

DIGITALES ARCHIV

ZBW – Leibniz-Informationszentrum Wirtschaft
ZBW – Leibniz Information Centre for Economics

Book

A better way to support veterans ; volume 1 ; Volume 1

Provided in Cooperation with:

ZBW OAS

Reference: (2019). A better way to support veterans ; volume 1 ; Volume 1. Canberra : Productivity Commission.

This Version is available at:

<http://hdl.handle.net/11159/3241>

Kontakt/Contact

ZBW – Leibniz-Informationszentrum Wirtschaft/Leibniz Information Centre for Economics
Düsternbrooker Weg 120
24105 Kiel (Germany)
E-Mail: [rights\[at\]zbw.eu](mailto:rights[at]zbw.eu)
<https://www.zbw.eu/>

Standard-Nutzungsbedingungen:

Dieses Dokument darf zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden. Sie dürfen dieses Dokument nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, aufführen, vertreiben oder anderweitig nutzen. Sofern für das Dokument eine Open-Content-Lizenz verwendet wurde, so gelten abweichend von diesen Nutzungsbedingungen die in der Lizenz gewährten Nutzungsrechte. Alle auf diesem Vorblatt angegebenen Informationen einschließlich der Rechteinformationen (z.B. Nennung einer Creative Commons Lizenz) wurden automatisch generiert und müssen durch Nutzer:innen vor einer Nachnutzung sorgfältig überprüft werden. Die Lizenzangaben stammen aus Publikationsmetadaten und können Fehler oder Ungenauigkeiten enthalten.

<https://savearchive.zbw.eu/termsfuse>

Terms of use:

This document may be saved and copied for your personal and scholarly purposes. You are not to copy it for public or commercial purposes, to exhibit the document in public, to perform, distribute or otherwise use the document in public. If the document is made available under a Creative Commons Licence you may exercise further usage rights as specified in the licence. All information provided on this publication cover sheet, including copyright details (e.g. indication of a Creative Commons license), was automatically generated and must be carefully reviewed by users prior to reuse. The license information is derived from publication metadata and may contain errors or inaccuracies.



Australian Government
Productivity Commission

A Better Way to Support Veterans

Productivity Commission
Inquiry Report
Volume 1

No. 93, 27 June 2019

© Commonwealth of Australia 2019

ISSN 1447-1337 (online)

ISSN 1447-1329 (print)

ISBN 978-1-74037-682-2 (set)

ISBN 978-1-74037-681-5 (volume 1)

ISBN 978-1-74037-680-8 (volume 2)



Except for the Commonwealth Coat of Arms and content supplied by third parties, this copyright work is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/3.0/au>. In essence, you are free to copy, communicate and adapt the work, as long as you attribute the work to the Productivity Commission (but not in any way that suggests the Commission endorses you or your use) and abide by the other licence terms.

Use of the Commonwealth Coat of Arms

Terms of use for the Coat of Arms are available from the [Department of the Prime Minister and Cabinet's website](#).

Third party copyright

Wherever a third party holds copyright in this material, the copyright remains with that party. Their permission may be required to use the material, please contact them directly.

Attribution

This work should be attributed as follows, *Source: Productivity Commission, A Better Way to Support Veterans, Report no. 93*.

If you have adapted, modified or transformed this work in anyway, please use the following, *Source: based on Productivity Commission data, A Better Way to Support Veterans, Report no. 93*.

An appropriate reference for this publication is:

Productivity Commission 2019, *A Better Way to Support Veterans*, Report no. 93, Canberra.

Publications enquiries

Media, Publications and Web, phone: (03) 9653 2244 or email: mpw@pc.gov.au

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).



Australian Government
Productivity Commission

Canberra Office
4 National Circuit
Barton ACT 2600
GPO Box 1428
Canberra City ACT 2601
Telephone 02 6240 3200

Melbourne Office
Telephone 03 9653 2100
www.pc.gov.au

27 June 2019

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission's final report into *A Better Way to Support Veterans*.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R Fitzgerald'.

Robert Fitzgerald
Special Advisor

(Commissioner to 26 April 2019)

A handwritten signature in black ink, appearing to read 'Richard Spencer'.

Richard Spencer
Commissioner

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]

Contents

The Commission's report is in two volumes. **This volume 1 contains the overview, recommendations and findings and chapters 1 to 10.** Volume 2 contains chapters 11 to 19, appendix A and references. Below is the table of contents for both volumes.

Volume 1	
Transmittal letter	iii
Terms of reference	iv
Acknowledgements	xi
Abbreviations	xii
Overview	1
Key points	2
1 About the veteran support system	6
2 What we were asked to do and our approach	12
3 What objectives for a veteran support system?	13
4 Why reform is needed	17
5 A better way to support veterans and their families	25
Recommendations and findings	45
1 About this inquiry	81
1.1 What was the Commission asked to do?	83
1.2 What the inquiry covers	85
1.3 Who are veterans?	85
1.4 The Commission's approach	88
1.5 A guide to this report	91
2 Military service and the veteran community	93
2.1 The Australian military	94
2.2 A profile of the veteran community	112

3	The veteran support system	123
3.1	How the system of veteran support evolved	124
3.2	An overview of the system today	134
3.3	The system's cost and client mix	148
4	Objectives and design principles	163
4.1	What should the objectives of the veteran support system be?	164
4.2	Best-practice features of other support schemes	177
4.3	What principles should underpin the support system?	185
4.4	Some policy design issues	188
5	Preventing injury and illness	197
5.1	Why preventing injury and illness is so important	198
5.2	Regulatory framework governing the WHS of ADF personnel	199
5.3	How is WHS delivered in the ADF?	206
5.4	ADF work health and safety outcomes	213
5.5	Is there scope to improve WHS outcomes further?	217
5.6	Defence's broader responsibilities	236
6	Rehabilitation	239
6.1	About rehabilitation	240
6.2	What rehabilitation services are available to serving and ex-serving ADF members?	245
6.3	Incentives for rehabilitation	253
6.4	A changing environment for rehabilitation services	255
6.5	Insights on the effectiveness of rehabilitation services remain scarce	260
6.6	Other ways to improve rehabilitation services	272
7	Transitioning to civilian life after military service	283
7.1	Why transitioning well matters	285
7.2	What do we know about those leaving the ADF?	289
7.3	There are many disparate strands of transition support ...	293
7.4	... and many initiatives to improve transition ...	300
7.5	... but the path to civilian life can still be hard	301

7.6	A new Joint Transition Authority	314
7.7	Preparing for post-service careers	330
7.8	Preparing veterans for other aspects of civilian life	335
7.9	Education and training for post-service careers	338
7.10	Other transition issues	345
8	Initial liability assessment	349
8.1	Steps involved in establishing initial liability	350
8.2	The Statements of Principles	358
8.3	Shortcomings of the SoPs and options for reform	366
8.4	The dual standards of proof and options for reform	382
9	Claims management and processing	393
9.1	Good intentions but not always good execution	394
9.2	Veteran Centric Reform — a vehicle for change	399
9.3	Some early signs of success	401
9.4	But there is still room for improvement	405
9.5	Will Veteran Centric Reform succeed?	424
10	Reviews of claims	427
10.1	Why do review processes matter?	428
10.2	How the review processes work	429
10.3	Why is there a high rate of variation on review?	436
10.4	Unnecessary complexity and duplication	447
10.5	A best-practice system	460
10.6	Other issues	462

Volume 2

11 Governance and funding	467
11.1 An overview of the governance arrangements	468
11.2 Where is the strategic policy?	475
11.3 Current funding arrangements do not support good outcomes	485
11.4 Institutional separation — Defence and DVA	486
11.5 A proposed path forward	492
11.6 A new Veteran Services Commission to administer the system	496
11.7 Levying a premium on Defence	502
11.8 Veteran policy and planning functions	518
11.9 Other governance changes	525
12 Advocacy, wellbeing supports and policy input	531
12.1 Advocacy for veterans	532
12.2 Claims advocacy	537
12.3 Moving towards strategic funding for wellness supports	562
12.4 Improved coordination on policy issues with veterans	567
13 The compensation package	577
13.1 Compensation for veterans and their families	578
13.2 Evaluating the package of compensation	596
13.3 Reforming the compensation package	606
13.4 The interface with military superannuation	611
14 Compensation for an impairment	633
14.1 Impairment compensation	634
14.2 Compensation for economic loss	647
14.3 Benefits for dependants	654
15 Streamlining and simplifying additional payments	661
15.1 The benefits and costs of additional payments	662
15.2 Options for reform	666

16	Health care	687
16.1	Health care — an original feature of veterans' support	688
16.2	What does the veteran health system cover?	693
16.3	How is the veteran health system performing?	696
16.4	Reforms to improve health outcomes for veterans	709
16.5	Should compensation be a feature of veteran health care?	720
17	Mental health and suicide prevention	729
17.1	About the mental health of veterans	730
17.2	What mental health supports are available to veterans and their families?	748
17.3	Problems identified with current arrangements	760
17.4	System-wide reforms will improve mental health outcomes	767
17.5	An increased focus on outcomes is required	768
17.6	Improving the veteran mental health system — a new Veteran Mental Health Strategy	773
18	Data and evidence	785
18.1	Persistent gaps in data and evidence on veterans and veteran supports	786
18.2	Collecting data on the effect of veterans' programs	795
18.3	Alignment with the design principles	799
18.4	Making better use of existing data	801
18.5	Action is required to improve evidence	805
19	Bringing it all together	817
19.1	Addressing legislative complexity	818
19.2	Support for families	834
19.3	Implementing the reforms	840
19.4	How will reform affect the future veteran support system?	848
A	Conduct of the inquiry	851
	References	867

Acknowledgements

The Commission is grateful for the valuable contributions of the many people and organisations across Australia who assisted us on this inquiry. Your assistance and insights helped us better understand the current system and provided us with ideas on where improvements could be made.

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, and veterans and their families who told us about their personal experience, participated in our roundtables and public hearings and who provided submissions and comments to the inquiry. The time that ex-service organisations, researchers, insurance companies and others gave to discuss issues and prepare submissions to the inquiry was also much appreciated.

We also want to thank the Department of Veterans' Affairs, Department of Defence and other government organisations for the time they spent responding to our many questions and for providing information and data that helped inform our analysis and cost estimates. However, the Commission's cost estimates have not been verified by the relevant Departments.

The Commissioners would like to express their appreciation of the staff who worked on the inquiry. The staff team was led by Rosalie McLachlan and Angela Woo, and included Colin Burns, Jacob Conway Smith, Imogen Curtis, Jared Dent, Bradley Griffiths, Anthony Housego, Alice Li, Aaron Mollross, Tom Nankivell, Jessica Nugent, John Papadimitriou, Stewart Plain, Taylor Rundell and George Steel, with administrative assistance from Pragya Giri and Ingrid Ottaway.

Abbreviations

AAO	Administrative Arrangements Order
AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACFID	Australian Council For International Development
ACOSS	Australian Council of Social Service
ADF	Australian Defence Force
ADFRP	Australian Defence Force Rehabilitation Program
ADR	alternative dispute resolution
ADSO	Alliance of Defence Service Organisations
AGA	Australian Government Actuary
ALRC	Australian Law Reform Commission
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
APSC	Australian Public Service Commission
ARC	Administrative Review Council
ATDP	Advocacy Training and Development Program
ATO	Australian Taxation Office
AWM	Australian War Memorial
BEST	Building Excellence in Support and Training
BoT	Board of Taxation
BPA	Bureau of Pensions Advocates
CBT	cognitive behaviour therapy
CCS	Coordinated Client Support
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
CSS	Commonwealth Superannuation Scheme
CTAS	Career Transition Assistance Scheme
CVC	Coordinated Veterans' Care
CWGC	Commonwealth War Graves Commission
DCO	Defence Community Organisation
DFAT	Department of Foreign Affairs and Trade
DFISA	Defence Force Income Support Allowance
DFRDB	Defence Force Retirement and Death Benefits
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>
DSS	Department of Social Services
DVA	Department of Veterans' Affairs
DWHSC	Defence Work, Health and Safety Committee
EDA	Extreme Disablement Adjustment
ESO	Ex-service organisation
ESORT	Ex-Service Organisations 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
GIA	Grants-in-Aid
GP	general practitioner
GST	Goods and Services Tax
HCH	Health Care Homes
HPABP	Health Peak and Advisory Bodies Program
ICT	Information and communications technology
IL	initial liability

ISS	Income Support Supplement
IP	Income Protection
JHC	Joint Health Command
JTA	Joint Transition Authority
MATES	Medicines Advice and Therapeutics Education Service
MBS	Medicare Benefits Schedule
MEAO	Middle East Area of Operations
MEC	Medical Employment Classification
MRCA	<i>Military Rehabilitation and Compensation Act 2004</i>
MRCAETS	Military Rehabilitation and Compensation Act Education and Training Scheme
MRCC	Military Rehabilitation and Compensation Commission
MSBS	Military Superannuation and Benefits Scheme
NCF	National Consultation Framework
NDAP	National Disability Advocacy Program
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
SYV	Supporting Younger Veterans
TAC	Transport Accident Commission
TIP	Training and Information Program
TPD	Total and Permanent Disability
TPI	Totally and Permanently Incapacitated
TTTP	time taken to process
UN	United Nations
V&CG	Veteran and Community Grants
VCES	Veterans' Children Education Scheme
VCR	Veteran Centric Reform
VEA	<i>Veterans' Entitlements Act 1986</i>
VHC	Veterans' Home Care
VITA	Veterans' Indemnity and Training Association
VRB	Veterans' Review Board
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

- Despite some recent improvements to the veterans' compensation and rehabilitation system, it is not fit-for-purpose — it requires fundamental reform. It is out-of-date and is not working in the best interest of veterans and their families, or the Australian community.
- 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 other workers' compensation schemes, this does not mean it is an effective system.
- The system fails to focus on the lifetime wellbeing of veterans. It is overly complex (legislatively and administratively), difficult to navigate, inequitable, and it is poorly administered (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.
- The institutional and policy split between Defence and DVA also embeds perverse incentives, inefficient administration and poor accountability, and results in policy and implementation gaps.
- A future veteran support system needs to have a focus on the lifetime wellbeing of veterans. It should be redesigned based on the best practice features of contemporary workers' compensation and social insurance schemes, while recognising the special characteristics of military service. This will change the incentives in the system so more attention is paid to the prevention of injury and illness, to rehabilitation and to transition support.
- The split in responsibility between Defence and DVA for the lifetime wellbeing of veterans also needs to be addressed. While the first-best option is for responsibility for veteran policy to be transferred to the Department of Defence, given a lack of trust and confidence by veterans in Defence to exercise this policy role, and strong opposition to the change, this is not realistic or feasible at this stage.
- New governance, funding and cross-agency arrangements are required to address the problems with the current system.
 - A single Minister responsible for Defence Personnel and Veterans is needed to ensure policy making for serving and ex-serving personnel is integrated.
 - An advisory council to the Minister should be established to provide advice on the lifetime wellbeing of veterans.
 - A new independent statutory agency — the Veteran Services Commission (VSC) — should be created to administer and oversee the performance of the veteran support system.
 - An annual premium to fund the expected costs of future claims should be levied on Defence.
 - A 'whole-of-life' veteran policy under the direction of the Minister for Defence Personnel and Veterans needs to be developed by DVA, Defence and the VSC. This should include more rigorous cross-agency planning processes (including external expertise).
 - Responsibility for preparing serving veterans for, and assisting them with, their transition to civilian life should be centralised in a new Joint Transition Authority within Defence.

(continued next page)

Key points (continued)

- DVA's Veteran Centric Reform program has some good objectives and is showing some signs of success. It should be closely monitored to ensure it is rolled out successfully and adjustments should be made, where necessary, to accommodate the proposed reforms.
- The current system should be simplified by: continuing to make it easier for clients to access; 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, based on a modified *Veterans' Entitlements Act 1986*. Scheme 2 should cover all other veterans, based on a modified *Military Rehabilitation and Compensation Act 2004*, and over time will become the dominant scheme.
- Veterans' organisations play an important role in the system. DVA could better leverage this support network by commissioning services from them, including for veterans' hubs. Engaging with these organisations when there is no peak body is not easy for government. Should a national peak body be established that represents the broad interests of veterans, the Australian Government should consider funding it.
- The Gold Card runs counter to a number of the key principles that should underlie a future scheme — it is *not* wellness-focused or needs based. It can also be inefficient (by encouraging over-servicing). It should be more tightly targeted and not be extended to any new categories of recipients. An independent review of DVA's fee-setting arrangements for health services is also required.
- The way treatments and supports are commissioned and provided to veterans and their families also needs to change. The VSC would more proactively engage with veterans and their families (taking a person-centred approach, tailoring treatments and supports) and have greater oversight of providers than under current arrangements. This approach will require more extensive use of data and a greater focus on outcomes.
- Expanding non-liability coverage to mental health care was a positive step. However, a new Veteran Mental Health Strategy that takes a lifetime approach is urgently needed. Suicide prevention should be a focus of the Strategy, informed by ongoing research and evaluation.
- Families of veterans have access to a number of support services provided by DVA, including access to Open Arms counselling services, respite care, and the Family Support Package. Eligibility for the Family Support Package should be extended. The VSC would have close engagement with families, providing them with more individualised support. Further research is needed to better understand the mental health impacts of service life on families and how they can be best supported.

Overview

An implicit principle underpinning the current veterans' compensation and rehabilitation system is that military service is a unique occupation. There are a number of features that distinguish military service from other occupations, including that members:

- are required to follow orders — members are subject to military law and discipline and are not as free as other Australians to make independent decisions or to choose to avoid personal injury in armed conflict
- have authority to apply lethal force against enemy forces
- are 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 affected. And sometimes the impacts of service do not become apparent until many years after discharge. The health and wellbeing of family members of serving and ex-serving veterans can also be harmed by a veteran's military service, especially the families of veterans who died as a consequence of service and families living with veterans with physical injuries, disease or a mental illness.

Australia supports veterans with a separate and beneficial system

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 regardless of whether they incurred a service-related 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. The 'beneficial' nature of the compensation recognises that there can be both anticipated impacts of military service but also unanticipated and unknown potentially harmful exposures.

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 report is that despite recent improvements to the system, the current veterans' compensation and rehabilitation system requires fundamental reform.

- It is not working in the best interests of veterans and their families or the Australian community.
- It is not set up in a way that minimises harm from service-related injury and illness.
- 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. This includes placing veterans and their families at the heart of the system and taking a more holistic, flexible and individualised approach to supporting them.
- It needs efficient and effective governance and administrative arrangements that are suited to meeting the future challenges and emerging needs of veterans.

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 should 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 in supports and the way they are provided.

Recognising that mainstream services are a 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 healthcare 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 more likely to enjoy fulfilling and productive lives. A lifetime focus will result in better outcomes for veterans, their families and the Australian community.

Some of the benefits from the proposed recommendations include:

- a set of principles and objectives to guide the system
- a greater focus on prevention of injury and illness, on rehabilitation and on 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.

We are proposing a comprehensive, coordinated and sequenced package of reforms. The reforms will take time to implement, but they are vital for a better future system of support for veterans and their families. A staged approach will minimise disruption costs, allow current worthwhile initiatives to be rolled out and provide time for legislative and administrative adjustments. It will also allow time for veterans and their families to see the benefits of the reforms and be assured that the changed approach is a better system of support. It is hard to achieve institutional change without trust, and trust is won slowly (particularly given many of the problems that historically have beset veterans' support). In part, this is why the Commission has focused on long-term changes to the veteran support system, in order to build confidence in those changes over time.

1 About the veteran support system

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

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

In 2017-18, DVA spent \$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 about \$440 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.

The Commonwealth Superannuation Corporation provided a further \$800 million to veterans and their families 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 ADF 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 of both living and deceased veterans.

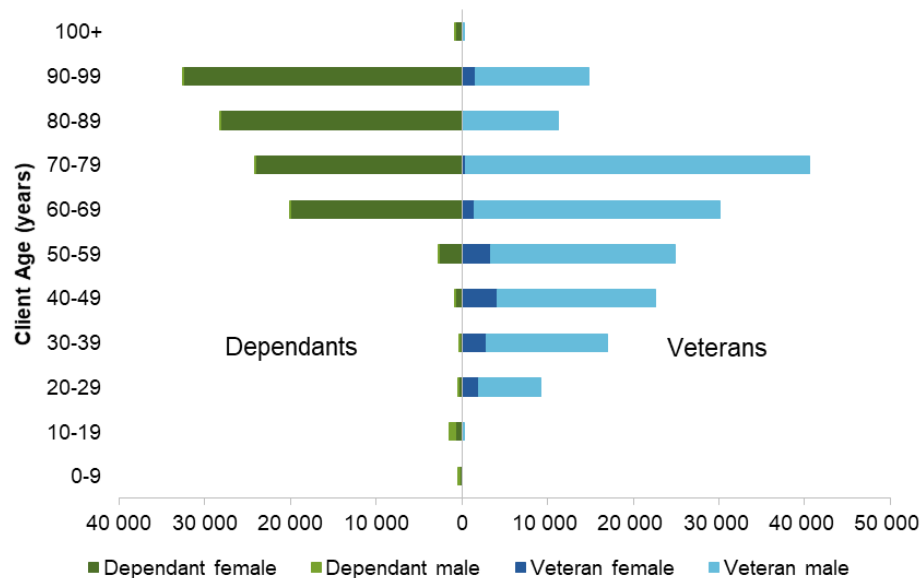
About the ADF and veteran population

- 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 extent and tempo of military engagements has increased since the early 2000s.
- Contemporary veterans have injuries that, in prior conflicts, would have resulted in death (for example, traumatic brain injuries).
- About 18 per cent of those 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).

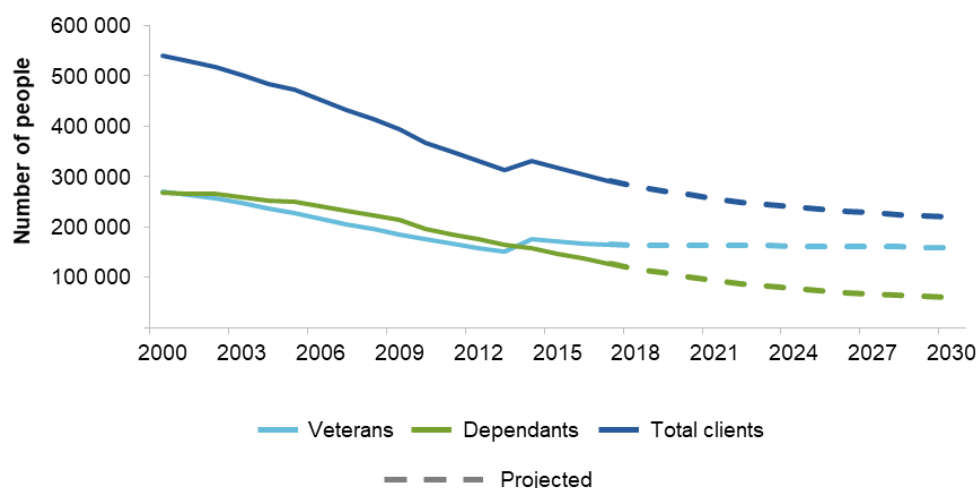
DVA clients span all generations and life stages — there are veterans and widows aged over 100 years and children of veterans as young as one year. However, the majority of DVA clients are in the older age groups — about 194 000 are 65 years or older and of these 98 000 are aged over 79 years (figure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

Figure 1 **DVA clients by age, December 2018**



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 cohorts (figure 2).

Figure 2 **DVA clients — veterans and dependants**



The profile and needs of veterans are changing. This is driven by the nature of recent and current military conflicts and the 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 about 18 per cent in 2018
- have been on multiple deployments — 38 per cent of permanent ADF members have 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' and Defence Personnel, 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.

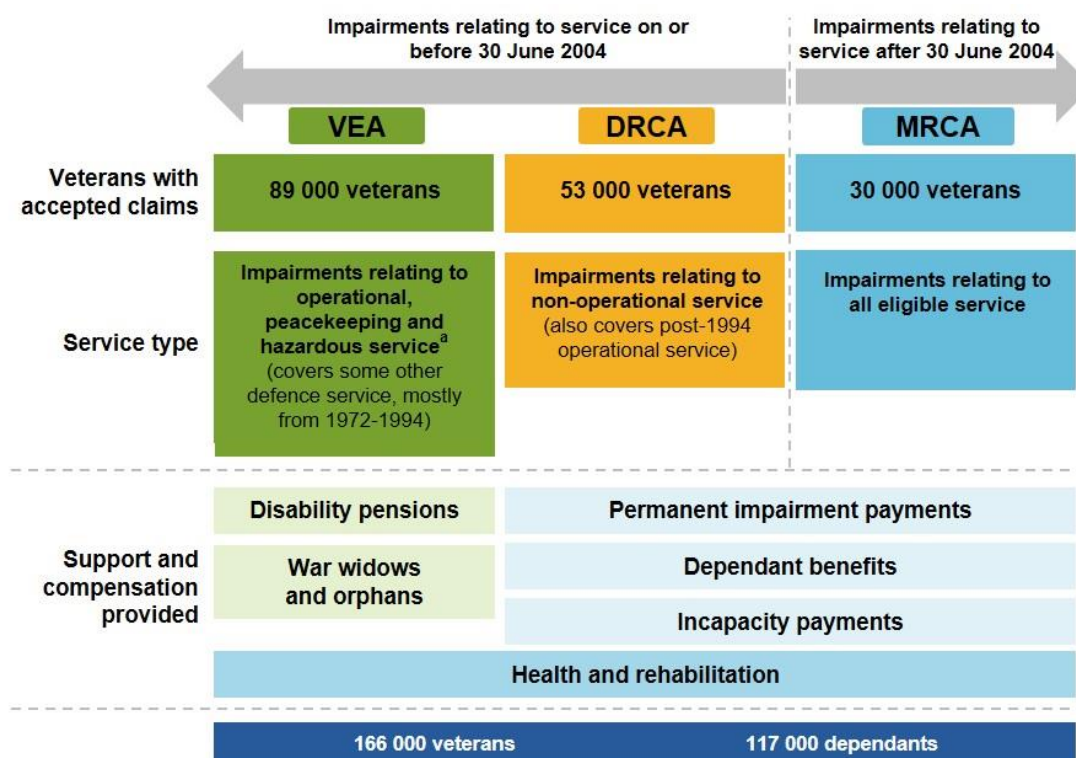
The legislative framework

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. Veterans with multiple impairments can also 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, though some are unique (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 generous 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.

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

	VEA	DRCA	MRCA
 Impairment compensation	General rate disability pensions (and Extreme Disablement Adjustment) 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 Veteran payment Legal and financial advice	Energy supplement MRCA supplement Service pension Veteran payment Motor Vehicle Compensation Scheme Legal and financial advice

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’. However, the important question is not so much the quantum of supports, but their outcomes. Put simply, does this unique system deliver for veterans and the community?

History provides insights into why the system is as it is

History explains, in part, why we have the system we have today. 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, 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, governments have added new features, 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 taken 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'.

It almost seems that because Australians value the sacrifices of those who have served, fewer checks and balances are applied to veteran policy (when compared to other areas of policy). While the contribution of our veterans to the nation's security should be recognised (and there are multiple ways to do this), it is also important that policy makers do not lose sight that the reason for supporting veterans and their families is to improve their lives. More funding for support does not necessarily equate to better outcomes and, in fact, it could undermine the recovery of veterans (for example, by providing a disincentive for veterans to return to work or to work to their potential).

As Gade, a United States veteran who served in Iraq, said:

A fundamental principle of design in any public-policy program can be found in the ancient Hippocratic Oath: 'First, do no harm.' This should be especially true of policy toward veterans. Having already taken risks in uniform to protect our society, they should not be exposed to risks from government policy ... which could harm them after their service.

There is also only one bucket of taxpayer funds, so it is always important to ask the question 'how could the money be best spent'?

2 What we were 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 said it chose the title *The Constant Battle* because it reflected the problematic nature of suicide by veterans and ex-serving personnel, noting that:

For modern veterans, it is likely that suicide and self-harm will cause more deaths and injuries for their contemporaries than overseas operational service.

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'.

Against this background, the Commission was asked to look at 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 providing evidence-based advice about policies that will improve the lives of current and future generations of veterans and their families, while also improving outcomes for the community as a whole.

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 us the objectives of the system should be, box 2). This objective 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.

And as with all other government programs, the objective should be achieved while ensuring value for money for the Australian community. Australians 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 harm or 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, which is unique in its design and purpose, 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 it drives 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.

Box 2 **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.

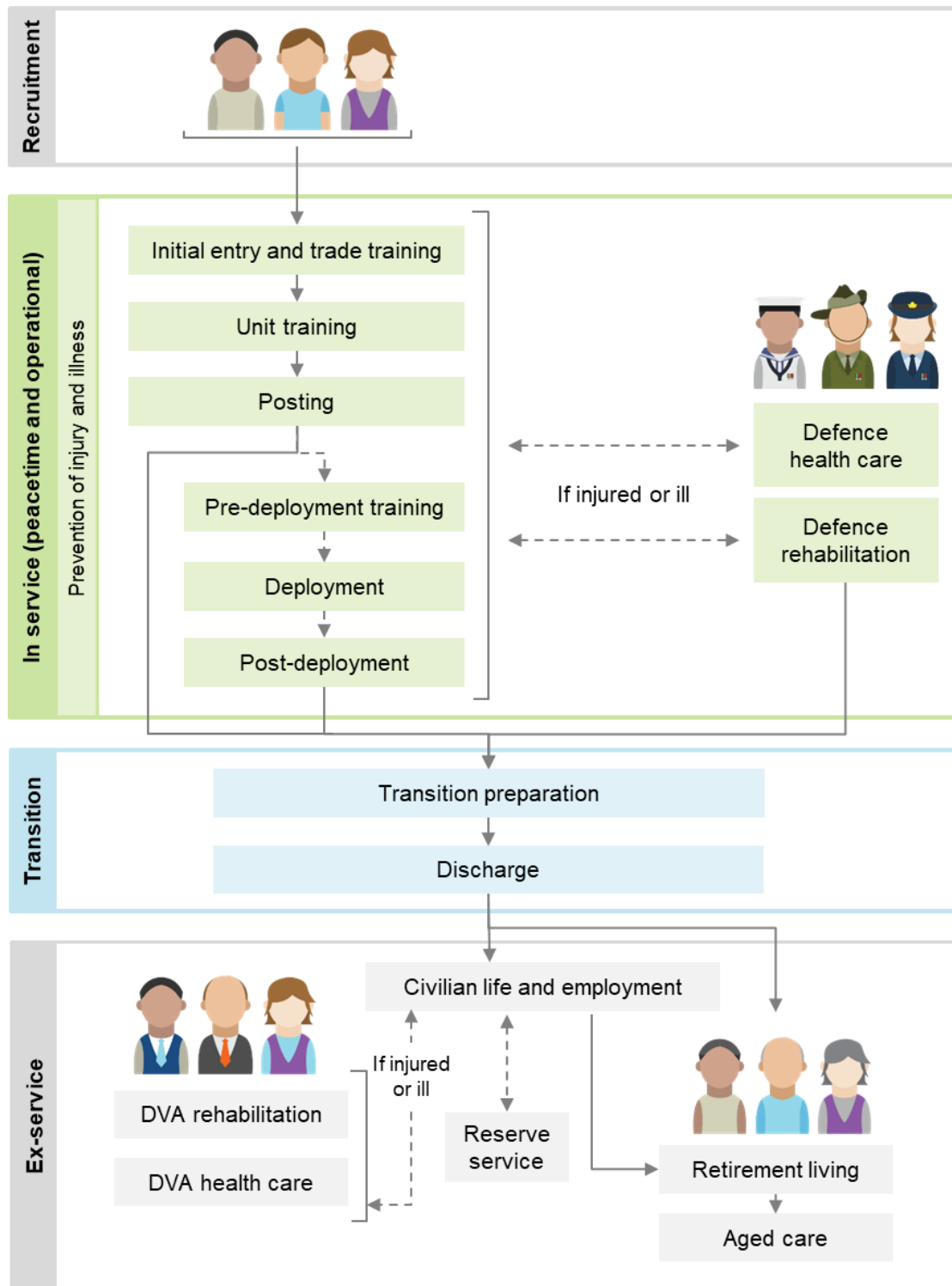
Mates4Mates:

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.

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 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.

Figure 5 Life stages of full-time military personnel

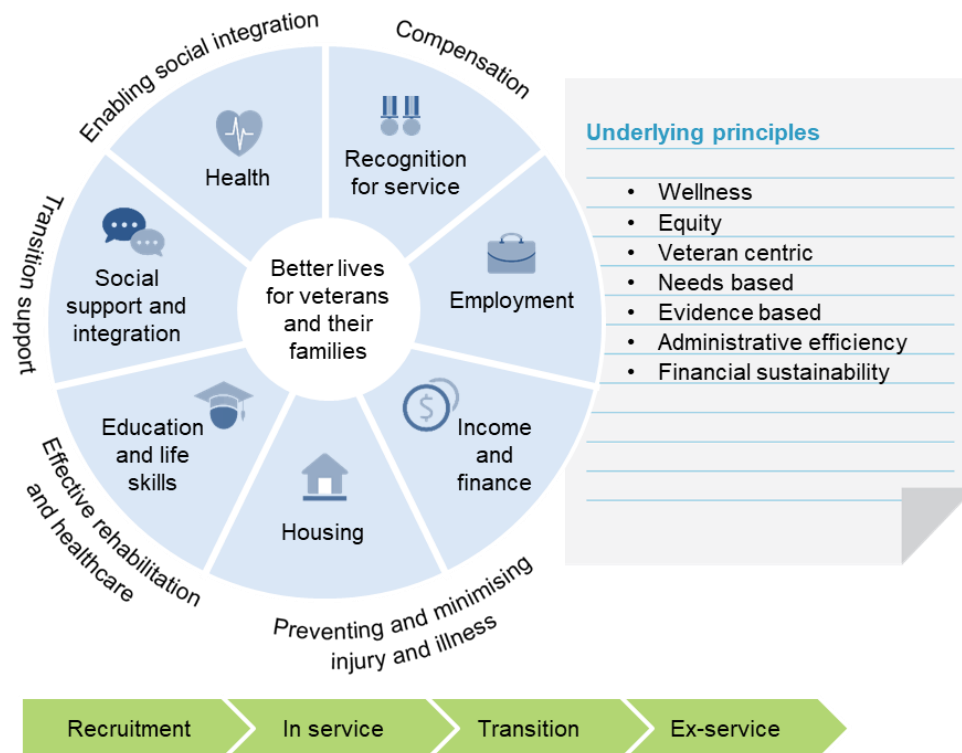


Using a wellbeing approach to support veterans and their families, together with insights from best-practice workers' compensation and contemporary social insurance schemes, the Commission considers that the veteran support system should be:

- wellness focused (*ability* not disability)
- equitable
- veteran centric (including recognising the unique needs of veterans and their families 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 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 does not perform well when assessed against the principles that should underpin the future system. This is in part because of the way the system has been added to over time, but also because of the way the system is set up and the incentives it creates for Defence, DVA and veterans. Veterans and their families could be getting far better outcomes from the dollars the Australian community is spending to improve their lives.

The system is overly 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. It is so complex that 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 operating alongside the support system means further offsetting and additional complexity.

The individual Acts are also complex. There are many additional payments beyond those typically provided by workers' compensation schemes (such as payments for damaged clothing, vehicle allowances and education payments). Veterans and their dependants can be eligible for at least 40 different payments or benefits, 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, and others are not. 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 and ad hoc policy making and a reluctance to take entitlements away from veterans or even

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.

rationalise them when their original rationale no longer exists — problems that DVA itself has highlighted.

... 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 paid, and how the compensation is calculated or paid, varies depending on which legislation applies. As RSL NSW said ‘veterans can seem to be effectively rewarded or punished for the timing of their service’.

Box 3 provides an example of the different amounts of compensation that a veteran could receive under the different Acts. There are differences based on the type of service they were undertaking (warlike and non-warlike or peacetime) when an injury or illness occurred. 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.

Different compensation for warlike and non-warlike service, and peacetime service adds complexity and veterans are required to demonstrate whether their injury was suffered as a result of warlike or non-warlike service. It also means there are inequities between different groups of veterans.

Some supports are poorly targeted ...

Some supports are poorly targeted, exemplified by the Gold Card. It covers the cost of a range of public and private health care services, irrespective of whether the impairment is service related (box 4). Most Gold Card holders (about 60 per cent) are dependants or veterans without severe service related disabilities (who qualify because of age or because they are receiving the service pension). The way the healthcare cards operate also means that cardholders are unlikely to be receiving co-ordinated person-centred health care.

... some discourage wellness

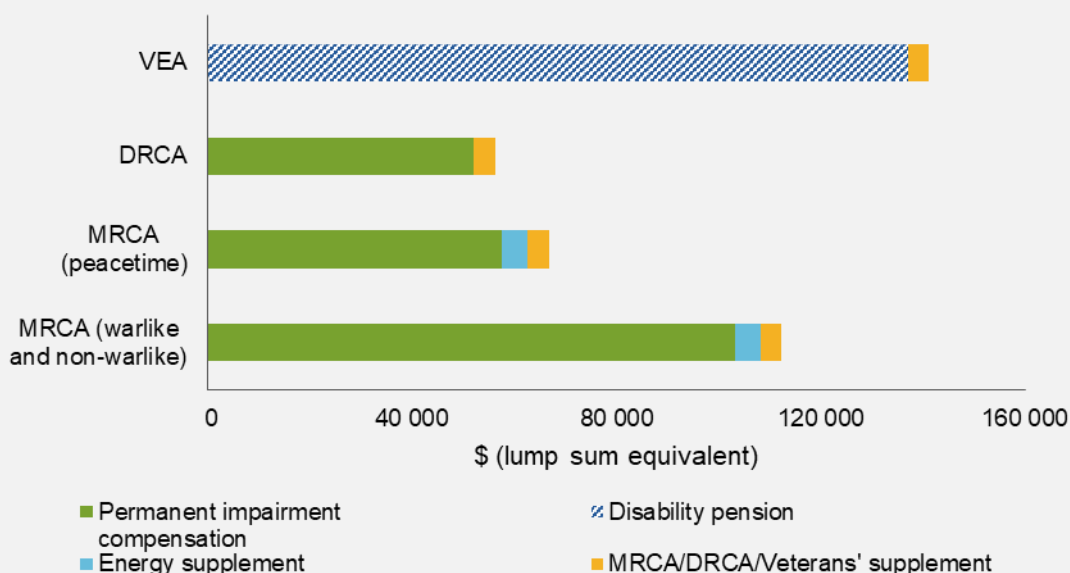
And some of the supports discourage wellness. One example is the Special Rate Disability Pension under the MRCA. It provides little incentive for veterans to rehabilitate and return to work because veterans lose access to their payment entirely if they return to work for more than 10 hours per week.

Box 3 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 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 70 years of age and the service pension.

The Gold Card can also work against the principle of 'wellness' by providing an incentive for veterans to seek to qualify for higher levels of support. A veteran with service-related impairments can substantially increase their compensation package by reaching the Gold Card eligibility. As 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'.

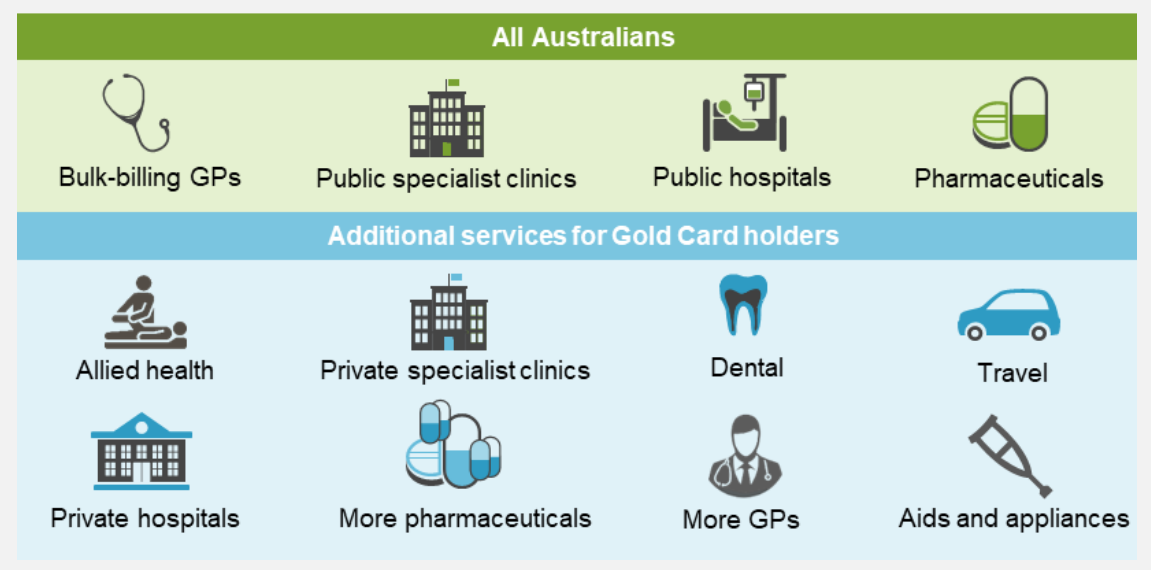
... The outcome sought for veterans should be rehabilitation, not monetary settlement. The 'gold card' nomenclature utilised by DVA reinforces a negative entitlement culture where success for veterans is the extraction of cash from the government, not their rehabilitation and return to being a productive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

Box 4 **Who is entitled to the Gold Card and what does it provide?**

The holder of a Gold Card is entitled to treatment and care for all health conditions. About 127 000 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.



Veterans can also be discouraged from seeking early intervention (which can lead to higher use of more expensive treatments) so they can maintain access to the Gold Card. As the National Mental Health Commission said:

A person eligible for the Gold Card on the basis of total and permanent incapacity, due to a mental health condition for instance, can lose eligibility if their condition improves or other circumstances change. The possibility of losing eligibility can therefore discourage people from seeking early intervention for mental health concerns and — in some cases — lead to higher use of expensive or unnecessary treatments.

There is strong support for the Gold Card from the veteran community — this is of no surprise — as it is, as the National Mental Health Commission said ‘a substitute for private health insurance’ (box 4). Gold Card holders are high users of healthcare services. In

2017-18, DVA funded 220 health services per Gold Card holder (by comparison, Medicare funded about 17 services per person and 44 services for each person aged 85 years and over).

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.

Inefficient processes that can place unnecessary stress on veterans

DVA's processes for administering claims are unnecessarily complicated and processing times can be lengthy. The time taken to process claims is typically many months, and some claims can take over a year to process (box 6). 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. The Australian National Audit Office, the Commonwealth Ombudsman and many ex-service organisations also highlighted problems with the administration of the system and the way DVA interacts with clients.

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
- high error rates.

Some of the factors contributing to these concerns are a lack of adherence by DVA staff to their own internal guidelines (particularly about how to communicate with clients), 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 systems.

While DVA approves most claims submitted by veterans and their families (box 6), many concerns were raised about DVA's adversarial approach to claims. However, the Commission's dealings with DVA staff during this inquiry indicated that most seek to operate in the interests of veterans.

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 outdated information and communication technology 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.

Some early, 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
- quicker and easier initial liability assessments via the rollout of the online claims system ‘MyService’.

MyService is showing early positive results (box 5). 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. 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 automate much of the claims process.

However, MyService is a complement to effective client management and not a substitute for human-to-human engagement with veterans and their families. Some clients need a higher level of support from DVA staff to help them manage the claims process.

Box 5 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. By June 2019 over 75 000 users had lodged nearly 50 000 claims 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)

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

Internal review processes fail to efficiently identify decision-making errors, with the majority of cases that reach the Veterans' Review Board (VRB) leading 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 its initial decision-making processes.

There are also unjustified differences in the review process between the various Acts and too many decision-making bodies and review pathways. The review process should 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

Best practice workers' compensation systems 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 DVA is funded on a demand-driven, pay-as-you-go basis, without a real budget constraint, which creates little accountability or incentives to operate the system efficiently and effectively.

For decades DVA has taken a passive welfare approach to providing support, with little focus on lifetime costs or outcomes. The consequence is that too little attention is placed on early intervention, rehabilitation and transition support.

DVA, with responsibility for both designing *and* implementing policy, has given most of its attention to the demands of the day-to-day administration of the veteran support system leaving long-term strategic thinking underdeveloped. The result is veterans' affairs policy that tends to be reactive, rather than a proactive, coherent approach with careful design and planning to avoid issues before they arise.

Responsibility for the wellbeing of veterans is also split between Defence and DVA. The wellbeing of veterans is *mostly* the responsibility of Defence while they are in full-time service. When they leave full-time service, veteran wellbeing and the financial costs of long-term, post-service care are *mostly* the responsibility of DVA (though only if veterans put their hand up for assistance, such as by filing a claim or applying for non-liability support). But most of the complex problems facing veterans originate from when they were serving. This gives Defence a preeminent capacity to reduce problems before (or just after) they arise.

However, the current demarcation of institutional roles between DVA and Defence sees many of the long-term costs of missed opportunities handed onto DVA. This happens because Defence can effectively settle its long-term work health and safety obligations by discharging its members. This is not an option for any other Australian employer because they pay a

financial premium (or self-insure to the same effect) that reflects the long-term costs of their employees' work-related injuries. In effect, what the current system does is it under prices the high long-term costs of supporting veterans compared to the lower short-run costs.

The institutional split between Defence and DVA means goodwill is working against the grain of the current system, and it leads to policy and implementation gaps, duplicated services, communication problems and inefficient administration. As Defence said itself, the system creates 'confusion, gaps, overlaps and less accessible services, reducing the effectiveness of the system'.

In practice, a split system serves no one well, including Defence, because the feedback loops that could inform change that enhances capability and cost effectiveness are severed. At the same time, accountability, particularly in the context of financial cost, is not sheeted home to those who are most able to do something to fix the problems.

The transition process provides a concrete example of the problems posed by split responsibilities and the absence of feedback loops and accountability. As one participant said:

The problem with transition is no one takes responsibility. Defence think it's DVA's responsibility, DVA think it's Defence's responsibility and, ... no one is actually doing anything.

Our son's medical transition in January 2018, following 20 years of service was a disgrace and highlighted the empty promises made by Defence about new and improved transitioning ... Changes and improvements need to start at the Defence workplace. Not after they've been kicked to the curb or disappeared down a crack in the floor. Those who are charged to deploy them should also be responsible for ensuring they are supported and encouraged in a positive working space when they return injured and ill. (Paula Dabovich)

And while Defence has a strong incentive to provide rehabilitation services to ADF members who have a high probability of redeployment or return to duty, it has a weaker incentive to rehabilitate members who are likely to be transitioning out. In the context of rehabilitation, a participant said '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'.

It is important to point out that the current governance arrangements and the incentives they create (or *do not* create) are the problem, *not* those who work in the system.

Outcome measures are also missing

Assessing the effectiveness of supports provided to veterans is difficult. This is because there is almost no data to objectively assess the effectiveness of the supports funded or provided by Defence or DVA (box 6). The consequence is that outcome measures are missing from the picture. There is very little to demonstrate to Australian taxpayers that what they spend on the veteran support system produces good outcomes for veterans.

Little is known, for example, about which rehabilitation and transition services provided by Defence and DVA work well, and where extra supports should be targeted. It is a similar

case in the area of health services for veterans. Beyond measures of services delivered and people attending training, there is also no assessment of the degree to which mental health services reduce mental illness or promote resilience.

More broadly, the focus of the veterans' health care system is on providing free and favourable access to health care for DVA clients, rather than achieving good health outcomes for veterans.

Box 6 **A few insights into how the system is performing**

Client satisfaction: In 2018, 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 81 per cent, however clients over 65 years were more satisfied (89 per cent) than those under the age of 45 years (58 per cent). Other results included:

- 78 per cent agreed that DVA is honest and ethical in its interactions
- 66 per cent agreed that it is client focused and thinks about clients' individual circumstances.

Claims assessment and management: The latest DVA data shows that the time taken to process claims is typically many months (for example, in 2017-18 the median time taken to process permanent impairment claims under the *Military Rehabilitation and Compensation Act 2004* (MRCA) was 78 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 about 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 — 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. Fundamental reform is required.

New governance arrangements for a lifetime wellbeing focus

Many participants to this inquiry argued that the problems with the current system could be resolved if DVA and Defence were given more time and money to implement the current suite of reforms, particularly the VCR program. But the current reforms do not address the system's fundamental governance problems or the perverse incentives in the system, and are insufficient to underpin a contemporary support scheme.

Well-designed workers' compensation schemes safeguard *both* the short- and long-term wellbeing of employees. The implication is that Defence as the 'employer' would not just attempt to manage the costs associated with short-term injury, but would play a more prominent role in trying to reduce long-term liabilities.

The ideal suite of complementary governance reforms would define roles and align incentives better, including:

- moving the administration of the veteran support system out of DVA into a newly created statutory agency — the Veteran Services Commission (VSC)
- levying an annual premium to fully fund the future veteran support system
- moving veteran support policy into the Department of Defence and creating a new Veteran Policy Group
- maintaining a single Minister for Defence Personnel and Veterans
- moving responsibility for commemorations and the Office of Australian War Graves to the Australian War Memorial
- establishing a new advisory council to the Minister for Defence Personnel and Veterans.

If implemented as a package, these reforms would create a unified veteran support system with aligned accountability and incentive structures. Responsibility for veterans' affairs would be centralised into a single portfolio department and VSC's sole focus would be on administering the veteran support system. This would create clear lines of responsibility and improve strategic direction by balancing Defence's national security objectives with its duty of care to members.

Notwithstanding the benefits of this package of reforms, there was strong opposition to moving policy responsibility for the veteran support system into the Department of Defence.

A key concern was that expanding the remit of an already very large department would mean that veterans' interests would not get the attention they would in a dedicated department. But it is not obvious why this would be the case in practice.

Others argued that Defence should not have to (or would be unable to) focus on veteran issues because its key role is warfighting, not looking after veterans. This argument ignores the fact that it is possible to set the goal of a workers' compensation scheme to reduce (not minimise) long-term liabilities subject to the constraint of being able to meet operational

requirements. In any case, there is already strong awareness by Defence that its personnel *are* its warfighting capability, so it needs to reduce injuries and illnesses to maximise the availability of deployable and motivated personnel. The missing ingredient is an incentive to account for long-term costs.

Resistance to the proposed change from veterans seems to stem from a lack of confidence in Defence to exercise such a policy role. RSL Tasmania, for example, said:

Any notion considering the possibility of passing the responsibility of veteran welfare, rehabilitation and/or compensation to the Department of Defence should be strongly resisted. Defence do not appear to have a good record of responsibility of care for members with regard to rehabilitation, either during service, or once the member has transitioned from the military.

However, other changes recommended by the Commission, in particular levying a premium and creating the Joint Transition Authority (discussed below), are likely to change Defence's capacity and willingness to take on the policy role in the future.

Nevertheless, the Commission acknowledges that without veterans having confidence in Defence's capacity to take on policy responsibility, and given the strong opposition, this proposal is not realistic or feasible at this stage.

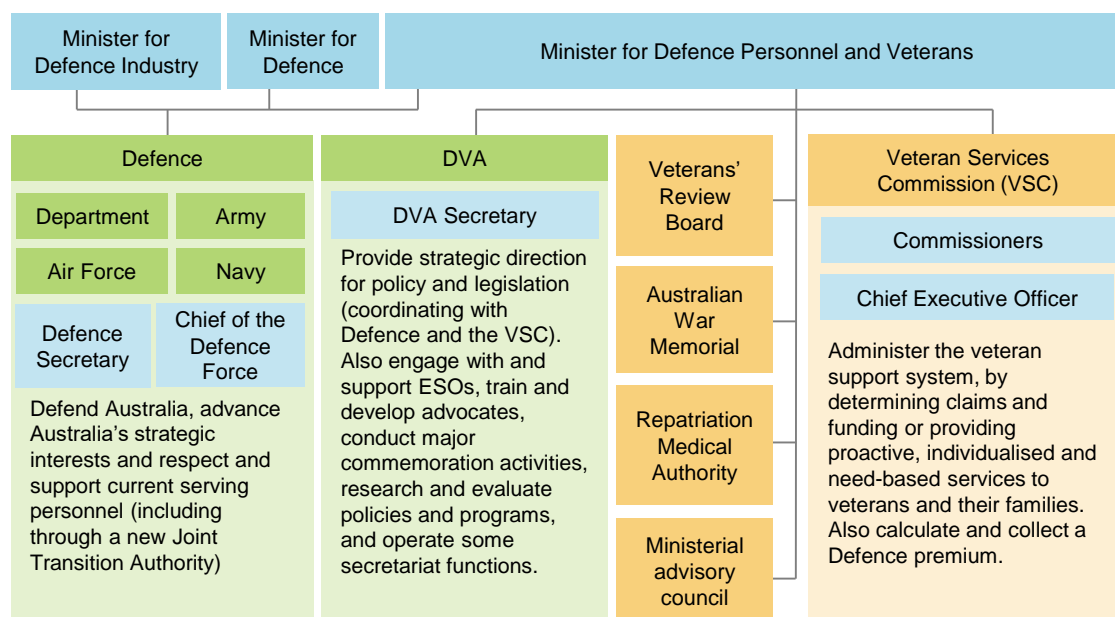
This means responsibility for veteran policy would remain within a retained DVA (figure 7), which also means the issues of cross jurisdictional policy development must be addressed.

There will need to be significant enhancement to the policy and strategic planning capabilities of DVA, with buy-in from Defence to address the most significant problems identified in this inquiry. Defence and the VSC will also need to work closely with DVA to develop an integrated 'whole of life' veteran policy. This policy and planning process should formally involve external expertise and the close oversight of the Minister for Defence Personnel and Veterans. This should be underpinned by a premium in order for Defence to accept responsibility for the lifetime impacts of military service on personnel.

The Commission is strongly of the view that a departmental structure is ill-suited to running a contemporary compensation and support scheme. Australian governments have recognised this by progressively moving away from departmental administration of such schemes. As discussed in detail below, shifting to an independent statutory agency — with dedicated expertise in managing service delivery and claims and a corporate governance structure equivalent to other compensation schemes — will be pivotal to much better outcomes. The Repatriation Commission, the Military Rehabilitation and Compensation Commission would cease to exist upon the establishment of the VSC.

Following the establishment of the VSC, DVA's functions would continue to include: strategic policy and planning in the veteran support system, legislative responsibility for the three main Acts, engagement, coordination and support for ex-service organisations, training and professional development of advocates, major commemorative activities and events, and coordination of research and evaluations (figure 7).

Figure 7 **Proposed new governance arrangements**



More about the VSC

The VSC's structure should mirror the best features of existing scheme administrators, while still recognising the unique features of military service. It should have a corporate model of governance with an independent board, be operationally independent from government, and have a focus on managing the lifetime costs of supporting veterans (based on insurance principles).

A lifetime approach encourages early interventions and investments that minimise harm from service, improve veterans' independence and their ability to work and participate in the community, and takes account of the circumstances of individuals.

Reporting 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
- have a Chief Executive Officer appointed by the Board
- administer, and have autonomous responsibility for, the veteran support system.

The VSC's functions would be to:

- achieve the objectives of the veteran support system, including making claim determinations under all Acts

-
- calculate, collect and administer a premium on Defence (for ADF members) under a fully-funded system
 - manage, advise and report publicly on the outcomes of the system, including its financial sustainability (based on insurance principles and supported by actuarial analysis)
 - fund, commission or provide services to eligible veterans, including health, mental health and community services
 - encourage social integration, including through ex-service organisations
 - collect, analyse and exchange data about veterans and veteran supports (including early intervention)
 - contribute to priorities for research into veteran issues.

The VSC should work with the ADF to help *optimise* operational approaches. For example, over time the VSC would be able to identify long-term health outcomes experienced by veterans and establish links to particular Defence activities. With this information, Defence could better understand the *long-term* impacts, including health effects and financial cost, of activities on service personnel. This information could then be used by the ADF to help modify training regimes to reduce long-term injuries and increase the in-service longevity of its personnel, at least cost.

Ultimately, this would improve Defence's treatment of its personnel, which in turn would improve Defence's warfighting capability. As one participant said, 'members and their families are capability — without them, the best design, best technology and best equipment means nothing'.

A premium to improve incentives and fund the veteran support system

Defence already faces a range of incentives to prevent *short-term* injuries and illnesses. It has an incentive to: maximise its operational capability, look after members of the service family, protect its reputation as an employer of choice, and 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 significant reduction in serious injuries and illness over the past seven years.

However, changing who pays for veterans' compensation and rehabilitation — by levying an actual insurance premium on Defence for uniformed ADF personnel — would provide incentives for Defence to improve the *long-term* wellbeing of its personnel (including through transition and rehabilitation for discharging members), as well as reinforce existing incentives to prevent short-term injury and illness. A premium is, in effect, a price signal about the real costs (lifetime costs not short-term costs) of Defence activities. The incentive is in part financial, but also informational, as the publicly available figure crystallises the extent to which the employer is acting responsibly.

A premium levied on Defence is also a funding source for the veteran support system: a premium is by definition equivalent to all the future costs of the compensation, rehabilitation, treatment and other relevant services for veterans and their families that are expected to be generated as a result of Defence activities during the year the premium is levied. The premium would be paid to the VSC and pooled and invested using standard approaches of workers' compensation schemes.

A dedicated, but constrained, funding source will provide a strong incentive for the VSC to control system costs and get value for money for veteran services, to ensure that the system is financially sustainable. This includes more efficient claims administration — to minimise time delays and the negative impacts of unsupportive claims handling on veterans and their families — and a greater focus on proactive, early treatment and rehabilitation for veterans.

A premium will be an additional cost to Defence's budget and a reasonable level of transitional funding from the Government to cover this cost would be justified. Any additional Defence funding to cover subsequent *increases* in the premium (or to cover capital shortfalls if funding turns out to be inadequate) should then be considered by the Government on a case-by-case basis, as part of the normal Budget process, to avoid undermining the premium's financial incentives.

This also applies to changes in the premium that are due to the cost of operational deployments (for instance, to war zones).

Improving veterans' transition experience

About 6000 members of the ADF transition to civilian life each year (box 7). Many are relatively young — they are typically in their mid-20s, and have served for about 8 years.

Leaving the military entails unique challenges and these can be easily underestimated. This is why veterans are supported reintegrating into civilian life by a system of transition support that is rarely required for movements from employer to employer for other Australians.

Box 7 **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, and the mean is less than 8 years.

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

Transition challenges result from the change in responsibilities of defence personnel and their disconnect from a supportive social network (the Defence ‘family’). Defence provides a job, dwelling, health care and social networks, whereas in transition, a veteran has to assume responsibility for managing all of these. 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 (and the rate of suicide for ex-serving male veterans under 30 years is twice that for Australian men of the same age, box 8). There is also a sound economic case for good transition support, as smooth transitions contribute to the wellbeing of veterans and their families, potentially increase labour force participation, and reduce reliance on other forms of government support.

As discussed above, while both Defence and DVA provide support to help smooth the transition process, neither has clear responsibility for all aspects of veterans transition and the rhetoric around the importance of transition is not matched by effective action. One veteran said ‘they paid a million dollars to train me, and 20 cents to discharge me’.

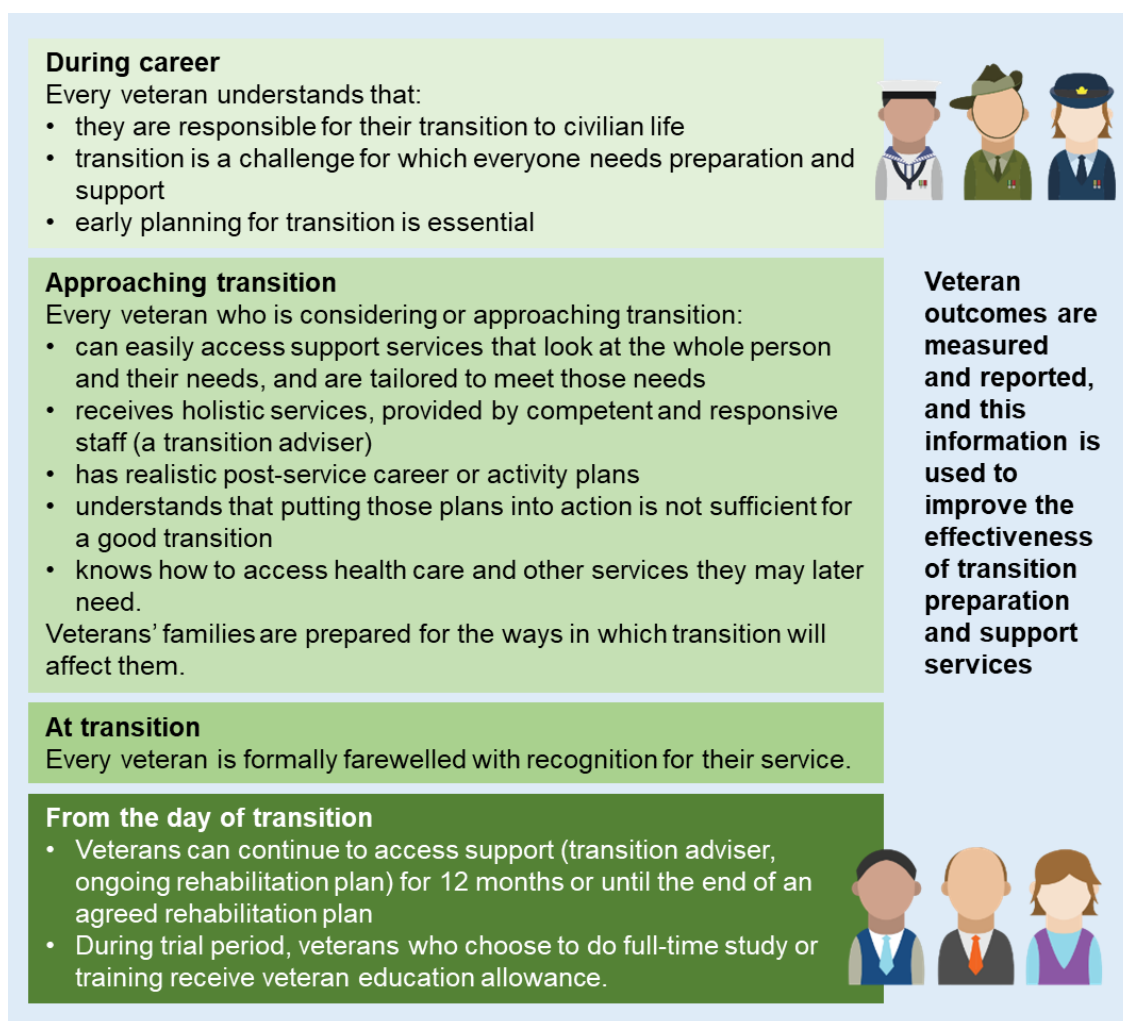
To improve military-to-civilian transition, two main changes are needed (figure 8). First, responsibility for assisting members in their transition to civilian life should be centralised in a new body within Defence — the Joint Transition Authority (JTA). The JTA would consolidate transition support currently provided by Defence and DVA, and be staffed by ADF and DVA personnel. Its functions would include:

- engaging every veteran 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 12 months as needed or until the end of an agreed rehabilitation plan)
- ensuring that veterans have continuity of rehabilitation and other support services
- reporting publicly on transition outcomes.

Longer-term transitional or reintegration supports will be through the VSC.

Figure 8 **Transition to civilian life: outcomes for veterans**



Second, an improved package of transition support is needed. The package should include the enhanced services provided by the JTA, as well as support for veterans to gain skills and qualifications once they leave the ADF, by trialling an education allowance to provide a source of income for veterans undertaking full-time education or vocational training.

Defence has also recently introduced a range of new programs and services to better support veterans and families during transition, and these have many promising features. However, it is unclear how Defence plans to keep track of what services work well (or not), and why and where extra supports should be targeted. The way 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.

Better health outcomes for veterans

The White Card, which funds treatment for service-connected conditions, is generally well-targeted and a good vehicle for funding veterans' health care (about 75 000 DVA clients have a White Card). However, the Gold Card has become more about compensation than health care. And it does not sit well with the key underlying principles for a future scheme.

The Gold Card should be more tightly targeted towards highly-impaired veterans (those who are most likely to benefit from comprehensive health care). Eligibility for the Gold Card should also not be extended to any *new* categories of veterans or dependants that are not currently eligible for such a card. This will not affect any current Gold Card holder or person who is entitled to a Gold Card under current legislation.

The VSC would take a different approach to health care for veterans than the current system. It would provide more proactive individualised health care case management and, like other administrators of workers' compensation schemes, it would be more actively engaged with health care providers and provide better oversight of outcomes (this will be driven by its focus on lifetime costs and a clear objective of improving the lives of veterans).

DVA has some good health initiatives, including the Coordinated Veterans' Care program, which funds coordinated care for Gold Card holders at risk of hospitalisation. The program could, however, be improved by better targeting and measuring of outcomes.

DVA's relatively low fees for some (but not all) health services, may mean that some veterans with service-related conditions have less accessible and lower quality services than people covered by civilian workers' compensation schemes. An independent review of DVA's fee-setting arrangements is required.

Improving mental health care access and services

There has been a heightened focus on veterans' mental health and suicide in recent years and a range of new policies, programs and research (box 8).

Box 8 Veterans' mental health

Those who serve in the Australian Defence Force are recruited and trained to be physically and mentally resilient, and to display strength and perseverance. While veterans are serving, there are a range of protective factors that are likely to reduce the risk of mental ill-health. A strong sense of purpose, camaraderie and easy access to health care provide some protection against the risk of mental ill-health. Many other aspects of defence life work the other way — veterans can be exposed to trauma, they spend time away from family and can relocate frequently. And once veterans leave the Australian Defence Force, 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.

There is some evidence that mental health disorders are more prevalent for veterans than in the wider population. The latest data also show that the age-adjusted rate of suicide for male ex-serving personnel is significantly higher than the general population. (There is an absence of data on mental health and suicide among female veterans).



Veterans can access mental health and support services provided to the general population, and additional services through DVA.

- Open Arms is run by DVA, and provides counselling, case coordination and an after-hours telephone counselling service for veterans and their families. Participants had varying views on the Open Arms service, and there is no published outcomes data, so effectiveness of its services is not clear. DVA should develop outcomes measures for Open Arms.
- The recent decision to expand non-liability coverage to include mental health care was about improving access to mental health services for veterans and was described by one participant as 'lifesaving'. However, DVA cannot demonstrate that the number of veterans accessing treatment has increased, and there is no monitoring of the quality of treatment veterans are receiving.

There are also a number of recent promising initiatives — including a Veteran Suicide Prevention Pilot, an early intervention measure for people in the Coordinated Veterans' Care program and a suicide prevention trial (Operation Compass) in Townsville. It is important that robust evaluations of these trials are undertaken to build the evidence base about what works (or does not work).

Veterans and their families are not always aware of the mental health services available. DVA should be more proactive in promoting mental health services for veterans.

To build and improve on recent policy changes and trials, a new Veteran Mental Health Strategy is urgently needed. The Strategy should be developed by Defence and DVA, cover each of the life stages of military personnel, and focus on building the evidence base on the causes of, and effectiveness of treatments for, mental ill-health. The National Mental Health Commission should provide oversight of the strategy and report annually on progress towards the goals of the Strategy.

Support for families of veterans

The impacts of military service extend to the families of veterans. While frequent relocations, the veteran's irregular hours and extended periods away from home can all take a toll, a particularly acute concern is for families that care for a veteran with an injury or disease related to service. The support of families can be important for veterans undertaking rehabilitation and when they are transitioning back into civilian life. And families of deceased veterans can have added pressures and needs.

Families of veterans have access to a number of support services provided by DVA (in addition to supports provided by Defence and those available more generally). These include:

- Open Arms for families of veterans who have a non-liability White Card
- respite care for carers providing ongoing care to veterans who have a White or Gold Card
- the Family Support Package for families of eligible veterans, which includes childcare support and brief intervention counselling. Counselling (provided in addition to Open Arms) can be accessed from any appropriately qualified professional and includes drug and alcohol counselling, resilience training, parenting skills and personal relationship counselling.

Supports for families are also provided by veterans' organisations, including counselling services, claims advocacy and wellbeing support.

The Family Support Package should be extended to:

- families of veterans without warlike service and families of veterans receiving the veteran payment
- give parents and eligible young children of veterans who have suffered a service death or a suicide related to their service, and families of veterans not under a rehabilitation plan, access to counselling services
- cover all counselling services for partners, widows and widowers, eligible young children and parents. For these family members, session limits and the requirement for an identified need should be removed and replaced with an appropriate cap on total payment.

The VSC would have close engagement with families (including providing them with support) as this can be important for supporting veterans on a more individualised basis. Further research is needed to better understand the mental health impacts of military service on families and how they can be best supported.

Data and evidence could be improved in every part 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 would place greater reliance on data and analysis and practices of continuous improvement as it would be required to compare actuarial forecasts of costs and veteran outcomes with the actual experiences of veterans. However, DVA should start work on developing performance and outcomes frameworks immediately.

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

- linking and analysing data held by DVA and reporting on outcomes
- conducting more high-quality reviews and evaluations. DVA has several projects aimed at improving veteran wellbeing, but there is little evidence on the effectiveness of some of these services
- taking a more strategic approach to research. Defence and DVA should set research priorities on issues affecting the health and wellbeing of veterans. The priorities should be published in a research plan and the plan published annually. The research plan and its implementation should be overseen by an Expert Committee on Veteran Research.

The role of veterans' organisations

Veterans' organisations play an important role in the veteran support system. They include ex-service organisations as well as organisations that assist current ADF personnel and the families of veterans. Each year, thousands of people volunteer to help veterans and their families in all aspects of their post-service lives.

Veterans' organisations undertake a wide range of activities, including:

- claims advocacy — assisting veterans and their families to prepare and lodge claims to DVA, as well as putting the veteran's case to DVA, the VRB and the Administrative Appeals Tribunal (AAT)
- wellbeing supports — assisting veterans and their families with transition, rehabilitation and social engagement
- policy input and influence — informing government about the practical experience of accessing the veteran support system and recognising veterans' interests in government policy.

Claims advocacy has traditionally been the focus of veterans' organisations, but the needs and expectations of younger veterans require a stronger focus on wellbeing supports. DVA (and in future, the VSC) should take on a greater role assisting people to put in claims. With many existing volunteer advocates nearing retirement, DVA could start contracting veterans' and other organisations to provide claims advocacy where there is identified unmet need. Claimants who want the services of an advocate should be able to access one.

DVA gives grants to assist veterans' organisations to provide wellbeing supports. DVA should better leverage this support network by developing a strategy for commissioning wellbeing supports provided by veterans' or other organisations. In particular, there is an opportunity for DVA to design and fund services through veterans' hubs.

Veterans' organisations — acting as representatives of veterans and their families — are highly influential in policymaking, but have no unified position. Despite being well placed to see the shortcomings in the system and to provide feedback about how the system is functioning, engaging meaningfully with thousands of veterans' organisations with no peak body is difficult for government. If a single peak body is formed within the Australian veteran community, and represents the broad interests of veterans, then the Australian Government should consider funding it. Such a body could engage more transparently and effectively with DVA and the Minister and replace the existing consultation framework.

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 the 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 — adopting the use of Statements of Principles (SoPs) in the DRCA would simplify the initial liability process and make it more consistent across all three Acts. Moving to the 'reasonable hypothesis' as a single standard of proof for all types of service under the MRCA would also simplify the system going forward
- 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 9) 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, and over time, should transition to exclusively helping veterans and their families to resolve their cases collaboratively with the VSC. The VRB should also provide more useful feedback on the types of cases where the original decision is most likely to be changed on review.

Box 9 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 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 allow claimants to resolve their cases with the Department of Veterans' Affairs. The VRB should retain its decision-making powers for some time, but the establishment of an independent Veteran Services Commission could allow it to take a role of solely aiming to resolve cases (rather than remaking the decision). 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.
- 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).

More substantial reforms are warranted in other areas of compensation.

- Compensation under the MRCA varies depending on whether the impairment was suffered as a result of warlike or non-warlike, or peacetime service. As '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. Moving to a single rate of compensation would increase equity between veterans and reduce complexity. A transition path is needed to ensure that veterans who have already lodged claims are not disadvantaged.
- The compensation system includes income replacement administered through DVA, and 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. 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.

- The funeral allowance available under the VEA should be aligned with the MRCA funeral allowance for veterans whose dependants would receive a funeral allowance under the MRCA.






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). 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 them are older, which means that the rehabilitation and return to work focus of the more contemporary Act is less relevant.

In this context, a two-scheme approach (figure 9) is warranted. 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.

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 19 only)	Wholly dependant partner payments Payments for eligible children Payments to 'other' dependants Funeral allowance Bereavement payment Income support supplement Education allowance (under 19 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

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

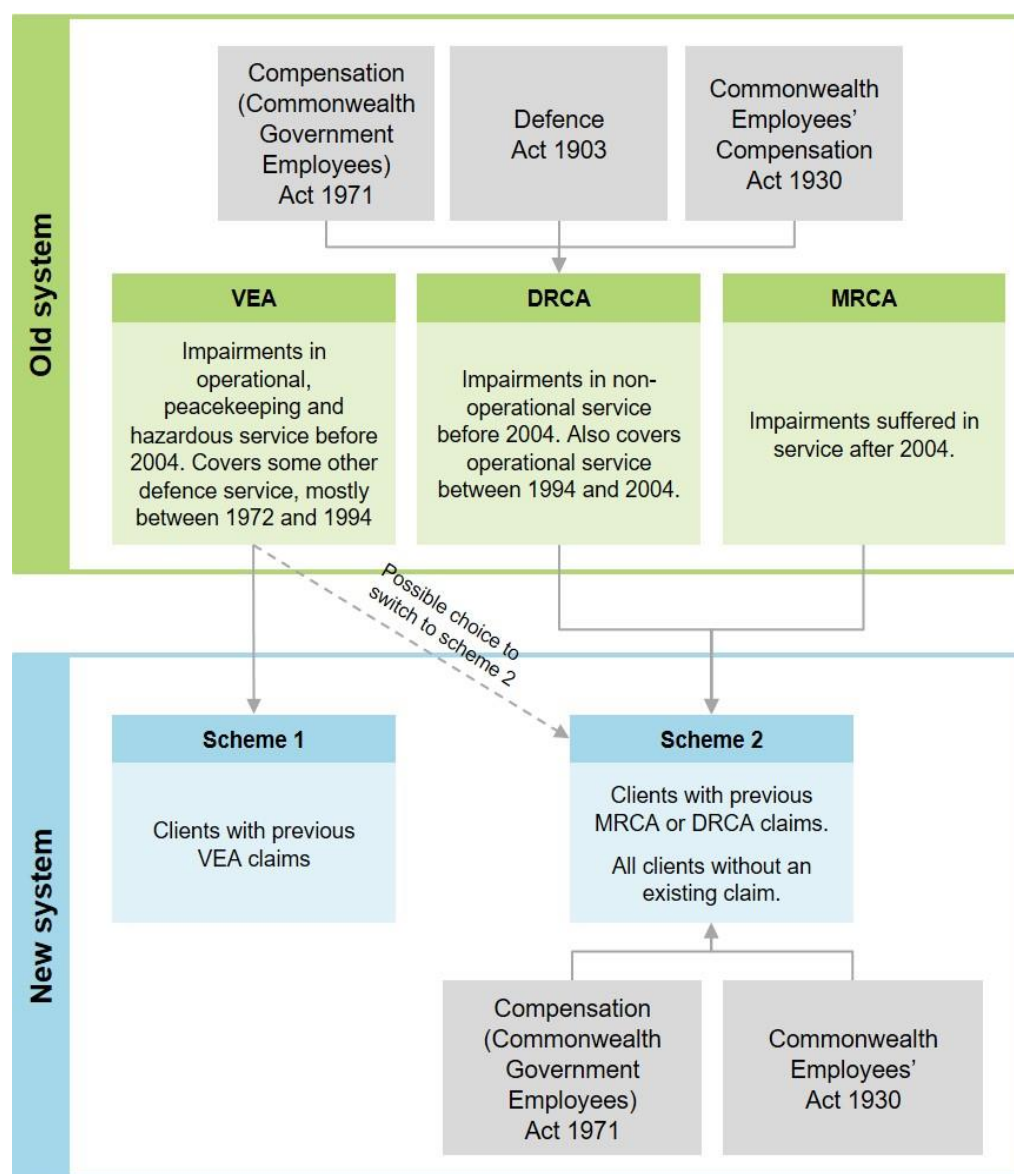
Eligibility should be based on the following principles:

- 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).

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 before making this decision.

Figure 10 Eligibility under the two schemes



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.

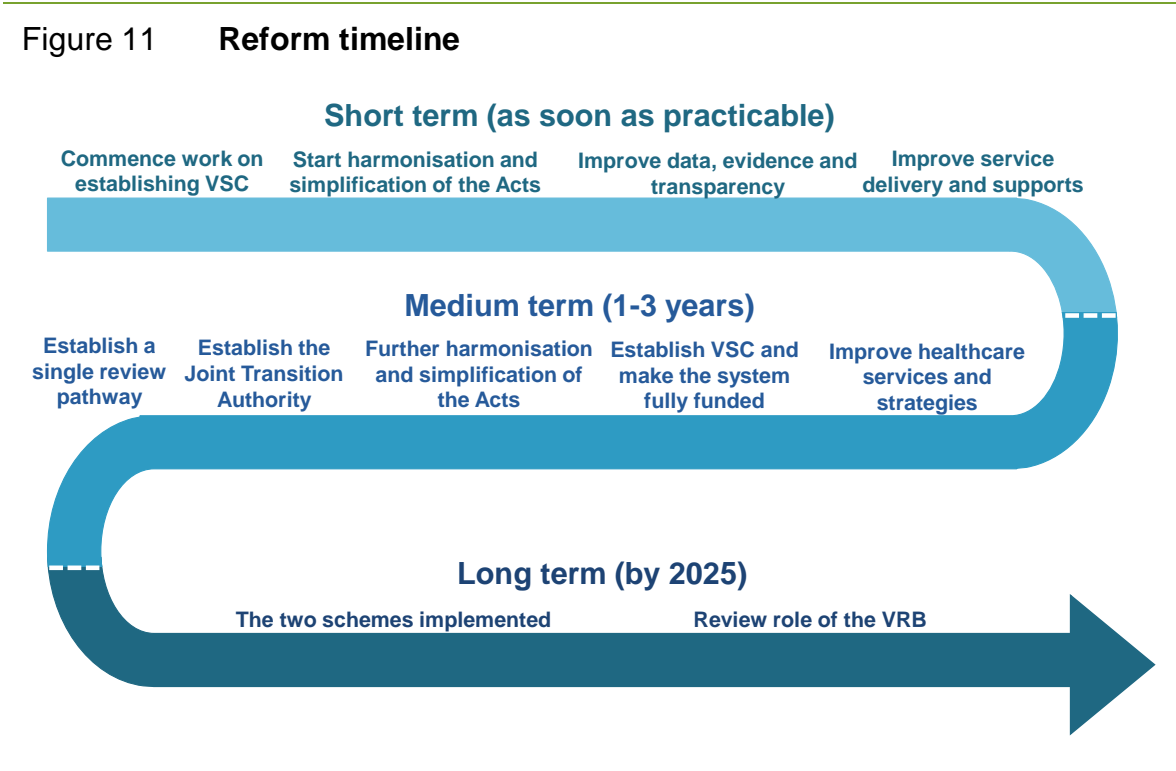
The design of the schemes is complicated by the fact that some veterans have current claims under multiple Acts. Eligibility for this group should be based on both their age and the current benefits they are receiving.

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.

A pathway for reform

Some of the proposed changes to the veteran support system, including improving both data and evidence and service delivery and support, could begin immediately. The new advisory council could also be put in place relatively quickly. Establishing the Joint Transition Authority should be a priority — it should be in place by mid-2020 (figure 11).



However, some of the more foundational changes (including 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, taking into account 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 schedule 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, and include:

- 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
- 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 provided an estimate of aggregate costs for the reforms, there are cost estimates (including in some cases cost ranges) for some reforms throughout the report. The focus of this report was not on saving dollars, rather it was about finding ways to achieve better outcomes for veterans. And in fact, if fully implemented, our proposed future veteran support system would cost more in the short term, but with a focus on wellness and independence, less in the longer term.

Recommendations and findings

Objectives and principles

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. A robust set of objectives and principles are needed to underpin a contemporary system to meet the needs of tomorrow's veterans.

RECOMMENDATION 4.1 OBJECTIVES AND PRINCIPLES FOR THE VETERAN SUPPORT SYSTEM

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 and their families 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.

FINDING 4.1

The Commission acknowledges that there are different risks, hardships and requirements of operational and peacetime service, and these are recognised in remuneration, allowances and honours. However, in principle, the basis for providing support should be *need*, not how or when an injury or illness was acquired. For compensation and support, the distinction between different types of military service should be removed where it is both practicable and cost-effective to do so.

Prevention

The Australian Defence Force (ADF) is committed to providing a safe and healthy working environment for its members and it has achieved significant reductions in serious injuries and illnesses since 2011-12. Nonetheless, more can be done to give the ADF better tools to help it achieve its commitment to improved work health and safety.

FINDING 5.1

There are no compelling grounds to change the current arrangements under which Australian Defence Force members are subject to Commonwealth work health and safety legislation. In fact, the introduction of the *Work Health and Safety Act 2011* (which took effect on 1 January 2012) has been instrumental in helping to significantly improve work health and safety outcomes in the Australian Defence Force.

FINDING 5.2

Since Defence introduced Sentinel (a work health and safety incident reporting system) in 2014, it has expanded its coverage, 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 in Sentinel (other than for serious, defined events that must be notified to Comcare) continues to be an issue.

RECOMMENDATION 5.1 IMPROVE REPORTING OF WORK HEALTH AND SAFETY INCIDENTS

Defence should assess the feasibility and cost of incorporating the information on 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 the capture of work health and safety data as a system requirement.

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

RECOMMENDATION 5.2 SUPPORTING A NEW APPROACH TO INJURY PREVENTION

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.

RECOMMENDATION 5.3 PUBLISH ANNUAL NOTIONAL PREMIUM ESTIMATES

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).

RECOMMENDATION 5.4 FORMALISE DEFENCE RESPONSIBILITY TO SUPPORT ADF MEMBERS

In line with the proposed Australian Defence Veterans' Covenant, the Australian Government should amend Defence's outcomes to include an additional objective, explicitly acknowledging that — due to the unique nature of military service — Defence has a responsibility to respect and support members of the Australian Defence Force having regard to their lifetime wellbeing.

Rehabilitation

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.

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.

RECOMMENDATION 6.1 **PUBLIC REPORTING ON ADF REHABILITATION**

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.

RECOMMENDATION 6.2 **EVALUATION AND REPORTING OF DVA REHABILITATION**

The Department of Veterans' Affairs should make greater use of its rehabilitation data 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.

RECOMMENDATION 6.3 COMMISSIONING AND INTEGRATION OF REHABILITATION SERVICES

Defence and the Department of Veterans' Affairs should 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 the Joint Transition Authority (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.

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. To improve military-to-civilian transition, and to clarify roles and responsibilities, the Commission is recommending creating a new authority responsible for transition preparation and support.

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. 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, and those who have skills that are not easily transferable to the civilian labour market. Despite considerable change in recent years, stewardship of transition remains poor and supports have not improved in ways that are tangible to veterans.

RECOMMENDATION 7.1 **ESTABLISH A JOINT TRANSITION AUTHORITY**

The Australian Government should recognise that Defence has primary responsibility for the wellbeing of discharging Australian Defence Force members, and that this responsibility may extend beyond the date of discharge. It should formalise this recognition by creating a 'Joint Transition Authority' within Defence.

Functions of the Joint Transition Authority 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 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 12 months after discharge
- reporting publicly on transition outcomes to drive further improvement.

RECOMMENDATION 7.2 **CAREER PLANNING AND FAMILY ENGAGEMENT FOR TRANSITION**

Defence, through the Joint Transition Authority (recommendation 7.1), should:

- ensure that Australian Defence Force members prepare a career plan that covers both their service and post-service career, and 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 veterans' families, so that they can engage more actively in the process of transition.

RECOMMENDATION 7.3 **TRIAL A VETERAN EDUCATION ALLOWANCE**

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 to provide a source of income for veterans who, after completing their initial minimum period of service or having been medically discharged, wish to undertake full-time education or vocational training.

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.

RECOMMENDATION 8.1 HARMONISE THE INITIAL LIABILITY PROCESS

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.

FINDING 8.1

Allowing accrued rights for repealed versions of the Statements of Principles (SoPs) under the *Veterans' Entitlements Act 1986* is contrary to the purpose of the SoP system, which is to reflect the latest sound medical-scientific evidence.

RECOMMENDATION 8.2 IMPROVE THE RMA'S RESOURCING AND TRANSPARENCY

The Australian Government should provide additional resources to the Repatriation Medical Authority (RMA) so that the time taken to conduct reviews and investigations can be reduced to closer to six months.

Following any investigation, the RMA should routinely publish a full bibliography of the peer-reviewed literature or other sound medical-scientific evidence used to create or update the relevant Statement of Principles. Stakeholders interested in how different pieces of evidence were assessed and weighed can continue to request the RMA's briefing papers under s.196I of the *Veterans' Entitlements Act 1986*.

RECOMMENDATION 8.3 ABOLISH THE SPECIALIST MEDICAL REVIEW COUNCIL

The Australian Government should abolish the Specialist Medical Review Council. The process for reviewing Repatriation Medical Authority decisions on Statements of Principles should instead be expanded to incorporate independent external medical specialists, where necessary.

RECOMMENDATION 8.4 **MOVE MRCA TO A SINGLE STANDARD OF PROOF**

The Australian Government should remove the distinction between types of service when determining causality between a veteran's condition and their service under the *Military Rehabilitation and Compensation Act 2004* (MRCA). This should include:

- amending the MRCA to adopt the reasonable hypothesis Statement of Principles for all initial liability claims
- requesting that the Australian Law Reform Commission conduct a review into simplifying the legislation and moving to a single decision-making process for all MRCA claims, preferably based on the reasonable hypothesis process.

Claims management 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 rollout of the VCR, both in terms of timeliness and outcomes is required.

RECOMMENDATION 9.1 **PUBLIC PROGRESS REPORTS ON RECENT REVIEWS**

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

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 many aspects of the claims process.

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

FINDING 9.2

The Department of Veterans' Affairs is failing to ensure that its staff consistently apply its own internal guidelines for communicating with clients. This leads to poor outcomes for clients and undermines confidence in the Department.

RECOMMENDATION 9.2 **APPROPRIATELY TRAIN STAFF**

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.

FINDING 9.3

The Department of Veterans' Affairs needs to negotiate a sustainable and predictable departmental 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.

FINDING 9.4

The Productivity Commission does not, at this stage, support automatically deeming initial liability claims at the end of a fixed period. 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.

RECOMMENDATION 9.3 **ENSURE QUALITY OF CLAIMS PROCESSING**

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.

FINDING 9.5

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.

FINDING 9.6

Under the Department of Veterans' Affairs' stewardship, the Veteran Centric Reform (VCR) program has some good objectives and has produced some early successes. However close supervision and guidance will be required to ensure VCR is rolled out successfully. Regular progress reporting and ongoing assurance reviews will facilitate this outcome.

Reviews of claims

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.

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.

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 (DVA) to better inform decision-making practices. Further, DVA is not incorporating the limited available feedback into its decision-making processes. This means that opportunities for process improvement are being missed.

RECOMMENDATION 10.1 IMPROVE AND USE FEEDBACK FROM ADMINISTRATIVE REVIEWS

The Department of Veterans' Affairs (DVA) should ensure that successful reviews of veteran support decisions are brought to the attention of senior management for claims assessors, and that accurate 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 state the cause for varying or setting aside the decision on review (including whether new information was provided by the applicant or if DVA's original decision misapplied the law).

DVA and the VRB should establish a memorandum of understanding 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 VRB decisions, as well as variations made with the consent of the parties through an alternative dispute resolution process. This information should be collected and provided to DVA on a quarterly basis and published in the VRB's annual report.

DVA should respond by making appropriate changes to its decision-making processes to improve accuracy.

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.

FINDING 10.4

The Veterans' Review Board has functions that overlap with those of the Administrative Appeals Tribunal. 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, rather than using it occasionally to resolve difficult cases.

RECOMMENDATION 10.2 **SINGLE REVIEW PATHWAY**

The Australian Government should introduce a single review pathway for all veterans' compensation and rehabilitation decisions (including decisions under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*). The pathway should include:

- internal reconsideration by the Department of Veterans' Affairs. In this process, a different and more senior officer should 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 (recommendation 10.3)
- merits review by the Administrative Appeals Tribunal
- judicial review in the Federal Court of Australia and High Court of Australia.

RECOMMENDATION 10.3 **VETERANS' REVIEW BOARD AS A REVIEW AND RESOLUTION BODY**

The Australian Government should amend the role and procedures of the Veterans' Review Board (VRB), so that:

- 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.

Where an agreement cannot be reached, a single board member should determine the correct and preferable decision to be made under the legislation and implement that decision.

When the Veteran Centric Reform program is complete and the Veteran Services Commission is established, this determinative power should be removed.

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.

RECOMMENDATION 10.4 REVIEW OF ONGOING ROLE OF VETERANS' REVIEW BOARD

The Australian Government should conduct a further evaluation in 2025 of the performance of the Veterans' Review Board in its new role. In particular, the evaluation should consider whether reforms have reduced the rate at which initial decisions in the veteran support system are subsequently varied on appeal. If the evaluation finds that the Board is no longer playing a substantial role in the claims process, the Australian Government should abolish the Board and bring its alternative dispute resolution functions into the Department of Veterans' Affairs or its successor agency.

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 not taken into account when policy decisions are made. New governance and funding arrangements are required for the veteran support system for future generations of veterans and their families.

RECOMMENDATION 11.1 **ESTABLISH A VETERAN SERVICES COMMISSION**

The Australian Government should establish a new independent statutory authority — the Veteran Services Commission (VSC) — to administer the veteran support system by July 2022. It should report to the Minister for Defence Personnel and Veterans, but be a stand-alone agency for veteran services (that is, separate from any department of state).

The functions of the VSC should be to:

- achieve the objectives of the veteran support system (recommendation 4.1) through the efficient and effective administration of all aspects of that system
- make all claims determinations under the veteran support legislation
- calculate, collect and administer a premium on Defence (recommendation 11.2)
- manage, advise and report on outcomes and the financial sustainability of the system, in particular, the compensation and rehabilitation schemes
- enable opportunities for social integration
- fund, commission or provide services to veterans and their families.

An independent board should oversee the VSC. The board should be made up of part-time Commissioners appointed by the Minister. Board members should have a mix of skills in relevant fields (such as other compensation schemes, project management or providing services to veterans), and some members should have experience in the military and veterans' affairs. The board should have the power to appoint the Chief Executive Officer (who should be responsible for the day-to-day administration of the VSC).

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.

RECOMMENDATION 11.2 **LEVY A PREMIUM ON DEFENCE**

The Australian Government should move towards a fully-funded system for veteran supports. This would involve the Veteran Services Commission levying an annual premium on Defence to fund the expected future costs of the veteran support system entitlements that were generated during the year. The premium should cover the costs of all compensation, rehabilitation and treatment benefits available to veterans or their families, as well as covering the cost associated with operational deployments.

The Australian Government should provide a level of funding to Defence to cover the reasonable costs of the premium. Any funding above the initial level should be considered on a case-by-case basis by the Government, in line with existing Budget rules, to avoid undermining the premium's financial incentives.

As the *Military Rehabilitation and Compensation Act 2004* (MRCA) will form the basis of the future veteran support system, the Government should also fully capitalise all existing MRCA liabilities (that is, back to 1 July 2004). Existing liabilities under the *Veterans' Entitlements Act 1986* and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* should be calculated and regularly reported as separate notional line items, acknowledging their implied call on future Budgets.

FINDING 11.1

Moving responsibility for veteran support policies and strategic planning into the Department of Defence is, in the Commission's view, the best option for improving the lives of veterans and their families, as it aligns incentives and accountability structures and gives Defence an 'enlistment-to-the-grave' responsibility for the wellbeing of Australian Defence Force personnel. Nevertheless, given the strong opposition and lack of trust and confidence by veterans in Defence's capacity to take on such a policy role, the Commission acknowledges that this proposal is not realistic or feasible at this stage.

RECOMMENDATION 11.3 **IMPROVING POLICY OUTCOMES**

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

In the absence of veterans policy being placed in the Department of Defence (finding 11.1), the Department of Veterans' Affairs (DVA) should focus on building its capacity for independent strategic policy advice in the veteran support system. DVA should commence this process immediately.

Following the establishment of the Veteran Services Commission (recommendation 11.1), the functions of a retained DVA could include:

- strategic policy and planning for the veteran support system
- legislative responsibility for the three main Acts
- engagement, coordination and support for ex-service organisations
- training and professional development of advocates
- major commemorative activities and events (in line with recommendation 11.5)
- coordination of research and evaluations
- some secretariat functions for small portfolio agencies.

In addition, DVA should work with Defence and the Veteran Services Commission to create a robust process for the development of integrated 'whole of life' policy, under the direction and close oversight of the Minister for Defence Personnel and Veterans. Defence, DVA and ultimately the VSC should establish inter-departmental steering committees and policy taskforces to further strengthen cross-agency cooperation and coordination, and use experts from appropriate disciplines to provide multidisciplinary advice.

RECOMMENDATION 11.4 **CREATE A MINISTERIAL ADVISORY COUNCIL**

The Australian Government should establish an advisory council to the Minister for Defence Personnel and Veterans, to provide advice on the lifetime wellbeing of veterans and the best-practice design, administration and stewardship of services provided to current and ex-serving members and their families.

The advisory council should consist of part-time members with diverse capabilities, including individuals with experience in military or veterans' affairs, health care, rehabilitation, aged care, social services and other compensation schemes.

RECOMMENDATION 11.5 MOVE WAR GRAVE FUNCTIONS INTO THE WAR MEMORIAL

To consolidate the agencies maintaining Australia's memorials to its veterans, the Australian Government should transfer primary responsibility for the Office of Australian War Graves to the Australian War Memorial.

Responsibility for major commemoration activities and ceremonies should remain with the Department of Veterans' Affairs.

Advocacy, wellbeing supports and policy input

Veterans' organisations play an important role in the veteran support system. However, there is scope for the Australian Government to better leverage this support to make it more effective and relevant to the veteran community. To achieve this there needs to be much greater clarity around why government funds advocacy and wellbeing supports provided through veterans' organisations.

RECOMMENDATION 12.1 REFRAME SUPPORT FOR VETERANS' ORGANISATIONS

The Department of Veterans' Affairs should reframe its support for organisations that provide services for veterans by clearly differentiating between:

- claims advocacy — the delivery of advocacy on behalf of claimants by accredited advocates
- wellbeing supports — the commissioning of a broad set of welfare supports or services delivered by and on behalf of the veterans' community (replacing the notion of welfare advocacy)
- policy input and influence — the provision of support to assist veterans' organisations to engage meaningfully in policy considerations.
- grant funding — for the general support of innovative programs and significantly worthwhile community initiatives for the veterans community.

RECOMMENDATION 12.2 DVA SHOULD PROVIDE ASSISTANCE WITH PRIMARY CLAIMS

One of the core functions of the Department of Veterans' Affairs, and when established, the Veteran Services Commission, should be to assist veterans and their families to lodge primary claims.

Claims advocacy assistance from veterans' organisations should remain available to any veteran who seeks it.

RECOMMENDATION 12.3 **FUND A CLAIMS ADVOCACY PROGRAM**

The Department of Veterans' Affairs (DVA) should fund professional claims advocacy services in areas where it identifies unmet need. Services should be delivered through ex-service and other organisations in a contestable manner similar to the National Disability Insurance Scheme Appeals Program and the National Disability Advocacy Program. DVA should also take a more active role in the stewardship of these services.

RECOMMENDATION 12.4 **ACCREDITATION OF ADVOCATES**

The Department of Veterans' Affairs (DVA) should ensure that all claims advocates who act on behalf of a claimant in primary claims or appeals are accredited under the Advocacy Training and Development Program (ATDP).

DVA should monitor and adjust the delivery of the ATDP in response to stakeholder feedback, including by providing more flexible training programs.

RECOMMENDATION 12.5 **FUND LEGAL ASSISTANCE AT THE AAT**

The Department of Veterans' Affairs (DVA) should fund legal advice and representation for claimants in the veteran support system on a means-tested and merits-tested basis.

The Attorney-General's Department should alter the Administrative Appeals Tribunal (AAT) Costs Procedures such that, if a veteran succeeds on appeal in the AAT for cases under the *Military Rehabilitation and Compensation Act 2004* and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, a presumption is created that 100 per cent of the veteran's party-party costs (measured using the Federal Court Scale of Costs) are paid by DVA. Scope should remain to:

- *reduce* this costs order to account for unsuccessful grounds of appeal
- *increase* this costs order to one of indemnity if DVA has unreasonably rejected earlier offers to compromise or otherwise unduly delayed proceedings.

In line with the beneficial intent of the veteran support legislation, and in line with the current legislation, there should be no power for the AAT to award costs against a plaintiff.

The *Veterans' Entitlements Act 1986* should be amended to permit costs awards for cases that reach the AAT.

RECOMMENDATION 12.6 PROGRAM FOR FUNDING WELLBEING SUPPORTS

The Department of Veterans' Affairs should develop a funding framework for commissioning of wellbeing supports through veterans' and other organisations. In particular, this should include guidelines for funding services and supports delivered by volunteers and paid staff in veterans' hubs. The funding could cover information and training programs for volunteers and paid staff.

RECOMMENDATION 12.7 FUNDING POLICY ADVICE FROM VETERANS' ORGANISATIONS

In addition to the ministerial advisory council proposed in recommendation 11.4 the Australian Government should consider:

- a funding contribution for a national peak body of veterans' organisations, which could provide advice on veterans' policy issues
- the establishment of appropriate reference groups to advise on mental health, rehabilitation, transition, supports for families and lifelong wellbeing issues, including in relation to the varying needs of veterans of different ages and circumstances
- reviewing the role or necessity for the Ex-Service Organisation Round Table in light of alternative, more targeted, approaches.

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.

RECOMMENDATION 13.1 HARMONISE THE DRCA WITH THE MRCA

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 should include harmonising the processes for assessing permanent impairment, incapacity and benefits for dependants, as well as the range of allowances and supplements.

Existing recipients of DRCA permanent impairment compensation and benefits for dependants 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.

FINDING 13.1

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.

RECOMMENDATION 13.2 **SIMPLIFY THE ADMINISTRATION OF INVALIDITY PENSIONS**

The Department of Veterans' Affairs (DVA) should work closely with the Commonwealth Superannuation Corporation (CSC) to streamline the administration of superannuation invalidity pensions, 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.

To give DVA the necessary legal authority to participate in a single 'front door', the Australian Government should amend section 36 of the *Governance of Australian Government Superannuation Schemes Act 2011* to allow the CSC to delegate authority to DVA (or the Veteran Services Commission (VSC)).

These reforms should be undertaken immediately and incorporated into the operational design of the VSC.

If by 2025 the interface between the VSC and CSC has not improved significantly, the VSC should be given the function of processing claims and administering payments for superannuation invalidity pensions under the *Defence Forces Retirement Benefits Act 1948*, the *Military Superannuation and Benefits Act 1991* and the *Australian Defence Force Cover Act 2015*.

RECOMMENDATION 13.3 **REPLACE INVALIDITY PENSIONS WITH INCAPACITY PAYMENTS**

The Australian Government should close off access to invalidity pensions under the *Australian Defence Force Cover Act 2015* (ADF Cover Act) for new applicants (existing pensioners would not be affected). Medically discharged veterans (who joined on or after 2016) should have access to incapacity payments under the *Military Rehabilitation and Compensation Act 2004* if the condition leading to their medical discharge causes them incapacity.

The death benefits for dependants under ADF Cover should remain the same but the Australian Government should amend the eligibility for reversionary pensions so that dependants of medically discharged veterans who were in receipt of incapacity payments are now also eligible for a reversionary incapacity payment.

These reforms would not affect current recipients of invalidity pensions.

RECOMMENDATION 13.4 REHABILITATION FOR INVALIDITY PAYMENT RECIPIENTS

The Australian Government should amend the provisions for invalidity pensions under the *Military Superannuation and Benefits Act 1991* to include a requirement for veterans to, if deemed appropriate after an assessment of the veteran, attend rehabilitation to obtain invalidity pensions. This would align with the approach taken to incapacity payments under the *Military Rehabilitation and Compensation Act 2004* (MRCA). Invalidity pensions should be made available during the rehabilitation process.

This would not affect those who are already receiving invalidity pensions.

Optional rehabilitation should also be offered to those claiming for invalidity pensions under the *Defence Force Retirement and Death Benefits Act 1973*.

The rehabilitation services should be administered by the Department of Veterans' Affairs (and then the Veteran Services Commission) as part of the rehabilitation that is offered to those under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* and the MRCA.

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. Subject to final determination by the Australian Government, 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.

RECOMMENDATION 14.1 **A SINGLE RATE OF PERMANENT IMPAIRMENT COMPENSATION**

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. This should be achieved via a transition path, with the compensation factors merging to a single rate over the course of about 10 years.

Prior to setting the single rate the Australian Government will need to balance the lifetime fiscal implications of the change with the benefits needed by veterans, as well as the transitional arrangements that will be necessary to implement a single rate.

FINDING 14.1

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.

RECOMMENDATION 14.2 **INTERIM COMPENSATION TO BE TAKEN AS A PERIODIC PAYMENT**

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.

The Department of Veterans' Affairs should adjust its policy on assessing lifestyle ratings for interim permanent impairment to more closely reflect the lifestyle rating a veteran would expect to receive once the condition has stabilised.

RECOMMENDATION 14.3 **INTERIM COMPENSATION TO BE FINALISED AFTER TWO YEARS**

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.

FINDING 14.2

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

RECOMMENDATION 14.4 **ELIGIBLE YOUNG PERSON PERMANENT IMPAIRMENT PAYMENT**

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to:

- remove the permanent impairment lump-sum payments made to the veteran for dependent children and other eligible young persons
- increase the rate of permanent impairment compensation by about \$37 per week for veterans with more than 80 impairment points. This should taper to \$0 by 70 impairment points.

RECOMMENDATION 14.5 **IMPROVE LIFESTYLE RATINGS**

The Department of Veterans' Affairs should review its administration of lifestyle ratings in the *Military Rehabilitation and Compensation Act 2004* to assess whether the use of lifestyle ratings could be improved to more closely reflect the effect of an impairment on a veteran's lifestyle, rather than being a 'tick and flick' exercise.

RECOMMENDATION 14.6 **TARGET INCAPACITY PAYMENTS AT ECONOMIC LOSS**

The Australian Government should amend the *Military Rehabilitation and Compensation Act 2004* to:

- remove the remuneration loading added to normal earnings for future claimants of incapacity payments
- provide the superannuation guarantee to veterans on incapacity payments who:
 - were members of the ADF Super or Military Superannuation and Benefits Scheme when they were in the military
 - are not receiving an invalidity pension through their superannuation
 - have been on incapacity payments for at least 45 weeks
 - are not receiving the remuneration loading.

RECOMMENDATION 14.7 REMOVE THE MRCA SPECIAL RATE DISABILITY PENSION

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

FINDING 14.3

Changes to eligibility for the service pension and other welfare payments mean 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.

RECOMMENDATION 14.8 REMOVE AUTOMATIC ELIGIBILITY FOR MRCA DEPENDANT BENEFITS

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.

RECOMMENDATION 14.9 COMBINE MRCA DEPENDANT BENEFITS INTO ONE PAYMENT

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
- 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.

RECOMMENDATION 14.10 HARMONISE THE FUNERAL ALLOWANCE

The Australian Government should amend the *Veterans' Entitlements Act 1986* (VEA) to align its funeral allowance with the *Military Rehabilitation and Compensation Act 2004* funeral expenses benefit for veterans who:

- were receiving the special rate of disability pension
- were receiving the extreme disablement adjustment pension
- were receiving an allowance for being a multiple amputee
- were a former prisoner of war
- died of service-related causes.

Other groups eligible for the VEA funeral allowance should remain on the existing benefit.

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.

RECOMMENDATION 15.1 SIMPLIFY DFISA

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*.

RECOMMENDATION 15.2 **SIMPLIFY AND HARMONISE EDUCATION PAYMENTS**

To align education payments across the veteran support system, the Australian Government should:

- amend the *Veterans' Entitlements Act 1986*, the *Military Rehabilitation and Compensation Act 2004* and the *Social Security Act 1991* to extend the education payments available for those under 16 years of age to those between 16 and 19 years of age and in secondary school — including allowing people to receive Family Tax Benefit while receiving this payment
- amend the *Veterans' Entitlements Act 1986* and the *Military Rehabilitation and Compensation Act 2004* to remove education payments for those older than 19 years of age (or older than 16 and not in secondary school). Those who pass a means test will still be eligible for the same payment rates under the Youth Allowance
- amend the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to adopt the Military Rehabilitation and Compensation Act Education and Training Scheme.

RECOMMENDATION 15.3 **CONSOLIDATE SUPPLEMENTS INTO UNDERLYING PAYMENTS**

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

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

RECOMMENDATION 15.4 **REMOVE AND PAY OUT SMALLER PAYMENTS**

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 receiving the allowances with an age-adjusted lump sum.

RECOMMENDATION 15.5 HARMONISE ATTENDANT AND HOUSEHOLD SERVICES

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.

RECOMMENDATION 15.6 HARMONISE VEHICLE ASSISTANCE

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 need to be re-targeted so that those in most need receive the most care. DVA also needs to improve its monitoring of client outcomes and service providers' effectiveness.

FINDING 16.1

The veteran health system, as currently administered by the Department of Veterans' Affairs (DVA), is largely about funding health care — DVA has little visibility of health outcomes for veterans.

- 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 financially sustainable (by potentially encouraging over-servicing).
- DVA has some good initiatives that are more focused on improving the wellness of veterans, such as Coordinated Veterans Care — although the targeting of this program could be improved (recommendation 16.1).

FINDING 16.2

The Veteran Services Commission, in line with other workers' compensation scheme administrators, would take a lifetime, person-centred, evidence-based approach to health care. It would also proactively manage health care providers and be focused on health outcomes.

RECOMMENDATION 16.1 **ELIGIBILITY FOR COORDINATED VETERANS' CARE**

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 — 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.

RECOMMENDATION 16.2 **PUBLIC REPORTING ON ACCESSIBILITY OF HEALTH SERVICES**

The Department of Veterans' Affairs (DVA) should improve its public reporting on accessibility of health services. It should report:

- accessibility complaints data in more detail, including the number of complaints (so as to develop a time series to monitor the trend), and complaints by service and location
- the use of contingency arrangements, including requests for, and approval of, prior approval by providers to charge higher fees
- the number of providers who have indicated to DVA that they will no longer accept cardholders as clients.

RECOMMENDATION 16.3 **INDEPENDENT REVIEW OF FEE-SETTING ARRANGEMENTS**

The Department of Veterans' Affairs should commission an independent review into its health fee-setting arrangements. This review should look at the merits of adopting workers' compensation-style fee arrangements, including the use of co-payments and options for monitoring fees over the longer term. The review should also consider and advise on future governance arrangements for the ongoing setting of fees.

RECOMMENDATION 16.4 BETTER TARGETED ELIGIBILITY FOR THE GOLD CARD

The Australian Government should amend the *Veterans' Entitlements Act 1986* to remove eligibility for the Gold Card for anyone other than veterans with severe service-related impairments.

Unless they qualify through having severe service-related impairments, this would remove eligibility from:

- all dependants
- veterans over 70 years old with qualifying service
- veterans on the service pension who meet the means test
- veterans on the service pension who are also receiving a disability pension above the general rate, or who have between 30 and 60 MRCA impairment points.

The Australian Government should provide financial compensation to dependants who lose eligibility for the Gold Card.

All current Gold Card holders should retain their eligibility.

RECOMMENDATION 16.5 NO FURTHER EXTENSIONS OF GOLD CARD ELIGIBILITY

Eligibility for the Gold Card should not be extended to any new categories of veterans, dependants or other civilians who are not currently eligible for such a card. All current Gold Card holders should retain their eligibility.

Mental health and suicide prevention

Timely access to effective mental health information and services can be critical to improving the mental health and wellbeing of veterans and their families. There has been a heightened focus on veterans' mental health and suicide in recent years and a range of new policies, programs and research, but little is known about outcomes.

FINDING 17.1

The Departments of Defence and Veterans' Affairs offer a range of programs and services to support serving personnel, ex-serving personnel and their families with their mental health. There have also been a number of reviews and inquiries into the mental health of serving and ex-serving personnel.

Despite this, the suicide rate for veterans is higher than the general population. Suicide has caused more deaths for contemporary Australian Defence Force (ADF) personnel than overseas operational service — between 2001 and 2016, there were 59 deaths of ADF personnel on deployment and 373 suicides in serving, reserve and ex-serving ADF personnel.

Veteran mental ill-health can also have flow-on adverse effects on family members, friends, colleagues and others.

RECOMMENDATION 17.1 **IMPROVE AWARENESS OF DVA MENTAL HEALTH SERVICES**

To ensure that veterans and their families are aware of the services that the Department of Veterans' Affairs (DVA) provides (including Open Arms and counselling through the White Card), DVA should develop relationships with, and advertise its services through, mainstream mental health service providers (such as Beyond Blue, the Black Dog Institute and Lifeline).

FINDING 17.2

All veterans are entitled to mental health care funded by the Department of Veterans' Affairs through a non-liability White Card. However, the extent to which the non-liability White Card has, in practice, increased the number of veterans who are able to access mental health treatment, and the appropriateness of the treatment they receive, is unclear.

RECOMMENDATION 17.2 **MONITOR AND REPORT ON OPEN ARMS' OUTCOMES**

The Department of Veterans' Affairs (DVA) should monitor and routinely report on Open Arms' outcomes.

- It should first develop outcomes measures that can be compared with other mental health services.
- Once outcomes measures are established, DVA should review Open Arms' performance, including whether it is providing accessible and high-quality services to veterans and their families, and publish all such reviews.

RECOMMENDATION 17.3 **EVIDENCE-BASED TREATMENT FOR VETERANS MENTAL HEALTH**

It is important that veterans who seek mental health care can access the right (evidence-based) care. The Department of Veterans' Affairs should:

- publish a list of practitioners who have completed Phoenix Australia's trauma-focussed therapy and cognitive processing therapy training
- make mental health a priority area within the veteran research plan (recommendation 18.3).

FINDING 17.3

The current (2013–2023) Veteran Mental Health Strategy has not been very effective and has been superseded by recent policy changes (notably the introduction of non-liability access to mental health care for veterans). Defence also has its own Mental Health and Wellbeing Strategy. A single Strategy would facilitate an integrated approach to veteran mental health and wellbeing across their lifetime.

RECOMMENDATION 17.4 **A NEW VETERAN MENTAL HEALTH STRATEGY**

The Departments of Defence and Veterans' Affairs, with input from the Prime Ministerial Advisory Council on Veterans' Mental Health, should urgently develop a new single strategy for veterans' lifetime mental health. The new Strategy should:

- cover mental health activities in each of the life stages of military personnel — recruitment, in-service, transition and ex-service
- ensure there are activities in each life stage that address the needs of those who are mentally healthy (promotion and prevention activities), at-risk (early intervention) and have a mental illness (treatment)
- ensure systems are in place to identify and support at-risk individuals and that there is an identified focus on the prevention on suicide
- ensure the needs of family members of veterans, including those of deceased veterans, are appropriately identified
- be evidence based, incorporating outcomes from trials and research on veterans' mental health needs
- set out priorities, actions, timelines and ways to measure progress
- commit the Departments of Defence and Veterans' Affairs to publicly report on the progress towards the goals of the Strategy.

The National Mental Health Commission should have oversight of the new Strategy and publicly report on its implementation and outcomes.

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 hampered by the lack of data and the poor linking of data. Reform is needed to improve data held on veterans and to build an evidence base on what does and does not work.

FINDING 18.1

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

RECOMMENDATION 18.1 **OUTCOMES AND PERFORMANCE FRAMEWORKS**

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.

RECOMMENDATION 18.2 **MORE HIGH-QUALITY TRIALS AND REVIEWS**

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.

RECOMMENDATION 18.3 **DEVELOP AND PUBLISH A VETERAN RESEARCH PLAN**

The Departments of Defence and Veterans' Affairs should set research priorities on issues affecting the health and wellbeing of veterans, publish the priorities in a research plan and update the research plan annually.

RECOMMENDATION 18.4 **EXPERT COMMITTEE ON VETERAN RESEARCH**

The Departments of Defence and Veterans' Affairs should establish an Expert Committee on Veteran Research. The Committee should have part-time members appointed on the basis of skills and experience. Members should have a mixture of skills in relevant fields, such as military and veterans' affairs, health care, rehabilitation, aged care, family support and other compensation systems.

The functions of the Expert Committee on Veteran Research should include:

- providing input into the development of the research priorities and research plan
- monitoring the outcomes of the research plan
- promoting the use of research in the veteran support system
- ensuring the Departments of Defence and Veterans' Affairs publicly report on research outcomes and progress towards the goals outlined in the research plan.

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.

An expanded range of supports for family members of veterans, including for those of deceased veterans, is required. The needs of family members should be better assessed and the responses more targeted to those specific needs. A more individualised approach is likely to achieve better outcomes.

RECOMMENDATION 19.1 **TWO SCHEMES FOR VETERAN SUPPORT**

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 who only have a current or accepted MRCA and/or DRCA claim (or who do not have a current or accepted liability claim under the VEA) 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 that is the predominant source of their current benefits at the implementation date. If this is unclear, the veteran would be able to choose which scheme they would be covered by at the time of their next claim.

Veterans who would be covered under scheme 1 and are under 55 years of age at the implementation date should be given the option to switch their current benefits and future claims to scheme 2.

Dependants of deceased veterans would receive benefits under the scheme that the relevant veteran was covered by. If the veteran did not have an existing or successful claim under the VEA 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.

RECOMMENDATION 19.2 AN EXPANDED FAMILY SUPPORT PACKAGE

The Australian Government should:

- amend the family support provisions in the *Military Rehabilitation and Compensation Act 2004* (MRCA) to remove the requirement for veterans to have undertaken warlike service
- amend the *Veterans' Entitlements Act 1986* and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to provide the same (or equivalent) family support provisions as the MRCA.

The Department of Veterans' Affairs should amend the Family Support Package to extend:

- eligibility to families of veterans without warlike service and families of veterans receiving the veteran payment
- eligibility for counselling services to parents and eligible children of veterans who have suffered a service death or a suicide related to their service, and families of veterans not under a rehabilitation plan
- the range of supports to cover all counselling services for partners, widow(er)s, eligible children and parents. For these family members, session limits and the requirement for an identified need should be removed and replaced with an appropriate cap on total payment.

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 was 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’.
- To assess how the current system was performing, and what a future system should look like, we looked at the benefits and effects 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 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, veterans’ organisations, 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 public hearings and both general and topic-specific roundtables (covering legislative reform, rehabilitation and families of veterans).

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 Australian Defence Force (ADF) members and their families. Access to some of the supports and services is contingent on a veteran having 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 said it chose the title *The Constant Battle* to reflect the problematic nature of the issue of suicide by veterans and ex-service personnel and that ‘for modern veterans, it is likely that suicide and self-harm will cause more deaths and injuries for contemporaries than

overseas operational service’ (SFADTRC 2017, p. xvii). And, for deaths, this is the case — between 2001 and 2016, there were 59 deaths of ADF personnel on deployment and 373¹ recorded suicide deaths of serving, reserve and ex-serving ADF personnel (figure 1.1).

The Committee found that the legislative framework underpinning the veteran compensation and rehabilitation system was unnecessarily complex and difficult to navigate, and it 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:

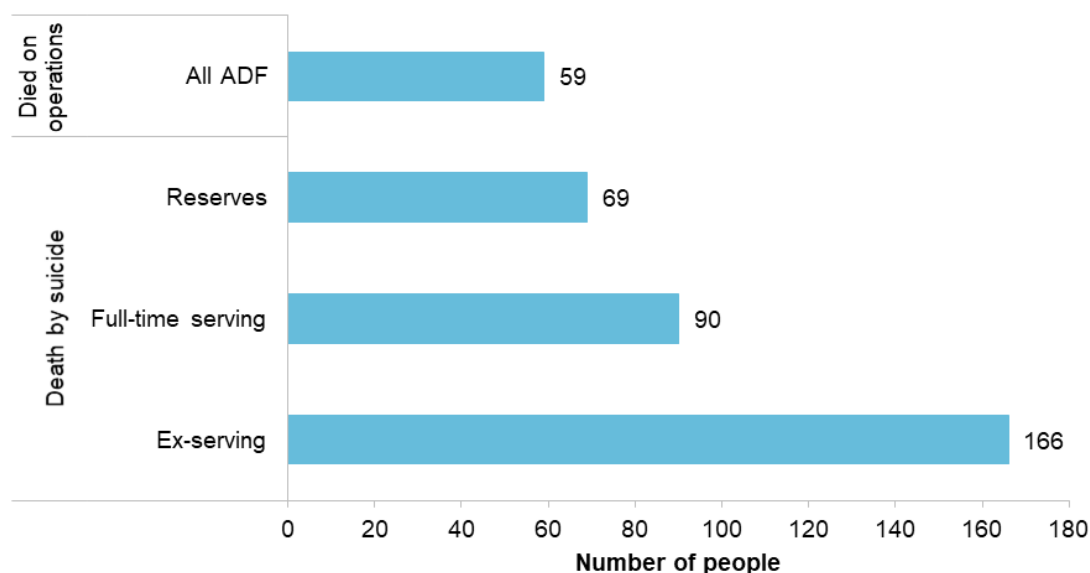
... there should be no topics which are off-limits including the differences in relation to operational service, standards of proof and the provision of services through the Department of Veterans Affairs (DVA) or alternative government agencies. The committee recognises that this will not be an easy 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 The below figure shows a lower total number of deaths by suicides because veteran suicide could not be disaggregated by service status up to 2016, only up to 2015.

Figure 1.1 Veteran deaths by suicide and on operations^a
Full-time serving, ex-serving and reservist between 2001–15^b



^a The number of deaths as a result of service with Australian units on deployment between 2001 and 2015 is based on the Roll of Honour. ^b Suicide deaths could only be disaggregated by service status up to 2015. Sources: AIHW (2017b, p. iv) and AWM (2019).

1.1 What was the Commission asked to do?

The Commission was asked to examine how the current compensation and rehabilitation system for veterans operates, how it should operate in the future, and whether it is ‘fit for purpose’. In undertaking this task, we were 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 was also to consider issues raised in previous reviews (box 1.1).

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 Paul Toose
- 1994 *A Fair Go: Report on Compensation for Veterans and War Widows* by Peter Baume
- 1999 *Review of the Military Compensation Scheme* by the Department of Defence, chaired by 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.

- *Efficiency of Veterans Service Delivery by the Department of Veterans' Affairs* by the Australian National Audit Office — released June 2018. This report focused on DVA administrative processes (ANAO 2018b).
- *Investigation into the Actions and Decisions of the Department of Veterans' Affairs in Relation to Mr A* by the Commonwealth Ombudsman — released July 2018 (Commonwealth Ombudsman 2018).
- *Use of the Quinoline anti-malarial drugs Mefloquine and Tafenoquine in the Australian Defence Force* by the Senate Foreign Affairs, Defence and Trade References Committee — released December 2018 (JSCFADT 2018).
- *Veterans' Advocacy and Support Services Scoping Study* by Robert Cornall (the 'Cornall Review') — released March 2019 (Australian Government 2018b).
- *Inquiry into transition from the Australian Defence Force* by the Joint Standing Committee on Foreign Affairs, Defence and Trade — released April 2019 (JSCFADT 2019).
- *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).

1.2 What the inquiry covers

The current system for veteran support has three main Acts.

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

These three Acts all have 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, the 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 the ADF's prevention policies, and its healthcare and rehabilitation services. Services designed to help ADF members transition out of the military are also considered.

Given the broad scope of its coverage, this inquiry makes frequent reference to the 'veteran support system' as any veteran-specific support provided to serving and ex-serving ADF members and their families. The 'veteran rehabilitation and compensation system' is used to refer more narrowly to compensation, rehabilitation and health care provided to veterans.

1.3 Who are veterans?

Defining veterans

The term 'veteran' can mean different things to different people.

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). And the *Veterans' Entitlements Act*

² In addition, the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act* also grandfathers some sections of 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.

1986 (in section 5C), defines a veteran to mean a person who has ‘taken to have rendered eligible war service’.

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, regardless of whether they were deployed abroad and regardless of the nature of their service.³

A number of other countries have also broadened the definition of veteran beyond its traditional meaning (box 1.2).

Box 1.2 How Canada, the United Kingdom, the United States and New Zealand define ‘veteran’

The ‘VAC [Veterans Affairs Canada] considers any former member of the Canadian Armed Forces who releases with an honourable discharge and who successfully underwent basic training to be a Veteran’ (VAC 2019).

The United Kingdom’s Ministry of Defence defines veterans as ‘anyone who has served for at least a day in Her Majesty’s Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations’ (Ministry of Defence (UK) 2017, p. 2).

In the United States, the veteran compensation legislation defines a veteran as ‘a person who served in the active [full-time] military, naval, or air service and who was discharged or released under conditions other than dishonorable’ [sic] (section 3.1 of Title 38 of the Code of Regulations).

New Zealand reserves the status of veteran for those with war service (referred to as ‘qualifying operational service’ in the legislation, section 7, *Veteran Support Act 2014* (NZ)).

The terms of reference for this inquiry asked the Commission to examine the compensation and rehabilitation arrangements for both serving and ex-serving members of the ADF.⁴ As such, 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.

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 proposed Australian Veterans’ Recognition (Putting Veterans and their Families First) Bill 2019 defines ‘veteran’ as ‘a person who has served, or is serving, as a member of the Permanent Forces or as a member of the Reserves’ (section 4).

⁴ Serving generally means those in ‘permanent’ service, and non-serving those who have discharged from such service (some join the reserves after discharge). Cadets and reservists (who have never deployed or served on a ‘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. 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. ‘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 2018p).

A number of participants to this inquiry raised concerns about the Australian governments' new definition of a veteran (box 1.3).

Box 1.3 Mixed views on the new definition of a veteran

Some stakeholders were critical of the new definition of a veteran.

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 agreed that veteran should not be exclusive to those with overseas service, but thought a single day of service was too low a bar.

I consider that there should be a time, whether it be 10 or 20 years within the service that people then get the name of veteran. Sometimes it's not their fault if they don't serve overseas, that they put their hand up to serve overseas and they haven't done it but to give somebody the terminology of a veteran after one day is just outrageous, in my opinion. (David Thomas, trans., p. 1419)

Some stakeholders pointed out the differences between operational and peacetime service.

I can assure the Commission that being shot at by someone who's trying to kill you is not like having a regimental barbecue on a Sunday afternoon. If we leave the definition as it is the value of and depth to the community or that the community owes to those who have endured the unique life changing pressures and dangers of war and warlike service will be lost. (John George, trans., p. 967)

Others raised concerns that the definition could create undue expectations about 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. (DFWA, sub. 118, p. 12)

Some argued for all veterans 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)

Some stakeholders raised concerns about the Commission using the new definition of veteran.

The major flaw in the report is the term 'veteran', which the commission saw fit to reclassify. It has put all members of the ADF into the one basket by inferring that they are all veterans from day one of entry into the ADF. (AATTW WA Branch, sub. DR174, p. 1)

Veterans' families

The veteran support system also supports widow(er)s and other family members ('dependants') of veterans. In fact, a large proportion of DVA benefit recipients are dependants (chapter 2; DVA 2018m).

When we use the term 'families' in this report we are including (unless the context states otherwise), parents, partners, widows, widowers, children and other family members of deceased or living veterans.

Families can also be significantly affected by military life and veterans' transitions to civilian life, and the impacts can be long lasting. Family support can not only be directly beneficial for family members but also enhance the effectiveness of system supports provided to veterans.

1.4 The Commission's approach

The Commission was asked to look at whether the veteran support system was, or how it could 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).

Other aspects of the approach we 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 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, we assessed the system based on what is known about outcomes (for veterans and families and the wider community). We 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 supports 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.

In conducting this study we met with a range of individuals and groups, held public hearings and 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 1.4).

The Commission would like to thank everyone who provided input to the inquiry (appendix A).

Box 1.4 **About our consultation**

In preparing this report, the Commission sought views from government departments, veterans' organisations, veterans, their families and other interested parties. We also met with many interested parties and conducted visits, roundtables and public hearings across the country. We released an issues paper in May 2018 (this set out issues and questions of relevance for the inquiry, and invited submissions) and a draft report in December 2018.

Submissions

We received 313 formal written submissions (these are published on the Commission's website) and 160 brief comments (through a portal on the inquiry's webpage). 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:

- the Department of Veterans' Affairs regional offices in Sydney to witness the claims handling 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)
- meetings with various stakeholders in cities including Sydney, Melbourne, Brisbane, Perth, Adelaide, Darwin and Canberra
- visits in New Zealand including with Veterans' Affairs NZ, the NZ Defence Health Directorate and Ron Paterson (author of the *Review of the Operation of the Veterans' Support Act 2014*).

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. A list of the consultation undertaken by the Commission is contained in appendix A.

Hearings

Following the release of the draft report, the Commission conducted a series of hearings across the country in all state capitals as well as Rockhampton, Townsville and Wagga Wagga. Transcripts of these hearings are available on the Commission's website.

1.5 A guide to this report

This report sets out the Commission's findings and recommendations on a better way to support veterans.

The next chapter looks at military service and the veteran community, chapter 3 provides a brief overview of the current veteran support system, and chapter 4 looks at objectives and design principles for the veteran support system.

Chapters 5 to 7 look in depth at the issues of preventing injury and illness, rehabilitation and transition support. Initial liability assessment, claims administration and reviews of claims are the topics covered in chapters 8 to 10. The governance arrangements for the veteran support system are examined in chapter 11 and advocacy and the role of veterans' organisations are discussed in chapter 12.

Chapters 13 to 15 focus on compensation issues and chapters 16 and 17 cover health care for veterans and their families, including mental health care. Data and evidence are discussed in chapter 18, and the last chapter (19) of the report brings together the key recommendations and discusses transition issues.

2 Military service and the veteran community

Key points

- Military service is a unique occupation that presents a number of challenges and risks to Australian Defence Force members and their families. Members are subject to military law and discipline, and are not as free as other Australians to make independent decisions, or to choose to avoid personal risk of injury in armed conflict. They can also be directed to apply lethal force against an enemy. Other features of military service include a higher than average risk of injury 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 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 estimated that there are about 640 000 serving and ex-service veterans — including 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 than members discharged for other reasons to rate their quality of life as poor
 - suicide rates for male ex-serving veterans under 30 years old are about twice those for the equivalent group in the general population
 - there is some evidence that mental health disorders are more prevalent for veterans than in the wider population, and that ex-serving veterans experience a higher rate of homelessness than the general population.
- The impacts of military service can also extend to veterans' families, not least to those whose partners or parents have died as a consequence of service.

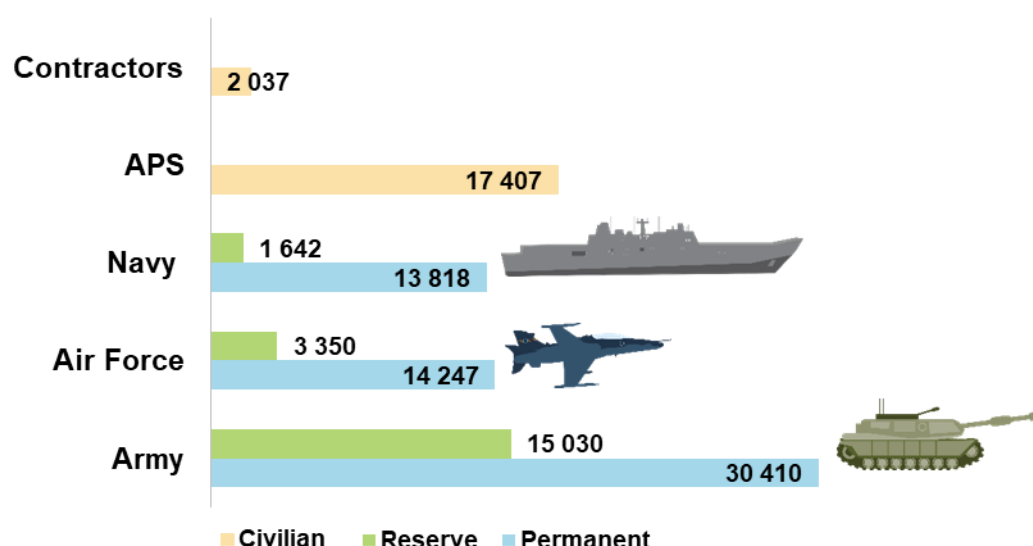
The veteran community is made up of serving and ex-serving members of the Australian Defence Force (ADF) and their families, as well as family members of deceased veterans. The Commission looked at each of the life stages of veterans — in service, transition and ex-service — to assess the ‘fitness’ of 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 World War I and II, Vietnam, Korea, Iraq and Afghanistan (Chester 2018d, 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 permanent members and 20 000 paid reservists (figure 2.1). 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, pp. 81, 83).

Figure 2.1 **Number of ADF members in 2017-18^a**
Permanent and reserve forces



^a Permanent forces are what the Australian Defence Force terms ‘average funded strength’. Reserve force numbers are the number of members paid during the financial year.

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

Between 1999 and 2016, more than 76 000 ADF members were deployed on domestic border security, humanitarian and international operations — about 18 per cent of these were reservists — with some members deployed 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. About 55 per cent of all serving members have been assigned to combat or related operations both domestically or internationally at least once (DoD 2016c, p. 19, nd).

Who joins the ADF?

The ADF requires people who are fit, adaptable, 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 are female (DoD 2018f, p. 81). The proportion of female ADF personnel has been steadily rising — from 12 per cent in 1991 to 18 per cent in 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 some 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 Queensland, sub. 73, p. 9).

The median length of service is 8.7 years, and the mean length of service is less than 8 years. This is longer than the typical civilian stays with the same employer (D’Arcy et al. 2012, p. 2; DoD 2009, p. 9, 2018n, p. 1). A ‘typical’ military career is described in box 2.1.

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. 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 2018b).

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 within Australia 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 a 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 requirements differ by gender and scale down with age.

Every two to three years members are re-posted and generally have to relocate (typically in regional areas where most ADF bases are located). Between 78 and 91 per cent (depending on service branch) of ADF members have had to undertake a service-related move (DoD 2016c, 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 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 working hours 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 typically serve for about 8 years, although some members have much shorter, or longer, careers (DoD 2018n, p. 1). For the large majority, their return to civilian life is successful, but for a minority the transition is difficult. This is why veterans are supported in their reintegration to civilian life by a system of transition support that has no civilian parallel.

The nature of military service

Many participants in this inquiry highlighted the distinctive characteristics of military life (box 2.2). Previous reviews also recognised these features (Campbell 2011a, p. 96; DoD 1997, pp. 7–8; Tanzer 1999, p. 167). Some other occupations have similar characteristics; for example, paramedics are exposed to trauma, long-distance truck drivers frequently work away from home and agricultural workers are exposed to many serious risks.

However, military service is clearly a unique occupation. The key features that distinguish military service from other occupations are that members:

- are subject to military law and discipline
- are not as free as other Australians to make independent decisions, or to choose to avoid personal risk of injury or death in armed conflict
- are authorised to apply lethal force
- may be injured or killed in military operations against a hostile enemy.

And their ability to mitigate risks is likely to be less than in other workplaces.

As the Air Force Association explained:

The nature of military service is much more than following directions, frequent relocations, long and irregular hours, and working in high risk situations. Many civilian occupations are subject to such working conditions. The difference between a civilian and military person commences on their enlistment or appointment. Apart from the human rights that are forfeited at this juncture, the military member is ‘licensed’ to take a human life and is expected to do so in war – not just to protect themselves or their comrades, but to kill an enemy. Such action may be taken in the field, on the sea, or in or from the air. The military role can include identifying human targets and authorising their demise. No other occupation has this duty. (sub. DR267, p. 2)

Serving in the ADF is likely to be more dangerous than most civilian occupations, although comparable injury rates are not available. War, or warlike conditions, bring 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 include live fire exercises, physically intense training and use of explosives. These distinct features of military life lead to exposure to the risk of injury and trauma, the effects 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 (ADSO, sub. 85; DFWA, sub. 118; DVA, sub. 125).
- In 2017-18, there were three fatalities of serving ADF members, 277 personnel suffered serious injury and illness and 8937 members suffered minor injuries or illness (DoD 2018f, p. 106). And there was a fatality as recently as April 2019 (Lynch 2019).
- Some of the illnesses are latent, including mental disorders, and often only present themselves after a member has left the service — sometimes decades later.

Box 2.2 **Participants described the unique features of military service**

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

Vietnam Veterans' Association of Australia described the traumas that can occur.

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. (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 ... (sub. 118, p. 14)

A number of stakeholders also raised concern about the Commission's understanding of military service. For example, David Kelly and David Jamison argued that:

... the description supporting the Commission's understanding rather than listing the core determinants of this uniqueness, outlines some of the characteristics of military service where there can be some overlapping of characteristics with for example, civilian policing and emergency services. Military service involves:

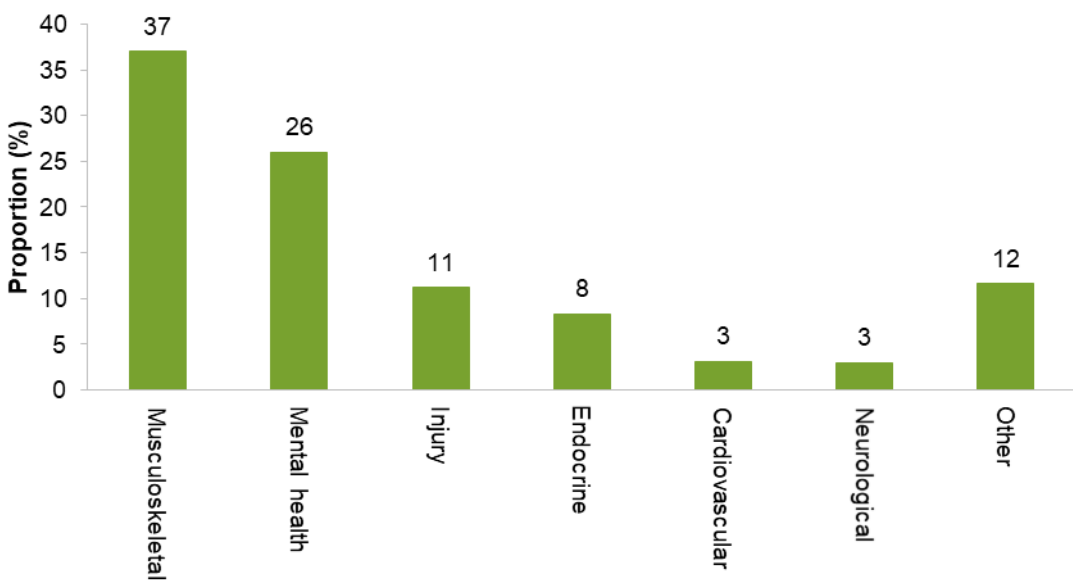
- the surrender of the individual's human rights under the UN Charter on Human Rights,
- the requirement to use lethal force against another human being when lawfully ordered to do so, and
- a requirement to follow orders regardless of the possibility that by doing so could very likely prove lethal for the service person being so ordered. (sub. DR212, p. 2)

Where illness or injury prevent ADF members from meeting the stringent fitness requirements, they are usually medically discharged. By contrast, in a civilian 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).

Other features of military service include:

- *inability to resign before a set date* — or face criminal penalties under military law
- *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. 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) (DFWA, 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 (DFWA, sub. 118). As the Department of Veterans’ Affairs (DVA) put it:

Military culture can be expressed as a form of ‘selfless service’ in that 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 2017b). 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 (chapters 7 and 17).

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 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 satisfying employment.

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 with land-based deployments), different training requirements and the proximity and nature of combat risks.

Different military service experience manifest different outcomes, including in rates and types of injuries.

- The Army — while making up about half of ADF permanent personnel and 57 per cent of combined reserve and permanent forces (DoD 2018f, p. 85) — is responsible for about 71 per cent of claims relating to post-2004 service (DVA MRCA claims data).
- Naval personnel (serving and ex-serving) have a higher incidence of suicide relative to the other service branches (AIHW 2017b) and a disproportionate share of claims for bipolar disorder, tinea and migraines (DVA MRCA claims data).

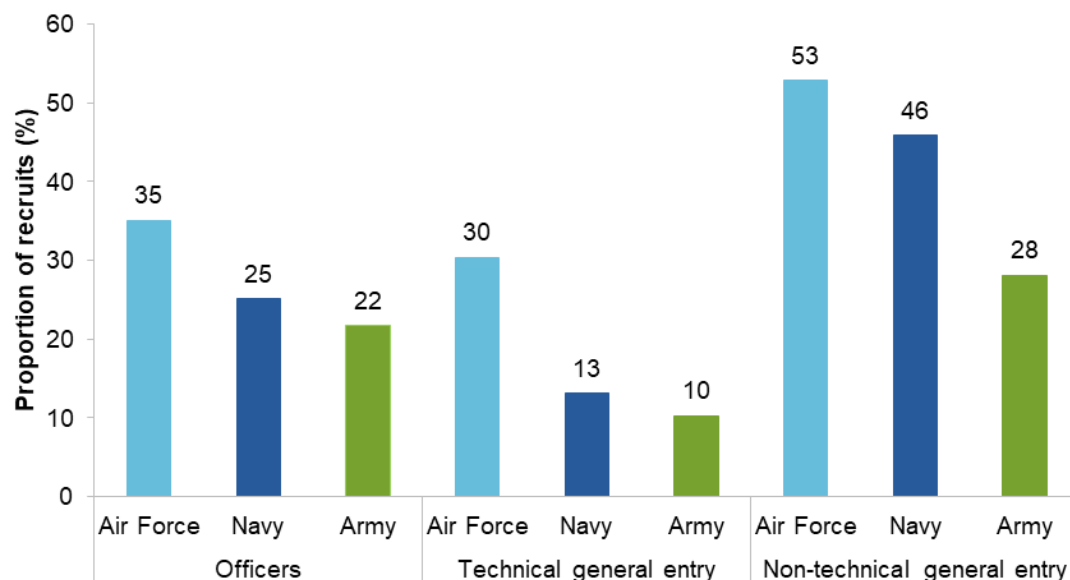
These differences also manifest in differing injury and claim rates — with discharges from the Army more likely to be on medical or other involuntary grounds (about 27 per cent) than those from the Navy and Air Force (about 23 per cent and 13 per cent respectively) (DVA and DoD 2018).

There are several other differences across the service branches.

- The proportion of female recruits differ significantly between the services — highest in the Air Force and the lowest in the Army, and they are typically most represented in non-technical general entry (non-officer) roles (figure 2.3).
- The median length of service differs between the service branches — ten years in the Air Force, and seven years in the Army and Navy (DoD 2016c, p. 17).

There are also differences in the patterns of injury 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 (Van Hooff et al. 2018b) and they proportionally claim more for this condition (DVA claims data).

Figure 2.3 Proportion of female ADF recruits by service branch and entry stream in 2017-18



Source: DoD (2018q, pp. 5–6).

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 service — 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)

The conditions of the profession has 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. Deployments are much shorter, typically 4-8 months, although many go on multiple deployments (DoD 2016c, pp. 19–20). As Ricky Ryan put it:

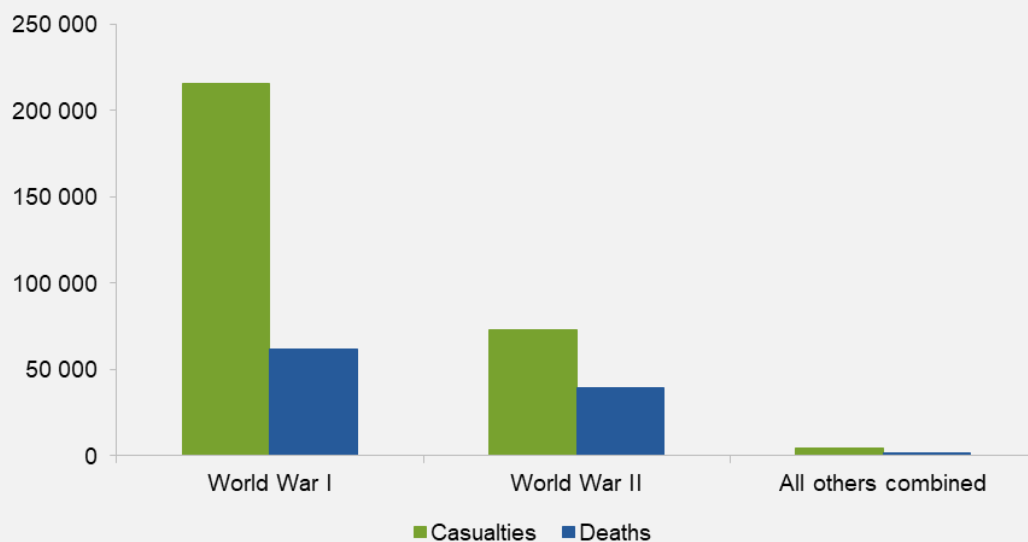
The ADF has evolved from a poor-paying service career under lousy conditions with questionable clothing, uniforms, et cetera, to now where people have good service pay, good military superannuation, far better conditions than we endured in our day, and I can probably, as an aside, a Vietnam veteran, I think we got about \$1.60, \$2 a day for being in a combat zone as opposed to the allowances which we believe are quite generous for those that now serve in operational service. (trans., p. 203)

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, World War 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 Australians (out of a population of less than 5 million) deployed overseas and in World War II about 1 million served in the military (out of a population of about 7.5 million), either at home or abroad. Today the Australian Defence Force stands at about 58 000 with about 2400 deployed overseas or on border patrol (DoD 2018f, p. 80, nd).

Australian casualties in overseas^a military operations^b



^a This includes service people within Australia during the World Wars. ^b As at 2013. Deaths are taken from the Roll of Honour and deaths that occur 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. Injuries not resulting in death, post-Vietnam, are not known and are probably underestimated here.

Sources: Australian War Memorial (2019) and National Archives of Australia (2018).

And the nature of warfare has changed. Chris Masters in his book on the modern Australian soldier — *Uncommon Soldier* — said:

... the battlefield has changed. Ground wars were not so often being fought in abandoned farmland and deserts, through defined trench lines and barbed wire. Instead the battlefield was all around us in remote villages, neighbourhoods, nightclubs and multiple-story office buildings. (2012, p. xii)

And, quoting the former Army psychologist, Damien Hadfield, the head of the New South Wales RSL James Brown commented in *Anzac's Long Shadow*:

... 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)

Reserve service

The reserve ADF are a latent force that can serve alongside the permanent force when required (including deployment on operations). Reservists can be 'active' or 'standby' — the former have to perform a minimum number of days of service while the latter only have to register their address and have a medical exam each year (former ADF members are automatically standby reservists) (DoD nd, pp. 23–25).¹ A sizeable proportion (31 per cent) of the 25 770 members of the active reserve force were previously permanent ADF members (DoD 2016c, p. 31). There are also specialist reservists such as doctors, lawyers and psychologists.

The reserves have been part of the Australian military since Federation. Historically they made up the bulk of Australia's peacetime forces, but following World War II the permanent forces have become much larger. The *Defence White Paper* highlighted the critical role played by reservists in achieving Australia's strategic objectives.

The ADF is increasingly drawing on the skills and expertise of Reservists to deliver defence capability. Many Reservists have critical specialist expertise not readily available within the

¹ The terms standby and active are obsolete with the ADF Total Workforce Model (box 2.4), but are used here for ease of reading. What is now called SERCAT 2 corresponds to what used to be called standby reserve service, while SERCAT 3–5 correspond to what used to be called active reserve service (ADF 2018a).

Permanent ADF, such as specialist medical and technical skills. Reservists are an important part of the ADF's deployed capability on operations within Australia and overseas. (DoD 2016a, p. 148)

There is considerable movement of members between the permanent and reserve forces. About 18 per cent of those deployed overseas between 1999 and 2016 were reservists, and about 25 per cent of recently transitioned veterans remained in the active reserves (DoD 2016a, p. 148; Van Hooff et al. 2018b, p. iv). Defence's 'Total Workforce Model' will further loosen the distinction between the two (box 2.4).

Box 2.4 The Total Workforce Model

Beginning in 2015-16, the Australian Defence Force 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 [ADF] entire workforce in a more agile and integrated way' (DoD 2018e).

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, p. 95)

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 who are force-assigned are SERCAT 1.

The number of days each Australian Defence Force reserve member works in a year can vary substantially, depending on their SERCAT, personal circumstances and organisational need.

Families of veterans

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

Family life during service

Many 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. A recent study conducted as part of the Transition and Wellbeing Research Programme (box 18.7, chapter 18) showed about 60 per cent of ADF members 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 (ABS 2010; Daraganova, Smart and Romaniuk 2018, p. 94; Smart, Muir and Daraganova 2018, p. 8). It 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 the member's service-related absences as the main reason (DoD 2016c, 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 affect their family life even where there is no evidence of an effect on physical and mental health of families (Dobson et al. 2012b, p. 43; McGuire et al. 2012, pp. 10–15) (box 2.5).
- 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).

Overall, about half of surveyed ADF families believe that the demands of service had a negative impact on their family. Further, 14 per cent were dissatisfied with their links to the general community and a quarter were dissatisfied with their links to the Defence community (DoD 2017a, p. 6). Nonetheless, about half of the partners of ADF personnel wanted their partners to continue serving in the long term or have not considered them leaving (DoD 2017a, p. 36).

However, military service can also have positive effects on family life, such as greater financial resources that provide opportunities that may not otherwise been available. And recent Australian research on the wellbeing of veterans' families (box 2.6) found a range of positive effects.

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)

Box 2.5 Studies on the effect of deployment on families

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

The Middle East Area of Operations Health Study 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. 2012a, p. 82).

The Vietnam Veterans Families study compared the outcomes of children of Vietnam veterans 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. This study 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 post-traumatic stress disorder), 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.

Also, 'combat exposure' — as distinct from the more common experience of overseas deployment — has been found (in international studies) to have a more detrimental effect on the long-term wellbeing of families (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 2.6 Wellbeing of veterans' families

The Family Wellbeing study, conducted as part of the Transition and Wellbeing Research Programme (box 18.7, chapter 18) looked at the wellbeing of families of Australian Defence Force members (and former members) who served sometime between 2010 and 2014. It found that:

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. (Smart, Muir and Daraganova 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 not being able to pay their 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, and 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 in providing support and companionship when defence force members are re-integrating following deployment, and when they are transitioning out of military service (box 2.7). The transition period can also be difficult for members of a veteran's family (chapter 7).

Box 2.7 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 Brandis, 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 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)

And RSL Queensland said:

... 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 bear 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)

Many partners become primary caregivers to veterans if they are severely injured as a result of their service. Mates4Mates said:

... the adverse physical and psychological effects that military service can have on our service men and women can also seriously affect the family unit. Integral to supporting veterans and ensuring they feel their life has stability, security and harmony, is providing direct support to their family and loved ones. (sub. 84, p. 7)

When an ADF member is killed during service, or when a veteran dies later as a result of service, this loss will significantly affect their widow(er) and children, and the parents and siblings of the veteran.

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’ (DoD, 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 2.8). 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 2.8).
- comprehensive free health care designed to maximise the health, fitness and preparedness of ADF members
- 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 14).

Other benefits from military service include a sense of camaraderie and purpose. The Department of Defence said:

The sense of camaraderie and purpose which underpin military service are considered its greatest strength. Camaraderie is associated with life-long friendships and, to a degree, co-dependence on the unit. It is, however, only occasionally replicated in civilian life; its absence can create a deep sense of loss following transition from the military. (sub. 127, pp. 8–9)

Commenting on the intrinsic rewards of serving in the ADF, one veteran said:

I loved my career in the [Royal Australian Air Force] 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).

The Senate inquiry into suicide by veterans also noted that:

The members of the ADF receive some of the best training in the world and leave service with valuable skills and experience that can be transferred to benefit the Australian society in a broad field of endeavours. (SFADTRC 2017, p. xvii)

Box 2.8 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'). The combined effect of grades and increments mean that members of lower ranks can sometimes be paid substantially more than their superiors, depending on role and experience.

Pay scale^a of selected ADF ranks in 2018

<i>Army rank</i>	<i>Navy rank</i>	<i>Air Force rank</i>	<i>Salary range (\$)</i>
Colonel	Captain	Group captain	150 728–201 087
Lieutenant colonel	Commander	Wing commander	128 194–178 469
Captain	Lieutenant	Flight lieutenant	70 334–130 704
Lieutenant	Sub lieutenant	Flight lieutenant	58 467–111 363
Second lieutenant	Acting sub lieutenant	Pilot officer	54 626–102 493
Sergeant	Petty officer	Sergeant	63 389–104 792
Corporal	Leading seaman	Corporal	54 776–95 824
Private	Seaman	Aircraftman/women	48 325–87 008

^a Excludes the \$14 271 service allowance that 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 through a service allowance (currently just over \$14 000) received by all personnel below 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. (DoD 2017d, part 2)

Sources: DoD (2017d, part 2, 2018d).

2.2 A profile of the veteran community

There is limited data and evidence on the veteran community. While the Australian Institute of Health and Welfare (AIHW) published *A profile of Australia's veterans* (AIHW 2018a), which provides a comprehensive summary of the currently-available evidence, there are persistent gaps in data and evidence on veterans and veterans' supports (chapter 18).

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 (2016, p. 5) estimates the number of veterans to be somewhere between 300 000 and 500 000. DVA estimates that there were just over 640 000 living veterans (serving and ex-serving) including reservists who have never deployed or served on a permanent basis at the end of June 2018 (figure 2.4). Ex-serving veterans comprise about 2 per cent of the general population.²

Clients accessing supports through DVA are a minority of the total veteran community (figure 2.5). 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)

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

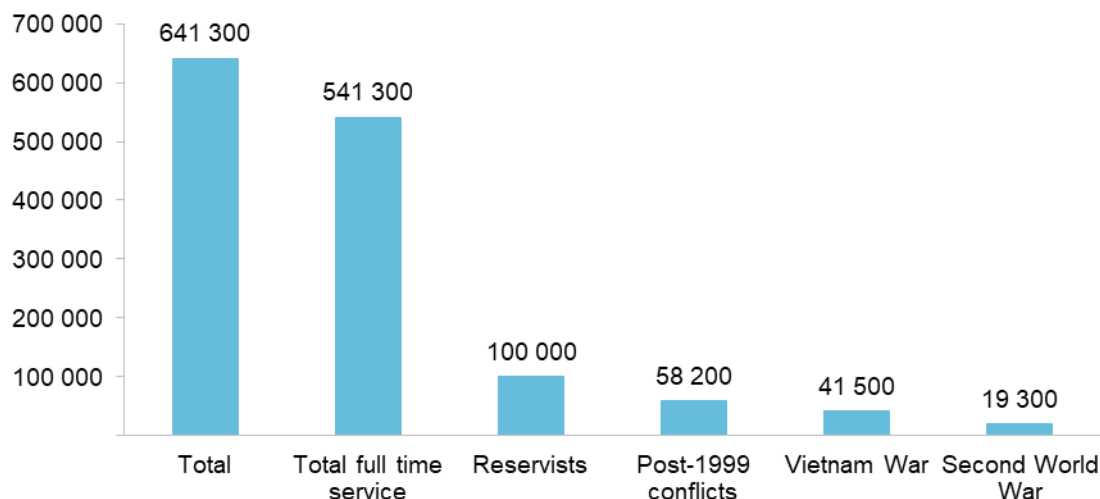
The stereotype of a veteran as an elderly white male does not represent the demographics of the current Australian veteran population. The veteran community is far from homogeneous; it has significant diversity, including:

- 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)

² This is based on DVA estimated numbers of living veterans (641 300) minus the 58 000 permanent 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 that veterans are about 2.6 per cent of the general population and ex-serving veterans are about 2.3 per cent of the general population (ABS 2018b).

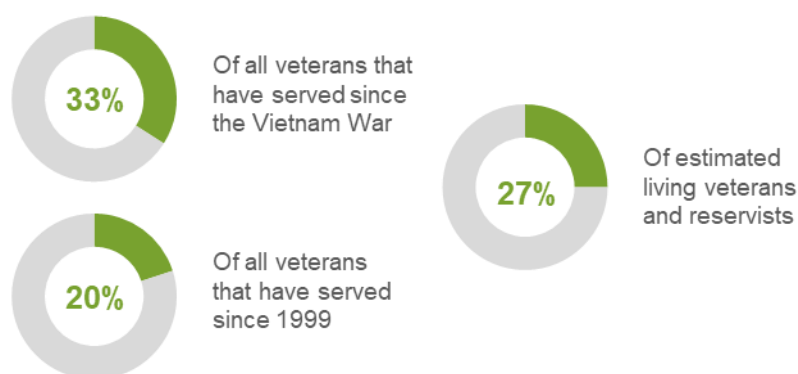
Figure 2.4 DVA estimates of the number of living veterans
Split by conflict^a and service type^b



^a Where the veteran served 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' (chapter 3).

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

Figure 2.5 Only a minority of veterans access DVA support
Proportion of veteran subpopulations that are DVA clients



Sources: DVA (sub. 125, p. 8) and Productivity Commission estimates based on DVA client data (as at 30 June 2018).

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 2018g, 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 2016c, p. 15).
- About two thirds of recently transitioned veterans are living with their partners (Van Hooff et al. 2018b, p. 44).

That said, ex-serving members are more likely to be living alone and have a smaller average household size than serving members (Daraganova, Smart and Romaniuk 2018, p. 109).

Employment

Veteran employment statistics are also sparse. However, the Mental Health Prevalence Study conducted as part of the Transition and Wellbeing Research Programme (box 18.7, chapter 18) provides some useful insights on employment (figure 2.6). It found that more than 80 per cent were engaged in purposeful activity and nearly two-thirds were employed.

In 2018, Defence started surveying discharging members. It 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).

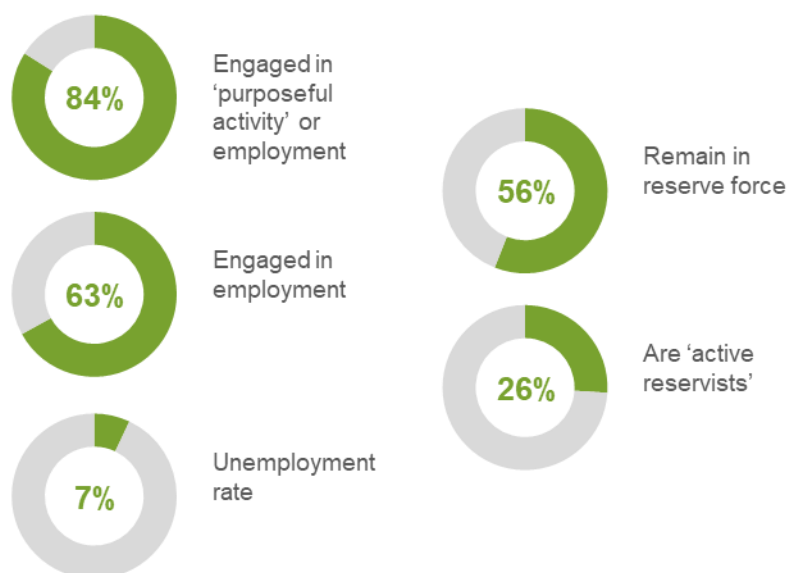
Health

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
- 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 2.9).

The available information that looks at 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 rates of suicide, especially those under age 30 (chapter 17).

Figure 2.6 Veteran employment outcomes
Ex-serving personnel who transitioned between 2010 and 2014



Source: Van Hooff et al. (2018b, pp. iv, 44).

Studies of 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 found a higher incidence of various health conditions following deployment to the Middle East (Davy et al. 2012). The conditions included psychological distress and PTSD symptoms, alcohol usage, suicide ideation, cardiovascular risk and lung function issues (box 2.10).

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 2.10).

Results from the Transition and Wellbeing Research Programme (box 18.7, chapter 18) provide a partial picture of the extent of injury and illness among veterans and also show that where injury and illness occurs this can significantly affect a veteran's wellbeing. For example, the study found recently transitioned veterans report being in poorer health than the general community — 35 per cent of recently transitioned veterans rate their health as 'fair or 'poor', while only 13 per cent of the general population say the same. And medically discharged veterans were 13 times more likely to rate their quality of life as poor compared to those who were discharged for other reasons (Kelsall et al. 2018, pp. 209, 337).

Box 2.9 **Some issues in understanding veteran health studies**

Most studies have limited scope

Most studies on the health of veterans tend to focus on veterans of particular conflicts (such as the Vietnam War or the Korean War) or on particular occupations (aircraft engineers for example). For recently serving veterans, only a few studies have examined a broad sample of both serving and ex-serving veterans with both peacetime and operational service. They include:

- the 2010 *Australian Defence Force 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)
- the series of studies about the wellbeing of serving and ex-serving members conducted as part of the *Transition and Wellbeing Research Programme* (box 18.7, chapter 18)
- the partnership between the Department of Veterans' Affairs and the Australian Institute of Health and Welfare to build a comprehensive profile of the health and welfare of Australia's veteran population (box 18.1, chapter 18).

There is a lack of comparison with the general population

Even where there is information on veterans' health, it is not always possible to compare it with information about the general population. For example, in the Physical Health Status study (Kelsall et al. 2018) conducted as part of the Transition and Wellbeing Research Programme, there was a decision not to make many comparisons of health outcomes for the general public (adjusting for age and gender). In other cases, the data simply were not available. For example, the last comprehensive study of the mental health status of the Australian public was the National Survey of Mental Health and Wellbeing by the ABS (2007), which was conducted over a decade ago, so it is difficult to make up-to-date comparisons between veterans and the general population for mental health conditions.

There are difficulties in inferring causation

Because of the Australian Defence Force'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 (McFarlane et al. 2011, p. 2). This 'healthy-soldier effect' makes determining the marginal impact of service on physical and mental wellbeing difficult.

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

Box 2.10 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 on veterans of the Vietnam war 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

The 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).
- 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 had lower mortality rates than the comparison group. However, as these studies were not longitudinal, there were significant potential 'healthy soldier effects' (box 2.9) 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:

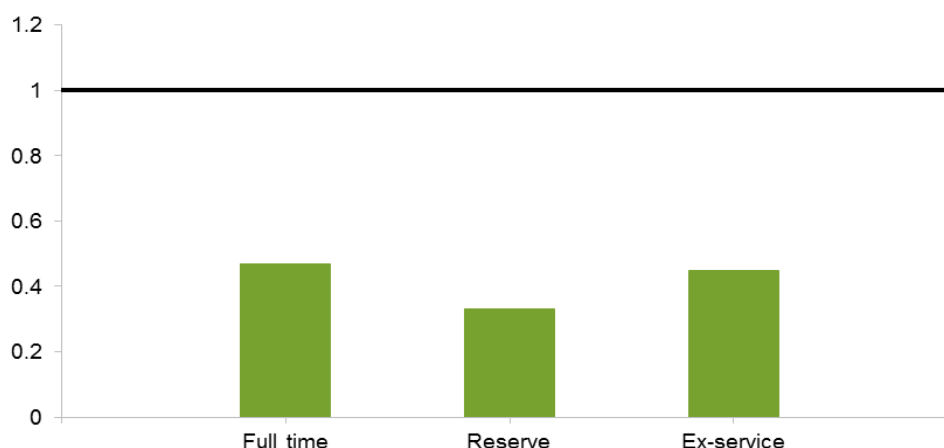
- the *2010 ADF Mental Health Prevalence and Wellbeing Study*
- the ***Middle East Areas of Operations (MEAO) Census Health Study*** — which measured the current health of ADF members who were deployed to the MEAO (2012)
- the ***MEAO Prospective Health Study*** — which measured the health of personnel 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).

Three of these studies found no relationship between deployment and health or mortality in comparison to personnel who did not deploy, while the longitudinal analysis (the MEAO Census Health Study) found higher incidence of various conditions and distress markers.

Mortality

Several studies of 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 2.7). An earlier study that looked at mortality of veterans who had deployed in the Middle East Area of Operations found that their mortality rate was less than half that of veterans who did not deploy to this area (box 2.10) (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.³

Figure 2.7 Mortality rate of serving and ex-serving veterans
Standardised mortality rates^a



^a Standardised mortality is a comparison of the mortality of a particular group with 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).

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

However, some studies indicate that older cohorts of veterans have higher mortality rates than the general population. For example, a study of the mortality of Korean War veterans found that they had a 21 per cent higher mortality rate than Australian males of the same age

³ Those in the ADF who 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 four times the mortality rate of transport accidents adjusting for age and gender).

(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 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.

Mental health and suicide among veterans

Mental health care and suicide prevention are key areas of need within both the general and veteran communities. There has been a heightened focus on veterans' mental health and suicide in recent years. This follows a number of veterans taking their own lives while seeking support from DVA. Increasing concerns about the mental health of veterans have led to a number of inquiries and reviews. Indeed, the Senate inquiry into suicide by veterans is the genesis of this inquiry (chapter 1).

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 (including a strong sense of purpose, camaraderie and free access to health care). But there are also risk factors — veterans can be exposed to trauma, and they spend time away from family and relocate frequently. Further, the ADF culture focuses on order and hierarchy to train recruits and mould them into warriors. This sometimes results in ADF personnel feeling unable to show signs of weakness which is a barrier to seeking help. 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.

The available evidence indicates that both the prevalence of mental disorders and the incidence of suicide among veterans is higher than that of comparable sections of the general population. In particular:

- 54 per cent of serving ADF personnel have been diagnosed with a mental disorder in their lifetime (which is significantly higher than the comparable section of the general population)
- ex-serving male veterans under the age of 30 are over twice as likely to die by suicide as men of the same age in the general population
- recently transitioned ex-serving ADF personnel are four times as likely to rate their levels of psychological distress as very high compared with the comparable general public (AIHW 2018g, p. 1; McFarlane et al. 2011, pp. xv, xxi; Van Hooff et al. 2018b, pp. v, 135, 202–203).

What is known is that where mental ill-health does occur, the effects can be severe and prolonged.

A longitudinal survey of veterans deployed to the Middle East Area of Operations found that those who were experiencing a subsyndromal or probable mental health disorder in 2010 had about a 78 per cent likelihood of having a probable mental health disorder in 2015,

compared to only 26 per cent for those who did not have symptoms in 2010. And reporting suicidality — suicidal thoughts, behaviours and planning — in 2010 was a significant predictive factor as to whether symptoms of mental ill-health were observed in 2015 (Bryant et al. 2019, pp. vii–viii, 118).

There is a common perception that most veterans experience mental ill-health. Brown, commenting on these perceptions, said:

The irony is that these one-dimensional portrayals of veterans bear a close resemblance to the preconceptions of many Australians I've met. Either veterans are chest-thumping heroes or they are quivering wrecks, ravaged by war. ... It's as if veterans are trapped in a martial Madonna/whore complex. On the one hand they are heroic warriors; on the other they are deeply flawed individuals. (2014, pp. 109–110)

The perceptions of ubiquitous mental ill-health among veterans are problematic for two reasons. First, they are mostly incorrect. The majority of veterans, at any given point, will not be suffering from mental ill-health — for example, over half of recently transitioned ADF personnel have not suffered from a mental disorder in the last 12 months (Van Hooff et al. 2018b, p. vi). And among the general public, about half can be expected to experience mental ill-health at some point in their lives and about a fifth can be expected to do so each year (McFarlane et al. 2011, p. xv).⁴ Moreover, although for male veterans, suicide is a leading cause of death, this is also true of the Australian public (AIHW 2018c, pp. 10–16). Second, the mistaken belief that all veterans suffer from mental ill-health may be impeding their transition to civilian life (chapter 7).

Chapter 17 provides a more detailed summary of the available evidence on veterans' mental health.

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 population, the State of Homelessness study found veterans were about 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

⁴ This statistic cannot be directly compared with the statistic in the previous sentence as there are gender and age difference between the two groups that have not been adjusted for.

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 like those of similarly aged civilians. Numerous participants commented on these traits. For example, the Alliance of Defence Service Organisations 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. (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' (sub. 113, p. 7).

The age profile of contemporary veterans also impacts the type of services they require. RSL NSW said 'when dealing with the system at an individual level, younger veterans consistently express their desire for a modern, professional, high-quality service offering independence and choice' (sub. 151, p. 5).

RSL Australia also 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 as this cohort reach the end of their service and move into the population of veterans claiming compensation and rehabilitation as a consequence of their service.

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, government reluctance to reduce entitlements (and veteran pressure against doing so) 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 discriminates 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 DVA having the primary role.
 - Veterans' organisations support the veteran community, including by providing advocacy services for veterans submitting or appealing claims and by providing 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 of World War I and widows of those who served in that conflict, veteran support has evolved into a generous but complex system. Understanding the original rationales for the various elements of the 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 evolved

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 (DoD) under the *Defence Act 1903* (Lloyd and Rees 1994, pp. 24–25; Sutherland 2004, pp. 40–1).

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 DoD 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. 16–17, 19, 24; 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 men¹ (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 first with the *War Pensions Act 1914*, which provided pensions for widows and disabled veterans that were proportional to the previous military

¹ Of those who enlisted, about 330 000 personnel were deployed (NAA 2018).

pay of the veteran (this later moved to a system based on degree of impairment). 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, p. 81; 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, pp. 88–89).

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. To this end, 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.

Those with peacetime service continued to be covered by the Commonwealth workers' compensation legislation. The *Repatriation Act 1920* (which had succeeded the War Pensions Act) was specific to World War I veterans 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).

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 (if they had both peacetime and war service) (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). These groups played a pivotal role in the continuity and development of the veteran support system.

If sheer necessity was one reason for an enduring commitment to repatriation, the persistence and increasing political power of the client groups constituted another. ... the returned soldiers' groups did not make the mistake of being 'too dam' modest' in their demands. (Lloyd and Rees 1994, p. 416)

The interwar period and World War II

The combination of the massive human toll of World War I and the poor economic conditions that followed put a lot of pressure on both the veteran support system and veterans and their families. 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 veterans' organisations, in 1924 the Australian Government established the Blackburn Royal Commission to examine war pension eligibility (Lloyd and Rees 1994, p. 232). 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 veterans' organisations, in 1929 the government established two appeal tribunals to assess eligibility and the level of disability (Lloyd and Rees 1994, pp. 233–235). 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 disproven (Lloyd and Rees 1994, pp. 276–277). (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.)
- 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 ex-service organisations (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. 251–252, 255). (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. 266)

World War II brought an expansion of the repatriation system to cover the one million Australians who served. Eligibility 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. 273–274). 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 transitioning returned soldiers back into civilian life, 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' for their studies, which ranged from short vocational courses to university-level education (Lloyd and Rees 1994, p. 275).

Critiques and reviews

The early veteran support system, although experimental and sometimes prone to failures (such as land settlement programs), helped returning service personnel and supported them and their families. In particular, it benefited many 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 three quarters of a century would have been incomparably greater’ (Lloyd and Rees 1994, p. 419). 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 the government of the day. By late 1930s, ESOs and the Repatriation 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. 265–266). 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 Senate 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’ (SSCHW 1973, p. 39).

The Senate 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 (SSCHW 1973, pp. 30–33).

The RSL and ESOs 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’ (Toose 1976, p. 1). 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 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 emerged 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, p. 357).

In the 1970s, the Government recognised the desirability of consolidating the six pieces of legislation detailing war veteran benefits into a single Act 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 13).

Health care and other entitlements were also extended

Veteran healthcare entitlements were widened in 1943 to include treatment for all conditions² (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
- peacetime national servicemen in 1973 (and therefore the same compensation and healthcare benefits available to war widows were extended to peacetime veterans' widows)
- 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 DVA 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

² 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).

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 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 et al., which led to (among other changes) the creation of the Defence Force Income Support Allowance in 2004 (chapter 15). 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 et al. 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 *Veterans' Entitlements Act 1986* (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 Australian Defence Force (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 DoD's *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* (Tanzer Review) in 1999 by the DoD, 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
- the new scheme should be funded by a ‘premium’ calculated by the Australian Government Actuary and paid for by DoD (Tanzer 1999, pp. 91–98).

Only the first recommendation was implemented. There was a new scheme for all military personnel five 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 the 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 compensation for pain and suffering for war veterans was designed to be comparable with the VEA and for peacetime veterans, comparable with the 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 2018u).

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 a \$500 million expansion of the Australian War Memorial (Morrison and Chester 2018a).

Box 3.1 **Veteran Centric Reform Program**

The Veteran Centric Reform (VCR) program is the umbrella term for a wide range of initiatives, investments and reforms that Department of Veterans’ Affairs’ (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 IT 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, p. 15).

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 (DVA, sub. 125, p. vi). To implement the VCR program, DVA was allocated \$303 million in funding between 2016-17 to 2018-19, most of which was for major IT infrastructure investments to update over 200 antiquated systems (Australian Government 2016b, 2017c, 2018a). The full VCR program is expected to last six years, with 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).

In addition, DVA funds commemorative activities and facilities, such as war graves and memorials (about \$60 million in 2017-18) (DVA 2018g, 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)

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, veterans’ organisations 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, medically discharged veterans may be eligible for invalidity pensions if their medical state is such that they have a significantly impaired ability to obtain and undertake civilian employment. 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, that can be converted into a pension, 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.

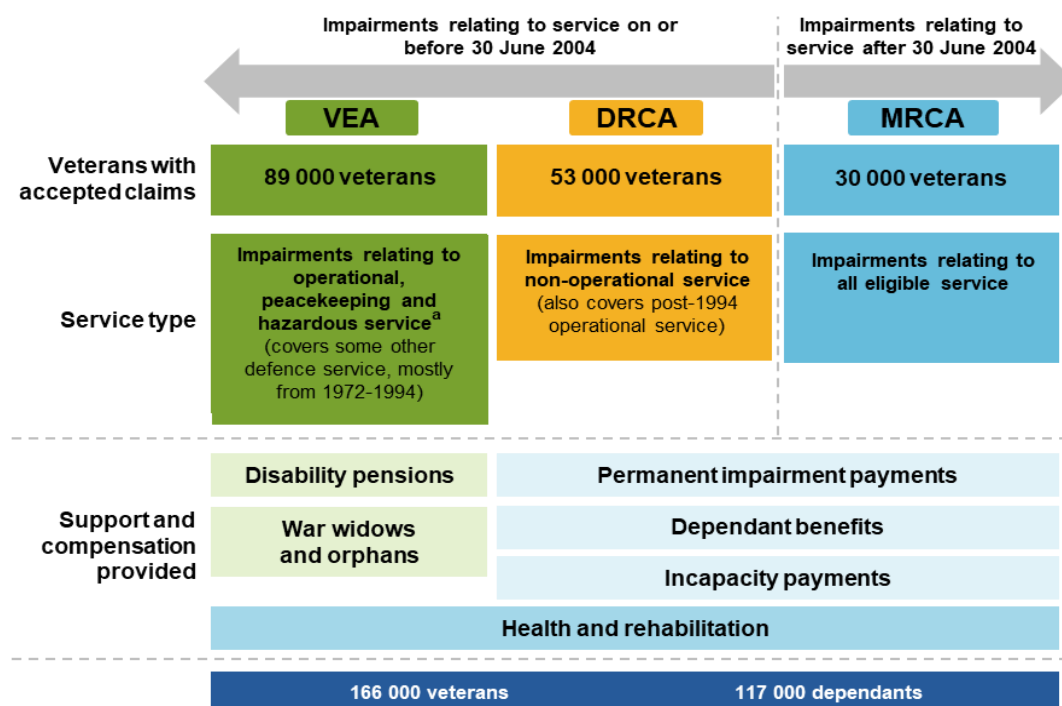
Source: AGA (2018b).

Liability-based supports: the legislation and eligibility requirements

Liability-based supports for veterans and their families are available under three main pieces (the ‘three Acts’) 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 a relatively generous workers’ compensation system with elements of the VEA, such as its eligibility 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.

Source: DVA (2018g, pp. i, 23).

In addition to these three Acts, several other pieces of legislation are also important. The DRCA grandfathers some of the benefits of the previous two Commonwealth workers' compensation systems³ 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 (not including military superannuation insurance and mainstream social security, which veterans and their families may also be entitled to).

A maze of service types

There are a number of service types under the VEA and the MRCA that determine eligibility and the level of benefits.⁴ These service types overlap and can be confusing — with similar terms describing different concepts and similar concepts having different terms.

Although the VEA has a range of service types (box 3.3), the level of liability-based benefits is the same for all service types; the differences are 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-based benefits differ between service types, along with the use of the 'reasonable hypothesis' test (box 3.4).

³ 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.

⁴ 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 (DRCA section 5).

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)
- *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 has used since 1994 to classify service for the purposes of pay and conditions for serving members (ss. 6A–F)
- *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)
- *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 2017d)
- *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 2017d)
- *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 United Nations peacekeeping missions in Mozambique, Haiti and Yugoslavia (s. 120). Since 1997, any service that would be classed as hazardous service would now be declared as 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))
- *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.

Box 3.4 **Service types under the MRCA**

Service under the *Military Rehabilitation and Compensation Act 2004* 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*.

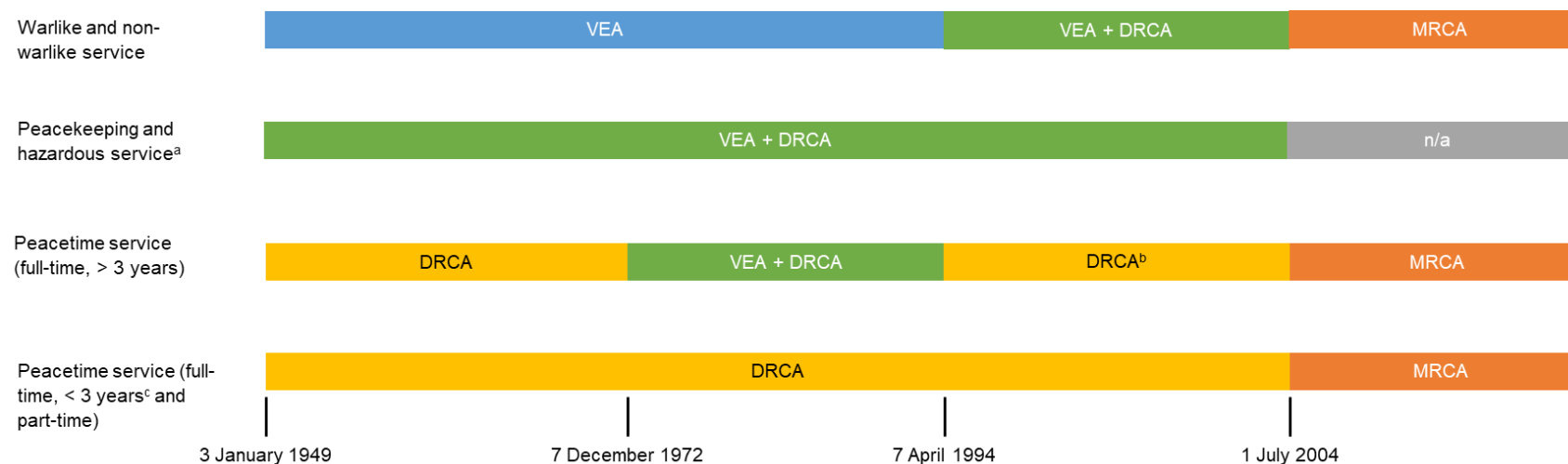
Multiple eligibility

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 13).

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.

- 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 that 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 more generous than that provided by civilian workers’ compensation (chapter 13), and the eligibility rules have numerous traits that are beneficial for claimants. For example:

- under all three Acts: there is no time limit on claims applications, and veterans can generally resubmit claims
- under the *Veterans’ Entitlements Act 1986* and *Military Rehabilitation and Compensation Act 2004*:
 - 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
 - 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 *Veterans’ Entitlements Act 1986*:

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 13).

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 that has a vocational focus (it also includes psychosocial and medical management aspects where relevant to increasing employability) (DVA 2017m).

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 2017p).

Both the MRCA and 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 14).

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 14).

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 provider on an uncapped, no gap basis (DVA 2017k). (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 for medications that treat 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 2017l).

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 Repatriation Pharmaceutical Benefits Scheme schedule regardless of whether they have conditions that relate to service (DVA 2018s).

Veterans can also be eligible for travel allowances (and or be provided transport services) to get to and from medical appointments. (Healthcare entitlements are discussed in more detail in chapters 16 and 17.)

Veteran death benefits and other family supports

Dependants' benefits for a veteran's death (or severe impairment) vary between the different Acts (chapter 14).

Under the VEA, partners (de-facto or spouses) and children (under 16, or under 25 and undertaking full-time studies) dependent on a veteran have access to war widow(er)'s and orphan's pensions respectively if the death of the veteran is related to their service. 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 2017j). 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 of age (chapter 15). 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 14).

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 who is not employed) who would have been wholly dependent on the deceased veteran, had they not died (chapter 14).

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 13).

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 (chapter 14).

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 2018f).

The 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.

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. It is taxable and subject to a means tests (DVA 2016f).

The Gold Card is another support available to veterans who have qualifying service (and certain other categories, chapter 16) and are aged 70 years or older, without the need to prove a condition was related to their service. 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 2018f).

Non-liability health care

The DVA offers free, uncapped health care (‘non-liability health care’) for certain conditions without the need to show a link to service through the provision of White Cards. The conditions are any mental health condition, cancer (malignant neoplasm) and pulmonary tuberculosis (chapter 16).

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. This includes reservists who have rendered any period of continuous full-time service 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 2018t).

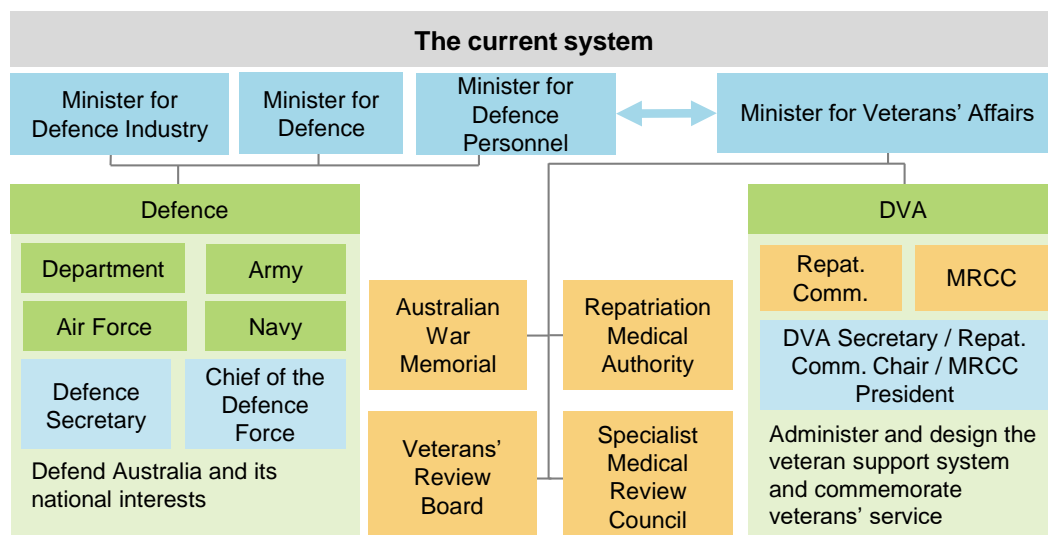
Governance arrangements

Several government bodies are directly involved in governing the current system of veteran support — Defence and the 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. DVA 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 (for the MRCA and DRCA). These two Commissions share common functions and membership, with the Military Rehabilitation and Compensation Commission having a few specific extra members — two from Defence and the chief executive officer of Comcare.

Most State and Territory governments also have veterans' ministries or small offices within ministries that are generally directed to policy advice, advocacy and accessibility related to services for veterans provided at the state level. Some governments also have employment-related initiatives and localised support activities.

Figure 3.3 **Governance of veteran support**



Veterans' organisations and their advocates

The veteran support system is highly dependent on veteran advocates (typically volunteer) provided by the veterans' organisations. Advocates help veterans understand their

entitlements and submit claims to DVA. They can also represent veterans to DVA and act as representatives (in place of lawyers) at appeal.

Veterans' organisations 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. Veterans' organisations and their functions are discussed in more detail in chapter 12.

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. This equates to about \$47 000 per client. In 2017-18, DVA allocated:

- \$7.4 billion was allocated to compensation (and income support)
- \$5.3 billion to health care (and rehabilitation and community care)
- \$437 million on enabling services such as workplace training, financial management and information technology
- \$60 million for commemorative activities and facilities (DVA 2018g, p. i).

In the same year, about \$800 million in invalidity pensions and death benefits was paid to veterans and their families by the Commonwealth Superannuation Corporation. The ADF spent about \$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 Defence's \$32.8 billion budget in the same year (DoD 2018f, p. 148).

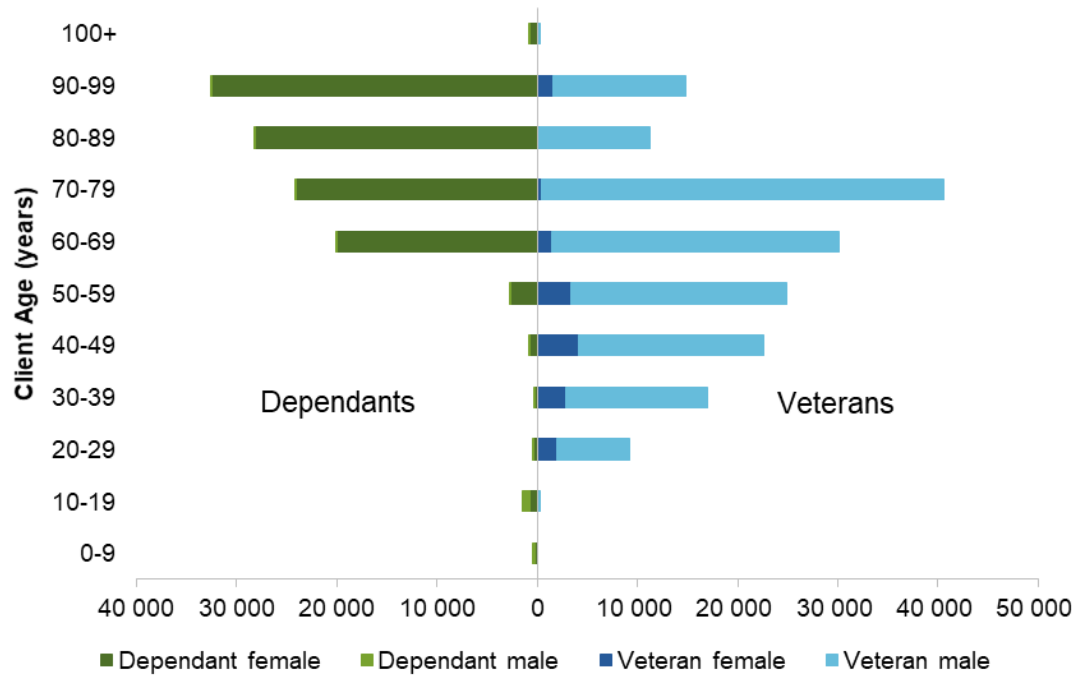
About DVA clients

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. 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 — only 10 per cent are below the age of 40 years old and over half are 70 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 (as at December 2018)



Source: Productivity Commission estimates based on unpublished DVA data.

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 II veterans is shrinking rapidly (discussed below).

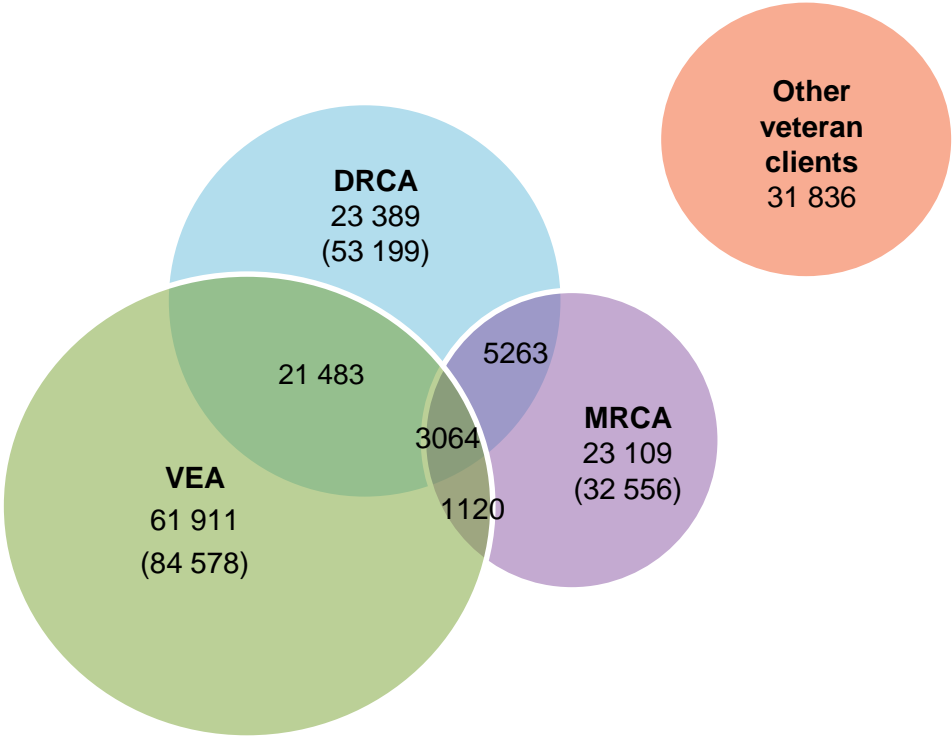
Commenting on its changing client base, DVA said ‘this change ... has created both more intensive health needs of an older, but declining, cohort, and more complex needs to younger cohorts’ (sub. 125, p. 14).

DVA clients — what Acts are they covered by?

More than 85 000 veterans have conditions accepted under the VEA, about 53 000 under DRCA and about 33 000 under MRCA (figure 3.5). Many veterans (about 30 000) have accepted conditions under multiple Acts — the majority (21 483) of these are veterans with claims under both VEA and DRCA.

Veterans with conditions accepted under VEA are the oldest group (the average age is 73 years). The average age of veterans with claims under DRCA is 53 years and 35 years for MRCA (Commission estimates based on unpublished DVA data).¹

Figure 3.5 **Veterans (DVA clients) with accepted conditions by Act^a**
As at June 2018



^a A DVA client with an accepted condition is a veteran with an injury or illness that DVA has accepted is related to service. 'Other veteran clients' are DVA veteran clients who do not have an accepted disability — including those receiving non-liability White Cards or Gold Cards given to veterans over 70 years old. These figures do not align precisely with the figures in the latest DVA annual report. Numbers in brackets are the total number of people under an Act, including those that are also eligible under other Acts.

Source: Commission estimates based on unpublished DVA data.

Expenditure on entitlements under the three Acts

The breakdown of expenditure under the three Acts differs depending on whether you only include cash flows or also include changes in DVA's liability for future expenditure under MRCA and DRCA (as DVA includes in its expenditure figures in its annual reports).

¹ These values count only clients who are eligible under a single Act, to avoid double counting.

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 VEA² and that non-liability health care (although available to all) is legislated in the VEA (Commission estimates based on unpublished DVA data; DVA 2018at).
- *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 the 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 two per cent of MRCA spending was on dependant benefits (unpublished DVA data).

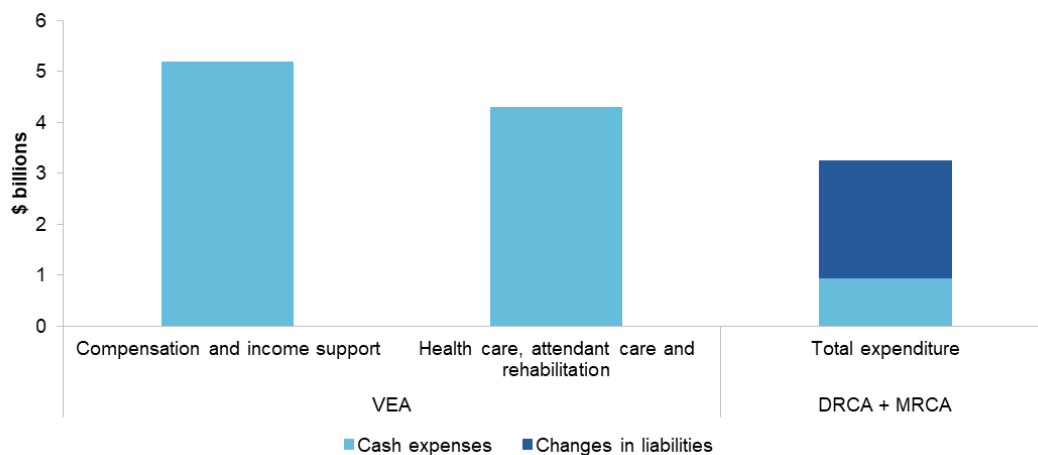
The pattern of DRCA outlays is similar to that for the MRCA.

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 into the future.

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.

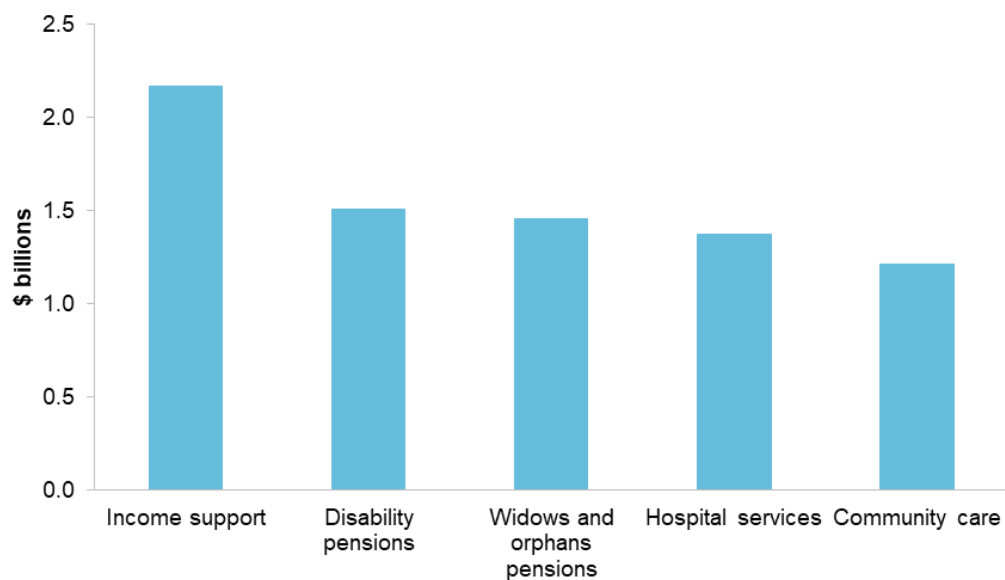
² The most common eligibility pathways for the Gold Card are via qualifying service/age and being a dependant of a deceased veteran (under various circumstances). Each of these are concentrated in older cohorts of DVA clients.

Figure 3.6 Costs under VEA and the other Acts
2017-18



Source: Productivity Commission estimates based on unpublished DVA data.

Figure 3.7 Spending on VEA programs^a
2017-18



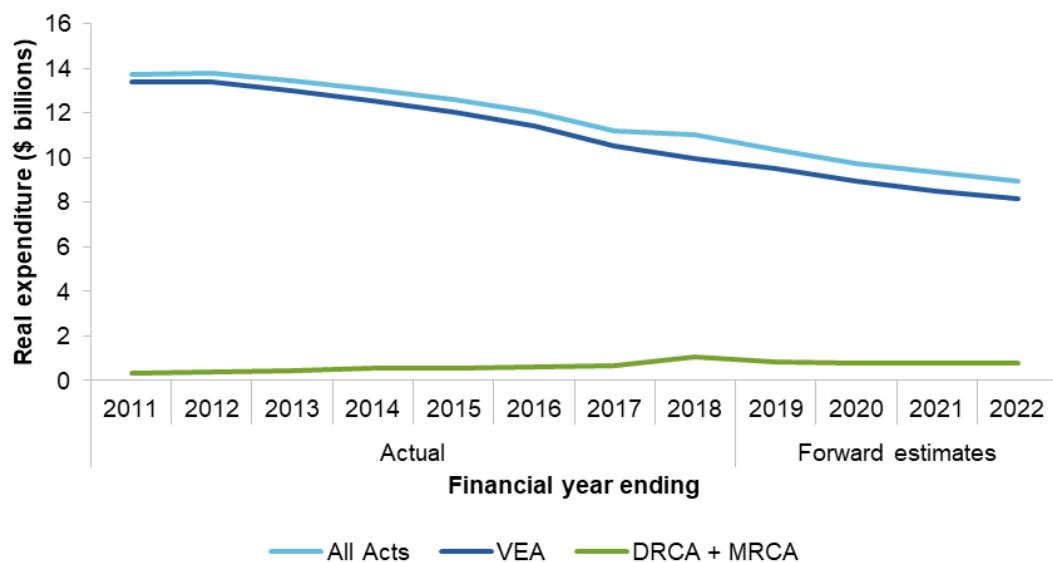
^a Excluding departmental costs.

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, which 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.

Sources: Productivity Commission estimates based on DVA (2011a, 2012, 2013b, 2014d, 2015e, 2016k, 2017o, 2018ai).

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).³

³ This may be due to the effects of age-based eligibility for some DVA benefits, including the service pensions and the Gold Card, which tend to increase the costs of providing clients with support as they age.

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 Department of Veterans' Affairs 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 they die.

The cost of providing supports to Department of Veterans' Affairs 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.

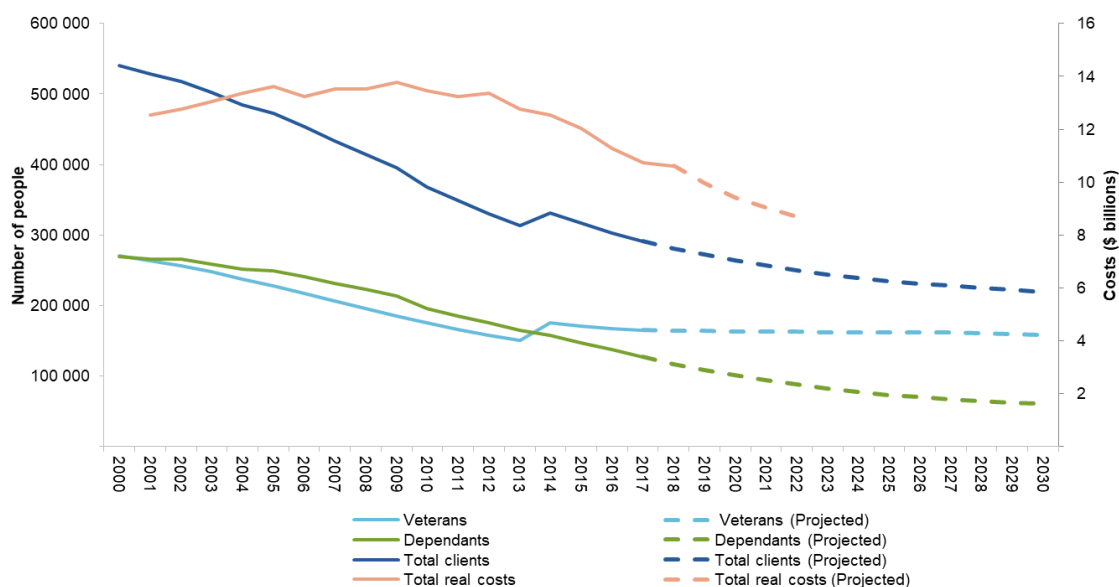
As with the changes in expenditure noted above, the changes in client numbers vary under the different Acts:

- 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

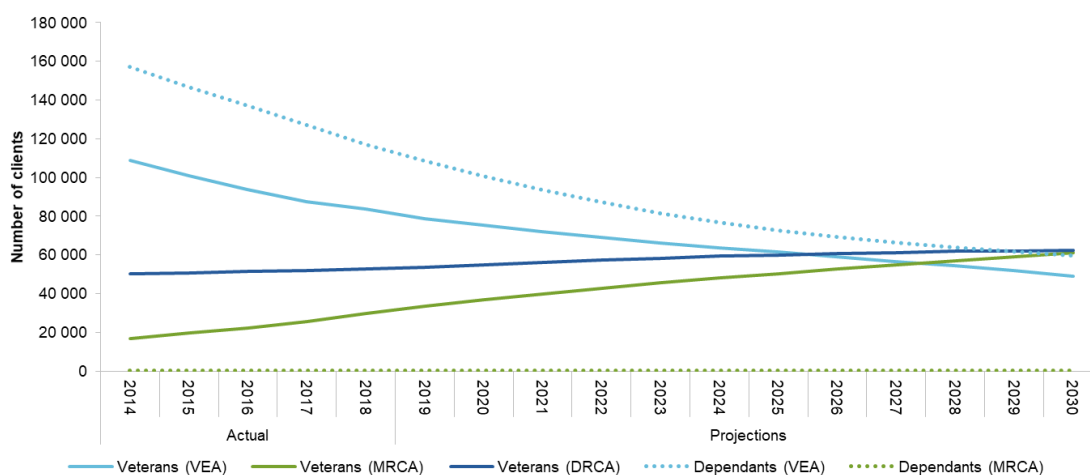


^a Using ABS (*Consumer Price Index, Australia, Sep 2018*, Cat. no. 6401.0) to adjust for inflation in historical data. For forecasts, inflation was assumed to be the mid-point of the Reserve Bank of Australia's medium-term inflation target (2.5 per cent each year). Costs are cash expenditure excluding accruals, commemorations and departmental expenses, and so may differ from the figures in DVA annual reports.

Sources: Commission estimates based on DVA (2018ai, pp. 30, 43, 2018m) and unpublished DVA data.

Figure 3.10 VEA veterans and dependants 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).

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, the expected cost of supporting veterans injured during recent service, under the MRCA, has been increasing — which has implications for the future cost of the system.

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 compensation system presents a number of challenges because of limited data. 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 are heavily influenced by 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.

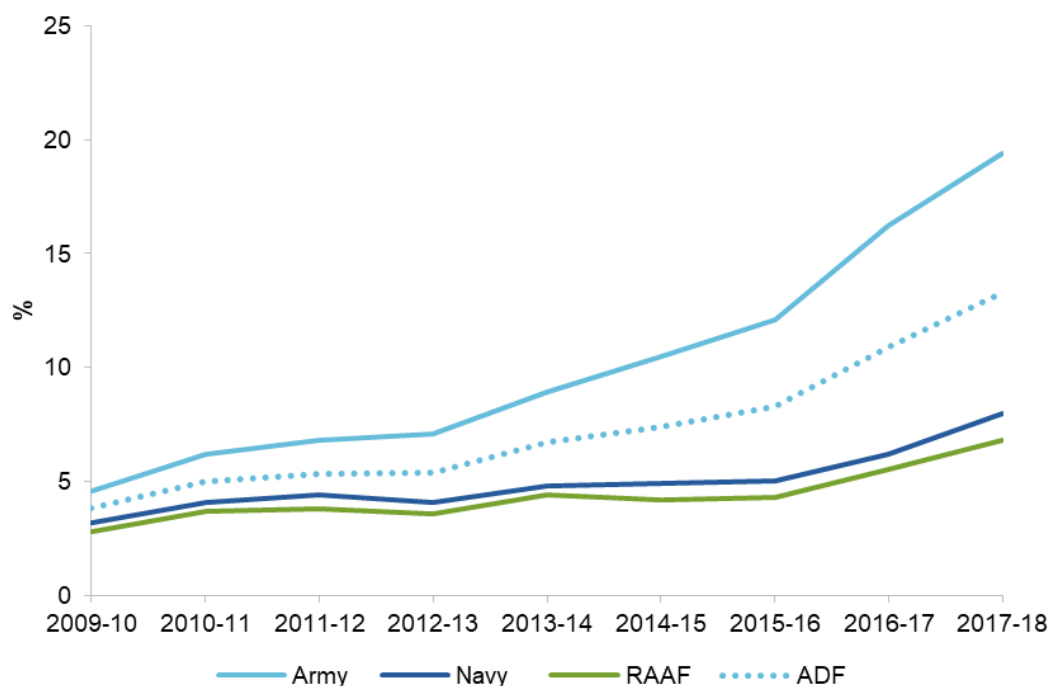
Also, in actuarial terms, MRCA is far from fully mature, with experience limited to at most 13.5 years after the injury date. This is in the context of payment obligations that could continue for 50 or more years after the injury date (entitlements are still being paid by DVA for dependants of World War I veterans). The AGA also does not have access to detailed ADF 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. (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.
 Sources: AGA (2013, 2014, 2015, 2017, 2017, 2018a).

There are a number of potential reasons for the rise in the estimated cost of new injuries to under the MRCA and DRCA (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 expected increase in the cost of new military injuries.

Increasing number of claims under DRCA and MRCA

New initial liability claims under the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA) and *Military Rehabilitation and Compensation Act 2004* (MRCA) have increased significantly — on average over 20 per cent per year over the past five years (2012-13 to 2017-18) (calculated from DVA (2014b, 2015b, 2016c, 2017f, 2018g)). 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 Australian Defence Force 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 past 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 an increased number of Gold Cards issued under the MRCA — from about 600 to 2300 over four years (DVA 2018at) — 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 13.)

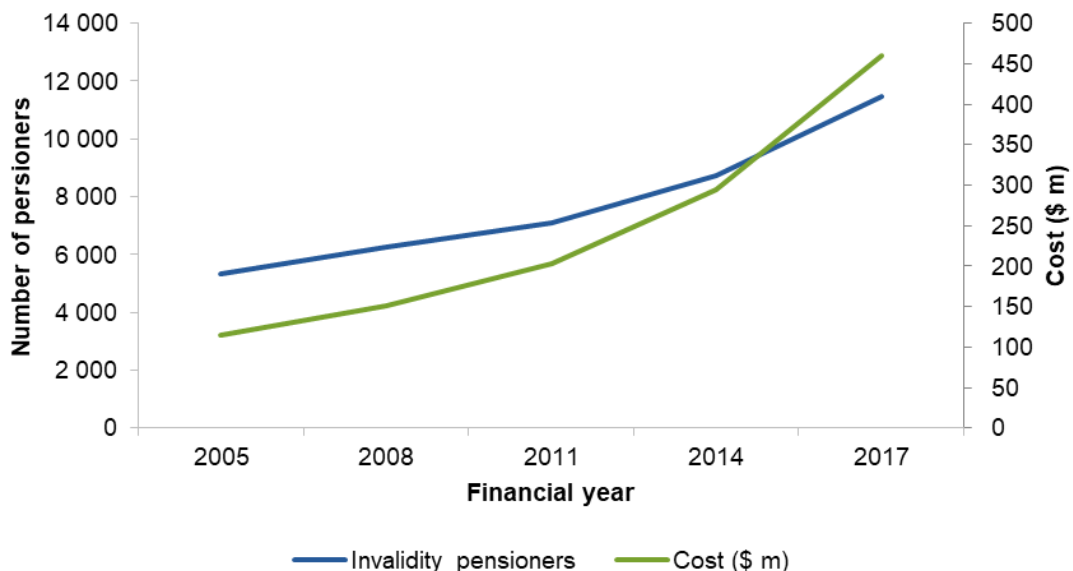
Increasing aggregate cost of permanent impairment payments

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 past 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 14).

The costs and clients 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; JHC 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'.

Sources: AGA (2006, p. 8, 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 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:

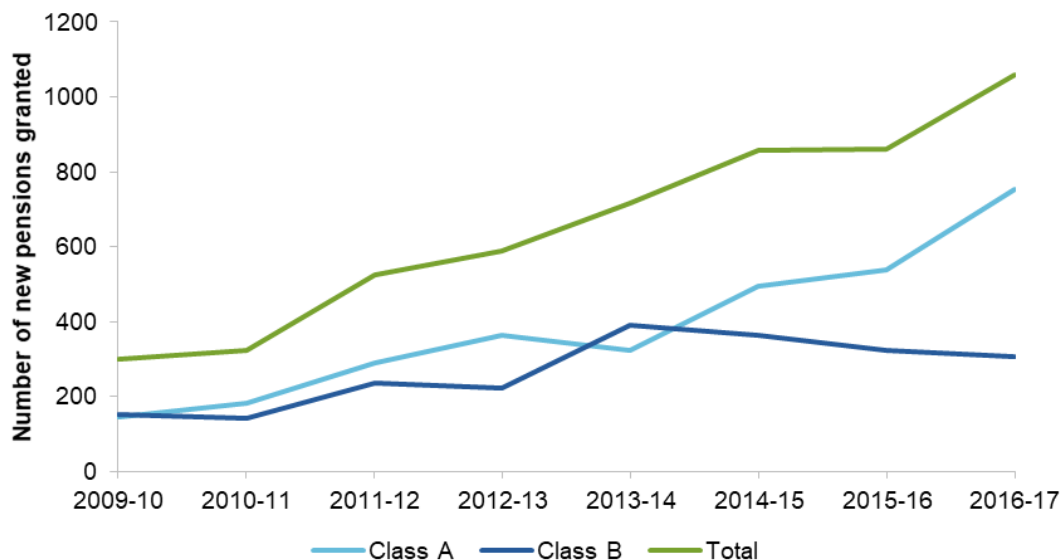
- increasing acknowledgment of PTSD and other mental health conditions
- the ADF has encouraged earlier reporting of injuries and incidents. This may have made individuals more aware of military compensation payments and invalidity pensions, and may in turn have made it more acceptable to claim these 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
By class



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 about 18 per cent⁴ as a

⁴ 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).

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 Defence. 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 health care and rehabilitation so they can participate in employment and life
 - providing effective support to facilitate successful transition to civilian life for veterans and their families following discharge
 - 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.
- The objectives and principles are consistent with best practice workers’ compensation and contemporary social insurance schemes (which focus 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 to do so.
- 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 was asked to look at whether the system of compensation and rehabilitation for veterans is ‘fit for purpose now and into the future’. It was also 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 veteran compensation and rehabilitation system and the principles that underpin the system is an important 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 into system design and underlying principles for effective support systems. Section 4.3 outlines the principles that should underpin the veteran support system. Section 4.4 discusses some policy design issues, including the different treatment of operational and peacetime service and the rationale for a separate veteran support scheme.

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 that 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 2018e, p. 9688).

Many participants to this inquiry also spoke about the Government's commitment to veterans and the recent announcement of a military covenant confirms this commitment to supporting ADF personnel and veterans (box 4.1; Morrison and Chester 2018b).

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' 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 of SA:

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)

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 illnesses (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 dependants 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)

Contributions 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 the Roll of Honour (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.

Australia has also had a separate veteran support system for over 100 years (chapter 3). DVA, commenting on the objectives of the current veteran support system, said they were:

... 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)

The objectives of the system, however, are not clearly set out in legislation (box 4.2).

Box 4.2 The objectives of the system are not defined in legislation

Across the three relevant pieces of veteran legislation, none have legislated objectives against which performance can be measured. The titles of the legislation, however, provide some insights on objectives.

- *Veterans' Entitlement Act 1986* (VEA): 'An Act to provide for the payment of pensions and other benefits to, and to provide medical and other treatment for, veterans and certain other persons, and for other purposes'.
- *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA): 'An Act relating to the rehabilitation and treatment of, and compensation for, members of the Defence Force, and for related purposes'.
- *Military Rehabilitation and Compensation Act 2004* (MRCA): 'An Act to provide rehabilitation, compensation and other entitlements for veterans, members and former members of the Defence Force, and for other purposes'.

While the common theme is providing support for veterans, the different Acts appear to have different concepts about what best constitutes support — the VEA has a focus on compensation, while the DRCA and MRCA have more of a focus on rehabilitation.

Some participants pointed out this dichotomy of objectives and priorities:

... there is conflict in the current mix regarding DVA intent. We have a VEA which is clearly compensation-focussed and DRCA and MRCA which have the legislative capacity to deliver very effective rehabilitation and wellness services. (RSL QLD, sub. 73, p. 6)

... the current system fails to uphold those priority objectives [outlined in the Commission's issues paper], in particular because the VEA has a very inadequate focus on rehabilitation and return to a fulfilled civilian life ... [the DRCA] had a much improved focus on rehabilitation. (Peter Sutherland, sub. 108, p. 1)

And 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 of SA 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) of 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 good outcomes for veterans while ensuring value for taxpayers' money (box 4.3).

Box 4.3 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 [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 of Australia (NSW branch) 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)

Dr Dabovich:

When our veterans are transferred to the care of DVA they also have no accountability because it's an open ended resourcing to which they are not motivated to monitor, and I think, you know, I am not one to suggest that our spending on veterans' health ought to be capped, but we need to do it more responsibly. (trans., p. 960)

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)

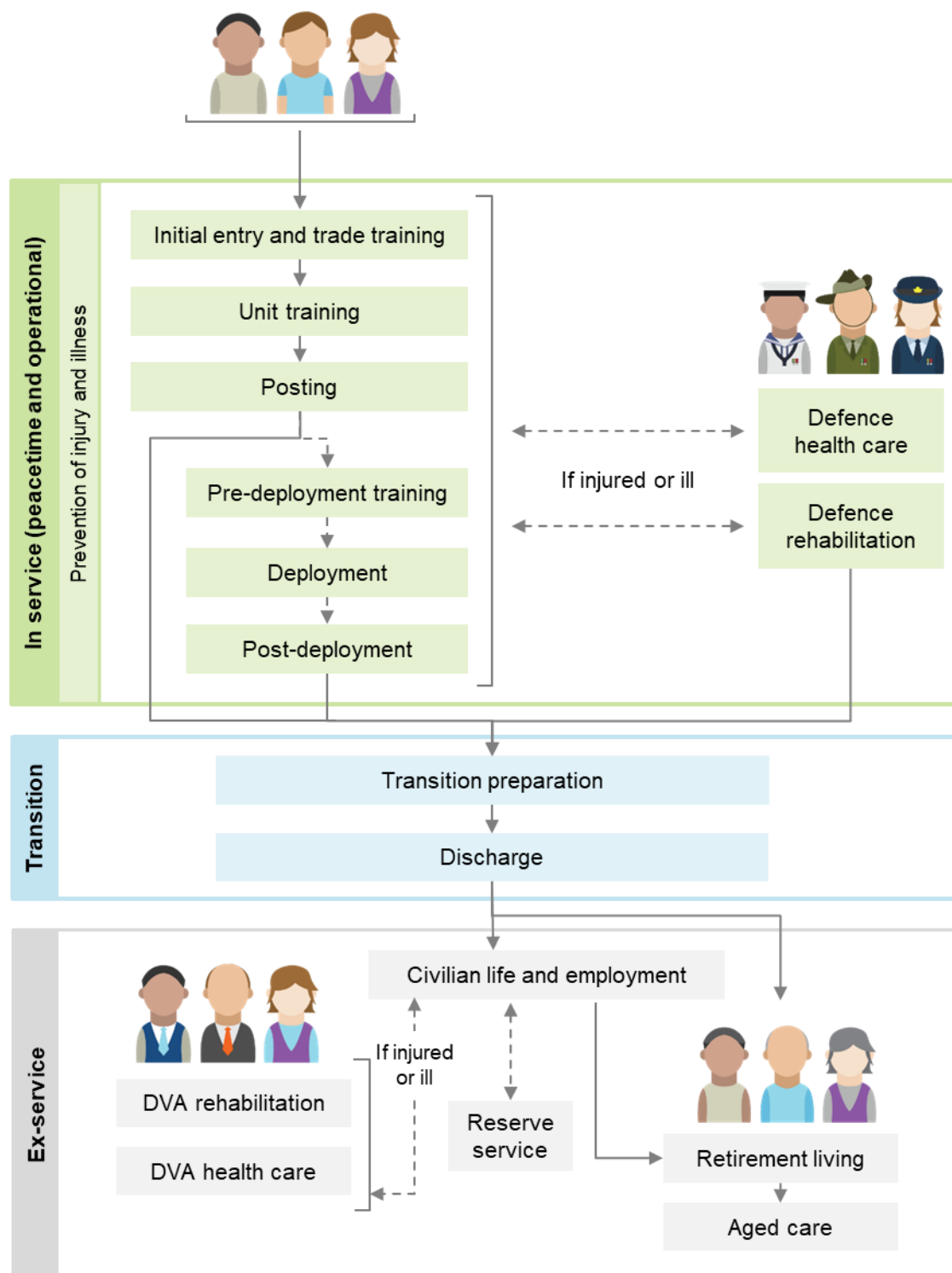
DVA also acknowledges that a core issue ‘as it progressively implements the veteran-centric model will be the extent to which it focuses on the *whole-of-life wellbeing* of veterans’, and that this is not its current focus:

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 life 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 long-term 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.

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 4.4).

That said, since the system's inception (about 100 years ago) knowledge about how to best respond to veterans' needs has broadened significantly.

Box 4.4 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 ... (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' wellbeing¹ (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 and their relationship to support is discussed below.

Figure 4.2 **A model of veterans' wellbeing**

Domains of wellbeing



Sources: Productivity Commission analysis, 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). The wellbeing of individuals can also influence their physical and mental health, leading to two-way feedback loops². Health is also important for the wellbeing of the broader community as healthy people are more productive and better able to engage with others.

¹ Though there are many competing definitions of wellbeing, the Commission has chosen to define veteran and family wellbeing as the physical, mental and emotional state of the individual.

² Some studies have shown that having positive or negative feelings (a proxy of wellbeing) can predict short- and long-term longevity (Stegeman 2014, p. 9).

Understanding the factors driving the physical and mental health of veterans is important for designing supports. 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 various (mental and physical) injuries and illnesses 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 incidence of mental health disorders among veterans and the importance of providing appropriate support. For example, Orygen (the National Centre of Excellence in Youth Mental Health) 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)

In a recent survey one in three 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 2018g, p. 1).

Some stakeholders noted the increasing proportion of women in the military also has ramifications for understanding veterans' health needs. For example, DVA (sub. 125, p. 14) noted that female veterans are more likely to need support for issues such as domestic violence, female health, and physical or sexual abuse or harassment.

Employment

Employment provides individuals with a sense of purpose and plays a substantial role in their quality of life — including in their mental health. The benefits of employment manifest themselves through greater financial independence, facilitating social relationships and enhancing emotional wellbeing (AIHW 2018d, p. 13).³ As with health, the overall wellbeing of the individual can also impact their ability to obtain employment.

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

³ Reviewing data from the ABS's National Health Survey, Flatau, Galea and Ray (2000) found that the unemployed exhibit poor mental health and wellbeing outcomes relative to the full-time employed.

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 features 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 2017b; Orygen, 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 of poorly integrating into civilian life 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 recurring theme (box 4.5).

Box 4.5 The importance of work for wellbeing

Many submissions mentioned the importance of work for the wellbeing of veterans.

Returned and Services League of 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:

... 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)

Department of Veterans' Affairs said:

Gaining employment, where appropriate, after leaving military service is a crucial element for the long-term health and wellbeing of veterans and their families, and particularly to achieve positive mental health outcomes. (sub. 125, p. 38)

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). The evidence shows that most of the impact of education on wellbeing is indirect, via its effect on income and health (Dolan, Tessa and White 2008).

As discussed above, many veterans have 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 (discussed above), and securing housing (discussed below).

Income and wealth

Financial status is also a significant factor in wellbeing, influencing, inter alia, an individual's independence, access to quality housing and family stability. The literature on the association between financial wealth and happiness generally indicates that when income falls below some threshold, wellbeing declines.⁴ And low-income status can cause poorer health outcomes and physiological distress for a person (AIHW 2018d, p. 22). There is also some evidence that the effect of being in poverty can lead to poorer decision making, which can have other adverse effects on wellbeing (Shah, Mullaithan and Shafir 2012).

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 be facing additional costs as they transition (relocation, housing and healthcare costs). And veterans who leave the military because of illness or disability can have a 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.

⁴ The wellbeing impact of extra money, once a certain threshold of wealth has been reached, is more controversial. The 'Easterling' paradox, inter alia, implied that *relative income* was a more important determinant of happiness than *absolute income*. However, more recent and richer cross-country data have cast doubt on this (Stevenson and Wolfers 2008).

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. Both perceived and actual social support are strongly predictive of wellbeing (Deiner and Seligman 2002; Siedlecki et al. 2014). 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).

The peer support offered through ex-service organisations also has 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, too, 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.

That said, in many instances, families should not be the sole source of support. 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 2018ac)

Recognition for service

Recognition for service can also be important for the wellbeing of veterans. As Brendan Nelson said:

One of the contributors to post traumatic stress is 'meaninglessness'. If you think that what you did doesn't count, that it's not appreciated, known and understood by your nation, and that your people are proud of it, you are more likely to suffer. (Nelson 2019)

As discussed earlier, commemorations, parades and other public ceremonies are important for recognising veterans' service, and they are a way of connecting veterans to the broader community. As DVA put it:

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)

Not all service needs be recognised the same way, and some veterans do not want any recognition for service. While the Commission has used the Australian Government's definition of a veteran (as anyone with a single day of continuous military service), it also recognises that a day of service is not same as many years of service or being deployed on operational service. It is important that recognition appropriately differentiates between the different kinds of service.

Recognition can also be important for the families of veterans. The War Widows' Guild of Australia encouraged the Commission to 'recognise, support and celebrate the Defence Family in the future arrangements for compensation and rehabilitation' (sub. 87, p. 2). Brendan Nelson also relayed the story of a mother of a commando who was killed in a Blackhawk crash in Kandahar, saying 'Thank you for making my son's memory live' on seeing the Afghanistan exhibition at the War Memorial (Nelson 2019).

Housing

Secure housing is an important determinant of the health, employment, education and social connections of veterans. Generally the location of a home can affect one's access to education, employment, medical services and public amenities (which promote 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. However, some veterans when they leave the service can find it difficult to secure suitable housing.

International evidence suggests that veterans are at greater risk of homelessness (chapter 7). And while there are a lack of good Australian data, surveys of (self-identifying) inner-city homeless populations have found that veterans were overrepresented (chapter 2). Homelessness is strongly associated with mental health problems — about one-third of those accessing homelessness services in Australia were experiencing mental health problems (AIHW 2018h, p. 43).

4.2 Best-practice features of other support 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 schemes. In these schemes, the focus is on getting the best outcomes for injured or ill 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 4.6). 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)

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 stakeholder expectations over an extended period so there is no financial need or political imperative to reform the scheme' (ICA 2015, pp. 3, 9). Employers Mutual Limited (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.

Box 4.6 Objectives and best-practice criteria

Insurance Council of Australia

The Insurance Council of Australia considers the following as appropriate objectives of workers' compensation schemes:

- to contribute to the prevention of injuries
- to support injured workers in returning to work/assist with full recovery
- to compensate fairly
- be affordable and financially viable (charge employers premiums that are affordable, reflect risk and fully fund the liability) (ICA 2015).

May and Casey

May and Casey identify similar objectives to the Insurance Council of Australia 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 are 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 (May and Casey 2014).

Heads of Workers' Compensation Authorities

The Heads of Workers' Compensation Authorities, commenting on features of well-functioning schemes, said these included:

... a workplace-based approach to managing injury, rehabilitation and return to work, supported by strong financial incentives and obligations for employers to get injured workers quickly and safely back to work and for workers to participate in focused programmes aimed at return to work ... 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)

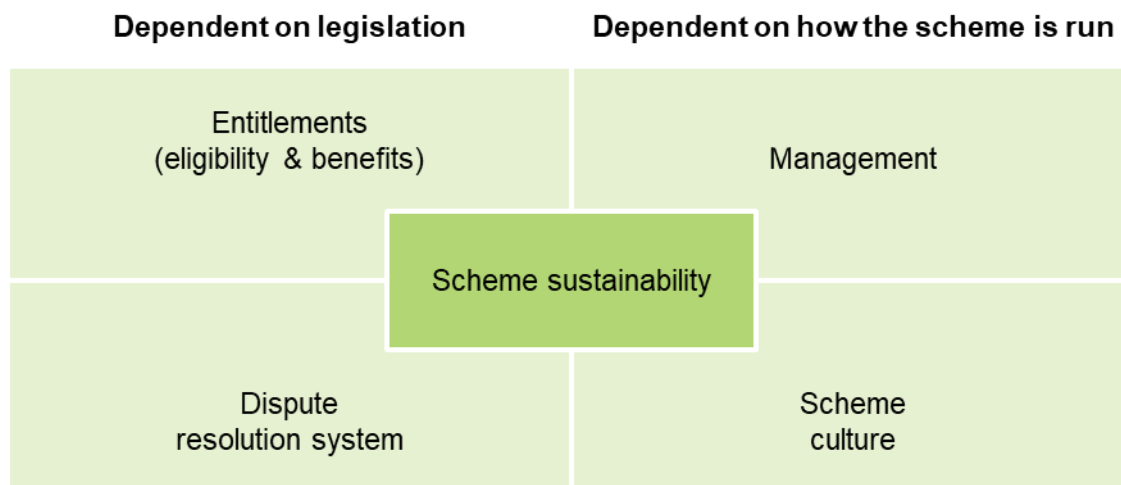
The features identified as driving scheme sustainability include:

- 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’ (ICA 2015, p. 10).

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 and on other issues, 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:

-
- high employer engagement in claim outcomes
 - open and transparent decision making
 - low appeal rates for decisions (ICA 2015).

Further, a strong emphasis on early rehabilitation and return to work — under the premise that return to work is good for you — is another element that is increasingly important for both the wellbeing of those injured and for the financial sustainability of the scheme (May and Casey 2014).

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 4.7).

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 2011a, p. 98). Using the example of someone who has lost a limb, 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)

Box 4.7 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 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 by individual decision makers.

Sources: PC (2011a, 2017d).

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 the link between 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)

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 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. (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 4.8). One shared feature is that they all have a separate support system for (at least war) veterans.

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). Returned and Services League of 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 4.8 **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 time and countries 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 (among those reviewed) 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 health care 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 directly 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 vary. 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, the Returned & Services League of 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 United States and the United Kingdom. (sub. 113, p. 26)

Sources: Campbell (2011b); NZLC (2008); Paterson (2018b); UK Ministry of Defence (2016a); 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 adverse effects of service) and taking a whole-of-life approach, the priorities of the system are about restoring veterans to their pre-service state (as far as practicable). 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 helps recovery and for that reason it 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 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 the workforce 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 (to ensure continued access to a stream of compensation)
- the compensation process itself can be stressful due to delays, cumbersome processes and the complexity of the system (May and Casey 2014).

These risks point to the need for careful design and administration of the compensation element of the veteran support system.

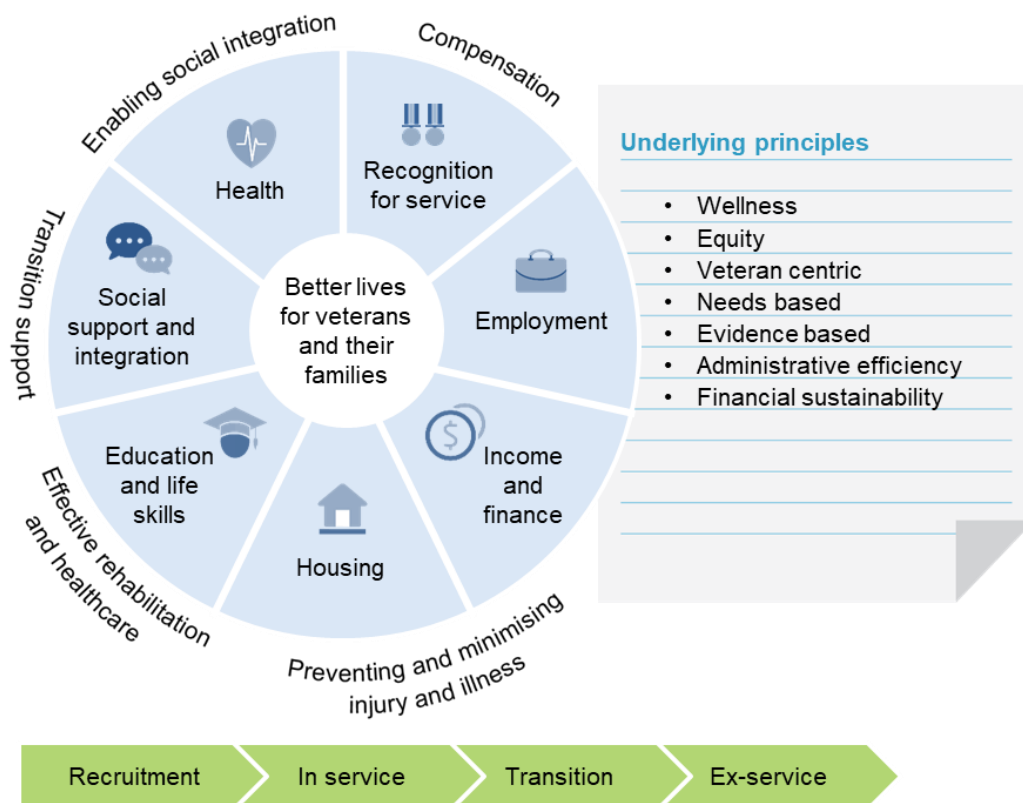
Any government system should also aim to be efficient, affordable (for taxpayers) and sustainable. A focus on efficiency and financial sustainability requires an understanding of cost drivers and support outcomes (which requires monitoring and analysis of data). A focus on sustainability is the means for achieving the best outcomes for both veterans and their families, and the community.

The 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 — achieving value for money and best outcomes for all stakeholders.

The Commission used these principles to assess the current veteran support system and the design of a future system (figure 4.4). The inner circle of the left side of the figure are domains of veteran wellbeing, while the outer circle presents the objectives of veteran support. The principles underlying this system sit beside the circle.

Figure 4.4 **Objectives and principles of veteran supports**



There was strong support for the Commission's proposed objectives and principles for the veteran support system (box 4.9).

Box 4.9 What participants said about the Commission's proposed objectives and principles

Air Force Association:

The proposed principles and overarching objectives of the veteran support system could not be refuted and, therefore, are strongly endorsed. The pursuit for wellbeing is the cornerstone of an effective veterans' compensation and rehabilitation system. The stated principles and objectives must be reflected in veterans support legislation, and not just in the preamble, so that their inclusion in the governance and administration of the system is assured regardless of the type of entity that has custodianship. (sub. DR267, p. 1)

David Peterson:

The system should embrace the wellness model as referenced in the draft report ... This model should simultaneously seek to maximise the return on investment made by the Commonwealth whilst simultaneously achieving the best possible wellbeing for service members and Veterans. (sub. DR223, p. 2)

David Kelly and David Jamison:

It is agreed that the overarching objective of the veteran support system should be to improve the lives or wellbeing of veterans and their families, be wellness focused and be administratively efficient. (sub. DR212, p. 3)

Returned and Services League of Australian (Queensland branch):

... fully supports this recommendation with the added proviso that there should be no detriment to existing entitlements for veterans. (sub. DR256, p. 10)

The War Widows Guild of Australia:

... agrees that wellness and a whole-of-life approach to the support of veterans should be the overarching goal of any veteran support system and that this should be focused on ability rather than disability. This goal should be higher in priority than any financial considerations. (sub. DR278, p. 4)

Alliance of Defence Service Organisations:

... supports without reservation ... the objectives and principles the Inquiry outlines ... (sub. DR247, p. ii)

RECOMMENDATION 4.1 OBJECTIVES AND PRINCIPLES FOR THE VETERAN SUPPORT SYSTEM

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 and their families 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 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 substantially different levels of compensation and support.

Some participants argued that the distinctions are unfair and should be removed (box 4.10).

Box 4.10 Participants’ comments on the distinction between types of service

Some participants said that making benefits contingent on service types is inequitable:

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)

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, diseases 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 of SA, sub. 96, pp. 3–4)

RSL NSW stands behind the principle that every veteran, no matter when or how they served, should be treated equally; that it is unfair for three equal conditions, sustained in different serving contexts, to receive different levels of compensation. (RSL NSW, sub. 151, p. 6)

However, others supported service distinctions for these purposes:

... 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. (RSL Queensland, sub. 73, p. 14)

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 warlike conditions. (Vietnam Veterans Association of Australia, sub. 78, p. 1)

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. As one participant said:

The lines between peacetime, peacekeeping, peacemaking, combat and training are often blurred and entangled. Units are held at high readiness for combat and the state of readiness requires challenging, frequent and often dangerous training. Today, our highly professional soldiers, sailors and airmen are expected to go from their living room to combat (and potentially back) in a matter of hours — not the months of sea voyages that preceded our First World War volunteer citizen soldiers. (David Petersen, sub. DR223, p. 2)

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 4.10).

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 three-quarters 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.

In the Commission’s view, veterans’ compensation arrangements ideally should treat injuries and illnesses 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 separate 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 Defence Force Welfare Association 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 high 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 an expectation by many in the community 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 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 remunerate for the 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 compensated for through higher 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 or indeed any other civilian who suffers the same loss. There are similar arguments as to why 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, not only are military personnel compensated, ex post, more than their civilian counterparts for the same harm incurred, they receive higher pay and allowances — some of which are explicitly for risk — than many of their civilian counterparts. It is unclear why it is necessary to remunerate a higher rate for the risk before it is incurred and provide a higher level of compensation once harm is incurred for the same injury relative to civilian norms.

Nevertheless, governments have frequently justified extensions to supports as a means of recognising the risks and onerous nature of military service (chapter 3). 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.

FINDING 4.1

The Commission acknowledges that there are different risks, hardships and requirements of operational and peacetime service, and these are recognised in remuneration, allowances and honours. However, in principle, the basis for providing support should be *need*, not how or when an injury or illness was acquired. For compensation and support, the distinction between different types of military service should be removed where it is both practicable and cost-effective to do so.

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 17).
- 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 Defence Force Welfare Association, 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 significant transitional costs and difficulties involved in any move to shift the provision of particular veteran services to mainstream health and welfare systems. As with any area of policy, the costs of reform options need to be considered along with the benefits.

Summing up

Many considerations are involved in assessing the current veteran support system.

Military service creates unique needs among veterans and their families 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 who are adversely 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 (as far as practicable) 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 unpin a modern veteran support system are that it should be:

- wellness focused (*ability* not disability), veteran centric (including recognition of the unique needs resulting from military service), equitable and needs based
- administratively efficient, financially sustainable, affordable, and evidence based.

Distinctions between different types of military service for the purpose of compensation are inequitable, and should be removed or reduced where practicable 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 regulations where it is involved in overseas operations: these exemptions, though, are relatively minor.
- Defence's *Work Health and Safety Strategy 2017–2022* sets out 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 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.
- ADF command at all levels have an incentive to prevent injury and illness (particularly to maximise force readiness) 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 data should be incorporated with other datasets, such as the Defence eHealth System and the Department of Veterans Affairs' claims database.
- Publishing the complete annual actuarial report for the 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 over 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.
- In addition to its core functions of defending Australia and protecting and advancing Australia's strategic interests, Defence also has a broader responsibility to respect and support members of the ADF, having regard to their life-time wellbeing.

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.
- Section 5.6 considers the case to extend Defence's existing duty of care to its personnel beyond the standard WHS duty of care, to include a broader responsibility for their lifetime wellbeing.

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 arising from in-service medical treatment and rehabilitation costs, and liabilities for compensation, healthcare and rehabilitation 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, Defence reported:

- three fatalities
- 277 people sustained a serious injury or illness
- 8937 people sustained a minor injury (DoD 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 2018g, 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 could be similar to that indicated by this study.

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. The effect of injury or illness on operational capability is therefore likely to be 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 was 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, Ozanne-Smith and Pope 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.

WHS 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

¹ Costs cover medical treatment and rehabilitation for serving members, irrespective of whether their injury or illness was service- or non-service-related. The Royal Australasian College of Physicians indicated that at least 20 per cent of presentations to ADF health services are service related (sub. DR234, p. 4).

representative (Chief of the Defence Force 2012, p. 4; DoD 2017i, p. 2) — the exemptions are relatively minor.

The work health and safety (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. 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 WHS 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, 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 (and the penalties for a breach of that duty) 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).

Defence is also subject to the *Public Governance Performance and Accountability Act 2013*. This Act requires Defence to ‘establish and maintain an appropriate system of risk oversight and management for the entity’ (s. 16). 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. 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.

The Victims of Abuse in the Australian Defence Force Association was sceptical about the efficacy of WHS legislation and Comcare as regulator of that Act. It claimed that Defence does not pay attention to Comcare and described the regulator as ‘an organisation who is loath to prosecute Defence for blatant and stupid occupational health and safety issues’ (sub. DR265, p. 13) and drew attention to the fact that at that time Comcare had not prosecuted the ADF for the death of Private Jason Challis during a live-fire exercise in the Northern Territory.

Box 5.2 **Work Health and Safety Act 2011**

The Commonwealth WHS 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).

However, there are reasons to believe this scepticism is unwarranted.

As Defence pointed out:

Comcare, as the workplace health and safety regulator for Defence, ... 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)

The monitoring activity of ADF compliance (excluding cadets) over the past five years is shown in table 5.1.

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 are not indicative of any underlying WHS risk in the ADF.
Source: Comcare (pers. comm., 4 June 2018).

Since the introduction of the WHS Act 2011, Comcare's investigations have resulted in three criminal actions against Defence for breaching the WHS Act. They relate to:

- two Army recruits who suffered severe electric shocks during a training exercise in regional Victoria (Cunningham 2018)
- a college student who was injured on an Army cadet camp (Comcare 2018c)
- the death of a soldier (Private Jason Challis) during a live fire training exercise in the Northern Territory in May 2017 (Comcare 2019).

In the case of Private Challis, Defence faces three charges of breaching its duties under the Act. All charges are Category 2 offences (box 5.2), and each carries a maximum penalty of \$1.5 million. As at the end of June 2019, all cases were proceeding through the courts and pleas were yet to be taken.

While these are the only three occasions where Defence has been charged with criminal offences under the WHS Act, these cases provide a salutary reminder that the Act and the regulator have teeth.

And as discussed in section 5.4, since the WHS Act 2011 was introduced there has been a significant decline in the number of people involved in serious, notifiable WHS incidents and ADF notifiable dangerous incidents. This is a strong indicator that WHS legislation and Comcare's regulatory activities are effective in helping to deliver improved WHS outcomes.

Is WHS legislation appropriate for the ADF?

Participants' views on the relevance of WHS legislation to ADF operations were mixed.

Some initial submissions endorsed the application of federal WHS 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)

Other participants expressed various concerns about applying WHS legislation to the ADF, including whether it was appropriate to apply to the ADF, for both peacetime and combat operations (box 5.3).

Box 5.3 Participants' concerns about applying WHS legislation to ADF operations

A number of participants said that Workplace Health and Safety (WHS) legislation was not relevant to the Australian Defence Force's (ADF's) combat operations (John George, sub. DR184, p. 4; Bert Hoebee, sub. DR195, p. 7; Marcus Fielding, sub. DR201, p. 1; and the South Australian TPI Association, sub. DR310, p. 2). However, there was some acceptance that WHS legislation had a place in peacetime operations. As John George said 'in peace-time the ADF should not be treated differently to any other workplace' (sub. DR281, p. 4).

But they and others (Claude Palmer, sub. DR179, p. 2, the Central Qld TPI Association sub. DR287, pp. 2 and 6 and Alan Sisley, trans., p. 1435) also suggested that even in peacetime, applying WHS legislation could inhibit realistic preparation for deployment or combat.

The Central Queensland TPI Association (sub. DR287 and trans., p. 1448) questioned the need to subject the ADF to any WHS legislation — for either peacetime or combat operations. It maintained that because the ADF already has an underlying incentive to prevent injuries in order to maximise operational capability, there was no need for WHS legislation to achieve this end.

The relevance of the WHS Act 2011 to the ADF was questioned by David Thomas on different grounds. He noted that 'work' in the ADF is so different from civilian work that general WHS legislation should not apply to the ADF (trans., p. 1419). Instead, he considered Defence would be best served by applying their own ADF-specific WHS standards. (The view about the different nature of military/civilian work was also noted by the Defence Force Welfare Association — sub. DR299, p. 7.)

These concerns, though, appear unfounded.

As noted, the WHS Act 2011 already contains provisions that exempt the ADF from various obligations in warlike deployments and to that extent it is effectively an instrument primarily

focussed on peacetime operations. This situation was recognised by the RSL Veterans' Centre East Sydney, which observed:

The Centre accepts that WH&S legislation [the WHS Act 2011] does apply to the ADF and to individual commanders, with necessary carve outs which reflect the unique nature of military service and operational requirements. (sub. 114, p. 10)

Concerns that WHS legislation inhibits realistic preparation for deployment or combat are also misplaced. The WHS Act does not prohibit arduous or dangerous training. Rather, it imposes an obligation on the ADF to ensure that such training is as safe as possible within the context of doing what the 'job' entails. This requires duty holders under the Act to assess and manage the risks of injury and illness from such training — the Act does not require that ADF personnel avoid those risks entirely. (The approved Code of Practice under section 274 of the Act (Safe Work Australia 2011) provides a guide on how to manage such risks and ADF training of its personnel on their obligations under WHS legislation draws on that code.) In this regard, the WHS Act readily accommodates the military philosophy of 'train hard, fight easy'.

While the Central Queensland TPI Association's (sub. DR287) observation that the ADF has a strong underlying incentive to prevent injuries is true, the evidence suggests that this incentive does not obviate the need for WHS legislation. As table 5.3 and figure 5.1 show, in the period since the introduction of the WHS Act 2011 the number of people incurring a serious injury or illness and the number of dangerous incidents have fallen by over 80 per cent. This suggests that there is a place for WHS legislation to complement the underlying incentive for the ADF to look after the health and safety of its personnel.

Is ADF-specific WHS legislation needed?

Previous reviews of military compensation and rehabilitation looked at 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 Tanzer 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 the 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).

Given this, 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 generally applicable federal WHS legislation.

FINDING 5.1

There are no compelling grounds to change the current arrangements under which Australian Defence Force members are subject to Commonwealth work health and safety legislation. In fact, the introduction of the *Work Health and Safety Act 2011* (which took effect on 1 January 2012) has been instrumental in helping to significantly improve work health and safety outcomes in the Australian Defence Force.

5.3 How is WHS delivered in the ADF?

Work health and safety in the ADF is currently driven by a number of factors.

As noted above, 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, as pointed out by Defence and other inquiry participants.

Reducing injuries allows a greater number of soldiers to be available to do their job. (Stephan Rudzki, sub. 40, attach. B, p. 27)

Defence and Commanders at all levels have an incentive to ensure their personnel are fit and able to do their job as often they are highly trained and replacements are not available. If replacements

are not available that has the potential to affect readiness and capability, increase the risk of injury to others and in the worst instance affect the defence of Australia. That is a very powerful incentive. (Defence Force Welfare Association, sub. DR299, p. 28)

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)

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)

The ADF also needs 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.

And the very nature of the ADF's 'business' means there is 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.) Defence expressed this in the following way:

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. 16)

Together, these incentives — as Comcare observed — have resulted in a genuine commitment to providing a safe and healthy working environment for serving personnel (box 5.4).

Box 5.4 **A regulator's view of ADF's commitment to work health and safety**

Comcare, through its role as an observer on the Defence Work Health and Safety Committee (DWHSC) and based on feedback from Comcare's inspectors and auditors who deal regularly with the Australian Defence Force (ADF), is of the view that Defence (and the ADF within Defence) is committed to effective work health and safety. 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 2018j).

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: Evolving Defence Culture* reform program, launched in 2012. (A program that built on the personal and institutional accountability reforms recommended by the 2011 *Review of the Defence Accountability Framework* — the Black Review).

An important focus of that cultural change strategy was directed at tackling unacceptable (sometime criminal) behaviour like sexual harassment or abuse, which can lead to mental health problems and, in some extreme circumstances, to suicide (Callinan 2018). That focus

was informed by the outcome of a series of reviews that immediately preceded the launch of the *Pathway to Change* program (box 5.5), and was bolstered by the subsequent establishment of the Sexual Misconduct and Prevention Response Office in July 2013 and the creation of a restricted reporting regime. These initiatives were designed to ensure that there is a centralised, safe, supportive and confidential resource within the ADF for complainants to disclose sexual misconduct and assault (AHRC 2014, p. 1).

Box 5.5 Cultural change aimed at tackling sexual harassment and abuse

In April 2011, following an incident at the Australian Defence Force Academy (ADFA) involving a female cadet — ‘the skype affair’ — the Minister for Defence announced a series of reviews into aspects of Defence culture. The reviews covered:

- treatment of women at ADFA and in the wider Australian Defence Force (ADF)
- use of alcohol in the ADF
- use of social media in Defence
- personal conduct of ADF personnel
- management of incidents and complaints in Defence
- Defence APS women’s leadership pathways.

In March 2012, the Defence Minister announced the outcomes of all the reviews with the exception of the second part of the review into the treatment of women in the wider ADF (which was released in August 2012). The Minister also noted that Defence’s response to the reviews would also be encapsulated in its *Pathway to Change* cultural reform program.

Defence subsequently noted that the *Pathway to Change* reform program:

... integrates the recommendations of six reviews into a coherent, cohesive plan of action with responsibility for implementation allocated to specific senior Defence leaders. Importantly, the authors of each of the reviews have been part and parcel of the development of the *Pathway to Change* and are supportive of the approach being taken. (Hurley 2012).

Sources: Joint Standing Committee on Foreign Affairs and Trade (2012); Gen. Hurley in Hansard (2012, p. 3).

The original *Work Health and Safety Strategy 2012–17* has since been succeeded by Defence’s *Work Health and Safety Strategy 2017–2022* and associated Implementation Plan (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).

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.

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 Royal Australasian College of Physicians (RACP), though, was critical of Defence's WHS strategy and practices. It claimed that not having occupational and environmental physicians (OEPs) on the Defence WHS Committee, and not using their expertise to inform its WHS strategy and prevention activities was a serious deficiency (sub. DR234 and trans., p. 572). Given that workplace and occupational exposures and hazards are a key factor in the causation or worsening of various medical conditions (Australian Peacekeeper and Peacemaker Veterans' Association, sub. DR270, p. 44), if true, this would be a serious deficiency.

However, it appears that Defence is using OEPs' expertise to inform its WHS strategies and practices and is taking steps to strengthen its occupational medicine and occupational hygiene capability.

While the RACP is correct in saying there is no OEP on the WHS committee, according to Defence, members of the committee are briefed by OEPs as required. This is also the case for the safety committees of the Army, Navy and Air Force. They benefit from advice from OEPs, which helps to inform and enhance WHS practices in each of those Services. In both cases, that OEP advice is bolstered by occupational and environmental health data collected by the Sentinel and the Defence eHealth systems — although both those systems are still being refined to improve their capture of relevant information (box 5.6).

Box 5.6 Improving existing data collection systems to better capture occupational and environmental health risks

The Defence incident reporting system (Sentinel) provides a vehicle to identify work health and safety hazards and risks. The Defence electronic health system (DeHS) enables monitoring for health effects related to occupational exposures to various hazards.

In 2018, the Chief of Staff Committee recommended that the Work Health and Safety Branch enhance Sentinel to improve its hazard monitoring features — which cover hazards such as asbestos, isocyanates, lead and noise.

Defence is also developing a system that will allow direct entry of health monitoring data into DeHS. Noise is the first hazard to be addressed and should be available in DeHS towards the end of 2019.

Source: Defence Joint Health Command pers. comm., 5 June 2019.

Defence has developed an integrated occupational medicine and occupational hygiene capability, which brings together strategic and individual Service components, supported by

data collected through Sentinel and DeHS. This has been the result of Defence recognising the contribution OEPs can make to improve WHS strategies and practices, and as part of an ongoing response to the recommendations of the F-111 Deseal/Reseal Board of Inquiry aimed at improving Defence's occupational and environmental medicine capabilities (RAAF 2001).

Also, because of the important role of occupational and environmental medicine in delivering improved WHS outcomes, in September 2017 Defence established an Emerging Hazards Capability, which consists of occupational health subject-matter experts across Defence. As the Defence annual report noted:

The focus of this capability is to identify emerging and disruptive technologies that may pose a significant hazard to the occupational health of Defence personnel across the enterprise. Through the dedicated identification and evaluation of emerging hazards, Defence can proactively develop strategies to control the hazards, allowing the safe and beneficial use of these new technologies. The capability uses a collaborative approach to identify emerging hazards through engagement with other areas of government, industry and academia. (2018f, p. 104)

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).

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 (2018b) and various previous years.

The importance of incident reporting systems in the context of prevention

As noted above, the Defence WHS strategy embodies ‘a strengthened focus on reporting incidents through the enterprise-wide Work Health and Safety Management System, Sentinel’ (box 5.7).

Box 5.7 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 through 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, Risks, and 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 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, p. 71)

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, Ozanne-Smith and Pope 2009, p. 470)

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. 52–53)

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:

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)

The RACP, at the Canberra public hearings, also noted:

Best practice indicates not only should there be timely reporting [of workplace illness and injuries] but there needs to be ongoing population-based analysis of trends over time to identify reported injuries and illnesses, and this can lead to investigation as to possible causation and hence implementation of preventive measures. (trans., pp. 569–70)

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 not 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 participants 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)

Kel Ryan (ADSO) also told the Commission that:

... daily our advocates see the result of Defence not having fulfilled its workplace and health and safety obligations. Our advocates are appalled by the number of 28 to 32 year old veterans with the body of a 70 year old that they are seeing. Then there are those on suicide watch all with severe mental health conditions, or others with multiple disabilities resulting from exposure to industrial toxins. We therefore support without reservation commanders' responsibility for their subordinates wellbeing and advocacy and that those responsibilities must be reinforced. (trans., p. 916)

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)

The Association notes there have been significant improvement in ADF safety awareness and safe workplace practices in recent years. (Air Force Association, sub. DR267, p. 5)

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 Number of people involved in 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	8	12	9	8	3
Serious injury or illness ^a	1 587	1 237	986	629	449	330	274	277
Dangerous incidents ^a	1 722	1 611	1 000	551	603	396	382	566
Minor injury	na	na	11 952	11 958	10 980	10 406	9 783	8 937
Near miss	na	na	26	553	1 256	1 243	1 305	1 745
Exposure	na	na	6 143	4 452	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. **na** Not available

Source: DoD (Annual Reports, 2018 and various back years).

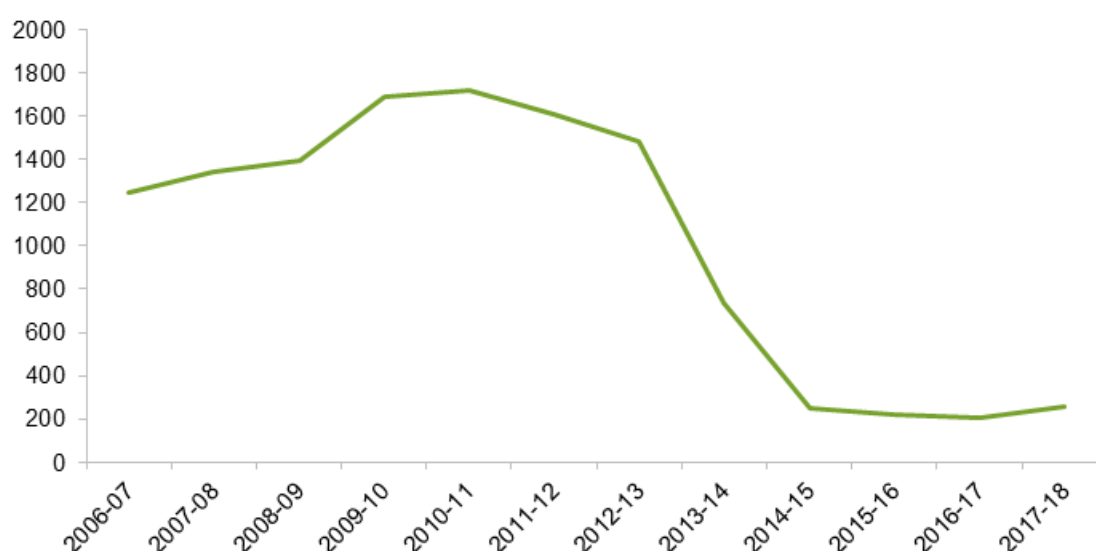
As table 5.3 shows, over the period 2010-11 to 2017-18 (before and after the introduction of the WHS Act 2011 and the *Defence WHS strategy 2012-17*), the number of people who

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.

suffered serious injury and illness each year has fallen steadily (by about 82 per cent). Over that same period, the reported number of people involved in dangerous incidents (that could have, but did not, result in a fatality, serious injury or illness) 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 dangerous incidents over the period 2006-07 to 2016-17 show a similar story. There is a rising trend in notifiable incidents from 2006-07 arrested in 2010-11, and a subsequent fall in such incidents from 2010-11 to 2017-18 of about 85 per cent (figure 5.1).

Figure 5.1 Number of ADF notifiable dangerous incidents^a



^a A dangerous incident is a near miss event that could have, but did not, result in a fatality, serious injury or illness.
Source: DoD (Annual Reports, 2018 and various back years).

This improved performance on notifiable WHS incidents has not, however, been mirrored in minor injuries, near misses and exposure.

The raw data on the reported WHS incidents in table 5.3 shows a reduction in minor injuries of about 25 per cent since 2012-13, but near misses and exposure over that period have tended to increase or exhibit an erratic path to reduced incidents, respectively. A recent study on the injury experience of Navy recruits in 2015 also found that 48 per cent of recruits suffered a lower limb injury over their 11 week training course (Bonanno et al. 2017, p. 300) — which equates to an incidence rate of about 230 lower limb injuries per 100 full-time

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).

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.

So while notifiable incidents have fallen substantially, there still appears to be considerable scope to improve WHS outcomes.

5.5 Is there 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 significant 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 and the ADF could have 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 (boxes 5.6 and 5.7) plays a central role in the ADF’s approach to improving WHS outcomes, participants raised two concerns about whether it is fit for purpose:

- the likely significant underreporting 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 affects the statistical power to detect emerging problems and to monitor the success of the ADF’s WHS activities (Pope, MacDonald and Orr 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 underreporting 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 underreporting are endogenous to the system — such as the lack of Service-wide coverage (and less than universal access to the system), the ease (or not) of use of Sentinel, and confidence by military personnel that reporting would 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 its introduction, Defence has addressed many of these barriers to access and has significantly extended the coverage of Sentinel across the Services.

User-friendliness and confidence in the system

During visits to Army and Royal Australian Air Force (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.

Some submissions were also critical of Sentinel's user-friendliness, with the Wynyard sub-branch of RSL Tasmania noting:

Having used the system for one of my troop's rehab I found it to be clunky, hard to use and highly impersonal. (sub. DR205, attach. C, p. 1)

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 2002a, 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 5.8.

Box 5.8 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 influenced by their confidence that such reporting would lead to the remediation of identified WHS risks. This point was observed by APM Workcare (sub. DR219, p. 1), and is supported by studies by McKinnon, Ozanne-Smith and Pope (2009) and Pope, MacDonald and Orr (2015), which found that those supplying and entering data in injury surveillance systems would 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).

FINDING 5.2

Since Defence introduced Sentinel (a work health and safety incident reporting system) in 2014, it has expanded its coverage, 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 in Sentinel (other than for serious, defined events that must be notified to Comcare) continues to be an issue.

Reluctance of serving members to record their injury or illness

Three interrelated factors are particularly significant in the reluctance 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.

Concerns about the disclosure of personal medical information can add to the reluctance of serving members to report injury or illness.

Through enforceable adherence to the command structure, there is an increased potential for sensitive medical information being shared at the expense of an individual's right to privacy — leading to compounding feelings of anxiety and mistrust. The capacity to trust health professionals is further diminished by the posting cycle and changeable contract arrangements within Joint Health Command. What this means is that personnel have limited ability to establish trusting relationships with those responsible for their care. (Deborah Morris, sub. DR307, p. 6)

The first of the three core factors 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* document, 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. (2016, p. 9)

The same point was made by a number of participants in their submissions and Ray Martin at the Commission's public hearings:

There is, particularly among [Air Force] aircrew, a strong culture of getting the job done, along with a desire to remain flying. Obviously flying is why you are aircrew but there was a tendency to ignore or carry injuries without reporting them for fear of losing one's ability to continue flying. (Hugh Baldwin, sub. 10, p. 2)

... there is ample evidence that serving members often deliberately fail to report or understate the extent of injuries and illnesses, fearing this will affect their chances of deployment and promotion or even lead to medical discharge. (War Widows' Guild of Australia, sub. DR278, p. 6)

... during my service between '74 and '99 we absolutely under-reported and really mental health reporting to put your hand up to seek support with a mental health issue is pretty well unheard of. ... [despite] the command system saying 'we encourage you'. The reality is that there's still people not willing to put their hand up to get that support because they think that's a career inhibitor. (Ray Martin, trans., p. 1374)

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 a reported 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 — 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).

Occupational Therapy Australia (sub DR289, p. 2), noting the rising incidence of psychological injury, considered that the ADF should place more emphasis on the prevention of mental illness — identifying resilience training as particularly important in this regard. In many respects, this is happening, with a recent study acknowledging that the mental health strategies of both Defence and DVA are moving away from a focus on illness and treatment to a focus on wellness and the prevention of illness (Burns et al. 2019, p. 194). Defence and DVA have also made investments in online tools and resources to help prevent mental illness among serving and former ADF personnel (box 17.7) (Burns et al. 2019, pp. 4, 5).

A broader discussion of mental health in the ADF — how military service shapes mental health, the prevalence of mental ill health, and mental health supports available for veterans — is discussed in chapter 17.

The Commission observed first-hand the changing attitude in the ADF to mental illness. One example was a senior serving base 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 form).

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 combine data from 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 obvious 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 and 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 5.9).

When the Commission visited RAAF Base Wagga and Army bases at Bandiana, Kapooka, 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).

To address this potential weakness in the data informing and guiding Defence's WHS efforts, they suggested Sentinel data be combined with information from other databases. The main candidate for this is the Defence eHealth System, which contains health information at the point of care. The RACP also proposed this option (sub DR234, p. 6).

Box 5.9 **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 Defense agencies, including records of hospitalisations, outpatient visits, deaths, disabilities, flying duty medical examinations, accident reports, clinical evaluations from Gulf War registrants with the Comprehensive Clinical Evaluation Program, reports of spousal abuse, 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).

At present, as Phillip Burton observed, such information sharing or interoperability is problematic for Defence, as no platform cooperates with any other system. He held that a single platform needs to be developed in order to reduce operational costs and ultimately provide better information to support services provided to veterans (sub. DR243, p. 9).

Another suggestion was to combine Sentinel data with 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 illnesses and allow a better prioritisation of remedial WHS activity. The Alliance of Defence Service Organisations strongly supported this approach to harness the power of 'big data' (sub. DR247, p. 26).

The value of incorporating 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 combined Defence and DVA initiative aimed at reducing the time to make determinations of liability and invalidity offers an insight into how data already collected by Defence and DVA might be better used to improve WHS outcomes in the ADF.

In 2016, Defence and DVA entered into a *Joint Memorandum of Understanding on Cooperative Delivery of Care and Support*. Collaboration under that Memorandum of

Understanding 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, as DVA pointed out, the information could also help inform 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 be resolved in the near term. However, incorporating information on 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 overcome this deficiency and, in the process, improve the breadth and depth of data available to inform Defence’s WHS strategy.

Given that the current Defence eHealth System is due to be replaced in the next 3–4 years (Defence issued a request for quotations for the initial elements of its health knowledge management platform for the ADF in the first half of 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.

RECOMMENDATION 5.1 **IMPROVE REPORTING OF WORK HEALTH AND SAFETY INCIDENTS**

Defence should assess the feasibility and cost of incorporating the information on 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 the capture of work health and safety data as a system requirement.

The Department of Defence and Department of Veterans' Affairs should assess the feasibility and cost of incorporating information from 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 in conflict or deployment.

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 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 people 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 (DoD 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 trial 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*) (Australian Army 2018, p. 8). 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 specific biometric strengths and weaknesses and, hence, injury risk profile (using Sparta Science's force plate technology and injury prediction software). Assessments can occur as often as required to monitor progress (and compliance with training regimes)
- 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. That information 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 report a level of musculoskeletal and soft tissue injury significantly greater than corresponding records on Sentinel and the important role of fatigue as a contributing factor to injuries. 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). It will also 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 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 is 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 made to support these programs, monitor their effectiveness and, most importantly, conduct comprehensive cost-benefit 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 are required)
- resources and access to information to facilitate a comprehensive and robust cost–benefit assessment of the programs' outcomes.

RECOMMENDATION 5.2 SUPPORTING A NEW APPROACH TO INJURY PREVENTION

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 support and 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 or 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 or 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)

The 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.

Phillip Burton questioned the worth of presenting Defence with a notional workers compensation premium. He argued that junior commanders responsible for day-to-day training would simply not take a ‘notional’ premium seriously. However, this misunderstands how a premium would work. A premium (even a notional premium) would bite at the organisational level — and provide an incentive for the organisation (for example, Defence or the ADF) to identify the drivers of high or increasing premium costs and to develop strategies and practices at all levels of service aimed at addressing those factors that increase premium costs. These might include, for example, strategies and practices to reduce the incidence and severity of service-related injury and illness, to better (and earlier) identify and treat injuries and illnesses, to improve the effectiveness of rehabilitation outcomes and to improve transition outcomes for veterans and lessen the strains of transition that might otherwise induce or exacerbate mental health issues.

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 indicates 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 yearly reduction in injuries or illnesses 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 the premiums exceed their cost.

RECOMMENDATION 5.3 PUBLISH ANNUAL NOTIONAL PREMIUM ESTIMATES

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).

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

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 (recommendation 11.2). These and other issues are discussed in more detail in chapter 11.

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 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

expenditure of Garrison Health Services, is about \$1.02 million, which exceeds the estimated cost of producing the notional premium estimates.

be pursued), the experience of the Electronic Information Exchange Strategy (many years in gestation) suggests that achieving this goal would be some years away.

5.6 Defence's broader responsibilities

Although the WHS Act 2011 imposes an explicit 'duty of care' on Defence, the ADF is not like other workplaces. Members of the ADF are not legally considered to be employees of Defence and are subject to the much harsher military justice system (chapter 2). Defence also has significant control over the lives of its personnel, including being able to order them into dangerous or life-threatening circumstances and/or to kill another human being.

Because of this, there is a strong case for Defence's existing duty of care to go beyond that of civilian employers and include a broader responsibility for the wellbeing of personnel who have been harmed for the sake of Australia's national security.

'Respect and support' ADF members

A broader responsibility for Defence would mimic recent moves toward legislating an Australian Defence Veterans' Covenant. The genesis of the Covenant was the Armed Forces Covenant in the UK, which stated that UK veterans deserve 'respect and support, and fair treatment' (MOD 2016b). Similarly, the Australian version considered by Parliament⁶ included a promise to 'welcome, embrace and support all military veterans as respected and valued members of our community' and was intended to create a responsibility for the Government and Australian society to 'acknowledge, honour and support veterans and their families' (Chester 2019a, p. 5).

Any commitment to 'respect and support' members of the ADF should first be applied within Defence itself, as the current employer of nearly 80 000 permanent and active Reserve members (DoD 2018f). However, the responsibility of Defence to ADF personnel (in exchange for the sacrifices of their service) is not currently a core focus for Defence. At present, Defence's corporate plan has two 'outcomes':

- Defend Australia and its national interests through the conduct of operations and provision of support for the Australian community and civilian authorities in accordance with Government direction.
- Protect and advance Australia's strategic interests through the provision of strategic policy, the development, delivery and sustainment of military, intelligence and enabling capabilities, and the promotion of regional and global security and stability as directed by Government. (DoD 2018b, p. 3)⁷

⁶ The Australian Veterans' Recognition (Putting Veterans and their Families First) Bill 2019.

⁷ Prior to 2017-18, Defence had three core outcomes to deliver to Government — provide advice to Government; deliver and sustain Defence capability and conduct operations; and develop the future capability Defence needs to conduct operations (DoD 2016b).

These outcomes appropriately prioritise the essential business of Defence — warfighting capability — but they are also limited, failing to acknowledge the complementary responsibility that Defence has to the personnel it trains and deploys to fight those wars. As one academic and former ADF member observed:

The core business of militaries means that there is a necessary requirement to prioritise functional imperatives over the welfare of individual members ... This does not suggest that the ADF does not support the welfare of its members, simply that, given the structure and competing forces within the institution, the institution requires capability to come first. The simplicity of this binary becomes complicated because members of the ADF are, in fact, the integral component for effective and sustainable capability. By properly acknowledging the principal business of the ADF and competing agendas and forces, well informed policy and systems can be designed to protect and ensure the wellbeing of members whose individual agency is diminished as a requirement for capability — potentially striking a workable balance between the functional and [welfare] imperatives of the ADF. (Deborah Morris, sub. DR307, p. 4)

The importance of ADF personnel to Defence capabilities is already acknowledged by both Defence and the Government. For example, Defence’s 2017-18 annual report stated that ‘capability is enhanced by providing support to ADF members and their families ...’ (DoD 2018f, p. 75). Similarly, the 2016 Defence White Paper stated that ‘the quality of our people is the foundation of Defence’s capability, effectiveness and reputation’ (DoD 2016a, p. 145), before concluding that ‘it is not enough to have the best equipment — it needs to be operated and supported by the best people’ (p. 150). For 2019-20, Defence has also committed to performance criteria that include creating a ‘safe and supported’ workforce and providing ‘appropriate support and services’ to Defence people and their families (DoD 2019f, p. 75).

However, these aspirations have not been matched by Government action, including through making Defence responsibilities explicit, creating concrete accountability measures or establishing a ‘culture of care’ within Defence.

The Commission is of the view that the Government should explicitly acknowledge that Defence has an existing responsibility to ‘respect and support’ current serving members of the ADF, as the *quid pro quo* for the unique nature of their service. This would complement many of the Commission’s other recommended reforms — including in rehabilitation (chapter 6), transition support (chapter 7) and mental health (chapter 17) — by encouraging Defence to take responsibility for personnel beyond its narrow WHS focus on preventing injuries and illnesses.

Similar to the WHS system that has operated successfully since 2012, this does not negate Defence’s existing responsibilities to develop warfighting capabilities and protect Australia — the *Work Health and Safety Act 2011* includes a provision (s. 12D) stating that nothing in the Act requires or permits any action or inaction that would be prejudicial to Australia’s defence. Instead, respecting and supporting ADF members would supplement Defence’s existing objectives with a responsibility to look after their own members.

In time, the Government could also legislate the ADF's functions in the *Defence Act 1903*, to provide it with greater clarity and certainty about its role and responsibilities. Uniquely for a statutory organisation, the ADF does not have any objectives outlined in the Defence Act 1903, rather it focuses on its specified powers and service requirements for personnel. The Chief of the Defence Force — as the commander of the ADF — also does not have any functions outlined in the Act. By comparison, New Zealand's *Defence Act 1990* outlines the functions of the New Zealand Chief of Defence Force.

RECOMMENDATION 5.4 FORMALISE DEFENCE RESPONSIBILITY TO SUPPORT ADF MEMBERS

In line with the proposed Australian Defence Veterans' Covenant, the Australian Government should amend Defence's outcomes to include an additional objective, explicitly acknowledging that — due to the unique nature of military service — Defence has a responsibility to respect and support members of the Australian Defence Force having regard to their lifetime wellbeing.

6 Rehabilitation

Key points

- Effective rehabilitation is critical to minimising the impact of injury and illness and restoring quality of life for serving and ex-serving members of the Australian Defence Force (ADF).
- ADF members who need rehabilitation access services through the ADF Rehabilitation Program and veterans with assessed need for rehabilitation for service-related conditions can access rehabilitation funded by the Department of Veterans' Affairs (DVA). DVA also funds rehabilitation for reservists.
- 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.
 - 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.
 - Defence has an incentive to rehabilitate individuals with a high probability of redeployment or return to duty, but a weaker incentive for those who are likely to be transitioning out.
- There is an absence of good quality data and evaluation of rehabilitation outcomes. Little is known about the effectiveness of rehabilitation services provided by Defence or DVA. Without this information, Defence and DVA do not know what rehabilitation services work for serving and ex-serving members of the ADF or how to improve the effectiveness of the services.
- The limited available evidence on outcomes from rehabilitation points to mixed results. And while civilian schemes cannot be used as the sole benchmark for the efficacy of veteran rehabilitation programs (there are key differences between defence roles and other professions and there can be a delay in access for ex-serving personnel), return-to-work rates are comparatively low.
- There is considerable scope to improve rehabilitation services. A more innovative and holistic approach 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 procure, organise and monitor rehabilitation services.
 - Changes are also needed to rehabilitation arrangements during the transition period to ensure continuity of care.

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 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, and the potential to improve veterans' rehabilitation by paying closer attention to outcomes. Options for improving the system of rehabilitation services are examined in section 6.4.

6.1 About rehabilitation

Why rehabilitation is important

Rehabilitation is about restoring a person with an injury or disease to as productive and as independent a lifestyle as possible. Rehabilitation can mean that injured and ill people can recover more quickly and resume their usual activities and lifestyle — including returning 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 help them to return 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 important for the wellbeing or quality of life of veterans. The New Zealand Law Commission, when looking at veteran support, found that:

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. (2008, p. 17)

Early and effective rehabilitation can also reduce the overall cost of care, the number of veterans being discharged on medical grounds and the incidence of compensable injury (which ultimately means a lower premium for the employer and a more affordable system). SwissRe estimated that, for the broader Australian workforce, for every \$1 spent on rehabilitation services, insurers saved \$25 on income protection claims costs (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 improving veterans' return-to-work outcomes (EML, sub. 90).

A number of participants commented on the importance of a system of support that focuses 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 are the aims of rehabilitation?

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 restore to the extent possible their physical, mental and social wellbeing (including helping them to participate in the community). Inquiry participants emphasised that the aim of rehabilitation cannot always be to return to employment, especially for those who have long since transitioned out of the military (box 6.1).

Box 6.1 Participants' views on the goals of veterans' rehabilitation

RAAC Corporation:

... regardless of the very best efforts at rehabilitating veteran back to an employable level of fitness, instances will occur where a veteran is permanently unfit for any remunerative employment for which a veteran is suited, by education, training or experience. Additionally, the kinds of remunerative work that a veteran might reasonably undertake by virtue of their skills is no longer possible, due to the catastrophic effects of their accepted disabilities or compensable injuries. That is the stark reality facing some veterans. To deny otherwise is to deny reality ... (sub. DR203, p. 28)

Combined SA Ex-Service Organisations:

... in workers compensation schemes the objective of rehabilitation is a successful return to work. In the DVA scenario, the objective is to return the client to acceptable lifestyle, consistent with community expectations. (sub. DR188, p. 9)

Vietnam Veterans' Federation of Australia:

While rehabilitation is a primary goal, it will not be an appropriate short-term goal in all cases, and the timing of its commencement may be problematic. This must be acknowledged and taken into account. (sub. DR215, p. 9)

The Commission acknowledges that return to work will not always be possible. But where it is, this should be the aim, as all the research evidence on the health benefits of work suggests that employment promotes wellbeing (box 6.2, chapter 4).

Box 6.2 The health benefits of good work

Most people wish to participate in meaningful work. This includes individuals who have health problems, whether those health problems are physical or mental. Not only does paid employment provide financial security, it can also give a sense of self-worth, daily structure and regular social engagement.

It is not surprising, therefore, that the research shows that workforce engagement is associated with improved wellbeing. As the Royal Australasian College of Physicians said there is 'compelling Australasian and international evidence that good work is beneficial to people's health and wellbeing and that long term work absence, work disability and unemployment generally have a negative impact on health and wellbeing' (RACP 2019). A systemic review of the benefits of work on mental health also found that it can be beneficial.

Accumulated quantitative and qualitative evidence demonstrates that having a job is associated with a greater sense of autonomy, improved self-reported well-being, reduced depression and anxiety symptoms, increased access to resources to cope with demands, enhanced social status and unique opportunities for personal development and mental health promotion. (Modini et al. 2016, p. 335)

And good outcomes are more likely when individuals understand, and are supported to access the benefits of good work when seeking re-employment or recovering at work following an injury or illness.

What is best-practice rehabilitation?

Rehabilitation covers not only clinical treatment (such as physiotherapy, occupational therapy, speech pathology, psychology or other clinical services), but also psychosocial and vocational support 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. The Australasian Faculty of Rehabilitation Medicine defines 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 stated 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.

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, box 6.3), state-based workplace authorities and others (see, for example, Casey and Cameron 2014).

Box 6.3 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).

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 terms of return to work and durability of treatment.

The guidance material also emphasises a tailored or person-centred, flexible and holistic approach (box 6.4). For example, Safe Work Australia talks about the importance of a biopsychosocial approach to rehabilitation.

A biopsychosocial approach is used to understand the [person on claim], identify barriers to desired outcomes and put in place the appropriate support, including treatment and rehabilitation, which are tailored to the [person] 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)

Inquiry participants also emphasised the importance of a biopsychosocial approach. For example, Abilita Services said:

When a person accepts the biopsychosocial nature of their condition, they are motivated and willing to learn and adopt self-management skills and strategies. (sub. DR191, p. 4)

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 return to work (RTW) or rehabilitation at work (Safe Work Australia 2017b).

Box 6.4 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 résumé 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)

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, and there continues to be a formal emphasis on rehabilitation for both serving and ex-serving veterans.

An increasing emphasis in legislation and policy on rehabilitation

The *Veterans’ Entitlements Act 1986* (VEA) (which largely covers veterans with operational service before 2004 — chapter 3) 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 ‘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 ‘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). 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).

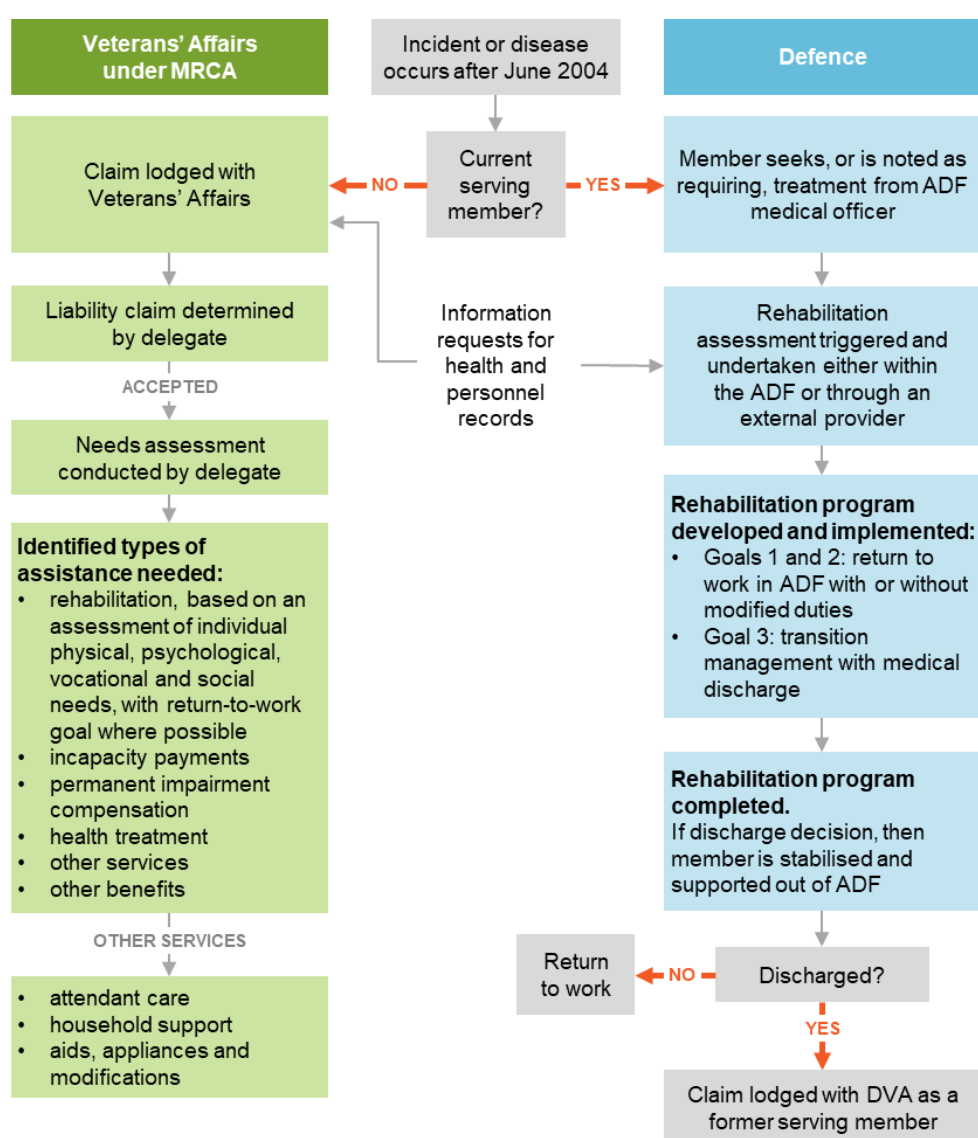
The policies of Defence and DVA mirror this stated emphasis on rehabilitation. For example, Defence said that:

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 2018o)

DVA's approach also combines elements of medical management, psychosocial and vocational support, in order to work with individual clients to develop whole-of-person rehabilitation plans tailored to their unique needs and circumstances (DVA 2014a).

The legislative framework and related policies result in a dual system of rehabilitation — rehabilitation is organised separately by both Defence and DVA. 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).

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).

Rehabilitation services provided by Defence

Rehabilitation is provided to serving ADF members as part of the health care that all members receive. Access to ADF rehabilitation is not dependent on whether the member's condition is work related or whether they have a compensation claim.

The Joint Health Command (JHC) organises rehabilitation services across the ADF. JHC 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 the *ADF Rehabilitation* and *Rehabilitation for Reservists* programs.

Serving personnel 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: Medical transition out of the ADF (DoD 2019e).

Services are provided by a mix of internal and external providers, and can include medical, occupational and psychosocial rehabilitation. Defence employs 50 APS rehabilitation consultants undertaking either rehabilitation case management or rehabilitation consultant duties. There are also 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 (JHC, pers. comm., 23 July 2018).

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 6.5), designed to further assist individuals during their recovery.

Box 6.5 About the Australian Army's Soldier Recovery Centres

The Army's Soldier Recovery Centres (SRCs) provide commanders with additional resources to manage members undertaking extended rehabilitation or transition. SRCs were established under the 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 a positive recovery environment where personnel are engaged in meaningful activities and are enabled to focus on their recovery mission.

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.

Source: Australian Army (2016).

Availability and use of ADF rehabilitation

In 2017-18, 6401 ADF members (or roughly 11 per cent of the full-time ADF workforce) received rehabilitation through the ADF Rehabilitation Program, and about 220 000 contracted service episodes were provided (JHC 2019).

The amount of time they spent in rehabilitation was not reported for 2017-18. But in 2016-17, the average time was:

- for Goal 1 and 2 cases (those returning to duty) 25.7 weeks
- for Goal 3 cases (those transitioning out of service) 59.5 weeks (an increase of 13 per cent on the previous year) (JHC 2017, p. 7).

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 2017-18, 197 ADF members participated in such activities (JHC 2019, p. 7).

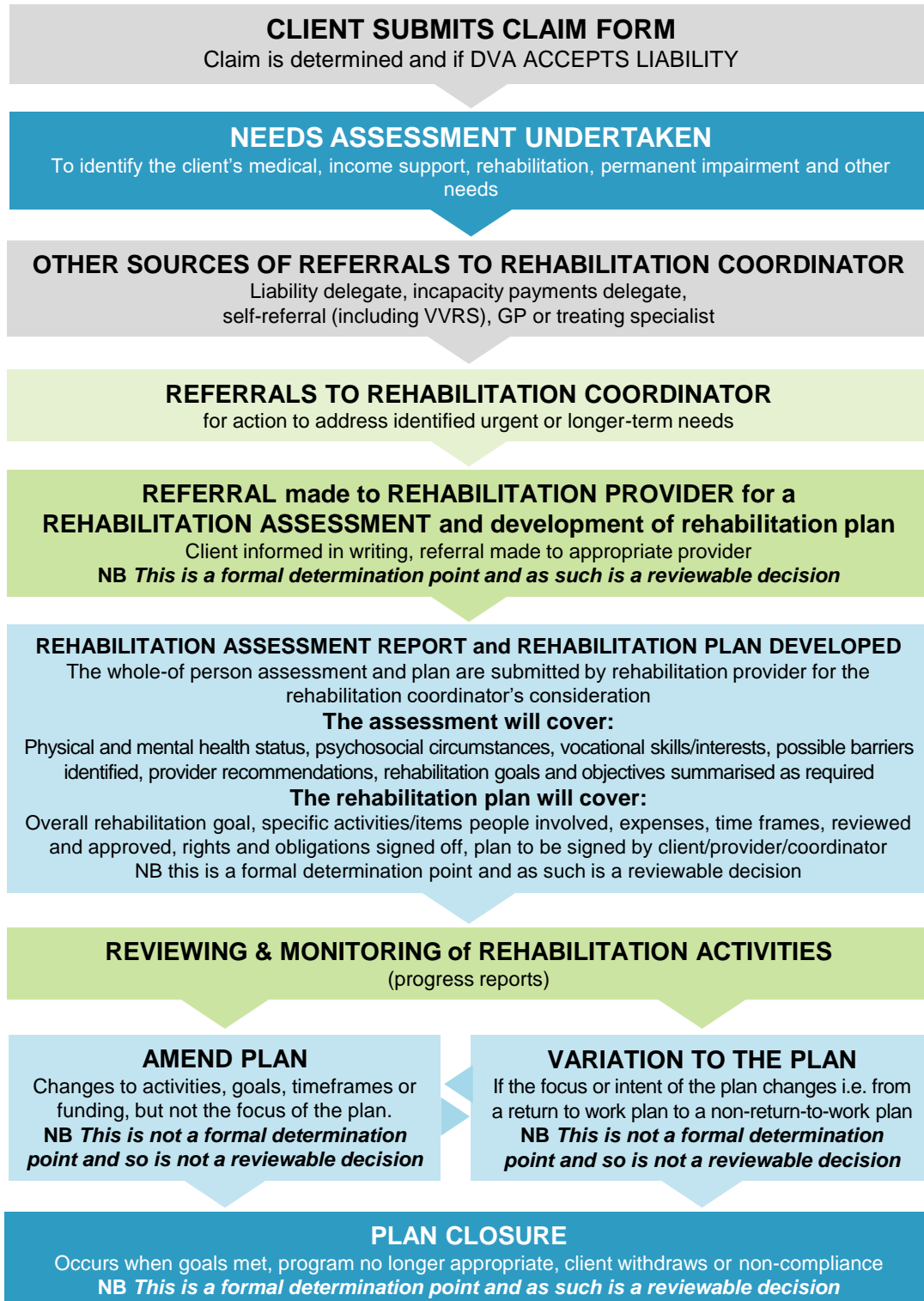
Rehabilitation organised and funded by DVA

For ex-ADF personnel, the main source of rehabilitation services is through DVA's rehabilitation program. 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).

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).

Central to DVA's approach is the case plan and case management pathway (figure 6.2).

Figure 6.2 DVA's rehabilitation case management pathway



fSource: DVA (2017b, p. 1).

Access to DVA-funded rehabilitation services is only available once DVA has accepted liability for an impairment. Given that assessing and deciding on claim eligibility can take considerable time (chapter 9), this can mean significant delays in personnel receiving rehabilitation services (this is discussed in more detail below).

Assessment and referral processes occur at several points throughout the DVA process. Referral for rehabilitation can be by self-referral, the DVA delegate, ex-service organisations, general practitioners (GPs) and treating specialists.

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.

DVA-funded rehabilitation services are provided 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)

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 Act(s) they are covered by (DVA 2015a, p. 3). As will be discussed later, those under the VEA are less likely to access rehabilitation (box 6.6).

DVA also provides counselling services via Open Arms (previously known as the Veterans and Veterans Families Counselling Service (VVCS)) (chapter 17), online resources, and health and wellbeing programs.

People who are participating in DVA rehabilitation can have either a 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. RTW plans tend to be of longer duration than non-RTW plans (figure 6.3).

Box 6.6 Veterans' Vocational Rehabilitation Scheme

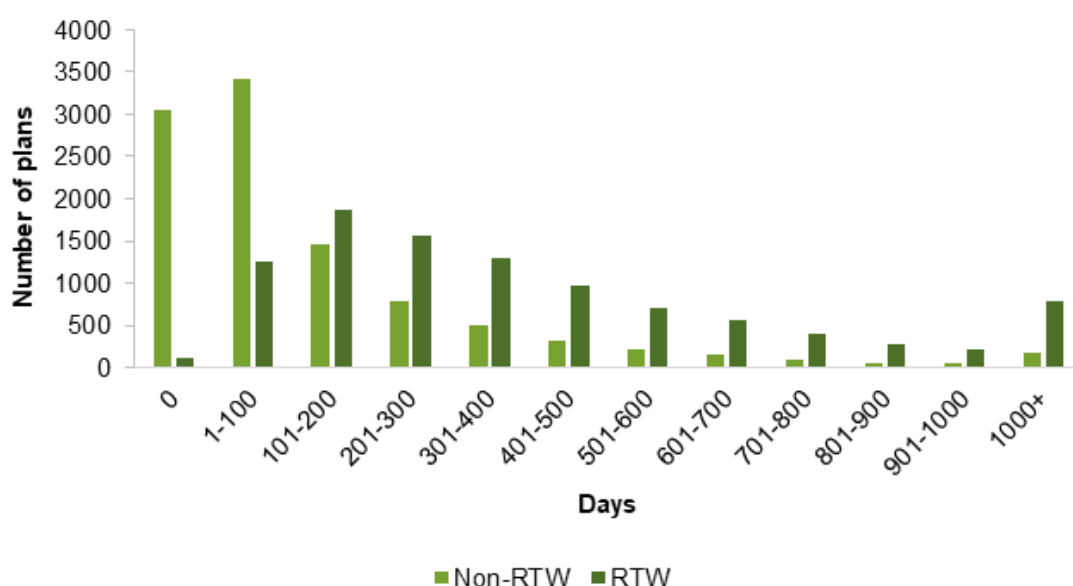
The Veterans' Vocational Rehabilitation Scheme (VVRS) is a program run by the Department of Veterans' Affairs (DVA) 'to assist veterans to find, or continue in, suitable paid employment, with particular emphasis on facilitating the transition from service in the ADF to suitable paid employment and assisting those veterans whose jobs are in jeopardy to retain suitable paid employment' (VVRS instrument, section 1.2.1). The assistance provided includes work-related support such as vocational assessments and interview skills training.

Unlike rehabilitation provided under the *Military Rehabilitation and Compensation Act 2004* (MRCA) and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA), veterans do not need to be in receipt of a DVA pension or medical treatment to be eligible for the VVRS. Veterans who need employment assistance and who rendered operational, peacekeeping or certain other types of service under the *Veterans' Entitlements Act 1986* (VEA) are all eligible. Participation is voluntary, and does not affect access to other supports (unlike participation in MRCA and DRCA rehabilitation, which can be required as a condition of receiving certain forms of compensation).

For many years, the VVRS provided only vocational rehabilitation. But since 2016, it has also included psychosocial and medical management rehabilitation, where those services are reasonably required to assist the veteran to achieve or retain suitable paid employment; or to overcome barriers to employment.

Source: DVA (2017m).

Figure 6.3 Plan length, DVA rehabilitation, by program type
2004–2016



Data source: Productivity Commission estimates based on unpublished DVA data.

Services provided

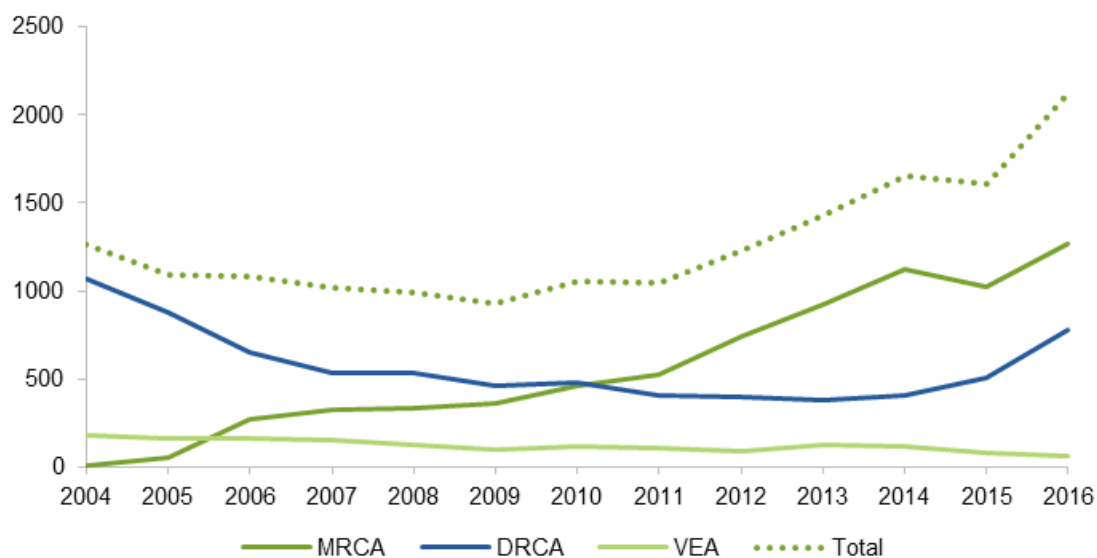
The types of rehabilitation services permitted under a person's plan as provided by rehabilitation consultants are set out in policy documents. The protocols of rehabilitation under the MRCA, first developed in 2004 and subject to regular updating, contain detailed requirements for eligible services and delivery costs (DVA 2017a).

Services funded by DVA are provided by external accredited providers (Comcare-accredited). There are currently 41 providers and around 700 rehabilitation consultants. In 2017-18, ten companies provided 41 per cent of DVA's rehabilitation services.

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 2017c). (The effect of these requirements on access to quality rehabilitation services is considered in section 6.6.)

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 pointed 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.

Figure 6.4 Number of rehabilitation cases, by Act



Data source: Productivity Commission estimates based on unpublished DVA data.

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.)

6.3 Incentives for rehabilitation

The services described in section 6.2 point (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. While some incentives are monetary (such as the incentive payments to employers), people and organisations respond to a much broader range of incentives. Indeed, incentives include the full range of extrinsic and intrinsic motivations that drive people and organisations to behave in certain ways.

The incentives faced by Defence and DVA

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 costs to the person and the community). 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 the Air Force Association put it:

Operational capability will always be Defence's top priority. Defence's focus is the personnel element in force capability. Hence its efforts go into rehabilitating those service men and women capable of returning to operational status. History reveals it has little interest in the rehabilitation of service men and women after separation. There is therefore a high likelihood that rehabilitation of separating service personnel could be a distraction and afforded a lower priority. (Air Force Association, sub. DR267, p. 10)

And Stephan Rudzki said:

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)

While some took exception to the idea that Defence has a stronger incentive to rehabilitate members who can return to deployable status than those who cannot (DFWA, sub. DR299, p. 29), many participants agreed with the Defence Force Welfare Association, which said that:

To think that Defence would provide a lesser level of service and support to a person who are likely to transition out or is transitioning out of Defence is abhorrent (sub. DR299, p. 29)

Strengthening Defence's incentive to promote the long-term wellbeing of *all* members is at the heart of the Commission's recommendations to change the governance arrangements of the veteran support system (chapter 11). But as it stands, 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 (because the long-term costs are less visible to Defence).

DVA also has few incentives to focus on scheme sustainability or long-term costs (because the support system is uncapped and demand driven), 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 is limited external oversight and accountability (chapter 11). The functional split between Defence, as the employer and provider of rehabilitation to serving members, and DVA, as the effective administrator of the compensation and rehabilitation system for ex-ADF members also affects incentives.

Several inquiry participants (including Deborah Morris (sub. DR307) and Peter Sutherland (sub. DR192)) recognised the differing incentives faced by the two organisations. And the TPI Federation considered:

DoD does not have as its core business the incentive or responsibility to care for, or rehabilitate, wounded or injured Veterans. ... if another conflict should occur and then DoD would have no interest in caring for those who can no longer assist with that conflict. What would happen to them? (TPI Federation, sub. DR290, p. 32)

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 physical injury and mental illness with the ADF, and to seek treatment for those injuries and illnesses (chapter 5). For serving personnel, this is driven largely by concerns about 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)

David Peterson commented that:

... deployments are hard to come by in the current setting. No one wants to be the broken person and so, therefore, people under-report and they are not incentivised to report. There is no benefit in reporting. There’s only cost, both in administrative and also in an appearance that you’re doing unsafe training. (trans., p. 1286)

The National Mental Health Commission (NMHC 2017b, 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 concern for many people (chapter 5).

Financial payments to compensate veterans for a reduced earning capacity due to an impairment, and to veterans and their families to compensate for the pain and suffering associated with an impairment, also affect incentives for veterans to participate in rehabilitation and to return to work where they are able to do so. These issues are considered in chapters 13 and 14.

6.4 A changing environment for rehabilitation services

Broader changes within Defence also affect rehabilitation

Fewer opportunities for rehabilitation while in service

Earlier in Australia’s history, almost all of the functions necessary for the effective operation of the Defence Force were performed by military personnel. But gradually, many tasks were transferred to civilian personnel and contractors. This has had the effect of reducing the opportunities available for members to undertake alternative duties as part of their rehabilitation, as the Defence Force Welfare Association explained.

Hundreds of uniformed roles in training, administration and support which were available for ... rehabilitation, respite and lower medical grade postings for ADF members were removed and replaced by civilians. As a result, the ADF now has few posts available to support in-service rehabilitation. (sub. DR299, p. 30)

Many veterans and ex-service organisations expressed similar views, and considered that veterans with service-related health conditions could, and should, be employed by the ADF (box 6.7).

Box 6.7 Reduced scope for rehabilitation while serving in the ADF

Disabled Veterans of Australia Network:

There is no reason why the ADF cannot retain, retrain and reassign those unable to carry out the work they were previously trained for post disability. And DVA should be the leader in government departments in employing our ADFs discharged less able ... As I look back to my Army days there were WWII blokes far less than 100 percent fit (shell shocked, bomb happy) employed around the camps as general duties, driving, cleaning, fencing, repairing, cooks etc. and in the DVA of the late '80s there were limbless and wheelchair bound former Diggers employed. Why have these modes of employment been discontinued? You may not get forty hours of super employee work from our ADF disabled but you will give them and get from the public respect for employing them. And when the alternative to paying out pensions is offset against salary they the department and the whole nation benefits. (sub. DR288, p. 12)

RSL Tasmania:

[Defence] are more interested in maintaining defence capability, as they should, and have little use of broken service men and women. In times past, we would put broken service men and women into sedentary jobs to keep them with their mates while they recovered. Now it appears that the sooner they are gone they may be able to get a fit replacement ... (sub. DR205, att. 1, pp. 1–2)

Combined SA Ex-Service Organisations:

Veterans with service related health issues [should] be kept in the ADF until their issues are resolved or have been stabilized. Given current establishment levels, how these personnel can be gainfully employed (or trained) when many service employment categories no longer exist (e.g. cooks, stewards, drivers etc.) is questioned. (sub. DR188, p. 9)

Association of Totally and Permanently Incapacitated Ex-Service Men and Women South Australian Branch:

Veterans who are medically discharged are people who care about guarding Australia, they are security aware; can't Australia find a meaningful role for them. Defence must look harder to find a meaningful role for them in Defence; maybe not on the active list but if we had fewer outsources logistic jobs, then maybe we could retain these people in Defence. (sub. DR310, p. 11)

Robert Black:

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. (sub. 45, p. 2)

Brian McKenzie:

In times past, we would put broken service men and women into sedentary jobs to keep them with their mates while they recovered. Now it appears that the sooner they are gone they may be able to get a fit replacement. (sub. DR275, p. 2)

The initial decisions to outsource functions such as maintenance and base security were made decades ago, and the extent to which it took into account the effect on rehabilitation (and by extension, on the long-term wellbeing of veterans) is not clear.

But even today, there is little to suggest that decisions about the way Defence meets its requirements for staff and services are made with the long-term wellbeing of veterans in

mind. The rules and policies that govern Defence procurement decisions require those decisions to be made on the basis of value for money, where value for money is not necessarily the lowest price, but rather ‘the best possible outcome over the whole-of-life of the goods or services’ (DoD 2019c, p. 19). But the procurement rules and policies apply to the process of acquiring goods and services (Department of Finance 2019), not to the preceding decision about whether or not it is necessary to acquire those goods or services (as opposed to producing them in-house).

New arrangements for outsourced health services

In January 2019, the Defence Minister announced new arrangements to deliver health services to ADF members. From 1 July 2019, Bupa Health Services will replace Medibank Health Solutions as the provider of primary and specialist health services at both on-base health facilities and through a network of off-base health care and service providers (Pyne 2019). Defence’s initial contract with Bupa runs until June 2025, at a cost of over \$3.4 billion (AusTender 2019).

The contract includes rehabilitation services, which Bupa has subcontracted to Acumen Health. Acumen will be the ‘sole supplier of occupational rehabilitation services ... to all Defence members, irrespective of their location’ (Generation Health 2019). That is, rehabilitation services for ADF members will, in future, be delivered by a single national provider.

Defence is currently unable to measure the overall effectiveness of rehabilitation services (section 6.5). In the absence of such measurement, the Commission has concerns about Defence’s ability to ensure the quality or value for money of subcontracted rehabilitation services.

Rehabilitation providers also told the Commission that they believe that the effectiveness of ADF rehabilitation is being reduced by the medical focus that comes from rehabilitation being only one small part of a much larger health services procurement arrangement. For example, the Australian Rehabilitation Providers Association said that:

... the ADFRP has been inappropriately grouped under the medical services delivery model for Garrison Health which is overwhelmingly a medical model for service delivery. Workplace and vocational rehabilitation are delivered under a biopsychosocial model and therefore the ADFRP has been largely squashed off to the side and sub- contracted out of sight and out of mind. (sub. DR249, p. 3)

When governments choose to commission other providers to deliver services (rather than delivering those services directly), they remain responsible for the range of functions that both determine what services should be made available and the effectiveness of those services. These functions include policy design, regulation, oversight of service delivery, monitoring of provider performance, and system improvement (PC 2017b). It is important that Defence does not distance itself from its core role of rehabilitating injured and ill

members. It needs to accept full responsibility for the stewardship and delivery of the rehabilitation support that members require.

Changes to transition support

Defence provides a range of services to support members as they transition from the military. In late 2018 and early 2019, it made significant changes to its transition support services. The new program is a ‘needs-based support system that delivers services to transitioning members specific to their, and their family’s needs, irrespective of the length of the member’s service or mode of their transition’ (DoD 2019g, p. 3). This represents a significant and positive change from the entitlement-based programs that operated until 2018.

These changes, together with the reforms to transition governance and service delivery recommended by the Commission (chapter 7), will increase support available to veterans whose rehabilitation needs mean they must transition from the ADF. But just as importantly, they will change the approach to one of providing individualised and timely support, advice and referrals to veterans and their families, with clear accountabilities for ensuring that veterans receive the transition assistance they need.

DVA rehabilitation pilots and initiatives

Since mid-2018, DVA has introduced several new initiatives linked to rehabilitation support. For example, the Family Support Package was introduced on 1 May 2018. Those eligible for the Family Support Package are families of veterans who have undertaken warlike service and are participating in an approved rehabilitation program (as well as widow(er)s of certain veterans). Supports include brief intervention counselling, child care support and (for widow(er)s only) home help assistance. (The Family Support Package, and proposed extensions to the package, are discussed in chapter 19.)

Other new rehabilitation initiatives and pilots include ‘streamlined access to incapacity payments’ (box 6.8) and the ‘Accelerated Access to Rehabilitation’ pilot (box 6.9).

The veteran payment (an interim, means-tested income support payment for veterans while liability for their mental health condition is being determined) (chapter 3) is ‘linked to rehabilitation support’ (DVA 2018g, p. 50). However, the nature of this link is unclear, as veterans whose claim for liability has not yet been determined do not have access to DVA rehabilitation (except for some of those who participated in the pilot program described in box 6.9).

Box 6.8 **‘Streamlined access to incapacity payments’**

The ‘streamlined access to incapacity payments’ initiative removes the need for certain veterans who need to reduce their hours of work, or may be unable to continue working for periods of time, to lodge a claim to have their incapacity payments reinstated.

Veterans eligible for the initiative are those who:

- have a mental health condition(s) accepted under the *Military Rehabilitation and Compensation Act 2004* (MRCA) or the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA)
- are receiving incapacity payments, or were eligible for incapacity payments when they commenced work
- are unable to remain in their current work arrangements due to the accepted mental health condition(s); and
- have been participating in a rehabilitation plan which has a vocational (return to work) focus.

If all these conditions are met, the veteran’s rehabilitation plan will be extended by up to 12 months if and when they start work, to enable ongoing support from the rehabilitation provider. Then, if the veteran needs to reduce their hours or cease employment due to the accepted condition, the rehabilitation provider will contact the Department of Veterans’ Affairs and let them know, so that incapacity payments can re-commence.

Source: DVA (2018v).

Box 6.9 **The ‘Accelerated Access to Rehabilitation’ pilot**

The Accelerated Access to Rehabilitation pilot involved allowing veterans to be referred for a whole-of-person rehabilitation assessment and development of a rehabilitation plan while they were waiting for their claims for initial liability to be determined by the Department of Veterans’ Affairs (DVA).

The pilot was designed to include 100 veterans who lodged their first claim for liability under the *Military Rehabilitation and Compensation Act 2004* (MRCA), and was limited to those whose conditions are likely to be accepted as related to their service (DVA 2017n).

If the pilot achieved its aims, it will have:

- ... ensure[d] that veterans participating in the pilot will have their rehabilitation needs identified early and in some cases rehabilitation activities will commence prior to the claim being accepted. This will assist to minimise the ongoing effects of injuries and illness, and promote recovery and wellbeing. (DVA 2017n)

The pilot commenced in September 2017 and closed at the end of March 2018, and participants were drawn from locations across Australia. DVA is ‘considering the outcomes to determine whether the service model could be further extended’ (DVA 2018g, p. 51), but the results of the pilot have not yet been publicly released.

DVA is also working to improve its internal processes. In March 2019, it was ‘about to commence’ a project to improve its rehabilitation policy information within the Consolidated

Library of Information and Knowledge (CLIK)¹ in order to ensure it provides clear policy statements in a consistent way (DVA 2019b).

6.5 Insights on the effectiveness of rehabilitation services remain scarce

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 easy to access. For example:

- DVA only began measuring outcomes using a Goal Attainment Scaling and a Life Satisfaction Index (box 6.10) in 2015
- data on rehabilitation outcomes from the ADF, or from its contracted providers, is not published and was not provided to the Commission in a form that allowed a detailed evaluation of outcomes.

Are rehabilitation processes efficient and timely?

Efficient case management is particularly important for people receiving rehabilitation as their injury or illness can make it difficult for them to self-manage aspects of their care.

DVA is working within the confines of existing legislation, and requirements within that legislation, such as the requirement for condition stabilisation in the MRCA (chapter 14), and the requirement that liability is accepted prior to ongoing access to rehabilitation services. These legislative requirements (compounded in many cases by the delay between the onset of an injury or illness and the veteran submitting a claim) make it challenging for DVA to provide timely rehabilitation services.

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 management approach that, on paper, looks well designed and has formal lines of accountability. However, the effectiveness of services provided by outsourced service providers remains a black box (because of a lack of data).

A number of members (serving and ex-serving) and providers told the Commission about their rehabilitation experiences and a common theme was that ADF's case management fell well short of best practice. For example, APM Workcare said that 'as a Rehab provider for both ADF and DVA we see significant delays in DVA referring a member for rehabilitation

¹ The Consolidated Library of Information and Knowledge (CLIK) contains legislative, policy, and reference material used by DVA staff in providing service to DVA clients.

once they have discharged with an average referral timeframe of over 2 years (over 1500 referrals)’ (sub. DR219, p. 2).

Box 6.10 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.

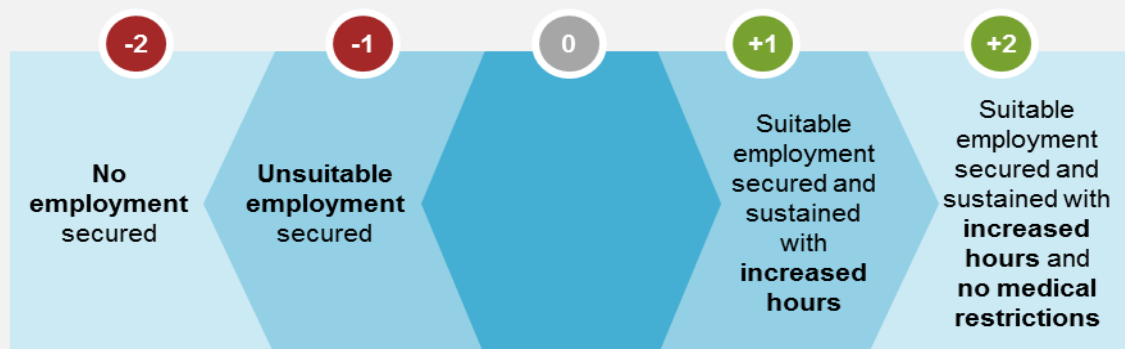
Providers work collaboratively with clients to tailor individual goals and to ensure they are appropriate and achievable. For each new goal, a scale is developed which describes specific outcomes.

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

DVA states that Goal Attainment Scaling improves its 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 (2017d).

There is little evidence on outcomes

In the case of both Defence and DVA, the evidence base on the outcomes from rehabilitation is *very thin* (box 6.11). This is in stark contrast to many other workplace health and safety schemes, where there is comprehensive reporting of outcomes. Defence and DVA are jointly working on developing the MRCA Rehabilitation Long-Term Study to deliver ‘a clear understanding of the effectiveness of current rehabilitation programs and services’ (DVA, sub. 125, p. 133).

The 2016 report by the Australian National Audit Office (ANAO) on the administration of rehabilitation services under the MRCA also made a number of recommendations on the need to improve measurement and reporting of rehabilitation effectiveness (ANAO 2016). Defence and DVA agreed to these recommendations, with qualification only regarding RTW measures. Despite this, many of the gaps identified by the ANAO persist.

Box 6.11 **An ‘evaluation vacuum’ that has persisted for decades**

In 2003, the Review of Veterans’ Entitlements found that:

There is a lack of evidence of a comprehensive, outcomes-focused approach to the evaluation of the rehabilitation programs conducted by DVA. Although DVA evaluates some programs, the Committee has been hampered in its considerations by the lack of evaluative data about some programs. (Clarke, Riding and Rosalky 2003, p. 679)

More than a decade later, the Australian National Audit Office made similar comments.

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. (ANAO 2016, pp. 8–9)

And 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. (NMHC 2017b, p. 29)

The effects of this dearth of information on veterans’ mental health care are considered in chapter 17.

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. In addition, DVA told the Commission that:

Given the breadth of activity currently occurring as part of DVA's transformation program and response to the Foreign Affairs, Defence and Trade Committee's report on the inquiry into suicide by veterans and ex-service personnel, commencement of the work [on the MRCA Rehabilitation Long-Term Study] has been deferred until 2019-20. (DVA, sub. 125, p. 133)

However, the reasons why or how these DVA activities are inhibiting the commencement of the second phase of a joint Defence–DVA study whose outcomes are already long overdue are unclear. If anything, the heightened awareness of the need to deliver better rehabilitation for veterans since 2011 provide added impetus for action.

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 (box 6.12); and other sources of feedback, such as surveys. It also took into account the views of inquiry participants.

Reported outcomes from ADF rehabilitation

The most comprehensive data on ADF rehabilitation outcomes is found in 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 ... 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. (JHC, pers. comm., 5 May 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, at least 20 percentage points below the Australian average (figure 6.5)
- Defence continues to not have a publicly available, reliable measure of treatment durability (although latest indications are that this is in development), and does 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.

Box 6.12 **Return to work: proxy measures?**

Both Defence and DVA noted a number of special features that, in their view, limit comparisons between return-to-work 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. Another difference is that Defence provides rehabilitation as an extension of a member's health care regardless of whether or not their condition is work related, and therefore includes members with conditions that would not be included in a workers' compensation system or return-to-work rate.

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. However, it considers that these comparisons do not take sufficient account of 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. (ANAO 2016, pp. 55–56)

While these points are noted, the rehabilitation literature places a strong emphasis on the connection between wellbeing and employment. 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)

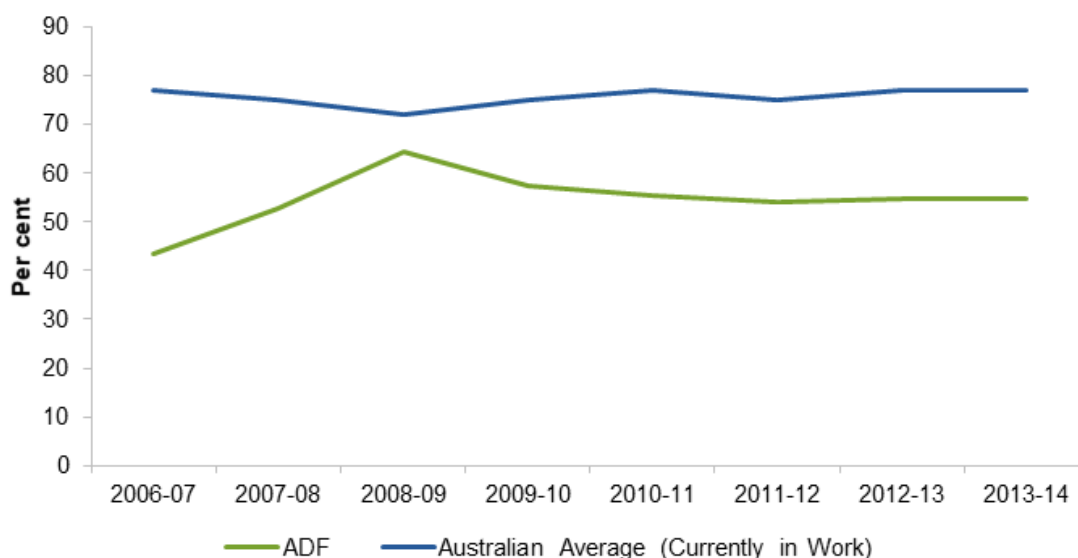
Employment is an important wellbeing domain for veterans (chapter 4), and as such, return to work should be a key measure of the effectiveness of rehabilitation services.

Defence also told the Commission that it 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)

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).

But the return-to-duty rate for financial year 2017-18 will only be calculated 12 months after the end of rehabilitation programs that conclude that year, that is, after June 2019. This means that the outcomes of rehabilitation for a veteran who received rehabilitation in, say, July and August 2017 are unlikely to be reported until September 2019 — a delay of more than two years. While the return-to-duty rate is a useful measure, the singular focus on a metric that can only be calculated with such delay is of concern, as it inhibits the kind of timely feedback that mean data can be used for service improvement.

These results and developments point to a reporting framework that remains cursory at best. The ADF rehabilitation program is now a long running program, but one that fails to demonstrate its outcomes relative to civilian programs in any comparable sense. Delays on further work on the MRCA Rehabilitation Long-Term Study 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.

The bottom line on outcomes of ADF rehabilitation

Participants shared the Commission's concerns about the effectiveness of the ADF rehabilitation program, and many participants supported the Commission's view that the ADF should do more to report on the outcomes of its rehabilitation program.² For example,

² See, for example, the Air Force Association (sub. DR267), APPVA (sub. DR270), Combined SA Ex-Service Organisations (sub. DR188), DFWA (sub. DR299), William Kaine (sub. DR197), Legacy

the Royal Australasian College of Physicians suggested that the ADFRP has ‘not been particularly effective with respect to actually returning ill and injured Navy (and by extension other ADF) members to normal duties’ (sub. DR234, p. 7). And Deborah Morris said:

Health professionals outside the ADF system are quite critical of the standard of care and rehabilitation that many members receive within the ADF including out of date practices which prolong rehabilitation and injury leading to poorer veteran outcomes. This raises a question pertaining to whether current medical arrangements are meeting the needs of individuals. (sub. DR307, p. 16)

Richard Salcole raised similar concerns.

Rehabilitation is outsourced to civilian organisations that do not understand nor take into account the full nature of service life. (trans., p. 429)

And, as noted above, rehabilitation providers told the Commission that they believe that the effectiveness of ADF rehabilitation is being reduced by the medical focus that comes from rehabilitation being only one small part of a much larger health services procurement arrangement. Thorough measurement of rehabilitation outcomes, and public reporting of those outcomes, is an essential first step in addressing such concerns and ensuring that ADF rehabilitation meets the needs of veterans.

RECOMMENDATION 6.1 PUBLIC REPORTING ON ADF REHABILITATION

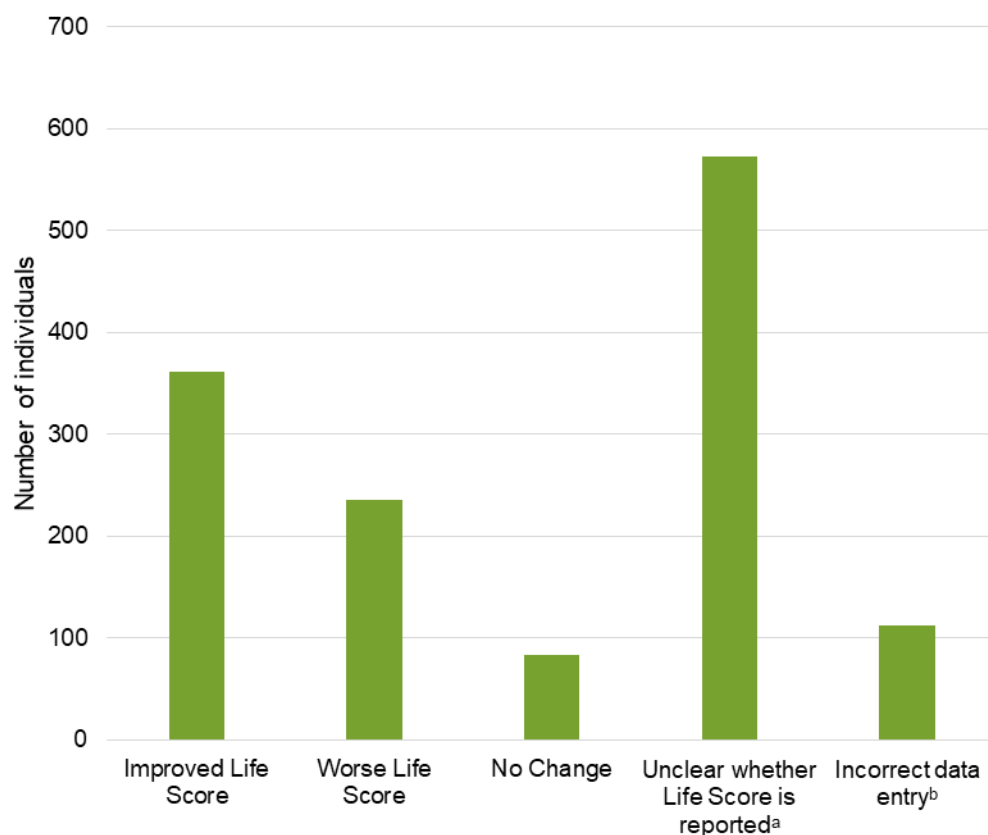
The Australian Defence Force Joint Health Command should report more extensively on outcomes from the Australian Defence Force Rehabilitation Program in its Annual Review publication.

Reported outcomes from DVA rehabilitation

Data provided by DVA on its rehabilitation program (discussed in more detail in chapter 18), are also of very limited use in the context of assessing effectiveness of the rehabilitation services it offers to veterans. In many instances the data are of poor quality due to the presence of coding and integration errors (figure 6.6).

Australia (sub. DR220), Brian McKenzie (sub. DR275), Deborah Morris (sub. DR307), RSL Victorian Branch (sub. DR273), TPI Federation (sub. DR290), Veterans’ Advisory Council of South Australia (sub. DR266), VVFA (sub. DR215) and the War Widows’ Guild of Australia (sub. DR278).

Figure 6.6 **DVA Life Score results**



^a This refers to cases where there is a zero 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 MRCA Rehabilitation Long-Term Study, DVA appears 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
- 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
Veterans' Vocational Rehabilitation Scheme				
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.

Rehabilitation providers told the Commission that they routinely collect data to fulfil the requirements of other purchasers of rehabilitation services. For example, Comcare requires providers to report RTW outcomes (including whether the RTW occurred at the same employer or a new employer), as well as information on the durability and cost of those RTW outcomes. Providers also collect customer and client feedback. But rehabilitation providers also told the Commission that they do not know how DVA uses the data that it

receives from providers to track and evaluate outcomes, or even whether DVA systematically captures the information. What this suggests is that DVA could, with relatively little cost or delay, substantially strengthen its data base on the rehabilitation services it funds.

Some participants also said that rather than taking a whole-of-person approach, DVA takes a narrow approach, to the detriment of rehabilitation outcomes.

I think it's costing a fortune and I don't think we're getting great outcomes. I have dealt with many rehabilitation providers that have come to us and said 'Oh, we only wanted you to get this man housed', and I say 'But he's a raging amphetamines addict. We can house him all week long. We're not going to get the outcome that we need for this gentleman [unless we're] dealing with his underlying problems.' 'Oh yes, let us worry about that.' (Jason Devereux, trans., p. 187)

This suggests the need for changes to the way in which DVA conceives of its role as steward of rehabilitation services (section 6.6).

Feedback surveys and results from other sources

Recent research on *Pathways to Care* undertaken as part of the Transition and Wellbeing Research Programme (box 18.7, chapter 18) looked at whether serving and ex-serving members had access to evidence-based mental health treatment. It surveyed a sample from both groups, and found that ex-serving members had more limited access to rehabilitation services while serving members were more satisfied with the services provided.

... satisfaction with [mental health] 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 we heard in this inquiry — rehabilitation service effectiveness and access is better for serving ADF members than for those who have transitioned out.

EML's recent review of forty DVA veteran claims, also found significant room for improvement in the approach to rehabilitation, particularly in terms of measuring success.

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)

And many other participants shared the view that DVA should substantially increase its efforts to measure and improve veteran rehabilitation outcomes.³ Allied Health Professions Australia noted the:

... significant challenge of reporting on outcomes given the current lack of agreed outcome measures, the lack of consistent systems to measure and report on these outcomes and the multitude of factors and time delays that can be involved in achieving outcomes. Many outcomes are heavily dependent on factors that are beyond the practitioner's control. We propose that an initial step towards the implementation of this recommendation is work with the relevant parts of the health and social support sectors in order to begin mapping consistent outcomes measures that could be applied across different types of rehabilitation service. (sub. DR261, p. 4)

DVA will need to include rehabilitation providers (as well as veterans and their families) as it works to establish better rehabilitation outcome measures, because robust performance and outcomes frameworks include input from both service users and service providers in their development (chapter 18).

RECOMMENDATION 6.2 EVALUATION AND REPORTING ON DVA REHABILITATION

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

- evaluate the efficacy of its rehabilitation and medical services in improving veteran 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

Questions were also raised about DVA's oversight of rehabilitation providers and 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

³ They included the Air Force Association (sub. DR267), APPVA (sub. DR270), DFWA (sub. DR299), Aaron Gray (sub. DR202), William Kaine (sub. DR197), Occupational Therapy Australia (sub. DR289), Legacy Australia (sub. DR220), RSL Victorian Branch (sub. DR273), TPI Federation (sub. DR290), Veterans' Advisory Council of South Australia (sub. DR266), Veterans Health Advisory Council (sub. DR251), Vietnam Veterans Association of Australia (sub. DR271), VVFA (sub. DR215) and the War Widows' Guild of Australia (sub. DR278).

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 and rehabilitation does not feature any of the three outcomes of DVA's reporting framework (box 11.2).

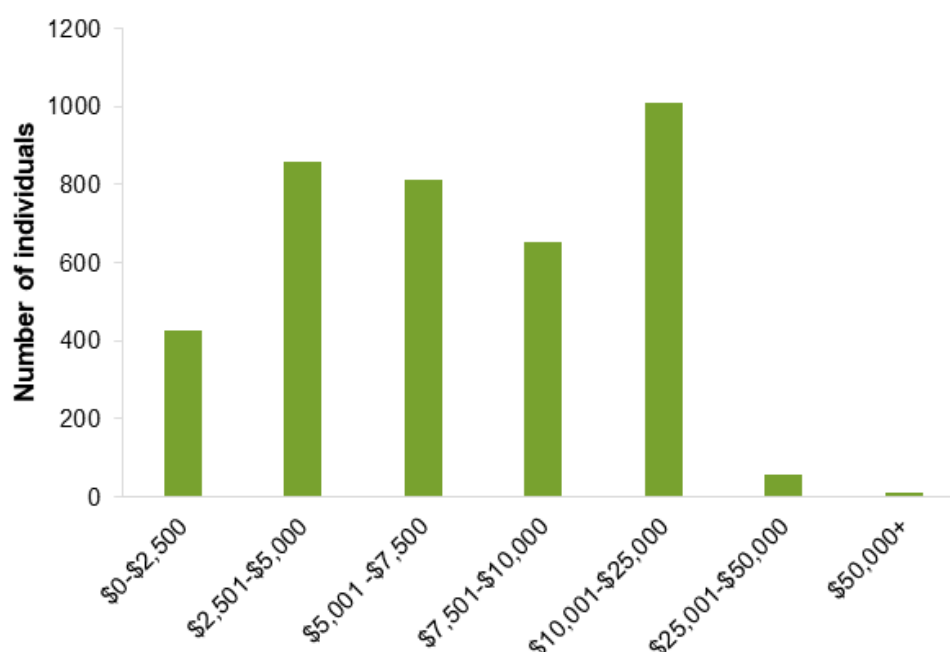
The ANAO also said:

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 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 was under \$20. 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 has not translated into sufficient priority being given to rehabilitation on the ground, or to 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 more 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 also 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.

6.6 Other ways to improve rehabilitation services

Better data collection and reporting will go a long way towards driving improvements in rehabilitation services for veterans. But other changes are also needed.

- Broader reforms to the veteran support system, so that priority is given to the wellbeing of veterans over their lifetime.
- A greater focus on stewardship of rehabilitation services, so that services are designed, procured and managed better.
- Attention needs to be given to the provision, oversight and funding of rehabilitation services immediately prior to, and following, discharge of personnel from the ADF.

The potential effects of broader reforms to the veteran support system

The Commission is recommending a suite of reforms that will improve the quality of veteran support, and lead to better outcomes for veterans.

Levying a premium on Defence and establishing the Veteran Services Commission (VSC) as an independent body (chapter 11) is 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.

- The VSC, for example, with a focus on the lifetime costs of supporting veterans would have much closer engagement with veterans. The VSC would identify and respond to the individual needs and circumstances of veterans (including taking into account the needs of a veterans' family in supporting a veteran to manage or recover from injury or illness). It is also expected that the VSC would proactively seek out at-risk veterans and offer them early rehabilitation and treatment before their conditions worsen.
- Based on the experience in other sectors and industries, levying a premium on Defence would drive enhanced reporting frameworks, as inputs into 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 would 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 the proposed governance arrangements discussed in chapter 11.

The VSC's approach to health care (chapter 16) and mental health (chapter 17) will also assist rehabilitation by improving the health and independence of veterans.

These changes should also strengthen the incentives to provide early and effective rehabilitation and to get serving members of the ADF to report problems and to seek treatment (and for commanding officers to support this). 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.

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 greater focus on stewardship

A common theme behind many of the observed deficiencies in the way rehabilitation services are provided is that both departments are performing poorly in their role as system stewards of rehabilitation for veterans.

Decisions about which services to provide

Many participants expressed concern that — regardless of its policies on whole-of-person rehabilitation — in practice, DVA staff and contracted rehabilitation providers do not take a sufficiently flexible and holistic approach to rehabilitation. For example, Legacy Australia said that ‘an open-minded approach to rehabilitation options would empower veterans to be in control of their future and have a positive impact on families. The current system is too prescriptive, which can cause unnecessary angst’ (sub. DR220, p. 4). The Australian Rehabilitation Providers Association also said that:

The potential for far greater civilian employment outcomes post service are significant and can be improved dramatically through evidence-based workplace rehabilitation that adopts the biopsychosocial model. (sub. DR249, p. 2)

And Pamela Garton said more could be done in the area of triage, tailoring rehabilitation and empowering people to manage their own lives. Soldier On’s view was that the current system ‘needs to be brought more in line with contemporary workers’ compensation schemes and modern person-centred approaches to rehabilitation’ (sub. DR245, p. 4). This would mean greater reliance on a case management approach. As RSL NSW said:

Case management can make an enormous difference for vulnerable veterans struggling to steer their own rehabilitation, however, this service currently represents the largest gap in service provision across the veterans’ sector as a whole. (sub. 151, p. 26)

Others advocated for rehabilitation to include a broader range of therapies, such as art therapy and arts engagement (box 6.13).

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 a willingness to consider new approaches. And they appear to be streets ahead of DVA in terms of providing holistic and tailored rehabilitation services. Another example of good stewardship comes from New Zealand, which last year released a Veteran Rehabilitation Strategy and work plan (box 6.14).

Box 6.13 Art therapy and arts engagement

There is emerging evidence about the role and value of art therapy and facilitated arts engagement in supporting veterans and families. For example, in the United States, art therapy in conjunction with cognitive processing therapy has been found to improve trauma processing in veterans with post-traumatic stress disorder. Veterans considered art therapy to be an important part of their treatment as it provided healthy distancing, enhanced trauma recall, and increased access to emotions (Campbell et al. 2016).

The arts can also address one of the reasons a service member or veteran might avoid seeking treatment. Unlike exposure-based therapies, when using the arts, individuals can express or experience their thoughts and feelings without necessarily having to talk about or directly confront the trauma, if they are not ready to do so (Collie et al. 2006). Participating in pleasurable activities also addresses emotional numbing, another feature of post-traumatic stress — a lack of interest in activities, detachment from others, and a restricted range of emotional expressiveness (Americans for the Arts 2013).

In Australia, the Australian National Veterans Art Museum (ANVAM) sees a role for arts-based physical, mental and social rehabilitation.

The arts offer a range of mediums (e.g. visual arts, creative writing and performance arts) that can be called upon to meet the needs of individuals in the veteran community. ANVAM's arts facilitators design person-centred programs in partnership with other support mechanisms. (sub. DR296, p. 8)

Art therapy and facilitated arts engagement could be particularly important for the large and growing proportion of rehabilitating veterans with mental illness.

Box 6.14 New Zealand's Veteran Rehabilitation Strategy

In 2018, Veterans' Affairs New Zealand released its Veteran Rehabilitation Strategy 2018–21. The strategy 'is designed to give practical support and assistance to the men and women who need it, so they can be well and independent, and achieve the best that they can for themselves, their whanau [families], and their communities' (VANZ 2018a, p. 6).

Veterans' Affairs New Zealand also published a detailed work plan for the most critical actions which are needed in the first two years of the strategy. The work plan:

- shows the actions that Veterans' Affairs New Zealand will take so that rehabilitation will be a positive and effective experience for its veteran clients
- contains timelines for each action
- includes measures to enable an assessment of progress against the action.

Sources: VANZ (2018a, 2018d).

Some said that DVA's current approach fails to recognise that families and carers are an essential element of veterans' rehabilitation. As Carers NSW highlighted:

Carers of veterans play a critical role in supporting their rehabilitation and reintegration following injuries sustained from service. (sub. DR264, p. 1).

EML, noting that there is a well-researched link between family support and effective rehabilitation for injured workers, and reflecting on the DVA cases it reviewed, said:

In EML's review, a majority of individual veteran cases showed a need for greater family engagement, support and assistance. DVA's current paradigm for personal injury management is narrowly focused on the injured person, which can overlook the fact that the first line of support for an injured veteran is often not a treating practitioner, ancillary support service, employer or the case manager — but rather, the veteran's immediate family. Engaging family and social support structures in the rehabilitation process would better facilitate mental and physical healing for veterans, supporting them back into the workforce where appropriate. (sub. 90, p. 4)

Carers NSW also pointed to potential models for providing increased support to veterans' carers. In a tailored problem-solving training program in the United States, for example, family caregivers of veterans who participated in the program experienced significantly decreased depression, fewer health complaints, increased satisfaction with life and demonstrated a more positive approach to problem solving (Easom et al. 2018). Evidence of the effectiveness of such programs is still emerging. Developing the evidence base for caregiver support interventions could form part of the priorities that are included in the veteran research strategy (chapter 18).

The Commission also recognises that the spouses or partners of veterans with PTSD are particularly likely to have symptoms of secondary traumatic stress and health issues (Easom et al. 2018). It is recommending changes to DVA's Family Support Package, so that it provides a broader range of support (including mental health support) to more families (chapter 19).

Relationships with contracted providers

Despite some recent improvements, many participants agreed with the Commission's observations about the need for change in the way that rehabilitation services are commissioned, and in the way in which DVA and Defence interact with providers.⁴

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 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)

⁴ They included the Air Force Association (sub. DR267), APPVA (sub. DR270), Bob Bak (sub. DR262), DFWA (sub. DR299), William Kaine (sub. DR197), Legacy Australia (sub. DR220), Peter Sutherland (sub. DR192), RSL Queensland (sub. DR256), RSL Victorian Branch (sub. DR273), TPI Federation (sub. DR290), Veterans' Advisory Council of South Australia (sub. DR266), Veterans Health Advisory Council (sub. DR251) and the VVFA (sub. DR215).

Other participants echoed that view, pointing to an excessive focus on minutiae.

‘It’s not about the amount of money, it’s about what the invoice and receipts look like’, and I thought that’s a pretty bizarre statement to make, because for us it’s got nothing to do with invoices and receipts, it’s got to do with the veteran and their outcome. (Jason Devereux, trans., p. 188)

DVA’s interaction with rehabilitation providers currently appears restricted to ensuring they fulfil the terms of their contracts. There is little or no evaluation of the success or otherwise of a client’s treatment. (War Widows’ Guild of Australia, sub. DR278, p. 7)

An open-minded approach to rehabilitation options would empower veterans to be in control of their future and have a positive impact on families. The current system is too prescriptive, which can cause unnecessary angst within the veteran family home ... it is unacceptable that the current system, in effect, waits until the veteran and or the family is in crisis before providing support. These services need to be more proactive prior to any crisis. (Legacy Australia, sub. DR220, p. 4)

Why a psychologist needs to approve attendance at meaningful engagement activities such as music or wood working is beyond reason. (RSL & Services Club Association 2018, p. 4)

There is also concern that DVA’s process-driven approach gives insufficient regard to individuals’ motivations. This means that interventions may not be effective in addressing underlying problems, as Pamela Garton pointed out.

What I do see DVA doing now is goal attainment, to scale in the life skills inventory, which — they’re a measure, but they’re not valuable in terms of actually assisting to develop an intervention plan, in my opinion. Because what they don’t do is identify ... what are the drivers for that individual? What are their beliefs, what are their expectations? What are their attitudes, how they seem in managing their pain. Are they fearful that, in fact, if they’re hurting, then it’s harm? Because unless you understand those components of the individual, you can’t assist them to achieve those goals. So having a goal attainment scale is all very well, but unless you know what’s actually driving behaviour underneath, you’re not going to help the individual persist. (trans., p. 319)

Rehabilitation providers told the Commission that DVA’s requirements are more onerous than those of many other workers’ compensation and life insurance rehabilitation systems. The Australian Rehabilitation Providers Association said:

The foundation for rehab provider organisations is the Comcare model, which is a mature and well-developed accreditation system, with extensive governance and quality assurance requirements upon the organisation. In addition to this are extra measures set by DVA to ensure that the individuals working in our organisations are highly skilled and carry levels of expertise in working with veterans. (trans., pp. 1302–03)

By ensuring a minimum level of experience, expertise and cultural awareness across all rehabilitation providers and individual rehabilitation consultants, it is possible that DVA’s additional requirements have improved the quality of the rehabilitation services provided to DVA clients. But it is equally possible that by increasing the administrative burden on providers above those imposed by other purchasers of rehabilitation services (such as Comcare and transport accident insurers), there could be unintended adverse outcomes. In particular, the highest quality providers (those who get the best results and are in highest

demand) may choose to no longer accept veteran clients, to avoid DVA's administrative and training load.

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 generally good. But even so, the Veterans Support Centre Belconnen and RSL Belconnen Sub Branch expressed concern about the 'significant shortfall' in rehabilitation support for serving members (sub. DR229, p. 10).

And questions remain about the efficacy of ADF rehabilitation, including around the mix of services provided in-house and by contractors. There are also concerns about an overly medical focus, and about the subcontracting of the ADF Rehabilitation Program more broadly (section 6.4).

Improving rehabilitation 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 contributing factor to poor rehabilitation outcomes. Many participants agreed with the Commission's observations about the need to improve the provision and coordination of rehabilitation during the transition period.⁵ For example, Stephan Rudzki said:

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)

Other participants highlighted how the current processes do not work together to promote veteran wellbeing.

RSL Queensland's observations — accrued over many cases — is that ADFRP, the On-base Advisory Service (OBAS), Case Coordination, Commonwealth Superannuation Commission and DVA Rehabilitation Coordinators come together in a series of disorderly communications, with the best interests of the client subservient to a process that is managed across different departments with no clear communication channels and which cut across different sections and management lines within DVA — also with no clear communication channels. (sub. DR256, p. 14)

RSL Queensland suggested that 'rehabilitation services and on-going case management for medically transitioning members should be brought together within DVA before the actual

⁵ They included APPVA (sub. DR270), Bob Bak (sub. DR262), William Kaine (sub. DR197), Legacy Australia (sub. DR220), Peter Sutherland (sub. DR192), RSL Queensland (sub. DR256), RSL Victorian Branch (sub. DR273), TPI Federation (sub. DR290), Veterans' Advisory Council of South Australia (sub. DR266), Veterans Health Advisory Council (sub. DR251) and the VVFA (sub. DR215).

transition so there is a holistic corporate memory and approach to the overall task' (sub. DR256, p. 15). RSL Tasmania took the opposite approach, and said:

... any rehabilitation program being undertaken at the time of discharge should continue to be provided by Defence until compensation claims are settled by DVA or the veteran is fully fit for suitable civilian employment. (sub. DR205, att. 1, p. 2)

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)

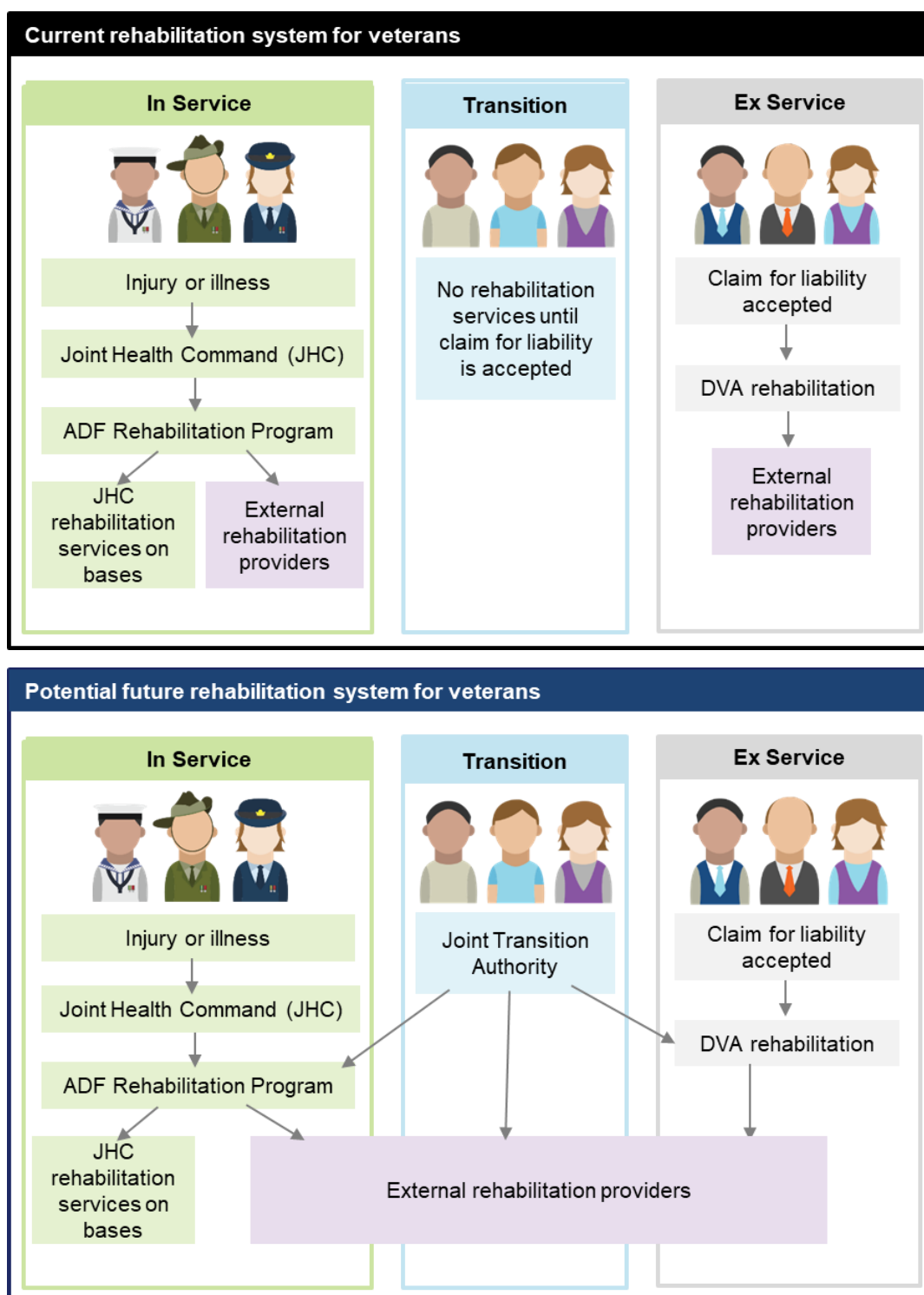
For transitioning personnel who require rehabilitation during transition, a more coordinated approach is required. The Commission's proposed new Joint Transition Authority (JTA) will play a key role in ensuring continuity of rehabilitation services for transitioning personnel, at some point prior to their discharge, and, on a continuing basis after discharge until their initial claim is determined by DVA (figure 6.8). The Joint Transition Authority would be tasked with 'bridging' the rehabilitation services provided or organised by JHC, while in service, and DVA-funded services provided following discharge.

As discussed in chapter 7, the new JTA should be responsible for preparing members to leave the ADF and supporting their transition to civilian life.

The JTA would need to ensure that all serving veterans who need psychosocial rehabilitation services have access to them. This would include addressing concerns about variable access to the meaningful engagement activities program, such as those raised by Kathleen Moore.

Meaningful Engagement during rehabilitation Program – although this program was initiated in 2012 it is not clear how to access this program and has not been made available to everyone. Again if the Command is not supportive to the injured individual or the program is not available in that State or Region, the individual misses out, and therefore there is not equal opportunity for all members. There are individuals and families who are missing out. (sub. DR221, p. 3)

Figure 6.8 An improved system of rehabilitation and wellness supports



RSL Queensland emphasised the importance of education as part of rehabilitation.

... all veterans who open a rehabilitation case should be encouraged to consider the possibility of further education to enhance their career prospects. (sub. DR256, p. 18)

The proposed veteran education allowance (recommendation 7.3) will also enhance the range of services available to rehabilitating veterans.

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 the 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.

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, demanding 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.

RECOMMENDATION 6.3 COMMISSIONING AND INTEGRATION OF REHABILITATION SERVICES

Defence and the Department of Veterans' Affairs should 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 the Joint Transition Authority (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.

7 Transitioning to civilian life after military service

Key points

- About 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 about eight years. About 18 per cent of those who leave the ADF do so for medical reasons.
- Leaving the military entails unique challenges, and these are easily underestimated. This is why veterans are assisted in their reintegration to civilian life by a system of transition support that has no civilian parallel.
- Despite the 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. But some find transition very difficult, and can go on to develop mental health or other problems. The transition period can also be difficult for members of a veteran's family.
- Defence has recently introduced a range of new programs and services to better support veterans and families during transition. But neither Defence nor the Department of Veterans' Affairs (DVA) has clear responsibility for all aspects of veterans' transition, and Defence is moving hastily to outsource much of its role to external providers. It is unclear how Defence plans to keep track of which services work well (and which do not), and why and where extra supports should be targeted. This is not an optimal approach.
- 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 they transition. But until very recently services were not targeted to this group. Navigating the available services can also be confusing for those who need them and there is insufficient focus on veterans' lifetime wellbeing.
- To improve military-to-civilian transition, two main changes are needed. First, responsibility for preparing members for, and assisting them with, their transition to civilian life should be centralised in a new body within Defence — the Joint Transition Authority (JTA). The JTA would consolidate transition support currently provided by Defence and DVA, and be largely staffed by ADF and DVA personnel. Its functions would include:
 - engaging every veteran 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 12 months as needed)
 - ensuring that veterans have continuity of rehabilitation and other support services
 - reporting on transition outcomes to drive further improvement.Longer term reintegration supports will be through the Veteran Services Commission.
- Second, an improved package of transition support is needed. The package should include the enhanced services provided by the JTA, as well as support for veterans to gain skills and qualifications once they leave the ADF, by trialling an education allowance for veterans undertaking full-time education or vocational training.

About 6000 people leave the Australian Defence Force (ADF) each year (DoD 2019g). Most make a relatively smooth and successful transition to civilian life, but some veterans can find transition difficult. Their family members — including wives, husbands, partners, parents and children — can also need support when veterans are reintegrating into civilian life.

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 their families 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.

A range of terms are used to refer to the time when a person leaves the military (box 7.1). The Commission has chosen to use the term 'transition'.

Box 7.1 Leaving the military: repatriation, reintegration, transition?

Many terms have been used to describe the point at which a veteran leaves military service. When Australia's veteran support system was first established, it focused on 'repatriation' of men who had recently been 'demobilised' and returned from war. In subsequent years, the Australian Defence Force (ADF) has spoken of 'discharge' or 'separation' as the moment a veteran leaves service. A parliamentary inquiry into the topic used many terms, including 'leaving one's job in the ADF, separating from the military, engaging in military to civilian transition, or transitioning from the ADF back to civilian life' (JSCFADT 2019, p. 9)

Within the military, the term 'transition' has been adopted, with Defence saying that it:

... now prefers the terminology 'transition' over separation or discharge, because it is reflective of the approach at the end of a period of full-time/permanent service to transition to a different Service Category rather than cutting ties to the organisation completely. This terminology also assists those who are leaving for medical or administrative reasons to understand that they remain a valued member of the Defence family, and have not been cut off from Defence or their military identity. (DoD 2019d, p. 13)

This change has not been welcomed by *all* veterans. For example, V360 Australia said:

I do not like the word transition. I think a lot of people have a problem with that word. We're not transitioning people at all. We might perhaps transition them into a military life, but we're then reintegrating them into our community, especially those that have joined young and those that have, you know, difficulty with things that we take for granted, perhaps financial literacy, dealing with connecting power for your house, in fact going and looking at a house that wasn't handed to you by [Defence Housing Australia]. (trans., p. 178)

However, others considered that they are not 'reintegrating', but rather becoming something completely new. 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. (Office of the Veterans Ombudsman Canada 2017, p. 24)

In this sense, 'reintegration' does not capture the experience. In light of this, the Commission has chosen to use Defence's preferred term, referring to leaving the military as 'transition'.

Transition in this report generally refers to transition from full-time military service, whether or not the veteran subsequently joins the reserve forces. The issues associated with leaving reserve service are dealt with briefly at the end of the chapter.

7.1 Why transitioning well matters

Leaving the military is a major life event

Everyone who joins the military will eventually leave the service, and a person's transition experience can shape their experiences for many years. For the large majority, transition to civilian life is successful, but for a minority transition is difficult.

The 65% of veterans that 'thrive' after transition (viz. increase social and economic capital) far outweighs the much smaller proportion (30%) that 'struggle to survive' and may therefore need to access [Department of Veterans' Affairs (DVA)] support. (ADSO, sub. DR247, p. 15)

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 the Returned and Services League (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 Royal Australian Armoured Corps (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* study (conducted as part of the Transition and Wellbeing Research Programme — box 18.7, chapter 18) pointed out:

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 2017b, 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)

Employment (or other meaningful activity for those who are not capable of paid employment) is also essential to a good transition. The Royal Australasian College of Physicians said that:

... focusing on gaining employment, or skills to enable employment, should be a key focus during transition from the ADF, as a far more effective measure for promoting mental health and well-being than the current emphasis on the provision of mental health services. (sub. DR234, p. 8)

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. 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 that they are ill-equipped to handle.

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)

As one veteran put it, in Defence 'the norms of society do not apply' (William Kearney, sub. DR285, p. 1).

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.

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 that require particular physical skills and have unusual timetables or schedules, such as professional sport or opera singing. 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 well managed, they can adversely affect veterans' success in living and working as a civilian, as well as their mental health (VACI 2017). Those who transition into unemployment are also at increased risk, as unemployment is a known risk factor for suicide. And the process of discharge can affect veterans for many years to come, as a veteran who discharged in 1972 pointed out.

The circumstances of my discharge from the Army has a direct bearing upon my life over the past 30 years under the DVA System (Disabled Veterans of Australia Network, sub. DR288, p. 10)

In addition, because the commitment to serve is a whole-of-family commitment, veterans' families can also be affected by their transition.

Effective transition support services are essential

To 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 veterans' 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 mean 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:

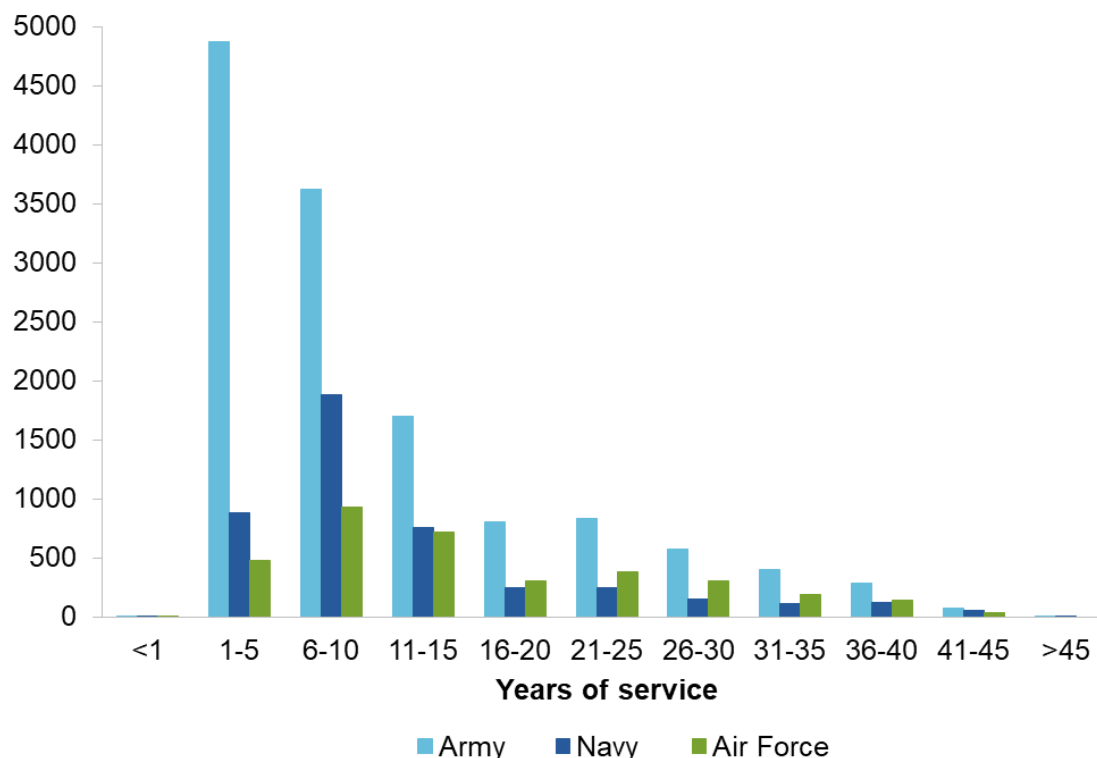
- about 62 per cent had served in the Army
- 21 per cent in the Navy
- 17 per cent in the Air Force
- over 60 per cent had served for 10 years or less when they left (figure 7.1).

Of those ADF members who transitioned in 2015, 45 per cent had served four years or fewer (DVA 2016e) The median length of service of permanent ADF members is currently 8.7 years (DoD 2018n), and the mean length of service is less than 8 years (DoD 2019g).

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 (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).

Figure 7.1 Length of service at separation from the ADF
2012–2016



Source: Australian Government (2017a).

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).

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 2018i). 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.

The data collected as part of the Transition and Wellbeing Research Programme (box 18.7, chapter 18) provide a partial snapshot. But 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 2018m)
- 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 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 7.2). Veterans also face particular health risks when they transition, including the risk of social isolation and weight gain (DVA 2015f, p. 7). And, as discussed in chapter 17, 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).

Box 7.2 **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 the total number of veterans is not known.

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 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 the unemployment rate for veterans is lower than, or similar to, that of the general community.

- In 2014-15, 3 per cent of working-age people who have served in the ADF were unemployed (AIHW 2018a, p. 30).
- A survey conducted as part of the Transition and Wellbeing Research Programme (box 18.7 in chapter 18) 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.

(continued next page)

Box 7.2 (continued)

- Surveys conducted by Defence of members who left the ADF since July 2017 suggest that 10 per cent were still looking for work seven months after transition (DoD 2018m).
- The Minister for Veterans' Affairs recently stated that 'the rate of veteran unemployment currently sits about 8 per cent 13 months after moving into civilian life' (Chester 2018c).

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. 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 searches take 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 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).

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 2017f, p. 71), but the results of this research are not yet published.

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.

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. Many veterans' organisations also provide transition assistance to veterans, often in conjunction with welfare support and advocacy (chapter 12). Examples include programs run by Mates4Mates and Soldier On.

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 [ex-service organisations] such as ourselves, and others, provide opportunities for veterans to access new 'social villages' or 'tribes' through various social connection activities. (Mates4Mates, sub. 84, p. 6)

Soldier On has placed considerable resources into the establishment of an employment and education program that is linked to its social connection, mental health support and case management services. Soldier On currently has over 140 companies that have signed up to work with us in a program that has seen hundreds of veterans and their families placed in meaningful roles and the business community educated as to what a veteran can bring to a work force. (Soldier On, sub. DR245, p. 5)

A range of charitable, philanthropic and other non-government organisations also have transition support programs for veterans. For example, The Prince's Trust Australia offers a range of programs designed to help transitioning ADF members to start or grow their own businesses (Prince's Trust Australia 2018). And the Australian National Veterans Art Museum said that it 'supports transitioning veterans and families through arts-based programs with the primary focus on identity' (sub. DR296, p. 8; box 6.13).

While State and Territory Governments have no formal responsibility for veterans' transition, some support veterans, such as through initiatives encouraging veterans' employment in the public service (for example, NSW Government 2017; Queensland Government 2018a; Victorian Government 2019b), and Western Australia is reportedly planning to introduce a quota for hiring veterans in the WA Public Service (Butterly 2019).

To attempt to make sense of the complex web of Defence and DVA 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, and the role of advocates in supporting veterans through the claims process is considered in chapter 12.

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 7.3) and finding civilian healthcare providers.

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 (DFWA) 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 (DoD 2017e). This is similar to the number reported by the Australian National Audit Office in its *Assistance Provided to Personnel Leaving the ADF* report 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.

Administrative arrangements differ between services, with the RSL Victorian Branch pointing to a 'marked gap in the way that an individual is handled as he or she leaves Navy, Army or Air Force' (trans., p. 739).

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 7.3 **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 pointed out 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 (DoD and DVA 2018). Decisions about a member's medical fitness are made in accordance with the Medical Employment Classification system (box 7.4).

Box 7.4 **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), a case manager must 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

A new needs-based support system ...

Defence provides a range of services to support members as they transition from the military. In late 2018 and early 2019, it made significant changes to its transition support services. The new program is 'a needs-based support system that delivers services to transitioning members specific to their, and their family's needs, irrespective of the length of the member's service or mode of their transition' (DoD 2019g, p. 3). This represents a

significant departure from the entitlement-based logic that underpinned programs that operated until 2018, notably the Carer Transition Assistance Scheme (box 7.5).

Box 7.5 The former Career Transition Assistance Scheme

The Career Transition Assistance Scheme (CTAS) was designed to facilitate veterans' transition into civilian employment. It was an entitlement-based scheme and offered limited support to members who transitioned voluntarily and had completed less than 12 years of service.

A review of the CTAS completed in August 2018 found that:

- there were 'no requirements in the policy to consider the well-being of the member or their family in the decision making process to access CTAS services' (2018h, p. 20)
- the CTAS, by being based on eligibility by length of service was 'failing to support those members most in need of support' and did 'not enable Defence to take into account the differing needs of members and adapt the scheme to meet individual needs' (2018h, p. 21)
- the CTAS did 'not cater for, or adapt to, the differing needs of members, including issues around self-perception when transitioning from the ADF' (2018h, p. 23)

These findings highlight the many inadequacies of the CTAS and, as a result of the CTAS review, Defence has changed the way transition support services are provided.

Source: DoD (2018h).

The changes include:

- introducing the concept of a transition specific support window, which starts when it is clear that the veteran is going to transition, and runs up to transition and then 12 months post transition for most veterans
- replacing the tiers of support provided under the Carer Transition Assistance Scheme (CTAS) with four risk-based pathways.
 - Pathway One — the member is likely to need minimal coaching and support in the transition process. The member is well prepared for the transition to civilian life and has a clear plan.
 - Pathway Two — the member would benefit from some needs-based coaching and transition support. The member has some uncertainty around his or her future plans and general direction.
 - Pathway Three — the member fits within a known risk cohort and would benefit from comprehensive coaching and transition support. The majority of the member's needs are related to employment.
 - Pathway Four — the member fits within a known risk cohort and would benefit from comprehensive coaching and transition support. The member and his or her family have complex needs that are multifactorial in nature and transition will require significant stakeholder engagement.

The new suite of services will include:

- One-day job-search preparation workshops for veterans and their partners, available at any time
- Career transition coaching, available to veterans and partners during the transition-specific support window. Career coaching will be provided on a one-on-one basis, with members being able to access one module, multiple modules or all modules of coaching depending on their assessed needs. The modules cover topics such as developing civilian career goals, personality profiling, job-search skills, personal branding and marketing, interview skills and negotiation skills (DoD 2019a).
- Personalised Career Employment Program — this is a service for veterans at higher risk (typically early leavers) who may, at Defence’s discretion, get 3 months of more intensive job-search support.
- Transition for Employment (T4E) program — this is a vocationally based service to deliver focused specialist employment support for those members with complex needs. The program incorporates both transition coaching and specialist employment services. Services in the program will be available for members to access for up to 2 years. This program is delivered on a one-on-one basis and is designed to provide a high level of attention and individual case management.

Defence is currently seeking to outsource these services (section 7.5).

... added on to a range of existing supports

Transition centres

The Defence Community Organisation (DCO) operates 13 transition centres around Australia. Staff at the transition centres have undergone training to become ‘qualified career development practitioners’ (DoD 2018l, p. 1). Transition centres also offer an outreach service to more remote areas (DoD 2019a, p. 1).

Transition seminars

Defence runs transition seminars once or twice a year in major towns and cities. It describes them as:

... 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 2018m, p. 3)

In 2019, it changed the format of the seminars. Veterans now choose which sessions to attend depending on their interests, and reducing their duration from 2 days to one day. Just over half of those who leave the ADF each year attend Defence transition seminars (section 7.5).

Other services that contribute to transition support

A range of other services assist ADF personnel to prepare for their transition to civilian life. For example, Defence has published the *ADF Member and Family Transition Guide* (DoD nd). There are also units to which members who are participating in rehabilitation can be posted, such as Army Personnel Coordination Detachments, Soldier Recovery Centres and Member Support Units (chapter 6), and these can play a key role in assisting those who are likely to be medically discharged.

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 offers a range of transition support services.

- The On Base Advisory Service (OBAS) provides a DVA presence on more than 40 ADF bases nationally. OBAS involves 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 2018ae).
- 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).

DVA also:

- administers the Prime Ministers’ Veterans’ Employment Program (section 7.5)
- funds the ADF Post-discharge GP Health Assessment (box 7.3)
- 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 ...

Both Defence and DVA are increasingly recognising the importance of an effective transition in determining the future wellbeing of veterans and their families. New measures designed to improve transition outcomes include:

- fundamental changes to the basis on which transition support is provided, including replacing CTAS with a range of needs-based services (section 7.3)
- 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 now has processes in place to ensure that 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. This is important as ‘successful transition processes require ... a number of interactions with the ex-service member after discharge, including annual reviews’ (NMHC, sub. DR208, p. 1)
- the establishment of a Transition Taskforce, co-chaired by the Departments of Veterans’ Affairs (DVA) and Defence, which published its first report in July 2018. This report considered barriers and enablers to transition and made a range of high-level recommendations (DVA and DoD 2018).

In January 2019, Defence also introduced increased support for the partners of medically transitioning member through expansion of the Partner Employment Assistance Scheme. This now offers eligible partners up to \$1500 towards professional employment services and occupational re-registration costs (DoD 2018k).

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 (sub. 114) and Soldier On provided a mixed report card. The latter 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 are 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). CSC emphasised that it 'remains actively engaged with Defence and the Department of Veterans' Affairs on the Transition Taskforce reforms, transition health assessment, improvements and ongoing information exchange developments' (sub. DR286, p. 3).

7.5 ... but the path to civilian life can still be hard

Concern about transition remains widespread

Despite recent and ongoing improvements (sections 7.3 and 7.4), the Commission heard many concerns about the adequacy, efficiency and equity of the support services available to veterans as they transition from military to civilian life. For example, 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 [ex-service organisation] 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). And Paula Dabovich said:

The problem with transition is no one takes responsibility. Defence think it’s DVA’s responsibility, DVA think it’s Defence’s responsibility and ... no one is actually doing anything. (trans., p. 964)

Many individual veterans expressed their concern about the current system and frustration at the slow pace of improvement.

The current transition system is broken!!!! (Richard Salcole, sub. DR293, p. 2)

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)

Before any real improvements to Transition can be made, Army, Navy and Air Force should have ONE set of rules and procedures to adhere to ... the system is woeful, and no such thing as slipping through the cracks. The cracks are more like the GRAND CANYON with hundreds falling through. This must be rectified, URGENTLY. (Bob Bak, sub. DR262, att. 1, p. 1)

... I left the Army as of two weeks ago ... services for former veterans who are leaving – it’s not really that good ... they put you in a two day course where they set you up with writing resumes and cover letters and possibly helping you with applying for jobs and that was pretty much it. (Marc Jones, trans., pp. 262–4)

Current practice is far from satisfactory. When a service man or woman finishes their service, whether voluntary or medical discharge, the main concern of the ADF is to get rid of them ASAP so that a replacement can be obtained. Most advice and assistance are cursory at best. (William Kaine, sub. DR197 and Brian McKenzie, sub. DR275, p. 3)

Veterans’ families echoed those concerns. For example, the mother of a deceased veteran said:

He served his country, risked and very nearly lost his life on several occasions and then dropped back into society and expected to continue his life as before. He told me before his first deployment the Army had spent a quarter of a million dollars training him to go to Afghanistan and he was looking forward to using that training. My problem with that scenario is that ADF did not spend one cent in training Jason to assimilate back into our society but left him to his own devices and told him to ‘man up’ when he first experienced symptoms of PTSD. (Lisha Taylor, sub. DR311, p. 5)

Other concerns about transition include that few veterans access transition support, many transition programs do not deliver on their promises, there is little support for families in transition and that poor stewardship of transition services has persisted.

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; Office of the Veterans Ombudsman Canada 2017). Medical discharge can also be a risk factor for transition and was a source of particular concern to veterans (box 7.6).

Box 7.6 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 ... 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)

Kerri-Ann Welch (a veteran who is also an academic researcher on veteran issues) said:

If a veteran is being medically discharged, and has exhausted all avenues for remaining in Defence, they are at a very mentally vulnerable time when discharge finally occurs. Often, this is a situation that they have been desperately trying to avoid, and the realisation that it is happening can feel like an enormous loss and defeat. Unfortunately, this then triggers a chain of events including meetings with rehabilitation coordinators, transition cell, DVA, Comsuper, and the list goes on. These veterans are often not in a state to take on a lot of very important information, and those without family or partner support feel extremely vulnerable and alone. (sub. DR235, pp. 6–7)

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 military. One Canadian study focused on veterans who self-identified as having successfully

transitioned from the military following medical discharge. It found that all veterans with less than 12 months to prepare for discharge felt unprepared (Office of the Veterans Ombudsman Canada 2017, p. 23).

The age of many of those reintegrating into civilian life is 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). Indeed, ‘the less time an individual has spent in the ADF the more difficult adjustment becomes both during and following transition’ (Prime Ministerial Advisory Council on Veterans’ Mental Health, sub. DR276, p. 6).

Veterans who were involuntarily discharged are also at increased risk during transition. (The most common reasons for involuntary discharge are ‘retention not in the service interest’, ‘unsuitable for service’ or ‘training failure’). And given that over 80 per cent of involuntary transitions occurred within the first five years of service (DVA and DoD 2018, p. 31), the risks of youth combine with those of their manner of discharge. This can mean that these veterans need particular support to overcome the reintegration challenges they face.

Too few veterans access transition support

Low participation rates

As noted above, about half of those who leave the ADF attend Defence transition seminars — in 2017 just over 2700 separating veterans attended a transition seminar (5270 personnel left the ADF in 2016-17) (DoD 2017f, 2018m). And about 12 per cent of those who attended transition seminars were parents and support people (such as spouses). (Though to be clear, these attendance figures are for the previous two-day seminars, not the current one-day modular program.)

One reason for low attendance rates at transition seminars 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 seminars that are typically offered twice a year in some locations. Transitioning members also questioned the relevance of 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. 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 rather than their successes, which suggests that veterans who need guidance are still missing out.

Veterans who need support are not always able to access available services

Some veterans do not use transition support services because they are unaware that the services are available. ADSO said that there is ‘widespread unawareness of legislated entitlements and services’ (sub. 85, p. 51). 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.

Others are unable to access services because those services are not available in their unit or location.

Currently a successful transition can be like having a lottery ticket and subject to a number of factors, including depending on the calibre of the command, which State you live in, which Service you are with, whether family support is available. The Transitioning procedures should be unified across Australia and not dependent on what State or Region the Defence member and/or family live in. (Kathleen Moore, sub. DR221, p. 2)

Transition programs do not always 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 2016g).

The Prime Minister’s Veterans’ Employment Program also does not directly support veterans’ employment (box 7.7). And Defence Families Australia (2018, p. 3) pointed out that while families are included in the title of the *ADF Member and Family Transition Guide* (DoD nd), their needs are not really addressed in the guide.

Box 7.7 **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 2018aj).

The most visible aspect of the program is the Prime Minister's Veterans' Employment Awards, which have been presented twice, in March 2018 and March 2019. 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 2018aa). 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 2018e). When it was launched, seven firms had signed the commitment (DVA 2018ap).
- The Departments of Defence and Veterans' Affairs established a 'transition taskforce', which has produced one report containing high-level recommendations.
- The Australian Public Service Commission developed a website designed to assist veterans to match their ADF rank with an APS classification (APSC 2017).
- 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 who are interested in hiring veterans. 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 16 November 2018, there were 116 295 jobs advertised throughout Australia on the jobactive website but only seven jobs were flagged as 'defence force experience desirable'. And on 17 April 2019, there were 121 318 jobs advertised, of which six were flagged.
- The Ex-service Organisation Industry Partnership Register is not proceeding (DVA 2018ab).

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 people said 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 2017b, 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).

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). One veteran told the Commission:

The defence force runs a resettlement seminar. It’s a joke. You get all these people there that say, ‘For \$3000 I can turn your service records into a resume or university degree’, instead of focusing on and providing support to people as they go out. (Darren Thompson, trans., p. 840)

(Again, the Commission notes that the format of transition seminars has recently been changed, but it is too soon for the effects of those changes to manifest themselves).

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.
- 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 many losses they will face as they reintegrate civilian life. In contrast, the transition guide produced by the Canadian Armed Forces Transition Group not only explicitly mentions the sense of loss that veterans can experience, it also covers strategies to mitigate that loss (CAFTG 2018).

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.

Absence of promised qualifications

Some said that transition is made more difficult because 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. David Peterson told the inquiry that:

In terms of career transition and the like, I don't have a single certificate for my time in the military. I don't have a single qualification for my time. I spent 11 years, I was a captain on discharge. I allegedly have qualifications but if I now email the Army to seek those qualifications, they say, you know, 'It's not our problem, you're no longer a serving member, we can't get them for you.' (trans., p. 1287)

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 also 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)

David Kelly and David Jamison attributed veterans' inability to obtain civilian qualifications to:

Defence's unwillingness to systematically embrace the provisions of the national vocational training structure and award nationally accepted certificates/diplomas etc and to 'cherry pick' modules from nationally accredited training courses rather than conducting the full course as specified ... this results in most discharging ADF members either moving into the community with partial qualifications or having to personally fund training modules to fill the gaps in their qualifications' (sub. DR212, p. 4).

In addition, officers are more likely to leave the ADF with recognised qualifications than are those who have served in other ranks. This difference makes transition more difficult

than it needs to be for veterans from other ranks (who make up the majority of those leaving the ADF).

Inadequate stewardship

Transition programs have remained stagnant and suboptimal for years

None of the concerns we heard about transition are new. The same issues were raised over 20 years ago (for example, ANAO 2004a, 2016; DoD 1997; Dunt 2009; SFADTRC 2016, 2017). And they were echoed in the recent Joint Committee *Inquiry into transition from the ADF* (JSCFADT 2019).

One reason to be cautious about the tangible effects of recent initiatives is that many of the recent changes are similar to previous initiatives. For example, the actions that were presented as recent progress in the 2011 review of the MRCA look very similar to those presented as progress in 2018 — and there is little evidence of any improvements since 2011. The ‘improvements’ include 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). But more collaboration is a poor substitute for governance arrangements that properly align incentives (chapter 11). And in the face of such incentives, an entitlements-based mindset that does not contribute to veteran wellbeing has been allowed to persist, as Defence’s own review of the CTAS pointed out:

The nature of an entitlements based scheme means that there has not been a requirement to continually improve the Scheme and incorporate feedback from members and their family to ensure it remains contemporary. (DoD 2018h, p. 22)

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 7.8).

Outsourcing the problem

Defence has recently decided to outsource a range of transition services. In March 2019, Defence issued a request for tender for ‘a single national provider to deliver a range of specialist transition support services’ (DoD 2019d, p. 51). The request covers all of the programs that Defence created as part of its new needs-based transition support system, including job-search preparation workshops, career transition coaching, the personalised career employment program and the transition for employment program. It also includes requirements for the successful tenderer to provide qualified career coaches to assist DCO deliver its transition support services and to run the post transition survey of former ADF members.

Box 7.8 **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. 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).

Bundling disparate services to be delivered across a wide geographic area together in this way reflects a simplistic approach to contract management that mitigates against good outcomes for users, especially when, as is the case for transition support, those services are complex and their success depends on trust and sound interpersonal relationships. Sturges put it succinctly:

... the procurement and contract management tools that are appropriate for buying 'paperclips' — highly commoditised, easily specified goods and services — are not appropriate for commissioning complex support services and front-line human services. (2017, p. 11)

Even where governments choose to commission other providers to deliver services (rather than delivering those services directly), they remain responsible for the range of functions that both determine what services should be made available and the effectiveness of those

services. These functions include policy design, regulation, oversight of service delivery, monitoring of provider performance, and system improvement.

But in proceeding to outsource new, untested transition services to a single national provider, and refusing to consider tenders for part of the services from providers that may have greater expertise in the services being sought (for example, expertise in running surveys or in placing veterans in employment in particular towns or cities), Defence appears to be distancing itself from its core role in transition, rather than accepting full responsibility for the stewardship and delivery of the support that transitioning members require. The outsourcing arrangements will not address the issues and deficiencies raised in this inquiry.

Claims processes are not designed with veterans in mind

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.

The process requires the client to defend their injuries and to confirm their impairment. This changed status, from member to benefit seeker, is corrosive to their confidence about the future. The lack of a clear process is foreign and confusing to transitioning members – most particularly those who are transitioning on mental health grounds. From our extensive experience, we believe this process is intensely confusing and destructive. Providing advice to members who seek support is fraught with concern because of the lack of clear insight into how the process really works. (RSL Queensland, sub. DR256, p. 14)

Claims processes can also affect mental health — this issue is discussed further in chapters 9 and 17.

Many argued that the ADF should not discharge members who have submitted a claim to DVA and/or CSC until the claim is processed (box 7.9). 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. However, in the event that significant improvements do not materialise or are not sustained then this approach may be warranted if requested by the transitioning member.

Box 7.9 **Processing DVA and insurance claims before discharge**

Many participants argued that the Australian Defence Force (ADF) should not discharge members who have submitted a claim to the Department of Veterans' Affairs (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)

Some went further, and 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)

Others suggested that:

No individual should be asked to complete Transition documentation when they are hospitalised, medicated and traumatised or about to undergo a medical and/or surgical procedure. (Kathleen Moore, sub. DR221, p. 1)

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 (box 18.7 in chapter 18) 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 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)

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 the potential 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 measurable improvements. The rhetoric around the importance of transition has not been 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, and both Defence and DVA losing sight of what is needed to improve veterans' overall wellbeing. There is also unjustified variation in the availability of transition support across the country, and even between individual units.

While many of the changes made to transition support in late 2018 and early 2019 hold promise, there is still little clear evidence of the nature and scale of any improvements. And there is considerable risk that in outsourcing so much of its role, Defence may place the wellbeing of transitioning personnel in the hands of an organisation that is even less well equipped to deliver the support that veterans require. It may also hinder the integration of services and supports to meet veterans' needs across the pre- and post-discharge continuum. With this in mind, a more substantial change in approach and delivery is required to provide the quality of transition support needed for future generations of veterans. The current system will not get us there.

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. 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, and those who have skills that are not easily transferable to the civilian labour market. Despite considerable change in recent years, stewardship of transition remains poor and supports have not improved in ways that are tangible to veterans.

7.6 A new Joint Transition Authority

Defence (with DVA and other agencies) has taken steps to address concerns about transition, and it has accelerated its efforts in the past year. But to achieve clear accountability for delivering the necessary improvements to veterans' transition, more fundamental changes are required.

Responsibility for the policy and delivery of military-to-civilian transition services should sit with Defence. This aligns Defence's existing duty of care for its personnel with its broader responsibility for the wellbeing of personnel who have been harmed for the sake of Australia's national security (chapter 5). Veterans are Defence personnel and Defence is responsible for preparing those leaving the military for civilian life and supporting them through transition (and importantly, ensuring that they are not harmed in the process). Having heard participants' views on this responsibility, and considered the best way to give effect to it, the Commission is of the view that a new and substantially different approach and structure are required.

In our draft report, we proposed that the new approach and structure should be a ‘Joint Transition Command’. We have refined our proposal in response to participants’ feedback, and are now recommending that all aspects of transition preparation and support be centralised in a new transition body in Defence to be known as the ‘Joint Transition Authority’. This approach aligns with other reforms we are recommending, including changes to governance arrangements to promote the lifetime wellbeing of veterans (chapter 11).

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, veterans need support from an organisation that has clear, measurable goals and well-defined accountabilities.

Why is a Joint Transition Authority the preferred option?

Transition is core business for the military

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 structure. This will place responsibility for transition support with the organisation best placed to control both its content and its costs. The ADF trains and moulds its members into warriors and inculcates them into military institutions, so it should be the government agency that bears the responsibility and the costs of ‘deinstitutionalising’ them when their services are no longer required or they are no longer able to serve.

As discussed in chapter 4, the Australian Government has accepted responsibility for ensuring that, on leaving the military, members of the ADF are successfully reintegrated 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). The Chief of the Defence Force recognises that ‘people are the Australian Defence Force’s core capability’ (DoD 2018e). 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.

This essential link between defence force capability and good transitions has also been 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 — and both improving veterans’ wellbeing and getting a better return on the

investment that the public has made in training and developing service personnel — is a core part of the Commission’s proposed approach to veterans’ transition.

That said, some veterans — both serving and ex-serving — argued that transition support should not be a high priority for the ADF (box 7.10).

Box 7.10 Participants doubted Defence’s ability to deliver on multiple priorities simultaneously

Many participants contended that the Australian Defence Force’s (ADF’s) mission is to defend Australia and its national interests and that preparing personnel for civilian life falls outside this mission.

Given the ADF’s role is to prepare for combat and prosecute operations, it is unreasonable to expect Defence to attach any priority whatsoever to lifelong care of transitioned personnel (Air Force Association, sub. DR300, p. 3)

We reject the proposal to create a Joint Transition Command. Such an entity would further divert Defence from its primary role: the defence of Australia. When compared with the activities of DCO, JTC would further divert Defence effort by extending administration of transitioning ADF Members well beyond discharge. (ADSO, sub. DR247, p. 9)

A separate Defence Joint Transition Command would not be the answer, given the ADF’s national role to defend Australia against armed attack (Bert Hoebee, sub. DR195, p. 9)

... 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)

But many who hold this view conflate transition preparation (a task that should be the clear and singular responsibility of Defence) with lifelong support to former members and their dependants (the Commission is recommending that this be the responsibility of the new Veteran Services Commission).

If it is indeed the case that Defence cannot simultaneously deliver on its national defence objectives and take steps to promote the long-term wellbeing of its personnel as they leave service, it also draws into question its ability to deliver ‘a future ADF that is potent, agile and ready to respond wherever our interests are engaged’ (DoD 2016d) — that is, to deliver on the objectives outlined in the Defence White Paper. And as noted elsewhere in this report, Defence’s lack of appreciation for the full impact of its actions on ADF personnel is likely *reducing* its warfighting capabilities, rather than enhancing them.

However, others agreed that transition support is 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 2018b, p. 4)

VHAC agrees that Defence has the primary responsibility for the wellbeing of discharging ADF members. The health and social consequences of getting this wrong are significant. VHAC supports an increased emphasis on the management of Defence Force personnel as they transition from service. This is consistent with an objective of early intervention and prevention. (Veterans Health Advisory Council South Australia, sub. DR251, p. 3)

Defence does not do Transition well at all, it needs to improve greatly ... and therefore I support the creation of a Joint Transition Command within Defence. (Association of Totally and Permanently Incapacitated Ex-Service Men and Women SA Branch, sub. DR310, p. 4)

People have to understand that it is a command responsibility to look after the welfare of your soldiers, today, tomorrow, until the end of time. When you decide to take on a commission, you're taking on that individual and those individuals that serve under you and with you forever. (Phillip Burton, trans., p. 1351)

And even some of those who did not support the Commission's proposals for a new transition body within Defence considered that there would be:

... tremendous benefit in ensuring that the ADF remains involved with and maintains a significant level of responsibility and care towards assisting members in successfully transitioning from the military. (Prime Ministerial Advisory Council on Veterans' Mental Health, sub. DR276, p. 7)

A new authority to give much greater emphasis to transition within Defence

The Commission rarely ventures opinions on how organisations should manage their own internal affairs, preferring instead to recommend governance arrangements, incentive structures and reporting mechanisms that, over time, lead to improved outcomes for users (in this case, veterans and their families) and the broader Australian community. But in the veteran system, it is clear that problems with the governance arrangements have persisted for decades, and there is resistance to reforms that would deliver long-overdue improvements to governance arrangements and incentive structures (chapter 11).

And so to avoid the same failures being perpetuated and negatively affecting the wellbeing of future generations of veteran, the Commission is taking a more prescriptive approach to its recommendations for veterans' transition. In particular, it is important to be clear that while 'organisations like Joint Health Command (JHC) and Defence Community Organisation (DCO) already have critical roles to play for current serving members and their families' (Soldier On, sub. DR245, p. 4), these organisations have only just begun to work towards delivering the types of services that veterans — particularly those veterans most at risk — require and deserve, and are yet to make inroads into measuring the effectiveness of those services.

So while it may seem that 'forming a Transition Command is a sledgehammer to crack a nut, and a largely administrative nut mainly requiring a co-ordinated approach' (DFWA, sub. DR299, p. 21), the Commission considers that the magnitude of improvements required to veterans' transition mean that reform of this scale is required. And while is some justifiable scepticism about the extent to which an institution can assist with deinstitutionalisation (box 7.11), it is clear that too many veterans are currently falling through the gaps between institutions, and fundamental reform of those institutions is required.

Box 7.11 Can an institution deinstitutionalise?

Several participants expressed doubt that the Defence Force who institutionalises members is best placed to deinstitutionalise them.

ADF input would not be appropriate as it is a transition from the ADF. (Neville Browne, sub. DR246, p. 1)

A Command structure within the ADF is counterintuitive to assisting personnel transitioning smoothly. What is being asked is for institutionalised people to tell other institutionalised people how not to be institutionalised when they leave the institution. (Deborah Morris, sub. DR307, p. 17)

While there is no question that the ADF as an institution has a moral obligation to provide transition support, this support should not be provided in-house. (Soldier On, sub. DR245, p. 5)

The Report recommends that the reverse transition process (re-training, re-orientation) from serving member to civilian, should be done by a uniformed military organisation and culture staffed by serving members who have not transitioned to a civilian (non-government) job and are not in the civilian culture. This is not logical. (DFWA, sub. DR299, p. 21)

These views equate service delivery with responsibility for ensuring that those services are delivered. But it not necessarily — or even typically — the case that those functions are one and the same. An organisation can have responsibility for delivery of services without maintaining in-house capacity to provide of those services. To take just one contemporary example, the Australian Government Department of Health does not (and could not) deliver general practice care to large numbers of people, but is responsible for the Medicare system delivering primary care to all Australians. So while the Commission is proposing that responsibility for all military-to-civilian transition services should be transferred to a newly created Joint Transition Authority, this does not imply that the Authority should operate with an internal focus. Indeed, the Joint Transition Authority will rely on the skills and knowledge of experts from a range of disciplines to ensure that transitioning veterans receive the holistic services they require.

The ‘Joint Transition Command’, modelled on the existing Joint Health Command, that we proposed in the draft report was supported by many participants — including Legacy Australia (sub. DR220), Peter Sutherland (sub. DR192), VVFA (sub. DR215). For example, the RSL Victorian Branch said:

We support the overall concept. Transition should start before separation, during separation and for a determinable period after separation. Transition varies in its effectiveness between Navy, Army and Air Force. The formation of a Joint Transition Command would better coordinate transition across all three services. (sub. DR273, p. 5)

And Paula Dabovich said:

... a ‘Transition Command’ within Defence ... may go some way in alleviating the question of ‘who is responsible?’ for developing programs and measures that would better prepare and support our veterans as they adjust to civilian life; and upon which states, local communities, and organisations can build upon. This proposal has great merit which is reflected by fact that the Canadian Armed Forces have raised such a Transition Group as a part of their National Defence Headquarters, to meet the needs of their veterans in this context. In Australia, such a command may also come to hold a level of expertise (which may be disseminated in the professional education of health providers) that could help cohere our veterans’ service and post-service lives, which is the very essence of what is currently lacking in the current disjointed system. (sub. DR242, p. 4)

The Central Queensland TPI Association suggested that:

... an Authority should be introduced and quickly in place that has as its sole responsibility for assistance to discharged military personnel for their re-establishment in civilian life and occupations. Its emphasis should especially be on those personnel who have discharged directly or indirectly due to service related wounds, injury or illness. (sub. DR287, p. 5)

After hearing participants' views — including input from Defence — the Commission now believes that the new transition body should be a Joint Transition Authority, as such a structure will have the appropriate level of recognition within the ADF and its members.

Such an authority 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. 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.

The creation of a Joint Transition Authority is designed to work in concert with the Commission's broader proposals for reform to the veteran support system. In particular, funding the system using an annual premium levied on Defence would give Defence the incentive provide better transition preparation and support (and the Joint Transition Authority would provide the means for doing so). Improving long-term wellbeing by encouraging a smooth transition to civilian life and reducing any future draw on benefits from veterans with poor transition outcomes would be one way in which Defence could reduce the premium (chapter 11).

Under a Joint Transition Authority model, the Head of People Capability Group within Defence would exercise authority over all aspects of Defence's interaction with transitioning members. This concept aligns with the technical control the Surgeon General Australian Defence Force exercises in the health domain as well as being Commander Joint Health. The Minister for Defence Personnel and Veterans (chapter 11) should have responsibility for transition issues.

Functions of the Joint Transition Authority

The new Joint Transition Authority 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 partners and family members as the veteran gets closer to transition, so that partners and families can engage more actively in the process of transition

-
- assist veterans to access 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 — until the end of an agreed rehabilitation plan or for up to 12 months where requested by the transitioning member. Many veterans will require no support after discharge
 - employ staff, including from the ADF and DVA (and then the Veteran Services Commission (VSC)), 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 rehabilitation supports if needed (the provision of health care and rehabilitation for ADF members remains the responsibility of Joint Health Command)
 - report on transition outcomes to drive further improvement.

The Joint Transition Authority 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.

The services may choose to continue to have units where members who are participating in rehabilitation can be posted (such as Army Personnel Coordination Detachments, 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 the Joint Transition Authority.

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 necessitate that support.

Tailored transition preparation and advice for every veteran

Personalised support services for transitioning veterans and families would be a core part of the role of the Joint Transition Authority. 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)

Ben Walker said that:

‘Care Coordination’ needs to be enacted — a method by which a Coordinator works as an advocate and coordinator for the transitioning member ensuring that sufficient care is given pre and post separation and that the transition to Civilian life and where appropriate into the DVA system is managed as seamlessly as possible. (sub. DR216, p. 3)

John Caligari (sub. DR253) also supported concierge services, and suggested that advocates could play that role (chapter 12). Regardless of whether they are framed as case managers, concierges or counsellors, the transition advisers would be 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 that veterans and their families could reach out to 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 résumés, interview coaching, mentoring and pre- and post-employment support services. But the key will be that the adviser has navigation and coordination skills, backed up by training, to ensure that they know where to direct the veteran.

Importantly (and in contrast to recent practice), access to Joint Transition Authority 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 serving personnel to 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 the Joint Transition Authority 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)

-
- for veterans receiving rehabilitation services under the ADF Rehabilitation Program, 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 a claims advocate at an ex-service organisation (chapter 12).

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 17).

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 who are at risk to be detected early. Such a tool could be valuable to the Joint Transition Authority.

Transition support before and after discharge

Members of the ADF would interact with the Joint Transition Authority in a similar way they currently interact with other expert services within the ADF — 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 the Joint Transition Authority 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). This type of early intervention was supported by inquiry participants, with DFWA noting:

For the vast majority of personnel who leave the ADF they do so without being DVA clients. The Department of Defence has not been proactive in taking any action to prepare their members to leave other than at the last moment, immediately before transition ... if it was mandated that on an annual basis members were briefed on post ADF support ... then this may well serve the purpose. There is already a mandated requirement to brief personnel on fraud and ethics, EEO and WHS. Personnel would not remember detail but would be aware there is a significant amount of support and know who to ask to access it. (sub. DR299. pp. 21–2)

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 — the Joint Transition Authority 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 the Joint Transition Authority 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 the Joint Transition Authority would depend on their individual needs. The essential point is that it be a gradual transition. To ensure that this is the case, the Joint Transition Authority should offer continued services and support to those who require it for a defined period after discharge — for up to 12 months where requested by the transitioning member (box 7.12). Veterans who are participating in rehabilitation should be able to access support from the Joint Transition Authority 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 Authority after discharge. Others may access support early in the process and a small number may need significant support post discharge.

Beyond that time, veterans will 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 VSC — chapter 11). Longer term supports and services for veterans will be the responsibility of DVA (and then the VSC).

Providing support to families

Because family members can also be affected when veterans transition to civilian life (section 7.5), ‘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 Authority 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)

Box 7.12 For how long should JTA support be available after transition?

The Joint Transition Authority (JTA) will offer continued support to those who require it for a defined period after discharge. While many veterans will not request or require continued assistance, it is important that such support is available because:

... the transition process can produce many unexpected challenges, even for those who have had smooth careers in the ADF, are voluntarily leaving the ADF, and who do not anticipate any major difficulty with their return to civilian life. (JSCFADT 2019, p. 14)

In our draft report, we sought 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.

Most participants considered that a period of one to two years would be an appropriate time.

... the period should be a minimum of 12 months, but the Joint Transition Command should consider extending that period on a need's basis particularly for those at risk. (War Widows' Guild of Australia, sub. DR278, p. 10)

... a 12 month period would be a reasonable thing (RSL Victorian Branch, trans., p. 739).

... a defined period of support of 2 years after discharge is appropriate. (Combined SA Ex-Service Organisations, sub. DR188, p. 5)

Joint Transition Command should continue to monitor the wellbeing and progress of all transitioning members for a suggested period of two years following transition, to complement and support any services provided by DVA and CSC. (RSL Queensland, sub. DR256, p. 18)

Hume Veterans Centre considered that transition services should be available for:

... a minimum 18 months perhaps two years ... Because a lot of people get out, and they go, 'Oh look I'm going to go and do this.' And they go, 'Oh, hang on a sec. I actually hate this, I don't want to do that,' and there is a bit of a loss. If they can reach back then, at that point in time, and still access those transitional services that are available to them, especially for retraining, I think that would be better. (trans., p. 381)

The NMHC said that 'some ex-serving personnel may have difficulty establishing or maintaining a meaningful and fulfilling life outside the ADF, for a number of years post-discharge. It is likely that these ex-serving personnel require support during this time' (sub. DR208, p. 2).

Others suggested that Joint Transition Authority support should be available for much longer.

Post military transition services should be for 5 years post discharge. Five years allows individuals and their families time to re-adjust and re-orientate in a supportive and reflexive way; time, continuity of care, and a stable anchor are key to successful transitions ... This does not mean that services are active, just that there is an 'opt in' option for up to five years post service. Over this period, members could be situated in an 'inactive reserve' pool which would also give them options to re-enter the ADF if appropriate. (Deborah Morris, sub. DR307, p. 17)

But a longer period would have risks, 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)

This suggests that it is important for veterans that they are not in the transition phase indefinitely. The Commission is recommending that Joint Transition Authority services be available for up to 12 months, where requested by the transitioning member.

These groups will have different concerns when it comes to transition, and so will need tailored information from the Joint Transition Authority. 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)

V360 Australia said that all veterans should be:

... given information at the time of discharge, as well as loved ones given a mirror of that information, of services available, of people available, of numbers of places of situations that 'If this, then that', and even if the veteran throws them in the bin, as we do see at those discharge cells, perhaps the mother, wife, brother, sister, or next of kin who's handed that other information will look at something and go 'Oh, when he discharged I got this. I'll have a look there'. (trans., p. 183)

Veterans' families can also experience mental health effects which may be related to the veteran's military service. And a veterans' mental ill-health can affect families. There are mental health services available to veterans' families through Open Arms (chapter 17). enhanced mental health support for families (recommendation 19.2) will also assist during the transition period.

Families with children may also have particular needs. When transition involves relocation, children can experience disruptions associated with changing homes, schools and peer groups. A range of excellent resources designed to support veterans' children during transitions 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 2018k). In January 2019, Defence extended the PEAP to partners of members transitioning on medical grounds. The Joint Transition Authority could consider a further extension, to partners of all transitioning veterans.

The Joint Transition Authority 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 while some supports for families have been enhanced as part of Defence's recent changes to transition, the absence of family support from nearly all aspects of the outsourcing of

transition support (other than adjustment coaching) suggest that Defence will, in the future, have limited ability to ensure that this occurs.

That said, families should 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 the Joint Transition Authority to be mindful not only of the needs of families, but also the needs of veterans who do not have family support (box 7.13).

Box 7.13 Not all veterans benefit from family support through transition

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 2015g, 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 so that it does not rely 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 the Joint Transition Authority.

Resources for the Joint Transition Authority

The starting point for thinking about the resources required to provide better support for the military-to-civilian transition should be a detailed assessment of the extent to which Defence's new risk-based transition support services are addressing current gaps in service provision. As the budget allocation for these new services is not public, the Commission was not able to assess its adequacy.

Physical presence

The 13 transition centres operated by DCO should be transferred to the Joint Transition Authority, to be used 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.

The Joint Transition Authority could complement its centres by working in partnership with veterans' organisations, including through the veteran hubs and veteran centres that some veterans' organisations 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 12).

Staffing

The Joint Transition Authority should be primarily staffed by transition advisers. The advisers would come from a range of professional backgrounds, both military and civilian. 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 veteran support system, so they can assist veterans when they are initially considering preparing a claim. DVA (and when established the VSC) should also provide staff members to work at all Joint Transition Authority centres. The role of DVA staff should include an enhanced version of the OBAS, 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 — is a possible template.

Budget

The funding required for the Joint Transition Authority to provide transition support to veterans and their families will depend on:

- the extent of unmet demand, which should be assessed
- the combination of services and support provided by the Joint Transition Authority
- the division of responsibilities between the Joint Transition Authority 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 Authority budget

will need to be larger than Defence's current expenditure on transition. Indeed, as one participant put it:

Without substantial additional resources, Defence could not handle the entire transition process as envisaged. (Bert Hoebee, sub. DR195, p. 5)

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 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 the Joint Transition Authority

Reporting on transition outcomes will require the Joint Transition Authority 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 used 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 18)
- 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 (chapter 18).

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)

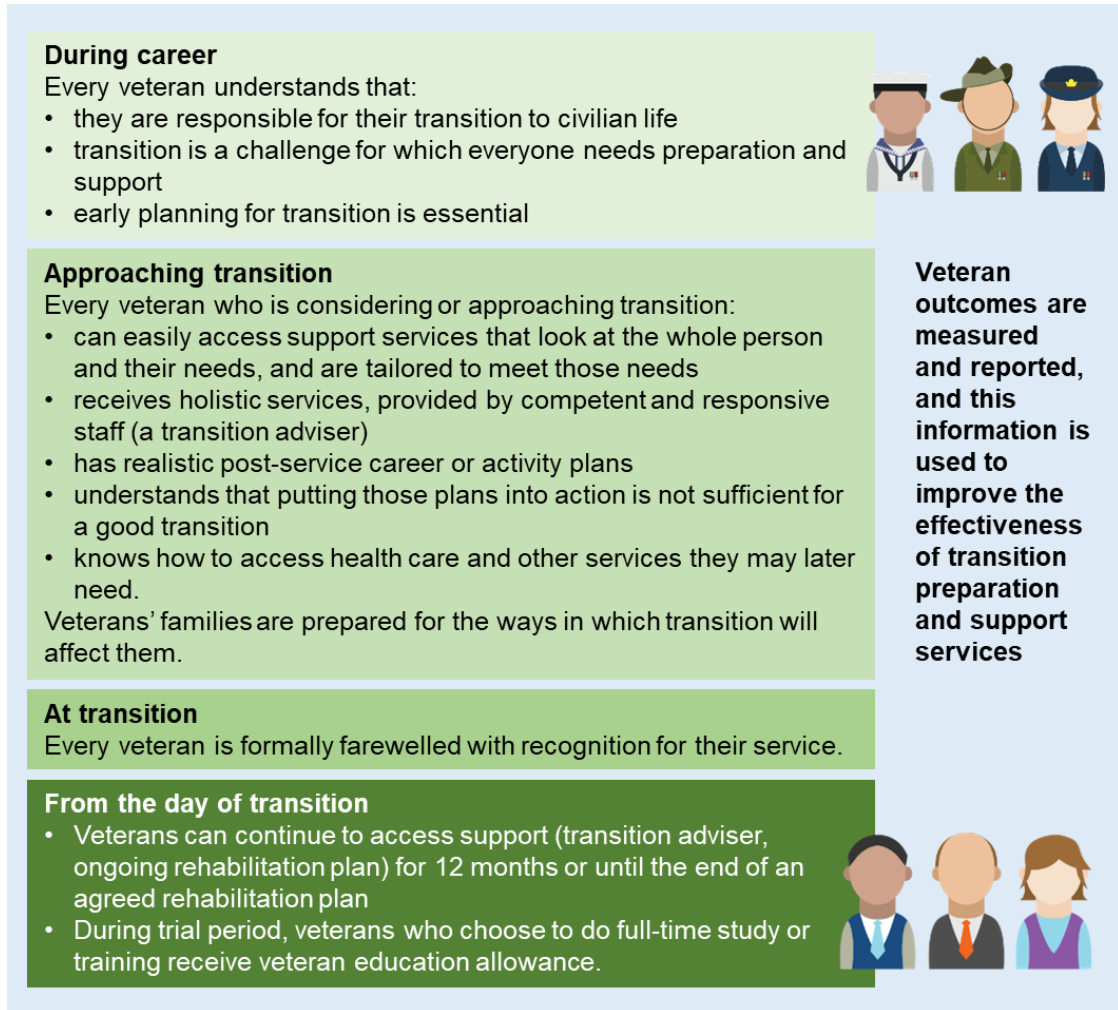
But more generally, it will be important for the Joint Transition Authority to understand not just the effects of its programs, but also how and why many veterans adapt to civilian life without its support. In addition, good practice in accountability and stewardship requires the Joint Transition Authority 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 to both governance and service delivery, with the aim of better equipping all 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 7.2).

Figure 7.2 **Transition to civilian life: outcomes for veterans**



RECOMMENDATION 7.1 ESTABLISH A JOINT TRANSITION AUTHORITY

The Australian Government should recognise that Defence has primary responsibility for the wellbeing of discharging Australian Defence Force members, and that this responsibility may extend beyond the date of discharge. It should formalise this recognition by creating a 'Joint Transition Authority' within Defence.

Functions of the Joint Transition Authority 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 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 12 months after discharge
- reporting publicly on transition outcomes to drive further improvement.

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, recognise that Defence service may only be a chapter of their lives — most service members will have second or subsequent careers after their military service, and 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. This lack of incentive to support ADF members to prepare for their future careers was reflected in the comments by a number of inquiry participants.

Having younger newly trained soldiers consistently review and plan for discharge so soon into their career is judged as being counterproductive and is sure to exacerbate issues of retention. (Combined SA Ex-Service Organisations, sub. DR188, p. 9)

We do not believe that the recommendation to prepare a career plan every two years is a practical proposal and necessary. (DFWA WA Branch sub. DR279, p. 1)

In contrast, many others (including Legacy Australia (sub. DR220), RSL Victorian Branch (sub. DR273), Veterans Support Centre Belconnen and RSL Belconnen Subbranch (sub. DR229) and VVFA (sub. DR215)) recognised the value of early career planning. For example:

- 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).
- Deborah Morris emphasised the importance of creating ‘an environment where individuals are in an active state of transition throughout their military life and beyond’ (sub. DR307, p. 24).
- the War Widows’ Guild of Australia said that it ‘believes that the ADF should be talking to its members about transition from the first day they enter the ADF’ (sub. DR278, p. 8).
- Transition Taskforce found 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’ (DVA and DoD 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). And in the United States, from 1 October 2019, service members will have to complete an individual transition plan no later than 365 days before retirement or the end of their enlistment.

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 7.14). Such a model could be used to increase the focus on future career planning as members move closer to transition.

Box 7.14 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 help participants to understand that transition also includes building a new sense of being, and belonging, in a workplace that can feel foreign and has a number of preconceptions about veterans. The sessions also 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 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 7.15). 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).

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).

Box 7.15 **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.

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. Similarly, dispelling veterans’ expectations that they deserve lifetime employment in the ADF (or at DVA if continued military service is not feasible) (chapter 6) would assist them in overcoming the ‘significant cultural challenge’ (DoD 2018h, p. 27) that a change from an entitlement-based approach can entail.

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 it is not yet clear that, under the new model of transition support, all veterans who need early access to advice about résumé writing, job-search strategies or interview skills will have access to that support. To the extent that veterans continue to lack familiarity with some of the basic skills needed to gain civilian employment, this will put them at a disadvantage. Progressively building job-search skills for veterans approaching transition will be one of the roles of the transition advisers employed by the Joint Transition Authority.

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 (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 be 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. As one veteran put it:

Most Defence members do not have a wide social basis outside of work, this insular connection especially at the junior ranks means that members separating literally feel the door slam behind them and are thrust into the isolation of the civilian world ... (Richard Salcole, sub. DR293, p. 2)

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, and where their former colleagues could provide social connections. By making its services available to veterans for 12 months after transition (section 7.6), the Joint Transition Authority will also be available to support and advise veterans if they find themselves struggling with social connections in the post-transition period.

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. Renee Wilson highlighted:

... the need to focus less on the tangible elements of transition and more so on the impacts of this significant change and challenges it can pose to a member's identity. (sub. DR257, p. 3)

And Paul Evans suggested that there would be benefit in creating:

... informal on-line discussion groups similar to the highly successful and voluntary U3A model. Essentially, veterans would develop and lead a discussion on a specific topic and invite other veterans to attend ... The purpose is to encourage veterans to become part of, and develop friendships within, a group with similar backgrounds and interests. (sub. DR218, p. 8)

Information about the importance of social connections, including the connections and camaraderie provided by veterans' organisations, should form a key part of the transition preparation provided by the Joint Transition Authority.

[Ex-service organisations] are currently under-represented during Members transition and could be more deeply engaged as mentors and family re-integration support providers. (Air Force Association, sub. DR267, p. 11)

But at the same time, it is important that veterans' organisations 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 into 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 explicitly prepares veterans for the uncertainty, loss of confidence and change in status they may experience as part of their transition. And it 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. The equivalent Australian publication 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. 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.

Preparing 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 the veteran's career.

RECOMMENDATION 7.2 CAREER PLANNING AND FAMILY ENGAGEMENT FOR TRANSITION

Defence, through the new Joint Transition Authority (recommendation 7.1), should:

- ensure that Australian Defence Force members prepare a career plan that covers both their service and post-service career, and 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 veterans' families, so that they can engage more actively in the process of transition.

7.9 Education and training for post-service careers

Education and vocational 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 they need to have recognised through formal recognition of prior learning (RPL) processes. But at present, many veterans receive no support for education, training (including apprenticeships and traineeships) or RPL when they leave the ADF, while others can access assistance 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 vocational 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 at the expense of employment and career outcomes that are sustainable and satisfying over the long term. This is one of the reasons 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 7.16).

Box 7.16 Overseas examples of higher education and training for veterans**United States**

For over 70 years, the United States has supported veterans to obtain a college education. 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 (VA 2013).

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 2017b).

Trialling a veteran education allowance to support veterans to participate in education and training

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. 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 those 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 non-means tested income 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 VSC (chapter 11) expanding it should the trial be successful. Many inquiry participants¹ supported the idea, with some expressing views on the four key issues that would need to be resolved in determining eligibility for the veteran education allowance during its trial phase: who would be eligible for the allowance; at what rate would it be paid; how long would it be paid for; and administrative arrangements for its delivery.

Eligibility for the veteran education allowance

The first question that arises in designing the veteran education allowance is 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 or serving for a certain numbers 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, and found at least some support from participants. Other participants were open to a range of possible eligibility criteria. For instance, the War Widows' Guild of Australia said:

... given that a veteran is defined as someone who has served one day or more in the ADF, then perhaps the allowance should be extended to all who have served. Alternatively, a minimum

¹ Participants who supported idea of trialling a veteran education allowance include the Air Force Association (sub. DR267), APPVA (sub. DR270), Combined SA Ex-Service Organisations (sub. DR188), Legacy Australia (sub. DR220), Deborah Morris (sub. DR307), RSL Victorian Branch (sub. DR273), VVFA (sub. DR215) and War Widows' Guild of Australia (sub. DR278).

could be completion of basic and speciality training for enlisted men and women and completion of the Duntroon, ADFA and similar courses for officers. Another option could be after completing a war-like deployment or four years' service, whichever comes first. (sub. DR278, p. 10)

Some went even further, and suggested that the veteran education allowance should be available to veterans who had not completed a minimum period of service.

Given the legislation deems a veteran to be a veteran after one day of service, and thereby be eligible for medical or vocational rehabilitation services, it would be inconsistent to require an additional period of service before a veteran achieves eligibility for the veteran education allowance. (Occupational Therapy Australia, sub. DR289, p. 3)

But the Commission considers that a balance needs to be struck between promoting retention in the armed forces and providing adequate reintegration support to those whose future lies in the civilian sphere. With this balance in mind, during its trial phrase the veteran education allowance should only be available to those who have completed an initial minimum period of service or who have been medically discharged.

Consistent with the principle — long established in the veteran support system — that the Australian Government should not pay two sources of income maintenance to the same person (chapter 13), the veteran education allowance should not be paid to those who are receiving incapacity payments (box 7.17) or veteran pensions.

Box 7.17 Interaction between the veteran education allowance and incapacity payments

Several inquiry participants (including APM Workcare, sub. DR219 and RSL Queensland, sub. DR256) questioned the need to create the veteran education allowance, arguing that the objectives of the allowance are already being met through recent changes to incapacity payments (which are compensation payments for a loss of earnings as a result of a service-related health condition — chapter 13).

Typically, incapacity payments 'step down' to 75 per cent (or a higher percentage depending on hours worked) of pre-injury earnings after 45 weeks of payment. But from 1 November 2018 to 30 June 2022, the stepdown will not apply to former ADF members who are undertaking approved full-time study as part of their DVA rehabilitation plan (DVA 2018d). For these veterans, incapacity payments will be paid based on 100 per cent of their normal earnings, 'ensuring eligible former ADF members can focus on their studies and not be concerned about a reduction in incapacity payments. It acknowledges that such reductions may lead to short-term decisions relating to employment at the expense of successful rehabilitation outcomes' (DVA 2018h).

This means that veterans who have service-connected health conditions and who are studying as part of their rehabilitation program will continue to receive their normal (pre-impairment) earnings. In practice, this will be higher than the proposed veteran education allowance, and so veterans who are eligible for incapacity payments will be better off continuing to receive them.

Rate of the veteran education allowance

The second question that arises in designing the veteran education allowance is — at what rate should the allowance 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.

Possible options at either end of this spectrum include setting 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
- at the same rate as the veteran payment (which provides interim support to veterans who lodge a claim for a mental health condition — chapter 13). 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. Participants expressed a range of views on this.

I strongly support a veterans' education allowance. Education empowers individuals and assists in preventative care. Veteran Education Allowance should be paid at the same rate as the Veteran's payment ... (Deborah Morris, sub. DR307, p. 17)

The rate of allowance should be equivalent to the prevailing Austudy payment (currently a maximum of \$499.90 a fortnight) plus a loading of — say — 10% to recognise service. Means testing could also be applied (War Widows' Guild of Australia, sub. DR278, p. 10)

Perhaps an indicative allowance based on Austudy would cover most transition training needs. (Brian McKenzie, sub. DR275 and William Kaine, sub. DR197, p. 4)²

... the rate of pay last received in the ADF (Neville Browne, sub. DR246, p. 2)

On balance, the Commission considers that during its trial phase, the veteran education allowance should be set at the same rate as the veteran payment. This would simplify administration by aligning payments that provide interim financial support to veterans. It should also 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. But one purpose of trialling the allowance is to assess whether this rate of payment is sufficient for achieving the objective of the veteran education allowance to support veterans to complete the education or training that will set them up for future careers and wellbeing.

² Austudy is paid to adults at multiple rates, ranging from \$299.80 per fortnight for an 18–21 year old living at home to \$1058.50 per fortnight for a Master's or doctorate student (DHS 2019).

Duration of eligibility for the veteran education allowance

The third question is — over what time period should the allowance be claimed? The Commission’s initial thinking was that 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 for one course of study, but should be allowed to defer their studies if medical or other issues arise. That is:

They should complete the course unless unforeseen circumstances arise such as medical reasons preventing completion. (Bob Bak, sub. DR262, p. 9)

And eligibility for the allowance should be conditional on passing each semester, or on having valid reasons, support by medical or other evidence, for being unable to successfully complete each unit of study.

Administration of the veteran education allowance

The fourth issue that arises in designing the veteran education allowance is how to create systems for access to, and payment of, the veteran education allowance.

The Commission recommends that a transition adviser in the Joint Transition Authority helps veterans to decide whether, and what, to study. As one participant observed:

The training is whatever the [Veterans Transition Authority] and former member agree upon based on applicable tests and aptitude assessments. Not much good wanting to be a pilot if the vision is not sufficient to gain a licence. (Neville Browne, sub. DR246, p. 2)

Legacy Australia said:

There should be no limits on what type of courses or industries the veteran may wish to study or pursue employment. As noted earlier, an open-minded approach will be more empowering for the veteran and in turn, provide financial stability for the family. (sub. DR220, p. 6)

This open-minded approach should involve looking at each individual’s aptitudes and career plan (section 7.7). The Joint Transition Authority would also assess whether the veteran meets 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 the Joint Transition Authority
 - receiving the veteran education allowance once study commences (with administrative processes having been completed in the background between the Joint Transition Authority and DVA without any need for action on the part of the veteran)
 - confirming the successful completion of each unit of study and 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 of sufficient duration, as outlined in chapter 18.

Another element that could be included, either in the trial or as part of the roll-out of the Veteran Services Commission, is the extension of the veteran education allowance to the veteran's spouse, partner or widow where the veteran is, through death or impairment, unable to benefit personally from the allowance. For example, the War Widows' Guild of Australia said that DVA:

... should consider making a contribution to the education or training of spouses in cases where a veteran for whatever reason, is unable to take part in education and training him or herself (sub. DR278, p. 9)

This would fit well with the VSC's more flexible approach focussed on the lifetime wellbeing of veterans and their families.

RECOMMENDATION 7.3 TRIAL A VETERAN EDUCATION ALLOWANCE

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 to provide a source of income for veterans who, after completing their initial minimum period of service or having been medically discharged, wish to undertake full-time education or vocational training.

Recognition of skills and qualifications

Not all veterans will want to undertake further education or training when they leave the ADF. 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. This has been acknowledged by Defence, 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, the Joint Transition Authority should ensure that this mapping meets the needs of transitioning veterans.

7.10 Other transition issues

Encouraging employers and the community 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 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). And in the United States ‘the public continues to believe that veterans suffer because of their military service, but veterans instead are facing great stress in their transition to civil society’ (Burgess 2018, p. 2).

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 2018a), 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 (recommendation 7.3) 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.

There is also scope for veterans' organisations to play a greater role in translating veterans' achievements into skills and experiences that can be easily understood by employers. For example, Phillip Burton (a veteran who has served in both Australia and the United States) said:

... some ex-service organisations within the United States ... they've gone out and they've reached into industry and they've said this is what our people can do. Not only can our guys run fast and shoot straight, but they can think on their feet. They're very good at, you know, at managing a team. That equates to leadership principles, it equates to the ability to administer a company, means that you are a pretty good executive assistant already. They've reached in the industry and they've done that. Whereas, perhaps, the [ex-service organisations] today and in Australia, have not reached in the industry, have not equated veteran's experience and veteran's skill sets to something that employers here can understand. (trans., p. 1349)

The Commission has also recommended that DVA takes a more active role in targeting outcomes and ensuring value for taxpayers' money for services delivered by veterans' organisations (chapter 12). Liaising with potential employers could consequently form a greater part of these organisations' role.

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. But these issues may be mitigated by Reserve members' greater connection to civilian life, as the War Widows' Guild of Australia pointed out:

... given that Reserves generally have civilian employment or are retired from the workforce, the WWG believes transition services for Reserve personnel may be minimal or not be required (sub. DR278, p. 10).

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).

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 'Total Workforce Model' (chapter 2).

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 full-time, 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.

Reservists can also differ from the permanent forces in their motivations for, and experiences of, service. This can mean that their service has different psychological effects. In particular, reservists have reported discrimination and bullying (West 2018, p. 113), but the effects of this on transition and on veterans' subsequent wellbeing are not clear. This could be a potential area for inclusion in the veteran research strategy (chapter 18).

8 Initial liability assessment

Key points

- To access most benefits in the veteran support system, claimants must first establish that a veteran's contemporary medical condition is causally related to their military service — that is, the Australian Government must accept liability for their condition.
 - Most claimants have liability for their conditions accepted. The overall acceptance rate in 2017-18 for individual conditions (claimants often have multiple conditions) was around 56-79 per cent, depending on the relevant Act. The probability of an individual having liability accepted for *at least* one condition under the *Military Rehabilitation and Compensation Act 2004* (MRCA) 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 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.
 - Expanding the SoPs to claims under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* would harmonise the initial liability process across all three Acts. It would also reduce complexity.
- Some concerns were raised about how slow the SoP system is 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 and require the RMA to list the evidence relied on for its decisions.
 - The Commission also found that the Specialist Medical Review Council is no longer necessary and the functions should instead be folded into an augmented review process within the RMA.
- The SoPs are created at two different standards of proof on 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. Decisions on an individual's claim are also made on these two different standards. To further reduce complexity, as well as remove an inequitable differentiation between types of contemporary service, the Commission is proposing that:
 - all initial liability claims under the MRCA (going back to 1 July 2004) should only use the reasonable hypothesis SoP, which recognises the uncertainty of evolving medical science.
 - the Australian Law Reform Commission should conduct an independent review into simplifying the legislation and moving to a single decision-making process for all MRCA claims, preferably based on the reasonable hypothesis process.

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 (referred to in this chapter as a 'condition') before any support can be granted. 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), the purpose of the Statements of Principles (SoPs), and how they are created (section 8.2). It also discusses concerns raised about the SoPs and options for reform (section 8.3) and looks at the two standards of proof in the initial liability system (section 8.4).

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, a predetermined list of causal factors for each condition (called Statements of Principles or SoPs) are used in most cases to link a medical condition to service. DRCA claims are assessed on a condition-by-condition basis with no formal requirement to satisfy the SoPs.

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 Australian Defence Force (ADF) 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 or their family member is entitled to.

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 18). 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 [the Department of Veterans' Affairs] 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 up to 35 per cent of DVA's target for the median time taken to process initial liability claims (DVA 2018g).

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.

However, in practice only a small fraction of total claims rely on incident reports. Available data suggest that under the MRCA just 2.4 per cent of more than 112 000 claimed conditions over the period 1 July 2004 to 30 June 2017 were linked to an incident report. And for claimed conditions related to operational service, the proportion is, on average, even lower — for example, of almost 15 000 claimed conditions related to service in Afghanistan since 2004, only 1.1 per cent relied on incident reports (Commission estimates based on unpublished DVA data).²

In the vast majority of cases where primary evidence is missing — because there was no incident report or, commonly, because the condition was caused by ongoing wear and tear — the date of clinical onset or worsening can be estimated after the fact. This is done by the current treating or assessing medical specialist based on the date of diagnosis or a discussion with the claimant around when symptoms first arose (DVA 2018ag, s. 3.4.4).

The retrospective assessment of clinical onset or worsening is allowed because the veteran support system has less restrictive requirements for supporting evidence than civilian workers' compensation schemes (box 8.2). This is one of the 'beneficial' aspects of the veteran support system (noted in chapter 3), which is legislated to deal with the long time lag between relevant service and claims.

¹ External medical assessors can also be used for assessing the level of impairment once a condition has been accepted (chapter 14).

² Other periods of operational service had significantly higher rates of linkages to incident reports, particularly claimed conditions related to service in Fiji (16.9 per cent), the Solomon Islands (4.8 per cent), and general peacekeeping service (5.1 per cent).

Box 8.2 **Supporting evidence in the veteran support system**

Under the *Veterans' Entitlements Act 1986* (s. 119(1)(h)) and the *Military Rehabilitation and Compensation Act 2004* (s. 334(1)(c)), 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'.
- 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' (Creyke and Sutherland 2016, pp. 397–398).

Linking conditions with service

The next step in the initial liability process is to confirm that the condition is *service-related*. At this point, the claims assessor is in a position to judge the total body of evidence provided to determine whether that evidence is sufficient to link a veteran's condition to their service, or not.³ This is similar to civilian workers' compensation schemes: there needs to be a link between employment — in this case, the member's service — and the medical condition.

The standards of proof

In the veteran support system there are two standards of evidence that are used to test the strength of the body of evidence: the 'balance of probabilities' standard and the 'reasonable hypothesis' standard.

With respect to VEA and MRCA claims, the former is used to assess all claims arising from peacetime service, while the latter is used to assess all claims arising from operational service, such as deployment overseas (the different types of service are outlined in chapter 3). All claims under the DRCA are considered on the balance of probabilities, as are all 'findings of fact' across the three Acts (box 8.3).

- The **balance of probabilities** is the standard used in civil law (including civilian workers' compensation systems) where the weight of evidence must be in favour of the claim being true before the claim can be accepted. In other words, the balance of probabilities test is satisfied if the administrative decision-maker is convinced that the probability that a claim is correct is greater than fifty per cent. The balance of

³ The true underlying cause of a condition is never known with 100 per cent certainty. 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.

probabilities standard is also known as the ‘reasonable satisfaction’ test, as assessors must be *reasonably satisfied* of a claim’s merit.

- The **reasonable hypothesis** standard is a more beneficial standard of proof from the point of view of the veteran. This standard evolved out of the much more onerous criminal standard, which is satisfied only if a decision-maker is convinced ‘beyond a reasonable doubt’ that all the elements in a body of evidence are true. In the veteran support system, the *reverse* of the criminal standard was introduced, where the onus was on DVA to prove beyond a reasonable doubt that the contended link in a claim was *not* true, although the claimant must at least raise a ‘reasonable hypothesis’ of a link.

Box 8.3 Findings of fact in the veteran support system

In the veteran support system, jurisdictional facts made by claims assessors are determined on the balance of probabilities standard. This applies throughout most of the claims process, including decisions under all three Acts about:

- whether a claimant has relevant service
- what the diagnosable condition is
- the date of clinical onset or worsening of their condition
- their level of impairment
- a multitude of other administrative decisions.

Sources: DVA (sub. 125, p. 107); Topperwien (2003).

The reasonable hypothesis standard of proof has a long history (box 8.4). It is designed to make it easier for veterans with war service to gain entry to the veteran support system. As noted by Justice Heerey⁴ of the Federal Court:

... 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 ...

Decision making under the dual standards

The different standards of proof guide how claims delegates should assess the body of evidence in front of them for an initial liability claim (the process is depicted in figure 8.1).

Under the reasonable hypothesis standard, a delegate must only assess whether the case *points to facts* that, if true, would raise a reasonable hypothesis connecting the claimed condition with the member’s service. Some of these facts (particularly the circumstances of service) can be assumed, as the delegate is not required to determine that the facts exist. The delegate must then accept liability once a ‘reasonable’ hypothesis has been raised, unless the delegate finds proof *beyond a reasonable doubt* that a fact relied upon to support the

⁴ In *Deledio v Repatriation Commission* [1997] FCA 1047.

hypothesis is *not* true, or that another fact, inconsistent with the hypothesis, is proved beyond a reasonable doubt.

When applying the balance of probabilities standard, a delegate must be ‘reasonably satisfied’ that it is more likely than not that the member’s service either caused or aggravated their condition. This includes determining whether the evidence suggests that the circumstances of the member’s service are more likely to exist than not.

Box 8.4 Some history of 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 further expanded the ‘benefit of the doubt’ for veterans.

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 criminal standard, with the onus on DVA to prove a claim was *not* true: 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.

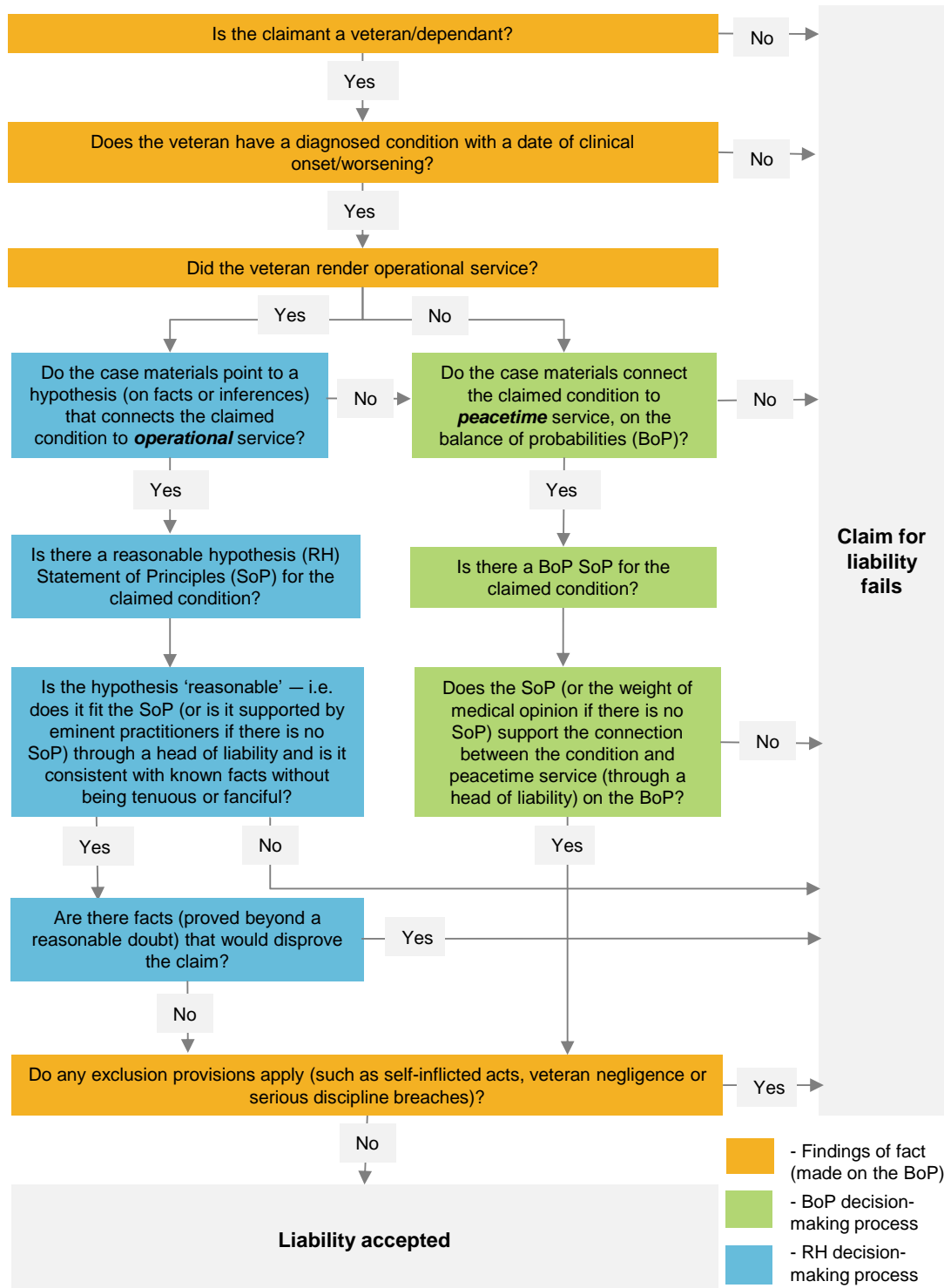
Sources: Baume, Bomball and Layton (1994); Creyke and Sutherland (2016); Lloyd and Rees (1994); Toose (1976); Topperwien (2003).

In addition, for all VEA or MRCA claims, a link between the condition and service can only be accepted under either standard of proof if it:

- goes through a factor in the relevant SoP (section 8.3) and
- the veteran’s service has made a ‘material’ (but not necessarily sole) contribution to that factor, under one of the heads of liability (box 8.5).

Claims under the DRCA do not require a link to a SoP factor, but do have to go through an equivalent DRCA head of liability.

Figure 8.1 The initial liability process under MRCA



Source: Productivity Commission analysis.

Box 8.5 **About the heads of liability**

There are several criteria (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 *Military Rehabilitation and Compensation Act 2004* (MRCA, ss. 27-30) and the *Veterans’ Entitlements Act 1986* (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.^a The most common heads of liability tests are that the condition:

- resulted from an *occurrence* that happened while the veteran was a member rendering defence service
- *arose out of*, or was attributable to, any defence service rendered by the veteran while a member.

Under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (ss. 5A-7) diseases and injuries are assessed under 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 (a causal link).
- For injuries, the delegate must be satisfied that the injury ‘arose out of or in the course of the employee’s employment’ before liability can be accepted (a temporal link).

Under all three Acts, a condition cannot be deemed to be service-related where it came about due to 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.

^aThe 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.

Favourable outcomes for most claims

Most claims submitted by veterans and their families for initial liability are accepted. For example, in 2017-18 DVA accepted:

- 61 per cent of over 14 000 liability determinations for VEA disability pensions
- 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 2018g, 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).

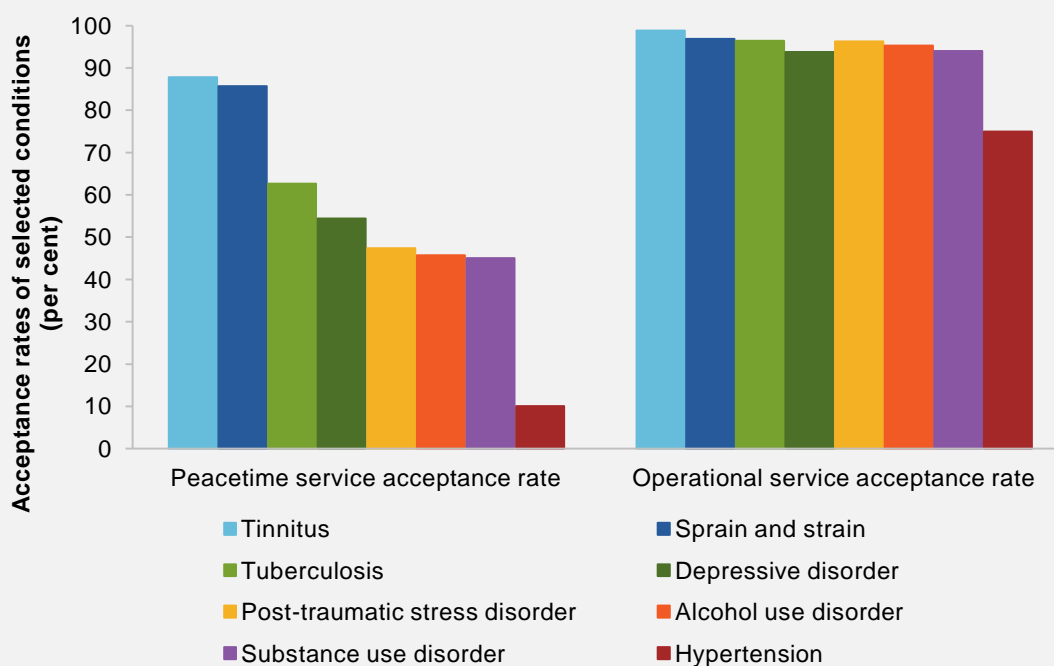
Box 8.6 Rates of acceptance under the MRCA

From 1 July 2004 (when the *Military Rehabilitation and Compensation Act 2004* (MRCA) was introduced) to 30 June 2017, nearly 29 200 individual claimants had lodged claims for liability. Of those, about 26 500 (91 per cent) had liability for at least one condition accepted. The remaining 2700 (9 per cent) had all of their claims fail.

More than 117 000 conditions were claimed. 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 about 73 per cent. For conditions related to operational service only, the acceptance rate was higher at over 90 per cent. For conditions related to peacetime service (including those related to both peacetime and other types of service), the acceptance rate was lower at around 68 per cent.

These trends are evident in the following chart showing a range of SoP conditions and their acceptance rates by type of service.^a



^a The most common claimed condition (at 17 per cent) was 'non-SoP'.

Source: Productivity Commission estimates based on unpublished DVA data.

8.2 The Statements of Principles

The Statements of Principles (SoPs) are a unique part of Australia's veteran support system. A key motivation for their creation (box 8.7 provides a brief history) was 'the lack of

confidence in non-medical tribunals to deal adequately with complex medical-scientific issues’ (Topperwien 2003, p. 283).

The SoPs are exhaustive lists of causative factors for medical conditions. A necessary condition for a claim to succeed is that the link between a veteran’s medical condition and events during their service is consistent with a factor in a SoP.

Box 8.7 A brief history of the Statements of Principles

After the introduction of the ‘reasonable hypothesis’ standard of proof in 1985 (box 8.4), 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 *Veterans’ Entitlements Act 1986* (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:

6. could prove that they had a medical condition and the relevant operational service
7. 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 have been. 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); Topperwien (2003).

The SoPs are legislative instruments created by the Repatriation Medical Authority (RMA) — an independent statutory authority — using the most up to date sound medical and scientific evidence available. The Specialist Medical Review Council (SMRC) reviews SoP

decisions made by the RMA (box 8.8). Both agencies are responsible to the Minister for Veterans' Affairs.

Box 8.8 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 *Veterans' Entitlements Act 1986* 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 (2018g, 2018e), SMRC (2018a, 2018c).

Individual SoPs define specific conditions, typically with reference to common symptoms, and list a set of causal 'factors' for that condition. Each causal 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 for all decision-makers, from DVA through to the federal courts. 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 2018g). The majority of claims to DVA are covered by SoPs — around 92 per cent of claims that had diagnosable conditions and were determined by DVA in 2017 (RMA, sub. 111 attach., p. 17).

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.

Dual standards? Dual statements

There are two different SoPs for each standard of proof applicable to claims under the VEA and MRCA. Consistent with the more beneficial reasonable hypothesis evidentiary standard, the reasonable hypothesis SoP often contains more factors, or factors that are easier to meet, compared to the balance of probability SoP.

Factors in the reasonable hypothesis SoP commonly have a lower level or extent of necessary exposure (the 'dose') or a longer 'latency' of time between exposure and clinical onset/worsening. For example, both SoPs for malignant melanoma of the skin (skin cancer), 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 also include more than 650 additional factors (around 16 per cent more) that are not in the balance of probabilities SoPs (table 8.1). One example is various anti-malarial drugs (such as mefloquine or chloroquine) included in the reasonable hypothesis SoPs as factors for some mental health conditions (RMA 2014a, 2014b).

Access to the reasonable hypothesis SoP for a given claim depends on whether the claimant has relevant operational service *and* is hypothesising a link between that operational service and their condition. All other claims are assessed under the balance of probabilities. For example, a veteran with operational service making a claim that their condition was caused by an accident that occurred during peacetime training in Australia will be assessed using the balance of probabilities SoP.

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)

The process for determining SoPs

SoPs are created and reviewed based on sound medical-scientific evidence by the RMA (figure 8.2). In 2017-18, the RMA made determinations on 93 different SoPs, including revoking and subsequently re-issuing 60 SoPs, creating SoPs for 22 new conditions and amending 9 SoPs (RMA 2018g).

The VEA (and MRCA) defines sound medical-scientific evidence — in s.5AB(2)(a) — as information that is:

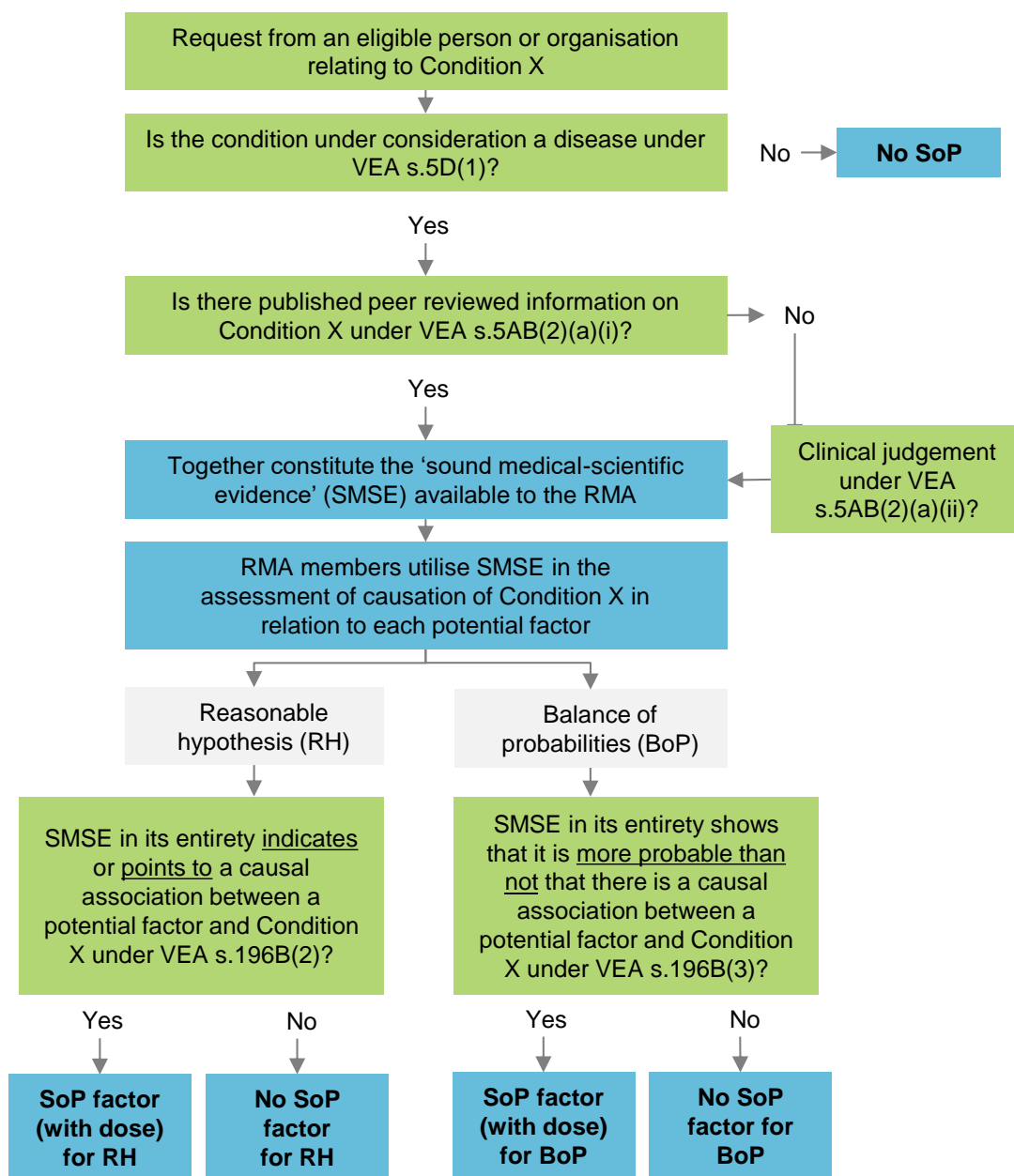
- (i) consistent with material relating to medical science that has been published in a medical or scientific publication and has been, in the opinion of the RMA, subjected to a peer-review process or
- (ii) in accordance with generally accepted medical practice, would serve as the basis for the diagnosis and management of a medical condition.

For each condition, RMA researchers (guided by a ‘lead Professor’ on the RMA panel) exhaustively review the global body of medical-scientific evidence to identify causal factors and summarise their findings in briefing papers (RMA 2018d). For each potential factor, the quality of individual pieces of evidence is weighed (e.g. well-conducted randomised controlled trials are considered high quality evidence, individual case reports are considered low quality) and the weighted body of evidence is given an overall grade:

- 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 2018e, pp. 13–15).

Figure 8.2 The RMA's process for determining SoPs



Source: RMA (2018e).

In line with the different standards, the required strength or quality of evidence before a causal factor can be included (and at what dosage level or latency period) is lower for the reasonable hypothesis SoP compared to the balance of probabilities 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 (2018e, pp. 15–16).

An attempt was made in 1997 to empirically test the integrity of the SoP system by defining the *minimum* probability that an accepted claim under each standard is *actually* causally related to the veteran's service. The study found that:

- for the balance of probabilities, the minimum standard is near a 50 per cent probability that the successful claim's condition is actually related to service (Pearce and Holman 1997, pp. 95–96)
- 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).

These findings suggest that the SoP system is largely operating as it was intended, with a much lower standard of proof required for a factor to be included in the reasonable hypothesis SoP.

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 for creating SoPs (RMA 2018e, 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, 2018f).

The SoPs are also reviewed periodically by the RMA. 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 2018e, 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 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. When conducting its review, the Review Council is only able to consider information that was used by the RMA at the time of their original decision. Individuals with new information are generally directed to the RMA review process.⁵

The SMRC cannot make or amend SoPs. 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 reconsideration (SMRC 2018b). Recent SMRC reviews have taken an average of 16 months to conduct, and 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 2017-18) include:

- chronic multisymptom illness — ongoing since August 2014
- motor neurone disease — commenced in October 2017 and finished in June 2018, finding that some factors included by the RMA should be removed, as there was insufficient sound medical-scientific evidence to support them at any standard
- chemically acquired brain injury caused by mefloquine, tafenoquine or primaquine — ongoing since August 2017
- rheumatoid arthritis — ongoing since November 2017 (RMA 2018g).

The federal 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).

⁵ However, the SMRC can consider new information if the RMA has refused to conduct an investigation and there seems to be sound medical-scientific evidence not previously considered by the RMA that might justify a fresh investigation (SMRC 2018b).

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 a 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).

8.3 Shortcomings of the SoPs and options for reform

The SoPs have helped to 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. As the Air Force Association noted, ‘the consensus is that they have helped create a more equitable, efficient and consistent system of support for veterans’ (sub. 93, p. 4). The Returned and Services League (RSL) Queensland branch also said the 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)

Most participants to this inquiry — including, for example, the Vietnam Veterans Association of Australia (sub. 78, p. 7), the Alliance of Defence Service Organisations (sub. 85, p. 36), Warren Harrex (sub. 89, p. 4), the Royal Australasian College of Physicians (trans., p. 571) and the Tasmanian Ex-Service & Serving Support Association (trans., p. 871) — supported the SoP system and its continued use. DVA, commenting on the SoPs, stated:

... 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)

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.⁶ 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 2018b, p. 94).

Some stakeholders, however, raised concerns about the SoPs in this inquiry, 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

The evidentiary burdens to prove select factors of service can be onerous, making it difficult for veterans to map the details of their individual service record to a specific factor of service. The Royal Australian Armoured Corps Corporation (RAACC), for example, 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)

To address this concern (as well as to simplify the administration of liability claims, and reduce the time taken to process claims), DVA has introduced 'streamlined' and 'straight-through' processing (box 8.9). Based on probabilistic assumptions about acceptance rates, DVA claims that making conditions 'decision-ready' allows the administrative process to be short-circuited, while still meeting the legal requirement to establish a link between the claimant's condition and their service. Though laudable, the costs of this policy are unclear, as it has not been subject to standard Budget oversight and accountability, despite effectively meaning that acceptance rates for streamlined conditions are almost 100 per cent, resulting in additional claims being accepted that might not be had they faced greater scrutiny.

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

⁶ 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).

occupational-defined exposures would make claims simpler where there is an automatic link between certain military occupations and impairments’ (sub. 125, p. 104). Again, it is unclear what the cost impacts of these administrative changes will be, and whether they will face adequate Budget discipline and accountability before being implemented.

Box 8.9 Streamlined and straight-through processing

Streamlined processing involves the Department of Veterans’ Affairs (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 Statement of Principles (SoP) factors because of the inherent nature of military service. DVA claims that there is only a low risk that claims for these conditions are not actually related to service, and 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 established when the conditions of Australian Defence Force training and service (e.g. being an infantry soldier for 5 years) 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 (2018ag, s. 3.4.5; pers. comm., 20-26 June 2018).

Plain English SoPs

SoPs are technical documents and are not designed for a lay reader. 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. 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

The SoP factors are applied by DVA claims assessors without any discretion or flexibility that might account for the circumstances of an individual case (Kenneth Park, sub. 2; Slater + Gordon, sub. 68; Legal Aid NSW, sub. 109). Participants to this inquiry argued that this is unfair. The Vietnam Veterans Federation of Australia contended that ‘delegates treat SoPs as though they’re chiselled in stone and there’s no deviation from them’, and argued that this was not ‘the original intent when they were brought in’ (trans., p. 491).

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 a perception that a legitimate claim has been declined without due consideration. As examples, several participants to this inquiry submitted complaints about specific SoPs that they claimed 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
- William Gore (sub. 97) argued that exposure to trichloroethylene should be a causal factor for Parkinson’s Disease
- Richard Menhinick (sub. DR236) disputed the SoP for chronic lymphocytic leukaemia, as it did not list monoclonal B cell lymphocytosis as a causal factor.

In comparison to the veteran support system for MRCA and VEA claims, civilian workers’ compensation schemes (and the DRCA) assess claims for liability on the individual merits of the medical-scientific evidence presented during the case, under the balance of probabilities standard. In theory, this means that a claim that fails under the SoP system could be accepted under the DRCA or a civilian workers’ compensation system and hence make the veterans system *appear* to be less beneficial, by effectively ‘neutralising the

beneficial intent of the VEA and later the MRCA' (RAACC, sub. 29, p. 15). As Maurice Blackburn noted:

Where we encounter difficulties advocating for the veteran is ... what we perceive to be the prescriptive nature of the statement of principles, providing an extra set of criteria that they need to navigate and meet, where if we just applied a common-sense approach to causation, to say, on the balance of probabilities, 'would they have been suffering that injury, but for their service?' (trans., p. 1215)

SoPs as guidelines only

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 outside the strict bounds of the relevant SoP factors. This includes hypothesising new causal factors that are not 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 (Defence Force Welfare Association, sub. 118; Kenneth Park, sub. 2; Legacy Australia, sub. 100; Legal Aid NSW, sub. 109; Maurice Blackburn, sub. 82 and trans., p. 1232; Richard Menhinick, sub. DR236; Slater + Gordon, sub. 68).

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)

The current application of SoPs should not change

The Commission does not support turning the SoPs into 'guidelines'. 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 got bogged down, as DVA had to investigate all the new hypotheses.

The introduction of flexibility in the application of the SoPs is *theoretically* more feasible at the balance of probabilities standard, similar to the current DRCA system. Participants

including Slater + Gordon (sub. 62) and RSL National (sub. 113, pp. 11–12) contended 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’ However, the Commission was unable to find any examples of claims being systematically accepted under the DRCA but failing under the MRCA or VEA (although this does not rule it out). But if this is occurring, it almost certainly means that decisions are being made that are not consistent with sound medical-scientific evidence.

The SoP system, supervised by epidemiological experts, deliberately limits acceptable claims (via factors in SoPs) to those where the totality of sound medical-scientific evidence suggests a causal link between the factor and the condition. As noted in section 8.2, the SoP system was created precisely to avoid non-experts making uninformed judgements about complex 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)

Indeed 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.

Those claimants who believe they 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 investigation. If the evidence genuinely supports a new or different causal link, the RMA is obliged to change the SoP.

As section 8.2 outlines, the SoP approach is based on clearly-defined evidentiary limits about what constitutes a reasonable claim. This inevitably means (and will so for any system that limits liability) there are some aggrieved claimants who feel that their legitimate case has been unfairly 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).

Applying the SoPs to DRCA decisions

Given that DRCA claims made outside the SoP system may not be consistent with sound medical-scientific evidence (and one of the principles underpinning a future system is ‘evidence based’, chapter 4), another option is to make the SoPs binding on DRCA claims as well. 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).

RECOMMENDATION 8.1 HARMONISE THE INITIAL LIABILITY PROCESS

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.

Accrued rights to previous SoP versions

Accrued rights allow a claimant going through a merits review process to have access to the version of the SoP that was in force when they first filed their primary claim, even if the SoP has been updated by the RMA since then. The claimant can then choose whichever version of the SoP is most advantageous for them. This is the situation that has existed under the

VEA since 2001, following two Federal Court determinations⁷ (Creyke and Sutherland 2016, p. 434).

By contrast, the MRCA mandates (under s. 341) that only the current SoP can be used for determining any claim (including during merits reviews or appeals) and that ‘no right, privilege, obligation or liability is acquired, accrued or incurred’ to permit delegates to use any SoP that is no longer in force. This section was inserted at the time the MRCA was first legislated ‘specifically to overcome the problems created in the case of *Keeley v Repatriation Commission*’ (Vale 2003).

Several participants raised this disparity on accrued SoP rights (see, for example, the Vietnam Veterans Federation of Australia, trans., p. 496), and generally argued that the VEA treatment was more beneficial and should be extended to the MRCA. The RAACC for example, called the MRCA provisions ‘manifestly discriminatory’, ‘completely indefensible’ and an ‘example of a callous and discriminatory process’ (sub. DR203, pp. 80-81). It went on to outline that veterans:

... find themselves in a position where they are denied a legitimate access to a benefit ... that is extended to a class of veterans under a different Act ... The failure by the Government to not introduce harmonising provisions to cross-vest this very important entitlement ... gives rise to the not unreasonable inference that the Government is not complying with its duty to act as an honest broker or model litigant. (p. 81)

The Alliance of Defence Service Organisations (ADSO) used similar language, describing the issue as ‘unconscionable, and an indefensible application of a policy based on bad law’ (ADSO 2018, p. 16), before contending that:

DVA and Government need to go further in the veterans’ entitlements space in terms of omnibus legislation, harmonising beneficial provisions and accrued rights. To do any less is to fail the veteran community. (p. 17)

The Commission agrees that harmonising the legislation to remove this disparity is desirable, but disagrees on the direction of those amendments.

The VEA’s current allowance for accrued rights fundamentally undermines the purpose of the SoP system. As the SoPs reflect the best available sound medical-scientific evidence at the time of their publication, allowing the continued use of a repealed SoP with an advantageous factor suggests that the causal link the claimant is trying to rely on is no longer supported by sufficient evidence. Continued claims based on that link should therefore not be allowed in the veteran support system. The MRCA provisions should therefore be put into the VEA, not the other way around.

⁷ The Full Federal Court first affirmed the existence of accrued rights in *Repatriation Commission v Keeley* [2000] FCA 532 and then affirmed the claimant’s right to choose the most advantageous version of the SoP in *Repatriation Commission v Gorton* [2001] FCA 1194.

FINDING 8.1

Allowing accrued rights for repealed versions of the Statements of Principles (SoPs) under the *Veterans' Entitlements Act 1986* is contrary to the purpose of the SoP system, which is to reflect the latest sound medical-scientific evidence.

The basis of the RMA's sound medical-scientific evidence

The RMA is bound by legislation to only incorporate sound medical-scientific evidence into SoPs. However, as William Gore asked, 'if the science is not available, what then?' (sub. 97, p. 1).

The answer is that the RMA treats an *absence* of solid evidence that there is a causal link (Grade 5a) the same as strong evidence that there is no causal link (Grade 5b) — both grades are insufficient for including a factor in the relevant SoP under either standard of proof (section 8.2). In many cases, such an assumption may be reasonable (e.g. a link is theoretically impossible), but not always. After all, an absence of evidence is not the same as evidence of an absence.

Similarly, 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 due to the relative scarcity of studies based on veteran populations (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 point was 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)

However, if veteran-specific evidence *was* available, the expected impact would be unclear, as the use of some forms of civilian evidence can be beneficial for claimants (box 8.10).

The RMA cannot conduct its own research

A potential solution to both these issues is more research. However, 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 when the RMA was being set up, there was a view that if it conducted 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 can request that DVA carry out research on its behalf (s. 196C(2)). This has happened twice in 24 years and both times 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. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) suggested that ‘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 undertaken 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 (2017b) 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 or others become aware of. There is also a difference between the health studies regularly conducted by the AIHW and the high quality 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 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)

Other participants did not support this idea. David Watts said:

The RMA could never be funded to the level that the international scientific community is. Researchers across the world are far better placed in terms of resources, veteran cohort sizes and a host of other pressing scientific advantages that make any potential contribution by the RMA to be of little to no benefit. (sub. DR177, pp. 2–3)

And the Gulf War Veterans’ Association said it had ‘an issue with giving the RMA more powers of research, like actually doing research, when they can’t even do literature review’, but agreed that RMA should be more accountable when making decisions (trans., pp. 664-665).

Box 8.10 Veteran-specific medical-scientific evidence?

Stakeholders pointed to three main areas in the medical-scientific evidence where veteran issues are unique:

- 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 levels of exposure 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).
- 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’. 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’.
 - 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’ evidentiary standards used to assess claims (discussed in section 8.1) can help to overcome some of these issues.
- 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 limited consideration of unique veteran profiles works both ways — if the RMA did consider service-related differences for SoP factors, this could actually reduce or restrict the available 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 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).

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 2018b, 2018c).

Although the RMA could adopt a similar function in Australia (there is minimal risk of the RMA overweighting their own evidence), ‘it is a vastly different matter for the RMA to

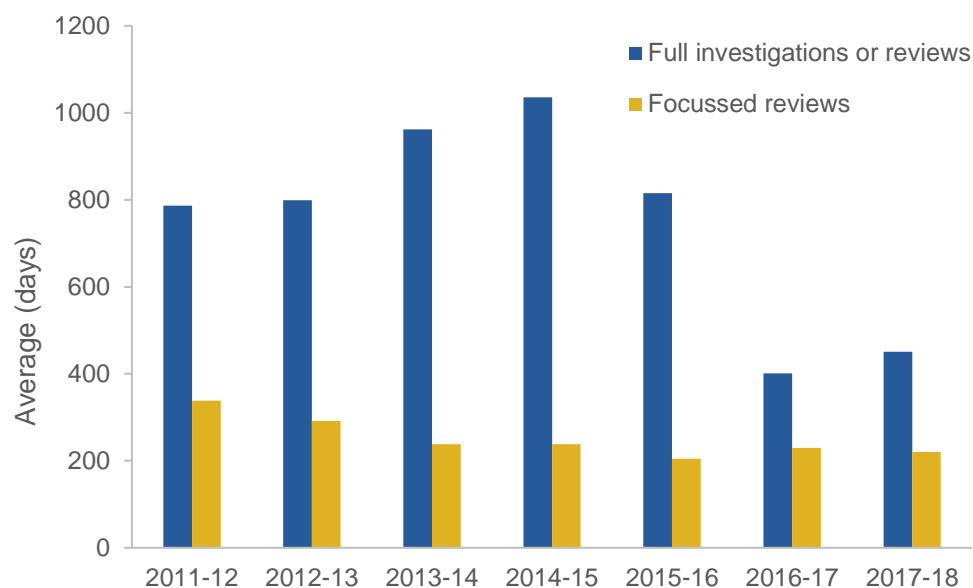
undertake primary research, as opposed to its existing role of conducting research using secondary sources’ (RMA, sub. DR209, p. 7). It would require new staff with new skillsets and subsequently higher costs. A RMA-controlled research fund would also be narrowly focused on filling gaps in epidemiology, ignoring the broader need for extensive research across the veteran system.

As such, a sector-wide approach to funding research into veteran-specific health issues is likely to be more appropriate and cost effective, with the RMA being just one body that could put forward suggestions for research priorities and ‘refer matters ... and provide assistance as required’ (RMA, sub. DR209, p. 7). Broader research problems in the veteran support system are discussed further in chapter 18.

The timeliness of RMA reviews and investigations

Completing a full investigation (for new SoPs) or review (for existing SoPs) is labour intensive and time consuming. The RMA is required to exhaustively examine relevant medical-scientific evidence, and this can involve analysis of many hundreds of journal articles, health studies and case reports for each potential SoP. Although significantly quicker than in the past, in 2017-18, the average time for the RMA to complete a full investigation or review of a SoP was still 15 months (figure 8.3). On average, the time between updates of any given SoP is around 7 years (RMA 2018g).

Figure 8.3 Time taken for the RMA to complete a review or investigation
Average number of days, by financial year



Data source: RMA (2014d, 2016, 2018g).

Some participants thought that this was too slow, and argued that, as a result, the RMA cannot be incorporating newly discovered medical science in the SoPs. 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). They argued that delays in updating or investigating SoPs ‘is causing significant distress to claimants’ (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). Delays in updating a SoP to include new medical evidence can also result in the final resolution of a legitimate claim being prolonged, generating unnecessary or even harmful obstructions for veterans seeking treatment, rehabilitation or compensation.

Reducing the time taken to conduct reviews and investigations

The Commission was unable to obtain data that could shed a light on the impact of the RMA’s lengthy SoP review and investigation processes. For example, the Commission cannot tell how many failed claims from the past might now be accepted, based on SoPs updated with new sound medical-scientific evidence. Similarly, it is not clear how many claims are on hold pending a SoP review or investigation.

However, DVA has asserted that:

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)

There are limitations on how quickly the RMA can conduct a SoP review or investigation. Reducing the time taken to *below* 6 months would be difficult, particularly for a review. The RMA is required to gather and interpret relevant sound medical-scientific evidence, as well as undertake wide-ranging consultation with interested stakeholders. 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 looking at removing a factor in a SoP during a review (RMA 2018b).

The RMA is a relatively small agency — in 2017-18, the secretariat had around ten full-time equivalent staff supporting the five RMA members, and an annual expenditure of just over \$2 million (RMA 2018g). Consultation with the RMA suggests that a relatively small increase in staff numbers (around 5–6 additional researchers) could increase the speed of the RMA’s investigations to around 6 months, better enabling them to keep SoPs up to date with the latest medical-scientific evidence (RMA, pers. comm., 17 June 2019).

Transparency of investigations

Some participants to this inquiry contended 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 and trans., pp. 664–672). 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 bibliography of the ‘sound medical-scientific evidence’ (generally peer-reviewed literature) it relied on to reach its conclusions. Nor does the RMA publish any information that explains to the public how the literature was interpreted and given relative weighting by RMA researchers (including 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 the 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).

Pearce and Holman concluded that ‘it would be desirable if the RMA could spell out in detail the basis on which it had arrived at a conclusion’ (1997, p. 37). Similarly, the RAACC said that increasing the RMA’s transparency:

... has merit as it will make the RMA more open and accountable to the veteran community and DVA, as to how it arrives at its decisions to accept or reject amendments to SOPs, delete risk factors from SOPs and justify any refusal to commence investigations in respect of developing new SOPs. (sub. DR203, p. 74)

However, Pearce and Holman declined to recommend changes, on the basis that it ‘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, some of the necessary work already takes place. As part of the investigation and review process, RMA researchers are 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 2018e, p. 8).

While the regular publication of the RMA’s briefing papers would be a positive step towards transparency, the Commission notes that preparing them for publication would still require additional time and resources (further delaying the SoP investigation process). That said, the briefing papers are already made available to interested stakeholders on request (under s. 196I of the VEA), as well as being subject to freedom of information laws. And this material, together with 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).

RECOMMENDATION 8.2 IMPROVE THE RMA'S RESOURCING AND TRANSPARENCY

The Australian Government should provide additional resources to the Repatriation Medical Authority (RMA), so that the time taken to conduct reviews and investigations can be reduced to closer to six months.

Following any investigation, the RMA should routinely publish a full bibliography of the peer-reviewed literature or other sound medical-scientific evidence used to create or update the relevant Statement of Principles. Stakeholders interested in how different pieces of evidence were assessed and weighed can continue to request the RMA's briefing papers under s.196I of the *Veterans' Entitlements Act 1986*.

The review process for RMA decisions

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 to review decisions on SoPs by the RMA. 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. The SMRC does not report separately to DVA, but its annual expenditures in the past two financial years have been around \$400 000 each year (SMRC, pers. comm., 11 September 2018).

Compared to the RMA’s process for creating and updating the SoPs, the SMRC’s review processes are also cumbersome and do not deliver timely outcomes.

- A new Review Council is convened for each investigation, often with newly appointed Councillors if no existing Councillors have a relevant speciality, creating delays as positions for new Councillors must be advertised and filled (SMRC, sub. DR200, p. 2). By contrast, the five RMA members are appointed for staggered, multi-year terms and have regular engagement with the RMA’s processes through bimonthly meetings and ongoing responsibility for multiple specific SoP investigations (RMA 2019).
- The appointment of new Councillors can also result in a considerable loss of institutional knowledge between reviews, further delaying the process as they have to learn about their role and the SoP system. This could 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), although the SMRC has mechanisms in place to reduce these risks and encourage consistency and predictability — including a permanent secretariat, ongoing legal advice to Councillors and the regular involvement of the Convener in Review Councils (SMRC, sub. DR200).

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. While the review acknowledged that the SMRC’s primary function was 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), this rationale for the SMRC was arguably stronger in 1997 than in today’s well-established SoP system.

Some participants to this inquiry agreed that there is no compelling case for a separate SMRC (Ray Kemp, sub. DR240; Richard Menhinick, sub. DR236; and Peter Sutherland, sub. DR192). But others disagreed and argued that the SMRC should remain a standalone organisation (Bob Bak, sub. DR262; and the RAACC, sub. DR203). ADSO noted that abolishing the SMRC would mean that an ‘independent review function [is] lost’, although it also observed ‘that few reviews [are] undertaken by SMRC’ (sub. DR247, p. 47).

The Commission is of the view that the SMRC’s functions are not best served by a separate agency, and should instead be folded into a review process within the RMA, augmented by

the formal use of additional medical specialists. Peter Sutherland suggested that an internal review process would have broad parallels with existing judicial processes:

... if you look at the Federal Court, essentially the Full Federal Court can review a single judge. You know, it's a bit embarrassing sometimes to be sort of changing the decision of one of your colleagues, but the Federal Court does ... Usually it's better evidence is why things change. (trans., p. 530)

One way to implement a new review process would be for requested reviews of RMA decisions to be co-guided by both a 'lead Professor' already on the RMA panel (as currently occurs) and one or more external medical experts in the relevant field, specifically selected for the role, similar to the current SMRC selection arrangements. The RMA suggested an alternative (that may be able to operate within the existing legislation), involving the RMA appointing one or more independent medical specialists to review the evidence and report back (possibly with recommendations) to the RMA members (sub. DR209, p. 8).

Under any new process, Parliament would continue to have a right of review for every SoP (as it does for all legislative instruments), while DVA's Commissions (or any successor Commission) would still be able to make a determination of compensation coverage for particular conditions if the RMA has given notice that it does not intend to create a SoP. The RMA reviews could also consider information in addition to what was available when the SoP was created or last updated, removing a key restriction on the SMRC's functions.

RECOMMENDATION 8.3 ABOLISH THE SPECIALIST MEDICAL REVIEW COUNCIL

The Australian Government should abolish the Specialist Medical Review Council. The process for reviewing Repatriation Medical Authority decisions on Statements of Principles should instead be expanded to incorporate independent external medical specialists, where necessary.

8.4 The dual standards of proof and options for reform

Similar to every other workers' compensation system in Australia, the veteran support system is liability-based. This means that, unlike a non-liability system (such as the healthcare system for full-time members of the ADF), access to support is conditional on the government accepting liability for a veteran's injury.

However, unlike those other workers' compensation schemes, which base decision making on a single evidentiary standard, the veteran support system is based on two standards of proof.

Differentiating between service types is inequitable ...

The standard of proof that applies to an initial liability claim ultimately depends on whether a veteran has operational service or not. As discussed in sections 8.1 and 8.2, the dual standards exist because the Australian Government wanted to make it easier (but without moving to a non-liability model) for veterans with operational service to access support. The end result is a system that discriminates between veterans with the *same injury* but with different types of service.

The Commission heard from many stakeholders who supported removing the distinction between operational and peacetime service across the veteran support system. The arguments against maintaining the distinction centred on the notion that ‘an injury is an injury’ and that it is inequitable to lower compensation or make access harder just because the injury was incurred in peacetime (discussed in more detail in chapter 4). Those arguing to maintain the distinction suggested it is an important and appropriate form of recognition of operational service.

The case against discriminating on the basis of service type is equally applicable to the dual standards of proof in the initial liability process. Although participants to this inquiry were still divided on the merits of dual standards (box 8.11), the two standards contrast with every other workers’ compensation system in Australia, as well as the principle of non-liability treatment for full-time members of the ADF. Historically, a single standard also applied for all operational and non-operational service from the genesis of the *Australian Soldiers’ Repatriation Act 1920* until the legislative amendments in 1977 (Baume, Bomball and Layton 1994, p. 26).

For the SoPs created at two different standards of proof, there is also nothing about operational service that justifies a lower strength of *epidemiological evidence* before a condition can be said to be related to a causal factor of service. While personnel on operational service can be more exposed to higher risk activities than individuals on peacetime service, this would affect the frequency and severity of any resulting conditions, not the underlying epidemiological issue of whether the conditions were caused by their service.

Some stakeholders, such as John Caligari (trans., p. 1340), pointed to the difficulty of keeping and maintaining accurate service records during operational service as a justification for two standards of proof. However, this issue is explicitly accounted for by the unique and beneficial clauses in the VEA and MRCA that allow for an ‘absence of, or a deficiency in, relevant official records’ during service and the ‘effects of the passage of time’ (outlined in box 8.2), unrelated to the separate standards of proof.

Ultimately, the Commission is of the view that the existing divide between operational and peacetime service is not justified, and should be removed, where it is practical and cost-effective to do so (finding 4.1).

Box 8.11 Divided views on applying different standards of proof

Some were in favour of treating different types of service the same ...

... 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 ... consideration should be given to establishing a standard of proof or test that could apply to both operational service and eligible Defence service. (Royal Australian Armoured Corps Corporation, sub. 29, p. 19)

... 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. (Vietnam Veterans Federation of Australia, sub. 34, pp. 24–25)

You have two different scales, one for the returned serviceman, one for the Defence service. Now to me that's absolutely ridiculous, because they've both been injured serving their countries whilst in the Defence forces. (Veterans of Australia Association, trans., p. 1142)

... but others were *not* in favour

Although the Alliance of Defence Service Organisations (ADSO) noted that some see 'inequity' in the different standards of proof — as it is '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' (sub. 85, pp. 37–38) — ADSO nonetheless claimed that 'differences in the standards of proof for warlike or non-warlike and peacetime service do not cause any inequity whatsoever' (sub. DR247, p. 7).

The combined South Australian ESOs supported different standards for the two categories of veterans (sub. DR188, p. 2) and argued that 'the circumstances under which a wound or injury is incurred is important. Things happen in war that don't happen in peacetime and accepting two standards of proof is a moral and equitable way of accommodating this' (trans., p. 7).

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 ... within the ADF' (sub. 13, p. 2). A similar argument was put by Robert Black (trans., pp. 15–17), the AATTV Association WA branch (trans., p. 206), Legacy Australia (trans., p. 477) and the Tasmanian Ex-Service & Serving Support Association (trans., p. 875).

Differentiating between service types in the context of contemporary service

The differentiation between service types is even less relevant to contemporary service, due to the changing nature of service and changes in attitudes towards deployments. In particular, the ADF has continued to professionalise since national service ended in December 1972, with enlistment no longer a response to a national emergency (as during World War II), nor a requirement under conscription. Contemporary ADF members are now career-oriented volunteers who are paid salaries competitive with other employment options and who often view deployments as an anticipated and sought-after goal of ADF service. As the Veterans of Australia Association said:

... most veterans would give their left leg to get on operational service, to put their employment, their job description into action. You've basically got to be standing in the right spot at the right time to be deployed. (trans., pp. 1142–3)

As most contemporary personnel are professionals, training to eventually be deployed, treating injuries sustained during peacetime activities differently from injuries on deployment can thus be seen as more inequitable than in the past. As such, the Commission more strongly favours removing the distinction between types of service that are covered by the MRCA (since 1 July 2004), as this would cover current and future ADF personnel, while leaving claims under the older VEA and DRCA with their existing differentiations.⁸

... but which standard of proof?

The Commission favours moving to a single standard of proof under the MRCA, but the question is *which* standard: the balance of probabilities or the reasonable hypothesis?

Most veterans and ESOs expressed a strong preference for the reasonable hypothesis to be the single standard of proof as this would mean that all claimants either benefit or are at least not disadvantaged — Bob Bak (sub. DR262), Defence Force Welfare Association (sub. DR299), William Kaine (sub. DR197), Brian McKenzie (sub. DR275), the Vietnam Veterans' Federation of Australia (sub. DR215) and the Veterans of Australia Association (sub. DR232). As one participant contended:

The fundamental legal and legislated principle of 'reasonable hypothesis' is the building block of the government and people's commitment to looking after our veterans returning from conflict in our name. (David Watts, sub. DR177, p. 2)

However, the choice is complicated by the initial liability system operationalising the two standards of proof through two separate mechanisms — the dual SoPs created by the RMA and the two different decision-making processes for delegates in DVA. Moving to a single standard of proof will have different implications for each of these mechanisms. We discuss these implications with respect to the SoPs first, followed by the decision-making process.

A single Statement of Principles

The Commission is recommending all initial liability claims under the MRCA use the SoPs based on *the reasonable hypothesis* standard of proof.

The reasonable hypothesis SoP represents a scientifically robust way to incorporate new and emerging epidemiology while minimising the probability that veterans who have a novel, but poorly understood, condition are denied support in the early stages of a condition's discovery. It does this by including some factors that would not have been included under

⁸ Over the longer term, under the Commission's proposed two-scheme approach (chapter 19), this would result in some continued differential between types of service within scheme 2, but only for conditions related to service prior to 1 July 2004, as currently occurs.

the balance of probabilities, while still ensuring that the additional factors are not ‘obviously fanciful, impossible, incredible or not tenable or too remote or too tenuous’ (discussed in section 8.3).⁹ The RMA’s continual process of reviewing and updating SoPs over time can then improve on the factors as new evidence comes to light, or remove them if the original evidence later turns out to be weak.

By allowing a lower level of epidemiological evidence before a condition can potentially be related to a factor of service, moving to the reasonable hypothesis SoP would result in more claims related to peacetime service being accepted, increasing the costs of the system. The magnitude of this effect (in claims numbers and expenditure estimates) is discussed further below.

A single decision-making process?

The Commission is not making a definitive recommendation about the decision-making process. There are four potential options available:

- Move to **the reasonable hypothesis process** — consistent with broader wellness principles (recommendation 4.1) it would allow claimants without operational service easier access to supports compared to the existing initial liability system. Combined with the structural changes outlined in chapter 11, this would encourage holistic, proactive intervention by the Veteran Services Commission (VSC), as early rehabilitation and treatment can lower the lifetime cost of support, including compensation costs in the long-run (EML, sub. 90; Occupational Therapy Australia, sub. DR289; SwissRe 2016).
- Move to **the balance of probabilities process** — this would align the initial liability approach in the veteran support system with standard processes for making administrative decisions across government. It could also make the decision-making process easier for delegates to understand, making training simpler and hence improving the quality of DVA (and then VSC) decisions.¹⁰ Although moving to the balance of probabilities process will lead to some veterans with operational service having their claims rejected, this could still align with a focus on wellness principles if access to rehabilitation (and possibly treatment) were considered outside of the narrow lens of the liability system. However, this would require a complete rethink of the liability-based system — something the Commission has not considered in this report.
- Create a **‘middle ground’ standard** and process — such as introducing a ‘benefit of the doubt’ to the balance of probabilities, as the Baume Review originally recommended (Baume, Bomball and Layton 1994, p. 28).¹¹ However, DVA already informally acknowledges that a benefit of the doubt exists within the balance of probabilities

⁹ As outlined in *East v Repatriation Commission* (1987) 74 ALR 518.

¹⁰ The balance of probabilities process is more intuitive, as it does not involve a negative decision based on reversing the criminal standard, nor determining whether a hypothesis is ‘fanciful’ or ‘tenuous’.

¹¹ This would be a return to the pre-1977 system, where the civil standard included provisions allowing for a ‘benefit of the doubt’, a ‘benefit of *any reasonable* doubt’ and then a ‘benefit of *any* doubt’, none of which were ‘criticised as being ungenerous’ at the time (Baume, Bomball and Layton 1994, pp. 15–16, 25).

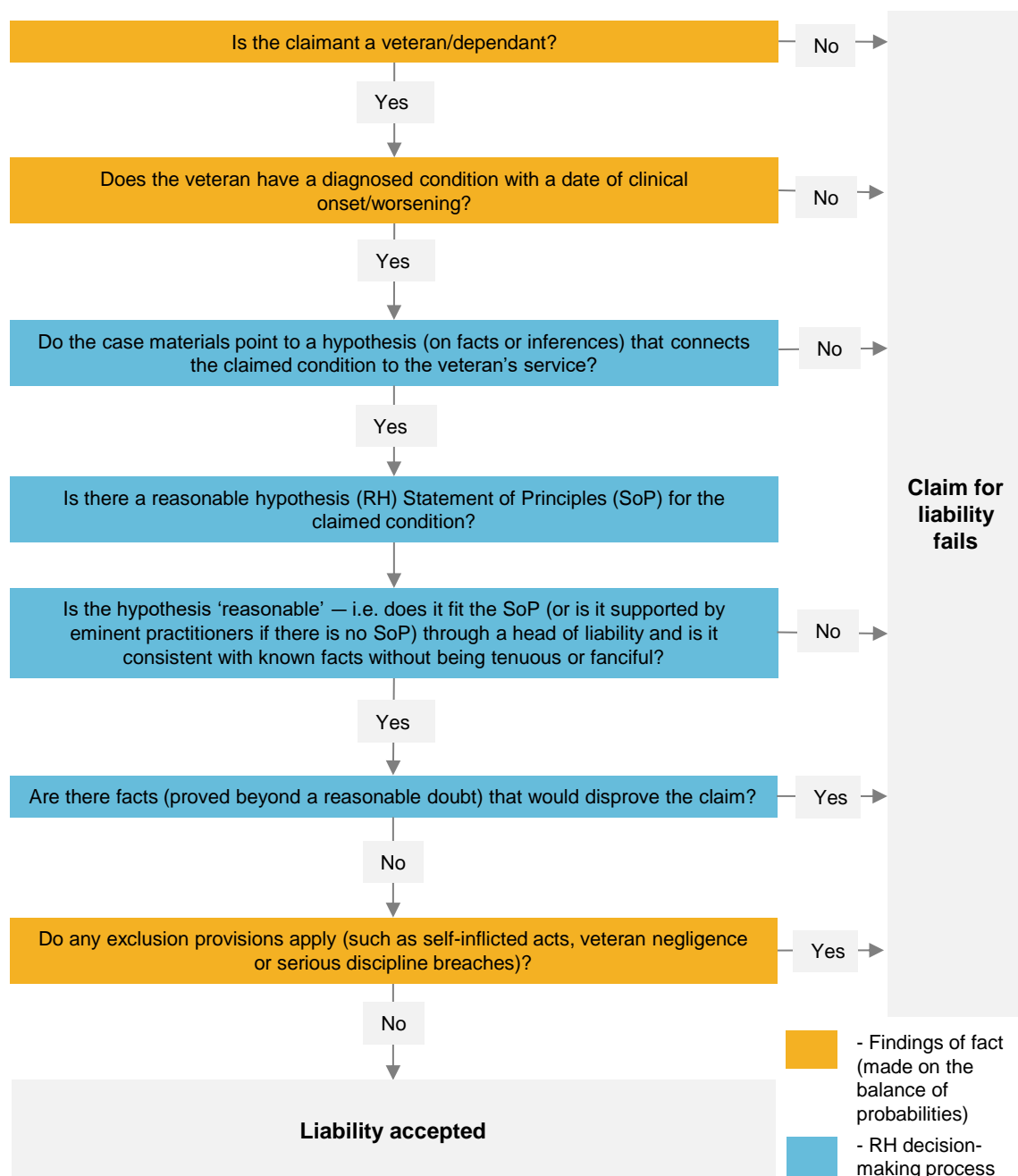
decision-making process if ‘a decision-maker is genuinely unable to decide’ (DVA 2018ag, s. 3.5.4). Legislating such a clause may also produce discrepancies during interpretation, as Topperwien (2003, pp. 293–294) found that different people have vastly inconsistent interpretations of a ‘benefit of the doubt’, while the RMA observed that ‘a “middle ground” approach may enlarge, not reduce, the potential for different interpretations of the statutory requirements’ (sub. DR209, p. 4).

- **Keep both existing standards** — although differentiating between personnel on the basis of their type of service is inequitable, both processes could remain if another basis was used to determine access to the different standards, although this would introduce new complexities into an already complex system. Two possible alternatives are:
 - access to the reasonable hypothesis process could be limited by time (either from clinical onset/worsening, relevant service or discharge), with claims after a set period considered under the balance of probabilities process. This would align with a focus on improving wellbeing by encouraging early intervention, and also acknowledge that, as time from relevant service grows, some conditions are more likely to be due to natural ageing processes or the effects of post-service careers. A similar approach has been used in the United Kingdom, where the burden of proof is more restrictive if a claim under the War Pension Scheme is made more than seven years after discharge (House of Commons Library 2018; Lord Boyce 2010).
 - the concept of initial liability could be split in two, with liability for benefits that most improve wellbeing — namely, rehabilitation and treatment — considered on the reasonable hypothesis process, while anyone seeking financial compensation (including incapacity and permanent impairment payments) would have to meet the balance of probabilities test. This would align with a greater focus on wellness principles and proactive, early intervention.

All of the options considered above would retain the unique caveats in the legislation that allow for the passage of time and poor record-keeping during service (box 8.2). It is the Commission’s understanding that, at present, these clauses are not frequently relied upon and the relevant case law lacks a consistent interpretation of how and when to apply them (Creyke and Sutherland 2016, pp. 397–403). Further work is needed by the Australian Government to clarify the role of these clauses in the future veteran support system, particularly if the system moved to a single standard. In particular, an inquiry by the Australian Law Reform Commission — an independent body with expertise in clarifying existing legislation and recommending simplifications (ALRC 2018) — would aid in understanding the full ramifications of moving to a single decision-making process for all MRCA claims, as well as provide clear guidance on the decision-making process and its interactions with these other relevant sections of the MRCA.

At this stage, assuming that access to veteran supports remains primarily liability-based, the Commission is inclined to support moving to the reasonable hypothesis decision-making process (depicted in figure 8.4), primarily on the principle that it will encourage a greater focus on wellbeing and early intervention in the short term. However such a move will also result in significant Budget implications over time (discussed below).

Figure 8.4 The Commission's preferred process under the MRCA



Source: Productivity Commission analysis.

RECOMMENDATION 8.4 MOVE MRCA TO A SINGLE STANDARD OF PROOF

The Australian Government should remove the distinction between types of service when determining causality between a veteran's condition and their service under the *Military Rehabilitation and Compensation Act 2004* (MRCA). This should include:

- amending the MRCA to adopt the reasonable hypothesis Statement of Principles for all initial liability claims
- requesting that the Australian Law Reform Commission conduct a review into simplifying the legislation and moving to a single decision-making process for all MRCA claims, preferably based on the reasonable hypothesis process.

How many claims are affected and what is the cost of moving to the reasonable hypothesis for all MRCA initial liability claims?

Data limitations mean we cannot estimate the precise impact of removing the differentiation between types of service on the number and cost of claims accepted or denied. The proportion of MRCA claims that would be affected 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 18) reduce the scope for such analysis. This has been made more difficult since the introduction of the Veteran Centric Reform program, as implementation problems to do with DVA's new shared services information and communication technology (ICT) agreement with Services Australia have created a discontinuity in client data from December 2017, meaning the Commission is unable to make comparisons before and after this date.

Nevertheless, a high-level comparison of acceptance rates for groups of individuals with different types of service (up to 2016-17) can be illustrative of the size of expected changes (box 8.13). These estimates suggest that moving all claimants to both the reasonable hypothesis SoP and the reasonable hypothesis decision-making process would have resulted in around 53 per cent of all failed claims between 2004 and 2017 being accepted instead. This broadly aligns with the survey findings in Topperwien (2003), which suggested that 41 per cent of the balance of probabilities cases reviewed by the Veterans' Review Board either *would* have or *may* have had a different outcome if the reasonable hypothesis SoP and process had applied instead.

Due to the issues with determining the number of affected claims, the financial impact from moving to the reasonable hypothesis standard 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 not), there may also be a minimal financial impact from more claims succeeding or failing, 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 an

unsuccessful claim for liability had other conditions that were accepted. This rises to 88 per cent for those claimants whose unsuccessful claims related to operational service (Commission estimates based on unpublished DVA data).

Box 8.12 **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 *Military Rehabilitation and Compensation Act 2004* (MRCA). By comparison, conditions related to peacetime service (including those related to both peacetime and other types of service), had an acceptance rate of about 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 post-traumatic stress disorder 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 (14.5 percentage points higher), equivalent to an additional 17 000 accepted conditions between 2004 and 2017, or an additional 2800 accepted claims in 2016-17.
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 6000 fewer accepted conditions between 2004 and 2017, or 1150 fewer accepted conditions in 2016-17.

Source: Productivity Commission estimates based on unpublished DVA data.

The Commission conducted a simple regression analysis on MRCA client and expenditure data, to provide a rough estimate of the costs of moving all claimants to both the reasonable hypothesis SoP and decision-making process. The results suggest that:

- among those clients who received a MRCA lump-sum payment in 2016-17, having an additional accepted condition was worth around \$7700 extra, on average. If this relationship applied to an additional 2800 accepted claims in 2016-17 (from box 8.13), the additional cost would be \$21.5 million.
- clients receiving periodic MRCA payments or using treatment cards generated an average of around \$1600 in extra expenditure in 2016-17 for every additional condition they had accepted. If this magnitude of additional expenditure also applied to 2800 extra

accepted claims in 2016-17, the additional cost would have been \$4.5 million.¹² As this expenditure is periodic, similar costs would then be incurred annually thereafter for the same cohort of newly accepted conditions — expenditure would thus rise rapidly, as new cohorts would also have higher acceptance rates and add increased costs.

The effects of combining the standards of proof (such as moving to the reasonable hypothesis SoP and the balance of probabilities decision-making process) have not been analysed, as the data available to the Commission cannot differentiate between the impact of the different SoPs compared to the different decision-making processes. Given that claims related to operational service are in the minority (about 21 per cent of claims), it is highly likely that any additional leniency for peacetime service claims would drive cost impacts, meaning that the net effect would be higher costs, somewhere between the status quo and the estimates of moving to the reasonable hypothesis, analysed above.

¹² This figure does not include any additional incapacity payments, as the complex offsetting arrangements with superannuation invalidity benefits mean that direct costs to DVA can often *decrease* with additional conditions, as costs are shifted onto the Commonwealth Superannuation Corporation instead.

9 Claims management 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 is 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 majority of clients.
 - To ensure the continuing success of MyService, DVA needs to resolve problems involving the shared ICT relationship with Services Australia (previously known as the Department of Human Services).
- While VCR has good overarching objectives and produced some early successes, some initiatives have been problematic, including the \$24 million Rehabilitation and Compensation Integrated Support Hub, which is not being used efficiently or effectively, and the transfer of DVA data holdings to Services Australia, which has undermined research capability.
- Notable ongoing areas of concern in the claims administration process that the Commission observed and participants raised include:
 - failure by DVA staff to consistently provide their direct contact details when interacting with clients in contravention of internal communication guidelines
 - 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.
- The rollout of VCR will need to be carefully managed and closely supervised to ensure success. Regular progress reporting and ongoing assurance reviews will help facilitate this outcome.

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 2018g).

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 found, these problems are driven predominantly by outdated information and communication technology (ICT) infrastructure and inefficient and poorly planned and executed administrative processes and less to do with DVA staff, who by and large are well-intentioned and dedicated (section 9.1).

DVA is attempting to fix its ICT and administrative shortcomings 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, support for clients with complex needs, 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).

9.1 Good intentions but not always good 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
- deliver 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

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.

-
- recognise that you have varying and changing needs
 - develop and equip 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)

The Returned and Services League (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). And the Commission heard about others, including David Stafford Finney — who died by suicide in 2019 — and Jason Grant — who died of a heart attack at 32 in 2017 — where administrative practices also appeared to be deficient.

Jacque Lambie's struggle with DVA is well documented in her book (Lambie 2018). She described DVA's approach to claims management as 'delay, deny, die' (p. 117) — a sentiment repeated in submissions by Timothy Chesterfield (sub. DR228) and Lisha Taylor (sub. DR311). On her thoughts prior to her attempt to take her own life in 2009, Lambie wrote 'well I had had a gutful of the first two, so now I only had the third one left' (p. 163).

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)

Dissatisfaction is particularly high among younger veterans who are more likely to be going through the claims process. DVA's 2018 client satisfaction survey found that just 58 per cent of DVA clients under the age of 45 were satisfied, compared to 89 per cent of clients over the age of 65 (DVA & Orima 2018).

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 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 [DVA] to provide effective service delivery to its stakeholder base to the detriment of that stakeholder base. (sub. 29, p. 3)

Box 9.1 **Many people spoke about poor experiences with DVA**

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)

Nothing in the DVA process ... 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)

[DVA has] a culture lacking in transparency, openness, honesty and veteran centric support. (Brendan Dwyer, sub. 15, p. 3)

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 reinstatement 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)

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)

On my discharge I submitted a claim through DVA to be recognised for my mental health condition ... I remember the onerous paperwork, the loss [of] records, the number of phone calls and assessments I had to endure, each interaction forcing me to relive my story and in some cases retell it from start-to-finish, a highly traumatic and, to be honest, scary thing to do. (Ben Walker, sub. DR216, pp. 1-2)

You [the veteran] are a thieving tax roting fraudster and parasitic lazy arse who has no right asking for money off the taxpayer and you will be stopped at all cost, regardless of the high threshold of supportive evidence you submit (t'was how I was treated). (name withheld, sub. DR255, p. 19)

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 inquiry into suicide by veterans (SFADTRC 2017, p. xxi). Submissions to the Senate inquiry raised concerns about staffing issues, delays in determining claims, incorrect payments, communication issues and a general adversarial

³ With the release of its 2017-18 annual report, DVA announced four more reviews as part of its response to the 2017 Senate inquiry into suicide by veterans. In November 2018 it announced another review of the review of the Department's response to the original review into Jesse Bird's suicide.

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 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 (2018). 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. The Ombudsman stated that ‘while cases involving this level of accumulated administrative errors are rare, the individual errors are not isolated incidents’ (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. (p. 1)

It is critical that DVA implements the recommendations aimed at addressing administrative shortcomings from these recent reviews.

RECOMMENDATION 9.1 PUBLIC PROGRESS REPORTS ON RECENT REVIEWS

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

9.2 Veteran Centric Reform — a vehicle for change

DVA began its latest major transformation program — known as 'Veteran Centric Reform' (or alternatively 'Transforming DVA') — 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 2017f, 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).

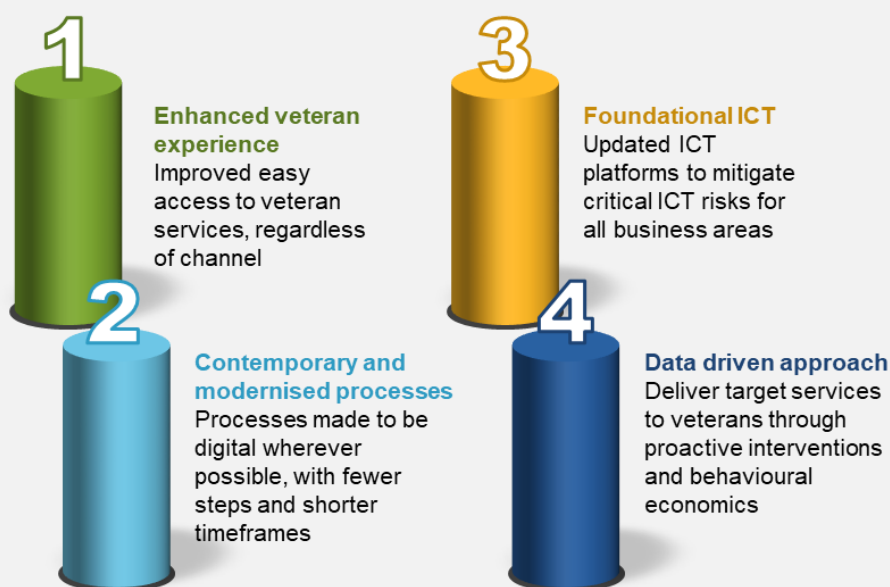
Funding for the first phase of the transformation program is aimed at improving the client-facing elements of the Department including by building new online systems, replacing outdated ICT infrastructure and software and overhauling existing business and administrative processes (box 9.2).

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 2016b, p. 154). Subsequent Budgets allocated an additional \$262 million to VCR, with approximately one half allocated to the Department of Human Services (now Services Australia) to provide ICT services to DVA as part of a broader whole-of-government shift towards centralising ICT delivery arrangements (Australian Government 2017c, 2018a, 2019a).

Organised around four strategic pillars (figure below; DoD, DoH and DVA 2017, p. 32), the end point of the VCR is intended to 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
 - 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 2017e, sub. 125; Lewis 2018).



9.3 Some early signs of success

Some of the initiatives introduced under the VCR banner are having a demonstrably 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 the VCR's aspiration of simplifying the client experience by leveraging ICT functionality, is the online claims-processing platform, MyService.

Box 9.3 A summary of VCR progress to date

Specific initiatives and programs introduced as part of the Department of Veterans' Affairs (DVA's) 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)
- **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 included:

- 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 — 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).

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 accept 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 Services Australia⁵ 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.

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.

⁵ Previously known as the Department of Human Services.

Box 9.4 Shared services: paired or pared services?

Shared services arrangements between the Department of Veterans' Affairs (DVA) and Services Australia (previously known as the Department of Human Services) were introduced in November 2017. By piggy-backing on Services Australia information and communication technology (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 Services Australia 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.

Outcomes so far

By June 2019, nearly 50 000 claims had been lodged through MyService from over 75 000 users (Chester 2019b). 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. (RAAC Corporation, sub. 29, p. 9)

As the RAAC Corporation 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:

4. enlists in or is appointed to an ADF service branch (after 1 January 2016)
5. 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)
6. commences transition from the permanent force or continuous full-time service (CFTS) in the ADF
7. completes transition from the permanent force or CFTS in the ADF
8. renders service which attracts eligibility as ‘qualifying service’ under the VEA.

There are, however, some missing triggers⁶, 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 can be combined with MyService functionality, this could mean automatic acceptance 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 allows the Chief of the Defence Force to lodge a claim on behalf of a member, with the member’s consent, was given Royal Assent in October 2018 (DVA 2018i). The Commission also understands that a pilot program is scheduled to commence in 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

⁶ 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.

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 (ACSQHC 2013, p. i).

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 many aspects of the claims process.

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

Five notable areas of concern where there is clear room for improvement are discussed below:

- client communication
- looking after vulnerable people during the claims process
- time taken to process claims
- quality assurance for claims
- the use of external medical assessors.

The quality of client communication is inconsistent

While online services such as MyService have the potential to automate much of the claims process and act as a one-stop-shop for claimants, they are a complement to a process where human-to-human contact should be a key element.

MyService does not eliminate the need for DVA staff to interact with veterans and their families. For one, medical conditions that are not 'decision-ready' require a claims delegate within DVA to manually assess a claim for initial liability under the SoPs. Automatic MyService assessment is also still to be rolled out to all 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).

As DVA's 2013 internal guidance states, human-to-human contact during the claims process can 'help to alleviate a significant amount of concern, worry and anxiety'. This was reiterated by Employers Mutual Limited (EML), a commercial claims manager, who 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. (sub. 90, p. 6)

The Commission heard numerous times during its consultation for this inquiry about situations where something as simple as a 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).

But three years into the VCR process — designed to put the veteran at the centre of DVA's service delivery philosophy — there is evidence that DVA is failing to consistently implement its own client communication protocols. For example, since at least November 2017, DVA staff have been instructed to 'include their direct phone number ... in all letters to clients' (DVA internal manuals). As a number of submissions to this inquiry show, some DVA staff continue to ignore this basic instruction, to the annoyance and frustration of veterans and their families:

... [there is] no way for a veteran to be informed of where their claims are in the queue as there is no point of contact for the veteran to reach out to ... This is not how [DVA] should treat clients or customers ... (Michael Kelly, sub. DR304, p. 1)

FINDING 9.2

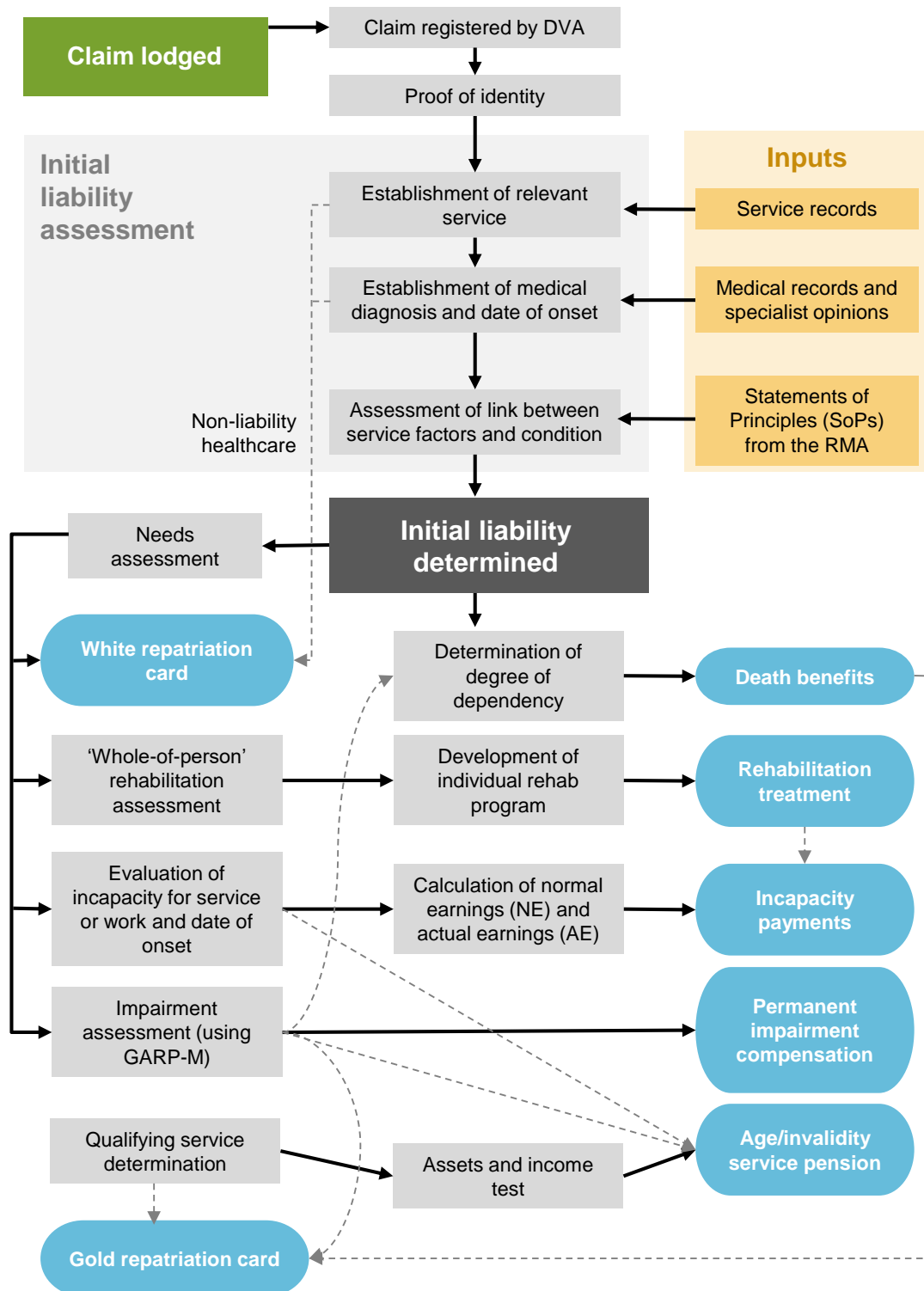
The Department of Veterans' Affairs is failing to ensure that its staff consistently apply its own internal guidelines for communicating with clients. This leads to poor outcomes for clients and undermines confidence in the Department.

The Commission also heard that empathy — conveying a sense of understanding — during conversations was important for clients. It is clear that not all DVA staff are appropriately trained to deal with potentially vulnerable clients, such as veterans who *could* become distressed during a call:

... although they try to help [DVA staff] can do extraordinary damage because they do not understand the mental condition of who they are talking to. To a veteran, the DVA response to a call for help seems to fall on deaf ears and indicates complete lack of empathy ... (Owen Bartrop, sub. DR165, p. 2)

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.

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 despite its relatively low cost ('Accidental Counsellor' 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 inquiry into suicide by veterans (SFADTRC 2017) and tragically and prophetically brought home in the case of Jesse Bird, who suicided not long after writing a very critical email to DVA about the lack of support and care by DVA personnel (including commenting on the tone and attitude used on the phone) and ended:

I have come close to becoming another suicide statistic. I've done my time and now I need your help, please. (Atkin 2017b)

A cost-effective approach to preventing DVA clients from being inadvertently nudged into a worse psychological position would be to provide claims assessors with adequate training to help them interact with potentially vulnerable clients. Providing 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)

In addition, a 2019 report by Alex Collie at Monash University, who was commissioned by DVA to review an unreleased previous review on the mental health impacts of DVA's claims process, found that there is an 'opportunity to provide further skills training within the current claims model' including 'motivational interviewing to enable staff to provide greater support to clients with more complex conditions' and implementing competency-based training and recruiting to optimise their claims-management teams (Collie 2019, p. 64).

Other stakeholders suggested that hiring more veterans in DVA could lead to more empathetic staff (box 9.5).

RECOMMENDATION 9.2 APPROPRIATELY TRAIN STAFF

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.

Box 9.5 **What makes a good claims assessor — a veteran or civilian?**

In 1921, the Repatriation Department was ‘dominated by men more experienced with “bomb and bullet” than with “pen and pencil”’ (Lloyd and Rees 1994, p. 85), with returned soldiers making up around 98 per cent of the 600 staff (p. 144). Similarly, in 1979 ‘almost all the decision making positions in the Department were held by Second World War veterans’ — a trend that prevailed well into the 1980s (Lloyd and Rees 1994; Topperwien 2003, pp. 295–296). This presents a stark contrast to the current Department of Veterans’ Affairs (DVA) staff profile, where 5 per cent of DVA staff self-reported as veterans in 2018, lower than the average of 6 per cent employed in other government departments (DVA, pers. comm., 7 June 2019; APSC 2018a).

This change lends some credence to criticisms of DVA that its staff are making mistakes or inaccurate assumptions when assessing claims, as they do not understand defence culture and the military experience (SFADTRC 2017, p. 81; Vietnam Veterans’ Federation of Australia, sub. 34, p. 31). Some suggested that employing more ex-serving defence members in DVA could remedy this (while also providing employment opportunities for transitioning members):

... DVA must recognise it is problematic for a DVA employee with no military experience to fully comprehend the circumstances that lead to a veteran engaging with DVA. Many of the issues that veterans experience with DVA can be addressed by DVA employing more ex-service personnel. (Matthew Crossley, sub. 83, p. 1)

Other submissions disagreed with this view, for example, claiming that ‘the toxic culture and mismanagement found within DVA’ is driven by the practice of employing former military officers (name withheld, sub. DR217, p. 3). Indeed the architect of the repatriation system, Prime Minister Billy Hughes, shared a similar view in 1921, stating:

... putting soldiers on all repatriation bodies had failed because soldiers, taking them by and large, were not capable of approaching matters with an open mind ... (Lloyd and Rees 1994, p. 193)

There does not appear to be any empirical analysis to support the claim that veterans more accurately assess claims or that they accept a higher number of claims compared to non-veterans (including those who may have taken DVA’s dedicated cultural awareness courses, ‘At-Ease’ and ‘It’s why we’re here’).

From a philosophical perspective, Bruce Topperwien — a former senior legal adviser in DVA — appealed to the notion that society owes a debt to those who have served when he suggested that non-veteran decision makers would be more sympathetic because ‘a veteran decision-maker might see other veterans as no more deserving than themselves’ (Topperwien 2003, p. 296). This view was supported in 1929 when George Yates, a Member of Parliament, said:

It has been my experience that returned soldiers receive just as harsh treatment from ex-soldiers as from civilians ... Civilians feel that they are under some obligation to the returned soldier, and would administer the Act in such a way that a far greater measure of justice would be meted out to returned soldiers than otherwise would be the case. (quoted in Topperwien 2003, p. 296)

There is anecdotal evidence of veterans lacking sympathy for other veterans. John Whiting’s infamous book, *‘Be in it, mate’*, in which the claims delegate and former Air Force pilot mocked many injury claims from veterans is one such example. At the time Whiting wrote his book (1969), when the Repatriation Commission was staffed predominantly by veterans, the acceptance rate for claims was 30 per cent — well below the current rate across any of the existing Acts. Similarly, some of the ongoing disagreement within the veteran community about the definition of a ‘veteran’ centre on who does and does not deserve to be called a veteran, including whether those without operational service should have easier access to more generous benefits (chapter 1, 8 and 14).

(continued next page)

Box 9.5 (continued)

In 2008, when the Repatriation Medical Authority (RMA) asked a group of Ex-Service Organisations (ESOs) to make a decision about what medical factors would go into a reasonable hypothesis Statement of Principles, the outcome was incorrect, and relatively unsympathetic:

It turned out that their standard [ESOs] was harsher than ours [RMA]. So, it was interesting. The ESOs, in looking at the information, would have left out factors that we'd already put in. (Donald 2008)

The RMA example hints at a still pertinent point made almost 95 years ago as part of the findings of the 1924 Royal Commission, that 'much of the difficulty [in assessing claims] has arisen owing to a confusion in the lay mind ... between sympathy for the soldier and just appreciation of the cause of his disability' (Blackburn et al. 1924, p. 6). The Royal Commissioners went on to note that the 'consideration of matters connected with the assessment of pensions is essentially medical' (p. 6). Indeed agreement on exactly how to assess the connection to service remains a live issue in the veteran community today (chapter 8).

What should matter most for the purposes of correctly assessing a claim is that delegates 'have technical expertise and administrative skills in addition to "soft-skills" to support positive engagement with clients' (Collie 2019, p. 64). That is, regardless of their background — civilian or military — they need to be effectively trained to make the legally correct decision, including to interpret the evidence as well as elicit the right evidence by interacting appropriately with potentially vulnerable veterans (finding 9.2).

Supporting clients with complex needs

In lieu of comprehensive training for *all* staff who interact with clients, DVA currently has a suite of programs and protocols that set out how the Department will interact with claimants classified as having complex or multiple needs while they navigate the claims process (box 9.6). It does this by directing clients toward specially trained staff or diverting them into external services, such as counselling.

Three programs have operated since 2007: the Client Liaison Unit, Case Coordination Program and the Service Coordination Program. Commencing in February 2016, these three programs 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).

Box 9.6 **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).

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 9.7). 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 2018j).

Should case coordination be the default?

Some participants to this inquiry (such as the Alliance of Defence Service Organisations, sub. 85) were complimentary of the CCS and DVA's attempt to better manage the stresses of the claims process by identifying and managing vulnerable clients. 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)

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)

Box 9.7 **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 June 2019, there were 11 client support coordinators and 25 case coordinators and an additional 8 positions were in the process of being filled (DVA, pers. comm. 18 June 2019).

Sources: DVA (2016d, 2018j).

Under 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 (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).

The review of the mental health impacts of DVA's claims-management system by Alex Collie found that the segmented and sequential nature of the claims process, which sees claimants interact with multiple claims delegates, may be 'potentially harmful to client mental health' (Collie 2019, p. 44). However, Collie also points out that the level of impacts are not uniform across DVA's client base and will vary depending on, for example, how a claim was lodged (i.e. paper based vs online via MyService).

Rather than universal case management, Collie, based on his analysis of existing best practice (which also includes 'enabling clients to self-manage their claim, where appropriate'), suggested the use of a 'risk screening / triaging model at claim onset to "stream" clients to appropriately resourced and capable claims staff' (Collie 2019, p. 46). This risk-based approach is not entirely dissimilar to the existing referral system (CCS) used

by DVA. However, a key difference is the level of automation. For example, Workcover Queensland uses risk factor identification based on data available at claim lodgement to allocate clients into risk groups. The majority of claimants subsequently self-manage while the higher-risk, complex clients, are provided with tailored care characterised by case managers who provide a single point of contact (Collie 2019, p. 52). On top of additional training (recommendation 9.2) automation could further assist DVA to minimise inadvertently upsetting claimants:

One of the areas of great concern is that on first contact, a client who's under a great deal of stress, not necessarily directly due to the condition that they're suffering, but under their general situation, is not necessarily identified and dealt with and a client in crisis is equally not necessarily identified well by the front-of-house system (Peter Alkemade, trans., p. 641)

However, Collie pointed out (pp. 60–64) that automated segmentation would require upgrades, or at least improvements, to the existing claims information system (section 9.5) as well as enhanced data analysis (DVA is in the process of finalising its data strategy for the next three years which will outline its plans in this area — chapter 18).

Collie noted that many of the best-practice trends he identifies in his report 'are consistent with DVA's stated approach to service delivery' (Collie 2019, p. 46). However he outlined a number of opportunities that could be implemented by DVA to help reorient the existing approach to claims management away from a claims-processing model to a client-centred approach, reflecting current best practice. These include:

... expanding the MyService offering and the Combined Benefits Processing model, introducing an approach to client segmentation that links delegate capability with client complexity, better targeting resources for psychosocial screening to clients most at risk, reforming [independent medical assessment] processes, and developing a client health and wellbeing outcome measurement framework. (Collie 2019, p. 7)

DVA indicated that they are considering the suggested actions contained in Collie's report.

Time taken to process

The Senate 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:

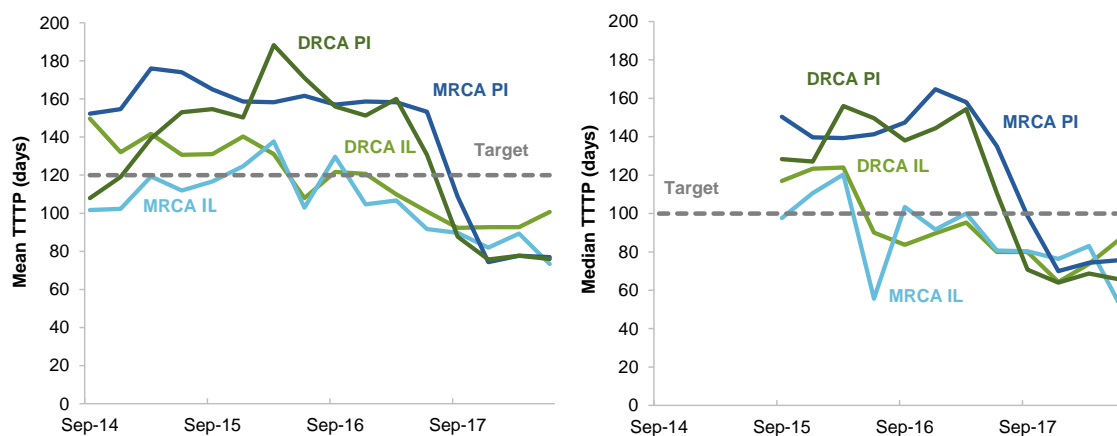
... our clients have reported that it has taken years for DVA to process their claim ... The financial difficulties caused by these delays resulted in some veterans almost losing their homes. (sub. 82, p. 10)

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)

Figure 9.2 Time taken to process (TTTP) claims^a
By Act, for initial liability (IL) and permanent impairment (PI)



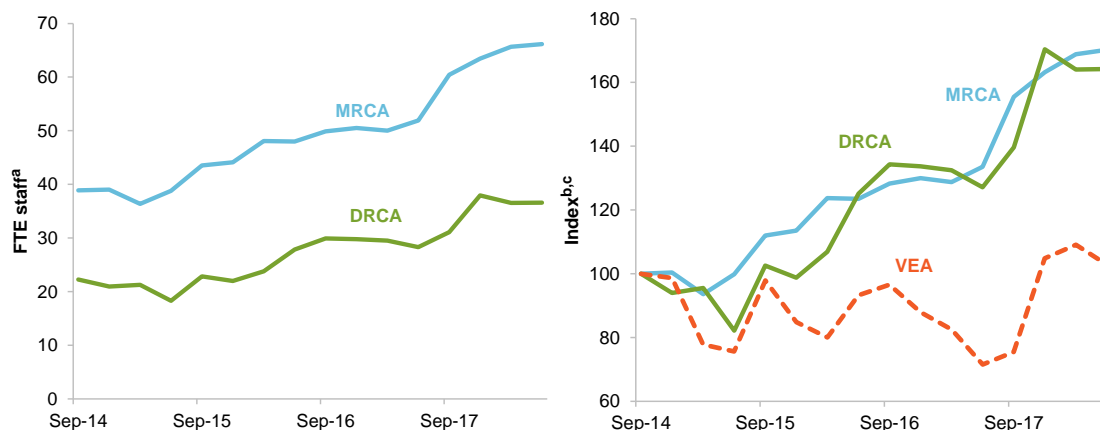
^a Three-month moving average.

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).

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 9.3 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 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.

FINDING 9.3

The Department of Veterans' Affairs needs to negotiate a sustainable and predictable departmental 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 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 and uncommon medical conditions, with 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.

- 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 towards the statutory time limit, would be an effective counter).
- Assessors would have an incentive to deny a claim if it was complex or required significant investigation that might take longer than the statutory time limit, and the Commission heard that DVA delegates are already risk averse (chapter 11).

FINDING 9.4

The Productivity Commission does not, at this stage, support automatically deeming initial liability claims at the end of a fixed period. 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 9.8) 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).

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.

Box 9.8 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 QA. The 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 initial liability claims under the *Military Rehabilitation and Compensation Act 2004* were checked, out of an intake of 9316 — a sample rate of 1.16 per cent
- 363 cases under the *Veterans' Entitlement Act 1986* 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.).

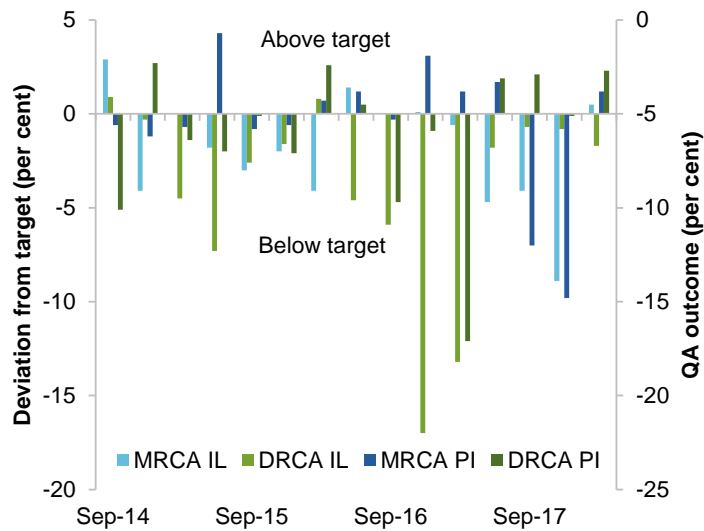
The QA system shows that DVA consistently makes mistakes

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.

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

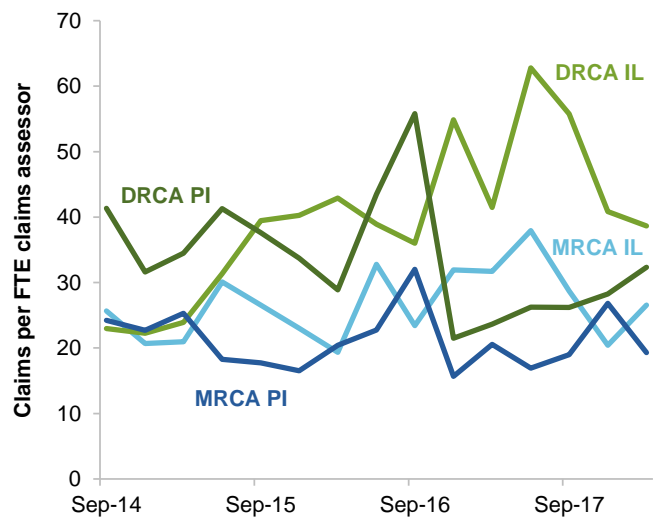
the suggestion made by some participants that within DVA, ‘the compensation system is severely understaffed and under resourced’ (confidential, sub. 9, p. 1).

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.

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.

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 9.9).

Box 9.9 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 public service staff numbers and strong growth in *Military Rehabilitation and Compensation Act 2004* claims, this has led to heavy reliance within Department of Veterans' Affairs (DVA) on contractors, who now account for almost 40 per cent of DVA's 2900 staff (by headcount). 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 [Community and Public Service Union] 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 [DVA]. 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)

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 ACT 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)

(continued next page)

Box 9.9 (continued)

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 about 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. (p. 22)

Remedying 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. (p. 1)

RECOMMENDATION 9.3 **ENSURE QUALITY OF CLAIMS PROCESSING**

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 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 Defence Force Welfare Association (sub. 118), Legacy Australia (sub. 100), David Melandri (sub. 61) and the Vietnam Veterans’ Federation of Australia (sub. 34) raised many of the same concerns.⁸ For example, 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 inquiry into suicide by veterans, the 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 31 December 2018, DVA’s progress update on implementing the Senate Committee’s recommendations stated that:

... an internal review of the issues associated with the collection of medical evidence was undertaken and completed in November 2018. Options to streamline the processes associated with accessing specialist medical advice, and to improve the service experience when dealing

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 13.

with medico-legal firms, are being considered with improvements expected from 2019-20. (DVA 2018ao, p. 6)

FINDING 9.5

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.

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* [now DRCA] 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), before concluding 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. (p. 18)

A key risk is that the VCR program creates new problems as it attempts to solve older ones. For example, DVA's ongoing work to reorganise their data holdings in collaboration with

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).

Services Australia has created a discontinuity in December 2017 between their historical claims data and their contemporary data, making time series analysis — such as looking at the effectiveness of health services accessed by veterans or causal analysis back to service-related injuries — much harder, if not impossible.

Further examples are highlighted in the 2018 ANAO audit which was critical of a number of DVA 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 2016h, p. 2). The audit findings clearly suggest that R&C ISH was 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 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 and the Commission during this inquiry. 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 and Cabinet who are responsible for overseeing the implementation of the VCR program.

FINDING 9.6

Under the Department of Veterans’ Affairs’ stewardship, the Veteran Centric Reform (VCR) program has some good objectives and has produced some early successes. However, close supervision and guidance will be required to ensure VCR is rolled out successfully. Regular progress reporting and ongoing assurance reviews will facilitate this outcome.

10 Reviews of claims

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*, *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* and *Military Rehabilitation and Compensation Act 2004* 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). Different review processes across the Acts are unjustified and cause unnecessary complexity.
- At both the VRB and AAT, alternative dispute resolution (ADR) processes help the claimant and DVA to discuss the claim and gather new information. This new information frequently allows previously-rejected claims to be approved. If the case remains unresolved, it moves to a full hearing.
- About half of all claims that are reviewed result in a change to the original decision. This creates the perception that the review process is used as a 'backstop' by DVA to avoid being more thorough and accurate in their initial decision-making processes.
- The absence of a time limit on claims or review applications, the duty to provide a beneficial interpretation to the veteran, and discretion in the legislation could, in part, explain a higher rate of successful review applications for veterans' claims than in other administrative processes. However, there are factors that are within the control of DVA and applicants, that are not being addressed. In particular, not all relevant information to a claim is provided to the initial decision maker.
- The primary aim of the review process, beyond correcting individual decisions, should be to support and improve DVA's ability to make accurate initial decisions and the earliest resolution of disputed matters.
 - Internal review processes are not effective in identifying recurring errors in either DVA's decision making, or the underlying processes that cause these errors. There is no clear process to harness review findings to improve the administration of original decision making.
- There should be a single pathway for all reviews, regardless of the legislation.
 - 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. It would retain determinative powers, but in line with the goal of improving initial decision making, these powers should be removed when the Veteran Centric Reform program is completed.
 - Formal merits review: The AAT would be the merits review body to provide formal hearings in the veterans' space, in line with all other areas of Commonwealth administrative review. 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 considers how proposed changes to the review process can interact with other reforms to the system to improve decision making by DVA.
- Section 10.6 discusses 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 person submits a claim to DVA for compensation under the veterans' support legislation,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 represents an avoidable cost to government. In the case of the veteran 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 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)

¹ Includes the *Veterans' Entitlements Act 1986*; *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*; and *Military Compensation and Rehabilitation Act 2004*.

Acknowledging that not all initial decisions by government will be correct, the review process exists to '[ensure] good governance, accountability and transparency in public administration' (Veterans' Review Board, sub. DR277, p. 1). One way that review processes do this is by providing oversight of individual decisions. Beyond this, the review process helps to assess the effectiveness of the broader decision-making process within an agency. External reviews can provide guidance on issues of merit or legal interpretation to improve administrative decision making. 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 higher payment.

External review processes include merits review and judicial review. Any person whose interests are affected by a decision can apply for review.

- Merits reviews are provided for by legislation and are undertaken by merits review bodies such as the Veterans' Review Board and the Administrative Appeals Tribunal. They 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 Administrative Appeals Tribunal reviews matters in the first instance in some cases (first-tier review) and reviews matters arising from decisions of the Veterans' Review Board (second-tier review).
- Judicial reviews are provided for both under legislation and in the Australian Constitution, and are undertaken by courts. They ensure that the determination was made lawfully. If it was not, a determination may be thrown out and sent back to the decision maker.

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 three 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 or during the VRB's review (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: judicial review applications generally must be made within 28 days of the initial decision, while applications for merits review can be made within 12 months of the applicant being given notice of a decision by DVA (*Administrative Decisions (Judicial Review) Act 1977*, s. 11; VRB 2018a, p. 9).

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 these 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. One participant, reporting on feedback he had received, said:

... largely it is considered [internal] 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.

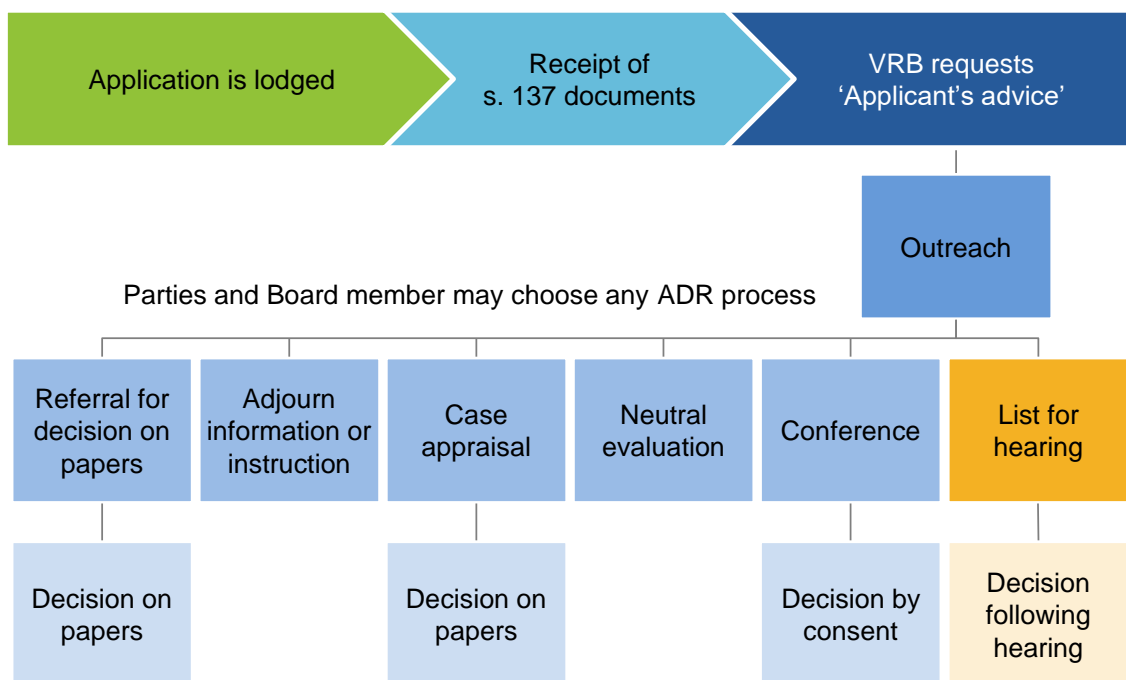
The VRB: alternative dispute resolution and hearings

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 and MRCA, veterans may seek a review of a DVA decision by the VRB, usually after an internal review. Under the DRCA, the first point of external merits review is at the AAT rather than the VRB. This is 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.

Figure 10.1 **What happens to a case in the VRB?**



Source: Adapted from VRB (2018b).

The VRB uses an alternative dispute resolution (ADR) process to resolve most cases. 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’.

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 (who may be part of the VRB staff or a Board member) then has an outreach conversation with the applicant. Aside from ensuring that the applicant understands the issues of the case and the broader ADR process, the registrar may offer preliminary views on the likelihood of success of each claim if it were to reach a full hearing. This creates opportunities for agreement between the applicant and DVA to reach a compromise outcome.

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 of 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. 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, within about four and a half months from being lodged, while the average VRB case (involving a hearing) took about a year (VRB 2018a, pp. 2, 11).

A number of participants said that the transition to ADR had improved the way reviews were dealt with at the VRB.

The [ADR] programme has been highly effective in boosting the efficiency of appeals before the [VRB], 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)

The VRB's [ADR] process is an effective means of conducting and resolving reviews of decisions under the VEA and MRCA. (Legal Aid NSW, sub. DR263, p. 9)

I've been fortunate enough to have cases go through the [ADR] and it was really rather seamless ... (Peter Larter, trans., p. 196)

The VRB seems to work reasonably well, although the ADR seems to be working better. (Max Ball, trans., p. 232)

When cases in the VRB reach a hearing, those hearings are generally conducted informally and in private. Lawyers cannot attend VRB hearings as representatives of a claimant seeking review, although non-lawyer advocates can (further discussed in chapter 12). Veterans may, however, seek legal advice prior to the hearing, make written legal submissions to the Board and appear with a lawyer at ADR processes.

DVA does not ordinarily have a representative at the hearings (VRB 2018a, p. 40); rather the VRB 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.

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 **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, p. xi) in its Better Decisions report. Most recently, the Migration Review Tribunal, the Refugee Review Tribunal and the Social Security Appeals Tribunal were amalgamated with the AAT (from 1 July 2015). This change was subject to a review by former High Court Justice Ian Callinan in 2018; the Attorney-General’s Department has not made the outcome of the review public.

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. 21408) 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 \$3849 on average (AAT 2018, p. 24). However, many cases in the AAT are likely to involve commercial parties with legal representation. 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 government incurred 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 (2016, p. 62) 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.

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

After these merits review processes, an unsuccessful claimant can 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 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.⁴

In 2017-18, there were six decisions of the Federal Court for claims under the three Acts (DVA 2018g, 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 2016⁵ and under the VEA in 2005.⁶ To date, no claims under the DRCA or MRCA have reached the High Court.

Other avenues of review can address administrative errors

The Australian Government provides other avenues for claimants to seek redress for administrative errors, even where there is no specific legal issue with the decision.

In cases of maladministration, where the complainant believes they have been unfairly or unreasonably treated, they can complain to the Office of the Commonwealth Ombudsman,

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. 5-6 (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 These grounds of judicial review are available at common law and are mirrored in the ADJR Act ss. 5-6.

⁵ *Military Rehabilitation and Compensation Commission v May* (2016) 257 CLR 468.

⁶ *Roncevich v Repatriation Commission* (2005) 222 CLR 115.

who can help resolve the complaint (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 DVA (Commonwealth Ombudsman 2018). The Ombudsman is also currently investigating concerns about the commutation of payments under the Defence Force Retirement and Death Benefits scheme (Commonwealth Ombudsman 2019b).

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, there is no central or public record of CDDA payments. In part, this is because payments under the CDDA scheme are often confidential; the agency may require a claimant to forego 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?

More often than not, DVA’s decisions are altered when they reach the VRB. In 2017-18, 3.4 per cent of the total number of decisions were changed upon review. Table 10.1 breaks down the number of determinations and reviews for claims under each Act.

Table 10.1 Number of determinations and reviews under veteran support legislation
2017-2018

<i>Act</i>	<i>Number of primary determinations</i>	<i>Proportion of determinations where initial decision is set aside^a</i>	<i>Number of internal reviews</i>	<i>Number of VRB decisions</i>	<i>Number of AAT decisions</i>
VEA	16 919	6.6%	1 000	1 456	191
MRCA	31 176	2.5%	1 254	915	57
DRCA	12 776	1.7%	714	..	144
Total	60 871	3.4%	2 968	2 371	392

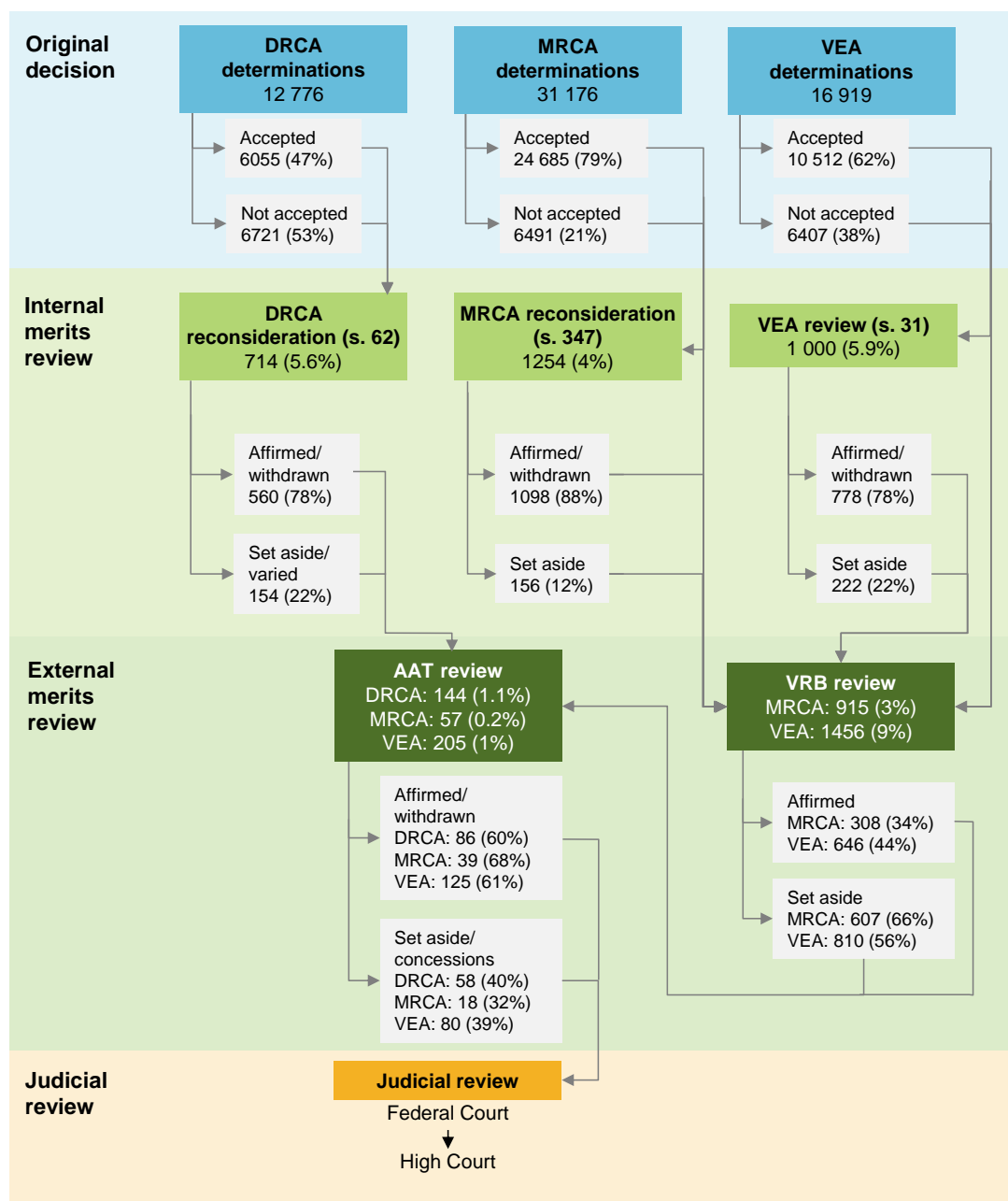
^a The total number of cases where the primary determination is set aside or varied by an internal or external review, as a proportion of determinations under each Act in 2017-18. .. Not applicable.

Source: Unpublished DVA data.

Figure 10.2 shows decisions at each stage of the review process in 2017-18, from an initial determination by DVA to the external merits review stage.

- A significant number of claims were not accepted (between 21 and 53 per cent, depending on the Act under which the decision was made). However, most of these determinations were not reviewed.
- Where decisions were subject to internal review, most DVA decisions (between 78 and 88 per cent) were either confirmed or left intact because the claimant withdrew their review application.
- 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.
 - 56 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, 40 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 (figure 10.3).
- 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 32 and 40 per cent) of AAT reviews led to another change to the decision.

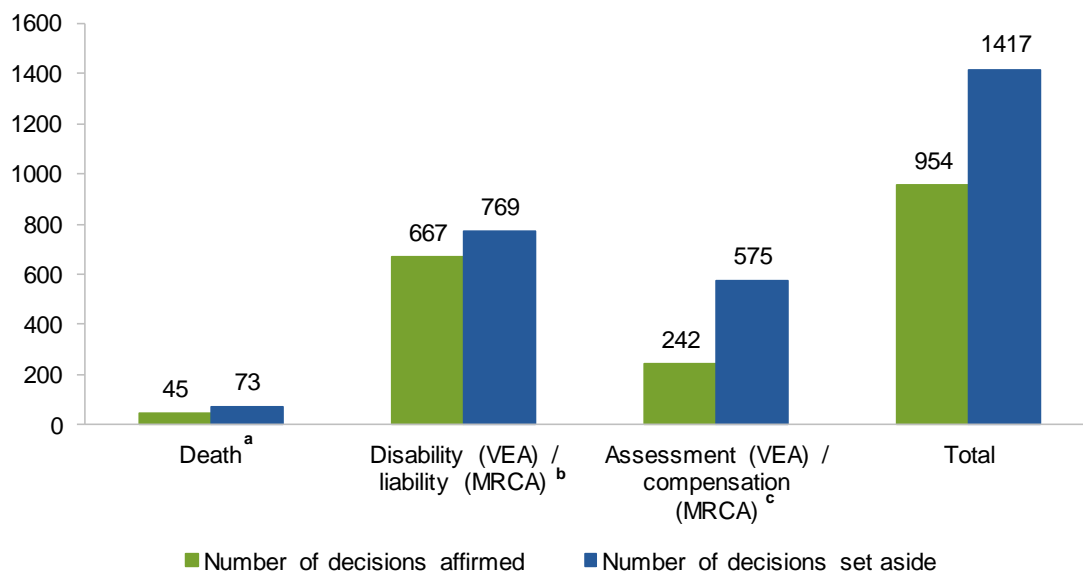
Figure 10.2 **Claim acceptance rates through the review pathway^a**
2017-2018



Note: ^a Percentages in the coloured boxes represent the proportion of DVA decisions that reach each stage. Percentages in the grey boxes represent the proportion of decisions at each stage that are either affirmed, or set aside.

Source: Unpublished DVA data.

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).

In comparison, in 2017-18, about 71 per cent of Comcare claims taken to the AAT in the same period for civilian workers' compensation led to the original determination being affirmed (Comcare and 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).

Both DVA and the VRB acknowledge that the proportion of claims changed on review is higher than desirable. There are a number of contributors to this.

- New information may be made available to the VRB that was not made available to the original decision maker.
- An applicant's condition may worsen over time, rendering them eligible for a higher rate of assistance than at the initial decision level (particularly given there are no time limits on claims in the veteran support system) (VRB 2018a, p. 24).
- The jurisdiction is highly reliant on complex medical evidence, which tends to result in more complex reviews (SFPARC 2003, p. 34).

There are also several points in the decision-making process where individual judgement is required. Sometimes, these decision-making processes are not clear to the people making the decision: for example, the 'reasonable hypothesis' standard of proof has been subject to

dispute, litigation and repeated policy change (chapter 8). The absence of service records common in many claims (chapter 9) exacerbates this issue: in many cases, it is up to the decision maker alone to determine whether the event that purportedly caused a veteran's condition actually happened, and different decision makers may arrive at different conclusions.

These characteristics are intended to benefit veterans. But if DVA does not actively clarify the legislation, Statements of Principle (SoPs, chapter 8) or procedures when the VRB changes a DVA decision, then decisions will continue to be appealed and varied. High variation rates persist at the AAT level, where a new decision is sometimes reached even though several reviewers may have already considered the case. Topperwien (2003, p. 260) noted that, although veterans' legislation may require the 'benefit of the doubt' be given to the claimant, the impact of this requirement on decision-making cannot be objectively measured. Consequently, 'decision-makers are left to determine matters using their own notions of justice'.

The review process is playing a useful role in properly examining the rights of individual claimants. Many claimants valued the opportunity to formally present their case, and to see it corrected:

... [the VRB] truly helps get to and understand the totality and the truth of a veteran's claim. (South Australian ESOs, trans., p. 6).

... [claims] all get rejected at a primary level and they're overturned at the VRB because once you explain to the VRB how a submarine operates they fully understand, but the delegates, they just [reject the claim]. (Ray Kemp, trans., p. 90)

The VRB is the independent unbiased watchdog which gives our veterans a level playing field. (Bob Bak, trans., p. 410)

However, the high rate of variation on review raises questions about the integrity of the original decision-making process, and the ability of the system to build in improvements based on feedback from the review process.

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 to reduce the time taken to process claims. However, DVA is failing to meet five out of six of its targets for correct decision making under the MRCA and DRCA (DVA 2018g, p. 77).⁷ It was also suggested that rejecting claims 'out of hand' would discourage claimants from pursuing the relatively complex pathways for review.

⁷ Accuracy in original decision making is covered further in section 9.4.

A number of participants argued that DVA could be resolving claims in a more timely manner, but instead looked for reasons to reject claims (box 10.3).

DVA has a duty to investigate claims under s. 324 of the MRCA. This should include an obligation for DVA to notify the claimant of the detailed information that it requires to make a decision on the claim. Private insurers face this requirement when deciding claims, under their code of practice (ICA 2014, p. 7). If anything, the duty to properly investigate claims is greater for DVA than it is on other compensation authorities, because of the requirement that DVA treats veterans in a ‘beneficial’ manner. While a similar duty does not exist under the VEA or DRCA, DVA has powers to request further information from claimants before rejecting their claim — and it should use those powers to seek the information it needs to properly decide a claim.

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 [totally and permanently incapacitated] 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 [the] claim. I appealed both decisions and [DVA] accepted my condition on 11 February 2015. (William Sim, sub. 148, attachment p. 4)

DVA told the Commission that it has a formal policy (established on 19 December 2017) of contacting clients where a negative decision is about to be made on their claim. However, this policy is not currently published in DVA's online policy library. Further, it does not give the applicant the opportunity to present any further information that might allow a claim to succeed, instead advising the claimant of their appeal rights. Rather than allowing claims to be resolved early, this approach pushes claims further into the appeal path even if they could be resolved quickly.

The Cornall review of advocacy and support services recommended that this policy be extended to cover negative internal reviews, and that the claimant also be given an opportunity at this stage to provide further information or advance any contentions towards their claim (Australian Government 2018c, pp. 50, 53).

At the moment, the VRB is picking up the slack for cases that could be resolved by collecting information from the claimant. 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).

The Senate Finance and Public Administration References Committee made the observation 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 likewise said that the 'approach taken by applicants and representatives' can change the outcomes for cases on review (2018a, p. 24).

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 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).

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 2018g, p. 96). Further, for the small number of VRB matters that are reviewed in the AAT, the VRB’s decision is often varied. 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’ (2018a, p. 28). Nonetheless, it raises questions about whether the 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.

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 biggest improvement that could be made to the review process is for DVA to improve the accuracy of initial decisions. However, currently DVA is not able to use the limited feedback it receives from the VRB to improve the way it makes decisions in the first instance. 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’ (sub. 117, p. 12). However, this communication does not appear to be systematic, regular, or driven by data. And by design, the written decisions of the VRB do not identify the cause of a change to DVA’s decision — it is not legally necessary for the VRB to identify an error in the original decision, or to attribute the decision to some other change (such as new information or deterioration in a person’s condition).

The lack of a formal arrangement to incorporate feedback from administrative review into original decision making 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 1992, p. 86) and the Senate Finance and Public Administration References Committee (SFPARC 2003, p. 35) emphasised the importance of resolving cases at the first decision-making level.

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, pp. 59–60). Likewise, decisions are not altered only because of administrative errors.

- 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 initial decision making.

The most immediate and necessary form of feedback is implementing the tribunal’s decision for the individual seeking review. However, DVA does not always implement the decisions of the VRB in a timely manner. One participant relaying his experience said:

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)

DVA indicated that sometimes the exact outcome of a VRB decision can be difficult to determine. For example, since late 2018, the VRB has trialled oral reasons for its decisions (VRB 2018a, p. 2). Although this allows a speedy resolution for the claimant, the recordings provided to DVA are not always clearly audible, requiring further contact between DVA and the VRB member to understand the ruling. DVA also reported that the complex calculations involved in incapacity assessments were not always translated well into written rulings by the VRB.

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).

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 (DVA) to better inform decision-making practices. Further, DVA 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 (or another reason for the new decision), then it will be more difficult for DVA to identify and eliminate systemic problems in their determinations.

The main feedback on DVA's decision-making processes come from individual VRB decisions reaching the desks of DVA managers. It is hard to glean any consistent issues that are happening with particular types of decisions.

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). These data should also identify the primary reason for the change of a decision, including:

- information being made available to the VRB member that was not available to DVA
- the deterioration of a person's condition between the DVA determination and the VRB decision
- misapplication of laws or SoPs to the person's condition.

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 established through a formal agreement between the VRB and DVA, not treated as part of 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 9) to ensure that accountability for making correct decisions becomes part of the culture of claims assessment.

RECOMMENDATION 10.1 IMPROVE AND USE FEEDBACK FROM ADMINISTRATIVE REVIEWS

The Department of Veterans' Affairs (DVA) should ensure that successful reviews of veteran support decisions are brought to the attention of senior management for claims assessors, and that accurate 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 state the cause for varying or setting aside the decision on review (including whether new information was provided by the applicant or if DVA's original decision misapplied the law).

DVA and the VRB should establish a memorandum of understanding 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 VRB decisions, as well as variations made with the consent of the parties through an alternative dispute resolution process. This information should be collected and provided to DVA on a quarterly basis and published in the VRB's annual report.

DVA should respond by making appropriate changes to its decision-making processes to improve accuracy.

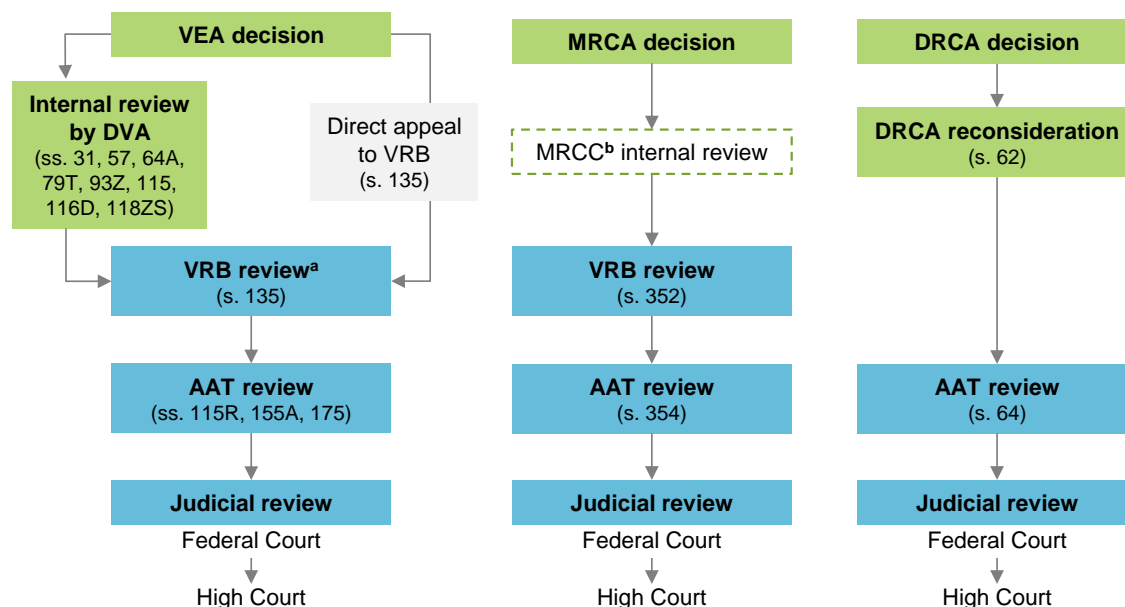
10.4 Unnecessary complexity and duplication

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).

Whether a decision can be reviewed or not depends on which Act the decision was made under (figure 10.5). And, as with many parts of the veteran support legislation, there are differences between the Acts with no clear underlying rationale.

- For example, decisions on rehabilitation or medical treatment under the VEA cannot be reviewed by the VRB, while some under the MRCA can.
- Some VEA decisions can be reviewed by the AAT immediately. Most of these decisions are themselves reviews of internal reviews.
- Internal review is available for some decisions where external merits review is not.
- Although judicial review is available as an option for all decisions under the legislation, it can only consider 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 10.4 **Review processes under the Acts**
2019



^a Only for decisions under ss. 14, 15 and 98, and for s. 31 reviews from decisions under those sections.

^b Military Rehabilitation and Compensation Commission, the body delegated to make decisions under the MRCA (chapter 11).

Sources: *Veterans' Entitlements Act 1986*; *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*; *Military Compensation and Rehabilitation Act 2004*; DVA (pers. comm., 27 November 2018).

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 treated separately. In addition, some participants felt that it was more difficult for veterans to put their case to the AAT (discussed further in chapter 12).

Figure 10.5 What decisions can be reviewed?

VEA, MRCA and DRCA, 2019

VEA decisions Review in the VRB (s. 135)		MRCA decisions Review in the VRB (s.352)	
Disability pension (s. 14)	War widow(er)'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).

These differences are, in turn, likely to cause confusion for claimants — who may have to pursue multiple proceedings for the same condition — 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.

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

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 anybody that takes on 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.

Bringing the outreach in: effective internal reconsideration

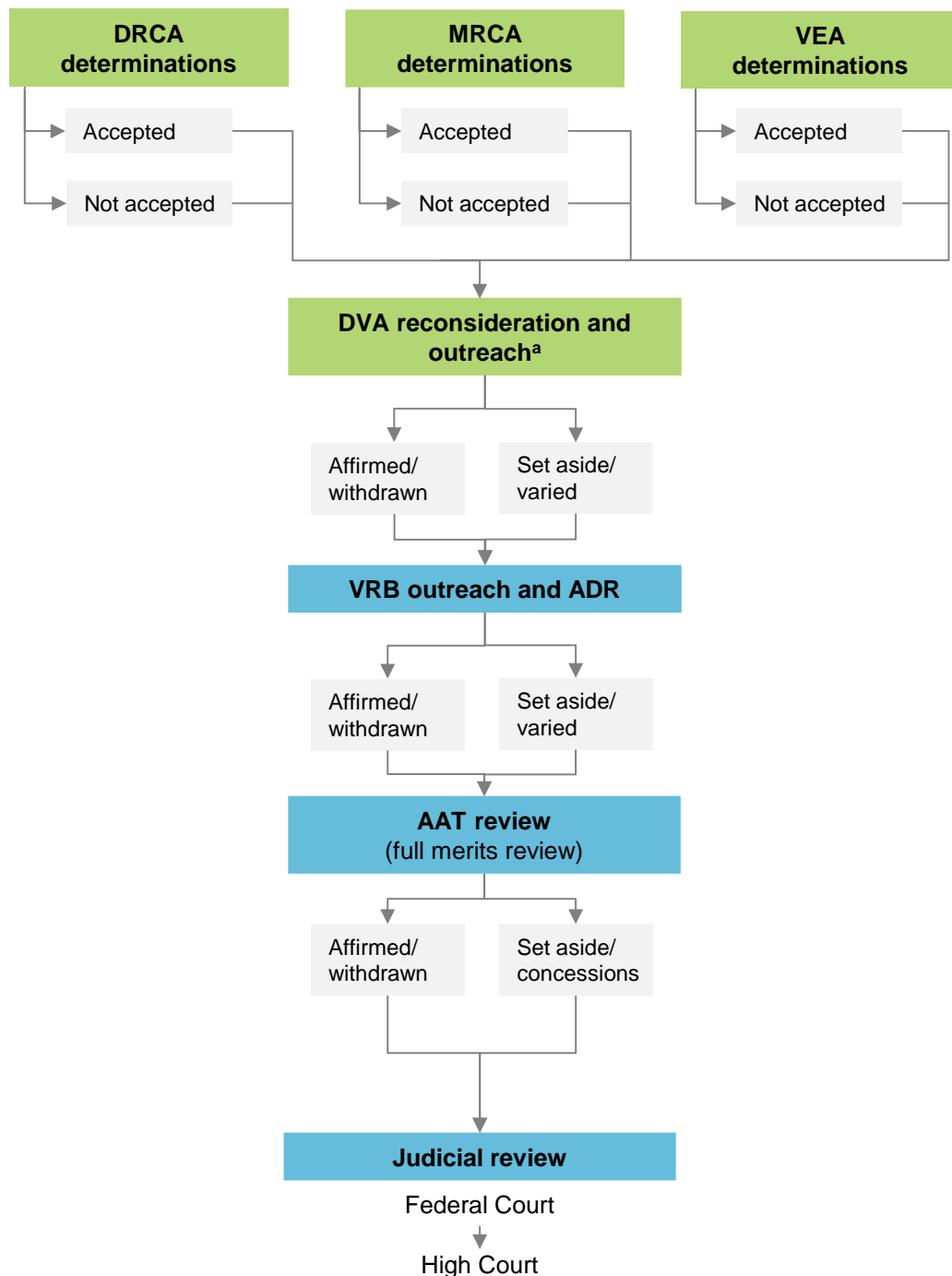
This single pathway should start with internal reconsideration and outreach by the agency responsible for the veteran support system.

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, in comparison, focus on only the evidence used to reach the original decision, checking for any egregious errors.

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 [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)

Figure 10.6 **Less complexity: a single review pathway**



^a This function would move from DVA to the proposed Veteran Services Commission (recommendation 11.1) upon its establishment.

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.

If a claim is being denied on internal review (for example, for failing to provide evidence in relation to a condition in a SoP), then the first step should be for DVA to clarify this information. DVA should give claimants the opportunity to provide additional information before making a negative decision, rather than letting the claim proceed to the VRB. An outreach call, modelled on the VRB's current ADR processes and made by the delegate responsible for reviewing the claim, would involve explicitly discussing the main issues of 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, pp. 1–3).

Participants generally saw value in a more thorough investigation before a case proceeded to the VRB:

... a similar [outreach] system may well be better earlier ... if we were to adopt that same system earlier in the playing process ... I think there might be a less need to go on, because if the delegate

was able to come back and say, ‘Oh, a bit weak here’, and we had a bit of a review before we lodged a section 31 [internal review] it would make our job much easier as advocates. (Bill Kaine, trans., p. 878)

The VRB draws out information that, arguably, DVA could have ascertained. (Combined SA Ex-Service Organisations, sub. DR188, p. 2)

Applying an additional ‘in-house’ outreach procedure, on top of that provided by the VRB, 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 for dealing with reconsideration processes.

This proposed outreach procedure is in line with recommendation 1.2 of the Cornall review:

... in each internal review or reconsideration where the reviewer is minded to reach a negative decision, the reviewer should contact the veteran’s advocate or the claimant (as appropriate), explain the reason for the tentative decision and give the advocate or claimant the opportunity to clarify any outstanding questions, rectify any remediable problems and advance any final contentions in support of the claim before the reviewer makes a determination. (Australian Government 2018c, p. 53)

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 be 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 (and cases that unnecessarily reach review at the VRB or AAT are more expensive both to the claimant and government). As such, it is sensible, based on overall costs, to properly resource the accurate processing at the 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 — the VRB is an anomaly among merits review bodies in Australia today. The VRB itself acknowledges that it ‘has remained a stand-alone body, in an environment where the majority of boards and tribunals at both a state and federal level are part of a unified framework’ (sub. DR277, p. 1).

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). Although the AAT already deals with

veterans' claims (in its Veterans' Appeal Division) it has noted that it is sometimes difficult to maintain available members for its veterans cases (AAT 2018, p. 29).⁸

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 no other high-volume Australian Government specialised merits review body devoted to reviewing one department's decisions — almost every other administrative decision of the Australian Government has a review path starting at the AAT.

In the Commission's view, the VRB is close enough to DVA that there is potential for DVA officers and veterans alike to treat the VRB as an opportunity for contentious claims to eventually succeed. This shifts the resolution of problems further away from their source, rather than addressing them at the point where they first occur.

Applicants 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:

You know, my client comes to me after going to the VRB, and they're disillusioned when I go, oh, we start the process again. We're going to get more medicals. I need a statement. We're going to subpoena your medical records, and we might end up in front of a two or three member AAT panel. (Greg Isolani, trans., p. 1040)

FINDING 10.4

The Veterans' Review Board has functions that overlap with those of the Administrative Appeals Tribunal. 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, rather than using it occasionally to resolve difficult cases.

If the VRB is to continue, it should have a clear objective and a clear role to play in the review pathway. This role 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 the ongoing 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.

⁸ The Government recently appointed 29 new members to the VRB (VRB, sub. 277, p. 2).

-
- **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, case appraisal and neutral evaluation. 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 DVA and the claimant cannot reach a resolution, 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.

There is a risk that amalgamation would remove a trusted institution in the review pathway, while increasing costs for all parties (by moving disputes to a more legalistic forum). This would not be 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 (VRB 2018a, p. 11), 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.

This would involve a shift in the legal role and powers of the VRB. The VRB should no longer be a primarily adjudicative body. Instead, it should 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 our draft report, we proposed removing the decision-making powers of the VRB, to ensure its primary focus is on dispute resolution. Some participants were concerned that this would disadvantage claimants and lead to a significant increase in the number of cases reaching the AAT (for example, Combined SA Ex-Service Organisations, sub. DR188, p. 7). Legal Aid NSW observed that the experience of the NSW Housing Appeals Committee, which also makes recommendations rather than binding decisions, had ‘not been positive’, and that:

Given reported issues surrounding the DVA’s compliance with determinations of the VRB and AAT, we are concerned that similar problems would arise following a recommendation of the VRB. (sub. DR263, p. 7)

John George also agreed that ‘while DVA delegates continue to make incorrect determinations there will continue to be a role for the VRB’ (sub. DR197, p. 6).

The Commission recognises that the VRB currently plays a significant supervisory role over DVA. Accordingly, a longer transition process may be necessary to ensure that initial decision making can be improved before moving to a model that focuses solely on resolving cases (rather than re-deciding them).

Accordingly, the VRB should retain its power to make decisions in the interim. But in the interest of rapid resolution of cases for claimants, full hearings focusing primarily on the legal issues of the case should be left to the AAT. The VRB’s role should be one of fact finding and of resolving the issue between the parties. If the decision-making power remains, it should be used as part of the suite of ADR tools held by the VRB (for example, at the conclusion of a neutral evaluation, or after an outreach that uncovers new information).

This decision making function should cease when the Veteran Centric Reform program is completed (the program is aimed at improving the accuracy of initial decision making), and the proposed Veteran Services Commission (chapter 11) is established.

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 (with a hearing) 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 some 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. 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). The AAT submitted that ‘the practicalities of pre-hearing preparation, identification of issues and

exchange of documents, can have the effect that the parties become more willing to reach agreement’ (sub. DR258, p. 7). Consequently, it submitted that it was likely that the AAT would continue to use pre-hearing conferences in veterans’ cases, but nonetheless, ‘the AAT’s conferencing process is sufficiently flexible to adapt’ (sub. DR258, p. 7).

In the longer term, a review pathway focused on accurate initial decision-making and dispute resolution will lead to fewer appeals. But in the short term, 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. About 480 cases were decided in the Veterans’ Appeal Division in 2017-18 — representing just 1 per cent of review applications finalised by the AAT. 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 and social services, which represented 47 and 45 per cent of the AAT’s caseload respectively (AAT 2018, pp. 127–128).

In practice, ADR processes are likely to help the parties in a more timely manner, avoiding the need for a hearing in any forum. Although many members of the AAT are appointed to multiple divisions, concerns were expressed about the availability of members for the veterans’ division. Additional resources may be required to respond to an increased caseload. One 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 19).

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. This would require an update to DVA's current policy, which provides a phone call to claimants upon receiving a negative decision without giving them a right to provide further information before seeking review.

Reshaping 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, and
- if resolution cannot be attained, then a single VRB member appraising/evaluating the key issues of the case can determine the appropriate entitlement of the claimant under the legislation.

Either party would be entitled to disagree with the outcome of a decision and appeal the matter to the AAT.

The power of the VRB to make binding decisions under s. 139(3) would remain until the Veteran Centric Reform package is completed. If the decision-making power were removed as recommended, then 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 need to be amended so that the VRB is no longer required to hold full (three person) Board hearings. Instead decisions should be able to be made by a single member following the conducting of appropriate ADR procedures.

In order to ensure it can meaningfully assist parties, the VRB should retain its powers to compel DVA or a veteran to provide information and both parties must be required to act in good faith in all proceedings including ADR.

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 the future, the VRB would not make binding decisions under any of the legislation. As a result, when the VRB's determinative power is removed, references to reviews of VRB decisions (for instance, in s. 175 of the VEA and s. 354 of the MRCA) should be amended to also include '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.

RECOMMENDATION 10.2 SINGLE REVIEW PATHWAY

The Australian Government should introduce a single review pathway for all veterans' compensation and rehabilitation decisions (including decisions under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*). The pathway should include:

- internal reconsideration by the Department of Veterans' Affairs. In this process, a different and more senior officer should 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 (recommendation 10.3)
- merits review by the Administrative Appeals Tribunal
- judicial review in the Federal Court of Australia and High Court of Australia.

RECOMMENDATION 10.3 **VETERANS' REVIEW BOARD AS A REVIEW AND RESOLUTION BODY**

The Australian Government should amend the role and procedures of the Veterans' Review Board (VRB), so that:

- 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.

Where an agreement cannot be reached, a single board member should determine the correct and preferable decision to be made under the legislation and implement that decision.

When the Veteran Centric Reform program is complete and the Veteran Services Commission is established, this determinative power should be removed.

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 A best-practice system

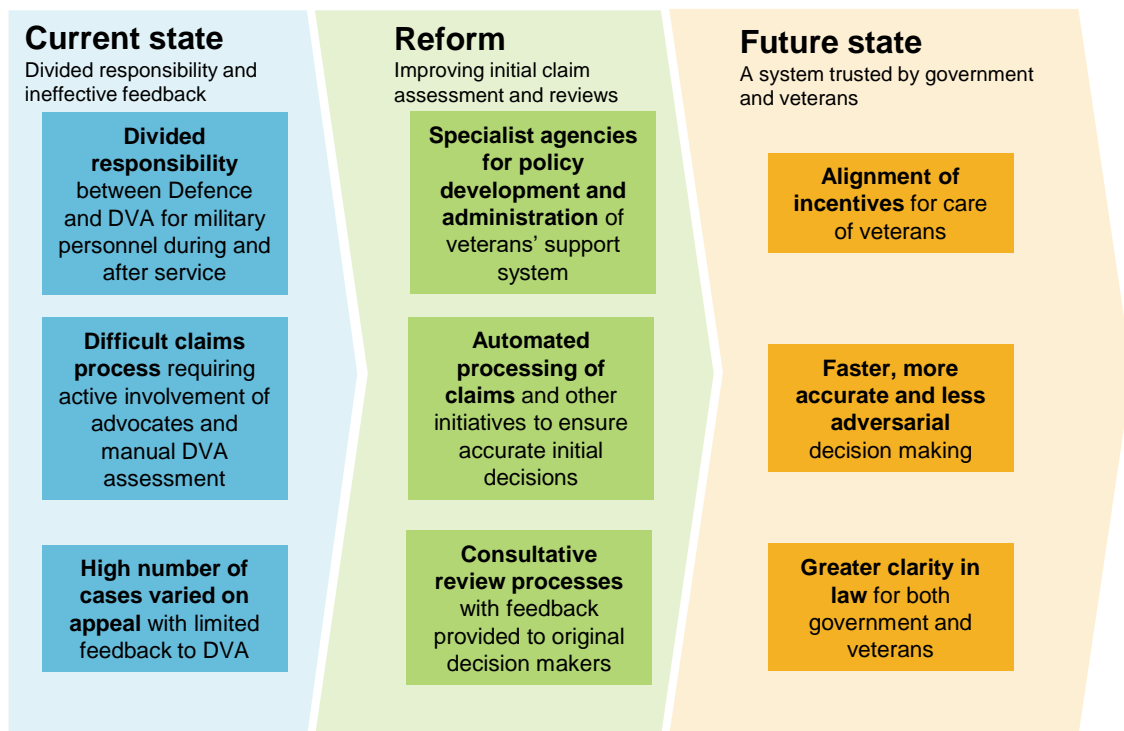
Reforms to the review process work hand-in-hand with the initial claims process (chapter 9) and governance of the veteran support system (chapter 11) (figure 10.7). Together with proposals in this chapter, there should be positive effects on the system as a whole.

- 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, DVA or the Veteran Services Commission (chapter 11) 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**



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.

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.

RECOMMENDATION 10.4 REVIEW OF ONGOING ROLE OF VETERANS' REVIEW BOARD

The Australian Government should conduct a further evaluation in 2025 of the performance of the Veterans' Review Board in its new role. In particular, the evaluation should consider whether reforms have reduced the rate at which initial decisions in the veteran support system are subsequently varied on appeal. If the evaluation finds that the Board is no longer playing a substantial role in the claims process, the Australian Government should abolish the Board and bring its alternative dispute resolution functions into the Department of Veterans' Affairs or its successor agency.

10.6 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. For example, there are no avenues to review the decision to include (or exclude) vocational or educational training on a veteran's rehabilitation program (DVA 2018b). In principle, review should be available for any decision where government can materially affect the interests of a person (ARC 1999). 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.

Maurice Blackburn (trans., pp. 1212, 1219-20) noted that decisions under the MRCA about treatments under the Gold and White Cards (chapter 16) can only be reviewed judicially, not through merits review. These decisions are excluded from internal or external review under s. 345(2)(h) of the MRCA. When the legislation was introduced, the explanation for the exclusion was that:

A determination of the Commission under Chapter 6 Part 3 (Treatment) is excluded because treatment will be provided by health care providers under general contractual arrangements covering the acceptance and use of the Repatriation Health Cards (the White and Gold cards). The person will not incur any costs and the treatment to be provided will be specified. (Vale 2003, p. 143)

Generally, this is correct — the appropriate treatment for any given condition will be determined by health providers. However, DVA reserves the right not to fund treatment that is not reasonably necessary for the adequate treatment of a person; DVA also has to specifically approve some types of medical treatment (such as treatments that are not on the

Medicare Benefits Schedule (MBS)).⁹ These decisions to fund or approve certain treatments cannot be challenged:

If a new treatment might be available, something that is experimental, or something that's not yet used in Australia, and I'm recommended to give it a go by my treating practitioner, I apply for that to be paid under the repatriation healthcare card, and it is rejected as a form of treatment, for various reasons – some may be good, some may be bad – I have no avenue to appeal that. (Maurice Blackburn Lawyers, trans., p. 1220)

These decisions can be difficult for DVA to make, given that judgements about appropriate treatment may be up to the treating doctor. The MBS is reviewed on an ongoing basis to ensure that the treatments available meet clinical need and are backed by evidence. DVA's discretionary decisions to provide (or not provide) treatment outside of the MBS are made based on whether there is clinical need for the proposed treatment, as well as the suitability and quality of the proposed treatment (among other factors).¹⁰

Although these decisions have potential to materially affect the interests of a person, they involve the discretionary use of government funding in the provision of treatment. Where government has not decided to fund particular treatments as part of the public health system, it is sensible that DVA is the ultimate arbiter of the use of those treatments. As a result, the Commission does not recommend any change to the review rights available in this space.

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 10.7). The reasons currently provided do not always 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)

In our experience some determinations do not adequately show the actual path of reasoning used by the decision maker to reach the decision, or include all of the material relied upon by the decision-maker. 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).

⁹ MRCA Treatment Principles (No. MRCC 53/2013), ss. 3.2.1, 3.5.2.

¹⁰ MRCA Treatment Principles (No. MRCC 53/2013), s. 3.2.2.

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). Legal Aid NSW (sub. 109, p. 10) also provide a case study where, when all of the information used to reach the determination was provided ‘the errors in the determination were clear’ and were corrected by an internal review. Slater + Gordon Lawyers (sub. 68, pp. 62–4) also expressed concern about DVA not providing all information used to reach a decision.

Box 10.7 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*).

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.

Perhaps more importantly, some letters fail to communicate in an empathetic and readily-understood manner to people in grief or trauma. DVA outlined improving its letters as a priority in 2018-19 (DVA 2018g, p. 46). However, one letter sent in late 2018 provided to the Commission — explaining why the mother of a veteran who died by suicide was not entitled to a lump sum — stood out as particularly egregious. Although it sought to explain the relevant legislative provisions in a detailed manner, it failed to communicate any empathy for the loss of the woman's son, only specifying at the end, 'I regret that the outcome could not have been more favourable for you' (Lisha Taylor, sub. DR311, p. 3).

It is important that DVA's approach to improving communication with its clients incorporates the support it provides in explaining reasons for its decisions, and balances the legal requirements of decision making with the empathy necessary for dealing with clients in grief, trauma and other complex circumstances.