can access specialist and allied services by referral from their GP, although dentists and optometrists do not need a referral.

In 2016-17, DVA funded 11.8 GP consultations per patient (DVA 2018ag). By comparison, in the same year Medicare funded 6.2 GP consultations per patient (DoH 2018). This pattern likely reflects the age of the DVA client cohort, as there are more than twice as many Medicare GP claims per person for people aged over 65 as for those aged under 65 (AIHW 2018g).

There are no public DVA data on specialist consultations.

Hospitals

In 2016-17, DVA funded about 190 000 private hospital separations and about 80 000 public hospital separations (DVA 2017d).

Private hospitals

DVA has contracts with 250 of Australia's 300 private hospitals (and 270 of Australia's 330 same-day facilities).

All private hospitals that have a contract with DVA are required to nominate a staff member to be a veteran liaison officer in each of their hospital locations. A veteran liaison officer's role is to coordinate with hospital staff to enhance the treatment and care provided to veteran patients. They are also responsible for providing pre-admission and discharge planning support and referring patients to other services, such as home care or the rehabilitation appliances program.

DVA will fund private hospitals to provide better discharge planning for people who are at risk of an unplanned readmission. The hospital is expected to involve the person's GP in planning their post-discharge support, which the hospital will provide for 14 days. No service can be outsourced to another hospital or third party provider.

DVA requires private hospitals to submit an annual quality report. But the quality indicators that DVA requests are largely not specific to DVA clients. For example, DVA requests hospital-wide clinical and infection control indicators. From 2016-17, the quality reporting has been streamlined to almost exclusively rely on other accreditation, including the National Standards for Safety and Quality.

Public hospitals

DVA has agreements with all State and Territory Governments to treat DVA cardholders in public hospitals. These five year agreements set out an activity-based purchasing model where DVA provides funding to the States and Territories in advance and then reconciles this against patient-level activity data that they provide. DVA cardholders can also be treated as private patients in public hospitals. Unlike private hospitals, DVA does not require any quality reporting from public hospitals.

Dental and allied health

DVA will fund dental and allied health services for cardholders. Allied health services include:

- mental health services: psychology, occupational therapy and social work (covered further below)

-
- musculoskeletal services: chiropractic, exercise physiology, occupational therapy, osteopathy, physiotherapy and podiatry
 - optometry
 - other clinical services: diabetes education, dietetics, social work and speech pathology.

In 2016-17, DVA funded about \$320 million in dental and allied health services for about 140 000 card holders (DVA 2018ag). DVA's average expenditure per patient was \$2285. Medicare's expenditure on allied health services was \$305 per patient in 2016-17 (DoH 2018).

DVA cardholders are entitled to more comprehensive dental services than those available through government public dental services. People who receive public dental services in public dental clinics have little choice over who provides their care, when and where, and can face long waiting lists (PC 2017b). DVA cardholders, on the other hand, can choose their provider (if they accept DVA cards) and face far fewer limits on the services they can receive.

DVA's expenditure on dental services for cardholders represented nearly 10 per cent of Australian Government total expenditure on dental services in 2015-16, while DVA cardholders represent less than 1 per cent of the Australian population. Only about one-third of the Australian population (not including DVA clients) are eligible for publicly-funded dental services, which are funded by the Australian, State and Territory Governments (PC 2017b).

Transport

DVA will pay for transport to attend medical appointments covered by the Gold and White Cards. This can be by any method, including ambulance, taxi, air travel, rail or private car. DVA will also pay for accommodation, meals, road tolls and parking.

The largest expense is on ambulance travel — DVA spent about \$80 million on ambulance travel in 2016-17.

DVA provides a pre-booked taxi or hire car service for some cardholders, in addition to the other transport services. A cardholder who is aged over 80, legally blind or suffering from dementia can contact DVA to book a car with a driver to take them to their medical appointments. Cardholders under 80 years with certain conditions, such as arthritis that severely limits their independence, can use the booked car scheme, but only to travel to some types of providers, such as hospitals or diagnostic services. This service offers two benefits to users: DVA handles the booking and DVA pays upfront, instead of the person having to seek reimbursement.

There were about 1.3 million booked trips in 2017-18, far outnumbering the 170 000 claims for reimbursement for other travel types (DVA 2018f).

The VEA and the MRCA differ in one important aspect: while the VEA will reimburse for travel by private vehicle (paying a kilometre rate plus car parking) the MRCA will only do so if the trip is more than 50km (and some other circumstances, such as the person not being able to travel by another means for medical reasons). The MRCA will, however, pay for a taxi. This means there is an incentive for a person to take a taxi rather than drive their own car for a short trip.

A person can claim an accommodation or meal allowance if they have to travel long distances for treatment. Accommodation allowance is payable where a person needs to travel more than 250km to attend a health provider or where their medical condition prevents them from travelling home on the same day.

All State and Territory Governments run travel assistance schemes which give financial assistance to patient who must travel long distances to access specialist medical treatment (National Rural Health Alliance 2014). DVA's travel assistance differs in three main ways.

1. It is not restricted to people in regional or remote locations.
2. It does not require a co-payment. State schemes generally only exempt people with health care cards from co-payments.
3. It is available for travel to non-specialist medical appointments.

One positive feature of DVA's reimbursement scheme, compared with State and Territory schemes, is that although the reimbursement is calculated based on the distance to the closest provider, DVA clients can use any provider they wish. This means DVA clients are able to have choice of provider but bear the extra cost of doing so. The booked car service, however, is only available to the closest practical provider.

Aged and community care

DVA funds several aged and community care programs: spending \$1.1 billion on residential aged care for about 23 000 veterans and widow(er)s in permanent and respite care and about \$100 million on veterans' home care for about 49 000 people in 2016-17 (DVA 2017d). Veterans' home care services include in-home respite, domestic assistance, personal care and safety-related home and garden maintenance services. DVA contracts providers to conduct the home care assessments and to provide the services.

DVA will pay a supplement for the home care or residential care for veterans who have a mental health condition accepted as related to their service. It is designed to ensure a veteran's mental health condition does not act as a barrier to accessing care. The supplement for veterans in residential aged care is \$6.69 per day, and the supplement in home care is 10 per cent of the basic subsidy amount.

DVA spent about \$133 million on community nursing services in 2017-18 (DVA 2018aa). Community nursing services can assist with medication, wound care, hygiene and help with

showering or dressing. The majority of DVA community nursing services are paid through a set schedule of items with associated fees.

The rehabilitation appliances program funds aids or appliances to help a person maintain independence in their home; in 2017-18 the program's expenditure was about \$145 million (DVA 2018aa). A wide range of aids and appliances are available, including home modifications, Continuous Positive Airways Pressure machines for sleep apnoea and personal response alarm systems.

Pharmaceuticals

Cardholders are entitled to a wide range of pharmaceuticals at a concessional rate through the Repatriation Pharmaceutical Benefits Scheme (RPBS). Cardholders can get all the items on the Pharmaceutical Benefits Scheme (PBS) and about 500 additional items, including a wider variety of wound dressings. Items not listed on either the PBS or the RPBS can be prescribed by a doctor, with DVA approval.

Cardholders' pharmaceuticals are subsidised in a variety of ways.

- Cardholders pay \$6.40 for each prescription until their family reaches a safety net threshold (\$384, or 60 prescriptions), and then they do not pay anymore. This is the same arrangement available to people with health cards issued by Centrelink.
- Cardholders are further subsidised via a pharmaceutical payment, which is paid as part of the Pension Supplement or the MRCA/DRCA/Veteran supplement (chapter 14). In 2017, the pharmaceutical payment was about \$160–\$170 per annum, so the maximum out of pocket expense was about \$220 (\$380 safety net minus \$160 pharmaceutical payment). A pharmaceutical payment is also available to some categories of Centrelink clients who receive income support, such as Newstart Allowance recipients, and the pension supplement is also paid to Centrelink pensioners.
- Some veterans with qualifying service² are also eligible to be reimbursed for the cost of co-payments for prescriptions up to the safety net threshold, minus the value of the pharmaceutical payment. That is, these veterans face no out of pocket costs. There is no equivalent arrangement for the general social security system.

Mental health care

DVA pays for mental health treatment without the need to establish a link between the condition and a veteran's military service. DVA will also initially fund treatment without the need for a diagnosis, but after six months DVA may review eligibility and request a diagnosis from a psychiatrist, clinical psychologist or GP.

² Veterans with qualifying service who also have a Gold or White Card and are receiving a disability pension under the VEA or permanent impairment compensation under the MRCA. Veterans who have a permanent impairment under the DRCA are also eligible if they also have qualifying service under the VEA or MRCA.

There are several ways to access to mental health treatment. A cardholder can seek treatment from (or be referred to) a GP, psychologist, social worker, occupational therapist, psychiatrist or hospital. In 2016-17, DVA funded allied mental health consultations for about 1400 people (data on the number of psychiatrist consultations or the number of GP visits for mental health problems are not available).

Mental health treatment is also provided by Open Arms — Veterans and Families Counselling, formerly the Veterans and Veterans Families Counselling Service (VVCS). Open Arms is a mental health service run by DVA that can be accessed by all health card holders, as well as the families of current and former Australian Defence Force (ADF) members. Services that Open Arms provides include:

- counselling for individuals, couples and families
- case coordination for clients with complex needs
- group programs to develop skills and enhance support
- an after-hours telephone counselling service
- referrals to other services or specialist treatment programs.

Open Arms staff provided counselling to about 4700 people in 2016-17 (DVA 2017d). Open Arms also has a network of outreach counsellors (psychologists and mental health accredited social workers), who deliver services to Open Arms clients unable to access an Open Arms centre. Open Arms outreach counsellors saw about 11 000 clients in 2016-17. Open Arms also provided intake assessments (which did not lead to counselling) to about 2000 people (DVA 2017d).

15.3 Who should be eligible for DVA health cards?

There are a number of reasons why governments may fund additional (above what is provided to the general community) health care for veterans or dependants.

- The first is to treat the health needs of veterans — particularly where veterans have unique medical needs or poorer health outcomes (compared to the broader community).
- Second, health care can be provided as a means of compensation — to treat service-related impairments.
- Third, as recognition for the community's gratitude towards veterans.

The optimal service offering would differ depending on the objective(s), as would the eligibility criteria and the government's stewardship responsibilities.

The health care needs of veterans

Governments may fund additional health services or run other targeted policies for population sub-groups that have poorer health outcomes. Veterans may represent one such group — there are longstanding concerns about the ongoing health effects of war service on veterans' health. As discussed in chapter 2, war service can expose people to a large number of environmental risks, including harsh climates, hazardous substances, and infectious disease risks. War service can also have an effect on a person's mental health — the decision to provide access to mental health care on a non-liability basis was, in part, a recognition of these effects (along with the mental health needs of those without war service) (box 15.3).

Box 15.3 **Support for the (non-liability) White Card for mental health conditions**

Many participants supported the decision to provide non-liability access to the White Card for mental health conditions. Some of the terms used to describe the initiative include 'life-saving', 'exceptional' and 'most positive'.

The Royal Australian Armoured Corps Corporation:

The White Card is automatically generated and sent to the veteran to enable early mental health treatment. The Corporation considers this move to be a major factor in enhancing early intervention for vulnerable veterans and contends this measure to be a life-saving initiative. (sub. 29, p. 9)

Defence Force Welfare Association:

The experience of our Advocates and the feedback from Veterans on social media has all been positive, especially the speed with which the approval is given and the White Card is issued. It has facilitated quick arrangement of treatment without administrative and delay stress which exacerbated the mental condition. (sub. 118, p. 73)

GO2 Health:

The non-liability coverage for mental health is probably the most significant positive change in recent years — this has made it much easier for veterans to access almost immediate mental health support. (sub. 98, p. 9)

Mates4Mates:

Non-liability coverage of any mental health through the White Card is one of the most positive initiatives DVA has introduced in recent times. (sub. 84, p. 4)

RSL Queensland:

The Non-Liability Health cover for mental health conditions for all veterans is an exceptional initiative. (sub. 73, p. 33)

Royal Australian and New Zealand College of Psychiatrists:

One element of the legislative framework that is strongly supported by the RANZCP is the extension of the non-liability health care to all mental health conditions. In allowing veterans to access appropriate treatment with minimal administrative burden, DVA has demonstrated significant commitment to more effectively supporting those veterans with mental illness. (sub. 58, p. 7)

Support was also provided by a number of other participants (sub. 85, sub. 61).

The Senate inquiry into suicide by veterans also noted that it had heard 'almost universal praise from stakeholders' regarding the decision (SFADTRC 2017, p. 113).

There is some historical evidence that veterans have ongoing health effects that can be attributed to their military service (although some of the evidence is mixed, box 15.4).

Box 15.4 Population health studies of veterans

Research on veterans' health has generally focused on the health outcomes of veterans of different conflicts.

- For Korean War veterans, health studies found evidence of negative health effects in the decades after the War. Mortality (excluding those killed in action) was higher, as was the incidence of cancer, mental health problems and suicide (Harrex et al. 2003).
- The evidence on the health effects of service in the Vietnam War on veterans is mixed.
 - One study found that overall mortality for Vietnam veterans was lower than for a comparable Australian male population (Wilson, Horsley and van der Hoek 2005b). This may reflect a 'healthy soldier' effect — soldiers are fitter and healthier at enlistment than the general population. Another study that controlled for this effect compared the mortality of National Servicemen who went to Vietnam with those who did not go (both groups were selected in the same way and the decision to send some to Vietnam was not based on fitness). The men who went to Vietnam had a higher overall mortality rate than those who did not go (Wilson, Horsley and van der Hoek 2005a).
 - One study that uses the conscription lotteries to identify men who did and did not go to Vietnam and finds no evidence of elevated mortality from 1994 to 2007 among Australian Vietnam-era army conscripts (Siminski and Ville 2011).
- A 2003 study concluded that the psychological health and some aspects of physical health of Australian veterans of the Gulf War were worse than for similar Australian Defence Force personnel who were not deployed to the Gulf (Sim et al. 2003). And Gulf War veterans were found to be more likely (than the comparison group) to develop most post-war psychological disorders. A study that followed-up Gulf War veterans over 2011–2013 found that many of the health effects remained a decade later (and twenty years after the war) (Sim et al. 2015).

Given the health effects of military service, should veterans be entitled to medical services in addition to those available through Australia's universal health care system? In 1976, the Toose report looked at whether a separate veteran health system would be necessary in light of the development of Medicare at the time (then called Medibank) and concluded that:

The need for the Department to provide medical and hospital treatment in the future in respect of past or future wars and warlike operations, and the basis on which it is done will depend very much on the general environment from time to time. It has been submitted that if an effective national health system is operating it could be utilised thus making unnecessary the existence of a parallel Repatriation treatment service. It was said however to do this, a national health system would need to guarantee the availability, on call, of high quality medical and patient care for members requiring treatment for service-related disabilities, and for those dependants judged to have valid entitlement to treatment. (Toose 1976, pp. 457–458)

And while it was generally agreed at the time that there would not be such a health care system in the immediate future, that was 40 years ago (and Australia's health care system is now considered to be world class).

Health care — part of a beneficial compensation package

Providing health care to veterans is clearly justified where a veteran has an impairment that is directly linked to service. The Australian Government, as the former employer of the veteran, is liable to pay for health care as part of workers' compensation. This is consistent with all workers' compensation schemes in Australia.

However, the veterans' health care cards provide broader health care coverage than other workers' compensation schemes — both through non-liability White Card coverage and the Gold Card. Indeed, the Gold Card is one of the key differences between the veterans' compensation scheme and civilian workers' compensation (chapter 12). In part, this reflects the historical development of the veterans' compensation system — health care for veterans has been provided since the genesis of the repatriation system, and has slowly expanded over time (box 15.5).

The Gold Card is perceived as being one of the most desirable benefits of the veteran support system. The Clarke Review said it 'is a valuable benefit and one that is highly prized by the veteran community' (Clarke, Riding and Rosalky 2003, p. 500). This may reflect its generosity — while there are annual limits for some services, overall a person's entitlement is uncapped. The highest spend on a Gold Card in 2015-16 was more than \$1 million.

RSL NSW said DVA's health card system 'encourages a view of the system as a contest to be won, with the Gold Card as the prize'.

... The outcome sought for veterans should be rehabilitation, not monetary settlement. The 'gold card' nomenclature utilised by DVA reinforces a negative entitlement culture where success for veterans is the extraction of cash from the government, not their rehabilitation and return to being a productive member of civilian society. (sub. 151, p. 7)

As outlined in chapter 12, compensation is best considered as a package. And the Gold Card can heavily affect the compensation package that a veteran or dependant receives. On the one hand, the Gold Card is a one-size-fits-all entitlement, as compared to, say, permanent impairment compensation which is paid along a continuum. It is somewhat inequitable to provide the same entitlement to the different groups currently eligible for the Gold Card. On the other hand, the 'value' of the Gold Card depends on how a cardholder uses it. Those with poorer health will make greater use, so in some ways it is proportionate to their needs. This is undermined, however, by the fact that the Gold Card is available to some groups for which there is no strong compensation rationale.

The 2003 Clarke Review of the veterans' compensation system is the only review since the introduction of the health card system to look in any detail at the rationale behind eligibility for veterans' health care, including the extension to non-service related treatment. Clarke et al. concluded that:

Although no clear rationale is discernible, it would appear that initially, the need to provide generous health care cover for veterans who were severely incapacitated by service-related disabilities was the primary factor in providing full health care benefits. (2003, p. 501)

Box 15.5 **A brief history of eligibility for health care**

Over the past century, eligibility for veterans' health care has widened.

Treatment of injuries and illnesses accepted as related to eligible service in the Australian armed services (and pre-existing conditions aggravated by war service) has been provided under repatriation legislation since the enactment of the *War Pension Act 1914*.

Limited access to medical treatment was expanded in 1924 to include widows and orphans of deceased soldiers and for widowed mothers of unmarried deceased soldiers.

In 1943, health care was widened to include treatment for conditions that were not related to war service for veterans receiving either the full general rate or the special rate war pension. Some types of treatment were specifically excluded, including alcoholism, drug addiction, chronic or incurable diseases requiring prolonged treatment in institutions, and 'conditions for which the member was entitled at law to receive free treatment from another source' (Toose 1976, p. 390). These exclusions were relaxed in 1972.

In 1959, treatment coverage for war widows, orphans and widowed mothers was extended. And in 1961 eligibility for veterans was widened again, this time to include treatment for all conditions for service pensioners. In 1969, a new means test extended eligibility for the service pension but the Government did not allow those made newly eligible to become eligible for health care. Eligibility for the war widow(er)'s pension, and hence eligibility for health care coverage for all conditions, was extended to defence widows in 1972.

In 1973, eligibility for treatment for all conditions was widened to include all Boer War and World War I veterans. In 1974, free medical treatment was extended to all Australian prisoners of war, and to all veterans with cancer, whether or not their disease was service-related. The Labor party platform at the time laid out the ultimate objective as being free medical and hospital treatment to all ex-servicemen.

In 1988, full medical entitlements were extended to World War II ex-servicewomen with qualifying service. This was in recognition that women had been paid less than men for their war service and had not been eligible for the same level of repatriation benefits after the war. In 1991, eligibility for the war widow's pension was widened again. In 1996, service pensioners who were excluded from the 1969 change to eligibility were granted the Gold Card. In 1999, eligibility was extended to all male World War II veterans over 70 with qualifying service.

From 2002, eligibility was further extended to post-World War II veterans over 70 with qualifying service. Eligibility for mental health care was widened in 2016 to all current and former Australian Defence Force members, irrespective of their date, duration or type of service. In 2017, eligibility for the Gold Card was extended to participants in the British nuclear test program in Australia and veterans of the British Commonwealth Occupation force.

Sources: Australian Government (2017b); Bell (2002); Clarke et. al (2003); Toose (1976).

Previous reviews considered that, while some health care entitlements are reasonable, the rationale for some groups of veterans was questionable.

The 1976 Toose report discussed the basis for entitlement to treatment under the repatriation legislation at that time and endorsed eligibility for veterans with service-related disabilities and dependants. Toose recommended that dependants of veterans on the disability pension be given full treatment benefits. Toose reasoned that since the nation had 'assumed

responsibility for the welfare of the family units while the members were alive ... it seems inconsistent to withhold treatment benefits from the dependents of these members until the members die' (Toose 1976, p. 461).

However, Toose concluded that eligibility for other groups, including all World War I and Boer War veterans, could not be justified as a compensation measure (Toose 1976). But Toose also concluded that there was no justification in pure repatriation terms for any further extension of entitlements.

Clarke et al. also commented that:

- the extension to nonservice-related health care was understandable at the time as it was before universal basic health cover was available. At the time it was also considered difficult to distinguish between service-related and nonservice-related conditions
- the extension to service pensioners with qualifying service was justified on the basis of financial and medical need (the service pension itself was created in recognition of the 'premature ageing' from war service)
- these and other extensions (such as to ex-prisoners of war) were provided after a careful assessment of the 'community's obligations to veterans' and were considered high priority for the provision of repatriation benefits
- there was no strong justification for extending the Gold Card to all veterans over 70 irrespective of their financial ability to pay for their own health care for nonservice-related disabilities
- there are no grounds for providing the Gold Card purely as a reward for service or in recognition of service in the ADF.

Clarke et al. concluded that the primary purpose of the Gold Card was to provide health care benefits to those with eligible service who have medical needs due to service-related disablement and to veterans in financial need who have qualifying service. The conclusion of Clarke et al. on dependants was that the Gold Card is provided to them as part of the compensation package for the loss of the veteran as a result of service or because the veteran was severely affected by service.

Part of the difficulty with the veteran health system is that there are at least four groups of people who could be eligible for different reasons and have different needs — demonstrated by the four health care cards which were used from 1987 until 1996 (box 15.1). Having only two health care cards may not allow more specific targeting. Ultimately, eligibility criteria are a blunt instrument where an ideal system would be needs based.

Where does that leave us?

The veteran health system has essentially three objectives, as outlined earlier

On the first objective — to treat the health needs of veterans — it is questionable whether the Gold Card is the best vehicle. There are a number of reasons for this.

- First, the Gold Card goes to many dependants who do not have service-related health conditions. This weakens the focus on veterans. And care for veterans with complex needs is an area identified for improvement within the current system (discussed later).
- Second, DVA can target veterans with specific health needs through the White Card. Also, where there is evidence of areas of emerging need for more comprehensive entitlements, DVA could consider providing the White Card on a non-liability basis, as it has recently done for mental health care.
- Third, many of the services that veterans need are already provided through the public health system.

The recent expansion of access to mental health care for all veterans undoubtedly addresses an area of demonstrated need. That said, any further expansion of non-liability healthcare should be based on clear evidence and only proceed where the benefits to veterans clearly outweigh the costs to the community as a whole.

The second objective of the veteran health system — treating the service-related health conditions of veterans — is consistent with modern workers' compensation schemes. But as discussed above, the eligibility criteria grant the Gold Card to a much wider group than would be justified on these grounds. And the range of services and entitlements covered by the Gold Card go well beyond that which would be required to treat service-related health conditions. DVA also places very few constraints on a cardholder's entitlement, unlike Medicare, civilian workers' compensation schemes or even private health insurance. The White Card is more closely aligned to a civilian workers' compensation entitlement.

The third objective, to express the community's gratitude to veterans, also arises from the historical development of the veteran support system. But many of the reasons which may have led to the Gold Card being provided for this purpose have diminished over time. For example, Australia's universal public health system means that veterans will have access to health care regardless of their financial circumstances. There are also government subsidies for private health insurance. Furthermore, the compensation system is now quite comprehensive and includes a range of financial supports for veterans. The eligibility criteria for the Gold Card can also have unintended consequences, including providing an incentive to remain unwell enough to reach the required permanent impairment rating.

The White Card is the most appropriate vehicle for funding veterans' health care needs. Against the key principles that underlie a future scheme, the Gold Card is not needs based (it is not targeted to service-related health needs), wellness focused or efficient (free health care can encourage over-servicing).

DRAFT FINDING 15.1

Funding the treatment of service-related conditions, as is done through the White Card, is well-justified — it appropriately targets veterans with health needs and is similar to workers' compensation healthcare entitlements.

The Gold Card, however, runs counter to a number of the key principles that should underlie a future scheme — it is *not* needs based (because it is not targeted to service-related health needs), wellness focused (there can be an incentive to remain unwell), or efficient (by potentially encouraging over-servicing).

Calls to further expand access to health care

Historically, DVA (and the Government) has faced pressure to widen eligibility, regardless of how that measures against the objectives of the system. The Clarke Review faced calls to widen eligibility for the Gold Card and generally recommended against it. In one significant case the Clarke Review recommended narrowing eligibility — that the VEA be amended so that there would be *no* further grants of the Gold Card to post-World War II veterans with qualifying service at age 70, unless the veteran satisfied some measure of financial need. This recommendation was rejected (DVA nd). The Government at the time said that a 'benefit granted in recognition of incurring danger from an enemy should not discriminate among veterans on the basis of wealth or income' (Vale 2004, p. 5).

Clarke et al. also recommended that the Gold Card *not* be extended to all veterans of the British Commonwealth Occupation Force, and that participants in the British nuclear tests only be made eligible for the White Card, giving them access to treatment for cancer. Both groups were granted the Gold Card in the 2017 Budget (Australian Government 2017b).

Some participants to this inquiry called for greater access to health care, including the Gold Card. For example:

- the Partners of Veterans Association argued that partners should be given access to treatment for stress-related illness, by either including them on the veteran's Gold or White Card or by issuing partners their own White Card (sub. 77)
- the War Widows Guild said that the Gold Card should be extended to widows aged 80 or older to recognise the widows of veterans 'lifetime of support to their family and country' and assist them in managing their health in later life (sub. 87, p. 9)
- the ACT branch of the Defence Force Welfare Association argued for all ADF members with war or war-like service to be granted a Gold Card on discharge and those with peacetime service be given a White Card for all conditions listed on the final discharge medical (sub. 13).

Senator Jacqui Lambie (herself an ex-army servicewoman) introduced a Bill on 11 November 2015 that sought to grant the Gold Card to all veterans who have served in war or war-like operations. Senator Lambie said:

By making access to the Gold Card a tick and flick exercise — or a simple bureaucratic process for those members of the ADF who had served in war or war-like conditions — it will allow vulnerable and often damaged people to bypass a traumatic and further damaging administrative process and immediately receive the medical care they need to get well (Lambie 2015, p. 8306).

The Senate voted on the Bill in February 2016 and it was defeated (the two major parties, the Liberal-National coalition and the Labor party, both voted against the Bill). Senator Linda Reynolds (an ex-army reserve officer) spoke for the Government and cited a number of reasons for not supporting the measure. They included that:

- it would be costly
- it was not targeted
- it would spread the entitlement ‘too thin’ and end up meaning that those who need assistance the most would end up losing out
- some in the veteran community supported the current arrangements (Reynolds 2016).

The Gold Card’s numerous problems mean that eligibility should not be widened any further. No current Gold Card holder or person who is entitled to a Gold Card under current legislation would be affected.

DRAFT RECOMMENDATION 15.1

Eligibility for the Gold Card should not be extended to any new categories of veterans or dependants that are not currently eligible for such a card. No current Gold Card holder or person who is entitled to a Gold Card under current legislation would be affected.

Should the Gold Card go to dependants and service pensioners?

If the system was being designed today, in accordance with best-practice design principles, it would not have a Gold Card. That said, the Gold Card is entrenched in the system (despite only being created in 1996) and for some it has become as a status symbol (Lambie 2015). And while there would be a case to provide access to a wide range of health care for veterans with service-related health conditions that result in severe impairment, it would not include the wide range of entitlements currently covered by the Gold Card.

The Gold Card is potentially flawed as a way to compensate dependants of veterans who have died from service-related causes — it is inequitable as the amount of compensation is related to how much a dependant uses health services. Increasing compensation payments to dependants instead would be a simpler and fairer approach. Questions could also be raised about the healthcare or compensation rationales for providing the Gold Card to veterans without service-related health conditions. These veterans have access to the generally available healthcare system and this funding could be better targeted towards groups of veterans with greater needs.

Veterans with qualifying service can get the age service pension from age 60 and can get the Gold Card if they meet an additional means test. Tying eligibility to the age service pension, and means testing it, suggests that the Gold Card is provided to this group as a form of additional assistance by way of an in-kind benefit rather than a payment. The age service pension was created in 1935 in response to concerns that war service had intangible effects that may result in premature ageing of the veteran, necessitating early retirement. Clarke et al. reasoned that the Gold Card was provided to this group as ‘an attempt to provide greater assistance to veterans who were needy and ‘burnt out’ due to their service in combat’ (2003, p. 501). The means test targets these benefits towards veterans who have reduced earning capacity.

Further questions could be raised about the suitability of the Gold Card as a form of additional assistance — it is essentially an uncapped benefit, unlike other forms of assistance. The original rationale from the 1930s for providing the Gold Card to this group is potentially out of date. The evidence on ‘burn out’ is unlikely to still be relevant, and the general health care system is much more developed than it was 80 years ago.

At age 70 the means test is essentially removed for the Gold Card — removing the connection between service (or financial) related need and the provision of veterans’ health care. If the means test was continued past 70 it would better target the Gold Card at those with limited capacity to fund their own healthcare.

INFORMATION REQUEST 15.1

Given the Gold Card runs counter to a number of key design principles, the Commission is seeking feedback on whether a future system should have a coloured health card system. If not, what are the other options?

In particular, the Commission is seeking feedback on the benefits and costs of providing the Gold Card to dependants, service pensioners and veterans with qualifying service at age 70.

The Commission is recommending removing access to wholly dependent partner payments for dependants of veterans who had not died as a result of service (chapter 13). By extension, this means they would also not get access to the Gold Card.

What about the DRCA?

As discussed above, the Gold Card is not well targeted to those most in need and it is the Commission’s view that it should not be extended further, including to veterans with impairments covered by the DRCA only. The White Card is the most appropriate vehicle for funding veterans’ health care needs and DRCA clients already have access to it.

There is also no need to give the Gold Card to DRCA clients from a compensation perspective as the compensation package is already beneficial (chapter 12).

Some veterans with impairments covered by the DRCA will also have impairments covered by the VEA or the MRCA, which means they may have access to the Gold Card. A veteran with a high impairment rating under the DRCA and a small impairment under the MRCA (or VEA) could be eligible for the Gold Card.

15.4 What is DVA doing to promote good health care for veterans?

The VEA and MRCA state that an eligible veteran or dependant is entitled to ‘treatment’, but do not specify anything further regarding the form or quality of treatment (VEA part V, s. 80-93J and MRCA s. 278-287A). The VEA Treatment Principles, which are the legislative instrument that set out the rules under which DVA will arrange or fund treatment for an eligible person, go a little further and describe the aim of DVA-funded medical services as being ‘to ensure that as far as is practicable entitled persons have access to free, safe and cost-effective treatment’ (s. 4.1.3). DVA describes their policy intent as being ‘to provide a universal service offer across Australia, to ensure that all eligible persons have access to the full range of services with minimal travel required’ (sub. 125 p. 46).

This section considers the dimensions of quality health care and how DVA ensures veterans (and other cardholders) receive high quality care.

What does good care look like?

The Australian Safety and Quality Framework for Health Care, endorsed by Australian Health Ministers in 2010, has three core principles for safe and high quality care. These are that care is consumer centred, driven by information and organised for safety (ACSQHC 2010).

- Consumer (or patient) centred care gives prominence to the preferences, needs and values of consumers. In some instances it is about making sure that patients’ experience of health care (subjective as they may be) are positive. In another context, it enables a more individually-based assessment of clinical outcomes. And in yet another, it is about supporting patient choice and collaboration between the patient and clinicians.
- Being driven by information means: using up-to-date knowledge and evidence to guide decisions about care; safety and quality data are collected, analysed and fed back for improvement; and taking action to improve patients’ experiences.
- Safe health care means avoiding harm to patients from the care that is meant to help them (Duckett et al. 2018). It is governed by a combination of regulations, accreditation, professional standards and workplace practices.

DVA's regulation of health care

One way that DVA controls the quality of care is through regulation (or other legally binding instruments). DVA's regulation comprises the Treatment Principles and the 'notes for providers' which are legally binding documents setting out the conditions for DVA payment for services and other accountability requirements.

DVA's regulation and contracts with service providers are generally focused on facilitating payment, setting eligibility and codifying the parameters of the service, such as what can be provided. But there are some safety and quality provisions. DVA has a provision in the 'notes for GPs' that allows it to conduct audits of GPs to, among other things, monitor the quality of health care being provided and the health care outcomes of cardholders. But DVA does not appear to provide any guidance to GPs about what it considers sufficient quality of care or expected outcomes.

DVA imposes quality standards on some hospital services. This includes the private hospital quality monitoring (discussed earlier). DVA also contracts mental health hospitals around Australia (although there are none in Tasmania, the Northern Territory or ACT) to provide trauma recovery programs, and in 2015 DVA introduced mandatory national accreditation standards for these programs.

Coordinated Veterans' Care

The Capability Review of DVA observed that the department had 'pockets of innovative programs', primarily in the field of health care (APSC 2013, p. 31). These include the Veterans' MATES initiative (box 15.6) and Coordinated Veterans' Care (CVC) (box 15.7).

Box 15.6 **Veterans' MATES**

The Veterans' Medicines Advice and Therapeutics Education Service (Veterans' MATES) program aims to improve the use of medicines and related health services of cardholders. The program uses DVA administrative health claims data to identify the prevalence of medication-related problems in the cardholding population. The program then identifies cardholders with these potential problems and notifies their GP that their medicines may need reviewing, such as lowering the doses of some medications. The program also sends information to the cardholder to act as a prompt for discussion with their GP, such as suggesting bone density tests for those at risk of osteoporosis.

Many of the program's interventions are successful. For example, Veterans' MATES research showed that antipsychotic medicines can cause serious harm in older persons, including raising the risk of hospitalisation for pneumonia or hip fracture, and even increasing the risk of death. Veterans' MATES delivered a range of initiatives to highlight the limited role of antipsychotics in the management of dementia, promoted non-pharmacological alternatives, and provided guidance on how to taper and cease antipsychotics. The program led to reduced use of antipsychotics in patient with dementia.

Source: Veterans' MATES (2017).

Box 15.7 **Coordinated Veterans' Care**

The Coordinated Veterans' Care (CVC) program provides ongoing, planned and coordinated primary and community care, led by a general practitioner (GP) with a practice nurse, to eligible Gold Card holders. The program is aimed at reducing unplanned hospitalisations for people with chronic conditions, namely:

- congestive heart failure
- coronary artery disease
- pneumonia
- chronic obstructive pulmonary disease
- diabetes.

GPs are paid an initial incentive payment to enrol a participant in the program and a quarterly care payment for ongoing care. GPs that use a practice nurse get a higher payment. A GP with a practice nurse will be paid about \$2200 in the first year per participant and then about \$1800 each year after.

The CVC program is associated with a reduction in overnight hospital episodes for program participants, but the associated cost savings are more than offset by the costs of the additional medical services under the program (Grosvenor Management Consulting 2015). The number of overnight hospital episodes were statistically significantly lower for high-risk CVC program participants compared to non-participants but not for the other risk groups. There were no differences for average length of stay or cost per episode, which shows that program participants had similar hospital care to non-participants.

About one in six Gold Card holders have enrolled in the CVC program since it commenced in 2011 (DVA 2017g). As at February 2015, about 28 000 people had enrolled in the program (Grosvenor Management Consulting 2015).

Gold Card holders (including war widows and other dependants) with chronic conditions, complex care needs and at risk of unplanned hospitalisation can enrol in the CVC program. The program is designed to increase support for cardholders with one or more targeted chronic conditions who are in the 80th to 95th percentile of the risk distribution for unplanned hospitalisations, based on a DVA risk rating tool. In addition, GPs and patients themselves have the discretion to enrol in CVC even if they do not meet all of the targeting criteria.

Making sure the right people are enrolled in CVC

A review of the CVC program in 2015 found that there was too much flexibility in the eligibility criteria, which had diluted its overall effectiveness in terms of reduced hospitalisations (Grosvenor Management Consulting 2015).

To achieve its goal of reduced hospitalisations, CVC targets people with risk ratings that put them in the 80th to 95th percentile. A review of CVC by Flinders University in 2015 said:

Identifying the optimal target population for care coordination programs is challenging. Patients need to be able to benefit from the program by being not too sick and not too well. In addition,

for the program to be cost effective the targeting criteria need to identify a group where the likelihood of generating savings is high while not limiting the target population so severely that the impact on total cost is small. (2015, p. 25)

While CVC is aimed at people with a high risk of hospitalisation, about 27 per cent of enrollees did not meet the risk threshold and did not have one of the specified chronic conditions. This is mostly due to the discretion GPs have to enrol people into the program. The Flinders review said:

The majority of patients enrolled in the CVC Program have been done so on the basis of a GP assessment of likelihood of benefit. Currently this assessment is subjective, unstructured and it appears that there is variation in how GPs are selecting patients for enrolment into the CVC Program. DVA should consider developing a more structured and standardised approach for GPs to use to identify appropriate candidates to the CVC Program. (Discipline of General Practice Flinders University 2015, p. 6)

The review recommended that the eligibility criteria be narrowed to increase participation of people at the highest risk of hospitalisation.

The payment model for CVC provides the incentive to enrol more people. The usual concern with a model that pays a periodic amount for each enrolled person, called capitation, is that providers will avoid high-risk or high-need people. There is no evidence of this behaviour for CVC, although the enthusiastic enrolment of low-risk people may be the other side of the same coin. DVA pays GPs more than \$1800 per year for a CVC patient, which is about the same as the highest tier payment for Health Care Homes (HCH), a similar scheme being trialled by the Department of Health. HCH has three tiers of payments based on level of risk and care needs.

Keeping people out of hospital is a desirable outcome regardless of cost savings. CVC may also be producing other positive health and wellbeing outcomes — the Grosvenor review found that GPs and patients had reported positive qualitative benefits (Grosvenor Management Consulting 2015).

To some extent, high levels of enrolment would be a positive development if GPs are taking a broader view of their patient's health than required by the eligibility criteria. For example, the patient may not have one of the named chronic conditions, but be overweight or smoke (and so at risk of developing a chronic condition). But the CVC is not set up for this purpose. It is aimed at keeping people at risk of hospitalisation out of hospital and on this front, given the current enrolment pattern, it is less effective than it could be. CVC is effective in keeping high-risk people out of hospital, but has no effect on hospitalisations for other risk groups (box 15.7).

The ideal reform should then balance targeting groups who:

- are likely to produce positive health outcomes and cost savings due to lower hospitalisations (high risk people)
- have positive health outcomes from CVC but who are lower risk.

And it should remove capitation incentives for enrolling low-risk people (with some flexibility).

There is a range of options for DVA (or the Veteran Services Commission, chapter 11) to improve targeting of CVC.

1. Stricter enrolment criteria. DVA could narrow the eligibility criteria to not allow enrolment in CVC unless the patient meets all the criteria (having a named chronic condition and being in the risk range). This was recommended by one set of consultants who reviewed CVC.
2. DVA could advise GPs about a patient's risk rating. If a GP recommends a patient be enrolled in CVC, but they fall outside the desired range for enrolment, DVA could go back to the GP with the risk rating and ask them to reconsider their recommendation. The weakness with this proposal is that the GP will still face the financial incentive to enrol the patient regardless of DVA's advice.
3. Vary the CVC payment based on a patient's risk rating. The Commission has previously recommended a risk-weighted payment model for public dental services. HCH also allows a GP to request an override of the risk classification where they can provide clinical evidence that they have a higher risk. This allows for some discretion and also allows a feedback loop to update the risk weighting tool in the future.

The last option would better target groups with different risks, needs and cost savings. It would retain the ability to enrol people at any point on the risk rating scale, reflecting the expected benefits. This is the Commission's preferred option.

DRAFT RECOMMENDATION 15.2

The Department of Veterans' Affairs should amend the payments for the Coordinated Veterans' Care program so that they reflect the risk rating of the patient that they are paid for — higher payments for higher risk patients and lower payments for lower risk patients. Doctors should be able to request a review of a patient's risk rating, based on clinical evidence.

Mental health and suicide prevention

The mental health policy landscape is changing

There has been a heightened focus on veterans' mental health and suicide in recent years and a range of new policies, programs and research.

- The Government extended access to treatment for post-traumatic stress disorder (PTSD) and depressive disorders on a non-liability basis in the 2016-17 Budget (Australian Government 2016a). This was then extended further to include treatment for any mental health condition from 1 July 2017 (Australian Government 2017b) (a further extension was made in the 2018-19 Budget to include some Reservists). Access to Open Arms was

also expanded to partners and children of serving and ex-serving ADF members who have had at least one day of full-time service.

- The National Mental Health Commission (NMHC) *Review into the Suicide and Self-Harm Prevention Services Available to Current and Former Serving ADF Members and their Families* reported in March 2017 and made 23 recommendations (box 15.8). The extension of non-liability access to mental health care in the 2017-18 Budget was in part in response to the NMHC review (DoD, DoH and DVA 2017). DVA also announced that it would be funding pilots of innovative approaches to suicide prevention and enhanced support.
- The Senate Foreign Affairs, Defence and Trade References Committee inquiry into suicide by veterans reported in August 2017. The Senate Committee made 24 recommendations, of which 13 were for further reviews (including this inquiry), studies or trials (box 15.8). The Government released its response in October 2017, and agreed to 22 of the recommendations (agreeing ‘in-principle’ to recommendations to support the provision of alternative therapies and to establish a Bureau of Veterans’ Advocates).
- In addition to the pilots, trials and reviews, DVA and Defence have also commissioned research into veteran mental health and suicide. The Transition and Wellbeing Research Programme is the most comprehensive study undertaken in Australia on the impact of military service on the mental, physical and social health of serving and ex-serving ADF members and their families. The Research Programme will comprise three studies: the Mental Health and Wellbeing Transition Study, the Impact of Combat Study and the Family Wellbeing Study. Two reports from the Mental Health and Wellbeing Transition Study have been released and one report from the Family Wellbeing Study (which including findings on families’ mental health). DVA have also commissioned the Australian Institute of Health and Welfare to provide annual updates on the level of suicide among serving and ex-serving ADF personnel.

Box 15.8 Recommendations and ideas to improve mental health care

The *Pathways to Care* report of the Transition and Wellbeing Research Programme presented five ideas to improve mental health care for veterans.

- Improve integration and coordination of services. This would help veterans make more informed decisions about their options for seeking care and, if coupled with a more clearly stepped system, would increase the potential for care to be delivered at the right level for a veteran's needs.
- Establish networks of excellence. These networks could identify services and practitioners with the appropriate capability to address veterans' mental health problems. This would assist veterans to make informed choices and improve the coordination of care.
- Support identification and service engagement in mental health and wellbeing through the transition period.
- Bolster the effectiveness of treatment. This includes increasing the delivery of evidence-based care to veterans, seeking to keep them engaged in care long enough for it to be effective and exploring innovative treatment options for veterans who do not respond to standard care.
- Develop ways to deal with stigma about seeking care. First, public messaging about the availability and benefits of treatment should be clearer. Second, there should be better self-care options for veterans who remain reluctant to seek out care from a professional. Third, concerns that seeking help will harm someone's career can be addressed by publicising positive examples.

A Senate inquiry in suicide by veterans and ex-service personnel made 24 recommendations. Key recommendations included:

- develop and implement specific suicide prevention programs targeted at those veterans identified in at-risk groups
- establish a National Veteran Suicide Register
- review the enhancement of veteran-specific online training programs intended for mental health professionals, in particular requirements for providers to undertake training and the introduction of incentives for undertaking training and demonstrating outcomes in clinical practice
- fund a trial program that would provide assistance animals for veterans with post-traumatic stress disorder.

The National Mental Health Commission made 23 recommendations, including:

- the Australian Defence Force (ADF) and the Department of Veterans' Affairs (DVA) should consider how to better promote services to former serving members and their families
- any new program to reduce the incidence of suicide and self-harm in the ADF or DVA must be evidence-based and have a clearly defined program of evaluation before commencement
- consider funding and developing further mental health centres of excellence within all major defence service regions
- the ADF and DVA should continue to implement a robust continuous quality improvement framework, with an annual report to Ministers noting significant achievements and any challenges.

Sources: Forbes et al. (2018); National Mental Health Commission (2017); Senate Foreign Affairs Defence and Trade References Committee (2017).

There have also been a range of initiatives by State governments and non-government organisations to improve veterans' mental health care (box 15.9).

Box 15.9 Initiatives by State governments and non-government organisations

Some State governments are using the sites of their former repatriation hospitals to develop new facilities for veterans health.

- The redevelopment of Concord Hospital in Sydney (scheduled to be completed in 2021) will include the country's first National Centre for Veterans' Healthcare. It is being billed as a comprehensive care centre that will integrate a range of specialist outpatient services in a one-stop shop.
- The Jamie Larcombe Centre in Adelaide, opened October 2017, is a veterans' mental health precinct that provides acute, sub-acute and rehabilitative mental health care for veterans. It also runs post-traumatic stress disorder programs for emergency service personnel.

Another initiative is The Oasis Townsville, which is a 'community space' that is being developed as a registered charity to provide a concierge service for the veteran community. The Oasis is participating in the Townsville suicide prevention trial being run by the Northern Queensland Primary Health Network.

DVA needs a better mental health and suicide prevention strategy

The myriad of policy changes in the mental health landscape mean that DVA's (or, in the future, the Veteran Services Commission, chapter 11) role in the system needs to evolve. Notably, its area of responsibility has substantially increased with the expansion of non-liability mental health care. DVA retains ultimate responsibility for the effectiveness of mental health services, regardless of the service delivery arrangements. DVA's responsibility over the system, called stewardship, involves oversight of all the functions of the veteran health system and directly or indirectly affects all the outcomes. As DVA is now funding more services, its stewardship responsibilities have widened.

A number of participants observed shortcomings in DVA's stewardship of mental health care.

- RSL Queensland (sub. 73) said that DVA had no process to identify where treatment was not working and where a veteran could be assisted to gain more effective treatment.
- Dr Warren Harex (sub. 89) noted that DVA should be evaluating mental health services to ensure quality and cost-effectiveness.
- The Royal Australian and New Zealand College of Psychiatrists said:
... DVA rely on a purchaser-provider system, whereby health services are contracted from external providers ... Veterans are required to source their own services, and there is little incentive to build specialised service areas related to veterans. This leads to a number of issues, including the possibility of market failure whereby certain services may simply not be available. In addition, the services which do exist cannot benefit from the advantages of consolidated

clinical knowledge. Thus fragmented, services offer varying models of care at varying levels of quality with no guaranteed continuity of care ... Instead of improving care, this system creates issues that can exacerbate mental ill-health, and clearly does not prioritise the needs of veterans. (sub. 58, p. 3)

Importantly, there is no strategy for coordinating the range of reforms undertaken and assessing whether they are improving outcomes for veterans. The usefulness of DVA's 10-year Veteran Mental Health Strategy, which was released in 2013, is questionable — it is telling, for example, that recent initiatives have been driven by community concern and related inquiries and not by the strategy. It also does not contain any tangible goals, commitments or indicators to measure progress. DVA released a Mental and Social Health Action Plan, for 2015-16, and a report on implementation of this plan. In the implementation report, DVA acknowledges a need to update its mental health strategy:

2017 presents an opportunity to consolidate and consider the findings and recommendations from the significant range of reviews, inquiries and research currently underway and ensure future focus in this area is evidence-informed, current and relevant. The next Action Plan will be informed by this work. (DVA 2016i, p. 8)

It is not clear what action DVA is taking on updating the Action Plan or if it is developing a new one. DVA told the Commission that it had commenced a review of its mental and social health strategic framework (sub. 125, p. 44). Defence and DVA are also undertaking a mapping exercise of all mental and social health services to identify weaknesses or gaps in treatment options (DoD, DoH and DVA 2017).

In light of the changes to the policy landscape, it is the Commission's view that DVA needs a new mental health and suicide prevention strategy. The strategy should focus on maintaining, and building on, the efforts of recent years and making sure that the responses to the NMHC and Senate are followed through. It will need to consider the findings from recent research and the results from the pilot programs.

Information is needed to support the strategy

Developing an effective mental health strategy or plan is an involved process (box 15.10). There is an interim step between recognising the need for a strategy and commencing development of a strategy — identifying information that should form the basis of the new strategy (and seeking out such information).

One common theme among the recent reviews of veterans' mental health is that DVA needs to build the evidence base in a number of areas as a necessary precondition for both filling service gaps and making services more effective. The NMHC found that it was not able to empirically assess the effectiveness of suicide prevention services because there was insufficient information. The NMHC noted a lack of evidence around effectiveness was not uncommon for mental health and suicide prevention services more broadly. But the NMHC pointed out that the lack of information had been previously recognised by the Dunt Review in 2008, which explicitly recommended rigorous evaluation of all programs. That this

recommendation did not result in ongoing improvements in the quality of information available suggests a new approach is needed to translate ideas and commitments into practice which is sustained over the long-term.

Recent research and reviews (including the forthcoming service-mapping exercise) will no doubt contribute, but before updating the Veteran Mental Health Strategy DVA should pause to consider the information it needs. That said, perfect information (which will never exist) is not a prerequisite to updating the strategy. It would also be counterproductive to delay the strategy unnecessarily, or to let the development of the strategy delay the progress of other policies and programs.

Box 15.10 WHO advice on effective mental health policies and plans

The World Health Organization (WHO) has guidance on what makes an effective mental health policy, which the WHO describe as a formally adopted document that defines a vision for the future and outlines a broad model for action to achieve the vision. The WHO also has guidance on what makes an effective mental health plan, which it describes as detailing the strategies and activities to realise the vision and achieve the objectives of the policy. The WHO's 'checklists' for evaluating a mental health policy or plan includes some important measures which are not well-developed in the Veteran Mental Health Strategy or Action Plan. These include being based on data from a situation assessment or needs assessment, and having timeframes, indicators and targets.

The WHO also has some advice on the essential steps to develop a mental health policy. The Department of Veterans' Affairs should follow these steps to update the Veterans Mental Health Strategy.

1. Gather information and data for policy development — what are the population's mental health needs?
2. Gather information for effective strategies — pilot projects, especially those that have been evaluated, are an excellent source of information on which to base policy formulation.
3. Consultation and negotiation — implementation, and a successful policy, depends on support at the grassroots level. Stakeholders will have different views on the mental health needs of the population, and an active compromise among stakeholders may be necessary.
4. Exchange with other countries — rapid development of mental health policies throughout the world make it very useful to exchange information with other countries.
5. Set out the vision, values, principles and objectives — the vision represents a general image of mental health care, including the types of services that are required. The values and principles are the base upon which to set objectives and goals, such as recognising the link between mental and physical health, or recognising the desire for equity of access to services. The three objectives of any health policy are to improve the health of the population, respond to people's expectations and provide financial protection against the cost of ill health.
6. Determine areas for action — including coordinating action, financing, and organising services.
7. Identify the major roles and responsibilities of different sectors.

Sources: Funk and Freeman (2011); WHO (2005).

What should the priorities for the new (or updated) strategy be?

While there is a lot of work underway that should inform an updated Veteran Mental Health Strategy, there are also potential priority areas identified in recent reports, including:

- the quality of mental health care that veterans have access to
- coordination of care for veterans with complex needs
- access to mental health care for families of veterans.

The Veteran Mental Health Strategy should also acknowledge the heightened risk of suicide for younger veterans and include dedicated strategies to address the needs of this cohort (Baker et al. 2017).

Access to high quality mental health care

When a veteran seeks help for a mental health problem, they should be confident that the professional they are seeing is either equipped to give them the best available treatment or can refer them to someone else who can. While easier access to mental health treatment, as has been facilitated through the non-liability White Card, is important, so too is access to treatment that is evidence-based, patient-centred and effective.

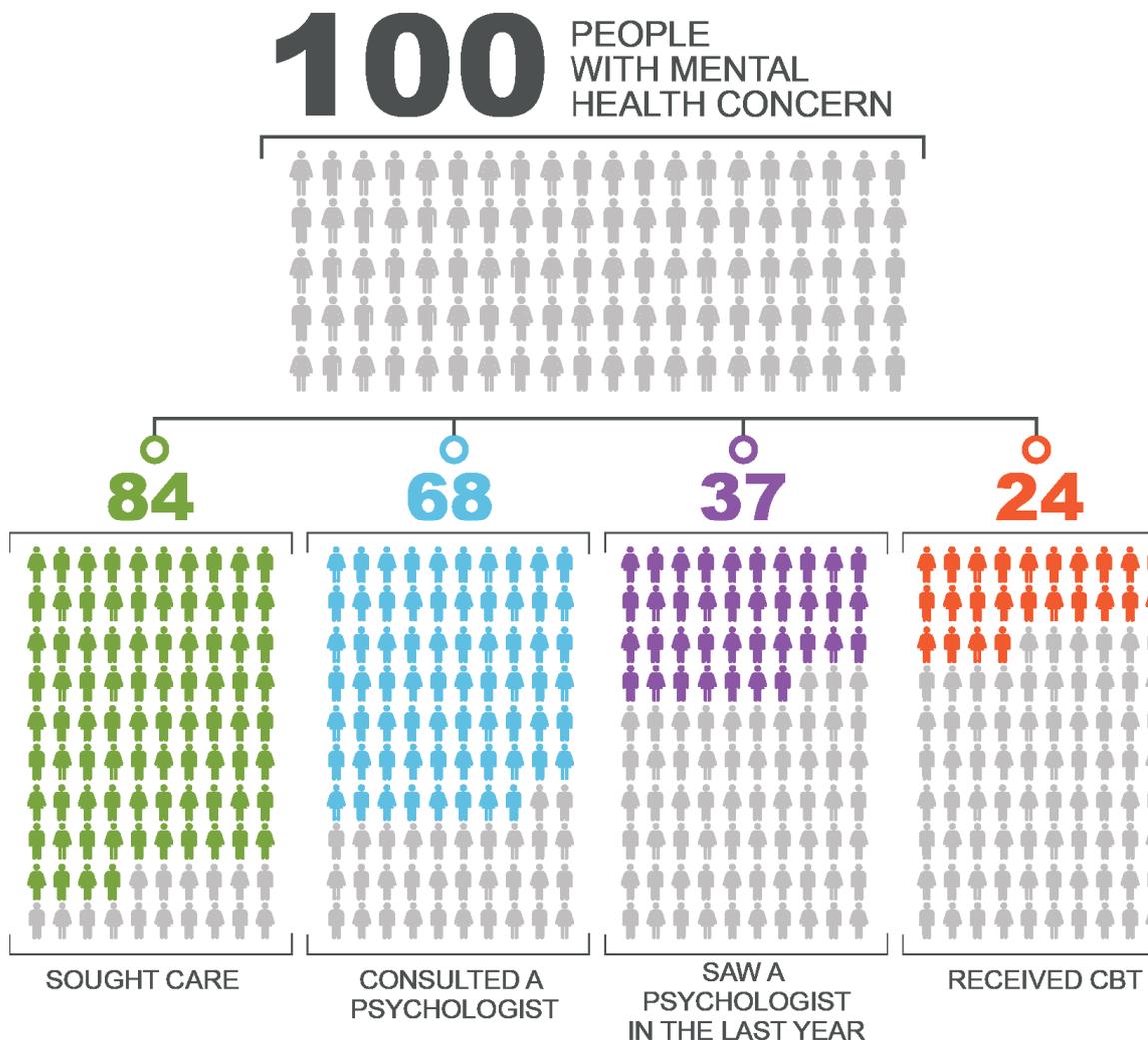
The *Pathways to Care* report found that while initial rates of engagement with mental health care among veterans was relatively high, only a small proportion of veterans were receiving best practice care (Forbes, Van Hooff and Lawrence-Wood 2018). Only about 24 per cent of veterans with a mental health problem had seen a psychologist in the past year and received cognitive behaviour therapy (CBT), which the researchers used as a proxy for evidence-based best practice treatment (figure 15.3).

The process of seeking and receiving care has multiple steps — while initial rates of engagement are high there is the potential to increase the extent to which evidence-based best practice treatment is provided and the degree to which veterans remain engaged in care long enough for treatment to be effective.

Veterans and their families may be reluctant to remain engaged if they are not receiving care that is patient-centred. The NMHC found that veterans and their families generally had poor perceptions of service effectiveness, particularly for mental health or suicide prevention support programs, PTSD treatment services and support for families (NMHC 2017).

Figure 15.3 **Veterans seeking and receiving mental health care**

Per cent



Source: Forbes et. al (2018).

The Commission heard from participants that an element of service quality that is important to veterans is that service providers understand their military experience. Mates4Mates said that unless service providers ‘understand the context from which veterans will operate, they will have little hope of developing positive therapeutic relationships with veterans’ (sub. 84, p. 4). The NMHC said it was told that:

... some service providers are perceived to have no/limited understanding of military culture and military service, which can be exacerbated by turnover amongst health service providers. This lack of understanding can have adverse consequences for the quality of treatment and the willingness of current and former serving members to seek help and assistance. (2017, p. 32)

DVA has a website, called *At Ease*, which contains some information for professionals about understanding the military experience and general recommendations for treatment of

common mental health issues specific to veterans. Mates4Mates suggested that DVA give veterans more information about suitable providers by developing a public register of those who have undertaken such training (sub. 84).

The Senate Foreign Affairs, Defence and Trade References Committee recommended that the Government enhance the provision of veteran-specific online training programs (SFADTRC 2017). The Senate Committee was approving of comments put to it by the Australian Psychological Society.

The Department of Veterans Affairs (DVA) currently provides the opportunity for upskilling of providers of psychological services to veterans to support quality service delivery. The current DVA suite of eLearning online training such as ‘understanding the military experience’ modules are important in building a cohort of providers informed in the military experience. Such training is vitally important for clinicians to be able to effectively translate clinical best practice to the particular issues confronting veterans. However, there is no requirement for DVA providers to undertake this training and there are currently no incentives for health practitioners to complete the training. Additionally, there is no mechanism for referrers or consumers to identify service providers who have undertaken the DVA training. (Australian Psychological Society 2016, p. 1)

The Australian Psychological Society (2016) made three suggestions:

- that training be enhanced
- a system for identifying practitioners who have undertaken the training be introduced
- incentives to undertake the training and demonstrate clinical outcomes be introduced.

The Government agreed to the Senate Committee’s recommendation for a review of its training but did not provide a commitment to actually introduce incentives or a way for identifying practitioners who have completed the training.

It would be in veterans’ and DVA’s interest to know whether DVA’s training material is effective in promoting quality care. Do practitioners find it useful? Can veterans tell if a practitioner has undertaken such training — do they provide noticeably better care? Do practitioners who have undertaken the training also have better treatment outcomes? This training material is a key way that DVA seeks to enhance the quality of care for veterans and so it is important to get right.

DVA’s most significant effort to promote quality treatment is its funding of Phoenix Australia, the Centre for Posttraumatic Mental Health. Phoenix Australia conducts research, provides education and training and publishes evidence-based treatment guidelines for PTSD. For example, Phoenix Australia is currently trialling whether an intensive form of one of the most effective treatments for PTSD (prolonged exposure therapy) is as effective as the standard form. The current form of treatment comprises one session a week for ten weeks, while the new intensive form that is being trialled will comprise daily sessions for two weeks. If the trial is successful it could make an effective therapy more accessible.

Phoenix Australia has also established the Centenary of Anzac Centre, which is intended to bring together research on treatment for veterans’ mental health problems and provide expert

guidance and support for practitioners working with veterans with mental health problems. The Centre's practitioner support service provides free consultations with veteran mental health experts for health practitioners, organisations that provide clinical services for veterans and other veteran-specific organisations (such as ex-service organisations).

The NMHC recommended that consideration be given to funding and developing specialist mental health 'centres of excellence' to build the evidence base through high quality research and service evaluation as well as use specialist multi-disciplinary teams to provide services (NMHC 2017). In response, the Australian Government noted the existence of the Centenary of Anzac Centre, which conducts research, and VVCS (Open Arms) which provides services (DoD, DoH and DVA 2017). The Jamie Larcombe Centre, a veterans' mental health precinct run by SA Health (box 15.9) could also be a model for a veterans' mental health centre of excellence.

The *Pathways to Care* report also raised the idea of establishing 'networks of excellence' which would identify services and practitioners with competence in addressing veterans' mental health problems, and promote high levels of connectedness between services (Forbes, Van Hooff and Lawrence-Wood 2018). Promoting connectedness goes towards providing coordinated care, which is discussed later.

Another initiative to support effective mental health treatment that DVA could consider is NewAccess, an early intervention program developed by Beyond Blue that uses low-intensity CBT delivered by specially-trained coaches. NewAccess, based on a successful program from the United Kingdom, is:

- evidence-based, and designed around best-practice guidelines
- effective, with clear metrics and reporting systems to assess progress
- accessible, with a recognised training program that means even people without mental health training can become coaches. The program also allows self-referrals to encourage access.

NewAccess is currently available to employees of Defence (ADF personnel and public servants) and has been commissioned by 13 Primary Health Networks. Given DVA's problematic lack of service evaluation (chapter 16) and concerns around the effectiveness of some of the services that it funds, NewAccess could be worth extending to veterans also. DVA could also consider adopting the high-intensity CBT element which is present in the UK program but not in NewAccess.

DVA also directly provides mental health services through Open Arms — the most direct way that DVA can improve services for veterans is to ensure that Open Arms is effective, which is discussed later.

The VVCS National Advisory Committee suggested that poor remuneration by DVA attracts lower quality providers which 'results in substandard care' (sub. 72, p. 4). The issue of remuneration and the fees that DVA pays providers is discussed later.

Coordination of mental healthcare

Veterans with complex or serious mental health problems would benefit from more coordinated care. As Phoenix Australia put it ‘the care system is a complex one, often difficult for the veteran to navigate, and hence there is the potential for veterans with elevated risk or complex problems to fall through the cracks’ (Phoenix Australia 2016, p. 6).

Coordinated care refers to deliberately organised patient care between two or more participants to facilitate the delivery of health care. Coordinated care can help a person with mental illness access a range of different services they may need to aid in their recovery and, importantly, aims to bring the multiple agencies and professionals involved together so they can work towards improving the person’s mental health. A designated care coordinator has the responsibility of coordinating, facilitating and integrating a person’s treatment, care and support (WA Department of Health nd).

Many veterans have complex mental health problems — about a quarter of transitioned ADF had two or more mental health disorders (Van Hooff et al. 2018b) — and so may benefit from coordinated care. In addition, mental health problems can be present alongside physical health problems. For example, PTSD has been found to be associated with negative physical health outcomes including chronic rashes and eczema, arthritis, asthma and hypertension (O’Toole and Catts 2008).

The *Pathways to Care* report observed problems with the coordination of care for veterans:

The service system available to Transitioned ADF compared with that of Defence is that it is provided largely by a broad array of private services, tertiary- and community-based services, and private health and mental health practitioners across the country ... There is little systematic coordination across the full array of services, between levels of care and between providers of care. As such, there is considerable risk that individuals may fall out of care or into gaps between services. (Forbes, Van Hooff and Lawrence-Wood 2018, p. 225)

Open Arms has a case management service, called Complex Needs Client Support, but it appears to be a small part of its activities. In 2016-17, Open Arms provided 317 case management sessions, compared to over 25 000 counselling sessions and 69 000 outreach counselling sessions (DVA 2017d). DVA also has a case management service, Coordinated Client Support, that assists people with complex compensation needs but does not provide clinical case management.

There are several coordinated mental health care pilots currently underway.

- DVA has commissioned two pilots targeting different cohorts:
 - veterans with severe and complex mental health conditions who have recently been discharged from hospital
 - veterans with chronic, but stable, mental and physical health issues.
- Open Arms is running a ‘community coordination’ pilot in Townsville.

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- The Australian Government is running a set of suicide prevention trials and one of the 12 sites, Townsville, is focused on veterans.

The first DVA-commissioned pilot is the Veteran Suicide Prevention Pilot (also called the Mental Health Clinical Management Pilot). This provides a support coordinator for up to three months for veterans who have experienced a suicide crisis and required hospitalisations (DVA 2018ap). The pilot is being delivered by Beyond Blue in Brisbane for up to 100 veterans (DVA 2017e, 2018ap). The support coordinator will: work with the veteran to develop a personalised safety plan that is aimed at safely re-engaging the veteran in everyday life; promote access to follow-up care (including tracking appointments with other services); and link the veteran with other support services, including Open Arms. Beyond Blue has run a similar service, called The Way Back, since 2014 and in the 2018-19 Budget the Government allocated nearly \$38 million to greatly expand the service.

The second DVA-commissioned pilot is trialling an early intervention measure for people in the CVC program — participants will complete a short CBT-based self-help course using an app on their phone or other device. This pilot is being run for up to 250 participants and specifically targets rural and remote regions where mental health services may be harder to access (or unavailable) (DVA 2018j). Despite being delivered to CVC participants, the pilot does not appear to be trialling coordinated mental health care in and of itself, and appears to be focused mainly on trialling the self-help app. When the trial was announced in the 2017-18 Budget, DVA said that the pilot would trial an expansion of CVC program to support veterans with chronic mental and physical conditions (DVA 2017e). Such an expansion would be worth trialling, given the effectiveness of CVC in keeping people out of hospital, and so it is curious why DVA has commissioned such a limited trial instead.

Open Arms is testing whether a new model of community-coordinated care can improve the clinical experience of veterans with complex mental health problems. Open Arms has established a Care Coordination Team, comprising Open Arms clinicians as well as lived experience peers, to build stronger relationships between service providers and veterans to promote comprehensive and integrated support (Lewis 2017). The Open Arms Care Coordination Team has:

- established a visiting service to the local psychiatric hospital to support community reintegration
- commenced building a mental health peer network
- engaged clients in Open Arms case management (Lewis 2017).

Open Arms' Townsville trial is separate to a broader suicide prevention trial, called Operation Compass, being funded by the Department of Health and run by the Northern Queensland Primary Health Network. Operation Compass has six campaigns, led by local expert teams, and is expected to be completed by June 2020. The campaigns include projects to:

- provide training in suicide awareness and prevention
- improve after-hours primary care, mental health and alcohol and other drug services

-
- create and promote a range of community support groups
 - engage veterans in volunteering, through The Oasis Townsville
 - gather more detailed information at a local level about the veteran community through surveys and focus groups (Northern Queensland Primary Health Network nd).

All four pilots contain significant promise for improving mental health care, which highlights the importance of rigorous evaluation and a credible plan for implementation, if they are found to be successful. DVA said that its intention is that the Suicide Prevention and CVC pilots will identify barriers and success factors, health outcomes and evidence for further expansion and that DVA will collect the evidence necessary to support a national scale-up, if either or both of the pilots are found to be successful (DoD, DoH and DVA 2017).

DVA has a complex task ahead of it in responding to these different pilots. They do not appear to be part of a cohesive strategy and indeed look to be at risk of overlapping in some areas, particularly the two pilots being run in Townsville. It is also not clear how DVA plans to build on the Operation Compass trial, which could have profound implications for service delivery and, if successful, imply a greater role for Primary Health Networks in commissioning mental health services for veterans. The Commission found there to be significant weakness in DVA's strategic policy capabilities (chapter 11) which creates a risk of a fragmented approach.

Mental health and families

Supportive families can help veterans with their mental health, including encouraging them to seek help for mental health concerns (families are often the first to notice symptoms).

A veteran's mental health condition can also affect their family. As the NMHC said:

- The routine of military life creates a set of unique stressors for families, including the anxiety and concern about the safety and wellbeing of the person who is in service, particularly when they are away from home, and especially when they are away on deployment.
- Incidents of domestic violence, and drug and alcohol abuse, and the impact on the family of living with a service person who has a physical injury or mental illness but cannot or will not access treatment services.
- The potential for negative mental health impacts for families as a consequence of their association with the military. (2017, p. 23)

RSL NSW also noted the mental health impacts on families:

When veterans suffer from serious mental health conditions, their family members can live in a traumatic environment, and often endure domestic violence and controlling behaviour, experience feelings of isolation, exhaustion and chronic sorrow, and/or begin to mirror the symptoms of the veteran (e.g. hyper-vigilance, anxiety, depression, anger, frustration, social isolation). (sub. 151, p. 23)

However, the Transition and Wellbeing Research Programme’s Family Wellbeing Study surveyed families of current serving and ex-serving ADF members, and found that their mental health was generally no worse than the comparable Australian population (Smart, Muir and Daraganova 2018). This study was limited to families of ADF members who had left in the last five years. It is possible that more significant problems arise over the longer term.

There are mental health services available to veterans’ families, most notably Open Arms (discussed below). However, when talking to the Commission many family members of veterans expressed dissatisfaction with Open Arms. The Senate Foreign Affairs Defence and Trade References Committee also heard concerns about a lack of support for families and recommended that DVA review the support for partners of veterans to identify further avenues for assistance (SFADTRC 2017). The Government response to this recommendation did not commit to any specific actions.

The Commission considers that Open Arms is the appropriate avenue for DVA to provide mental health services for families. However, Open Arms and other supports for families should be included in the service mapping exercise that is currently being undertaken. The results of this exercise should feed into the updated Veteran Mental Health Strategy. As discussed later, the Commission is also recommending better monitoring of the performance of Open Arms.

DRAFT RECOMMENDATION 15.3

The current (2013–2023) Veteran Mental Health Strategy has not been very effective and should be updated in light of recent policy changes (such as non-liability access) and research findings on emerging needs.

The Department of Veterans’ Affairs (DVA) (in consultation with the Departments of Health and Defence) should urgently update the Veteran Mental Health Strategy, so that it guides policy development and implementation over the medium term. It should:

- be evidence-based, including outcomes from policy trials and other research on veterans’ mental health needs
- set out clear priorities, actions and ways to measure progress
- commit DVA to publicly report on its progress.

The Strategy should include ways to promote access to high-quality mental health care, and to facilitate coordinated care for veterans with complex needs. It should also have suicide prevention as a focus area and explicitly take into account the mental health impacts of military life on veterans’ families.

Open Arms (formerly the Veterans and Veterans Families Counselling Service)

Open Arms provides counselling, referrals to mental health providers and case management services. It describes itself as the cornerstone of the veterans’ mental health system (sub. 72). Open Arms is unique in the veterans’ health space as it is run by DVA, rather than by State

health services or private providers. This makes DVA solely responsible for Open Arms' performance.

DVA does not publish outcomes data for Open Arms, which makes assessing its effectiveness difficult. The only performance information released are measures of timeliness, consumer satisfaction and complaints.

On timeliness, Open Arms seeks to have client needs identified and supports in place within 14 days of the initial intake. In 2017-18, counselling was provided within 14 days for about two-thirds of clients (DVA 2017d). Open Arms also received 30 complaints in 2016-17, and most of these were about the responsiveness of their services (DVA's 2017-18 Annual Report did not report complaints for Open Arms).

The timeliness measures could be more informative and include:

- mean, median and maximum wait times
- wait times by State and Territory (or for each of Open Arms 25 centres) — to gauge whether services are more accessible in some locations than others
- wait times by priority group — even a short wait for someone in crisis would be a problem
- length of time taken for the initial intake.

One participant to this inquiry raised concerns about delays in accessing Open Arms services in some locations (sub. 34).

On satisfaction, DVA's client satisfaction survey showed more than 93 per cent of Open Arms clients were satisfied or very satisfied with the services they received (DVA 2017d). Similarly, the NMHC said VVCS was one of the highest rated services in their survey, particularly for current serving and former ADF members (NMHC, sub. 107). However, more than 50 per cent of family members rated VVCS services as low or very low effectiveness. This suggests that DVA should be reporting client satisfaction data at a more detailed level, and the high-level results may be obscuring a more nuanced picture of satisfaction.

Open Arms has a central role in the veterans' mental health system and is also the main way that mental health care is offered to families of veterans. Given its role in the mental health system, Open Arms could significantly contribute to both the provision of high-quality mental health care and the coordination of care for veterans with complex problems (outlined earlier). It is also currently participating in a number of pilots and trials which, if successful, could further expand its role. As such, it is critical that its performance is measured and evaluated in terms of clinical or other mental health-focused outcomes, in addition to the current timeliness and satisfaction measures.

The broad range of services that Open Arms provides raises the question of what the most informative and practical outcomes would be. Open Arms describes itself as 'nationally accredited', presumably against the National Standards for Mental Health Services. These

standards require some degree of safety, quality and outcomes measurement. But an outcomes framework could still be a valuable way for Open Arms to fundamentally embrace a culture of performance improvement, and allow DVA more broadly to consider the position of Open Arms in the veterans' mental health system.

State and Territory mental health services are required to collect outcomes data for their consumers. Nine clinician-rated and consumer-rated measures are reported to the Australian Government through the Australian Mental Health Outcomes and Classification Network (some data are reported in the annual Report on Government Services). If Open Arms were to participate in this process then its performance could be compared with other services, improving accountability. The data are also shared among the services, to enable benchmarking and assist clinicians and others to better understand outcomes and variability of those receiving mental health services in the public sector. Open Arms could also benefit from participating in such a process.

It may be the case that not all of the outcomes measures used by the States and Territories are applicable to Open Arms services. Even if Open Arms only used some measures, it may find that the process of adopting routine outcomes measurement could foster a culture of benchmarking and contribute to a process of ongoing quality improvement, as required by the National Standards for Mental Health Services.

If Open Arms is not able to use the measures used by the States and Territories, its National Advisory Council should lead the development of an outcomes framework. The goals of the outcomes framework should be to:

- measure mental health and wellbeing
- use indicators that are useful to informing practitioners and others in the service
- use indicators that allow benchmarking against other providers, where possible
- use data sources that minimise the cost of collecting outcomes measures.

DRAFT RECOMMENDATION 15.4

The Department of Veterans' Affairs (DVA) should monitor and routinely report on Open Arms' outcomes and develop outcome measures that can be compared with other mental health services.

Once outcome measures are established, DVA should review Open Arms' performance, including whether it is providing adequate, accessible and high-quality services to families of veterans.

Access to services

According to some participants, there are providers that will not accept DVA cardholders (Commonwealth Ombudsman, sub. 62; VVCS National Advisory Council, sub. 72; Prime

Ministerial Advisory Council on Veterans' Mental Health, sub. 99; Victims of Abuse in the Australian Defence Force Association, sub. 133). The Commonwealth Ombudsman indicated that this is of particular concern for individuals seeking psychiatric, neurological and orthopaedic services.

This is in part because providers cannot charge DVA cardholders a co-payment. If the DVA fee schedule is set too low, providers can respond by either cross-subsidising from other patients (or their own income) or not treating DVA clients. Some suggested that the DVA cardholders are being treated by less-experienced clinicians or recent graduates (Occupational Therapists Australia, sub. 71; VVCS National Advisory Council, sub. 72). If providers are not accepting DVA cardholders, this could contribute to delays in accessing VVCS outreach services (discussed earlier).

The fees the government pays under the Medicare Benefits Schedule and the fees that DVA pays under its scheme have not been indexed since 2013. What this means is that the cost to providers of treating a DVA patient, relative to another patient, could have increased. The Australian Government will recommence indexing fees over 2018 to 2020. Fee indexing for GPs and specialists will recommence in 2018, specialist procedures will recommence in 2019 and fee indexing for diagnostic imaging will recommence in 2020.

Medicare and specialist bulk billing rates for the general population have not deteriorated during the indexation pause. Nonetheless, high cost clients or locations may be experiencing more noticeable effects. And there is some suggestion that DVA clients may be more costly to service. For example, the Royal Australian and New Zealand College of Psychiatrists suggested that DVA's burdensome paperwork requirements may discourage providers from accepting DVA patients:

... RANZCP members have indicated that time-consuming paperwork requirements are directly impacting the availability of clinicians for clinical assessment and treatment. Such requirements discourage medical practitioners from taking on veterans that require engagement with DVA. (sub. 58, p. 5)

And:

Burdensome paperwork requirements and limited rebates from DVA may further discourage health services from accepting veterans and ex-service personnel as patients, even when they do have appropriate services. It is important that such barriers are reduced to ensure veterans are able to access psychiatric services. As such, the RANZCP encourages DVA to review remuneration rates and schedules for psychiatric consultations, and consider options to encourage mental health services to accept veterans as patients. The administrative burden of patient care with compensable injuries is more reasonably reflected in the workers compensation systems reimbursement schedule which is a direct competitor for clinicians' time. (sub. 58, p. 5)

DVA acknowledges the administrative burden that it places on providers. The Treatment Principles concede that the legally-binding notes for GPs may be 'exacting' (and hence require remuneration higher than the Medicare fee schedule) but claim that medical specialists 'are not prepared to submit to the same level of regulation' as GPs (s. 4.1.3).

There is no set of legally-binding notes for psychiatrists or other specialists (aside from the Treatment Principles).

DVA pays fees that are higher than the Medicare fee schedule — 15 per cent higher for GP consultations, 35 per cent higher for specialist consultations and 40 per cent higher for procedures (Prime Ministerial Advisory Council on Veterans’ Mental Health, sub. 99). There is also another payment of between \$7 and \$11, called a Veterans’ Access Payment, for GPs. However, industry groups claim that DVA fees are below market rates and below the rates paid through other workers’ compensation schemes. GO2 Health (sub. 98) estimated that DVA fees are 40 per cent lower than private fees and another participant estimated that physiotherapists, occupational therapists and psychologists can earn as much as 50 per cent more for treating non-DVA clients (David Tymms, sub. 79).

It is difficult to come up with a true like-for-like comparison of the fees paid under different schemes. For example, some schemes pay an hourly rate, while others pay per appointment. And some schemes provide different fees for consultations at the practitioner’s office or elsewhere (in or out of rooms), while others do not (paying a travel allowance instead). Having said all that, some comparisons can be made.

- DVA’s fees for an initial physiotherapy consultation are somewhat below those paid by other schemes, but the in-room standard consultation rate is above the Transport Accident Commission (TAC) and Worksafe Victoria rates and slightly below the Comcare rate (table 15.2).
- DVA’s fees for psychologist consultations are below other schemes, except for very short appointments where they are above TAC and Worksafe Victoria, but still below Comcare (table 15.3).

Table 15.2 Physiotherapy fee comparison
\$ per consultation

	<i>Initial consultation (in rooms)</i>	<i>Initial consultation (out of rooms)</i>	<i>Standard consultation (in rooms)</i>	<i>Standard consultation (out of rooms)</i>
DVA	64.25	69.05	64.25	64.25
TAC	71.55	102.12	54.51	81.70
Worksafe Victoria	103.71	103.73	54.46	56.97
Comcare (Victorian rate)	81.80	na	66.60	na

Sources: Comcare (nd); DVA (2018y); TAC (nd); Worksafe Victoria (2018a).

Table 15.3 Psychology fee comparison

\$ per consultation (length)

	20 minutes	30 minutes	45 minutes	60 minutes
DVA	72.95	72.95	72.92	102.95
TAC	54.26	81.39	122.08	162.78
Worksafe Victoria	55.78	83.67	125.50	167.33
Comcare	119.00	119.00	166.00	218.00

Sources: Comcare (2018a); DVA (2018ad); TAC (2018); Worksafe Victoria (2018b).

Comcare pays fees for medical practitioners, including GPs, psychiatrists and specialists, according to a list prepared by the Australian Medical Association. Allied health fees are paid according to a fee schedule maintained by Comcare. Providers are not restricted from charging over the Comcare rate. The process of claiming medical treatment from Comcare is different to using the DVA White or Gold Card — the claimant must submit a treatment plan to Comcare for approval. The treatment plan must set out the types of treatment needed, how often and for how long. Costly treatment, such as surgery, also requires prior approval from Comcare.

The Prime Ministerial Advisory Council on Veterans' Mental Health considered the issue of accessibility of mental health services at its March 2018 meeting and concluded that 'there are adequate contingency arrangements in place for DVA cardholders should they be refused treatment by a particular service provider' (Prime Ministerial Advisory Council on Veterans' Mental Health 2018, p. 1). One contingency is the provider seeking prior approval from DVA to charge a higher fee before undertaking any treatment or consultation. DVA considers requests for prior approval on a case by case basis, taking into account clinical need and the patient's ability to reasonably access another provider (DVA 2018ag). On this issue, the Commonwealth Ombudsman, noted that:

While DVA does have the discretion to pay above the repatriation rate, it can only do so where there are exceptional circumstances, and these situations must be applied for in advance of any treatment. This becomes problematic for veterans who have paid for the treatment and seek reimbursement of out of pocket costs. (sub. 62, p. 5)

Another way that DVA can ensure access to medical services is to pay for the cardholder's travel to an alternative provider. However, this may be a problematic solution for people with mental health problems, where proximity to services can encourage their use. While DVA travel assistance may be available, the distance and logistics required to arrange travel can present a barrier to services, which may be a particular concern for people with mental health problems (NMHC 2017).

These issues are not new. In 2004, the Australian National Audit Office (ANAO) reported that DVA was aware of a shortage of certain specialist services for veterans in particular regions of Queensland (ANAO 2004b). There were also instances of specialists indicating that the cardholder would be asked to pay for the initial consultation as a private patient and

would only accept the health card if subsequent treatment was deemed necessary. Some specialists also asked for co-payments, which are not permitted for health card holders. But, in the end, the ANAO concluded that cardholders had a reasonable level of access to medical services and that DVA acted to provide alternative solutions to any who encountered difficulties.

What to do?

DVA has to find the right balance between paying fees that support sufficient provider participation, contain overall costs and ensure quality services for cardholders. This balancing act is made all the more difficult by the differences between groups of cardholders — particularly the differences between cardholders with service-related conditions and those without.

The fee schedules are potentially not striking the right balance for veterans with service-related conditions. DVA's relatively low fees for some services may mean some veterans with service-related conditions are worse off, in terms of accessibility of services, than people covered by civilian workers' compensation schemes. DVA should consider adopting Comcare's fee settings for these veterans. This would include all White Card holders. Participants have identified mental health services as being a particular area of concern, and DVA's fees for psychologists are below those paid by Comcare. For Gold Card holders with service-related conditions, DVA should consider either issuing them with a White Card, or modifying the Gold Card to name conditions for which it has accepted liability and hence will pay the Comcare rate.

Importantly, Comcare strives to find the right balance in its fee settings by paying higher rates, but also requiring a formal treatment plan. DVA is planning to trial a new 'treatment cycle', which could form the basis of this reporting and oversight.

But the balance might be different for treatment of non-service related conditions. As outlined earlier, funding of such treatment is part of a generous compensation package — and it is ultimately up to DVA and society more generally to decide the scope of such generosity. One element of the Gold Card's ostensible generosity is that users cannot be charged co-payments, with the downside being reduced accessibility for some services. If there is an expectation that Gold Card holders be able to visit any health care provider of their choice, then providers should not be restricted from charging co-payments.

The Commission is interested in participants' views on the trade-offs in these approaches.

INFORMATION REQUEST 15.2

The Commission is seeking participants' views on fee-setting arrangements for veterans' health care that would promote accessible services while maintaining a cost-effective system.

What would be the benefits and costs of separate fee-setting arrangements for Gold Card and White Card holders? To allow cardholders more choice of provider, should providers be allowed to charge co-payments? Should co-payments, if permitted, be restricted to treatment of non-service related conditions?

Achieving a cost-effective system

There are three reasons to suspect that DVA could achieve better health outcomes for veterans at lower cost. First, veterans (and other cardholders) may be getting more services than they need. Second, DVA does not make sufficient effort to target veterans with high needs. And third, DVA funds a broad range of services and other entitlements, and not all of these are targeted at genuine need.

As DVA health entitlements are largely uncapped and users face few co-payments, there is the potential for cardholders to make more intensive use of the DVA health system than may be strictly necessary. This can be wasteful, and this expenditure could be re-directed to those people and services that need them the most.

In that context, it is worth noting that DVA has relatively few controls over its health expenditure, or over service usage more broadly. Employers Mutual Limited said they:

... did not observe any line of sight within DVA of its overall treatment expenditure. There is an inadequate focus on managing individual veteran treatments and scheme costs (i.e. a passive approach), resulting in over-servicing, as well as the regular administration of concurrent, ineffective and/or potentially harmful treatments. (sub. 90, p. 6)

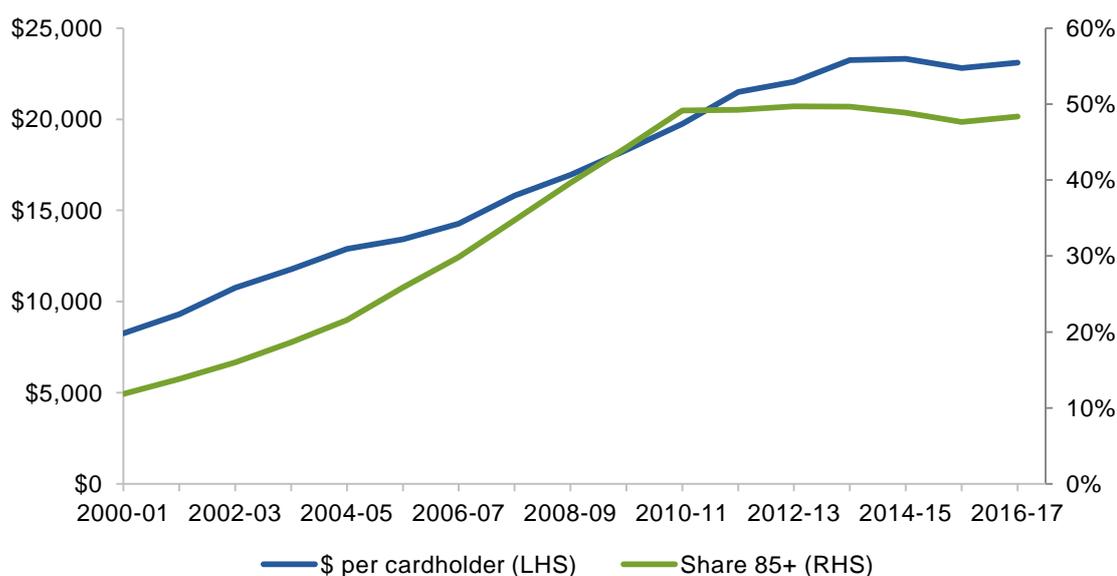
There has been increased service usage by DVA cardholders, some of which can be explained by an ageing population. For example, expenditure per cardholder has increased alongside an increase in the share of the population aged over 80 years (figure 15.4).

There are other signs that suggest health service usage is not fully explained by ageing. Since 2010 the age profile has not changed much — as shown in figure 15.4 where the share of the population aged over 85 has remained just below 50 per cent. Yet from 2011-12 until 2016-17, the average number of dental and allied health services per patient has increased by nearly 50 per cent (DVA 2018ag). Over the same period, mental health services per patient had increased by about 150 per cent, possibly reflecting non-liability access.

The Australian Medical Association suggested that DVA's allied health arrangements do not sufficiently guard against high levels of service usage:

For GPs, the referral process for patients to an Allied Health Provider (AHP) is relatively easy via the D904 form. However, current referral arrangements do not encourage AHPs to report back to the GP and may, in some circumstances, encourage treatment by an AHP to persist beyond what is clinically indicated. (2016, p. 1)

Figure 15.4 Rising costs appear related to ageing
All cardholders



Source: Commission estimates based on unpublished DVA data.

Another way to make sure resources are going to their most productive use is to target services to the right people. Some groups of people make very intensive use of the health care system and tailoring services to these people's needs can have large social and economic benefits.

DVA funds some services for which there is not a strong rationale. For example, more than half of Gold Card holders are eligible for the booked car with driver scheme. This is in addition to their entitlement to reimbursement for travel costs, the Recreation Transport Allowance and/or vehicle modifications. There is also not a strong rationale for DVA to fund other services or entitlements that are not funded for the wider community, such as the RPBS.

The comprehensive range of services that DVA funds and the way that it funds them creates the risk of over-servicing and wasteful expenditure. Over-servicing means providing (and paying for) unnecessary medical interventions. Wasteful expenditure, in this case, refers to paying for other services that are unnecessary or poor value-for-money.

The Commission is recommending that the veteran support system be reformed to adopt insurance principles, including a focus on long-term scheme costs (chapter 11). Such an approach would be particularly valuable in improving the veteran health system — for promoting better health outcomes while at the same time delivering a higher quality service

to patients and value for money for the funder of the system. The Gold Card, as it currently exists, will not sit well under an insurance approach.

The Commission is also recommending that DVA improve the evidence base on veterans and their families (chapter 16). This evidence would be valuable in improving the veteran health system, by increasing the focus on health outcomes and the effectiveness of the services that DVA funds. If DVA were to evaluate much of its health expenditure in terms of achieving health outcomes for veterans, it would be able to design the system in such a way as to improve its cost-effectiveness.

Private health insurance

A few participants raised the idea of subsidising private health insurance for veterans (and dependants). One suggestion was to replace the Gold Card with a private health insurance subsidy or subsidise private health insurance for all ex-service members. Little detail, however, was given about how this proposal would work in practice. And there are a number of complexities.

- It is not clear whether funding private health insurance would cost less than the current arrangements. For example, top level private health insurance can cost over \$6000 per year, while providing less benefits than the Gold Card. Any cost savings would depend upon DVA ceasing to fund benefits and entitlements not covered by private health insurance, such as travel costs. The private health insurance subsidy would be in addition to public health expenditure.
- DVA would still need to fund health care for veterans with service-related conditions. So administration could be made more complicated for DVA, and entitlements could be made more complicated for veterans.
- What would happen to non-liability treatment for cancer, tuberculosis and mental illness?

To fully evaluate the idea of subsidising private health insurance for veterans, key details of the policy need to be considered. What is the rationale? Who would be eligible? What would be subsidised? Design issues, such as how the subsidy would be paid and how DVA would manage the subsidy, are secondary to the policy issues outlined earlier. At this stage, the Commission does not see strong merit in this proposal, but is seeking further participants' views on the policy issues associated with subsidising private health insurance for veterans and dependants.

INFORMATION REQUEST 15.3

The Commission is seeking participants' views on the desirability of subsidising private health insurance for veterans and dependants in place of other forms of healthcare assistance.

16 Data and evidence

Key points

- Good quality data and evidence are critical to:
 - achieving good outcomes for veterans and their families
 - knowing what services and interventions are cost-effective
 - managing the performance of service providers
 - understanding the lifetime costs of supporting veterans and managing the long-term costs of the veteran support system
 - informing and improving the design of services and policies.
- Data are a key component of any good workers' compensation scheme. They are lacking in the veteran support system. And where data are collected, opportunities are lost because they are not used as well as they could be. This inquiry was limited by the lack of data and the poor linking of data.
- Good quality evaluation of the supports that Defence and the Department of Veterans' Affairs (DVA) provide to veterans and their families is also lacking.
- The future veteran support system, with a focus on outcomes for veterans and their families and financial sustainability, will demand better collection and analysis of data.
- Action is needed to strengthen the evidence base on veterans and their families in three main areas.
 - *Performance and outcomes frameworks.* These frameworks are a feature of best practice workers' compensation schemes. They will help address the data gaps highlighted throughout this report, and set up a system that allows ongoing monitoring of data (to help identify emerging trends and outcomes). The development of indicators for outcome measures can leverage off existing data holdings to help minimise the cost of data collection. Developing robust performance and outcomes frameworks should be a priority.
 - *High-quality reviews and evaluations.* Reviews and evaluations are essential for generating evidence about what works, for who and in what circumstances. To minimise the costs of reviews and evaluations while also ensuring high-quality evidence, the methodology of (and subsequently the resources devoted to) reviews and evaluations needs to reflect the characteristics of the services or programs being assessed.
 - *Strategic approach to research.* There needs to be a research plan which sets out research priorities on issues affecting veterans, and timeframes for research completion and publication. Updating the research plan annually will help DVA track its research progress and provide transparency about research outcomes.

The veteran support system, like any good workers' compensation scheme, requires good quality data and evidence. Data and evidence are essential to:

- help deliver good outcomes for veterans and their families, by informing and improving the design and delivery of supports and policies
- monitor the performance of the system (including understanding clients' experiences, analysing error rates, and ensuring the system is financially sustainable)
- monitor and manage the performance of service providers.

This chapter looks at the role of data and evidence in the veteran support system. Section 16.1 looks at the gaps in data and evidence on veterans and veterans' supports. Sections 16.2 and 16.3 set out why data, evidence and performance measurement are important for the future veteran support system. Section 16.4 describes how to better use the data to build an evidence base, and section 16.5 looks at the role of policy trials, evaluation and research in improving veterans' wellbeing.

16.1 Persistent gaps in data and evidence on veterans and veterans' supports

Inadequate data on many aspects of the veteran support system

Basic data on veterans is missing

The gaps in information about veterans are significant. A number of inquiry participants raised concerns about the lack of data.¹ The Defence Force Welfare Association, for example, said:

Before one can fix a problem, one has to be able to quantify the problem. To measure the success or otherwise of service delivery, or an intervention, the definition of success must be identified and ways of measuring it decided. There is a dearth of statistics in many areas. (sub. 118, p. 33)

This inquiry identified and was limited by gaps in the data collection on veterans.

- There is very little information on the veteran population. The number of living Australian veterans is not known. The Department of Veterans' Affairs (DVA) estimates that about a quarter of the estimated living veteran population are DVA clients (chapter 2). This means that the health and welfare status of three quarters of living veterans is largely unknown to DVA.
- DVA only collects limited information to evaluate the effectiveness of the services it provides to veterans and their families. DVA does not measure and publicly report

¹ They included the Defence Force Welfare Association (sub. 118), Giselle Fleming (sub. 33), the National Mental Health Commission (sub. 107), RSL Queensland (sub. 73), Robert Shortridge (sub. 76) and the Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia (sub. 96).

meaningful veteran health and wellbeing outcomes. DVA should be able to demonstrate the effectiveness of the activities it funds. It cannot currently do this.

- There are gaps in the information about veterans, including in the areas of education, employment, justice and safety, income and finance. There are also substantial gaps in the understanding of women's experiences in the Australian Defence Force (ADF) (reflecting in part the historically small number of women in the ADF) (AIHW 2018b, p. 297).
- There are notable gaps in the data on the aspects of the veteran support system for which Defence is responsible. Gaps noted in previous chapters of this report include in the areas of preventing illness and injury (chapter 5), rehabilitation services for serving members (chapter 6) and transition preparation and support (chapter 7). These gaps are exacerbated by the dispersed nature of Defence records (chapter 8).

Each of these gaps would, on its own, merit concern, but taken together this points to significant shortcomings in the administration of the veteran support system.

No whole-of-client analysis

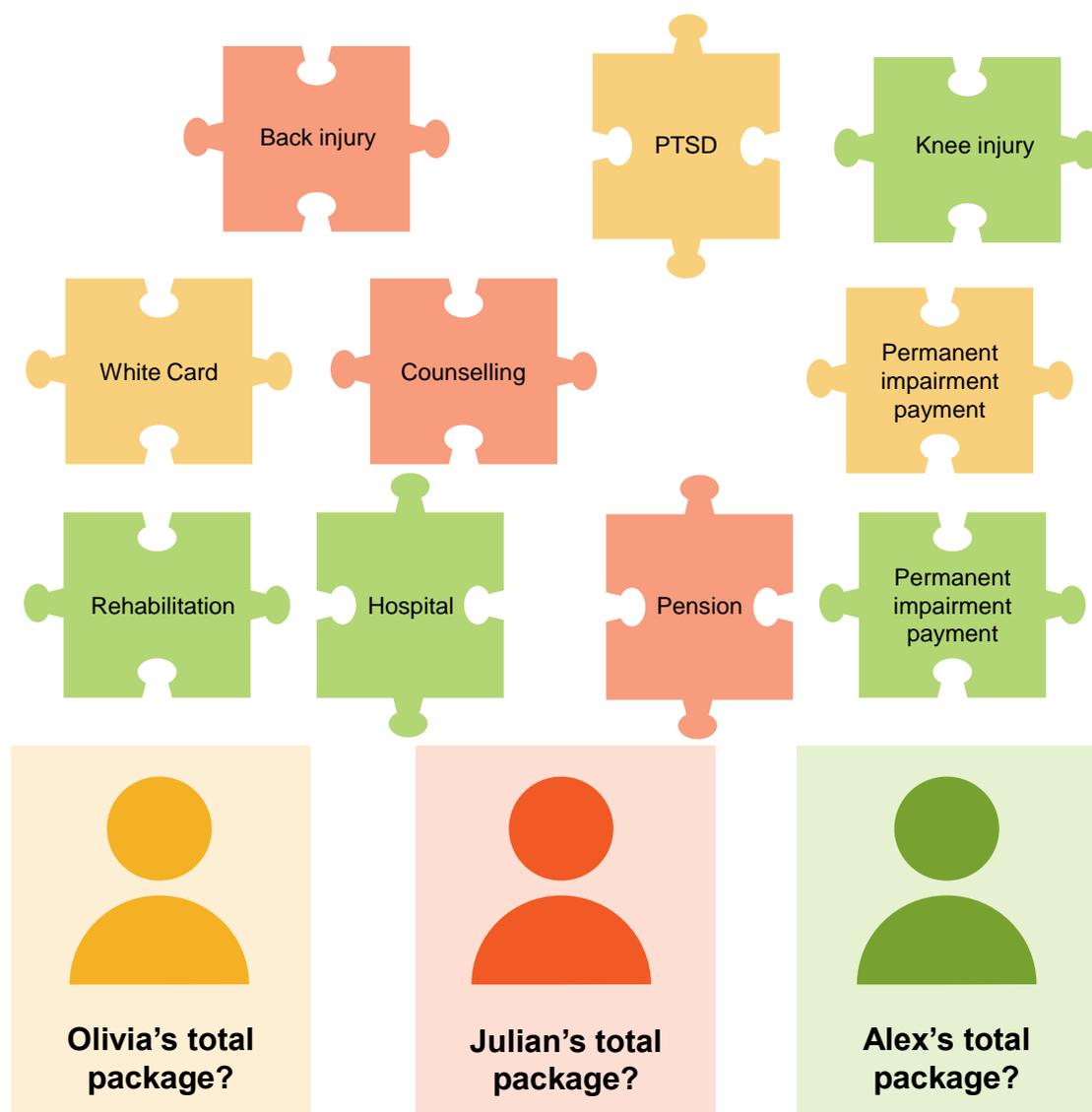
DVA should be well placed to understand and respond to the needs of its clients — it provides (and has provided for decades) a range of supports to veterans and their families, and supports are often provided over an extended period of time. As the Australian Public Service Commission (APSC) said:

DVA has a long, close relationship with its unique client base which allows the department to collect a wealth of data relating to health and social wellbeing, such as income support, compensation and rehabilitation information. This data in many cases spans the entire life of a veteran. (APSC 2013, p. 27)

But in practice, DVA does not link the data it collects to gain a whole-of-client view. Each process undertaken by DVA has its own dataset, and these datasets are not linked to each other. For example, DVA's claims data has the type and severity of a veteran's service-related injuries, but these data are not linked to the veteran's rehabilitation or health care data. What this means is that DVA does not have an overall picture of the total package of services it provides to individual veterans, and so it cannot assess the effect of those services on veteran wellbeing (figure 16.1).

In addition, the data that Defence collects about veterans from the day of enlistment (including information about their training, service, deployments and health care) is not used by Defence and DVA in a joined-up way to achieve a whole-of-client view. The Commission's proposed changes to the governance of the veteran support system (including establishing a new Veteran Services Commission (VSC) (chapter 11)) should help to achieve a greater focus on the lifetime wellbeing of veterans.

Figure 16.1 **DVA holds lots of data about veterans, but does not connect the data in meaningful ways**



Limited action to improve evidence

Shortcomings in DVA data have been evident for many years

Concerns about the lack of data, and the failure to make optimal use of the data that are collected, are not new. For example:

- an Australian National Audit Office (ANAO) performance audit on the quality and integrity of DVA's income support records in 2008-09 found that 'key fields in many electronic records were not accurate, complete or reliable' (ANAO 2009, p. 17)

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- another report by the ANAO on the administration of rehabilitation services under the *Military Rehabilitation and Compensation Act 2004* (MRCA) found that neither Defence nor DVA reliably measured, monitored or reported on rehabilitation outcomes (ANAO 2016, p. 8).

DVA also makes very little use of its extensive health and social care data — this is a lost opportunity. Unlike other government agencies involved in funding health and social care services, DVA is in the unique position of having access to data on many aspects of a person’s care — their use of public and private hospitals, general practice, allied health, pharmaceuticals, aged care and more. The value of this comprehensive data was highlighted by the APSC.

DVA has one of the most valuable health datasets in the country. While this dataset has been used to achieve positive health initiatives, greater whole-of-client analysis would inform future service provision. (2013, p. 24)

DVA has plans to improve the use of data — one of the strategic pillars of the Veteran Centric Reform (VCR) program is to embed the use of data and data analytics into day-to-day functions (chapter 9). But DVA is a long way from best practice workers’ compensation schemes when it comes to the use of data and data analytics, the monitoring of service delivery and provider performance, and its focus on client outcomes.

Long overdue upgrades to DVA ICT architecture

One reason for the gaps in data about DVA clients is that DVA is still in the early stages of addressing concerns about the reliability and efficiency of its information and communication technology (ICT) systems. Many of DVA’s ICT systems remain archaic and not fit-for-purpose. This issue was flagged as far back as 2009 when the ANAO found that:

A key challenge for DVA is managing the risks associated with maintaining the department’s heritage IT systems, while developing new system capabilities. (2009, p. 21)

And then in 2013 the APSC said:

... there are some 200 individual ICT systems operating in the department with a dated desktop. Typically a client facing employee or assessor may need to open three or four separate applications, none of which ‘talk to the other’, in order to deal with a single client request or claim. Furthermore, staff or assessors may need to access additional separate applications (likely through another staff member) to determine if a client had a transport booking, or to check a client’s eligibility for glasses or dental treatment. (2013, p. 8)

The APSC considered that DVA’s ‘multiple ageing ICT systems pose a significant threat to its data holdings’ (2013, p. 28). The systems are so outdated that paper-based claims are only just being phased out.

Until 2015, some 25 tonnes of paper were being moved around the country each month, as part of usual DVA operations, with more than a million files taking up space in three warehouses and other storage facilities. (DVA 2017p, p. 12)

DVA also told the Commission that its programs rely on multiple systems, ‘some dating back more than thirty years’ (sub. 125, p. 16).

It was not until the 2016-17 Budget that significant funds were allocated to develop a business case to improve DVA’s ICT infrastructure (this was the first business case for the VCR program) (DHS 2017).

Recent initiatives hold some promise

Some recent initiatives, while overdue, are promising in the context of improving the evidence base about veterans. DVA has entered into a partnership with the Australian Institute of Health and Welfare (AIHW) to develop a comprehensive profile on the health and welfare of the veteran population (box 16.1).

Box 16.1 **A partnership to profile the health and welfare of veterans**

In 2017, the Department of Veterans’ Affairs and the Australian Institute of Health and Welfare (AIHW) commenced a 4-year program of work ‘to build a comprehensive profile of the health and welfare of Australia’s veteran population’ (AIHW 2018a, p. vi). Recent publications from this partnership include:

- *Incidence of suicide in serving and ex-serving Australian Defence Force personnel: detailed analysis 2001–2015*. This report analysed the incidence of suicide in serving and ex-serving personnel, along with characteristics that may be associated with suicide risk
- *Development of a veteran-centred model: a working paper*. This paper set out a model to support holistic analysis and reporting of veterans’ health and welfare
- *Australia’s Health 2018*. This publication included a chapter on veterans’ health, including data limitations and information from the incidence of suicide study
- *Causes of death among serving and ex-serving Australian Defence Force personnel 2002–2015*. This report explored the leading causes of death among the Australian Defence Force population between 2002 and 2015
- *National suicide monitoring of serving and ex-serving Australian Defence Force personnel*. The annual national suicide monitoring of serving and ex-serving Australian Defence Force personnel
- *A profile of Australia’s veterans 2018*. This report sets out what is known about the health and welfare of veterans, the gaps in information about veterans and how to address these gaps.

Sources: AIHW (2017b, 2017c, 2018d, 2018b, 2018c, 2018f, 2018a).

Information sharing processes between Defence and DVA have also improved recently. Under the Early Engagement Model, members who joined the ADF from 1 January 2016, and those who separated from the ADF after 27 July 2016 are now registered with DVA (DVA, sub. 125, p. 37). Defence has also provided DVA access to eHealth records and has begun to digitise other health records (DoD, sub 127, p. 11–12).

Gaps in research

High-quality research into issues affecting veterans can help to build an evidence base on what does and does not work in improving veteran outcomes. Research can also inform the design and delivery of effective services, and can reduce costs or make better use of the money spent on veterans (programs that are found to not be cost effective can be replaced with more effective services).

The importance of research is reflected in the MRCA. Under section 362 of the MRCA, the Military Rehabilitation and Compensation Commission is required to promote research into:

- the health of members and former members
- the prevention of injury and disease
- the rehabilitation of persons from injury and/or disease.

To this end, DVA undertakes a number of research projects. However, despite having worthwhile aims, the benefits of some of these initiatives have not yet eventuated. One example is DVA's MRCA Rehabilitation Long-Term Study. The study came about following a recommendation in the review of the MRCA in February 2011 (Campbell 2011a, p. 46), but to date, all that has been produced is a proposed study design framework (dated November 2016, but not publicly available) (chapter 6).

Many inquiry participants called for more research on veterans, noting that many questions remain unanswered. Olivia Pursey, for example, advocated for:

... more academic research, encouraged by fellowships, funding honours theses and further study, particularly into the kinds of mental illness suffered by veterans, and how best to treat and rehabilitate veterans of modern warfare. (sub. 51, p. 6)

The Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia noted benefits in conducting:

... research on the causal aspects/drivers behind why the majority of serving and former serving personnel are healthy and view their military service with fondness and positivity, including those exposed to significant stress and trauma during service. Such research may improve recruitment procedures and/or assist to identify individuals at risk earlier. (sub. 96, p. 4)

And Stephan Rudzki said more research was needed into novel therapies for post-traumatic stress disorder.

Defence and DVA should be at the forefront of conducting research studies examining the effectiveness of novel therapies. The current default position is one of passive waiting for other nations or organisations to develop the evidence. (sub. 40, p. 6)

Participants also expressed concern about DVA's inability to provide strategic guidance on research. For instance, the Royal Australian and New Zealand College of Psychiatrists said that:

Recent research into veterans' health has suffered from fragmentation from a variety of directions. DVA has lost much of its technical capacity to act as a coordinating research body as

well as corporate memory, meaning that much of what was learned from its earlier post-deployment research has not been directly utilised in more recent studies. (sub. 58, p. 6)

RSL NSW commented on the poor dissemination of research funded by DVA.

DVA funding for research should be made conditional upon the inclusion of ‘clinical applications’ as a research outcome. This research should then be distributed to major ESO [ex-service organisation] service providers (for forwarding on to advocates, etc.) and made easily available online. ... More thought needs to be given to the way DVA-funded expert research is communicated to non-expert audiences. (sub. 151, pp. 12–13)

A focus on outputs limits performance reporting

Like all government entities, DVA and Defence report on department performance in accordance with the reporting requirements of the *Public Governance, Performance and Accountability Act 2013*. Under this Act, entities must publish statements about their performance in their annual reports. Comprehensive and reliable data and evaluation are key to meeting the spirit of, not just the letter of, this requirement.

DVA’s performance statements are output focused. This type of reporting provides little insight into whether supports provided are improving veterans’ health and wellbeing. For example, performance measures include claims processing times and the number of clients accessing a service (but no direct measures of clients’ financial wellbeing). On health outcomes for veterans, DVA mostly reports outputs such as the ‘number of clients accessing services versus the number who have registered a complaint in relation to un-met access and/or quality’ (DVA 2018k, p. 30, 2018f, p. 80).

DVA’s focus on outputs, rather than outcomes, was highlighted by inquiry participants. For example, the National Mental Health Commission said:

There are no direct measures of effectiveness (i.e. achievement of outcomes) for the mental health services provided by the ADF and DVA. The only data that is available relates to outputs (e.g. the number of services provided, and the number of people attending training), which does not provide meaningful information about whether a service has achieved its intended outcome for its client (e.g. higher resilience) or client group (e.g. lower rates of mental illness or suicide attempts). (sub. 107, p. 4)

DVA also acknowledged that its focus is on outputs rather than outcomes.

... most of DVA’s performance assessments have tended to measure *delivery* (or *outputs*), rather than *effect* (or *outcomes*). (sub. 125, p. 148)

In some cases DVA has not only neglected to consider outcomes but has omitted basic output measures before committing further resources. For example, there is no published information on the uptake and effectiveness of the ADF Post-discharge General Practitioner Health Assessment. But DVA has announced that eligibility for the health assessment will be expanded fivefold — instead of being available to each veteran on a once-off basis, it will

offered in each of the first five years after leaving the ADF. The rationale for such an expansion is unclear (chapter 7).

Better performance reporting is needed across the entire veteran support system, including the parts of the system that Defence are responsible for (particularly in the areas of injury prevention and rehabilitation).

DRAFT FINDING 16.1

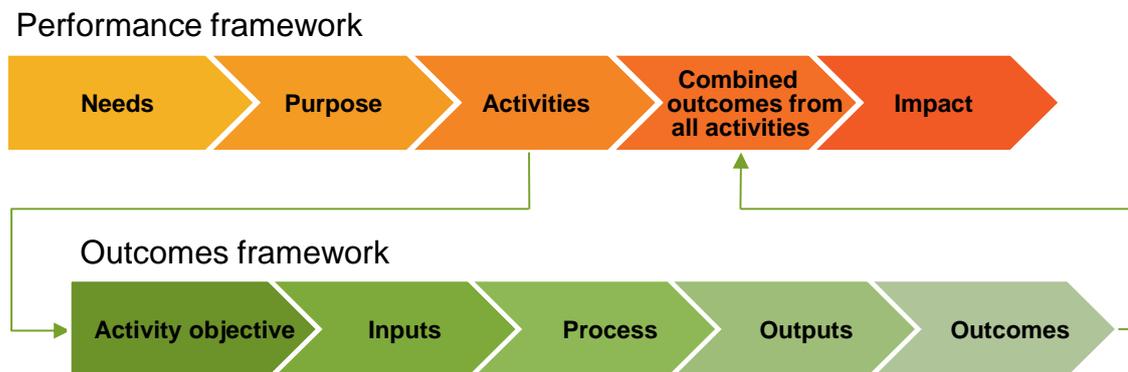
There is a lack of robust data and evidence on many crucial aspects of the veteran support system. This impedes the design and delivery of effective supports for veterans and their families.

16.2 Collecting data on the effect of veterans' programs

Insights (and data) on outcomes are an important element of any evidence base and are crucial for accountability and performance reporting. Any effective organisation should have performance and outcomes frameworks to guide measurement of the effect of its actions.

- Performance frameworks provide a holistic view of performance.
- Outcomes frameworks are a subset of performance frameworks and are unique to each activity (program or service). An outcomes framework identifies the relevant data (outcome measures) which quantify how an activity contributes to specific outcomes, and how the data are collected (figure 16.2).

Figure 16.2 Outcomes and performance frameworks



Source: Adapted from Department of Finance (2015b).

A performance framework identifies:

- the needs of the user population (needs)
- how the needs will be met (purpose)
- the activities that will be done to meet the purpose (activities)
- the overall effect of the activities (combined outcomes)
- the long term impact of achieving those outcomes (impact).

An outcomes framework sets out:

- the objective of the activity (objective)
- the resources being used in the activity (inputs)
- how the activity will be done (process)
- the tangible services delivered (outputs)
- the outcome of those tangible services, along with what data will be used to measure these outcomes and the processes for collecting the data (outcomes).

There are a number of examples of outcomes frameworks, including the National Disability Insurance Scheme Short Form Outcomes Framework (which seeks to measure the outcomes of National Disability Insurance Scheme support) and Veterans Affairs Canada's wellbeing framework for veterans' services (box 16.2). The domains of wellbeing discussed in chapter 4 (health, employment, income and finance, housing, education and life skills and social support and integration) could also be used to inform the development of outcomes frameworks.

Box 16.2 Examples of outcomes frameworks

The National Disability Insurance Scheme Short Form Outcomes Framework

The National Disability Insurance Scheme Short Form Outcomes Framework is an approach to measure the outcomes of National Disability Insurance Scheme support. It includes eight indicators of participant experience (known as participant domains) as well as outcomes related specifically to families and informal carers. It was piloted in the first three months of 2015 and is now being rolled out scheme wide.

The framework will allow tracking of participant and scheme progress over time, and demonstrates how participants are faring relative to other Australians and to other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Participant domains

Choice and control — improved choice and control and planning and delivery of supports

Daily activities — increased ability to undertake the daily activities with adequate levels of support

Relationships — increased levels of social inclusion and reduced experiences of loneliness

Home — improved satisfaction with home environment now and five years into the future

Health and wellbeing — improved health and wellbeing and increased ease of access to health services

Lifelong learning — increased opportunities to learn new things

Work — increased uptake of paid employment (and the associated social inclusion)

Social, community and civic participation — increased participation in community activities chosen by the participant, and reduced negative experiences associated with being excluded

Family and carer domains

Families have the support they need to care

Families know their rights and advocate effectively for their family member with disability

Families are able to gain access to desired services, programs and activities in their community

Families have succession plans

Parents enjoy health and wellbeing

Veterans Affairs Canada well-being framework

Veterans Affairs Canada developed a well-being framework comprised of seven domains of wellbeing (employment or other meaningful activity, finances, health, life skills and preparedness, social integration, housing and physical environment and cultural and social environment). Good wellbeing across the seven domains is used as an ultimate strategic objective for veterans' policy and programming and as a measure of successful transition for veterans.

Measurement of the domains is used to segment the veteran population along a continuum ranging from those doing well to those in crisis. The population segments that are doing well might meet all seven criteria, or be at low-risk of experiencing difficulty. On the other end, the in-crisis segment may be veterans with severe problems in one or more domains.

This framework takes a lifetime view of a veteran, focusing on particular points in the life cycle of a veteran, such as during transition or post discharge.

Sources: National Disability Insurance Agency (2017) and Thompson et al. (2016).

Collecting data on outcomes, however, is not without some challenges — outcomes data can be difficult to collect and quantify. Attributing outcomes to particular services can also be difficult, particularly if a veteran or family member is receiving many services.

And while more data provides the benefit of a stronger evidence base, collecting data involves costs, and the benefits must be weighed against these costs. There are also costs associated with establishing and supporting effective ICT systems and modifying programs to enable information to be recorded. Some cost minimisation strategies include leveraging existing data collection processes and reviewing data collection processes to ensure they are streamlined and effort is not duplicated.

The Defence Force Welfare Association, while acknowledging the costs of collecting data, also pointed to the importance of knowing what improves outcomes for veterans.

There is no doubt that there are overheads in collecting statistics and that, unless carefully considered, the information put together may not be effective measures. This should however, not stop attempts to define what success would look like when committing funds to Veteran support. (sub. 118, p. 34)

While outcomes measurement is the ‘gold standard’, in light of the costs and challenges of collecting this data, ‘second-best’ metrics, such as measures of outputs that proxy outcomes (combined with appropriate caveats) and used in concert with other means, can be useful alternatives.

Implementing performance and outcomes frameworks is a vital step for DVA to improve data collection and performance reporting. It will also promote transparency and accountability about how the veteran support system has performed in light of the resources invested in it, reveal where weaknesses in the system lie and guide resource allocation. To meet the needs of the future veteran support system, the VSC will need to continue to implement and refine performance and outcomes frameworks.

16.3 Alignment with the design principles

As outlined in chapter 4, the overarching objective of the veteran support system should be to improve the lifetime wellbeing of veterans and the Commission is proposing a number of governance changes (including establishing a new VSC) to help achieve this objective.

In the future veteran support system, good data and evidence will be essential to knowing whether the supports veterans and their families receive are improving their wellbeing. Two of the principles that the Commission considers should underpin the future veteran support system rely heavily on the collection and analysis of data.

- A financially sustainable and affordable system requires information on costs and outcomes.

-
- An evidence-based system requires evaluation of the effectiveness of services, interventions and policies, as well as high-quality research.

Data to ensure a financially sustainable system

Good quality data are needed to estimate the long-term costs of the veteran support system and to understand the cost drivers and emerging risks. As in other workers' compensation schemes, actuarial modelling will play a key role in monitoring and evaluating the performance of the future veteran support system (the VSC will need to use actuarial modelling to ensure the premium income is aligned with scheme costs). This will require data to estimate the annual costs of the scheme over future years (and to estimate liabilities) which will facilitate continuous monitoring and evaluation of clients' outcomes and costs. The cycle involves:

- establishing a baseline by estimating the long-term costs of the system and long-term outcomes of clients (or the 'expected' experience of clients in the system)
- continuously collecting data on the actual experience of clients
- using the data collected to monitor clients' outcomes, identify factors that contribute to the achievement of outcomes and investigate cost drivers
- using the data collected to update the 'expected' experience of clients (figure 16.3).

Figure 16.3 A monitoring framework for ensuring financial sustainability



The continual monitoring will mean that any changes in costs and liabilities can be identified early and addressed. And because monitoring ensures that the system is continuously improved, and the cycle is repeated, the approach should become more refined over time as more data are collected on client supports, lifetime costs and outcomes. As EML said ‘successful schemes aim to continuously improve in order to provide fit-for-purpose services and value for money’ (sub. 90, p. 3).

Building the evidence base

Building the evidence base about what works and does not work (and what is cost-effective and what is not) will support the monitoring of progress against the objectives of the scheme, and will help DVA (and then the VSC) to find new and innovative ways to improve outcomes for veterans and their families. It will also improve transparency and accountability (including around the performance of service providers and client outcomes) and give taxpayers confidence that money spent on veterans and their families is money well spent.

The monitoring and evaluation required under the financial sustainability monitoring framework is an important first step in building an evidence base on veteran services and policies. However, investing in research is also important for building the evidence base. Research builds the capacity and capability for innovation, outcome analysis and evidence-based decisions on policy, services and programs. Disseminating research findings can also help inform services provided by other organisations.

The remainder of this chapter focuses on areas of reform for improving the data held on veterans and building an evidence base. These reforms reflect the escalating data needs of the future veteran support system and should be commenced by DVA and continued by the VSC.

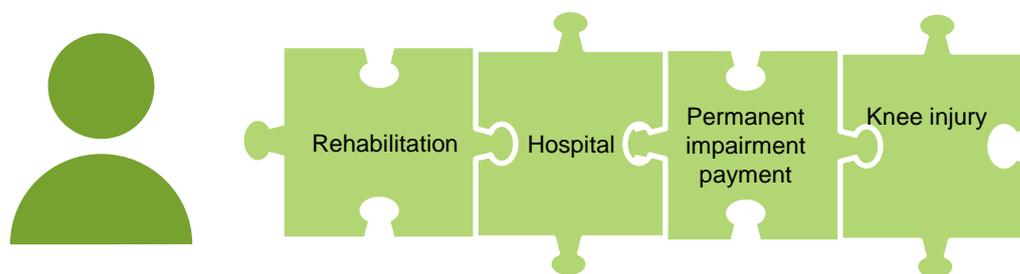
16.4 Making better use of existing data

As noted earlier, a component of the VCR program (chapter 9) is to improve the data analytics capability of DVA. This will include connecting data sources to create a consolidated veteran view and embedding data analytics in the service delivery environment (DVA, sub. 125, pp. 77–8). As part of this process, DVA has been working with the Department of Health ‘to develop an integrated DVA — Health dataset and a partnership on analytics work’ (Department of Veterans’ Affairs 2018a, p. 88). These are positive steps in the move to link and analyse data in the veteran support system.

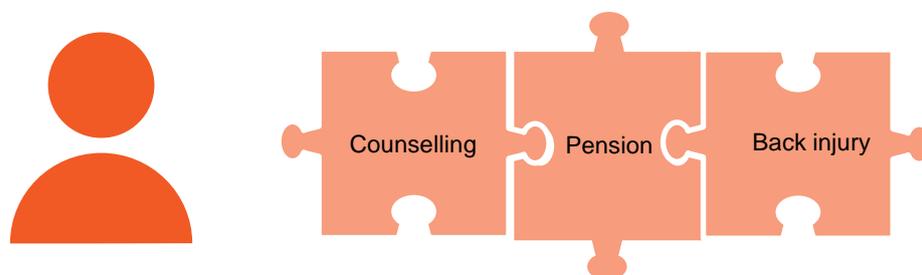
Linking and analysing existing data

DVA would benefit from linking its datasets to provide a whole-of-client view. Linking claims data, especially information about injuries and illnesses, to information about an individual’s health care use and rehabilitation services would allow DVA to assess how well the services provided to that person are meeting their needs (figure 16.4).

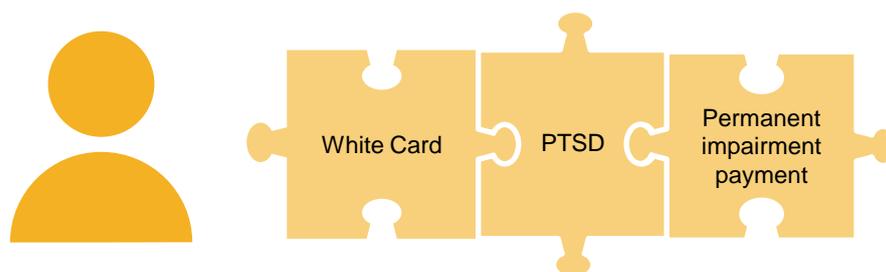
Figure 16.4 **Putting the picture together**



Alex's total package



Julian's total package



Olivia's total package

DVA also holds longitudinal health data, that is, data that track the same individuals over a period of time. These data are highly valuable as they allow for analysis of how a program, or an event, might affect individuals over time. Given veterans' conditions may take time to

manifest, having long-term data on veterans allows for identification of ‘trigger events’ and could provide insight into why and how certain conditions affect veterans.

... the ability to obtain information about multiple dimensions of the life course as it unravels is invaluable. The longitudinal nature of such data also makes it easier to assign causal ordering to a series of life-course events by allowing analysts to place them in sequence. Finally, longitudinal data pay attention to time and place by allowing the effects of military service to vary across the life course. As indicated earlier, the effects of military service may wane or grow as time passes. Longitudinal data collection will capture these shifts in the relationship between military service and various outcomes at different points in the life course. (Burland and Lundquist 2013, p. 284)

Building data capability

Initiatives in the VCR program that are focused on improving the data analytics capability of the department are still in the early stages and it is unclear when the projects will allow for linkage and analysis of DVA data.

There are three actions that DVA can take to maximise the success of these projects and build data capability. First, incorporate principles for data integration into data linking projects (box 16.3). Adhering to these principles will improve data quality through good data management, including the use of standard definitions and classifications and the maintenance of datasets. It would also help ensure DVA maintains adequate controls over the use of veterans’ data in data integration projects.

Box 16.3 High-level principles for data integration

- Strategic resource. Responsible agencies should treat data as a strategic resource and design and manage administrative data to support their wider statistical and research use.
- Custodian’s accountability. Agencies responsible for source data used in statistical data integration remain individually accountable for their security and confidentiality.
- Integrator’s accountability. A responsible ‘integrating authority’ will be nominated for each statistical data integration proposal.
- Public benefit. Statistical integration should only occur where it provides significant overall benefit to the public.
- Statistical and research purposes. Statistical data integration must be used for statistical and research purposes only.
- Preserving privacy and confidentiality. Policies and procedures used in data integration must minimise any potential impact on privacy and confidentiality.
- Transparency. Statistical data integration will be conducted in an open and accountable way.

Source: Cross Portfolio Statistical Integration Committee (2010).

Second, to enhance the quality and consistency of data collection processes, DVA should develop standard definitions of key terms, and collate those definitions into data dictionaries.

Data dictionaries are used to set out data definitions and act as a guide on data. They contain information such as:

- what values the data can take on, such as if values are set or free text
- what values might mean if the data has been coded
- units of measurement
- relationships between different data fields collected in the same dataset
- relationships with other datasets.

In the absence of data dictionaries, data are unlikely to be collected in a consistent and comparable manner. For example, in the data on claims made under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, claims submitted by veterans who have both depression and anxiety were listed in ten different ways, including ‘depression anxiety’, ‘anxiety/depression’, ‘anxiety & depression’ and ‘depression and anxiety’ (this does not include variations involving other words such as major, severe or disorder). Irregularities such as these, particularly when there are many, severely inhibit data analysis, but could be avoided with the use of data dictionaries.

The Commission’s inquiry into *Data Availability and Use* noted the importance of setting out data definitions:

Consistent use of standard definitions and units of measurement are necessary to achieve coherence. Information that could assist interpretation include the variables used, the availability of metadata, concepts, classifications, and measures of accuracy. (PC 2017a, pp. 160–161)

It is important to minimise changes to data dictionaries wherever possible to help ensure data recording remains constant over time, permitting data analysis over these periods. Once data dictionaries are established they should only be updated when there is a clear need to do so, such as to take into account changes in policy or legislation. Changes should be made in batches rather than changing one component at a time and should be scheduled so that data users and collectors have clarity about what data is comparable to what and what data should be collected.

The third component to improving DVA’s data capability is to build the capacity of its staff to make the most of data. Data dictionaries will assist in this regard, as using data dictionaries in staff training will provide a guide to data collectors in what data should be entered into systems. Data dictionaries should also be made available to staff members who wish to analyse the data, and have permission to do so, to ensure staff have complete understanding of what information is being recorded in the data. Retaining the skilled staff involved in current improvement projects will also be essential (chapter 9).

Another way to build the capacity of DVA staff is to leverage the knowledge of other organisations. Partnerships with organisations such as the Australian Bureau of Statistics, AIHW and universities could play an important role in developing data analytics capability. Similarly, other workers’ compensation schemes and the National Disability Insurance

Agency have expertise in actuarial modelling that could be relevant to the future veteran support system.

DRAFT RECOMMENDATION 16.1

The Department of Veterans' Affairs should develop outcomes and performance frameworks that provide robust measures of the effectiveness of services. This should include:

- identifying data needs and gaps
- setting up processes to collect data where not already in place (while also seeking to minimise the costs of data collection)
- using data dictionaries to improve the consistency and reliability of data
- analysing the data and using this analysis to improve service performance.

16.5 Action is required to improve evidence

As the government agency responsible for the veteran support system, DVA's role does not end once services are designed and delivered — it should also be looking for ways to continually improve services and policies and guard against poor outcomes. In the veteran support system, this means building an evidence base on what works and does not work to improve the wellbeing of veterans and their families. This can be done by:

- undertaking high-quality policy trials, reviews and evaluations
- taking a strategic approach to research.

Policy trials

Reforms can be costly and time-consuming, and testing policies prior to system-wide implementation is important. Testing can be in the form of policy trials which can be used to minimise costs, reduce wasted efforts and smooth transition to new policy. Policy trials allow the testing of ideas, including simultaneous testing of variations of a program, such as different contract structures or delivery models at different trial sites.

Policy trials need a sound methodology, this helps ensure results can be used to form evidence-based policy. A range of methodologies can be used in policy trials, and the most appropriate methodology depends on the policy topic and whether it is an ex-ante or ex-post assessment of a policy. However, there are common features of all good trial methodologies (box 16.4).

Box 16.4 Features of good policy trials

Well-designed policy trials have the following features. They:

- *are designed to test a theory* — about why the policy will be effective in meeting the needs of the service users
- *capture baseline data* — taking stock of the current situation before a policy is implemented allows for analysis of the impact of the policy over time
- *clearly specify a counterfactual* — what would have happened in the absence of the policy. A trial needs to have a counterfactual so the effects of the policy can be compared to the counterfactual
- *consider direct and indirect effects* — although a policy is designed for a particular purpose, there might be wide-ranging and unintended effects. A trial needs to consider both direct and indirect effects, and quantify both where possible
- *are conducted at an appropriate time* — trials should take into account that effects of a policy may take time to appear. But, there is also concern that at times a trial report may take too long to be developed to add any input into policy development. People undertaking trials need to strike a balance in the timing of undertaking and delivering trial results
- *set out uncertainties* — be aware of and take steps to control for any influences on outcomes where possible
- *are designed to avoid errors* — trials need to take steps to reduce the risk of biases. Examples of where bias may come from include:
 - self-selection. If trial participants choose whether or not to be involved in the trial, this can skew results
 - attrition. There are a range of reasons why individuals could drop out of a trial. If they drop out due to a particular effect of the policy, not capturing their information would bias results
- *include sensitivity tests* — to take into account factors that may influence results, testing should be made on these factors where possible to determine the effect they have on conclusions
- *incorporate learnings* — findings from the trial are incorporated into policy development. Feedback mechanisms could also be built into the trial
- *can be tested and replicated by third parties* — any data from the trial should be made available (with appropriate safety precautions in place) so that others may test results to determine the robustness of the analysis.

Sources: ANAO (2018c); Banks (2009); Hallsworth et al (2011).

DVA is currently conducting and funding trials that have a sound methodology. For example, DVA funds the Rapid Exposure Supporting Trauma Recovery trial which is testing whether intensive treatment for post-traumatic stress disorder (daily sessions for two weeks) is as effective as the standard form of treatment (one session a week for 10 weeks). The trial is currently recruiting volunteers from across Australia. Although this trial is still in the early stages, it already contains a number of good features of trial methodologies including a clearly outlined theory and counterfactual (Phoenix Australia 2018).

However, not all DVA trials are founded in a robust methodology. For example, DVA recently conducted a trial of methods for increasing awareness of the services and programs

available to veterans and their families. The trial involved placing information about DVA services in Australia Post stores. But it was conducted at only three sites (Woden (ACT), Mount Gambier (South Australia) and North Lakes (Queensland)) and for a very limited period — the Mount Gambier and North Lakes sites opened in April 2018 and the ACT site opened in December 2017 with the pilot ending in June 2018 (Chester 2018b; DVA 2018ae). A longer trial running at more sites would have been more in keeping with the good trial methodologies shown in box 16.4.

Reviews and evaluations

Reviews and evaluations are a key part of a financially sustainable and affordable system as they identify any issues within processes or programs and generate evidence about what works, for who and in what circumstances. Reviews and evaluations can be conducted for many different purposes. For example, one-off reviews may be carried out when responding to an identified or emerging problem with a service. Evaluations are often planned well in advance, during the design of a program or service, in order to test its effects. Both reviews and evaluations can also be embedded within a framework for constant improvement and can assist in proactively identifying issues.

Previous chapters have highlighted a lack of evaluation of services in the veteran support system, including mental health services (chapter 15), rehabilitation services (chapter 6) and transition preparation and support (chapter 7). The current lack of rigorous, open and transparent evaluation is a barrier to understanding how services work for veterans and improving service design and delivery.

It is crucial that high-quality evaluation of programs and services be conducted so that DVA (and later the VSC) can build an evidence base on what does and does not work at improving veterans' outcomes. This evidence base will help inform policy development, improve planning decisions and help both DVA and the VSC provide more targeted and effective services for veterans, including for those who do not currently have contact with the veteran support system (box 16.5).

Inquiry participants recognised the importance of increasing the frequency of evaluation to build an evidence base to design future services. For example, the National Mental Health Commission said:

Independent evaluation of suicide prevention and self-harm services within ADF and DVA is good practice and should be embedded, with the results used to inform further service development. Any new program to reduce the incidence of suicide and self-harm in the ADF or DVA, including services commissioned through ESOs, must be evidence based and have a clearly defined program of evaluation before the program commences. (2017, pp. 53–54)

Box 16.5 What about the veterans not known to DVA?

The total number of veterans is not known. To address this gap, several inquiry participants (including the Alliance of Defence Service Organisations (sub. 85), RSL NSW (sub. 151), Robert Shortridge (sub. 76) and the Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia (sub. 90)) suggested that a question related to military service should be included in the *Census of Population and Housing*.

In its submission to the review of Census topics, DVA described a number of potential benefits of including a question related to military service on the Census. A question on the Census could:

- provide a better estimate of the number of veterans in Australia
- help DVA to understand the changes in the veteran population over time
- provide information on the location and age distribution of veterans which can be used to target services
- overcome many of the issues that make other data sources incomplete (excluding particular categories of veterans, for example) or unreliable (because the data were collected many years ago or only include small sample sizes).

However, adding a question to the Census is costly. Costs could include:

- increasing the time taken for the Australian population to complete the Census
- increasing Census processing time and costs
- displacing another question from being included on the Census. For example, the current review of Census questions is assessing whether questions on long-term health conditions should be included in the Census. (While not veteran-specific, such a question could provide more insight into the needs of veterans with long-term health conditions and help facilitate the provision of targeted services that meet their needs.)

And these costs presuppose that it is possible to add a question to the census. However, as the Australian Bureau of Statistics (ABS) noted, 'There is a limit to the number and type of questions that can be reasonably asked through a Census due to the burden on respondents in answering questions and the cost of collecting and analysing the information collected' (ABS 2018d).

Another consideration is that the benefits of the information collected through the Census may be smaller than DVA has suggested. DVA stated that Census information will help DVA provide more targeted and effective support strategies for veterans. However, as noted earlier, the effectiveness of many DVA services is not known and this is a more significant impediment to the design and delivery of effective support strategies for all veterans (whether or not they are currently known to DVA).

Taken together, these factors suggest that the rationale for adding a question on veterans to the Census is far from clear. A better strategy would be for DVA to focus on improving the evaluation of its services. Not only will evaluating current DVA services help veterans known to DVA by improving those services, it will also put DVA in a stronger position to help the veterans not known to DVA.

Sources: ABS (2018a, 2018d) and DVA (2018af).

Similar to policy trials, reviews and evaluations require a sound methodology so that findings can be used to build a robust evidence base. And because reviews and evaluations can be costly, the methodology of (and subsequently the resources devoted to) reviews and

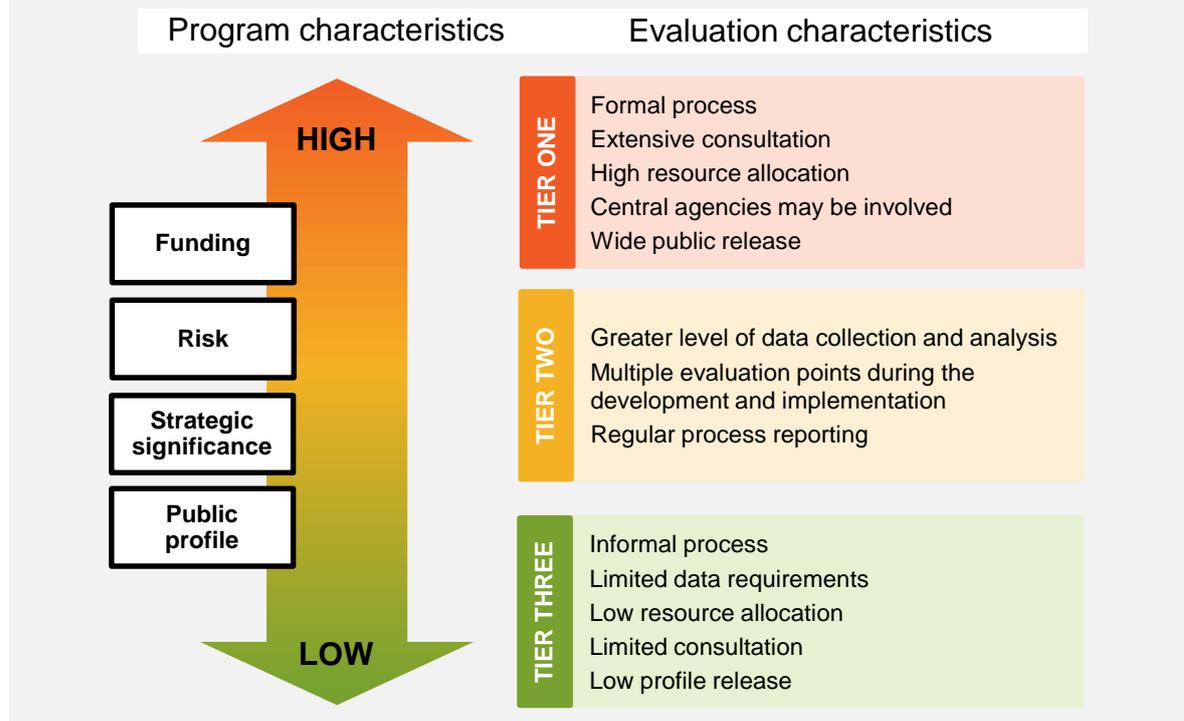
evaluations should reflect the size, complexity and other characteristics of the services or programs being assessed (box 16.6).

Box 16.6 A strategic approach to evaluation

The decision to conduct an evaluation should be made strategically because evaluations are costly.

There should be a deliberate and strategic decision about what the evaluation is intended to assess. The evaluation should seek to measure the impact of an intervention (or set of interventions) on a specific outcome, rather than just describing the program or intervention.

Decision makers should also consider the manner in which evaluation is to be undertaken. The evaluation method chosen should be appropriate to the particulars of a given program — a ‘one size fits all’ approach will not be as effective as a more tailored approach. The Department of Industry, Innovation and Science (2017) has developed a tiered approach to program evaluation which ranks programs based on their level of funding, risk, strategic significance and their public profile.



Regardless of whether they are identified through monitoring or reviews, potential improvements to services will only improve outcomes for veterans if they are implemented. An effective veteran support system would incorporate a learning system — findings from evaluations and reviews should inform changes to system planning and program design. This means not only should DVA (and later the VSC) disseminate the lessons from evaluations and reviews within the organisation, it should publish evaluations and learnings to increase uptake of research on veterans’ wellbeing throughout the veteran community.

Reviews and evaluations should identify problems and consider if the solutions lie in direct service reforms or broader system reforms. Importantly, reviews should identify means of

‘checking’ (such as types of data or information to collect) that the reforms are progressing as intended towards their objective, and that unintended consequences are not emerging. Ultimately, the financial sustainability monitoring framework is a continuous cycle, as the trends identified when comparing veterans’ expected experience to actual experience can trigger further changes to the design and delivery of a service.

DRAFT RECOMMENDATION 16.2

The Department of Veterans’ Affairs should conduct more high-quality trials and reviews of its services and policies for veterans and their families by:

- evaluating services and programs (in ways that are commensurate with their size and complexity)
- publishing reviews, evaluations and policy trials, or lessons learned
- incorporating findings into future service design and delivery.

Taking a strategic approach to research

DVA has a number of research initiatives that are resulting in high-quality, relevant research.

- The Transition and Wellbeing Research Programme has ten objectives, including determining the prevalence of mental disorders among ADF members who have transitioned, assessing pathways to care for transitioned ADF members, examining the physical health status of transitioned ADF members and conducting predictive modelling of the trajectory of mental health symptoms and disorders of transitioned ADF members. Recent publications have aimed to address gaps in what is known about families of veterans and serving personnel (DVA 2018a).
- Partnership with the AIHW (box 16.1) to develop a comprehensive profile of the health and welfare of Australia’s ex-serving population (AIHW 2017c).
- The veterans’ medicines advice and therapeutics education services (Veterans’ MATES) program which uses data from the Repatriation Pharmaceutical Benefits Scheme to identify and address common medication-related problems among veterans and war widows. The Veterans’ MATES program has led to successful interventions which have improved veteran health and reduced costs by lowering hospital admissions (chapter 15).

However, as noted in section 16.1, there are still gaps in research on issues affecting veterans. To address these gaps and provide direction to research, DVA could set national research priorities. National research priorities are used in other sectors and act as guides to research funding allocations. For example, in housing, national research priorities guide the research program administered by the government-funded Australian Housing and Urban Research Institute.

National priorities for veteran research that emphasise research on what works best, for whom and in what circumstances should be developed — the research priorities should have

clear policy implications. This type of research would include evaluation of ways to improve the adoption and adaptation of the evidence in veteran services. That is, research is also needed to evaluate how to turn best practice into common practice in the veteran rehabilitation and compensation system.

International research on issues affecting veterans covers a broad and diverse set of topics and can be used to inform national research priorities in Australia (box 16.7). However, as issues affecting overseas veterans are not necessarily the same as in Australia, given the different social and institutional settings, research priorities developed by DVA also need to reflect the needs of Australian veterans. The domains of wellbeing set out in chapter 4 could help guide the development of research priorities.

Box 16.7 International research on issues affecting veterans

The United States

For over 90 years, the US Department of Veterans Affairs has run a Research and Development program into issues affecting the health and wellbeing of veterans. There are four research divisions within the program: biomedical laboratory, clinical science, health services and rehabilitation. High-priority research areas currently include chronic disease, homelessness, Iraq and Afghanistan veterans, mental health, pain management, precision medicine, women's health, and prosthetics and amputation.

Canada

Veterans Affairs Canada established a Research Directorate in 2001, with the aim of supporting decision makers by providing evidence related to veteran health and wellbeing. Its primary activities include conducting and funding research into veteran health, building partnerships which enable research and monitoring of veteran health, interpreting and monitoring veteran health issues, providing methodological expertise and transferring and exchanging knowledge both within Veterans Affairs Canada and with other parties. Recent publications include analysis of income for veterans after transition from military to civilian life, a suicide mortality study and a profile of personnel deployed to Afghanistan.

Sources: U.S. Department of Veterans Affairs (2017) and Veterans Affairs Canada (2018).

This strategically guided research would not displace research undertaken through other channels. Rather, it would complement that research and focus effort directly on meeting the needs of governments and build an Australian evidence base about what does and does not work.

To formalise the national priorities for veteran research, DVA should develop and publish a research plan. This plan could provide a formal platform for embedding evidence into future planning and policy direction and identify priority areas for generating further knowledge in a systematic and coordinated way. The plan could also be used to communicate research findings to other organisations that provide services to veterans. This will help other organisations improve their service design and delivery.

The research plan should also set out information on the way in which data collected through research will be managed, and provide guidance on the way in which DVA's data will be shared with universities and other institutions for use in research. One of the ways in which the risks around sharing data with external researchers can be managed is to use the 'five safes' approach. This model focuses on providing data to trusted researchers in safe settings and protecting the privacy of individuals (PC 2017a).

Other important features of a research plan include:

- consulting with veterans and researchers on potential research priorities
- setting long term goals and national priorities for veteran research
- establishing timeframes for research completion and publication
- frameworks for releasing information to external researchers.

When developing research priorities and a research plan, DVA also needs to consider the research priorities of the Repatriation Medical Authority, under its proposed new power to fund and guide medical and epidemiological research (chapter 8). This will help minimise the risk of duplication of research efforts and provide a cohesive approach to research.

This research plan should be updated annually to reflect the research activities that have been undertaken under the national priorities and any research findings. This provides a transparent system for monitoring research progress.

In addition to annual updates of the research plan, the national research priorities should be reviewed periodically, perhaps every three to five years, to ensure they are still relevant to the strategic direction of the veteran support system. This will provide adequate time to undertake research under each priority and for findings to be communicated, but also for national research priorities to remain relevant for veterans' policy.

DRAFT RECOMMENDATION 16.3

The Department of Veterans' Affairs should set research priorities, publish the priorities in a research plan and update the research plan annually.

17 Bringing it all together

Key points

- The Commission is proposing a ‘two scheme’ approach to simplify the veterans’ compensation and rehabilitation legislation.
 - Scheme 1 is based on the *Veterans’ Entitlements Act 1986* (VEA), and will continue to provide benefits to older veterans (and their families) who are currently receiving benefits under the VEA. Younger veterans covered by the VEA will be offered a one-off choice to switch their benefits to scheme 2.
 - Scheme 2 is based on a modified *Military Rehabilitation and Compensation Act 2004* (MRCA). It will provide benefits for veterans (and their families) who are not covered by scheme 1, including:
 - ... those with current MRCA or *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) benefits
 - ... those without a current or accepted claim (including under VEA) at the commencement of the two scheme approach.
- A two scheme approach will reduce confusion around eligibility and minimise/remove the need for offsetting, and it will effectively abolish the DRCA. However it is not a panacea for the issues facing the veteran support system — the system will remain complex to some extent.
- Moving to one Act is not possible at this stage.
- It is important that the reforms are rolled out over time, to allow veterans and other stakeholders time to adjust, and so the Veteran Centric Reform process is not interrupted. That said, it is also essential that the proposed new veteran support system is fully implemented and operationalised within a reasonable period.
 - The simplification of payments, improvements to claims processes, and reforms in the areas of rehabilitation, transition and data and evidence will cause minimal disruption and should be undertaken as soon as practicable.
 - The governance changes and the two scheme approach are more fundamental and should be implemented in the medium to long term (with all recommendations implemented by 1 July 2025).
- All the proposed reforms seek to place an increased focus on the wellbeing of veterans and their families, and will result in a simpler, fairer and more accessible system of compensation and support.
- Ex-service organisations will continue to play a vital role in supporting veterans, but their collective effort may need to be better harnessed as part of a future veteran support system.

The previous chapters in this report outline recommendations designed to transform the veteran support system into one that is better suited to meeting the needs of veterans and

improving their wellbeing. This chapter outlines the long-term pathway to implementing the Commission’s recommendations, including outlining a two scheme approach to simplify the legislation (section 17.1) and a timetable for reform (section 17.2). The benefits of a modern system of veteran support are outlined in section 17.3.

17.1 Addressing legislative complexity

As discussed in chapter 1, one of the key drivers of this inquiry was the legislative complexity that arises from multiple Acts for veteran support. There are up to six different pieces of legislation covering the veteran support system. They include:

- the three main veterans’ support Acts
- two older pieces of Commonwealth workers’ compensation legislation that are included in the *Safety, Rehabilitation and Compensation Act (Defence-related Claims) Act 1988* (DRCA) through transitional arrangements
- the *Defence Act 1903* that supplements some DRCA claims.

Other compensation systems, including the generally available welfare system and superannuation invalidity pensions, operate alongside this framework. When recommending that the Productivity Commission undertake this inquiry, the Senate inquiry into veterans’ suicide said:

The committee considers that a system which is as complex and challenging to navigate as the current arrangements will compromise any efforts to make claim processes ‘veteran centric’. (SFADTRC 2017, p. 68)

The previous chapters have recommendations designed to simplify the legislation. This section considers broad approaches to legislative reform in this area, and sets out an indicative timeline for legislative reform.

Why is the veteran support system so complex?

Multiple and overlapping Acts

Several decisions led to the complex array of overlapping Acts that is in place today. As discussed in chapter 3, notable decisions included:

- the 1973 decision to allow veterans injured in peacetime service access to the repatriation Acts, but still allow them to make claims under the Commonwealth workers’ compensation legislation
- the 1994 decision to close off dual eligibility for veterans injured in peacetime service and open it up for those with operational service — allowing them to claim under either the *Veterans’ Entitlements Act 1986* (VEA) or the then *Safety, Rehabilitation and Compensation Act 1988* (SRCA)

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- the introduction of the *Military Rehabilitation and Compensation Act* (MRCA) in 2004. A decision was made, based on the recommendations of the Tanzer Review (Tanzer 1999), to base eligibility under this Act on the time of the service the impairment was related to, rather than the time of enlistment, or close off new claims under the old Acts entirely.

These changes were made with several objectives in mind — to move veterans towards a new system of support and to improve equity between veterans. But priority was given to ensuring that veterans' existing entitlements were not affected. For example, in the context of closing off the existing VEA and SRCA schemes at the time the MRCA was introduced, the Tanzer Review stated:

Although the new scheme incorporates the best features of the SRCA, and relevant aspects of the VEA, there will be some people, depending on their age and other circumstances, who will feel disadvantaged if at the time they claim they no longer have dual entitlement. (1999, p. 79)

The net effect of these decisions is that veterans can be eligible for compensation under multiple Acts, whether for the same impairment or different impairments over time (chapter 3). Almost 30 000 veterans have had liability accepted under more than one of the three main Acts (chapter 3). And this understates the true extent of the problem — many of the veterans who have only submitted claims under one Act would have been eligible to lodge a claim under one of the other Acts at some point, which can lead to confusion in itself. And, as noted by NSW Returned and Services League (RSL), this may become more of a problem:

[The three Acts] makes the system for veterans' compensation intimidating and stressful for veterans to navigate. Under this complex system, veterans can seem to be effectively rewarded or punished for the timing of their service. As individuals with service covering all three Acts begin to reach their 60s and come out of the shadows, the complexity of claims will continue to increase. (sub. 151, p. 4)

One of the consequences of this is the need for the offsetting of compensation between Acts, to ensure that veterans are not being over or under compensated. For example, if a veteran has a claim accepted under the VEA, and later lodges a claim for the same impairment under the DRCA, the veteran's VEA compensation will be reduced (or offset). DVA noted that 'the clearest manifestation of complexity from having three Acts is that veterans can have eligibility under more than one Act, requiring offsetting of compensation payments for the same incapacity or death' (sub. 125, p. vii).

Offsetting creates confusion for veterans — the Commonwealth Ombudsman noted that offsetting was one of its largest areas of complaints (sub. 62, p. 5). The Defence Force Welfare Association noted:

... another set of policies and processes had to be developed to cater for the complexities introduced when a Veteran's incapacity spanned 2 or 3 Acts. This area remains a mystery to Veterans and Advocates as applicable policies and processes are not available to them. There are probably still more complexities being discovered. (sub. 118, pp. 42–3)

Offsetting can also lead to errors in estimating compensation, which can have serious financial consequences for the veteran. For example, the Australian Veterans' Alliance (sub. 81) noted that offsetting can often result in overpayments, with tax implications for the veteran when they are required to repay the payments.

Multiple Acts can cause inequities between groups of veterans — with different veterans receiving different levels of compensation for the same impairment. This was brought to light in the Black Hawk Helicopter crash in 1996, where the compensation available for veterans who were severely impaired, or dependants of deceased veterans, varied depending on whether they were covered by the VEA or the SRCA.

These differences remain — compensation is heavily dependent on whether the veteran is eligible under the MRCA, DRCA or VEA (chapter 12). DVA noted that 'there can also be different outcomes for veterans who are in similar circumstances, depending on their eligibility under the different Acts, and the order in which claims are made' (sub. 125, p. vii).

Ultimately, the multiple Acts create confusion for veterans about which Act they should claim under, and what they are entitled to. As Olivia Pursey put it:

... determining which Act to claim under and the exact expectations of how the veteran should go about applying for compensation can be a daunting, even insurmountable, first challenge to the majority of veterans who are attempting to claim entitlements without legal advice, especially in circumstances where they suffer more than one injury, served in different conflicts and were deployed at home and overseas (these cases are not rare). (sub. 51, p. 2)

The complexity of individual Acts

While much of the focus of legislative reform is on the multiple Acts, the individual Acts are also complex. The Acts feature numerous payments, over and above what is usually provided by workers' compensation schemes. The eligibility for compensation and rehabilitation can vary depending on whether the impairment was suffered during operational service or not. The net result is that it can be unclear to veterans exactly what they are entitled to receive.

The complexity of the individual Acts is not the focus of the discussion below — the Commission has made recommendations throughout the report that will simplify the Acts, and we will give further consideration to proposed changes before the final report. That said, even if it was possible to move to one veterans' support Act, some degree of complexity would remain.

The difficulty of legislative reform

This section looks at some of the barriers to reforming the veterans' support legislation.

The first point to make is that legislative reform is not a panacea for the issues ailing the veteran support system. By its nature, workers' compensation and support is a complex area,

so while some simplification is possible, the system will remain complex to some extent. In fact rather than legislative reform, the largest gains from reform are likely to come from improving the governance structures and claims processes. RSL NSW, while noting the benefits from simpler legislative arrangements, agreed it was not the highest priority.

There are clear, strong arguments for some level of legislative simplification. Merging the three Acts would be ideal and would greatly improve the well-being of veterans as well as claims advisors and advocates. However, RSL NSW believes there are significantly higher priorities for reform than legislative merging, especially considering the gargantuan task this may present. (sub. 151, p. 6)

However, many participants called for simpler legislative arrangements. Some called for a single veterans' support Act. For example:

Commence the process to merge the three pieces of legislation (VEA, DRCA and MRCA) to create a single Act, like the NZ 'Veterans' Support Act 2014' ... This is not only 'the right thing to do', it will simplify the claims and advocacy environment and decrease dependence on the letter of the law and place more emphasis on natural justice. (The Oasis Townsville, sub. 92, p. 1)

Legislation in a consolidated, omnibus form would simplify administration and enable the best elements and most beneficial aspects of existing Acts to be combined, while eliminating the inconsistencies and anomalies of the current range of veteran legislation. (VVFA, sub. 34, p. 18)

The Acts can be vastly different

The MRCA and DRCA are the most similar of the veterans' support Acts — they have similar compensation structures and a focus on rehabilitation. However, there are also many differences between the two, including:

- the amount of compensation received
- access to the Gold Healthcare Card
- the use of Statements of Principles (SoPs).

But there is scope for some harmonisation between these Acts.

While the MRCA has retained some aspects of the VEA, the VEA is fundamentally different to the other Acts in many aspects. The VEA offers set rate pensions to disabled veterans and dependants for life, with no requirement for the veteran to participate in rehabilitation. The MRCA has a greater focus on rehabilitation, and also structures compensation to be more consistent with the loss (both economic and non-economic) faced by the veteran as a result of their impairment.

Given the fundamentally different objectives and focuses of the Acts, achieving full harmonisation between the MRCA and the VEA would require a change in veteran benefits and be very costly.

Benefits for some veterans would need to change

It is not possible to simplify the veteran compensation legislation without changing the benefits that some veterans would receive (either upwards or downwards) in the future.

Some participants called for one Act that would effectively provide veterans with the most generous benefits of the three Acts, or would not lead to any reduction in benefits for veterans. For example, the Victims of Abuse in the Australian Defence Force Association (sub. 133) stated that all veterans should be covered under the VEA, with a no disadvantage test. Similarly, the Royal Australian Armoured Corps Association (sub. 29) and the Vietnam Veterans Federation of Australia (sub. 34) called for a single Act that contains the best or most beneficial provisions of the three Acts.

This type of single Act is not practical (or necessarily desirable). It would likely lead to a large increase in expenditure on veteran compensation. But more fundamentally, it would not lead to a reduction in complexity. Working out what Act is most ‘generous’ to the veteran is not easy, and depends on the veteran’s circumstances, such as their age, other income and welfare payments. Providing veterans with the most generous compensation would require detailed assessments of the benefits available under each Act, either by DVA or the veteran, which would be no simpler than the current situation.

Simplification requires trade-offs, and one of these is that there will be a change in benefits for veterans — in some cases downwards. This needs to be undertaken in a way that is fair and reasonable, both for veterans and the community as a whole.

VEA — well supported, but not suited for future generations

In the future, the MRCA should be the predominant piece of veteran compensation legislation. It is a more modern Act than the VEA, and reflects modern workers’ compensation principles, such as a focus on rehabilitation and returning to work where possible, rather than simply providing pensions for life. Any legislative simplification should be focused on speeding up the transition to the MRCA.

That said, the VEA remains the Act preferred by many veterans, particularly amongst Vietnam veterans. For example, the Vietnam Veterans Association of Australia noted that it is ‘opposed to any consolidation or amalgamation of the VEA 1986 and to any amendments to that Act that removed or diluted current benefits under that act’ (sub. 78, p. 5). In part, this reflects a familiarity among this group of veterans with the VEA, rather than an assessment of the benefits actually received by veterans (as noted in chapter 12, the MRCA is often the more beneficial Act) or what will improve the wellbeing of veterans.

A path forward

Legislative simplification is not straightforward, and there is the risk of unintended consequences (including creating further complexity). Nonetheless, there has been a strong push for simplification following the Senate inquiry into veterans' suicide, and many participants saw simplification as important. And some degree of simplification is possible.

This section outlines the Commission's proposal for a new, simpler legislative structure. The proposal is preliminary, and the Commission is seeking feedback from participants on the feasibility of this proposal.

Moving to one Act is not possible at this stage

Moving to one Act covering all veterans is the ultimate objective of simplification. In particular, the MRCA and its focus on rehabilitation is likely to have benefits for many veterans. Eventually, even without simplification, the MRCA is expected to become the sole Act, although this could take many decades. As RSL NSW said:

A veteran of the peacekeeping operation in Somalia in early 1993, for example, could be covered under VEA until the 2060s, and DRCA could be relevant for another decade beyond that. (sub. 151, p. 6)

However, moving to one Act is not possible at this stage. There remain many veterans on the VEA — either with current benefits or likely future claims. And many of these veterans are older, for whom a focus on rehabilitation and returning to work is less beneficial. The costs of moving these veterans on to the MRCA is unlikely to outweigh the benefits.

This view was supported by several participants. For example, Lenard and Russell said:

We believe that the further replacement of these three existing Acts with their complex trail of amendments dating back a century, with a single Act, would be an administrative nightmare and definitely a step too far. ... We consider that it would be most beneficial to concentrate updating MRCA to improve the efficiency and operation of that Act. (sub. 13, p. 2)

Similarly, Peter Sutherland said:

The real outcome of this simplistic answer would be to worsen the complexity because there would then be six Acts rather than five, and a whole new set of transitional and application provisions. (sub. 108, p. 3)

And the Vietnam Veterans Association of Australia doubted that it 'would be practical to consolidate the entitlements into one act' (sub. 78, p. 5).

In the short term, the focus should be on achieving some degree of harmonisation between the Acts.

A two scheme approach?

The Commission sees merit in a two scheme approach where the majority of older veterans claiming benefits under the VEA remain in a VEA-based scheme (scheme 1) and all other veterans receive support under a modified MRCA-based scheme (scheme 2).

The MRCA and DRCA are similar enough that harmonisation of these Acts is feasible and desirable, and can be achieved within a short period of time. Once harmonisation is achieved, the DRCA could be rolled into the MRCA to create one Act. This would underpin scheme 2 and be the predominant scheme going forward.

For the VEA (scheme 1), the Commission's focus is on retaining the benefits for veterans where moving them to the MRCA is unlikely to be beneficial, while allowing or requiring some veterans to receive benefits under the MRCA-based scheme. Scheme 1 will eventually cease, but not for some time.

This approach is similar to that taken in New Zealand following the Law Commission Report in 2010. A group of veterans remained on an older, pension-based scheme, while younger veterans were placed into a more modern scheme. While moving to a system where eligibility is based on the date of service, as in New Zealand, is unlikely to be feasible in Australia given the existing complex eligibility arrangements, some clarification of eligibility would be needed. This would lead to fewer veterans having dual eligibility or being confused about which scheme they are covered by.

There was some support from participants to the inquiry for this approach. Peter Sutherland said:

In my opinion, a satisfactory solution to this policy dilemma can be achieved by a detailed remake of the overall scheme which focuses on improving outcomes for veterans and consigning the complexity to the back end — the administration of the scheme by DVA. Features of this 'harmonisation' approach are:

- MRCA is recognised as the one new Act and is amended to reduce its complexity and enhance its suitability for harmonisation with the other four Acts (VEA; 1930 Act, 1971 Act, SRCA/DRCA);
- DRCA is brought more and more in line with MRCA over time, and the VEA is harmonised with MRCA where compatible;
- Cohorts currently under the VEA and DRCA are moved into MRCA coverage through a combination of measures such as outright transfer, irrevocable election and grandfathering (sub. 108, p. 3).

And the Air Force Association Australia said:

Legal opinion is a single veterans' support Act would be difficult to draft but not impossible. A possible more immediate achievable pathway is to harmonise the three Acts. DRCA would appear to be the easiest to modify. (sub. 93, p. 2)

Scheme 1

Scheme 1 would be based on the current VEA. Most veterans and dependants who are receiving benefits through the VEA will remain eligible under scheme 1. The core benefits received through the VEA will remain largely unaltered.

Given its historical basis, the Commission does not see a lot of scope for reform to the VEA. However, it has made some recommendations to:

- harmonise important aspects of the VEA with the other Acts
- improve the administration of the VEA
- streamline and harmonise some of the small payments available under the VEA.

These changes would not affect the beneficial nature of the VEA, and scheme 1 would retain the lifetime pension focus of the VEA. Benefits would be predominately delivered through disability pensions, including the Special Rate Disability Pension, and war widow(er)s' pensions (figure 17.1). Beneficial access to dependant benefits would remain.

The Act itself is an unnecessarily complex piece of drafting, and there is room for updating the legislation without changing the outcomes for claimants — although the Commission has not made recommendations in this area.

Scheme 2

Scheme 2 would be based on the MRCA. Veterans not eligible under scheme 1 or who are given the opportunity to switch into scheme 2 (discussed later) will claim through scheme 2.

As a starting point, changes would be made to the MRCA and the DRCA to harmonise the benefits received under these Acts (consistent with the recommendations made throughout this draft report). Eventually, the DRCA would be rolled into the MRCA to form one Act — the basis of scheme 2. Recommendations to harmonise the two Acts are contained throughout this draft report.

Combining the MRCA and the DRCA was considered by the 2011 review of the MRCA (Campbell 2011b). However, combining the Acts was not recommended at that time — in large part because of the sizeable potential increases in costs involved in moving current DRCA recipients on to the MRCA. Chapter 12 assesses in detail the costs involved with harmonising the MRCA and the DRCA, but some points are worth making here.

- While there is likely to be an increase in costs involved with the switch, due to the age-based lump sums that apply in the MRCA, and because the group of people claiming under the DRCA are now likely to be older, the cost will be lower than it was in 2011.
- The MRCA Review noted that simplification of the MRCA and DRCA could be achieved in the future — the Commission considers that now is the time.

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- The MRCA Review also noted that some people could be made worse off under the MRCA than they would be under the DRCA. This continues to be the case (chapter 12), but some trade-offs need to be made if there is to be a simpler system.
 - The MRCA Review suggested that such a change could lead to calls for previous recipients of DRCA benefits to have their compensation reassessed under the MRCA.

The Commission sees merit in DRCA compensation recipients moving to the MRCA model of incapacity payments (chapter 12). However, reassessing permanent impairment payments would be complex, and the Commission does not support reassessments of past DRCA claims.

Scheme 2 would retain the beneficial nature of the MRCA, although the Commission has proposed streamlining some of the payments and provisions that reflect the historical nature of the scheme, and have little rationale in modern society — including the MRCA Special Rate Disability Pension and eligible young person payments.

Scheme 2 would be a simpler scheme, with compensation based around:

- permanent impairment payments
- incapacity payments
- wholly dependent partner payments and orphans' pensions
- health care, attendant and household service allowances (figure 17.1).

Who would be covered by what scheme?

The eligibility criteria for each scheme should be revised to avoid the confusion caused by the current injury-based approach to eligibility. The Commission's proposal to change eligibility is based on the following principles:

- veterans should only be eligible to make claims under one scheme — that is, all future claims for each individual veteran would be processed under either scheme 1 or scheme 2
- veterans should not have their current benefits affected, unless they elect to switch their current benefits to the other scheme
- veterans should be placed into the scheme that most reflects the current range of benefits they receive.

Applying these principles would reduce the need for compensation offsetting and confusion among veterans, and speed up the transition towards scheme 2 becoming the predominant scheme. In practice, however, implementation and transitional issues need to be carefully considered.

Figure 17.1 Compensation available under the schemes

	Scheme 1	Scheme 2
 Impairment compensation	General rate disability pensions Additional payments for specific disabilities	Permanent impairment payments
 Income replacement	Above general rate disability pensions Superannuation invalidity pensions	Incapacity payments Superannuation invalidity pensions (offset)
 Dependant benefits	Widow(er)'s pension Orphan's pension Funeral allowance Bereavement payment Income support supplement Education allowance (under 16 only)	Wholly dependant partner payments Payments for eligible children Payments to 'other' dependants Funeral allowance Bereavement payment Income support supplement Education allowance (under 16 only)
 Health care	Gold Card White Card Attendant care Household services	Gold Card White Card Attendant care Household services
 Other allowances	Service pension Motor Vehicle Compensation Scheme	Service pension Veteran payment Motor Vehicle Compensation Scheme Legal and financial advice

The simplest way to determine eligibility would be to base it on the Act the veteran has claims under at the date of the implementation of the two schemes approach (the implementation date).

Veterans with current claims or impairments for which DVA has accepted liability under the VEA prior to the implementation date would remain in scheme 1, subject to the following.

- Veterans over 55 years of age at the implementation date would remain on scheme 1, with no option to switch to scheme 2. For this group, there are unlikely to be benefits in switching to scheme 2 — they are likely to be better off on a lifetime pension — and the Commission does not consider that there would be benefits in offering these veterans the choice to switch. All future claims for this group would be through scheme 1, regardless of their current eligibility for other Acts.
- Veterans 55 years of age and younger as at the implementation date would remain on scheme 1, but be provided with the option of switching their current benefits and all future claims to scheme 2. These veterans *may* be better off on the rehabilitation and income replacement focus of scheme 2, and so should have the option to switch schemes. They should receive financial advice to help make this decision. The option could be exercised at any time prior to or on the lodgement of the next claim after the implementation date, but would be irrevocable.

Most veterans receiving benefits under the VEA will be over 55 at the implementation date. Thus it is expected that the second group would be relatively small. About 4000 veterans receiving a VEA disability pension in December 2017 would be under 55 in 2025, and this is expected to decline over time. The costs of offering financial advice and processing requests to switch scheme should be manageable.

Veterans who are eligible, or would be eligible under the VEA, but who do not have a current claim or have not had a claim for liability accepted by DVA prior to the implementation date, will have all their claims dealt with under scheme 2.

Scheme 2 would cover the remaining veterans and their dependants, including those with current MRCA and DRCA claims, and those without a current or accepted claim under any of the Acts as noted above (figure 17.2).

This approach is complicated by the fact that some veterans have current claims under multiple Acts. For these veterans, they could be assigned to a scheme based on the Act that is their predominant source of compensation, or their age, at the implementation date. The Commission will give further consideration to this issue in the final report, including how transitional arrangements might be best managed.

For example, those on a VEA Special Rate Disability Pension could prima facie be covered by scheme 1. For veterans on incapacity payments, they could be covered by scheme 2 (their existing VEA benefits *would not be affected*).

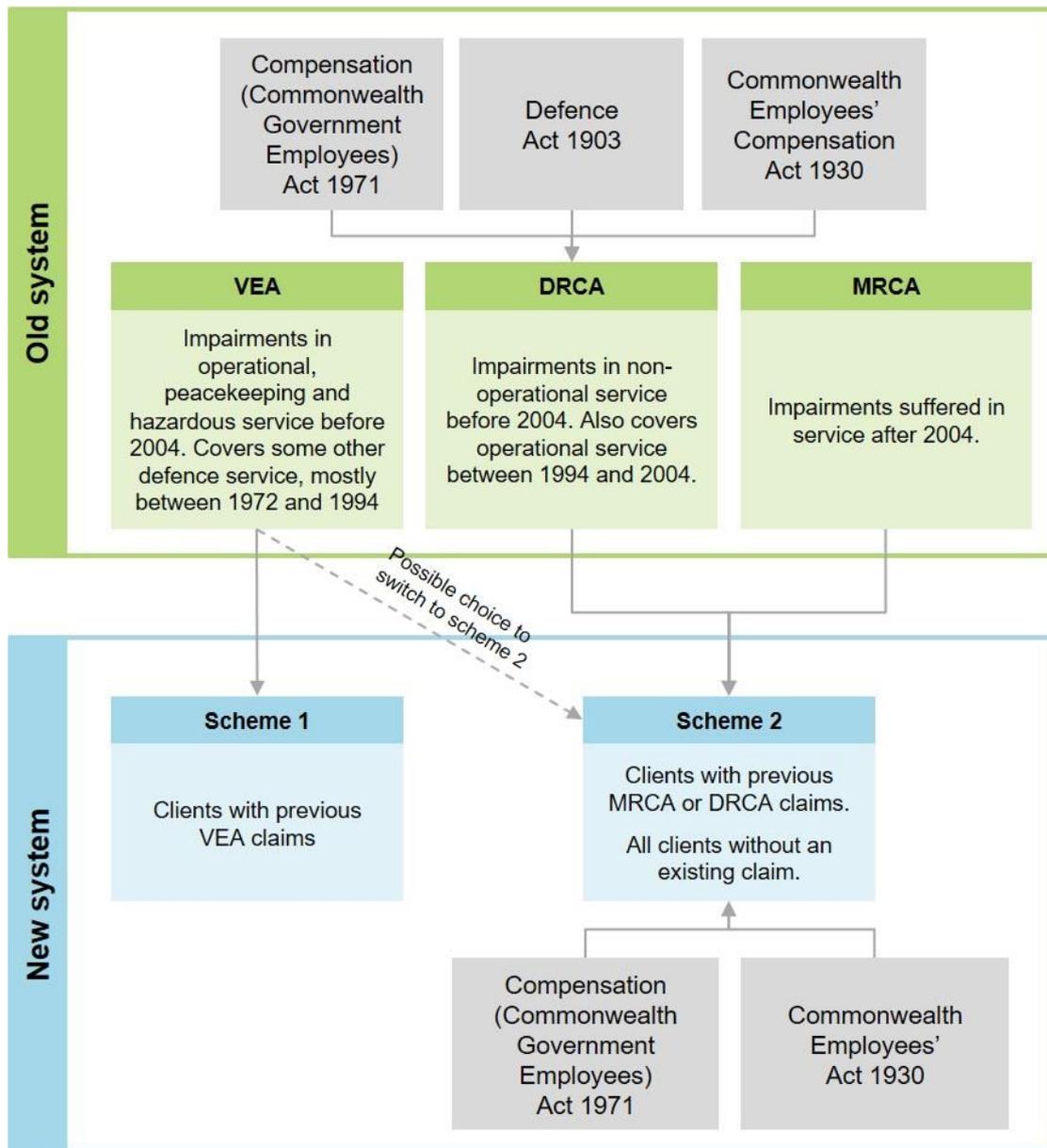
Enough time should be given before the reform is implemented to provide veterans with time to adjust to the new approach. Veterans without an existing claim who wish to be covered by scheme 1 would have the opportunity to submit a VEA claim if they have current eligibility under that Act prior to the implementation date.

When a veteran dies, dependants would receive compensation based on the scheme the veteran was covered by. If the veteran did not have an existing claim accepted by the DVA prior to implementation date, dependants would receive compensation through scheme 2. In most cases, the compensation available to dependants through scheme 2 would be higher than that available under scheme 1 (chapter 12).

An exception — the pre-1988 Commonwealth workers' compensation legislation

One difficulty with the two scheme approach is that there are two pre-1988 pieces of Commonwealth legislation — the *Commonwealth Employees Compensation Act 1930* and the *Compensation (Commonwealth Government Employees) Act 1971*. While these Acts have been repealed, transitional provisions mean that veterans with impairments that stabilised prior to 1988 can still receive compensation based on these Acts. About 25 per cent of DRCA permanent impairment claims determined in 2017 were based on injuries that occurred prior to the assent of the SRCA in 1988 (Productivity Commission estimates based on unpublished DVA data).

Figure 17.2 Two schemes — the eligibility



The compensation received under these Acts is very different in nature to that received under the three veterans' compensation Acts. For example, in the 1971 Act, compensation for permanent impairment is based on a table of maims approach, which only covers a limited number of impairments. Conditions such as mental health and back pain are not included as compensable conditions. The maximum amount of compensation available is substantially less than under the DRCA.

Rolling these veterans on to scheme 1 or scheme 2 would potentially provide a large windfall gain to some veterans, purely as a result of delaying their compensation claim. The

Commission does not consider this reasonable. Veterans who would receive compensation under the pre-1988 Commonwealth workers' compensation Acts should remain covered by these schemes for those injuries. These provisions would be included in the modified MRCA.

DRAFT RECOMMENDATION 17.1

By 2025, the Australian Government should create two schemes for veteran support — the current *Veterans' Entitlements Act 1986* (VEA) with some modifications ('scheme 1') and a modified *Military Rehabilitation and Compensation Act 2004* (MRCA) that incorporates the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) ('scheme 2').

Eligibility for the schemes should be modified so that:

- veterans who only have a current or accepted VEA claim for liability at the implementation date will have all their future claims processed under scheme 1. Veterans on the VEA Special Rate of Disability Pension would also have their future claims covered by scheme 1. Veterans under 55 years of age as at the implementation date should be given the option to switch their current benefits and future claims to scheme 2
- veterans who only have a current or accepted MRCA and/or DRCA claim, (or who do not have a current or accepted liability claim under VEA) as at the implementation date will have their future claims covered under scheme 2. Other veterans on MRCA or DRCA incapacity payments would have their future claims covered by scheme 2
- remaining veterans with benefits under the VEA and one (or two) of the other Acts would have their coverage determined by the scheme which is the predominant source of their current benefits, or their age, at the implementation date.

Dependants of deceased veterans would receive benefits under the scheme in which the relevant veteran was covered by. If the veteran did not have an existing or successful claim under VEA as at the implementation date, the dependants would be covered by scheme 2.

Veterans who would currently have their claims covered by the pre-1988 Commonwealth workers' compensation schemes should remain covered by those arrangements through the modified MRCA legislation.

INFORMATION REQUEST 17.1

The Commission is seeking feedback from participants on how the two scheme approach would work for veterans who currently have claims under multiple Acts. What factors should determine which scheme these veterans are covered by for their future claims? Should these veterans be given a choice of which scheme would cover them going forward?

17.2 A timeline for reform

While some of the reforms proposed by the Commission could be implemented relatively quickly, some should be implemented over the longer term to allow stakeholders time to adjust, enable consultation with relevant groups, and to help ensure that existing processes are not disrupted. This section outlines an indicative timeline for the reform process. We have devised a timetable that allows current Defence and DVA reforms to continue to be rolled out, while also ensuring the proposed new veteran support system is fully implemented and operationalised within a reasonable period. Feedback is sought on the proposed timeframe to inform a more comprehensive timetable for the final report.

Legislative simplification

The previous chapters in this draft report outlined numerous recommendations designed to simplify the veteran support legislation. The Commission's proposals are wide ranging, and should be phased in over time. The process should culminate in the adoption of the two scheme approach outlined above (table 17.1).

The starting point for reform should be simplifying and streamlining the Acts. This would include many of the recommendations in chapters 12 and 13 designed to simplify the range of payments available (predominantly in the MRCA). At the same time, some simple harmonisation between the DRCA and the MRCA could be achieved, such as aligning the incapacity payments between the Acts (draft recommendation 12.1), and SoPs in the DRCA (draft recommendation 8.1). These reforms would set the framework to roll the DRCA into the MRCA.

By 1 July 2025 the two scheme approach should be implemented. This would involve rolling the DRCA into the MRCA, as well as assigning veterans to each scheme and providing some veterans with the option to switch (although switching need not take place immediately). This time period has been chosen to:

- allow time for other reforms to be implemented
- allow veterans time to adjust to the new approach and consider their options.

Table 17.1 Legislative simplification recommendations — implementation

<i>Description</i>	<i>Draft recommendation no.</i>	<i>Notes</i>
Implemented as soon as practicable		
Harmonising the initial liability process across all Acts	Recommendation 8.1	These are priority reforms that should be implemented to simplify the system and make it fairer
Alignment of the DRCA with the MRCA, including incapacity payments, and allowances such as the education payments	Recommendation 12.1 (in part)	
Removing access to, streamlining, or merging various payments, supplements and allowances across all Acts	Recommendations 13.4, 13.5, 13.6, 14.1, 14.2, 14.3, 14.4, 14.5 and 14.6	
Medium-term reforms (2–3 years after the reform process commences)		
Remaining alignment of the DRCA and MRCA, including permanent impairment payments and dependant benefits	Recommendation 12.1 (in part)	These reforms are likely to be more complex, and require stakeholder negotiation as to how they should be implemented. Time should be given to allow these reforms to proceed as smoothly as possible
Introduction of one rate of permanent impairment compensation in the MRCA covering peacetime, non-warlike and warlike service	Recommendation 13.1	
Changes to permanent and stable provisions in the MRCA — limit the length of time an impairment can be considered unstable, and interim compensation paid as periodic payments only	Recommendations 13.2 and 13.3	
Changes to dependant benefits to limit eligibility under the MRCA, and provide for one, simpler payment.	Recommendations 13.7 and 13.8	
Longer-term reforms (by 1 July 2025)		
Adoption and full implementation of the two schemes approach	Recommendation 17.1	Longer-term reform that should only be implemented after other reforms. Time is required to allow veterans to adjust to the new schemes

Governance and responsibilities reform

The Commission is recommending fundamental changes to the governance arrangements for veteran support, to address the shortcomings of the system (table 17.2). They involve large-scale changes to the existing functions of DVA and parts of Defence. In particular, the consolidation of veteran support policy in Defence and the establishment of the Veteran Services Commission (VSC) are foundational changes to governance in the veteran support system that would result in DVA ceasing to exist.

Due to the scale of the recommended changes, there is a risk that such disruption could undermine DVA’s existing reform program, particularly the continued rollout of the Veteran

Centric Reform (VCR) program (chapter 9), which is currently expected to be completed around 2021.

While the work to establish the VSC should commence as soon as possible, it should have regard to the continued rollout of the VCR program. Once the VCR program has been completed (due in mid-2021), the changes to DVA and Defence's governance structures should be implemented. This should allow the VSC to begin operating no later than 1 July 2022, and earlier if possible. Any delays in the roll out of the VCR program should not delay the establishment of the new governance and administrative arrangements.

Other governance changes could be put in place more quickly. The new Joint Transition Command (JTC), for example, is based on an existing model (Joint Health Command) and many of its functions are already the responsibility of Defence. This means that JTC should be able to be operating by 1 July 2020, and earlier if possible. The Veterans' Advisory Council could also be in operation by 1 July 2020.

Similarly, the Commission is recommending changes to the roles and responsibilities of the Veterans' Review Board and DVA processes, to allow for a single review pathway. As the Commission is not recommending that new bodies be established, the single review pathway could be put in place relatively quickly with amendments to legislation and DVA processes where relevant — the Commission suggests no later than 1 July 2020.

Transitioning to a premium

The Commission has recommended that the veteran support system move to a fully-funded model going forward (draft recommendation 11.5). By definition, a premium designed to achieve full funding would only apply to new liabilities created from the first year it is imposed. For example, if the scheme commences in 2021-22, the premium paid that year would cover the expected liabilities (lifetime costs of the veteran support system) created by ADF members during 2021-22, and so on for subsequent years.

The Commission is also seeking feedback on whether existing liabilities for the veteran support system should continue to be funded on a pay-as-you-go basis, or whether these liabilities could also be fully-funded to make the cost of future policy changes clear.

Table 17.2 Governance and responsibilities recommendations — implementation

<i>Description</i>	<i>Draft recommendation no.</i>	<i>Notes</i>
Short term (as soon as practicable)		
Streamline the administration of superannuation invalidity pensions and veterans' compensation	Recommendation 12.2 (in part)	Recommendation is a continuation of existing processes
By 1 July 2020		
Establishing the Joint Transition Command and preparing members better for civilian life	Recommendations 7.1 and 7.2	These reforms will involve minimal disruption to existing processes, and can be undertaken relatively quickly
Giving the Repatriation Medical Authority the legal and financial capacity to guide medical and epidemiological research	Recommendation 8.2	
Establishing a single review pathway and modifying the role of the Veterans' Review Board	Recommendations 10.2 and 10.3	
Establishing the Veterans' Advisory Council and giving primary responsibility for commemorations to the Australian War Memorial	Recommendations 11.3 and 11.4	
By 1 July 2022		
Establishing the Veteran Services Commission and transferring responsibility for veterans' policy to Defence.	Recommendations 11.1 and 11.2	These reforms involve major reorganisation of the roles and responsibilities for veterans' support. Time is needed to avoid disruption of existing processes
Make the veteran support system a fully-funded compensation system	Recommendation 11.5	
Consider transferring responsibility for the superannuation invalidity pensions to the Veteran Services Commission	Recommendation 12.2 (in part)	
By 2025		
Review the role of the Veterans' Review Board	Recommendation 10.4	Longer term to allow time for other reforms to become established

Improving service delivery and supports

DVA is taking steps to improve the delivery of its services through the VCR program. However, there remains scope to improve the assessment of claims — the Commission has made recommendations in this area such as improving the experience of vulnerable people interacting with the compensation and rehabilitation system. These reforms could be adopted immediately alongside the VCR program.

The delivery of rehabilitation and health services could also be improved immediately by changing the way that DVA contracts with providers of rehabilitation. Improvements to health care — particularly mental health care — need to be guided by a longer-term strategy

that makes better use of an improved evidence base (see the data, evidence and transparency section below) (table 17.3).

Ex-service organisations (ESOs) play an important role in delivering services to veterans, including advocacy services to help veterans through the claims process, transition support and employment services. They will continue to play a vital role providing peer support for veterans and their families, and improving social integration as veterans transition from the defence force. However, there are numerous ESOs, and the group as a whole lacks coordination. There appears to be no strategic vision by DVA as to how to leverage the expertise of ESOs. As a result, ESOs may not be as effective as they could be.

The role of ESOs, particularly in relation to advocacy, is the subject of a scoping study by Robert Cornall, due to be finalised in December 2018. As a result, the Commission has not made any recommendations on the role of ESOs in this draft report, but intends to make recommendations on this area in its final report, informed by that study.

Table 17.3 Improved service delivery — implementation

<i>Description</i>	<i>Recommendation no.</i>	<i>Notes</i>
Commence as soon as practicable		
Better engagement with rehabilitation providers and better coordination of rehabilitation for transitioning personnel	Recommendation 6.3	These reforms can commence immediately, alongside the Veteran Centric Reform program
Trial a new education allowance for veterans undertaking full-time study	Recommendation 7.3	
Better claims administration — better staff training in trauma and reassessment of claims assessment batches with excessive error rates	Recommendations 9.2 and 9.3	
Medium term reforms		
Amend the payments for Coordinated Veterans Care to better reflect the risk rating of patients	Recommendation 15.2	These reforms require better evidence and consultation, and may take 2–3 years to implement fully.
Update the Veteran Mental Health Strategy	Recommendation 15.3	

Data, evidence and transparency

The Commission has made several recommendations designed to improve the data and evidence base for veteran support (and injury prevention), and ensure that this evidence is publicly available. These reforms are intended to underpin longer-term reform to the veteran support system, and should commence as soon as practicable (table 17.4).

Improving the data and evidence base within the veteran support system will require development of competencies in information technology, data management and analysis —

encompassing both software and people — with many more resources than currently allocated to this function.

The increasing focus on data and evidence will require staff with specialist knowledge in data analytics as well as outcome measures. And from a whole-of-system view, staff capability in actuarial modelling will be needed to implement a financially sustainable model.

Table 17.4 Data, evidence and transparency — implementation

<i>Description</i>	<i>Draft recommendation no.</i>	<i>Notes</i>
Commence as soon as practicable — ongoing processes		
Investigating augmenting the Sentinel database with information from the Defence e-health system	Recommendations 5.1 and 5.2	These reforms should commence as soon as practicable to underpin longer term reform and change.
Piloting injury prevention programs		
Publishing a report that estimates notional workers' compensation premiums for the Australian Defence Force	Recommendation 5.3	
Reporting on outcomes from the Australian Defence Force Rehabilitation Program	Recommendation 6.1	
Better use of data to evaluate the effectiveness of rehabilitation services	Recommendation 6.2	
Reporting on the progress of implementing recommendations from recent reviews	Recommendation 9.1	
Reporting on the Veterans' Review Board's reasons for varying decisions	Recommendation 10.1	
Monitoring, reporting on, and reviewing the performance of Open Arms'	Recommendation 15.5	
Development of outcome measures to assess service effectiveness. More trials, reviews and evaluations, and an annual research plan.	Recommendations 16.1, 16.2 and 16.3	

17.3 The future veteran support system

While the Commission has not quantified the benefits of its reforms, they are likely to be significant and across multiple domains (table 17.5).

One of the key objectives of the Commission's reforms is an increased focus on the wellbeing of veterans over their lifetime, including through improved rehabilitation, work health and safety and transition support. Ultimately, this should mean that:

- fewer veterans and families need to deal with injury, illness or death
- when impairments do occur they are managed better and more veterans are able to return to work

-
- veterans and their families are better prepared to manage their lives post service, and veterans are provided with the skills needed to have a post-military career.

Nonetheless, injuries and illnesses will still occur, and compensation is needed to provide restitution and support for veterans and their families. The Commission's recommendations aim to reduce the complexity through the liability system, from the initial liability process right through to the reviews and appeals process. Along with the changes to the structure of compensation, this will result in a simpler, fairer, and more accessible and timely system of compensation.

The Commission's recommendations seek to set up the veteran support system so that it is not only a better system in the short term, but it continually improves and remains effective well into the future. The Commission has made several recommendations designed to create a better evidence base to inform improved design and delivery of services, programs and policies. The new governance structures should also facilitate better decision making, ultimately leading to improved outcomes for veterans and their families.

There will also be efficiency gains from the proposed changes, including by placing a greater focus on accountability and lifetime costs of support and reducing duplication. A greater focus on wellness and lifetime costs should also translate into increased economic and social participation of veterans and reduced reliance on income support.

Table 17.5 What benefits for current and future veterans?

<i>What we propose</i>	<i>What it will achieve</i>
Prevention	
Augmenting Defence work health and safety incident reporting with other health and claims data	Better information on the incidence and lifetime costs of harm, improved safety and prevention
Provide support for trial injury prevention programs at Lavarack and Holsworthy barracks	Better evidence base to support a servicewide rollout of new approaches to injury prevention
Rehabilitation	
Extension of rehabilitation to discharging members	Better and more continuous rehabilitation services, potentially increased economic participation
Evidence-based services and evaluation of outcomes	
Military-to-civilian transition	
Creating a new command within Defence to centralise responsibility for preparation and support	Veterans and their families are better prepared to cope with the practical, psychological and social challenges of transition
More transition support for veterans and families	
Trial a new education allowance for veterans undertaking full-time study	More veterans have skills and qualifications for future career success
Compensation	
Streamlining the compensation package, by removing payments that are poorly targeted or have little rationale, simplifying payments, or rolling them into underlying payments.	A simpler, fairer and more accessible system of compensation.
Harmonising compensation in the MRCA and DRCA, and eventually moving to a two scheme approach.	Some changes in the levels of compensation received by veterans making claims in the future. Existing benefits would be largely unaffected.
Mental health and suicide prevention	
Updated veteran mental health strategy	More veterans could access mental health care and receive evidence-based treatment
Reporting on outcomes of Open Arms services	
Governance	
Shift responsibility for veteran policy into the Department of Defence	Long-term wellbeing of service personnel is considered in broader Defence policy
Fully funding the long term costs of the system via a premium collected from Defence	Make the long-term cost implications of future policy decisions affecting veterans transparent. Sharper incentives to reduce harm and focus efforts to improve work health and safety and rehabilitate injured veterans
A new independent statutory agency (the Veteran Services Commission) to administer the veteran support system	Achieving the objectives of the system in the most cost-effective manner possible
Initial liability and claims administration	
Harmonise the initial liability process across all three Acts, including moving to a single standard of proof	Less complexity and increased consistency of claims assessments
Expand the powers, resources and transparency of the Repatriation Medical Authority	SoPs are created and updated faster, better explained, and with an improved evidence base
Reviews	
Single review pathway across the veteran support Acts, with internal reconsideration	A quicker and simpler review process
Better feedback to DVA claims assessors	Less time and cost spent pursuing reviews
	More accurate initial decision making by DVA
Data and evidence	
More high-quality evaluations and trials, and a strategic direction for veterans' research	A better evidence base to inform the design and delivery of effective services

A Conduct of the inquiry

The Commission received the terms of reference for this inquiry on 27 March 2018. It subsequently released an issues paper on 3 May 2018 inviting public submissions and highlighting particular matters on which it sought information.

In total, 153 public submissions were received and placed on the inquiry website. A list of all public submissions is contained in table A.1. The Commission also received 115 brief comments, and these are also available on the website.

During the course of the inquiry, the Commission held informal consultations and roundtable discussions with veterans and their families, ex-service organisations, service providers and academics, as well as a number of government departments and agencies. Tables A.2 and A.3 list these participants.

The Commission would like to thank all those who contributed to this inquiry, and is now seeking additional input for its final report. The Commission welcomes further submissions on the draft report, including responses to information requests and the draft recommendations and findings.

Table A.1 Submissions^a

<i>Participants</i>	<i>Submission number(s)</i>
Air Force Association	93
Alkemade, Peter	66
Alliance of Defence Service Organisations (ADSO)	4, 85
Anderson, Julie	152
Ashmore, Alan	55, 95, 102 #*
Australian Acupuncture and Chinese Medicine Association	80
Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (TPI Federation Australia)	134, 145 #
Australian Veterans Alliance	81 #
Baker, Terence	132 *
Baldwin, Hugh	10
Ball, Max	140
Bartrop, Owen	20
Benton, Ross	63
Berg, Chris	52, 105 *
Black, Robert	45
Brandis, Fiona	103
Brown, William	110
Browning, Avelon Richard	136 #*
Bucci, Ronald	126
Burrows, John	27
Cartner, Steven	21
Chesterfield, Timothy	24
Coathup, Richard	124
Commonwealth Ombudsman	62
Community and Public Sector Union (CPSU)	94
Cornish, John	64
Crossley, Matthew	83
Defence Force Welfare Association (DFWA)	118
Délboux, Brad	60
Department of Defence	127
Department of Veterans' Affairs (DVA)	125
d'Hagé, Adrian	54
Doctors on Demand	139
Dwyer, Brendan	15
Edwards, Robert	5
Eglinton, Ian	123
Employers Mutual Limited (EML)	90
Enno, Keith	147, 150
Fielding, John	130
Fisher, Petrina	75
Fleming, Andrew	1 *
Fleming, Giselle	33
Fogarty, Terry	32
Foley, Daniel	19
Forsbey, William	3
Fuller, Brian	11

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Table A.1 (continued)

<i>Participants</i>	<i>Submission number(s)</i>
GO2 Health	98
Gore, William	97
Green, D	50
Griffiths, Geoff	104
Harkness, Harry	91 #
Harrex, Warren	89
Harrison, David	129
Hawes, Peter	30, 47
Hayes, Peter	8
Hemburrow, Keith	17 #
Hewitt, Chris	38
Horner, Christopher; Chandler, Jarrod; Allen Hine, Scott; Jones, Gareth; Newell, Steven; Kirkels, Brad; Kendall, Kenneth; Stamp, Catherine; Sullivan, Kieron; Harding, John; Inglis, Jane Megan and Dennerley, Michael	28
Hume Veterans' Information Centre	121
Janz, Stephen	65
Jones, Roy	135 #
Kemp, Raymond	37
Kirkwood, Neil	44
Legacy Australia	100
Lenard, Hilton and Russell, Keith	13
Linden, Mattheus	41
Manning, Robert	43 #
Mates4Mates	84
Maurice Blackburn Lawyers	82
McFarlane, Alexander	69
Meehan, Terence	35
Melandri, David	61
Miller, Russell	138 *#
Mollison, Charles	14
Moore, Leslie	7
Muldoon, Ian	22
Name withheld	9, 12, 36, 57, 70, 101, 112, 119, 122, 128, 141 *#
National Mental Health Commission (NMHC)	107
Nelms, Peter	6
New, Brent	153
Occupational Therapy Australia (OTA)	71
Orygen - The National Centre of Excellence in Youth Mental Health	67
Palmer, Claude	18
Park, Kenneth	2
Parnell, Rodney Kenneth	48
Partners of Veterans Association of Australia	77
Prime Ministerial Advisory Council on Veterans' Mental Health	99
Purse, Olivia	51
Reading, Warwick	88
Redenbach, R P	31
Reece, Peter	49
Reeves, John	26

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Table A.1 (continued)

<i>Participants</i>	<i>Submission number(s)</i>
Rehabilitation Counselling Association of Australasia (RCAA)	74
Repatriation Medical Authority	111 #
Returned and Services League (RSL) of Australia — National Office	113
Returned and Services League (RSL) of Australia — New South Wales	151
Ridge, Garry	25 #
Robson, Neil	146
Rollins, Martin	23 *
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	58
Royal Australian Armoured Corps Corporation (RAACC)	29 #
RSL Queensland	73
RSL Veterans' Centre East Sydney	114
Rudzki, Stephan	40 #
Shafran, Geoffrey	115, 120, 144 #*
Shortridge, Robert	76
Sim, William	148 #
Slater + Gordon Lawyers	68
Sullivan, Don	53
Sutherland, Peter	108 #
The Oasis Townsville	92
Thomas, Rustyn	39 #
Thompson, Rod	116 #
Totally and Permanently Disabled Soldiers Association (Queensland)	86
Townsend, Helen	46
Tymms, David	79
Uildriks, Kim	131
Veterans and Veterans Counselling Service (VVCS) National Advisory Committee	72
Veterans' Advisory Council (VAC) and the Veterans' Health Advisory Council (VHAC) of South Australia	96
Veterans' Review Board	117
Victims Of Abuse In The Australian Defence Force Association	133, 137 #
Vietnam Veterans and Veterans Federation ACT Inc and Belconnen RSL Sub Branch	42
Vietnam Veterans Association of Australia (VVAA)	78
Vietnam Veterans' Federation of Australia (VVFA)	34
Volunteering Australia	142
War Widows' Guild of Australia Inc.	87
Watson, Campbell	143 *
Watts, David	106
Wombold, Raymond	16 #
Wood, Ross	59

^a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 Consultations

Participants

Administrative Appeals Tribunal
Attorney-General's Department
Australian Federation of Totally and Permanently Incapacitated Ex Servicemen and Women
Australian Government Actuary
Australian Institute of Health and Welfare
Australian National Audit Office
Australian Peacekeeper and Peacemaker Veterans' Association
Australian War Memorial
Baker, Don
Bird, Karen and John
Blackman, Deborah
Boeing Defence Australia
Bravery Trust
Comcare
Commonwealth Ombudsman
Commonwealth Superannuation Corporation
Creyke, Robin
Defence Force Welfare Association
Department of Defence
Department of Finance
Department of the Prime Minister and Cabinet
Department of Veterans' Affairs
Employers Mutual Limited (EML)
Hickie, Ian
Konekt Australia
Legacy Australia
Legal Aid NSW
Maurice Blackburn
McFarlane, Sandy
Medibank Health
Morris, Deborah
Murdoch, Paul
New Zealand Accident Compensation Corporation
New Zealand Defence Health Directorate
New Zealand Veterans' Affairs
O'Flynn, Janine
Palmer, Geoffrey
Papamau, Talissa
Paterson, Ron
Phoenix Australia
Pope, Rod

(continued next page)

Table A.2 (continued)

Participants

Queensland Department of the Premier and Cabinet
Queensland Veterans' Advisory Council
Reece, Peter
Repatriation Medical Authority
Returned & Services League of Australia – National Branch
Returned & Services League of Australia – New South Wales Branch
Returned & Services League of Australia – Queensland Branch
Returned & Services League of Australia – South Australia Branch
Returned & Services League of Australia – Victorian Branch
Ridges, Garry
Rolling, Martin
Royal Australian Air Force Association
Royal New Zealand Returned and Services Association
Rudzki, Stephan
Schulze, Jason
Slater + Gordon Lawyers
Specialist Medical Review Council
Sutherland, Peter
Tharwa Valley Forge
Travers, Mark
Treasury
Tune, David
Veterans' Affairs New Zealand
Veterans' Review Board
Vietnam Veterans' Federation of Australia
War Widows' Guild of Australia
WithYouWithMe

Table A.3 Roundtables

Organisations

Brisbane – 18 July 2018

Alliance of Defence Service Organisations
Australian Peacekeepers and Peacemakers Association (Queensland)
Australian War Widows (Queensland)
Defence Force Welfare Association (Queensland)
Defence Welfare Organisation (National)
Jamie Whitehead
Karen Bird
Legacy (Brisbane club)
Mates4Mates
Peta Miller
Queensland Advisory Committee for the Commemoration of the Anzac Centenary
Queensland Forensic Mental Health Services
Queensland Veterans' Advisory Council
Returned and Services League of Australia (Queensland)
Royal Australian Regiment Association (Queensland)
Slater + Gordon Lawyers
The Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (Queensland)
Toowong Specialist Clinic
Vietnam Veterans Federation of Australia (Queensland)

Townsville – 19 July 2018

Operation Compass
Returned and Services League of Australia (Queensland, Townsville sub-branch)
The Oasis (Townsville)
Totally and Permanently Disabled Ex-Servicemen and Women Association
Trojan Trek

Hobart – 6 August 2018

Australian Peacekeeper & Peacemaker Veterans' Association
Jon Lane
Mates4Mates (Ex-Officio)
Royal Australian Air Force Association (TAS Division)
The Partners of Veterans Association of Australia Inc. — (Tasmania)
Vietnam Veterans' Association of Australia

Melbourne – 8 August 2018

Carry On
Defence Families Australia
Defence Force Welfare Association
Defence Reserves Association
Department of Premier & Cabinet — Veterans Branch
Michael Quinn
Returned and Services League of Australia — Victoria
Royal Australian Air Force Association
Totally and Permanently Incapacitated Ex-Servicemen & Women of Victoria Inc.

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Table A.3 (continued)

Organisations

Darwin – 13 August 2018

Legacy Northern Territory
Naval Association of Australia
Returned and Services League Darwin
Returned and Services League Katherine
Returned and Services League Palmerston
Veterans Australia Northern Territory

Adelaide – 16 August 2018

Adelaide Legacy
Defence Force Welfare Association
Ex-Military Rehabilitation Centre
National Malay & Borneo Veteran's Association Australia
Slider On
The Road Home
Veterans South Australia

Perth – 17 August 2018

Australian Federation of Totally and Permanently Incapacitated Ex-servicemen and Women
Australian Special Air Service Association
Defence Force Welfare Association
Definitiv
Returned and Services League of Australia
Royal Australian Air Force Association
Vietnam Veterans' Association of Australia
War Widows' Guild of Australia

Sydney – 5 October 2018

Alex Collie
Employers Mutual Limited
Generation Health
Konekt Australia
MedHealth Group
Transport Accident Commission Victoria
Work Health Group

Canberra – 16 October 2018

Australian Institute of Family Studies
Defence Families Australia
Legacy
Partners of Veterans Association of Australia
Veterans and Veterans Families Counselling Service
War Widows' Guild of Australia

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