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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/>

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Productivity Commission

A Better Way to Support Veterans

Productivity Commission
Inquiry Report
Volume 2

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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).

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11 Governance and funding

Key points

- Good governance arrangements are critical to achieving good outcomes for veterans and their families, as well as for the broader community.
- Veterans' policy is reactive and largely driven by crises or external pressures (often making the system more complex). Much of this is because of the emotive nature of veterans' policy, which can work against good policy and long-term outcomes.
- Under the governance arrangements in the Defence portfolio, no single agency has responsibility for the *lifetime* wellbeing of military personnel. Most of the complex problems facing veterans originate from when they were serving personnel. This gives Defence a preeminent capacity to reduce those problems before (or just after) they arise. Instead, responsibility for veteran wellbeing, including the costs of long-term, post-service care sits with the Department of Veterans' Affairs (DVA). This results in policy and implementation gaps, duplicated services and inefficient administration.
- Funding for the veteran support system is on a pay-as-you-go basis. This creates unfunded liabilities and leads to a short-term, passive approach to veteran supports.
- The governance and funding arrangements are unfit for a modern veteran support system.
 - From a modern perspective on compensation and rehabilitation, a more unified system would have always made sense. As such, the first-best approach is to move veteran policy into Defence, to better align Defence's 'duty to prepare' with its broader 'duty to care' for personnel. However, strong opposition to this proposal from veterans, who lack trust and confidence in Defence's policy capability, means a shift to this model is not realistic or feasible at this stage.
- A suite of complementary governance reforms would better define roles and align incentives.
 - A single Minister responsible for Defence Personnel and Veterans, to ensure integrated policy development for serving and ex-serving veterans.
 - A new advisory council to the Minister for Defence Personnel and Veterans.
 - An independent statutory agency led by a board of Commissioners, the Veteran Services Commission (VSC), to administer the veteran support system. The VSC would replace the Repatriation Commission and the Military Rehabilitation and Compensation Commission.
 - An annual premium levied on Defence, set to fully-fund future liabilities of the veteran support system. Premiums provide critical information about the long-term impacts of policy changes, improve accountability and provide a stable and predictable funding base.
 - A reformed DVA focused on policy and strategic planning, research and evaluation, veterans engagement, training for advocates, and major commemorations activities.
 - The Australian War Memorial taking responsibility for war graves functions from DVA.

This chapter examines the governance arrangements of the veteran support system, including the relationship between, and the functions of, the Departments of Veterans’ Affairs (DVA) and Defence (section 11.1). The first few sections of the chapter (11.2 to 11.4) set out the problems with the current arrangements, while the second part (11.5 to 11.9) proposes a detailed set of solutions.

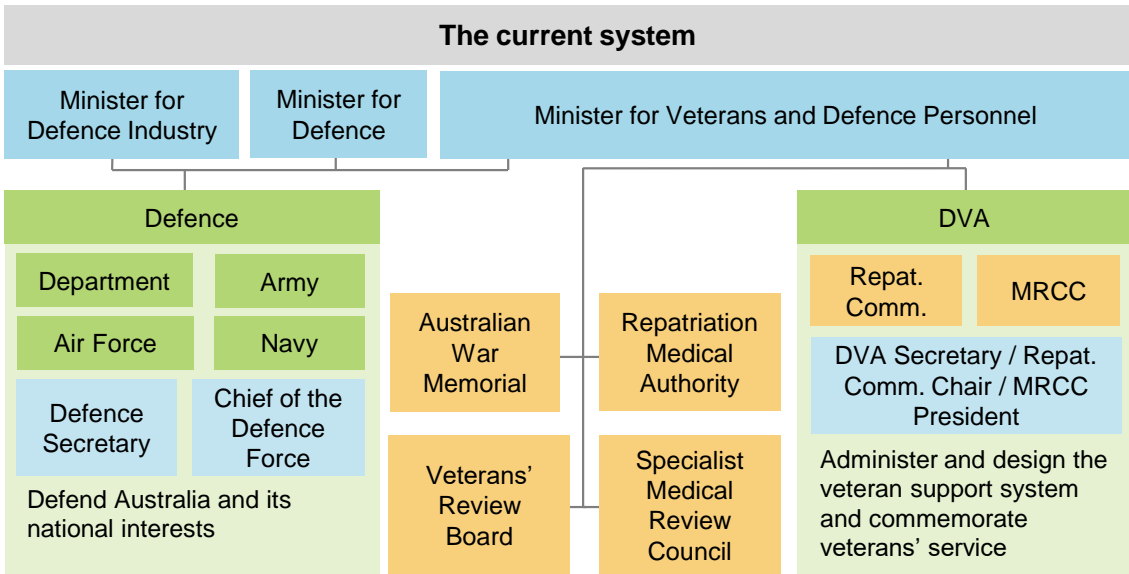
11.1 An overview of the governance arrangements

Governance and institutional arrangements matter because they influence whether the goals of providing supports to veterans and their families are met well — being responsive, well-managed, accountable and coherent. Governance may sound dry, but ultimately it is about improving people’s lives (CIPFA and IFAC 2014, p. 6).

Institutional governance arrangements for public sector entities in Australia are set out (at the broadest level) by the Administrative Arrangements Orders (AAOs), which establish policy portfolios and departments of state within each portfolio, while also outlining the legislation and ‘matters’ administered in each portfolio (DPM&C 2019). Specific legislation subsequently sets out some ‘day-to-day’ functions and can potentially establish other bodies (statutory agencies) responsible for undertaking those functions.

The veteran support system has a number of agencies directly involved in governance. There are two departments, the Department of Defence (DoD) and DVA, as well as the Australian Defence Force (ADF). Collectively, DoD and ADF are known as the Australian Defence Organisation, or just ‘Defence’ (figure 11.1).

Figure 11.1 Governance in the veteran support system



As in all other areas of public policy, ultimate responsibility for Defence and DVA (including underlying policy and its day-to-day administration) is with the relevant Ministers. More specifically, under the *Defence Act 1903*, the Minister for Defence has overarching control and administration of Defence, while DVA is subject to the Minister for Veterans' Affairs and is a sub-portfolio of Defence under the AAOs.

The Defence portfolio

Under the AAOs, Defence is responsible for defence, including defence-related: international relations and co-operation; scientific research and development; procurement and purchasing; and industry development and cooperation (DPM&C 2019). Defence is also responsible for administering 28 pieces or groups of legislation, including the *Defence Act 1903* under which the ADF is constituted. The role of Defence is:

... to defend Australia and its national interests, to play an active role in contributing to regional security and stability, and to contribute to coalition operations around the world where our interests are engaged. (DoD 2017f, p. 10)

Under the 'One Defence' operational model, the day-to-day administration of Defence is shared between the Secretary of the DoD and the Chief of the Defence Force (CDF) in a 'diarchy', which is unique among Australian Government departments (box 11.1). The DoD has no direct command functions over the ADF branches (Army, Navy and Air Force), although more than 4000 ADF members work in 'non-service groups' within the DoD (Peever et al. 2015, p. 57). As a department of state, DoD has traditional departmental responsibilities and advises the Minister on defence policy, resources, organisation and finance (Horner 2007, p. 150). The public servants in the DoD have occasionally been referred to as 'the fourth service' of the ADF under the One Defence model (Dennett 2018).

Box 11.1 A brief history of Defence's governance arrangements

After Federation, the Australian Government assumed responsibility for defence matters, in line with the Constitution. The military forces of the colonies were unified in the *Defence Act 1903*, creating a single armed force (renamed the Australian Army in 1980).

The Royal Australian Navy was created as a separate service branch in July 1911, following panic at the news that Germany was building dreadnoughts to challenge the supremacy of Britain's Royal Navy. The Royal Australian Air Force was formed in 1921 out of the experience of the Australian Flying Corps, which had served as part of the Army during the First World War.

Prior to the 1960s, coordination between the service branches was weak. During World War I, Australia's Army and Navy units effectively fought separately, operating under British command. Little changed during World War II, although some notional joint command arrangements existed under US control in the Pacific theatre. For most of this period, each service branch had its own department within the 'Defence group', alongside additional departments for Supply, Production and Defence, while there were often separate Ministers responsible for each branch.

(continued next page)

Box 11.1 (continued)

Australia's involvement in Vietnam from 1966 led to a rearrangement of the operational command structure. The Army and Air Force commitments to the Vietnam War were controlled through a single headquarters — the Australian Force Vietnam — with a single commander. Although the new command structure came with challenges (particularly from a lack of clear strategic direction), this set a precedent for later military operations:

The government realised that, for overseas operations, there was great value in appointing a national commander who could ensure that Australian policy was followed. Further, if more than one service was deployed, there was advantage in having one national joint service commander deal with allied commanders-in-chief and host governments. (Horner 2007, p. 147)

In 1967, the then Chairman of the Chiefs of Staff Committee proposed reorganising the armed services, with a unified Department of Defence and the service branches amalgamated into an integrated Australian Defence Force, and this 'diarchy' responsible to a single Minister for Defence. This model retained the separate identities of the service branches to 'preserve morale and operational efficiency', but as most operations would be joint, there should be a 'single clear chain of operational control' (Horner 2007, p. 148). This reorganisation was carried out incrementally over the ensuing years, and was completed in 1976 (following the Tange Review).

Since then, the diarchy has been criticised for a 'duplication of effort between the public service and military functions of Defence and consequent opacity around accountability at all levels in the organisation' (Peever et al. 2015, p. 20).

Sources: AWM (2018c); Grey (2008); Horner (2001, 2007); Khosa (2010); Tange (1973).

Under the joint ADF structure, each service branch (through the Chiefs of the Army, Navy and Air Force) is responsible for raising, training and sustaining combat forces. All military operations and exercises are controlled by Joint Operations Command, using personnel and equipment from all three service branches as needed, to produce 'a synergy in the conduct of operations' (The Australian Approach to Warfare, quoted in Horner 2007, p. 145).

The Veterans' Affairs sub-portfolio

DVA's key responsibility is 'repatriation income support, compensation and health programmes for veterans, members of the Defence Force, certain mariners and their dependants'. They are also responsible for commemorations, war graves and Defence Service Homes (DPM&C 2019).

In performing these roles, DVA is responsible for administering 23 pieces of legislation, including the three that are most relevant to this inquiry:

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

These three Acts establish the Repatriation Commission (RC) and the Military Rehabilitation and Compensation Commission (MRCC), which delegate to DVA certain functions,

including the administering of payments and services for eligible veterans and their families, as well as the conduct of commemorative programs (box 11.2).

Box 11.2 DVA's purpose and reporting framework

The Department of Veterans' Affairs' stated purpose is to 'support those who serve or have served in the defence of our nation and commemorate their service and sacrifice' (DVA 2018g, p. 12). The Department reports on its responsibilities in three outcomes.

- Compensation and support — maintaining and enhancing the financial wellbeing and self-sufficiency of clients through access to income support, compensation, and other support services.
- Health — maintaining and enhancing the quality of life of clients through health and other care services that promote early intervention, prevention and treatment.
- Commemorations — acknowledging and commemorating veterans' service, through promoting recognition of service and sacrifice, preservation of Australia's wartime heritage and official commemorations.

The Repatriation Commission

The RC is a statutory body under the VEA empowered to provide treatment, and grant pensions and other benefits to veterans and their dependants. It also advises the Minister for Veterans' Affairs on the operation and administration of the VEA. It has a complex origin, and its history is emblematic of the challenges in coherently meeting the needs of successive cohorts of defence personnel (box 11.3).

Membership of the RC is made on appointment by the Governor-General and consists of a President, a Deputy President and a Repatriation Commissioner (also known as the Services Member, as they are appointed from a list of names provided by ex-service organisations). All three members also have senior executive management roles within DVA. Under the VEA (s. 184), the Secretary of the DVA also holds the office of President. The Deputy President and the Repatriation Commissioner hold roles equivalent to a Deputy Secretary and directly manage several key functions of the Department, including the DVA's claims operations and Open Arms counselling (formerly the Veterans and Veterans' Families Counselling Service).

The rationale for the overlapping membership between the RC and the senior management of the Department is 'to ensure alignment of the functions and objectives of the Commissions and the Department' (DVA 2017f, p. 13).

Box 11.3 **A brief history of the Repatriation Commission**

The Commission and the Department

In April 1918, the newly formed Repatriation Commission (RC) and the separate Department of Repatriation began operations, implementing the *Australian Soldiers' Repatriation Act 1917*. The RC was made up of six voluntary members (plus the Minister for Repatriation). Its functions were to oversee and implement policy (through drafting regulations for assistance and benefits), and to hear appeals on decisions made under those regulations (Lloyd and Rees 1994, p. 82; Payton 2018, p. 14).

The then Department of Repatriation, by contrast, was a department of state responsible for the day-to-day administration of repatriation policy under the supervision of State Boards, operating on the delegated authority of the RC (Lloyd and Rees 1994; Repatriation Department 1919). The Department's activities covered employment services and vocational training for discharged soldiers, medical and general assistance to re-establish returned soldiers in the community, and more general housing and financial support for totally and permanently incapacitated soldiers or the dependants of deceased or incapacitated soldiers (Repatriation Department 1918, 1920).

The Commission becomes the Department

In 1920, the structure of the RC and the Department were altered by the *Australian Soldiers' Repatriation Act 1920*. The RC became a paid, full-time commission of three members (including a Services Member). Control of the Department also passed to the RC at this time, generating additional administrative functions for the RC. The State Boards were also changed to full-time paid Boards of three members. Administration of war pensions was transferred from the Treasury to the Repatriation Department (Repatriation Department 1920).

As noted by Lloyd and Rees (1994, p. 208), this post-1920 arrangement was cumbersome and raised 'problems of duplication and overlap in the presence of the two administrative bodies'. However, it ultimately 'provided the administrative continuity which ensured repatriation's survival' in public policy and administration during the inter-war years, even as the repatriation function 'disappeared intermittently' from the Cabinet Ministry.

During the inter-war years, the system was characterised by increasingly blurred dividing lines between the Department and the RC, with uncertainty about whether the RC was a statutory commission or a government department — labels of 'Commission' and 'Department' were often used interchangeably. Partial clarification came in 1923, when the High Court held (in *Repatriation Commission v Kirkland*) that the RC was a 'very special [Commonwealth] department for a very special purpose' (Lloyd and Rees 1994, pp. 309, 312). However, 'the [RC] was thought to be a hybrid temporary creation, not quite a "commission" in the way the term was often understood, and not exactly a department in its own right either' (Payton 2018, p. 65).

Although set up as temporary organisations with the expectation that they would 'fade away' after repatriating soldiers returned from the First World War, the Department and RC were still operating in the late 1930s. The Second World War created a new and much larger pool of returned soldiers with an expanded range of needs, which justified keeping the Department and incorporating it into the public service in 1947 (Lloyd and Rees 1994; Payton 2018).

(continued next page)

Box 11.3 (continued)

A Joint Public Accounts Committee report in 1954 suggested that the status and functions of both the Department and the RC should be reviewed, as the administrative functions of the Department had taken precedence over the initial quasi-judicial functions of the RC (JPAC 1954; Lloyd and Rees 1994) and the RC had 'become in effect the senior executive arm of the Repatriation Department and was best understood in that light' (Payton 2018, p. 66).

In the early 1970s, the Secretary of the Repatriation Department was also appointed as head of the RC, 'a formal recognition of a de-facto situation that had existed for many years' (Lloyd and Rees 1994, p. 342). Following the Toose Report (1976), the Repatriation Department acquired the administration of the Defence Service Homes Scheme and the War Graves Commission and was renamed the Department of Veterans' Affairs (DVA) to more 'accurately set out the range of functions performed by the Department' (Lloyd and Rees 1994, p. 354). The RC retained its existing name, 'but its relationship with DVA remained unchanged' (Payton 2018, p. 71).

The Military Rehabilitation and Compensation Commission

The MRCC is a statutory body (box 11.4) empowered under the MRCA and DRCA to accept liability and provide rehabilitation, compensation, treatment and other benefits to veterans and their dependants. Membership of the MRCC is made on appointment by the Governor-General and currently consists of six members. Three of these are the same three members of the RC (with the President of the RC also the Chair of the MRCC). The other three members are:

- a person nominated by the Minister for Jobs who either administers the Commonwealth's workers' compensation scheme or is a public servant working in the Department of Jobs and Small Business (currently the CEO of Comcare)
- two people nominated by the Minister for Defence who are either permanent members of the ADF or public servants working in the DoD (currently the Joint Health Commander and the Head of the People Capability Division).

Box 11.4 **A brief history of the Military Rehabilitation and Compensation Commission**

The 1999 Tanzer Review recommended the creation of the *Military Rehabilitation and Compensation Act 2004* (MRCA). Tanzer also recommended that a new separate regulatory authority for the MRCA be located within the Defence portfolio. This body was to have members from Defence, the Department of Veterans' Affairs (DVA) and other existing regulatory agencies, including the Safety Rehabilitation and Compensation Commission (SRCC), the primary policy agency for the operation of the *Safety, Rehabilitation and Compensation Act 1988* (SRCA). In recommending this structure, Tanzer aimed to 'reverse engineer' the structure of the SRCC, particularly its independence from the department (Tanzer 1999, pp. 83–84).

(continued next page)

Box 11.4 (continued)

The Military Rehabilitation and Compensation Commission (MRCC) was subsequently established under section 361 of the MRCA as 'a new, five-person commission responsible for strategic monitoring and management of the scheme's performance' (Campbell 2011b, p. 254).

The MRCC's functions under the MRCA (s. 362) are to:

- make determinations — 'accurately and quickly' under s. 142 of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) — on liability for service-related conditions, the payment of compensation and the provision of treatment and rehabilitation
- minimise the duration and severity of service-related conditions by 'arranging quickly' for rehabilitation
- promote the return to suitable (civilian or military) work
- promote research into the health of members and former members, the prevention of injury and disease, and rehabilitation
- provide advice and information to the ministers and departmental secretaries of Veterans' Affairs and Defence and the Chief of the Defence Force, either on request or on own initiative (DVA 2018g).

In line with Tanzer's recommendation that a single agency should be responsible for the entire veteran support system, the MRCC also assumed responsibility for administering Defence-related SRCA claims, which had previously sat with the Military Compensation and Rehabilitation Service (MCRS) within the Department of Defence (Tanzer 1999, p. 86).

In 2011, the MRCA (Campbell) Review recommended that the MRCC be expanded from five members to six, with the additional member drawn from Defence to improve effective information sharing between the Department of Veterans' Affairs and Defence. The impetus for this change came from Defence — 'Defence believes that current Defence representation on the MRCC is inadequate' (Campbell 2011b, p. 255).¹

Other veterans' affairs agencies

There are also two medical authorities, an appeals review body and the War Memorial within the veterans' affairs sub-portfolio:

- the Repatriation Medical Authority (RMA) is an independent statutory authority. Its role is to determine the Statements of Principles (SoPs) for any disease, injury or death that could be related to military service (chapter 8)
- the Specialist Medical Review Council (SMRC) reviews the RMA's decisions on SoPs and directs or recommends that the RMA amend the SoPs (chapter 8)
- the Veterans' Review Board (VRB) reviews certain decisions made under the VEA and the MRCA (chapter 10)

¹ It is not clear why only one Defence member on the MRCC was an obstacle to effective information sharing or whether the adoption of an additional Defence member since then has made any difference to this.

-
- the Australian War Memorial (AWM) maintains and develops the national memorial to Australians who have died in wars or warlike operations, while also maintaining and exhibiting a national collection of historical material and conducting research into Australian military history (section 11.4).

11.2 Where is the strategic policy?

Under its administered legislation, DVA is responsible for both making *and* implementing policy, functions that are typically separated in the public sector for good reason (box 11.5). And the main task dominates — that is, the day-to-day administration of the existing veteran support system, which includes assessing claims, paying pensions and managing relationships with clients.

Box 11.5 The policy–administration divide

It is common in Government for policy development to be split from administration. For example:

- Claims for pensions and other forms of social security payments are considered, administered and paid by the Department of Human Services (through Centrelink), while the Minister for Social Services (with advice from the Department of Social Services) has responsibility for the Government's policy on pension eligibility.
- The tax system is administered by the Australian Taxation Office (ATO), but the Treasurer, with advice from Treasury, has responsibility for the relevant tax legislation.

There are a number of reasons for separating policy development from administration. One of the primary rationales is to help avoid conflicts of interest, such as policy that is designed to suit the administrator's needs, not the client's (OECD 2014; Tahmasebi and Musavi 2011). The Department of Finance's 'three-stage gateway test' for governance structures suggests that a separate autonomous body may be most appropriate if it helps to avoid these conflicts, 'even if that may not be the most efficient structure' (Department of Finance 2018).

Other reasons include: creating mutual monitoring and oversight of work (Abelson 2012, p. 278); generating creative tensions between agencies, leading to better outcomes through competition (O'Flynn 2007); encouraging an efficient division of labour, allowing those responsible for administration to focus on that task (Stewart 1996); making use of labour specialisation to give better results (Gulick 1933, cited by Overeem 2010, p. 93).

The benefits of an independent statutory authority (particularly 'for undertakings that require special powers defined by statute and appropriate combination of public accountability and operational autonomy') were recognised by the Air Force Association (sub. DR267, p. 3).

This means that the typical departmental policy functions, such as the design of supports, their level, eligibility, program evaluation and the development of accountability arrangements for veterans' affairs — the architecture of the system — are not well developed, coordinated or as strategic as they would usually be in a department. A 2013

capability review by the Australian Public Service Commission (APSC) highlighted DVA's lack of attention to strategic policy:

... what strategic thinking and policy development occurs within DVA seems often ad hoc and silo bound. Insights are not usually shared or actively sought across the department and subsequent service offerings are seen as disjointed and at times appear to overlap or allow for gaps. It is notable that the functional area responsible for defining the strategic framework and bringing the client's perspective to bear in service design is comparatively under-resourced given the imperative for major reform. (2013, p. 10)

The APSC also noted that DVA's governance arrangements:

... tend to work against the conduct of vital strategic conversations within DVA ... Across the governance framework more generally, it is unclear where strategic discourse is being conducted. (2013, p. 7)

Although DVA's internal structures have changed since the APSC review in 2013, there is little evidence of stronger strategic capability.

A lack of strategic thinking results in poor policy outcomes

The outcome is that policy tends to be reactive. So rather than a proactive, coherent approach that focuses on the long-term interests of veterans, with careful design and planning to avoid issues before they arise, policy is driven by crises and immediate external pressures. This risks 'political pressure on "the system" to do something ... or be seen to be doing something', when a more considered approach would be preferable (DFWA, sub. 118, p. 33).

Policies that arise out of crisis are not necessarily poor ones. DVA's current reform program, Veteran Centric Reform (VCR), came about in response to a perception that 'problems with the compensation claims process were ... contributing factors to suicide by some veterans', while outdated information and communications technology (ICT) infrastructure faced potentially catastrophic failures (ANAO 2018b; SFADTRC 2017, p. 42). The problem is that the need for VCR could have been anticipated a decade or more ago, and the program developed earlier.

A reactive approach can also mean that the capacity and impetus to progress already-identified reforms can sometimes languish. Examples include the 'Veterans First' initiative from the early 2010s (chapter 9) and the lack of sustained action around the veterans' long-term rehabilitation study which came about from the 2011 MRCA Review (also known as the Campbell Review, chapter 6).

DVA itself acknowledged that decision making is often reactive and that this:

... adds to complexity and can ignore the needs of the whole veteran community, or can overlook the circumstances faced by other cohorts of veterans and their families in otherwise similar situations. (sub. 125, p. 29)

DVA also observed that reactive changes can lead to cycles of ever-increasing benefits, as they ‘introduce relatively minor but nevertheless compounding amendments to legislation’ that can lead to ‘new differences that may then lead to calls for further extensions’ (sub. 125, p. 29). DVA said:

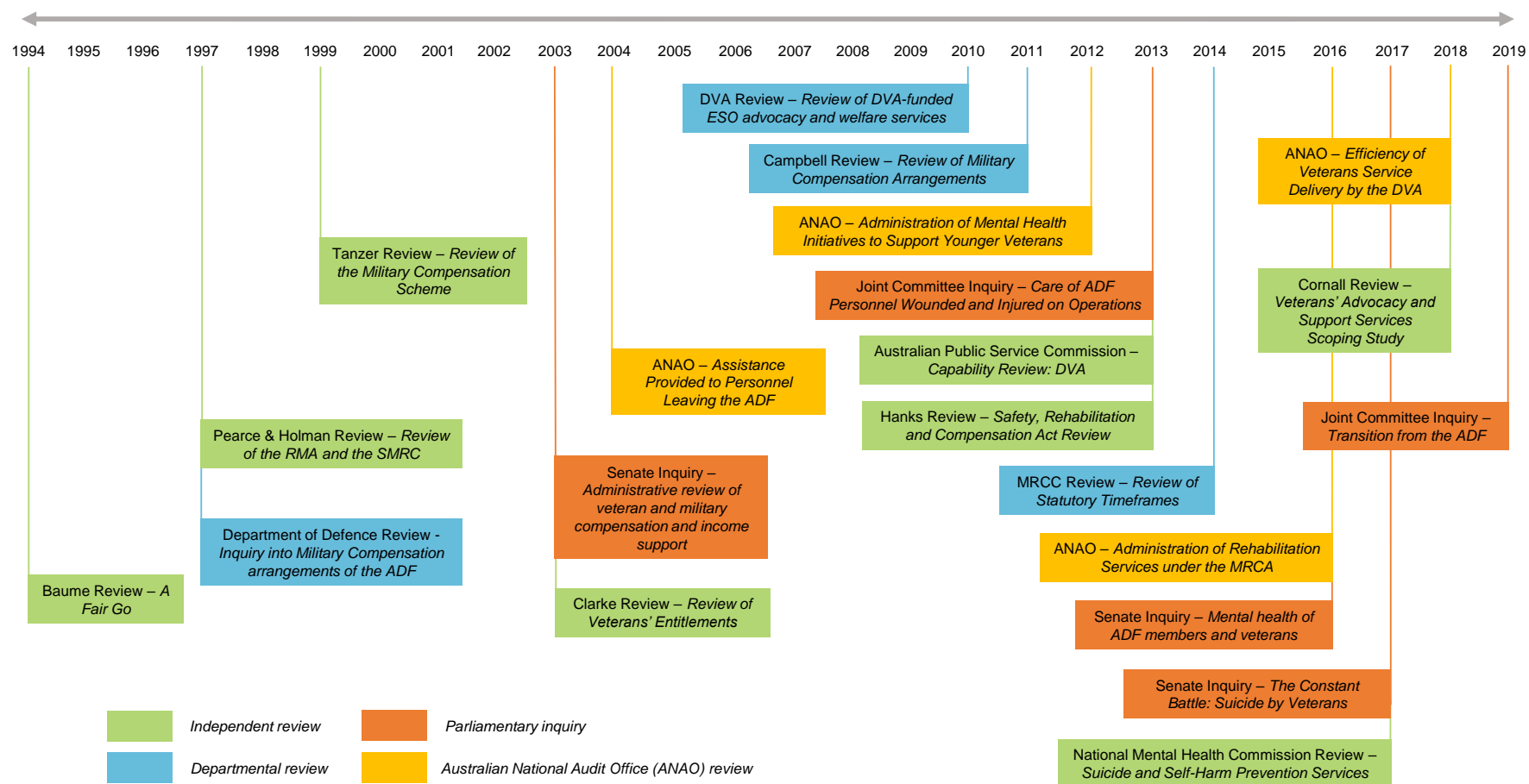
Such responses are also likely to be based on particular historical or current circumstances, without considering all veterans’ future needs and without prioritising improvements. (sub. 125, p. 29)

There are several notable examples where a reactive policy response is the genesis of a future policy problem.

- The June 1996 Black Hawk accident that killed 18 soldiers (chapter 3) shed light on the problem of dual eligibility, particularly the inequities in payouts between the VEA and the then *Safety, Rehabilitation and Compensation Act 1988* (SRCA, now DRCA) for soldiers (or their dependants) with the same condition (in this case, death). The variation in payouts were as high as \$300 000 (DoD 1997). The inequities caused by having two compensation Acts had been known for some time, but were only addressed following this high-profile accident. The accident led to an additional SRCA payment through the *Defence Act 1903* — which sought to top up the SRCA payments to the level of VEA payments — and ultimately, via the Tanzer Review, to the creation of the MRCA — which was meant to (but did not) solve the dual eligibility problem.
- The expansion of non-liability mental health treatment in successive Budgets between 2016 and 2018 (Australian Government 2016b, 2017c, 2018a) and the introduction of the Veteran Payment for claimants with pending mental health claims was a response to large numbers of veteran suicides and recommendations from the resulting Senate inquiry into veteran suicide (Atkin 2017a; DVA 2018u; DVA and DoD 2017; Maurice Blackburn, sub. 82; Tehan 2017a; Thompson, sub. 116). There does not appear to have been consideration of the broader implications of introducing non-liability financial support (the Veteran Payment) to the veteran support system, which is fundamentally based on the Government accepting liability for a service-related condition *before* compensation is provided. It is notable that the National Mental Health Commission’s review into suicide and mental health (NMHC 2017b, p. 52) asked that the Government ‘consider whether there are superior models for supporting optimal health and wellbeing of current and former members and their families, including models that separate compensation, liability and health care provision’. The Government’s response was that the link ‘has already been separated through the provision of non-liability health care’, so ‘the proposed economic study would have limited value’ (DoD, DoH and DVA 2017, p. 65).

The strategic thinking and policy development for the veteran support system appears to be mainly undertaken by other parties, such as Senate inquiries and ‘independent’ reviews. Over the past decade alone there have been at least 14 reviews into various aspects of the veteran support system (figure 11.2), as well as numerous health studies into veteran outcomes.

Figure 11.2 Numerous reviews, but still little strategic policy
Major reviews and inquiries into the veteran support system, 1994–2018



Source: Commission analysis.

The Defence Force Welfare Association (DFWA) claimed that:

There are probably well over 50 government projects, studies, inquiries, task forces, and new organisations that had their genesis in the public alarm and political pressure concerning veteran suicides, mental health and transition. (sub. 118, p. 33)

The following parts of this section discuss the factors that appear to be consistently contributing to ad-hoc policy making and poor policy outcomes in the veteran support system, including:

- a confusion between the distinctive reverence that the public has to veterans and the goal of veteran policy, which is to take an objective, long-term and holistic approach to their wellbeing
- lack of effective oversight for spending and strategic planning
- lack of clarity around the roles of the RC and MRCC, whose functions overlap and duplicate each other.

Veterans' affairs policy is almost sacrosanct

Over the past two decades there has been a resurgence of interest in the Australian community about the country's military history and the role of our armed services. This is exemplified by the large numbers of Australians travelling overseas to attend ANZAC Day ceremonies. In 2015, DVA had to hold a ballot to ration attendance at the centenary Dawn service at Anzac Cove and Lone Pine in Gallipoli — almost 8000 Australians attended this ceremony more than 15 000 km from the Australian capital (Payton 2018, p. 95).

The interest in commemorating the service of Australian soldiers extends to expectations about government support for veterans, but not necessarily in a way that is helpful to good veterans' policy. If you ask Australians for their opinion, as this inquiry did, they often endorse an entitlement approach to veterans' services ('what do veterans *deserve*?'). For veterans and the public, the best interests of veterans can then become equated with the funding level of support, especially if there is a concern that vital services may be undersupplied. As noted by the Air Force Association (AFA):

The 'best interests' of veterans and their families described initially in 1920 legislation prevails today. This time-honoured commitment needs to be maintained. The demands on our servicemen and women and their families have not diminished. Societal expectations are that veterans and their families are a national asset and any diminution of support would be viewed seriously. (sub. 93, pp. 3–4)

However, this viewpoint can be counterproductive. For example, in an analysis of the sources and nature of public opinion about the ADF, Major Cate Carter of the Australian Army argued that the image of 'veteran entitlement' in the media reflects a 'distortion' that has a 'degrading effect on relations with the public' by contributing to 'a conflicting image' of veterans, who are frequently regarded 'as both hero and victim at the same time' (Carter 2018, p. 79).

In other public policy arenas (such as public education and health care) there is a growing awareness that the right goal is good outcomes for clients or service users, and that high-quality support should focus on this (equivalent to ‘what do veterans *need*?’). If careful analysis suggests more dollars are required, that would be justified, but an entitlement to spending itself is not the measure of a good support system.

Meanwhile, ex-service organisations (ESOs) — acting as organised representatives of veterans and their families — are highly influential, but have no unified position. Despite ESOs being well placed to see the shortcomings in the system and to provide feedback about how the system is functioning, engaging meaningfully and productively with thousands of ESOs, particularly given they have no peak body, is difficult (chapter 12). This is almost certainly handicapping policy development and undermining the effectiveness of existing initiatives, including the VCR program.

While lacking a unified voice, ESOs still appear to be an important driver of policy change. As DVA noted:

To date, veterans’ military compensation policy has often been developed in reaction to requests advocated by individual veterans or by ESOs ... (sub. 125, p. 29)

This can make reform difficult. As noted above, benefits and payments tend to accumulate bit by bit, adding complexity, but without the desired evidence about whether each marginal addition actually improves veteran outcomes or represents value for taxpayer money (chapter 15). Often the perception that benefits (particularly financial benefits) may be taken away from *any* veterans can be enough to stop or seriously compromise efforts at reform. Such undue focus on historical issues and short-term gains means that ESOs can unduly influence outcomes at the expense of broader public policy considerations, or even other (future) veteran cohorts.

To some extent the deferential behaviour (generating an unwillingness within Government and the public service to say ‘no’ to representations for change from ESOs and others) appears to be driven by fear of bad publicity. As the APSC said:

Departmental staff have described DVA as being ‘terrified’ of the risk of adverse media attention, particularly in relation to its rehabilitation and compensation functions, and how the department works hard to avoid risk at all costs rather than proactively managing it. (2013, p. 41)

This risk-averse approach can result in poorer outcomes for veterans and their families. The attempt to solve dual eligibility when the MRCA was created is instructive. It was originally envisioned that new claims under the existing Acts (VEA and SRCA) would cease with the introduction of the MRCA. But this was rejected by ESO representatives, with DVA taking the view that VEA provisions, ‘most particularly the Above General Rate Pensions ... were untouchable’ (RSL Queensland, sub. 73, p. 18). The possibility that the MRCA legislation would present a better overall package for veterans, with its increased emphasis on wellness, rehabilitation and restoring veterans ‘to at least the same physical and psychological state ... as he or she had before the injury or disease’ (s. 38 of the MRCA) compared to the VEA

(with its focus on pensions for life), carried too little weight. As one former DVA employee said of the VEA:

... I quickly came to appreciate the complexity of compensation legislation, and especially the anachronistic nature of the VEA in a political climate where it was (and still is) treated as a sacred cow, stymying any serious reform. Sadly I fear that is still the case. (Peter Reece, sub. 49, p. 1)

As in all areas, governments must decide where to allocate their finite resources amongst many competing problems. Money spent in one place displaces money spent elsewhere. A recent signature demonstration of this tension is the controversial spending on upgrades to the Australian War Memorial (Zhou 2019). A retired Lieutenant General had one view:

We should be diverting funds from the Anzac Centenary Commemorative Grants towards assisting veterans as there's still an enormous problem with suicides, with homelessness, with lives unfulfilled, problems with education and employment, family breakdowns and just people living in despair. (Peter Leahy, quoted in Paterson 2018a)

The Commission is in no position to judge the level of funding for either purpose. But the essential point of the debate is that choices between alternatives are inevitable, and that the higher the stakes and the greater the amount of resources, the more critical it is that decision making is disciplined, coherent and led by good information and analysis.

Veterans are also more likely to favour a veteran support system that is *authentically* outcomes based and that makes sensible trade-offs between alternative ways of allocating spending. A dilemma for veterans is the need to trust that the Australian Government will genuinely seek to achieve good outcomes for them, rather than save dollars for fiscal reasons. It is hard to achieve institutional change without that trust. Winning trust has several implications for governance and for the process of change, with a need for:

- high-quality and transparent evaluations of outcomes to see if, or where, services work, which must be a part of any strategic policy function, but requires good data collection and analysis
- visibility to veterans, ESOs, experts and the general community of the processes to develop outcomes-based approaches and the measurements that underpin them. In patient-centred health care, for example, Patient Reported Experience Measures and Patient Reported Outcomes Measures are not developed just by clinicians — and by their nature cannot be — but in collaboration with patients and experts. Absent collaboration, outcome measures and approaches will lack legitimacy
- time. 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, to build confidence in those changes over time.

Accountability has not achieved lasting change

In line with principles of good governance, oversight bodies for DVA and Defence should ensure accountability for, and transparency of, policy and administrative decision making

(there is also a merit and judicial review process — chapter 10). However, it is difficult for the accountability bodies to effectively influence change. In addition to the issues raised in the previous section, this is because these bodies do not have formal responsibility to pursue these types of strategic changes, nor an ability to compel change when it is identified.

Oversight bodies operating outside (or independent from) Defence and DVA can be split roughly into two groups. The first group provide ongoing or regular oversight and report directly to Ministers and include the three central departments of state — Prime Minister and Cabinet (PM&C), Finance and Treasury (known as the central agencies). The second group are those that provide ad hoc or reactive oversight in response to a complaint or a referral and include the Commonwealth Ombudsman, the Australian National Audit Office (ANAO) and the APSC.

Ongoing oversight bodies

In their ongoing oversight role as part of the normal Budget and Cabinet process, central agencies are in frequent contact with line departments such as DVA and Defence and will typically set up small ‘shadow’ teams (such as the Agency Advice Units in Finance). These teams work closely with the relevant agencies to ensure that policy proposals and outcomes are consistent with the Government’s broader Budget and policy priorities, as well as specific Cabinet decisions.

We know of some instances where a central department has had significant involvement with the DVA. Finance has taken a stewardship role overseeing the VCR program, in line with its Budget accountability responsibilities, including commissioning annual assurance reviews (chapter 9). Assurance reviews are designed to assist with implementing the VCR program, ensuring it keeps to its budget and aligns with whole-of-government information and communication technology and service delivery systems, including the Department of Human Services’ Welfare Payment Infrastructure Transformation (WPIT).

However, because the day-to-day deliberations between central agencies and DVA (or Defence) are not public, assessing their broader effectiveness as oversight agents is difficult. Nevertheless, like DVA, their influence may be circumscribed by the political sensitivity of policy in this area. One possible instance of this is the recommended *inaction* by an interdepartmental committee in 2011 on the controversial issue of transitioning future SRCA claimants into MRCA, notwithstanding their strong agreement about the in-principle merits of doing so (Campbell 2011b, pp. 273–280).

Independent (and quasi-independent) oversight bodies

Independent oversight bodies also have a vital role to play in the veteran support system. These bodies (the most prominent are outlined in box 11.6) do not report directly to a Minister, but release public reports and are relatively free of the types of public pressures discussed above.

Box 11.6 Independent oversight bodies

- The *Commonwealth Ombudsman* (as the Defence Force Ombudsman) has the power to 'consider and investigate complaints from people who believe they have been treated unfairly or unreasonably' by the Department of Veterans' Affairs' (DVA's) administrative practices, with the aim of effecting 'significant improvements in the quality of government administration' (Commonwealth Ombudsman 2017a). Under the *Ombudsman Act 1976*, these functions include special investigative powers (including self-initiating an investigation) and the capacity to recommend changes to individual decisions or to broader departmental rules and procedures. In 2017-18, the Ombudsman received around 170 complaints about DVA's administration (Commonwealth Ombudsman, sub. 62, p. 2).
- The purpose of the *Australian National Audit Office* (ANAO) is 'to improve public sector performance and support accountability and transparency ... through independent reporting'. More specifically, the Auditor-General, as an independent officer of the Parliament, provides independent assurance of the executive branch and holds it accountable for 'its use of public resources and the administration of legislation passed by the Parliament' (ANAO 2018a, p. 11).
- Led by the Public Service Commissioner, the *Australian Public Service Commission* (APSC) is a statutory agency within the Prime Minister and Cabinet portfolio, whose purpose is 'to create a high-performing Australian Public Service [APS] that delivers quality results for government, business and the community and to make genuine and enduring changes to the way the APS operates'. The APSC has responsibility (under the *Public Service Act 1999*) for increasing 'awareness and adoption of best-practice public administration by the public service through leadership, promotion, advice and professional development' (APSC 2018b, p. 7).

However, these bodies tend only to respond to individual incidents (such as the Commonwealth Ombudsman's investigation into 'Mr A' — chapter 9) or referrals to investigate specific issues (such as the ANAO investigation into the efficiency of service delivery by DVA) rather than broader veteran support policies and the underlying legislation.

In the veteran support system, these broader strategic issues tend to be considered by quasi-independent (as they often include DVA staff in their membership or use a secretariat in DVA), ad-hoc review bodies, such as the Toose (1976), Baume (1994) and Tanzer (1999) Reviews. Agencies with a broader remit to investigate policy (such as the Productivity Commission) are unusual, and rely on a formal reference before any investigation or inquiry can be undertaken.

Both of these sets of oversight bodies — those with a specific remit and a broader policy remit — can only make recommendations. Their power is one of disclosure — they have no ability to compel policy change or administrative action by a Department or a responsible Minister.

DVA's internal governance arrangements

DVA's internal governance structures are characterised by duplicated functions and forms, confused dividing lines between institutions, and a lack of clarity about their purpose and

rationale. In particular, the RC and MRCC sitting alongside the normal structure of a department of state creates confusion and complexity, without any identifiable benefits. As the APSC in their capability review said: ‘the number of committees, duplicated membership and confused accountabilities inhibit decision making’ (2013, p. 7).

Effective governance requires clear objectives and clarity of purpose. As Department of Finance guidelines state:

A lack of clarity about an activity’s purpose can result in ineffective governance structures that inhibit the efficiency and performance of the body tasked with undertaking the activity. In particular, it can make it difficult for the accountable authority to set a clear direction for the body to achieve the scope and objectives set for it by the Parliament or the Government ... Put simply, form follows function. (2015a)

The overlap between the Commissions means it is not clear ‘who’ (one of the Commissions or the Department) is doing what. And much of this confusion is a function of the legislation. Within their guiding legislation, the dividing line between the Commissions and the Department is unclear — the RC (in s. 179A of the VEA) and MRCC (in s. 363 of the MRCA) are both ‘taken to be part of the Department’ for the purposes of the *Public Governance, Performance and Accountability (PGPA) Act 2013*.

This confused accountability structure permeates into interactions between the Commissions and the Department. For example, DVA on occasion refers to the RC and MRCC as entirely separate entities (without common membership). The Department’s 2017-18 annual report states that ‘DVA reports to the [RC] on the administration of major programs and the progress and outcome of all major reviews’, implying that DVA’s senior executives report to themselves, given both organisations are headed by the same individuals (DVA 2018g, p. 28).

The reality seems to be that the RC *is* the Department, and effectively has been since 1920. For example, the Secretary of DVA is the President of the RC and the RC has a significant overlap in functions and purpose with the Department. But with no independent staff of its own, the RC is not able to function without the Department, so it seems unnecessary to define it as a statutory body independent of the Department.

Given the overlapping membership between the RC and MRCC, there is a similar case that the MRCC is also just the Department under a different title, particularly as the RC (acting as the ‘MRCC subcommittee’) can make decisions on behalf of the full MRCC. Indeed, DVA noted that the two Commissions ‘often consider the same issues and hold joint meetings’ (sub. 125, p. 4).

The functions of both Commissions are also not unique roles that can justify their existence separate from the Department. For instance, the RC and MRCC both have as a legislated function the provision of advice to the Minister for Veterans’ Affairs (and the Minister for Defence for the MRCC). But providing advice to Ministers is a normal and foundational function of any department of state, such as DVA. It is unclear why this function needs to

be duplicated, particularly as neither Commission is providing advice to the Minister that is truly independent from DVA.

The key difference between the RC and the MRCC is the inclusion of the three non-DVA members on the MRCC (one from Employment, two from Defence). In theory, this allows the MRCC to create value in the veteran support system where the RC (and even the DVA) cannot, particularly by injecting new, external views into the policy and administration process. Given the governance and administrative problems documented throughout this report, and notwithstanding that the deliberations of the MRCC are not public, the effectiveness of these additional members seems unclear.²

11.3 Current funding arrangements do not support good outcomes

Contemporary civilian workers' compensation systems in Australia are funded via premiums levied on employers, the sum of which goes into an account (a capital pool) to fund the system. In 'fully-funded' systems, collected premiums are sufficient to cover the long-term cost of workplace injuries including treatment and compensation. That is, the premiums create a capital pool that is large enough to ensure the system's long-term financial viability. This funding approach encourages beneficial behaviours by scheme administrators — who manage claims and the capital pool — and employers — who pay the premiums (this approach is discussed in more detail in section 11.7).

However, this funding arrangement, and the beneficial behaviour that it would encourage, does not exist in the veteran support system.

Existing pay-as-you-go funding arrangements send the wrong signals

Unlike civilian workers' compensation systems, the veteran support system is funded on a pay-as-you-go (PAYG) basis, similar to Australia's aged pension system. PAYG funding meets the immediate cash requirements of the system — such as payments for compensation, rehabilitation and treatment — from the Government's current revenue. No assets are accumulated to meet future entitlements or management expenses in respect to incidents that have already occurred (PC 2004, p. 279).

Compared to a fully-funded approach, a PAYG approach leads to worse outcomes, including:

- unfunded liabilities, where a scheme's liabilities are not covered by its assets. In the veteran support system, contingent liabilities are large and there is no specific source of

² Any three-three vote splits between DVA members and non-DVA members would be resolved in the DVA members' favour, as the Chair has a casting vote. However, it is unclear how often these splits occur, given the MRCC reportedly 'tends to make decisions by reaching consensus' (DVA 2011b, p. 256).

financial capital to fund annual liabilities — funding comes from the Australian Government’s general revenue and, as such, can be subject to other short-term Budget priorities

- cross-subsidisation over different generations. In the veteran support system, past generations of ADF members make claims, while current and future generations of taxpayers pay the bill. In an ageing society, this can strain available resources, as a shrinking base of workers can end up paying for conflicts decades in the past (noting that they do also benefit from any national security provided in the past)
- dampened incentives to improve workplace health and safety (PC 2004). In the veteran support system, there is no institutional price signal providing information about the lifetime costs of injury and illness, meaning cost-effective preventative actions are not able to be identified by Defence
- a bias towards offering claimants a ‘pension-for-life’ (the costs of which will be spread out over decades), rather than providing an up-front investment (which is often more expensive in the short term) to support the claimant becoming a self-sufficient member of society
- less timely and responsive claims administration. The cost of poor claims administration that delays treatment, exacerbates existing illnesses or creates new mental health problems during the process is borne by future generations, not the decision-making organisation in the present
- a failure to provide the Government, Defence and DVA with useful information about the impact of contemporary decisions that create long-run changes in scheme costs. This is problematic in the veteran support system because the impacts of decisions (liabilities from injuries or illnesses for ADF members) are often not manifest until many years or even decades after a new measure is introduced — the average MRCA and DRCA claimant does not submit a claim until 16 years after the injury occurred (ANAO 2018b, p. 55)
- a short-term administrative focus, as PAYG schemes with large contingent liabilities (such as the veteran support system) encourage scheme managers to ‘focus on the next 12 months and then the next three years, and not beyond that’ (PC 2011b, p. 669).

The demand-driven, unfunded liability backed by the Australian taxpayer means DVA does not face well-defined budget constraints and has weak institutional incentives to operate the system in an efficient, cost-effective and financially sustainable manner.

11.4 Institutional separation — Defence and DVA

By definition, in a system that is based on determining liability for service-related conditions, most of the complex problems facing veterans originate from when they were serving ADF personnel, under the responsibility of Defence. This gives Defence a preeminent capacity to reduce those problems before (or just after) they arise.

However, the current demarcation of institutional roles between DVA and Defence can frustrate that capacity, by pushing many of the long-term costs of missed opportunities onto DVA instead. In effect, the institutional separation between Defence and DVA means goodwill is working against the grain of the current system, leading to policy and implementation gaps, duplicated services, communication problems and generally inefficient administration — none of which serve the interests of service personnel or the community as a whole.

Fractured responsibilities produce worse outcomes at higher cost

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 (but only if veterans put their hand up for assistance, such as by filing a claim or applying for non-liability support). These arrangements have not fundamentally changed since the Repatriation Department was created more than 100 years ago.

However, from the point of view of the serving and ex-serving members who need support, this functional split is arbitrary and unhelpful, because no single agency has legislated policy responsibility for the *lifetime* wellbeing of Australians with military service. This results in an overly complex and disorganised system of support, where there are often overlapping responsibilities. The split in responsibilities is an accident of history, and from a modern perspective on good compensation and rehabilitation systems, it would always have made sense to have a more unified system.

Some disagree that split responsibilities matter much, arguing that expanding the remit of an already very large department would mean the relegation of veterans' interests, or that Defence should not have to (or is unable to) focus on veteran issues because its key role is 'war fighting ... not looking after veterans' (RAACC, sub. DR203, p. 20). The Commission has taken such objections very seriously, but consider that neither negates the desirability of a more unified set of responsibilities.

Starting with the first concern, while some might see veterans' interests as a minnow in the preoccupations of the defence portfolio, the budgetary facts belie this, with spending on the veteran support system accounting for one quarter of the entire Defence portfolio budget.

Equally, the contention that there is a tension between defence capability and injury management is not one that Defence endorses. In fact, there is some *synergy* between warfighting capability and better injury and illness prevention. Defence rightly points out that its effectiveness requires maximising the availability of deployable and motivated personnel, which would be hindered by any injuries or illnesses. Like every other employer in Australia, Defence also faces a suite of work health and safety requirements under existing Commonwealth legislation (chapter 5). Recruitment can also be affected by the way Defence deals with injury prevention and management. In this context, Defence does have incentives

to care about the wellbeing of its personnel, but only over the short run. ESOs, such as Soldier On, recognised this responsibility:

... the current mission of the ADF ... has the ‘support of the ADF’s *current* personnel’ at its core. The ADF cannot meet its mission if it fails to support its *current* serving personnel. (emphasis added, sub. DR245, p. 4)

These short-run incentives will *somewhat* reduce the personal and financial costs of the veterans’ support system, as Defence will have managed to prevent or manage some *short-term* injuries or illnesses that would otherwise end up in that system.

However, Defence has no policy remit (or source of funding) to support the short- or long-term wellbeing of *former* ADF members. As Defence itself noted, an arrangement in which an employer has no onus to fund the *long-term* costs of work-related injuries incurred by its employees is unusual:

... the unique aspect of the current system of veterans’ support is that Defence as the employer is *not financially responsible* [its emphasis] for the compensation of its personnel for the impact of their service. (sub. 127, p. 18)

Defence can effectively settle its long-term work health and safety obligations by discharging its employees. This is not an option for any other Australian employers because, as part of Australia’s systems of workers compensation legislation, they pay a financial premium (or self-insure to the same effect) that sends a clear signal to employers about the long-term compensation and treatment costs of any employment-related injuries (discussed in more detail in section 11.7).

Defence’s view is that while its arrangements are unusual, the absence of a responsibility for long-term costs does not create a barrier to risk reduction (sub. 127, p. 18).

This seems overly optimistic. While many Defence injuries may be the inescapable outcomes of an inherently hazardous job, the accumulated global evidence of workers’ compensation schemes is that the incentives of employers (even the most good-willed) matter, and creating mechanisms for long-term responsibility (such as a premium) can encourage them to put in place better systems to manage and avoid the risks of costly injuries or illnesses. This is all the more important the bigger and more enduring such costs are — for instance, veterans who lose limbs or suffer brain injuries will need lifelong support, but under the current governance structures, Defence can discharge their responsibility to that member by discharging them.

And indeed, some people have suggested that Defence *is* doing this. For example, Julie-Ann Finney wrote about her son, David Finney, who was discharged from the ADF following an attempt to end his own life:

The ADF washed its hands of him — he never heard from them again. What other employer in Australia ... would not bother with any form of follow-up care? David’s treatment with the DVA was now self-care — it was up to him to follow up and make his own appointments. (Finney 2019)

In effect, the existing system for veterans' compensation under-prices high long-run costs, compared with lower short-run costs — an undesirable feature of any workers' compensation scheme. The implication is that Defence is likely to underinvest in personnel wellbeing. As one former ADF member put it:

... the ADF has no penalty imposed on it for the poor choices that negatively impact on the health and wellbeing of service members, and will only achieve cultural change when both incentives and penalties are imposed. When leaders are held accountable. Time and time again service members who could receive early intervention or treatment for minor, and at the time short-term injuries, do not do so due to cultural pressures within the ADF ... (David Peterson, trans., pp. 1282–3)

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. Meanwhile, accountability, particularly with respect to financial cost, is not sheeted home to the parties most able to do something to fix problems.

Transition processes provide deep insights into the problems

A concrete example of the costs that severed feedback loops and lack of accountability impose on the system is the transition process as ADF members leave full-time service and return to civilian life — often a period of vulnerability that leads to subsequent problems (chapter 7).

In transition, Defence is operating in a twilight of information — it may try to pre-empt problems prior to discharge, but the long-run costs associated with transition (to veterans, their families and DVA's support system) are only partly visible to it. Indeed, ironically, Defence has an incentive to make the actual transition supports — which it *does* pay for — perfunctory and short, as the long-term consequences of poor transition are not its burden.

The result of these deficiencies is that the transitioning member finds that treatment and rehabilitation provided by the ADF ceases on discharge, and they then need to enter the stressful and uncertain DVA claims process, which can take months or even years to complete. DVA then picks up the pieces, paying for the subsequent cost of treating the conditions associated with service, as well as the mental health issues that can sometimes arise from the clunky and inefficient transition process itself. Despite DVA's role in providing assistance, veterans can still fall through the cracks, which is one of the precipitating factors for the very high suicide rates among them:

Although improvements have been made, the transition from ADF to DVA health systems is still not a smooth one. There is a lack of continuity in clinical care — members often have to terminate with one mental health provider and commence with another at the point of discharge. This not only disrupts treatment but, more importantly, creates a high risk of the person falling through the cracks and out of the care system. (Phoenix Australia 2016, p. 4)

The Commission heard about some very poor transition experiences (box 11.7), including a member who was medically discharged from the ADF while in hospital following a suicide

attempt and not given any follow-up support. In the context of rehabilitation (chapter 6), one participant said that ‘once a member becomes injured or ill for a prolonged period they are on a one-way conveyor belt into the community requiring DVA assistance and support’ (Stephan Rudzki, sub. 40, p. 4). Similarly, DFWA claimed that:

... the ADF has no further responsibilities for those medically discharged and [in] fact, is quite enthusiastic in removing members who adversely impact on ADF operational readiness and effectiveness. (sub. 118, p. 27)

Better data — a need recognised by all stakeholders in this inquiry — would help to identify the frequency, nature and causes of problems of this kind. Regardless, the system is not well-designed to consistently provide good outcomes. The core of the problem is that, due to the institutional split, transition remains no single agency’s responsibility and so no agency is wholly accountable for veterans’ long-term wellbeing beyond discharge. And so while everyone has accepted the importance of transition to veterans’ health and wellbeing, work is still needed to determine which services are working well, which are working poorly and where additional efforts should be targeted.

Box 11.7 Participants point out what the policy split means in practice

Peter Alkemade:

Defence has had the opportunity to deal with people who it is getting good value from and then when those people separate from Defence, they can hand them all as a group over to another organisation which they have no direct control or influence over. One of the big problems with this is that as a consequence, the ADF have very little visibility of the long-term impacts of a lot of their practices. (trans., p. 639)

Darren Thompson:

... once you have indicated that you wish to separate, whether that’s under your own steam or medically, that’s it. They do not want to know, they do not have the time for you because you’re basically part of the tail, you’re not part of the head, you’re not part of a war fighting machine. (trans., p. 840)

John Pilkington:

When it comes to people that are medically discharged, they really haven’t got a clue what they’re doing. They’re either mentally unstable, physically unable to do anything and they’re being shafted. There’s nobody there to sort of look after them. Defence sort of shoves it across to transition, transition shoves it to DVA, it’s like playing cards ... They don’t get any follow up ... (trans., p. 707)

Kathleen Moore:

Prior to being deployed or sent on operations, Defence personnel attend force preparation. It is surprising and disappointing to veterans that the military have overlooked the most dangerous and unknown operation of all, leaving the ADF. Unfortunately there are no force preparation courses, or training provided to members before they leave the ADF, the biggest operation and deployment of their life. (trans., p. 1016–17)

(continued next page)

Box 11.7 (continued)

Graeme Mickelberg:

To me there's a distinct lack of integration between programs at the strategic level, at the operation level, and dare I say at the tactical level, as a military person would break it up. My own son recently left the ADF after seven or eight years of service including Afghanistan and elsewhere. His view is that arguably Defence, the ADF, are failing in that area of ... bridging that transition. My view as a long term practitioner is we talk a good talk about the Defence family from when they enter basic training to right through their career and yet where we're failing is, they're dropping off the edge when they're discharged from the services ... and some of them are disappearing into an abyss and sadly there are consequences of that. (trans., p. 1260)

Robert Dick, RSL Tasmania:

... the mindset of the culture within Defence at the moment is if you're injured and you can't deploy, you're upsetting the team management and the team play in this area. You're pushed to one side ... And then they tend to forget about you. You're seen [as] ... a secondary citizen in their mind. That's the culture that has to change. (trans., p. 861)

Paula Dabovich:

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)

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. (trans., p. 1016)

Inefficient and ineffective administration

The functional split between Defence and DVA also results in inefficient and ineffective administration of supports for current and ex-serving personnel. This is partly because both Defence and DVA are undertaking tasks that could be carried out more efficiently and effectively by just one agency. For example:

- information about the medical, health and service records of veterans that is required to assess claims needs to be coordinated across multiple software systems and via a series of cross-departmental voluntary memorandums of understanding. Data and information exchange is historically poor, cumbersome and bureaucratic (chapters 8 and 18)
- rehabilitation and health care is not well coordinated across Defence and DVA. There is duplication and a lack of any continuum of care (which results in poorer outcomes for veterans and taxpayers). Better commissioning of services and coordination of care could generate cost efficiencies through economies of scale.

As Defence said itself, the functional separation with DVA (and, to a lesser extent, the Commonwealth Superannuation Corporation) in the veteran support system creates 'confusion, gaps, overlaps and less accessible services, reducing the effectiveness of the system' (sub. 127, p. 4). DVA also said that the split undermines operational capability by

impeding the flow of information that could ‘assist Defence to better understand occupational risks and to identify opportunities to proactively manage those risks’ (DVA, sub. 125, p. ix).

While Defence has committed to improve the flow of information, the incentives in the system to pursue such action are lacking because the benefits of change accrue to DVA, not Defence. The need for a better flow of information has been talked about for decades, but progress has been slow. As one participant said:

... many of the problems within the current [veteran support] system exist because of the separation between the Departments of Defence and Veterans’ Affairs. Over at least the last ten years the departments have been trying to work more closely, significant amounts of money and time are spent to synchronise the ICT systems, and data collection enabling DVA to become more proactive yet we are still nowhere near where we should be. (Renee Wilson, sub. DR257, p. 2)

11.5 A proposed path forward

To create a contemporary system, significant reforms are needed

The current governance structures undermine good policy outcomes for veterans by failing to hold decision makers accountable and instead encourage short-term, band-aid solutions.

Many participants to the inquiry thought that the problems of the current system could be solved if DVA and Defence were given more time and financial resources to continue to implement the existing suite of reforms, especially the VCR program. This view was particularly common among established ESOs.³

But others disagreed. These typically younger participants (including some with no formal connection to existing ESOs) noted that the current system ‘provides almost no incentive to the bureaucracy to achieve the best possible wellness for Australia’s veterans’ (David Peterson, sub. DR223, p. 2), and that problems remain despite decades of attempts to fix them (Renee Wilson, sub. DR257, p. 2).

Despite some improvements, the bottom line is that the Commission considers that the current suite of reform programs underway in Defence and DVA will not tackle the fundamental governance problems or underlying systemic issues. They are insufficient to underpin a contemporary support scheme that achieves the best outcomes for veterans and their families. Instead, as one participant expressed it, they are a continuation of ‘a hundred years of evolutionary, incremental messing around’ (Peter Reece, sub. DR194, p. 2).

³ For example, Alliance of Defence Service Organisations (sub. DR247, pp. 8–9), Defence Force Welfare Association (sub. DR299, p. 5), Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (sub. DR290, p. 11), Royal Australian Armoured Corps Corporation (DR203, pp. 18–19), RSL Queensland (sub. DR256, pp. 8–9), RSL Victorian Branch (sub. DR273, p. 2).

Creating a modern veteran support system

The Defence and Veterans' Affairs portfolios should be reformed to create a set of complementary accountability structures and institutional bodies that mimic, in form and function, those of other modern workers' compensation systems in Australia. Tried and tested over at least the past three decades, these systems are designed to safeguard the short- and long-term wellbeing of employees. They do this by relying on a set of complementary regulatory and financial incentives that make it clear that the employer is ultimately accountable for workplace injuries and illnesses, their costs, and the measures that can reduce or manage those injuries.

Applied to Defence, such a system would ensure that in the future, the impact of ADF service on the long-term wellbeing of Australia's veterans is a key consideration in all Defence activities. Ultimately, this would improve Defence's treatment of its personnel, which in turn would improve Defence's warfighting capability. As noted by Renee Wilson, 'members and their families *are* capability — without them, the best design, best technology and best equipment means nothing' (emphasis added, sub. DR257, p. 2).

The Commission's package of ideal changes to the Veterans' Affairs sub-portfolio and Defence portfolio (set out in our draft report) includes moving responsibility for veteran support policy into the Department of Defence. This would make Defence accountable for policies affecting the long-term outcomes of veterans, as accountability would rest with those inside Defence who are best placed to influence change, particularly the Chief of the Defence Force and the Secretary of Defence.

However, there was strong opposition to this proposal (discussed in section 11.8), particularly as it would lead to the abolition of DVA. Veterans also lack confidence in Defence's ability to undertake DVA's current policy responsibilities and oversee veterans' policy. This is in part due to a lack of trust from veterans, especially given that their service-related injuries or illnesses arose under Defence's watch. Due to the strong opposition to this proposal and the lack of confidence and trust by veterans, the Commission does not see a shift to this model as realistic or feasible at this time.

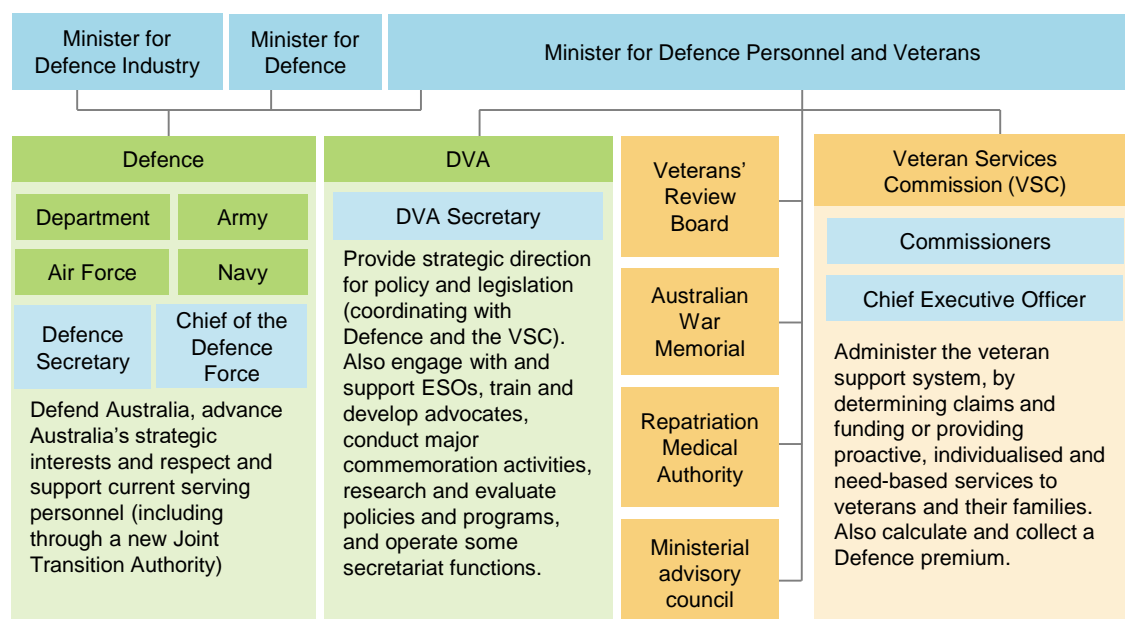
As such, the Commission is recommending the following set of complementary reforms (represented in figure 11.3).

- A permanent combined Minister for Defence Personnel and Veterans (section 11.8) — *to ensure integrated policy development for serving and ex-serving veterans.*
- A new advisory council to the Minister for Defence Personnel and Veterans (section 11.9) — *to provide independent advice on the lifetime wellbeing of veterans.*
- Administration of the veteran support system moved out of DVA and into a newly created statutory agency — the Veteran Services Commission (VSC) — designed to serve the best interests of veterans (section 11.6) — *to create a single agency whose sole focus is maximising veteran welfare.*

- An annual premium levied on Defence. The levy would be designed to fully fund the veteran support system. This sends a clear price signal about the long-term cost of ADF activities and makes the veteran support system financially sustainable (section 11.7) — *to make Defence financially accountable for the long-term cost of veteran policy.*
- An improved strategic policy and planning capacity in a reformed DVA. This will require DVA to work in close cooperation with Defence and the VSC to ensure cross-agency ‘enlistment-to-the-grave’ policy development (section 11.8) — *to significantly enhance DVA’s ability to deliver long-term policies that focus on veteran wellbeing across government.*
- Responsibility for the Office of Australian War Graves moved to the Australian War Memorial (also section 11.9) — *to consolidate the agencies maintaining Australia’s memorials to its veterans.*

The institutional and governance changes that the Commission is recommending are designed to create a system that works in the interests of the ADF, veterans and the Australian community more generally (some examples of benefits are listed in box 11.8).

Figure 11.3 The Commission’s proposed new governance arrangements



Box 11.8 **What would change under the new governance arrangements?**

This box provides some specific examples of how the recommended system, including retaining a reformed Department of Veterans' Affairs (DVA), could change outcomes in Defence and the veteran support system.

- The Australian Defence Force (ADF) may use the cost breakdown from a premium to identify and alter training and operational practices that risk harming personnel without contributing to ADF capabilities. For example:
 - if a particular training regime is repeatedly inducing high rates of injury, the regime could be altered to achieve the same level of training and fitness, but without as many injuries. RSL Queensland suggested that 'physical training should be graduated and conducted using world-leading sports science principles to reduce injury and increase performance' (sub. DR256, p. 7), which is not possible without evidence on the extent and sources of *long-term* damage to personnel from existing training regimes
 - there may sometimes be scope for investments in capital equipment that reduce risks to personnel, a practice that has been an increasing feature of operations, such as robotic investigation and disposal of improvised explosive devices using remote-piloted Talon vehicles in Afghanistan (Slocombe 2015).
- Defence could support a smoother transition to civilian life after service, improving long-term wellbeing and reducing any future draw on benefits from veterans with poor transition outcomes (chapter 7). This would also include providing discharging members with a more seamless continuity of services, particularly for those engaged in ADF treatment or rehabilitation (chapter 6).
 - Improving transition would likely enhance Defence's operational capability, as the poor post-service outcomes of some personnel (including well-publicised instances of suicide) could discourage others from enlisting, making Defence's recruitment task more difficult.
- Defence (and the Government) may reverse the outsourcing of some support roles and instead offer the positions to injured personnel who are unable to undertake their previous role. This could provide those personnel with an opportunity to stay in the Defence organisation with continued employment and purpose as part of the 'ADF family', rather than forcing them to medically discharge.
 - As the Defence Force Welfare Association said, 'in the past, when there were budget cuts to be applied to Defence the "veteran care" area suffered ... 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).
- Defence may reassess its recruitment practices, to ensure they are recruiting personnel with physical and mental traits that make them more resilient to some injuries and illnesses.
 - As an example, Dr Kenneth O'Brien (sub. DR302) suggests that the latest medical-scientific evidence might point to genetic and hormonal influences on mental health outcomes, which improved recruitment processes may be able to screen out.

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Box 11.8 (continued)

- Defence would have strong incentives to encourage early reporting of injuries and illnesses and reduce chronic under-reporting (chapter 5), in order to enable early intervention, minimise long-term costs, and enhance Defence capability (as under-reporting probably results in personnel who are already injured being deployed). As one veteran noted, ‘only when leaders within the ADF encourage, support and require injuries to be managed early, quickly, inexpensively and at the earliest possible level will the costs of compensation and rehabilitation for veterans be reduced whilst improving the wellness of service members and veterans alike’ (David Petersen, sub. DR223, p. 3). This might include:
 - encouraging commanders to actively discourage personnel from hiding their injuries and illnesses, as well as encouraging commanders not to ignore issues raised by personnel
 - conducting more rigorous health assessments before, during and after a deployment
 - inculcating a ‘culture of care’ towards personnel, where they are not afraid that they will be punished for identifying an injury or illness, but instead are confident that their unit will support them and work with them to get them back to service as quickly as possible. As David Petersen noted, ‘time and time again, service members [who] could receive early intervention/treatment for minor, and at the time short-term injuries, do not do so due to cultural pressures within the ADF’ (sub. DR223, p. 3).
- Under the proposed arrangements, Defence may also rethink some equipment and capital purchases, placing more emphasis on the capability of purchased materials to protect ADF personnel, even if this comes at a slightly greater cost, as this could help to prevent future costs of injuries or illnesses through a premium.
- To minimise long-term costs, the Veteran Services Commission (VSC) might actively seek out at-risk current or ex-serving veterans and offer them early treatment before their conditions become worse (and more costly).
 - For example, DVA and the VSC may find that offering rehabilitation to former ADF personnel on a non-liability basis is a more cost-effective way to get them back into a fulfilling role in society and a workplace (and hence minimise the long-term damage from incapacity), rather than waiting for the individual to file a claim and have their liability accepted (chapter 6).
 - Similarly, with adequate data transfers from Defence, the VSC may be able to automatically file claims for veterans without their involvement, once the VSC is notified of an incident by Defence or the veteran hits various exposure thresholds during their career.

11.6 A new Veteran Services Commission to administer the system

At the heart of all workers’ compensation schemes are scheme administrators whose mission is solely to serve the best interests of scheme participants. The mission statements of some prominent workers’ compensation scheme administrators are instructive:

We work with employees and employers to minimise the impact of harm in the workplace, improve recovery at and return to work, and promote the health benefits of work through good work design. (Comcare 2018a)

... we deliver best in class insurance and care services to the business, people and communities of NSW. Whether a person is severely injured in the workplace or on our roads, *icare* supports their long-term care needs to improve quality of life, including helping people return to work. (icare 2019a)

The VSC should be created to administer the veteran support system.⁴ A dedicated scheme administrator will professionalise the veteran support system and bring a lifetime care perspective to Australians with military service.

The VSC would work in close cooperation with the ADF to help improve operational approaches. For example, the VSC will seek to identify the long-term health outcomes experienced by veterans and link them back to past Defence activity. This will enable Defence to better understand the *long-term* impact, including the health and financial costs, of Defence activity on service personnel. The information could then be used by the ADF to help design tailored training regimes that reduce long-term injuries and increase the in-service longevity of personnel at least cost.

A departmental structure cannot deliver good outcomes

The VSC should not be a department of state like the current scheme administrator, DVA. A departmental structure for operating a modern compensation scheme is inappropriate — Australian governments have recognised this by progressively abandoning such structures. A department of state is principally designed to serve a Minister of the Government of the day, and they typically focus on immediate, rather than long-term outcomes. The expertise of departmental staff is also unlikely to be suited to administering such a scheme.

Instead, the VSC's structure, purpose-designed to support veterans should mirror the best features of existing scheme administrators in Australian workers' compensation schemes. That is, it should be independent (both of government and the department of state that sets policy) and have a clear focus on the long-term health and wellbeing outcomes of scheme participants, while also adapting to accommodate any unique needs of veterans or their families. In short, the scheme administrator should exist solely to serve the veteran support scheme and its recipients.

This approach replicates best practice elsewhere in Australia. For example, claims for workers' compensation by Australian Government employees are determined and administered by Comcare as an independent statutory agency, while the Minister for

⁴ The Commission also considered whether Services Australia (formerly the Department of Human Services) could administer the veteran support system, particularly given it already provides some back-office functions to DVA. However, as Services Australia primarily administers income support pensions, it would be ill-suited to the administration of a contemporary veteran support scheme, so this option is not discussed further. Some participants to the inquiry — such as the Australian Peacekeeper & Peacemaker Veterans' Association (sub. DR270, p. 3), the Naval Association of Australia (QLD branch, trans., pp. 1269–1280), the RAACC (sub. DR203, p. 17) and TPDESA Townsville (trans., pp. 1356–1369) — agreed that Services Australia was not suited.

Industrial Relations (under advice from the Attorney-General's Department) has responsibility for policy and the enabling SRCA legislation. Other examples include the Victorian Transport and Accident Commission and New South Wales' *icare* agency.⁵

Functions of the VSC

The new VSC would replace many of the functions of DVA, the RC and the MRCC, including managing all claims and providing or commissioning all services related to compensation, rehabilitation and treatment for veterans and their families. For most veterans, the VSC would be the primary (and only) organisation they engage with in the veteran support system.

A critical function of the VSC should be the modern, evidence-based management of the veteran support system, including putting in place processes and infrastructure for data collection and storage, and building the capability to analyse that data using actuarial, economic and other outcomes-based approaches. An evidence-based approach is integral to better outcomes for veterans and their families because it allows for the systematic identification of what services work and which ones do not.

The VSC should implement best-practice case management approaches designed to minimise hardship during the claims process and maximise people's wellbeing. The VSC should tailor available services to meet veterans' needs and avoid one-size-fits-all approaches, which characterise parts of the current veteran support system. Services provided by the VSC should include direct support (such as counselling, mental health services and respite care) to the families of veterans where there is an identified need — family support is often vital to helping injured or ill veterans achieve better life outcomes (EML, sub. 90, p. 2).

The VSC's functions (legislated in the MRCA) should include powers to:

- achieve the legislated objectives of the veteran support system (recommendation 4.1), particularly:
 - restoring injured and ill veterans by providing timely and effective rehabilitation and health care so they can participate in work and civilian life
 - providing adequate compensation for veterans (or if the veteran dies, their family) for pain and suffering and lost income from service-related harm
 - enabling opportunities for social integration

⁵ In response to the Commission's draft report, the Alliance of Defence Service Organisations (ADSO) proposed an alternate structure that 'is respectfully distant from government and militates against the invidious features of a statutory agency' like the VSC (sub. DR309, p. ii). The proposal seems to involve incorporating a registered charity (governed by a board of key stakeholders and funded by donations) as a substitute for the VSC. The Commission has not considered this proposal any further, as administering and regulating the veteran support system is a core, non-commercial function of government and currently funded by taxpayers.

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- make *all* claims determinations under the veteran support legislation (and delegate this power to VSC staff, computer programs or other entities, as appropriate)
 - calculate, collect and administer a premium on Defence (for ADF members) under a fully-funded system (discussed further below)
 - manage, advise and report on the outcomes of the veteran support system, including the financial sustainability of the MRCA scheme
 - fund, commission or provide services to eligible veterans, including health, mental health and community services
 - collect, analyse and exchange data about veterans and veteran supports (including early intervention)
 - contribute to priorities for research into veteran issues (chapter 18).

The other functions of DVA that would not be part of the VSC's remit (including strategic policy development, engagement and coordination with veterans and ESOs, commemorations and war graves and advocate training) are considered below.

The VSC would also be expected to:

- provide advice to the Minister in relation to its functions and powers
- work closely with the responsible department of state (discussed in section 11.8) by providing feedback on the workings and outcomes of the current system with the aim of improving policy design
- engage regularly with clients (veterans and their families) and service providers and other stakeholders, including ESOs and advocates to get feedback on how to improve its systems and processes.

Internal governance of the VSC

The VSC would be set up with a standard corporate model of governance for statutory agencies. It should be led by an independent board similar to a corporate board of directors, made up of part-time⁶ Commissioners, appointed by the responsible Minister. The board members would:

- be empowered to decide the most appropriate manner to carry out the functions of the VSC
- independently appoint a CEO, responsible for the day-to-day administration of the VSC
- number about seven in total
- include as members those with experience in other workers' compensation or rehabilitation schemes, project management or providing services to veterans (such as in

⁶ In this context, 'part-time' refers to the members only meeting periodically throughout the year (such as monthly), not being involved in the day-to-day administration of the VSC (which is the CEO's role) and often being able to maintain their other roles outside the VSC (subject to conflict-of-interest requirements).

veteran health care, rehabilitation, treatment, etc.) to ensure that the veteran support system keeps up with industry best-practice and avoids pitfalls from elsewhere. While it would also be important to include some members with direct military experience and an understanding of veteran issues, these members should not form the major part of the board — the board’s purpose is not to replicate a consultative or representative forum, but to provide professional leadership and guidance to the administration of the veteran support system.

In line with chapter 13, the VSC could also be the body responsible for administering invalidity claims under the military superannuation system. This would mean administering compensation payments for incapacity or death under the *Australian Defence Force Cover Act 2015*, the *Military Superannuation and Benefits Act 1991* and the *Defence Force Retirement and Death Benefits Act 1973*, while policy responsibility remains in the Defence portfolio (as currently). As noted in recommendation 13.2, consideration of this option is required if other approaches are unsuccessful in improving the interface between the superannuation and compensation systems.

Establishing the VSC

The VSC is a necessary precondition to improving the veterans’ support system and it represents a significant change to the system’s governance. Some participants, including the Alliance of Defence Service Organisations (ADSO) and the Combined SA ESOs, were concerned that there would be disruptive impacts during the transition to the VSC and that ‘existing services may well be compromised’ (Combined SA ESOs, sub. DR188, p. 11).

To prevent major disruptions to the administration of claims, the transition to the VSC will need to be handled carefully by several agencies across government, including Defence, Services Australia (previously known as the Department of Human Services) and other agencies directly involved in the veteran support system. In addition, drawing on the practical experience of existing claims administrators, such as Comcare and the various state agencies, could help facilitate the smooth introduction of the VSC.

The preparatory work to establish the VSC should commence as soon as possible and should be done in the context of the continued rollout of the VCR program (chapter 9). Once the VCR program has been completed (due in mid-2021), the changes to DVA’s governance structures should start to be implemented. This should allow the VSC to begin operating by 1 July 2022, and earlier if possible. Any delays in the rollout of the VCR program should not delay the establishment of the VSC.

Extensive preparatory work throughout a long lead time will enable the new structure at the top of the VSC (the board and CEO, operating independently of government departments to maximise veteran wellbeing within a fully-funded system) to begin to drive change in the culture of the organisation and improve outcomes for veterans and their families from day one.

As the VSC would be taking over many of DVA's existing administrative functions, its funding should be drawn from the nearly \$400 million in annual departmental appropriations that DVA currently receives (DVA 2018g, p. 214). Additional funding injections from the Government would probably be needed for the first few years to cover transitional costs, while overall funding may need a permanent increase to support investment in the VSC's more client-centred approach.

Other administrative decisions that the Government and the independent VSC board will need to consider during and after transition include:

- the location of the primary VSC office — DVA and Defence are headquartered in Canberra so it may be desirable to base the head office of the VSC in Canberra, at least initially. Although it is likely that administrative and other frontline staff will be dispersed around the country to maximise active engagement with clients.
- the type of staff employment — moving to an employment system that is not covered by the *Public Service Act 1999* (as the Commission recommended for the National Disability Insurance Scheme) has the potential to increase hiring flexibility and the 'cultural independence' of government agencies (PC 2017d). However, a modern compensation scheme can be run by public servants (for example, Comcare and SRCC 2018), and an over-reliance on short-term contractors for core business is one of DVA's primary problems, with some participants concerned that 'the creation of a statutory authority continues a 25-year old program of downsizing the APS' (AFA, sub. DR300, p. 7)

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.

11.7 Levying a premium on Defence

Premiums are vital to a modern military compensation system

A critical driver of beneficial outcomes in workers' compensation systems in Australia is a premium levied on employers. Premiums create positive incentives for change and cooperation between scheme administrators and employers (box 11.9).

A premium levied on Defence by the VSC would sheet home financial accountability for the veteran support system directly to Defence, and send a clear price signal about the impacts of reducing injuries and the associated positive flow-on effects to the capability of personnel. In addition, a premium would create a dedicated funding source for the VSC — the independent body responsible for getting the best possible long-term outcomes for veterans.

Box 11.9 **Premiums provide a multitude of powerful incentives**

A levied workers' compensation premium can:

- send a strong information signal to the employer — particularly about how changes in working conditions (such as an organisation's workplace health and safety performance), benefit structures and other underlying factors (such as dangerous events) are linked to quantifiable changes in the premium. Premiums can therefore provide a powerful signal to employers about the costs of injuries and illnesses occurring under their watch, which enhances or complements existing incentives for workplace health and safety (chapter 5). In Defence's case, a premium acts as a price signal about the cost of not achieving the long-term wellbeing of serving personnel.
- create financial pressure for change — premiums affect employer behaviour because budget constraints mean the premium has financial 'bite'. Where the employer controls the levers affecting the premium, they can take direct action to improve outcomes or behaviours (such as by reducing workplace injuries) to lower their premium (other things equal). As the Commission has previously said, where risks are high 'this should feed through into premiums, which in turn should signal to employers the need to invest in workplace safety and rehabilitation' (PC 2004, p. 282). An employer that does little to reduce the number or impact of workplace injuries will face rising premiums and falling workforce productivity due to more sick days. Conversely, an employer that works hard to reduce workplace injuries and their impact will face relatively lower premiums and rising workforce productivity.
- encourage early treatment and efficient claims administration — a scheme administrator, operating within a funding envelope set by the premium, has incentives to minimise system costs. It can achieve this by, for example, eliminating inefficient and unsupportive claims handling, which can aggravate existing illnesses or create new mental health problems. The administrator can also get people back to work quickly by avoiding a passive approach to identifying, treating and rehabilitating injured or ill employees. For veterans, this means a premium would mutually reinforce the Veteran Services Commission's goal of improved administration.
- promote better data collection and use — good quality data about the risks of injury or illness and the costs and outcomes of compensation, rehabilitation and treatment are key to calculating a premium and understanding drivers and emerging risks for employees and employers (discussed in chapter 18). Scheme administrators can also work with employers to prevent injuries by sharing information that they have gathered about what works or does not.
- act as a powerful mechanism for accountability and transparency — by making the lifetime cost (both financially and in terms of health impacts on veterans) of changes to veteran support policy and broader defence policy transparent at the time policy decisions are made. This information is missing under current institutional arrangements, obscuring long-term policy costs to Defence, the Government and the public.

A dedicated, but limited, funding source will provide a strong incentive to manage system costs and get value for money for veteran services to ensure that the system is financially sustainable.

As such, the veteran support system should be funded by the VSC levying an annual premium on Defence, set at a level to sustain a fully-funded scheme.

Although several issues with a premium were raised by participants (discussed below in more detail), none represent principled objections that would undermine the broad case for levying a premium on Defence. The problems raised can be broadly categorised into those associated with creating a new scheme — and hence are surmountable over time and with experience — or those that represent misunderstandings of how a fully-funded system works.

The premium must be set to achieve full funding

For the benefits of a premium to be fully realised, the premium must be designed to achieve full funding of the veteran support scheme. As discussed in section 11.3, a PAYG approach is deficient compared to a fully-funded scheme, because it creates unfunded liabilities, encourages cross-subsidisation over different generations, dampens incentives to improve workplace health and safety and leads to a short-term administrative focus and less timely and responsive claims administration.

In a fully-funded veteran support system, Defence would pay premiums for uniformed ADF personnel (those covered by the veteran support system) to the VSC, who would manage the pool similar to any civilian workers' compensation scheme.⁷ The premium paid by Defence would be equivalent to all the future costs of the veteran support system (compensation, rehabilitation, treatment and other services) that are expected to be generated as a result of new or aggravated service-related conditions created during the year the premium is levied.⁸ These costs (referred to as the scheme's 'liabilities') are then discounted across time and summed to a single figure to generate the premium (further details are in box 11.10).

⁷ These premiums would be in addition to those that Defence already pays to Comcare each year for the workers' compensation scheme covering its public servants (SRCA), which was around \$22 million in 2017-18 (DoD 2018f, p. 165). Although this would result in Defence paying two premiums each year, they would cover mutually exclusive sectors of its workforce (public servants or uniformed ADF personnel).

⁸ Although some claimed conditions will be related to specific events at a point in time (such as fractures), other claims will be more attributable to ongoing exposure over the course of an ADF career (such as musculoskeletal conditions). For a premium, these conditions may need to be attributed on an incremental probability basis, effectively accounting for expected additional costs per member, per year of exposure.

Box 11.10 **How a fully-funded workers' compensation system operates**

In a fully-funded scheme, compensation benefits are paid from a 'capital pool', a collection of assets which are built up over time by levying annual insurance premiums. In contrast to pay-as-you-go (PAYG) funding, full-funding means that existing claimants do not rely on future contributions — the liability associated with their injury is covered by the insurance pool. As the Commission previously outlined:

Full-funding is where sufficient assets are accumulated in the scheme to meet all expected entitlements to compensation, regardless of when they may be paid, and all costs associated with managing claims that have occurred. It is expected that investment income earned on the funds set aside to meet future claims will also be available to meet emerging costs. (PC 2004, p. 279)

The annual insurance premium is calculated, using actuarial models (chapter 18), to cover the long-run expected costs of the scheme. For a not-for-profit scheme (like the veteran support system) the annual premium would be equivalent to the net present value of expected future entitlements from liabilities created from injuries or illnesses suffered by service members during the year (plus an allowance for the insurer's costs of administration) (Gallagher Bassett 2018; IC 1994; PC 2004).

Differences in the magnitude of the premium from year to year will reflect discrepancies between modelled outcomes and actual outcomes. These discrepancies could be a result of:

- changes in behaviour (such as a higher or lower rate of injury)
- changes in policy (such as higher or lower payment rates)
- changes in scheme administration (such as the claims process becoming easier or harder)
- exogenous economic events (such as higher or lower returns on insurance pool investments).

There is no substitute for a premium

The full incentive effects of a premium cannot be achieved without the premium *actually* being levied.⁹ Levying the premium gives it 'bite' and makes it impossible for senior managers and commanders to ignore what is driving changes in the premium, as those changes will have a real impact on the employer's budget.

By contrast, *notional* figures — such as the Defence premium calculated annually by the Australian Government Actuary (AGA, discussed in chapter 5), which was estimated at \$798 million in the year to June 2017 (AGA 2018a) — do not draw the same attention, nor are they likely to prompt action. As one commissioned officer in the ADF put it:

Notional figures are considered a fairytale by junior commanders who are responsible for the day-to-day training of Defence personnel. Should the Department of Defence desire a reduction in injury and illness, real repercussions will need to become tangible at the ... Section Commander level. (Phillip Burton, sub. DR243, p. 12)

⁹ In the near term, the Australian Government Actuary's calculations of a *notional* Defence premium should be published (recommendation 5.3).

Similarly, a recent initiative by DVA to explore the implied lifetime costs of their client base — the Priority Investment Approach (PIA) (sub. 125, p. 79) — is a good initiative, but not a substitute for a premium. Like a premium, the PIA uses an actuarial approach and the same data (and so has the same data limitations as a premium, discussed below) to derive the future cost of existing liabilities (box 11.11). It is an information tool that can subsequently be used to identify (for alternative treatment) high-cost cohorts within the claims profile, and in this way complements a premium.

Box 11.11 The Priority Investment Approach

An investment approach is a method of actuarial analysis that helps policymakers identify the future lifetime costs of different sub-groups within a client population. It is an information tool.

Since 2016, the Department of Social Services (DSS) has been undertaking an investment approach for welfare payments, following the recommendations of the McClure Review and based on New Zealand's experience with a similar approach (Arthur 2015; DSS 2018a; McClure, Aird and Sinclair 2015). In the DSS system, an investment approach uses annual actuarial valuations to estimate the future liability of income support payments for different cohorts of recipients. This allows groups of people most at risk of long-term reliance on income support to be identified, and this information can subsequently be used to design and target policy interventions (or modify existing policies) that prevent dependence and improve outcomes (Arthur 2015).

The Department of Veterans' Affairs (DVA) has outlined a range of outcomes it hopes to achieve in the long-run after its Priority Investment Approach (PIA) is fully developed and operational, including:

...to understand which veteran cohorts would most benefit from targeted policy interventions. Under this approach, an actuarial model will be developed that will enable DVA to understand and monitor the expected outcomes of their veterans over their entire lifetime. In doing so, groups of veterans who may significantly benefit through more informed decision making will be identified, and DVA will look for ways to engage them, informed through appropriate behavioural economics analyses, which may achieve better and earlier self-management. (sub. 125, p. 79)

The PIA model is data intensive and for it to be useful, significant changes will be required to the way DVA collects information about outcomes for veterans, including the long-term experiences of clients receiving treatment, rehabilitation and compensation payments. These changes will need to be implemented before the outcomes from a PIA can be used to inform potential policy changes, such as proactive early intervention or changes to client engagement and case management practices that might improve outcomes for veterans and their families.

However, unlike a premium a PIA is not an accountability mechanism — it lacks bite, much like a notional premium. It is also not a substitute to a premium *levied on Defence*. If accountability is not sheeted home to Defence, a key imperative for action — the expectation of rising costs within a limited budget — will be non-existent.

What's more, a DVA PIA, by focusing on costs incurred by DVA, has no impact on Defence activities. It takes the damage that clients have already received during their service as given and hence has no impact on injury prevention. If high-quality Defence data were available, the PIA could theoretically be extended back to the point of enlistment (at which point

Defence could potentially act to avoid injuries or illnesses). However, such an ‘extended’ PIA is still analogous to a *notional* premium and is not a substitute.

How would a premium be calculated?

The premium would be calculated by actuaries inside the VSC, applying the same insurance principles and approaches used for calculating a civilian worker’s compensation premium.

Some stakeholders were concerned that the characteristics of the existing body of claims for assistance to DVA would make levying the premium unworkable. These characteristics include that:

- benefits have a much longer ‘tail’, as they can be payable over many more years
- there is a significantly longer time lag between the relevant incident(s) and the corresponding claim
- claims often arise after a series of cumulative events, rather than a one-off incident
- multiple claims can be submitted by each claimant, resulting in incremental adjustments to benefits
- it is a more ‘beneficial’ scheme, implying greater costs
- claiming rates are not as stable, and have recently been increasing rapidly.

Few of these characteristics are unique to military compensation schemes. For example, medical indemnity insurance is also long-tailed — compulsory for all medical practitioners, it is designed to insure against long-onset complications from medical procedures.

But more importantly, many of these characteristics are actually a function of the design and the policy choices underpinning the current system, as opposed to being inherent characteristics of a claim for assistance by veterans. In a better-designed, fully-integrated system, they are able to be changed or mitigated because they are either in the control of the employer (Defence), the scheme administrator (DVA and then the VSC) or the policymakers (the Government).

For example, the long time lag between service-related incidents and a corresponding claim exists largely because DVA does not proactively reach out to injured clients after an incident. This is in part because Defence has a culture of systemically underreporting injuries, compounded by not having systems in place to pass incident reports or medical information onto DVA in a timely manner. The long tail of benefits is also in part due to the Government’s historic focus on providing pensions-for-life (the VEA legislation has no rehabilitation option), rather than early intervention for treatment and rehabilitation.

Similarly, unstable claiming rates (for example, due to increasing mental health claims) are a trend affecting all workers’ compensation schemes. To some extent, this is driven by a changing recognition and acceptance of mental health conditions, which means more claims

are being lodged across all workers' compensation schemes that might have remained hidden in the past.

Other characteristics of the existing claims profile are a function of the poor data holdings of both Defence and DVA, due to significant gaps in their systems (chapter 18). Defence and DVA's current data holdings do not satisfy the needs of an insurance system based on actuarial modelling because their current institutional arrangements do not require or encourage the collection, maintenance and sharing of data to serve that purpose. Indeed, even the recent volatility experienced by the AGA's notional premium estimates (AGA 2018a) can be partly explained by inadequate data, as it does not have access to any Defence holdings, so the rapid rises in claims numbers were not foreseeable in Defence service, injury and incident reports.

The data gaps will need to be filled and systems created or modified to collect, share and analyse that data for use by the scheme's actuaries. The recommended governance and funding changes would create strong incentives to turn this around and pursue improvements in data collection and capability. In particular, under a fully-funded experience-rated insurance model, low-quality or insufficient data leads to a poor understanding of risk which will put upward pressure on premiums.

What benefits and activities would be covered by the premium?

As a general rule, the premium should reflect the cost of the full range of supports that a veteran (or a dependent, following a service-related death) is entitled to. In this way, the premium sends the broadest possible price signal about the cost of defence activities.

However, the strength and effectiveness of the price signal will tend to vary based on the amount of control that Defence or DVA has over the mechanism that is causing the condition in the first place (this is an important reason why the split between Defence and DVA is detrimental — it severs the price signal). The price signal sent by the premium is at its strongest where Defence can take direct action to affect it. For example, where the premium reflects a *service-related condition*, that is a condition that came about due to an activity performed under Defence supervision, Defence can take action to avoid or reduce the impact of that activity. In other cases, where Defence has less control — for example at the micro level, where the link between a condition and service is more tenuous (or has long onset), or at the macro level, such as the decision to deploy troops on operational service — the ability for Defence to influence subsequent changes in the premium is reduced.

However, the signal is not reduced to zero and so excluding the costs of some benefits in the veteran support system from the premium calculation — which some participants have called for — should be avoided. As discussed below, this would mask the true cost of the veteran support system, undermine accountability and create perverse incentives for Defence. Other compensation schemes do not exclude some scheme costs.

Operational service

Some stakeholders raised concerns about whether the premium should include operational service — that is, whether it should cover the future expected costs of injuries incurred on operational service, not just in domestic training activities. Defence, for example, argued that the ‘high-risk nature’ of its operations means a premium is not suitable (sub. 127, p. 18), with similar objections made by DFWA (sub. DR299), the Prime Ministerial Advisory Council on Veterans’ Mental Health (sub. DR276), and the Vietnam Veterans’ Federation of Australia (sub. DR215).

However, a premium that does not cover the cost of operational service to the veteran support system will not fund the long-term costs of Australia’s overseas deployments. This does not mean that those costs will not be incurred, only that they are hidden from the public and will eventually fall on the veterans, their families and taxpayers many years or decades later. As one contemporary veteran put it, ‘veteran compensation and rehabilitation is the cost of war by other means’ (David Petersen, trans., p. 1283) and this needs to be acknowledged.

Not including operational service in the premium would mean decision-makers — whether in Defence or within Cabinet — are not fully aware of the long-term costs of ADF deployments overseas (through the effect on the premium), and hence cannot be making fully-informed choices about whether to deploy members. As David Petersen went on to note:

Imagine when the National Security Committee of Cabinet meets, and they say, ‘We want to deploy 1000 soldiers to Afghanistan’ ... We’re going to have this many people, this many planes, this many ships. Well, off our previous experience on a similar style operation, the ongoing cost per annum for our veteran rehabilitation and compensation system is this. That’s just a factor to be factored into all the other costs ... that are already presented to Government. I think it’s okay for Government to say ‘for us to go and do this, it’s going to cost us X amount of dollars for the life of these veterans, and that’s a higher cost and we’re willing to pay that’ ... That is something that the government should know, and it’s mind-boggling that they don’t currently know that cost. (trans., p. 1288)

Other concerns about including the costs of operational service in the premium seem to be less about whether such costs are legitimate inclusions (they are), and more about whether Defence should bear those costs — who should pay for the premium is discussed further below.

Non-liability benefits — certain Gold Cards, White Cards and service pensions

The inclusion of non-liability benefits is also an area of contention for implementing the premium. The primary ‘non-liability benefits’ include:

- non-liability White Cards for mental health and some cancer and tuberculosis treatments
- service pensions for those aged over 60 with qualifying service
- Gold Cards for veterans on the service pension or over age 70 with qualifying service.

Some participants thought that including the cost of non-liability benefits in the premium would result in Defence (by definition) having to pay for the cost of entitlements that are not related to any accepted service-related conditions. This could be seen as contrary to similar practice in civilian workers' compensation systems and leave Defence on the line for costs that it may not have created.

However, much like for operational service (above), failing to include these entitlements in the coverage of the premium would not make them disappear, only hide their long-term costs from the public. Given their eligibility is often dependent on qualifying service, they are also a known, highly-predictable cost of warlike deployments that should be made clear to decision-makers.

Not covering non-liability benefits under a premium would also introduce severe distortions into the system, creating adverse incentives for Defence. For example, exempting all Gold Cards from coverage under the premium means treatment costs associated with severely injured personnel *are not* paid by Defence, while the costs for less severely injured personnel (with White Cards for service-related conditions) *are* included in Defence's premium. Similarly, an exemption for non-liability health care under a White Card would encourage a continued expansion of the eligibility for and treatment coverage of the cards, in order for Defence to avoid the associated costs through the premium (which can be done by determination under s. 88A of the VEA).

Ultimately, as these non-liability benefits are an integral part of the 'beneficial' veteran support system, they should be funded as such.

Other coverage issues — commemorations and the VSC's administrative costs

The Commission also considered other costs within the veteran support system that might be covered by a premium, and did not have strongly held views on their inclusion.

- Typically, a premium also includes a payment for the costs of administering the system. While this could be replicated in the premium charged to Defence — by apportioning some future VSC administrative costs to the premium — it is not necessary to create the strong price signals that will drive improved outcomes.
- As it is an ancillary service to recognise veterans (not a direct part of the compensation, rehabilitation and treatment package), the cost of commemoration events and activities could be justifiably exempted from coverage.

Defence should pay for the premium

Making clear the cost of engaging in high-risk behaviour, military or otherwise, is the point of a premium. It is another piece of information that should be considered — and weighted appropriately — among the broader suite of information that informs departmental and Cabinet deliberations about national security. Defence is best placed to account for these costs.

It follows that, as the ‘employer’ of ADF members responsible for putting them into high-risk situations, Defence should pay the premium to the entity administering the scheme (the VSC), similar to the premium it currently pays to Comcare for the workers’ compensation scheme covering Defence public servants.

Participants to this inquiry disagreed that Defence should pay. Arguments included that it would undermine defence capability (sub. DR310, p. 4, sub. DR276, p. 5) and separately, as ‘many liabilities are incurred due to Government decisions ... not Defence decisions’ (sub. DR299, p. 5) — such as the decision to go to war — the bill should be paid out of general government revenue.

The Commission acknowledges that Defence’s primary responsibility is defending Australia’s national interests. The Commission disagrees that if Defence were liable for a premium, this would undermine its ability to defend Australia or its capability to fight wars. For such an outcome to occur requires an explicit recommendation by Defence, agreed to by the Government, allowing the redirection of funding from capability development (as opposed to elsewhere in the sizeable Defence budget) to the payment of a premium knowing that the outcome is likely to seriously compromise Defence’s ability to wage war and defend the nation’s interests. This is implausible.

Given the political realities around the prioritisation of national security that mean Defence may not be budget constrained in the same way as other government organisations, a more likely outcome is that the Government will provide funding to Defence to offset any increase in their costs that a premium might create. This will mean there is *no impact* on existing capability, but will effectively neuter the potential positive impacts from behavioural change that the premium would encourage.

If the Government decides not to require Defence to find savings elsewhere in the Defence budget (which other departments are expected to do in the context of their workers’ compensation premiums), what is required is a framework that guides additional Government funding to Defence to cover the reasonable costs of the premium, but which does not undermine the premiums effectiveness. This additional expenditure is unlikely to represent a significant added imposition on the Government, as the premium reflects future expenditure that is expected to occur anyway — it is not new expenditure (on a whole-of-government basis), just a movement of expected expenditure forward in time.

Initially, to fund the transition to a levied premium, there are two main options available.

- Additional funding for Defence, roughly equivalent to the Government’s expectation of what the size of the Defence premium should be in the first year (this expectation may differ from its *actual* size, particularly if the Government believes that reasonable improvements in Defence policies, culture and training practices can reduce the

premium). The additional funding would then need to continue each year, to cover subsequent premiums.¹⁰

- This option is similar to the Treasury Managed Fund in NSW, where public sector agencies in NSW are provided with annual funding by the NSW Treasury to cover the reasonable cost of their premiums, but then keep any surplus or pay any shortfall (icare 2019b).
- A proportional phase-in of the premium over several years, with no additional funding for Defence. For example, Defence could be levied 20 per cent of the full premium in the first year, 40 per cent the next, and so on. This gives Defence (and its budget) time to adjust to the imposition of a premium, but does not require additional Government funding.

Following the transition, the Government needs to consider whether Defence will be funded for subsequent changes in the premium. Under a *civilian* workers' compensation scheme, changes in the premium over time would normally be absorbed into the underlying budget of the employer — if the premium falls, the employer keeps the gains, while if it rises, it must find the resources to pay for it.¹¹ This financial incentive (the premium's 'bite') is a key driver for improvements in employee wellbeing over time.

A significant question is how to fund an increase in the premium due to a decision to deploy ADF members on operations? While this policy is unique to Defence, it is still a government decision. And like other government decisions, it is informed by the relevant department — in this case Defence, which provides advice about the size, frequency and tempo of the overseas deployment, with direct effects on the risks borne by ADF personnel. It follows therefore, that like all other government decisions, changes in the level of the premium that reflect the long-term costs of deployments should be made clear in the Budget.

Although the Commission does not have a firm view on where the money should come from, to avoid undermining the premium's financial incentives any addition to the Defence budget must be contingent on Defence requesting and justifying the additional funding from Cabinet first, in line with existing Budget rules. The point of these processes is to ensure that the long-term impact of Defence's actions (via the premium) on ADF members is made transparent and accountable to the Government, the Parliament and the public.

At what level in the ADF would the premium be paid?

The Commission is only recommending that a single premium be levied across the ADF — there would not be individual premiums for the Army, Navy or Air Force, or premiums for individual commands or sub-commands within those structures.

¹⁰ We assume that baseline funding for the premium will account for factors such as inflation and increases (or decreases) in the number of serving personnel in the ADF.

¹¹ This might include costs caused by changes in economic conditions or societal attitudes that affect all employer premiums (box 11.10).

Once the premium is levied, however, it is likely that Defence will take an interest in knowing which parts of the ADF are driving movements in the premium. It could discover these drivers by working with the VSC to disaggregate the premium. For example, the Australian Government Actuary already disaggregates its estimate of the notional premium into the components that are attributable to Army, Navy and Air Force personnel. Similarly, Comcare currently works collaboratively with public service employers to provide cost breakdowns under the civilian SRCA scheme. The employers want to know what specific workplace practices are driving their premiums, to determine whether there are other ways to achieve their objectives while minimising the health and safety impact on their employees (Comcare, pers. comm., 17 June 2019).

Some stakeholders suggested that such disaggregation would be more valuable than a single headline Defence premium. For example, Paul Evans asked ‘which is more effective, a single levy calculated on total ADF personnel or a levy by [service] branch?’ (sub. DR218, p. 2). Similarly, DFWA argued that a premium ‘is a gross measure and does nothing to target areas where Defence can realistically act’, before suggesting a range of categories that cost drivers could be better disaggregated down to (sub. DR299, p. 28). The Commission agrees and notes that disaggregation into more granular and useable information is entirely consistent with (and will be facilitated much more quickly by) the application of an annual premium to Defence. Ultimately, the premium will be the sum of all these disaggregated parts and would be levied on the Defence organisation as a whole.

Would disaggregation encourage under-reporting?

Some participants were concerned that a premium would encourage the underreporting of injuries and other incidents (increasing the already widespread underreporting — chapter 5) if the premium were excessively disaggregated and attributed to low-level ADF commanders. This might happen because lower level commanders, knowing that fewer *reported* claims or incidents means a lower premium in the short term, would order or encourage their subordinates to not report injuries. This would then lead to, as Phillip Burton contended ‘repercussions at the junior level [that] will foster a spirit of risk aversion’ (sub. DR243, p. 12).

To be clear, the Commission is *not* recommending that the costs of the premium be *attributed* down to individual commanders. But even if the premium was disaggregated, the ADF is a hierarchical organisation. Junior commanders take actions based on the decisions and orders of senior officers. This includes not only major decisions about deployments or exercises, but also more day-to-day decisions around how, when and where personnel are trained. If a junior commander is following the training policies or orders issued by those above them, then that is a broader ADF problem to be reflected in the premium.

However, encouraging — or even tolerating — underreporting at any level would ultimately be self-defeating for the CDF and Defence Secretary (and the Government and taxpayers). A premium is a calculation of the expected lifetime costs of supporting injured veterans. Not immediately reporting injuries which *did actually occur* and which are liable for support in

the future does not remove those costs from the system. It hides them in the short run from the premium calculation, but in the long run likely means even greater costs (both to the health of veterans and the capability of Defence) as opportunities for early intervention are missed.

Over time, a data-driven, evidence-based VSC is also likely to be able learn from claims and reporting experience and spot when junior or senior commanders are fostering or permitting underreporting in their command.

What liabilities should be funded to create a fully-funded system?

By definition, a fully-funded system would be one where the VSC's pooled assets are sufficient to cover all future expected liabilities in the veteran support system. This raises a design and implementation question: what are the relevant liabilities to fund?

In short, there are two distinct groups of liabilities, which can be considered separately:

- future — or prospective — liabilities under the MRCA (and then Scheme 2)
- existing — or retrospective — liabilities under the MRCA, DRCA and VEA.

Future liabilities would be covered by premiums

On its own, the premium is a prospective levy — it would only cover new liabilities, being those future costs created due to ADF service after the first year it is imposed. For example, if it commenced in 2021-22, the premium paid that year would cover the expected liabilities (lifetime costs of the veteran support system) that were created for ADF members during 2021-22, with future premiums covering subsequent years.

As the growing liabilities from service-related injuries after the first year would be matched by the VSC's growing assets from collecting and investing successive premiums, the veteran support system would be 'fully-funded' going forward (prospective coverage).¹²

What would happen if the premiums were insufficient?

As the premium is calculated based on expectations about future events (liable condition numbers, claims activities, costs), it is obviously subject to considerable uncertainty. Although the VSC would endeavour to minimise the chance of error and the estimates would improve over time as the VSC obtains more data and experience, premiums will over or underestimate the future costs of compensation, rehabilitation and treatment.

¹² The Government might also consider some amount of starting capital, in order to mitigate small pool risks (such as highly volatile investment returns) that could result in higher premiums than otherwise.

Several participants were concerned that if the premium was systemically underestimated by the VSC (in part due to the calculation difficulties discussed above), it would create a shortfall in assets that led to the funding ratio falling below 100 per cent — that is, assets would cover less than 100 per cent of liabilities. For example, the DFWA (WA Branch) questioned ‘what arrangements are needed to fund the system in the event that premiums based on past history are insufficient to fund an upsurge in veterans requiring support’ (sub. DR279, p. 3). Some of these stakeholders were subsequently worried that a shortfall would affect veteran supports, requiring them to be reduced in order to make up the gap.

However, a fully-funded system does *not* mean any entitlements would be undermined if the funding turns out to be inadequate. At no point would existing claimants be denied benefits or suffer reduced benefits. The VSC would not have the legislative authority to take such action. The size and scope of the benefits in the veteran support system are legislated by Parliament, and would remain available under a fully-funded model to anyone who can meet the legislated eligibility criteria.

If a premium-collecting VSC found that the number of people claiming was likely to be unsustainable in the long run, it would review its actuarial models and increase future premiums to cover the gap, based on their previous expectations of the damage incurred by Defence personnel being an underestimate.

Whether this addition to the premium comes from the Defence budget or is supported by the Government would be subject to the same Budget rules as other changes to the premium (discussed above), with each case considered on its own merits and accounted for transparently. Recently, Comcare faced such a scenario and introduced an additional margin on employer premiums to offset a shortfall in the workers’ compensation scheme covering public servants (Comcare 2017) — no benefits were reduced or additional claims denied during the four years the margin applied.

Existing liabilities are large ...

The existing liabilities represent the total future costs that are expected to arise from claims connected to ADF service up until the start of the fully-funded system. For example, the costs of treatment associated with a veteran who develops lumbar spondylosis in the future (say, 2022) due to service from 2006 to 2012 are an existing MRCA liability. Similarly, the future payments of a disability pension for a Vietnam veteran are an existing VEA liability. These expected payment streams can be forecast into the future (on an actuarially-fair basis), summed up and discounted over time, then aggregated among the approximately 280 000 existing clients and thousands of others with service who are yet to make a claim.

As the veteran support system has been providing compensation, rehabilitation and treatment for veterans for over a century, there is already a considerable stock of existing liabilities under each Act.

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- As at June 2018, DVA reported (based on estimates by the Australian Government Actuary) that the combined size of existing MRCA (from 1 July 2004 to 30 June 2018) and DRCA liabilities was around \$13.2 billion (DVA 2018g, p. 157).
 - No public estimates split the liabilities between the two Acts, however work done by the Australian Government Actuary on behalf of DVA suggests that MRCA liabilities are around 80 per cent of the total — about \$10.5 billion at June 2018, compared to less than \$3 billion for DRCA liabilities (DVA, pers. comm., 29 May 2019).
 - Public estimates are also not available for existing liabilities under the VEA. However, *annual* PAYG expenditure on VEA benefits was approximately \$9.8 billion as of June 2018 (DVA 2018g), which suggests, based on simple back-of-the-envelope calculations, that VEA liabilities are likely to exceed \$100 billion (Productivity Commission analysis).

To fully-fund all these existing liabilities, the VSC's assets would have to match their size, requiring an initial capital injection of over \$130 billion.¹³

... but capitalising them would make the costs of policy change clear

Although capitalising all existing liabilities would be expensive, it would make the financial implications of policy changes obvious and immediate to the decision-makers of the day (in both Defence and the Government), instead of occurring years or decades later. Although past injuries and illnesses cannot be affected by policy changes today, the range of benefits provided to injured or ill veterans can be. Indeed, governments regularly make policy changes that affect these benefits. Recent examples include the expansion of non-liability mental health care and extending the Gold Card to civilian medical teams from the Vietnam War. These policy changes impact the size of the veteran support system's liabilities.

However, as discussed in section 11.3, under the current short-term PAYG approach, the lifetime costs of these changes are largely hidden from those making the reforms, meaning that they incur none of the costs or benefits of their decisions.

Under a fully-funded system that also covered existing liabilities (retrospective coverage), any policy change that altered the size of the liabilities would need to consider whether the VSC's existing asset pool was sufficient to continue to meet all expected entitlements. If not, a policy that was expected to increase liabilities would require a fresh injection of capital ('recapitalisation'), in line with the expected cost of the changes.

By introducing a form of Budget discipline for decision-makers, it would bring the responsibility for policy changes home to those making the decisions. As such, there would be considerable merit in covering as many existing liabilities as possible.

¹³ Depending on its structure, the initial VSC capitalisation may be able to be considered a Budget neutral capital expenditure, rather than an administered expense. Instead of a capital injection, a more limited asset pool could also be built up incrementally, through the use of additional margins on the Defence premium (as above).

A notional capital account as an alternative for the VEA

Given that the full capitalisation of VEA (and, to a lesser extent, DRCA) liabilities would be prohibitively expensive and not create any opportunities for preventing injury or illness in the ADF, the Commission is instead recommending that a notional asset in the VSC's financial statements be created to record and monitor changes in VEA and DRCA liabilities.

As Peter Sutherland noted (sub. DR192, p. 2), lessons can be drawn from similar arrangements in Comcare. Prior to 1 July 1989, Comcare did not collect premiums from employers. Expenses associated with these 'pre-premium' claims are funded from special appropriations, much like the current PAYG veteran support system. Unlike the veteran support system, however, Comcare accounts for the outstanding liability for these pre-premium claims through a notional account on its balance sheet. As at 30 June 2018, the balance of this account was \$339.7 million (Comcare and SRCC 2018, pp. 105–106).

Although similar accounts for VEA and DRCA liabilities would only be notional and do not create the same level of budget discipline as an actual capital pool (as discussed above), it would still be valuable for the VSC to transparently recognise its implied call on future Budgets. In particular, a notional account would provide some useful information signals about the long-term costs of policy changes, beyond the usual forward estimates period. Changes in policies that affect the size of liabilities would also result in a transparent increase or decrease to the notional account, even though no funds changed hands.

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.

11.8 Veteran policy and planning functions

Following the creation of the VSC (section 11.6), responsibility for strategic policy and planning in the veteran support system, including responsibility for the three existing Acts (MRCA, DRCA and VEA), which outline the broad suite of supports available to veterans and how they are accessed, would have to remain in a department of state as a core function of the Australian Government. Other policy functions that would be the responsibility of a department include:

- veterans' organisation engagement, coordination and support functions (chapter 12)
- training and professional development of advocates (chapter 12)
- major commemorative activities and events (section 11.9)
- policy research and program evaluation (chapter 18)
- some secretariat functions for smaller portfolio agencies (such as the VRB and RMA).

A first best approach — move veteran policy into Defence

As discussed earlier, moving veteran policy into Defence is the most efficient and effective way to align accountability structures and create the right incentives to ensure that the long-term wellbeing of veterans is weighted appropriately in broader Defence decision making.

This move, combined with the creation of the VSC, would effectively abolish DVA, creating a single, unified portfolio and doing away with the century old functional split between DVA and Defence (discussed in section 11.4).¹⁴ Removing the institutional split would bring all the relevant policy levers under the control of Defence (and the Defence Ministers). This includes responsibility for day-to-day ADF policies (such as workplace health and safety guidelines), policies affecting compensation and benefits for current and ex-serving members and Australia's broader defence policy.

It would make it easier for Defence to develop integrated and long-term policies for enhancing the wellbeing of serving and ex-serving military personnel and their families throughout the whole of their lives — an 'enlistment-to-the-grave' model of care for veteran wellbeing. It would also ensure that the legislation and policy settings that makeup the veteran support system and provide for the long-term wellbeing of all current and ex-serving personnel are considered in the context of broader Defence policy.

¹⁴ To effect such a change in practice, the AAOs would need to be changed to move all of the legislation and policy matters of the veterans' affairs sub-portfolio into the defence portfolio. At an organisational level within the Department of Defence, the changes could be achieved by creating a new 'Veteran Policy Group' led by a Deputy Secretary.

Shifting policy responsibility into Defence tangibly recognises that Defence's responsibility to ADF members (as outlined in recommendation 5.4) goes beyond their time in service. In practice it should enable Defence, working in close collaboration with the VSC, to:

- provide continuity of care during transition
- realise administrative efficiencies, such as by generating economies of scale from service commissioning across serving and ex-serving member supports, where appropriate (such as for rehabilitation services)
- facilitate seamless data and information sharing to make the claims process quicker and easier.

With respect to funding, if Defence was responsible for all the relevant policies, the size and annual change in a premium levied by the VSC would solely reflect the costs of Defence's policies or changes to policy.

Conversely, levying a premium on Defence without giving it responsibility for veterans' policy would result in the reverse of the current situation — Defence would pay for policy changes made in DVA's sub-portfolio. Some of these changes are the result of Cabinet decisions, so a combined Minister for Defence Personnel and Veterans (discussed below) could go some way towards balancing the different interests and advice of the two departments (although only one department would still wear any long-term financial liabilities). However, other policy changes made within DVA may not be subject to Cabinet processes, but can still have large effects on liabilities and the premium. For example, the recent expansion of 'decision-ready' conditions (chapter 8) was not subject to the usual Budget processes, but is likely to have a sizeable impact on future liabilities by expanding eligibility. Improved cross-agency coordination on veteran policies (discussed below) could assist in moderating this issue.

Stakeholder reactions and concerns

A number of participants supported making Defence responsible for veteran policy and recognised that making Defence directly accountable — financially and administratively — for the long-term wellbeing of veterans is the only way to achieve fundamental change (box 11.12). The Tanzer Review also reached a similar conclusion twenty years ago, recommending that 'policy responsibility [should] also rest with Defence' (Tanzer 1999, p. 87), but this recommendation was never enacted, preserving many of the system's problems.

However, many other stakeholders were not confident that making Defence responsible for veteran support policies would improve outcomes, because in their view, Defence does not currently have the capacity or willingness to care about veterans' affairs.

The well-publicised behaviour of certain senior ranks in the ADF ... demonstrates senior ranks' low priority to veteran welfare. (Claude Palmer, sub. DR179, p. 1)

Some of the veterans' concerns appear to arise from a lack of trust in Defence, particularly given that (by definition) all service-related injuries and illnesses arose while in the care of Defence, and its effectiveness in prevention, rehabilitation and transition has been found wanting (section 11.2).

Box 11.12 Support for moving strategic policy into Defence

Renee Wilson:

Putting Defence in charge of and making them accountable for veteran and family support policies will enhance force design, capability development and strategic decision making ... Currently Defence as an organisation lacks the ability to understand the impacts of their strategic decision making on their people because they don't get to see the effects, effects which may take many years to manifest. A leader with the capacity to properly make the link between capability realisation, force raising and veteran's policy will be the one that will make this recommendation work. (sub. DR257, p. 2)

David Petersen:

We need to change the culture within the entire Defence portfolio, and we need to both incentivise and penalise those who mistreat the Commonwealth's investment in its personnel ... So only when the Chief of Defence Force can no longer buy another tank, because [they] broke too many soldiers ... will that leader actually be incentivised to go and do something upstream. (trans., pp. 1283–1285)

Peter Sutherland:

It is very important to enhance the policy attention given to this area by the Defence Department and the ADF as many of the necessary reforms must improve in-service practice, and not take effect only after discharge. (sub. DR192, p. 2)

Fiona Brandis:

I welcome the proposal to have a combined Defence Ministry for both Personnel and Veterans, this ideally will facilitate smoother transitions from military to civilian life. It may also force Defence to have more accountability when injured or ill members are transitioning out of service: there is currently a 'tick 'n' flick' mentality in Defence when these veterans are discharged ('they are DVA's problem now'). (sub. DR295, p. 2)

Deborah Morris:

... I really appreciated the draft report of trying to have incentives and accountability in the Department of Defence, I think that that's very important. (trans., p. 1242)

It is true that, at present, Defence does not have capacity to undertake veteran policy. But rather than an indication that Defence is incapable of successfully undertaking veteran policy, this is a reflection of the fact that it is not *currently* the agency responsible for that policy (ensuring the long-term wellbeing of ADF personnel). Over time, however, other recommendations by the Commission — including levying a premium (section 11.7) and the Joint Transition Authority (chapter 7) — are likely to enhance Defence's interest in, and capacity to, take on a greater strategic policy role in veterans' affairs.

Other participants were concerned that Defence control would result in an underfunding of veteran supports, arguing that the ADF would prioritise its warfighting capabilities. For example, the Royal Australian Armoured Corps Corporation (RAACC, sub. DR203, p. 11) raised the problems of control by Defence ('an entity that has a capped budget with no fiscal

flexibility’) instead of DVA (whose budget is ‘not capped with inbuilt fiscal flexibility’). Similarly, the DFWA stated that:

Placing veteran affairs in any form into Department of Defence will mean they will have to compete for funding and resources with the war fighters and the priority must go to the war fighters. This may well result in a degradation of support to veterans and is not supported. (sub. DR299, p. 15)

However, all major entitlements under the veteran support system would remain as they are — uncapped and ‘demand-driven’ (in the sense that anyone who meets the eligible criteria has access). This means that funding for supports under the veteran legislation would *not* have to compete with appropriated Defence funding.

It would also not be in Defence’s interests to undermine existing entitlements, as reducing benefits could make it more difficult to recruit and retain members, and would normally require legislative changes to go through Parliament.¹⁵ Similarly, a passive response to injury prevention and reporting could lead to higher premiums.

Separate from the funding for entitlements, the administrative funding for the VSC that allows it to operate the system (its departmental appropriations, discussed further in section 11.6) would be independent from Defence, under its own funding arrangements and subject to Cabinet approval for any changes (up or down).

Similarly, some participants stated that veterans’ issues would be swamped in a large department like Defence. But it is not obvious why this would be the case in practice, particularly given that the current budget for the veteran support system accounts for around a quarter of the entire Defence portfolio budget.

Conversely, other participants raised concerns that if Defence has responsibility for both Australia’s defence policy and veterans’ affairs policy, the opposite problem would occur. The concern was that instead of prioritising warfighting, Defence could compromise national security by undermining its warfighting capability. For instance, ADSO said that:

To adequately assure the effective defence of Australia, the focus of Defence efforts must be on strategic posture and combat readiness. Anything that diverts that focus weakens Australia’s defence. (sub. DR247, p. 8)

Many others expressed similar views. For example, Ray Kemp noted that ‘Defence is there to fight and protect the country [while] DVA is there to protect veterans’ (sub. DR240, p. 1), and Rod Murray contended:

A commander would be strangled in his/her mission if he/she had to try to balance the casualty rate against the financial cost ... Defence cannot be responsible for the total rehabilitation of their

¹⁵ The Commission would be more concerned about the opposite risk: namely that Defence — strongly influenced by the ADF members in its ranks who will directly benefit from the veteran support system — will gold-plate the system and *increase* entitlements. Ensuring the veteran system is fully-funded and that the Veterans Policy Group is led by non-ADF personnel would mitigate this risk, as would publicly available regular actuarial assessments of scheme sustainability and the sources of cost pressures.

personnel. It is contrary to the principle that Defence must wage war, if and when necessary and continue to do so without distraction. (sub. DR189, p. 1)

However, moving DVA's strategic policy and planning into Defence does not change Defence's existing objectives — it would still be required to achieve its current outcomes of defending Australia and advancing its strategic interests. Defence would be failing to achieve these objectives if it did not adequately train personnel to defend Australia, even if that action spared some personnel from injuries or illnesses.

Instead, moving veteran's policy into Defence would acknowledge a long-term responsibility for ex-service personnel, building on its existing responsibility to 'respect and support' current serving ADF members (recommendation 5.4). In effect, it would better align Defence's 'duty to prepare' for war with the Government's broader 'duty to care' for service personnel.

In response to bearing the consequences of its actions, Defence may find that there are different ways of doing things that still enable it to reach the same level of capability, but with fewer illnesses, injuries or deaths among its personnel. In some areas, Defence may find that a renewed focus on veteran wellbeing is likely to *improve* their warfighting capabilities, rather than undermine them (some examples are outlined in box 11.7). In other areas, the ADF is likely to discover that there are some activities it currently undertakes that create only marginal increases in capability, at considerable additional costs of injury, illness or death for those personnel. As one veteran put it during the public hearings:

... the tactical athlete analogy is perfect. We allow people to go onto the sporting field and become injured in the pursuit of the final or the game or the points. But it doesn't mean we don't provide for their health and wellbeing in other areas, and prepare them actually better. So the analogy is always, 'well, if we train them softer they'll break'. Well, sports team today are far better than they were in the past, because they have these systems in place that prepares them for combat better, and incentivises them to do that. And when a commander doesn't do that, they become penalised in some way that's appropriate and not detrimental to Australia's national interests. (David Petersen, trans., p. 1285)

Other concerns by stakeholders were largely due to misunderstandings of what was being proposed. The Australian Commando Association, for example, objected to Defence having responsibility for veteran supports, as it 'has no present infrastructure to undertake the significant task of managing veteran compensation and rehabilitation' (sub. DR298, p. 4). Similarly, several stakeholders were concerned that moving strategic policy into Defence represents a return to the old Military Compensation and Rehabilitation Service, which existed prior to 1999 and which 'failed the administration and provisioning of care for veterans' (TPI Federation, sub. DR290, p. 4).

The Commission is not suggesting that the Department of Defence itself would ever be engaged in directly assessing claims from veterans or their families or in providing or commissioning services for veterans — these tasks would be for the VSC, operating as a wholly independent statutory agency.

Reforming a retained DVA

Notwithstanding the benefits of moving policy into Defence, the Commission acknowledges that there is strong opposition, including by both DVA and Defence, with many participants still opposed to the idea of not having a DVA at all (box 11.13). Opposition from stakeholders is rarely a basis for rejecting recommendations that we consider to be the best solution for a policy problem. However, given the lack of trust and confidence by veterans in Defence's capacity to assume DVA's policy responsibilities, the Commission accepts that reform along this line is not realistic or feasible at this stage.

This means that a reformed DVA will retain primary responsibility for veteran support policy, including ancillary responsibility for engagement and consultation with veterans and ESOs, commissioning research and evaluation on veteran's issues, advocate training and professional development, and major commemorations activities and events (as above).

However, this does not mean stasis in that role. There will need to be significant enhancements to the strategic policy and planning capabilities of DVA, with buy-in from Defence, to address the most significant problems identified in this inquiry. The current arrangements are not working well enough and are not robust enough to deliver good outcomes for the future veteran support system.

Due to the problems outlined in section 11.2, DVA's strategic policy-making functions would need significant reform in order to improve outcomes for veterans and their families. In particular, its structure and culture would have to move away from the short-term, reactive focus that DVA has had for several decades. Separation from the day-to-day administration of the veteran support system (in the VSC) would go some way toward helping with this goal, as it would allow DVA management to focus on rebuilding their independent strategic policy capability by becoming a more typical department of state.

A standalone DVA would also have to develop strong, long-lasting mechanisms to work with Defence and overcome the challenges created by their institutional separation (section 11.2). One way to achieve this would be through the use of a series of inter-departmental steering committees or policy taskforces, to develop a collaborative approach to cross-agency policies and integrated systems. At the highest level, constant engagement between Secretaries (and the CEO of the VSC) would be vital, but a range of steering committees below this level could be used to focus on particular areas, issues and policies. Care would also be needed to ensure that such committees are not temporary, personality-driven solutions, liable to collapse when key members of staff (or the Minister) move on.

Since 2016, the ministerial arrangements in the defence portfolio have included a single Cabinet member as both the Minister for Veterans' Affairs and the Minister for Defence Personnel. Ongoing cooperation between Defence and DVA would be greatly improved if there was substantial buy-in from a single Minister with responsibility for both departments. As such, a single ministry for Defence Personnel and Veterans should continue to be maintained, with the Minister having responsibility for veteran support policy, from enlistment to the grave.

Box 11.13 Some participants were strongly opposed to not having a DVA**Royal Australian Armed Corps Corporation:**

In its Draft Report, the Commission has not adduced any compelling evidence to support its proposal to destroy DVA and move its functions to Defence. Defence has an unfortunate and unsuccessful history in the past in looking after damaged veterans. (sub. DR203, p. 16)

Veterans' Advisory Council, South Australia:

The Council considers the loss of a department of state would seriously diminish the standing of veterans and the recognition of their service. The commensurate loss of a department secretary is considered disadvantageous to the veteran community removing an advocate at department secretary level with a seat at the Secretary's table. (sub. DR266, p. 7)

Air Force Association:

The Association considers the abolition of DVA to be revolutionary when an evolutionary approach may be more appropriate. The Association's view is, however, contingent on DVA rehabilitating itself and delivering within an acceptable timeframe a veteran support system that reflects the key principles and objectives espoused by the Productivity Commission. (sub. DR267, p. 3)

Defence Force Welfare Association WA Branch:

Veterans' policies should not be a subordinate role of the Department of Defence, and we do not accept the folding of the ministries of Defence Personnel and Veterans Affairs into one portfolio. A contingency planning approach also suggests that in the event of an expansion of the ADF, Defence will be pre-occupied to the extent that policies for veterans will be subordinated to more pressing issues. (sub. DR279, p. 2)

Australian Commando Association:

The [Commando Association] rejects any dismantling of DVA, with the view to handover the responsibility of Veteran Compensation and Rehabilitation to the Department of Defence, under a Transition Support Command. The ADF is involved in the development of the capability of warfighting, with commitments to overseas operational deployments and the protection of Australia ... The retention of DVA is vital to the ongoing relationships and managing of client's needs. (sub. DR298, p. 4)

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.

11.9 Other governance changes

Create a standing ministerial advisory council

Across government, advisory councils to ministers or to agencies often have value in providing a pragmatic perspective from diverse groups of customers, community members and suppliers in areas where policy and service delivery is complex and sensitive.

Advisory groups are not substitutes for other consultation mechanisms, but instead provide some regularity to advice on best-practice policy design and the administration and stewardship of services. One example is the Board of Taxation, which provides real-time advice to the Government on taxation issues from the perspective of tax professionals (box 11.14). In New Zealand, a Veterans' Advisory Board provides advice to their Minister for Veterans (box 11.15), although in that instance, the members are almost entirely from the armed services.

The veteran support system has many of the traits that would justify a standing council that met regularly with the Minister for Defence Personnel and Veterans. Like the Board of Taxation, this could sensibly include the relevant agency heads — in this case, DVA’s Secretary, the CEO of the VSC (recommendation 11.1) and possibly a senior representative from Defence.

The Commission found general support for an advisory body of this kind,¹⁶ but much less consensus on its membership. Some veteran groups envisaged little, if any, space for civilians in any advisory group (TPI Federation sub. DR290, p. 27; Veterans of Australia Association, sub. DR232, p. 9).

However, the purpose of an advisory group would only be adequately met if non-veteran expertise were also included. So in addition to some veteran representation, membership would need to include people with experience in mental and physical health care, vocational and medical rehabilitation, aged care, and social services and other compensation systems — all of whom would have the capacity to provide practical advice to improve veteran services and policies. This broader representation would not subvert veterans’ voices, which are instead intended to be enhanced through other measures recommended by the Commission for increasing effective consultation and advocacy (chapter 12).

A key question for a new advisory council is its interaction with those existing consultation arrangements and the Commission’s proposed changes (chapter 12). One potential concern, voiced by several participants, was that there were already a plethora of existing roundtables and committees serving the advisory council’s intended role (or that could do so with augmentation). For instance, some expressed concern about simply adding to the existing mechanisms for advice (Vietnam Veterans’ Federation of Australia sub. DR215, p. 30), while others argued that an existing body could fulfil the advisory council’s role instead (the ESO Round Table in the case of Legacy Australia sub. DR220, p. 11; and the Prime Ministerial Advisory Council on Veterans’ Mental Health in the case of the War Widows’ Guild, sub. DR278, p. 18).

However, rather than an objection to the advisory council itself, many of these views seem to be aimed at existing weaknesses in the consultation arrangements between DVA, the Government and the broader veteran community. As discussed in chapter 12, the current consultation framework can often be fragmented, superficial and unrepresentative. The Commission agrees that reforms in that area are needed (such as the potential creation of a veterans’ organisation peak body) to provide a more coordinated approach to consultation that does not neglect the needs of vulnerable groups of veterans.

¹⁶ For instance, full or in-principle support was given by the Air Force Association (sub. DR267), DFWA’s WA branch (sub. DR279), Ray Kemp (sub. DR240), the SA Veterans’ Advisory Council (sub. DR266), the TPI Federation (sub. DR290), the Veterans of Australia Association (sub. DR232), the Vietnam Veterans Association of Australia (sub. DR271), and some RSL state branches (Queensland; sub. DR256; and Victoria, sub. DR273), among others.

Box 11.14 **The Board of Taxation**

Consisting of 11 members (eight from the non-government sector, plus the Secretary of the Treasury, the Commissioner of Taxation and the First Parliamentary Counsel), the Board of Taxation (BoT) is a non-statutory advisory body charged with 'contributing a business and broader community perspective to improving the design of taxation laws and their operation'. More specifically, the BoT provides advice on tax policy to the Treasurer, undertakes in-depth reviews when requested and offers real-time input on law design and administrative matters. The BoT is assisted in its functions by a voluntary advisory panel with over 60 members sourced from business, professional and community organisations, as well as a secretariat based within Treasury (BoT 2018).

The creation of the BoT was first recommended by the 1999 Review of Business Taxation (the Ralph Review) as a way to achieve 'a more open, consultative, accountable and systematic approach to business taxation' (Ralph, Allert and Joss 1999, p. 120). Formed the following year, the objective of the BoT is 'to achieve better legislative and implementation outcomes, ensuring they correctly reflect the Government's policy intent, are compatible with commercial realities and the circumstances of individuals, minimise complexities and associated compliance costs, and avoiding unintended consequences' (Treasury 2001, p. 61). A key to the BoT's effectiveness 'is in the background, experience and independence of our Board members, supported by the frank input of the business and tax community, the Treasury and the [Australian Taxation Office]' (Andrew, M., quoted in BoT 2017, p. vii).

The BoT 'does not have responsibility, but nor is it accountable, for taxation policy, which ... remains with the Treasurer and the Government'. Similarly, the BoT 'has no authority or powers to direct the Commissioner of Taxation on how to run the ATO' as the Commissioner is an independent statutory role (Treasury 2001, p. 60). The BoT cost around \$2.5 million in 2016-17, including remuneration for non-government members (BoT 2017).

Box 11.15 **The New Zealand Veterans' Advisory Board**

Under the *Veterans' Support Act 2014* (NZ), the Veterans' Advisory Board (NZVAB) operates in New Zealand 'to provide advice to the Minister on its own motion or on request, including advice on policies to be applied in respect of veterans' entitlement' (s. 247). Membership of the NZVAB is limited to seven members appointed by the Minister and 'who are representative of the veteran community', as well as one serving veteran nominated by the Chief of the New Zealand Defence Force (s. 248). Resources and administrative support for the NZVAB are provided by Veterans Affairs New Zealand (s. 251).

The genesis for the NZVAB was a 2010 Law Commission report on the previous veteran system, which envisaged the NZVAB as providing 'a mechanism through which veterans can have a direct voice to the Minister' (NZLC 2010, p. 121).

A 2018 review of New Zealand's new veteran support system found that the NZVAB lacked sufficient transparency in its advice to the Minister and a defined work program, making its operations 'ad hoc'. The breadth of experience among its members was also limited, as 'skills and experience in public service policy and in contributing to governance and advisory bodies would also be useful' (Paterson 2018b, pp. 91–92). The review concluded that the NZVAB should be merged with the Veterans' Health Advisory Panel into a single body.

Overall, a ministerial advisory council would still play an important role in a reformed consultation system. It could be established immediately, providing practical advice during the transition to the VSC and the implementation of several major reform initiatives. It should be adequately funded to undertake its roles and responsibilities effectively, although the Commission does not anticipate that its costs would be high.

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 systems.

Consolidating some commemoration activities within the AWM

DVA emphasised that commemoration activities are a 'relatively small but enormously significant part' of its broader functions and can contribute to 'validation of [veteran's] service and their mental health and wellbeing' (sub. 125, p. 12).

Among the organisations currently involved in providing commemoration activities in Australia (box 11.16), many aspects of DVA's commemoration functions overlap significantly with the Australian War Memorial's (AWM) functions, particularly the Office of Australian War Graves (OAWG). As Paul Evans noted, 'the OAWG has a fundamentally different role to that of commemorations', as 'its first duty is to protect the sites which it manages in Australia and overseas' (sub. DR218, p. 8). As a result, there is solid ground to transfer primary responsibility for the OAWG to the AWM.

A subsequent question is whether *all* of the commemoration activities currently undertaken by DVA should be assumed by the AWM. This would reduce the number of entities involved in commemorative functions, minimising duplicated administrative costs and the need for coordination. Shifting responsibility for commemoration to the AWM would also be a logical extension of the AWM's growing role in commemoration activities and ceremonies, as part of its mission to 'assist Australians to remember, interpret and understand the Australian experience of war and its enduring impact on Australian society' (AWM 2018a).

However, several participants raised concerns that administering the commemorative activities currently undertaken by DVA would be a significant change for the AWM, given its current activities are largely based in and around the War Memorial in Canberra. For example, the RAACC noted that 'DVA's remit is national and international, whereas the AWM is Canberra-centric' (sub. DR203, p. 88), while the TPI Federation stated that the AWM are only 'expert in the field of domestic commemorations' (sub. DR290, p. 27).

Box 11.16 Existing commemoration and war graves organisations

Department of Veterans' Affairs (DVA)

In 2017-18, DVA spent around \$92 million on commemorative and war graves activities (up from \$75 million in 2016-17), including staffing and other departmental expenses, and had around 87 staff working on these activities (down from 154 in 2016-17) (DVA 2017f, 2018g).

The largest expense for DVA is for the Office of Australian War Graves (OAWG) under the *War Graves Act 1980*, at approximately \$55 million in 2017-18. The role of the OAWG is to: maintain war cemeteries and individual war graves in the region (as agents of the Commonwealth War Graves Commission); officially commemorate eligible veterans upon their death; provide and maintain national memorials overseas.

The Australian War Memorial (AWM)

The AWM was initially founded after the First World War, although the AWM building in Canberra was only completed in 1941. The AWM was formally established as a corporation under the *Australian War Memorial Act 1980*, operating within the Veterans' Affairs portfolio as an independent statutory agency. The Australian Government contribution to the AWM's operating costs was \$53 million in 2017-18 (total expenses were \$69 million).

The purpose of the AWM is to maintain and develop the national memorial to Australians who have died as a result of active service. It also maintains and exhibits a national collection of historical material about Australia's conflicts, and conducts and arranges for research into Australian military history. The day-to-day administration of the AWM is managed by a Director, responsible to the AWM Council.

Commonwealth War Graves Commission (CWGC)

The then Imperial War Grave Commission was established by Royal Charter in 1917 with the purpose of acquiring, maintaining and documenting all military graves belonging to the forces of the British Empire as a result of the First (and then Second) World War. By 1918, nearly 600 000 graves had been identified and a further 560 000 casualties were registered as having no known grave. In 1964, its name was changed to the CWGC.

The CWGC is led by the United Kingdom and members include representatives from Australia, Canada, New Zealand, South Africa, India (since 1964) and Pakistan (since 1964). CWGC members from these countries are generally the High Commissioners to the UK.

Sources: AWM (2018a, 2018b); CWGC (2018b, 2018a); DVA (2016m, 2016b).

Expanding the AWM's remit to *all* commemorative activities would indeed be a significant change in its focus, both geographically (covering activities across Australia and at memorial sites around the world) and functionally (requiring the planning and execution of a wide-range of sensitive commemoration activities and ceremonies). While this change may present some transitional challenges, the AWM would be able to adapt, particularly if it absorbed the experienced staff and relevant systems that already exist in DVA.

The RAACC contended that the recent announcement of a \$498 million expansion and redevelopment of the AWM in Canberra (Morrison and Chester 2018a) would 'distract and

detract from maintaining the same level of high-quality expertise demonstrated by DVA' (sub. DR203, p. 89).

More importantly, there are some aspects of DVA's current commemoration functions that provide the Australian Government with a useful opportunity for 'soft diplomacy' liaison with other governments. In particular, international and domestic ceremonies, conducted alongside Australia's allies or former adversaries can complement other diplomatic efforts. As the South Australian Veteran's Advisory Council contended:

... the soft diplomacy opportunities offered by commemorating our war dead in overseas locations is not something that the Australian War Memorial could support. (SA Veteran's Advisory Council, trans., p. 23)

As such, it is appropriate that major commemoration activities and ceremonies (other than the ceremonies for individual veterans that are conducted by the OAWG) remain with a department of state, under the close control of the Government. A reformed DVA should thus keep this function, particularly as giving Defence primary responsibility for commemoration activities may not be considered appropriate by some veterans groups (due to its historical role in the activities being commemorated). Over the longer term, there could also be an increased role for the Department of Foreign Affairs and Trade in commemoration activities, as this would allow alignment with the broader diplomatic efforts of the Australian Government.

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.

12 Advocacy, wellbeing supports and policy input

Key points

- Veterans' organisations (ex-service organisations as well as other organisations that assist serving personnel and the families of veterans) play an important role in the veteran support system. They undertake a wide range of activities, including:
 - claims advocacy — assisting people to prepare and lodge claims
 - wellbeing support — providing financial and social support, as well as referring veterans and their families to services in the broader community
 - policy advice and influence — informing government about the practical experience of accessing the veteran support system, and recognising veterans' interests in government policy.
- Supports are mostly provided by volunteers, although some larger veterans' organisations employ paid advocates (with some grant funding provided by the Department of Veterans' Affairs (DVA)).
- DVA has an informal policy of not providing advice on eligibility for claims before they are lodged. Most other government departments and authorities provide advice to users about the services or supports they provide. DVA should assist veterans and their families to lodge primary claims. This will help meet its clients' expectations, particularly younger veterans.
- The MyService platform, and other improvements to the initial claims process, are likely to reduce the demand for advocates. However, advocates will continue to play an important role, particularly assisting claimants at the Veterans' Review Board. DVA should identify areas of unmet need and support advocacy services by providing funding in these areas.
- Legal assistance is not readily available for the several-hundred claimants whose cases reach the Administrative Appeals Tribunal (AAT) each year. Changes to costs rules at the AAT is likely to increase the number of lawyers offering conditional billing in the space. This should be complemented by a legal aid program for novel and complex cases and for those who are financially disadvantaged.
- The services provided by veterans' organisations are moving away from membership-based clubs to hubs that are accessible to the whole veteran community. DVA could take a more active role in targeting outcomes for these services.
- To better assess the policy priorities of the veteran community, DVA's consultation framework should be reconfigured to better encourage a more consolidated approach to the representation of veterans' interests and issues in policy considerations.

The veteran community in Australia has, over the past hundred years, established a number of charities and organisations for current and ex-serving personnel (box 12.1). These advocates

play an important role in the current veteran support system. Each year, thousands of people volunteer to help veterans and their families in all aspects of their post-service lives.

This chapter looks at the role of veterans' advocates and organisations in the veteran support system.

- Section 12.1 describes the main services provided by veterans' organisations.
- Section 12.2 looks in more detail at the issue of assistance for veterans and their families who are lodging claims (claims advocacy).
- The role of government and veterans' organisations in a changing landscape of wellbeing supports is considered in section 12.3.
- Section 12.4 looks at the approach the Department of Veterans' Affairs (DVA) takes to engaging with advocates for veterans' policy interests and proposes some changes.

12.1 Advocacy for veterans

Veterans' organisations

A number of organisations support veterans. Traditionally, the organisations providing support to veterans have been known as ex-service organisations (ESOs). However, some organisations now prefer to be known as 'veteran support organisations', as they do not focus exclusively on ex-service members (for example, Soldier On, sub. DR245, p. 2). And others (like Legacy, the War Widows' Guild and Partners of Veterans Australia) focus on assisting dependants and family members of veterans. The term 'veterans' organisations' is used throughout this report to refer to all these organisations.

While there is no comprehensive list of veterans' organisations, the Aspen Foundation (2015, pp. 24, 42) found that there were:

- about 520 charities that nominated veterans as the sole beneficiary
- about 3500 charities that nominated veterans and their families as a beneficiary
- ESOs and their branches in 2780 locations across Australia.

And despite the large number of self-identified veterans' organisations, there are a few large dominant organisations. The recent scoping study of veterans' advocacy and support services (the Cornall review) identified the Returned and Services League (RSL), Legacy, War Widows' Guild of Australia, Vietnam Veterans' Association of Australia and Vietnam Veterans' Federation of Australia as the most recognisable veterans' organisations (Australian Government 2018c, p. 29). DVA also noted that 'while there are a significant number of [veterans' organisations] ... those expending more than \$1 million per annum in support of veterans and/or their families are primarily only the RSL, Legacy, Mates4Mates, Soldier On, and RSL DefenceCare. ... only RSL and Legacy expend over \$6 million per annum' (sub. 125, p. 48).

What veterans' organisations do

The services provided by veterans' organisations are broad, but can be grouped into three main categories.

- Claims advocacy (sometimes called 'compensation advocacy' or 'pensions advocacy') involves assisting veterans and their families prepare and lodge claims to DVA, as well as arguing the veteran's case to DVA, the Veterans' Review Board (VRB) and the Administrative Appeals Tribunal (AAT).
- Wellbeing supports (sometimes called 'welfare advocacy' or 'wellbeing advocacy') covers assistance for veterans and their families with transition (including finding post-military employment), rehabilitation and social engagement.
- Policy input and influence includes informing government about the practical experience of accessing the veteran support system and recognising veterans' interests in government policy.

Beyond these roles, veterans' organisations undertake a wide range of activities to help veterans in their post-service lives. These include:

- providing a 'soft entry point' to support services available, where initial meetings at social gatherings provide opportunities for members to seek assistance with issues that come up later
- commemoration and recognition activities
- social events
- education and training as well as mentoring.

As RSL NSW said:

... our volunteers are sherpas for people navigating the system, they path find services, they bring together all — you know, as services become more specialised having someone who can bring it all together, it's informal case management in a way and welfare, that becomes a critical role the more complex the system becomes. (trans., p. 907)

Box 12.1 **A brief history of veterans' organisations**

Prior to World War I, veterans of Australian conflicts repatriating to Australia were supported by 'patriotic funds' funded by private charity (Lloyd and Rees 1994). After the war broke out, the Australian Government recognised the need for support beyond the voluntary activity (because of the enormity of the task) for the wounded and the families of those who had died:

... it soon became apparent that voluntary effort, vital as it was, would not be enough. The task was already enormous, and growing at an alarming rate, while the patriotic funds' financial reserves were running low. (Payton 2018, p. 7)

In these early days, the Red Cross was the administrator of the largest patriotic fund but was constrained in the assistance it could provide by its charter:

The Red Cross made an important contribution to rest homes and sanatoriums, and it supplied medical equipment for military hospitals and incapacitated veterans in Australia. It could not participate in ameliorative work such as payment of separation allowances, providing financial support for dependants and incapacitated soldiers, nor the rehabilitation and reestablishment of returned servicemen. (Lloyd and Rees 1994, p. 25)

In 1915, the Federal Parliamentary War Committee recommended that each state and territory take action to support the activities of the various patriotic funds. This was followed soon after in 1916 by the *Australian Soldiers' Repatriation Fund Act* which better coordinated the efforts of state governments and the patriotic funds.

The Returned Services Association (later to become the Returned and Services League, or RSL) was among the first public organisations to provide services for returned soldiers in this context. By 1919, it had close to 115 000 members and was lobbying for more effective action by the Australian Government. The RSL at the time argued that:

... those who had served overseas were now 'superior citizens' who deserved privileged treatment, and that their repatriation included an 'inalienable right' to pension, medical care and employment. (Payton 2018, p. 12)

Meanwhile, the Australian Government's Repatriation Commission and Department (described in more detail in chapter 11) were expected to 'fade away' once the World War I veterans had been successfully repatriated. However, 'an articulate and powerful veterans' lobby ... the most influential interest group in the nation' (Lloyd and Rees 1994, p. 243) successfully argued for their continued existence during the inter-war period, before lobbying the Government to shield veterans and widows from universal reductions of entitlements during the Depression.

Over time, there has been a pattern of new organisations emerging after each major war (while some older organisations withered). This process was particularly evident after the Vietnam War, where veterans of that conflict felt excluded from the establishment of ex-service organisations.

The RSL sought to apply common policies to all veterans regardless of war, and it maintained a certain detachment from ... exclusively Vietnam issues. This was resented by Vietnam veterans who detected a generation gap between themselves and other ex-service members. In particular, they argued that the RSL did not take sufficient account of the peculiar strains and complexities which distinguished Vietnam from earlier wars. ... The creation of the [Vietnam Veterans' Association of Australia] in the late 1970s was thus a reaction by a significant number of Vietnam veterans, albeit a minority, to what they perceived as official indifference and dislike. These veterans rejected the established ex-service movement, they were hostile to the government, and they were 'angrily dissatisfied' with the conduct of the DVA. (Lloyd and Rees 1994, p. 359)

According to the Department of Veterans' Affairs, the 'pattern of new and fading organisations ... is occurring again with the most recent wars in Iraq and Afghanistan' (sub. 125, p. 48).

A changing role for veterans' organisations?

The invaluable work of veterans' organisations over more than 100 years was acknowledged by many during this inquiry, as was the fact that each generation of veterans have had organisations to look after their cohort (box 12.1). But there was also a call for a new approach to advocacy and wellbeing support, particularly by younger contemporary veterans. Younger cohorts of veterans, for example, expect that they can access information and support directly from DVA, rather than having to go through the veterans' organisations. RSL NSW said:

Veterans increasingly expect a modern service they can confidently navigate independently as available in other sectors, both government and private sector. (sub. 151, p. 13)

Contemporary veterans also tend to join virtual veterans' organisations (such as a Facebook page). As Mates4Mates said:

... veterans are still relatively young upon transition. This cohort is much more technologically savvy than previous generations and as such, they seek much of their information online (particularly social media platforms) and expect quick access to services and quick response times. (sub. 84, p. 3)

To fit these changing demands, new types of support organisations have emerged in recent years, including Soldier On and Mates4Mates, that are more focused on mental health and wellness needs, rather than achieving compensation outcomes for veterans. As James Brown of RSL NSW said:

Only a small percentage of those returning from Afghanistan will need compensation from the government for their wounds or injuries. Most will return smiling and standing. What they need from ex-service organisations is a sense of pride and place in society, as well as somewhere to share their stories. (2014, p. 139)

The Cornall review also noted that the veterans' organisations are undergoing a period of change and stated that:

ESOs have assets, resources and income for the sole purpose of assisting veterans. It is important that they adapt to changing veteran needs and preferences so they can continue to do so. (Australian Government 2018c, p. 8)

What DVA funding is available for veterans' organisations?

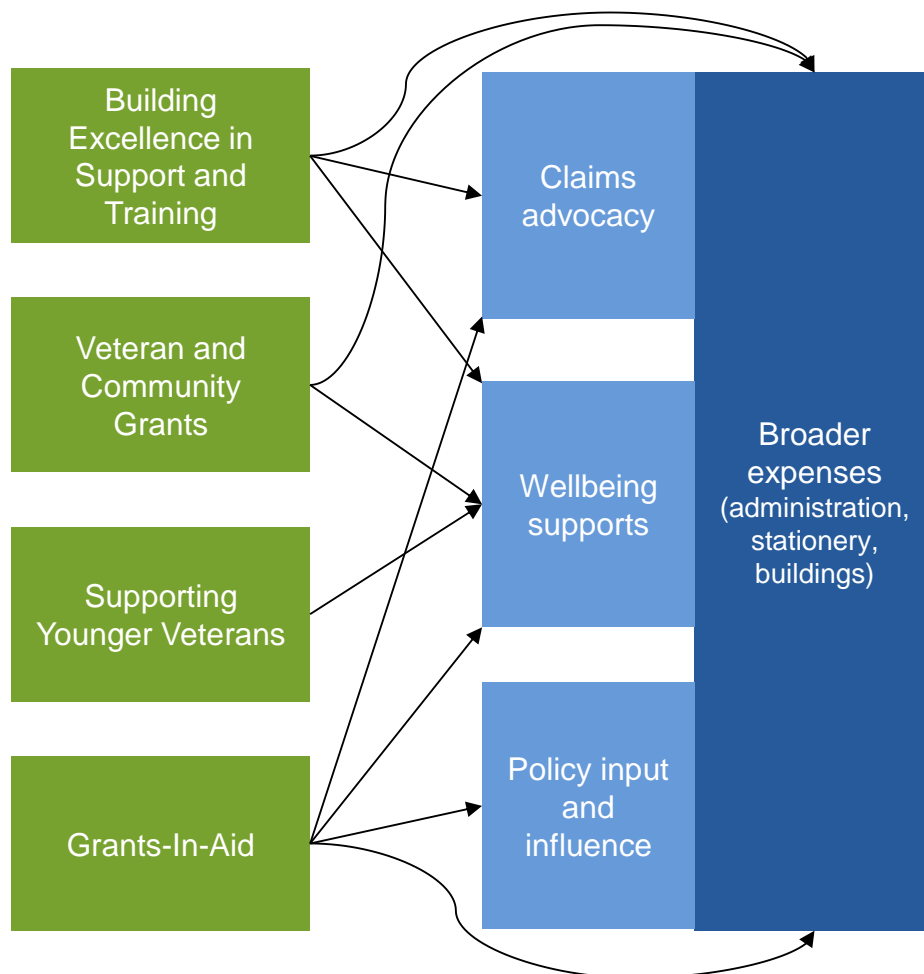
DVA provides grant funding to veterans' organisations through several programs:

- Building Excellence in Support and Training (BEST) — \$3.8 million was provided in 2018-19 to support veterans' organisations to provide compensation and welfare assistance to the veteran community (Community Grants Hub 2018a, p. 6).
- Veteran and Community Grants (V&CG) — \$2.17 million was provided in 2018-19 (up to \$50 000 per grant) to veterans' organisations to improve veteran health and wellbeing (Community Grants Hub 2018c, pp. 6–7).

- Supporting Younger Veterans (SYV) — \$1 million was provided in 2018-19 to veterans' organisations delivering new services that target younger veterans (DVA 2018aq).
- Grants-In-Aid (GIA) — \$145 000 was provided in 2018-19 to national ESOs for projects and activities that encourage cooperation and communication between veterans, veterans' organisations and the Government, as well as to support the provision of advocacy services to veterans (Community Grants Hub 2018b, pp. 6–7; DVA 2018q).

One issue with these grants is that they have mixed objectives (figure 12.1). For example, the BEST grants fund both claims advocacy and wellbeing supports (DVA 2015c), the V&CG funds support programs that benefit the wellbeing of veterans, while also funding buildings, equipment, vehicles and administrative costs associated with those programs (Community Grants Hub 2018c, pp. 8–9). The GIA supports claims advocacy, wellbeing supports and policy input (Community Grants Hub 2018b, p. 5).

Figure 12.1 Many grants, many goals
DVA grant funding streams for veterans' organisations



Sources: Community Grants Hub (2018b, p. 5, 2018c, pp. 8–9), DVA (2015c, 2017r, 2018aq).

This makes it difficult to assess whether the dollars invested improve outcomes for veterans and their families or whether they represent good value for taxpayers' money. A much clearer funding framework is warranted.

As the Commission said in the context of the human services sector:

Broad system-level objectives can provide little direction as to how specific services should be designed, funded and provided ... Specific objectives [for government programs] facilitate decisions within the program to target the service and also sets benchmarks for monitoring and evaluation. (PC 2017b, p. 84)

DVA should differentiate between the different advocacy supports and provide grant funding in a manner that aligns with these key supports provided by veterans' organisations. This will facilitate better monitoring and evaluation of funding provided to veterans' organisations for veterans' support.

The Australian Government, through DVA, may also want to maintain a more flexible funding tool that can support general innovative programs or worthwhile community initiatives by veterans' or other organisations. However, government should apply similar stewardship measures, including the setting of goals and the measurement of outcomes.

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.

12.2 Claims advocacy

Claims advocacy has been the core business of ex-service organisations for much of their history. Services provided include:

- information and general advice to claimants on the full range of entitlements
- assistance with claims lodgement (for example, ensuring that forms are correctly filled out and with all relevant information)

-
- arguing the claim on behalf of the veteran and liaising between DVA and the claimant to ensure that the claim progresses as quickly as possible
 - assistance with reviews, including filing and presenting legal or administrative challenges to DVA decisions at the VRB and AAT.

Services are mainly provided by part-time volunteers, though an increasing number of veterans' organisations are hiring paid claims advocates: RSL Queensland and its sub-branches employed 34 paid advocates (Australian Government 2018c, pp. 39–40); RSL Western Australia reported that 4 of its 5 advocates were paid (RSL Western Australia 2018, p. 1) while the 'core team' of RSL NSW advocates are also employed (sub. 151, p. 18). That said, outside the largest advocacy organisations, most of the services are provided 'in the main ... through volunteers' (DVA 2010, p. 9). The total number of claims advocates is unknown.

Should DVA provide more help for veterans to access support?

A key issue for future claims advocacy is the role DVA plays in providing support and advice to claimants seeking to access the veteran support system.

Unlike other service delivery agencies who offer advice about how to access their services, DVA does not generally offer advice about a person's circumstances outside of a formal determination (for example, on their eligibility for particular supports) (Australian Government 2018c, p. 51).

A reason put forward by DVA for its lack of assistance to claimants is that it may create a conflict of interest (though initiatives such as the On Base Advisory Service — chapter 7 — have started to shift this paradigm) (Liz Cosson, trans., p. 463). In this case, the purported 'conflict of interest' is between supporting the individual veteran to claim for supports, and wanting to maintain integrity in providing entitlements and avoiding overpayments. Another rationale outlined by the Cornall review was 'a concern about the risk of giving incorrect advice if a DVA officer assists a veteran to fill in a claim form' (Australian Government 2018, p. 51). Instead of providing advice directly, DVA relies on claims advocates to provide information about the system and help claimants. As the Rolfe Review noted:

Focussing on the role of 'Mates helping Mates' ... has always been an element of DVA/ESO relations and historically ex-servicemen and women have been encouraged to turn to ESOs for assistance rather than DVA. (Rolfe 2014, p. 5)

Despite this policy, it is still not always clear where to go for help. DVA acknowledged to this inquiry that the system, with advocates as the 'front door' to making a claim, can be difficult to navigate (Liz Cosson, trans., pp. 448, 463).

Other agencies do more to help their clients

Several participants emphasised that claims advocates are filling an assistance role that is more often met by government (for example, name withheld, sub. DR255, p. 14). Indeed, other government agencies are generally not only *willing* to give advice to claimants, but are also *expected* to explain their programs and systems.

When someone wants to know if they are eligible for a Centrelink payment, they can ask a customer service officer — they are not directed to an advocate. Similarly, the Australian Taxation Office (ATO) can provide binding advice over the phone (ATO nd).

In addition to providing assistance to claimants, if the Department of Human Services gives incorrect advice about payment eligibility, its legislation:

- requires that the government not recover debts that are attributable to administrative error (s. 1237A of the *Social Security Act 1991*)
- allows it to pay special benefits in circumstances where there is demonstrated financial hardship and unique circumstances, including when misleading advice has been given.¹

DVA is improving information availability ...

A first step for helping claimants is for DVA to provide better information in a more user-friendly system (as discussed in chapter 4, a future system should be easy to navigate).

Ideally, claimants should be shielded from the complexity of the current legislation through innovative and user-friendly design, such that a veteran or dependant can apply for support without the help of an advocate. MyService has gone part of the way towards achieving this (chapter 9).

Further improvements could also be made to DVA's website, for example, making it obvious where to go to make a claim. As RSL NSW observed:

Currently, information can be difficult to find, seemingly hidden in obscure corners of the site. ... An effective, modern online presence fits well with the overall Veteran Centric Reform programme. It should be supplemented with a direct-line help desk for professional advocates, claims advisors and support workers to have direct access to DVA delegates who can answer technical questions. (sub. 151, p. 13)

DVA has recently tested a new website and expects to launch it in 2019 (DVA nd).

¹ *Mansour v Department of Families, Housing, Community Services and Indigenous Affairs* [2009] AATA 433.

... but should do more to help claimants and claims advocates

DVA should also be providing advice to claimants. The Commission agrees with the Cornall review's recommendation that:

... the Department of Veterans' Affairs reverse its current approach of declining to help veterans lodge primary claims, encourage veterans to come to DVA for assistance, and widely publicise that service. The officers assisting them should receive training in veterans' entitlements, client service and dealing with vulnerable veterans. (Australian Government 2018c, p. 19)

Similarly, DVA should also provide advice to claims advocates (at both the primary claim and review stage). The Cornall review also recommended that DVA set up a direct help desk to respond to technical questions from veterans' advocates and others (Australian Government 2018c, p. 19).

That said, there are some individuals who will continue to need further assistance with claims than can be provided by DVA's immediate support team. DVA already has a program to assist clients with complex needs (chapter 9), but the assistance provided to these clients still involves a relatively low level of intervention in the actual claims process. The existing advocacy corps is currently best placed to provide independent assistance with claims where it is needed. Over time, there may be a need to develop specialist assistance targeted at more vulnerable clients, over and above general advice.

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.

Concerns about declining numbers of volunteer claims advocates

A number of participants raised concerns about the declining number of volunteer advocates. For example:

A particular concern is the falling numbers of advocates, pension and welfare officers and the corresponding reduction in support to veterans, their families and dependants ... ESO succession plans aren't being as fruitful as they have been in the past. Furthermore and very sadly some of the well intentioned replacements aren't coping with the complications and associated difficulties of the current system so they are not staying. (John Burrows, sub. 27, p. 1)

Younger volunteers just are not coming forward with a result that ESO's are struggling to maintain numbers of advocates. (Vietnam Veterans and Veterans Federation Australian Capital Territory and Belconnen RSL Sub Branch, sub. 42, p. 6)

The Cornall review also pointed out that nearly 85 per cent of advocates were born before 1965 (Australian Government 2018c, p. 37).

These concerns are not new — they have been raised by veterans' groups, as well as DVA over a long time — at least since 1998 when DVA raised it in an evaluation of advocate training (ANAO 2001, pp. 18, 60, 62; DVA 2010, p. 7; SFPARC 2003, p. 51).

Data to evaluate claims about declining volunteer numbers are hard to come by. There are anecdotal examples of ESOs having fewer volunteers. For example:

- two Canberra ESOs reported their advocacy ranks had 'dwindled in the space of five years from a high of 25 Advocates/Pension Officers to 13 currently' (Vietnam Veterans and Veterans Federation Australian Capital Territory and Belconnen RSL Sub Branch, sub. 42, p. 6)
- the Naval Association of Australia said that new accreditation and training requirements had resulted in 'something like a 90 per cent reduction' in advocates in that organisation (trans., p. 626).

However, the picture remains unclear because there is no register of all existing claims advocates, volunteers or paid (DVA does keep track of those who have recently completed training).

One explanation for falling numbers of volunteer claims advocates could be the changing careers of members of the Australian Defence Force. Historically, volunteer claims advocates were themselves pension recipients (Rolfe 2014, p. 14), however, contemporary veterans are more likely to discharge and transition to full-time work (something noted by RSL Queensland, in its submission to the Cornall review (Australian Government 2018c, p. 40)). As contemporary veterans retire, they may take up the torch of volunteer assistance that their predecessors have provided over time.

In addition, some veterans' organisations are moving away from solely relying on volunteers and are hiring paid claims advocates, an outcome assisted by the existing subsidies provided through the BEST grants program.

On the other hand, fewer claims are likely to be made under the *Veterans' Entitlements Act 1986* (VEA). In addition, initiatives such as MyService will mean claims under the legislation that covers most contemporary veterans are easier to make (chapter 9). Other things being equal, fewer VEA claims also means that fewer will reach review stage at the VRB and AAT, where claims advocates are typically in high demand.

Changes to the way veterans make primary claims, and fewer cases requiring review, could mean that advocacy services will continue to meet need in the medium term. However, if in the future there is evidence of unmet demand for claims advocates, DVA should target its funding towards this unmet need.

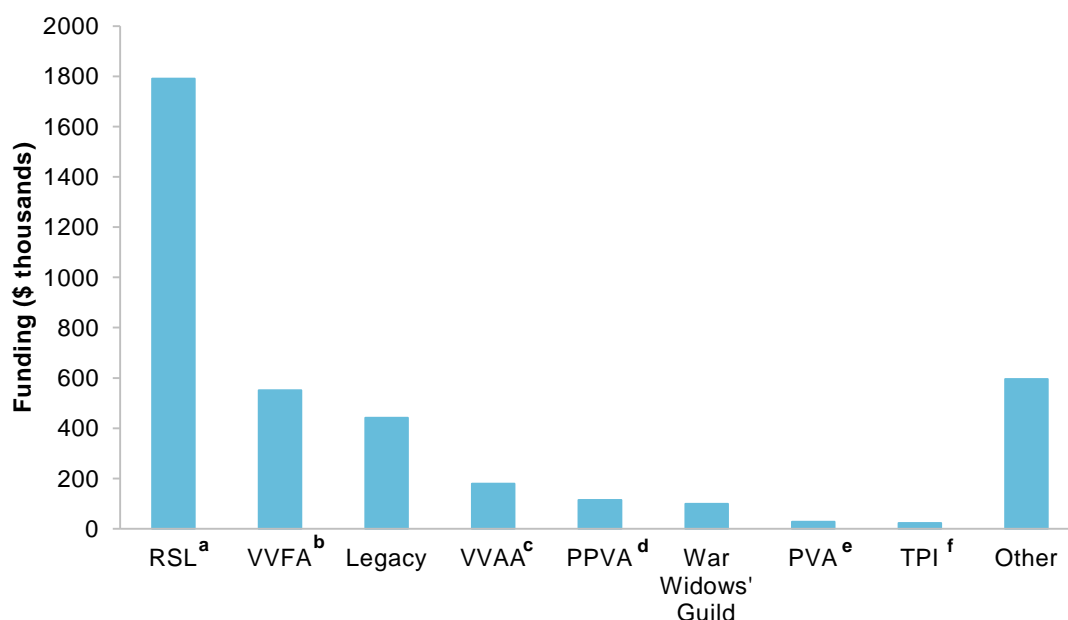
A better way to fund claims advocacy?

Organisations providing advocacy services can apply for grant funding through the BEST grants, which provide support for salaries and administrative costs such as computer equipment and travel costs (Community Grants Hub 2018a).

The current BEST funding model distributes the total pool of funding in proportion to the weighted amount of work undertaken by each organisation in the preceding year (DVA 2015c). Weightings are applied based on the type of work done. For example, a primary claim has a weight of between 1 and 3 and a VRB appeal is worth 15.

This funding approach uses the demand for services in the preceding year as a proxy for the underlying need for compensation advocacy services. This approach is problematic in some circumstances. For example, where demand is growing or falling, grant funding will under- or over-fund actual expenses. Smaller advocacy organisations are unable to expand their operations if they cannot meet demand, while well-resourced advocacy organisations continue to attract more work and expand. And this explains why the vast majority of BEST funding goes to established, existing veterans' organisations. In 2018-19, nearly half of all BEST funding — just less than \$1.8 million — went to RSL sub-branches (figure 12.2).

Figure 12.2 **BEST funding is mostly provided to large national organisations**
BEST funding, 2018-19



^a Returned and Services League. ^b Vietnam Veterans' Federation of Australia. ^c Vietnam Veterans' Association of Australia. ^d Peacekeepers and Peacemakers Veterans Association. ^e Partners of Veterans' Association. ^f Totally and Permanently Impaired Veterans' Federation.

Source: Commission analysis of Australian Government (2019b).

By focusing on measures of workload, some raised concerns that the BEST funding model provides additional funding to advocates for cases that are not resolved early. As one advocate put it, ‘BEST funding rewards failure ... if you take a matter to the AAT you get more points than if it goes to the VRB or if it settled as a primary matter’ (Mark Raison, trans., p. 1108).

But this fails to account for the additional cost, particularly time, involved in taking a case to the AAT or the VRB, compared to a primary claim. This is an empirical matter, and the Commission did not have access to data to examine this issue.

BEST funding guidelines also restrict grant allocations in a prescriptive manner — 60 per cent of the BEST funding money is provided for advocates’ salaries, with the remainder to cover administrative costs (DVA 2015c). In tandem with the historically focused funding model, this means that only the largest veterans’ organisations are able to fund salaried claims advocates.

Ultimately, there is no way to determine whether present or future community need for claims advocacy services is being supported by the current available paid or volunteer advocates. As the Cornall review pointed out ‘... there is no way of knowing how many hours or days a week, or a fortnight or a month individual volunteer advocates set aside to assist veterans’ (Australian Government 2018c, p. 40).

The current BEST funding model will not encourage a greater proportion of paid advocacy services. If it is determined that there is increased need for paid claims advocates, then a new funding model will be needed.

Different models of paid advocacy are used in other sectors and countries and some of these have been proposed to be transferred into the Australian veterans’ context (box 12.2):

- The Australian National Audit Office (2001, p. 15) recommended that DVA ‘consider the costs and benefits of supplementing their work with an advocacy service of choice funded on a fee-for-service basis’.
- The Senate inquiry into suicide by veterans recommended that, in light of the decreasing numbers of advocates, a Bureau of Veterans’ Advocates be established, and staffed with legally trained public servants to assist and advocate for veterans in making legal claims, to support the current system of volunteer advocates (SFADTRC 2017, p. 152). Some participants in this inquiry also suggested that DVA provide professional advocates directly (see, for example, Daniel Tellam, trans., p. 293; David Coffey, trans., p. 309).
- The Cornall review suggested that DVA move towards a ‘modern professional sustainable advocacy service’ in consultation with veterans’ organisations (Australian Government 2018c, p. 103). It suggested the development of a Veterans’ National Advocacy Coordination service that could (among other things) accredit individual advocates and ‘deliver a consolidated, coordinated approach to the national delivery of veterans’ advocacy and support services’ (Australian Government 2018c, p. 103).

- RSL NSW (sub. 151, p. 29) proposed that DVA should formally fund half of the cost of paid professionals to provide advocacy services, with advocacy organisations providing the remaining half. Under this proposal, the case management services provided by an advocate would be uncapped, and funded based on the workload of each advocate.

Box 12.2 Claims advocacy models in Australia, the UK and Canada

National Disability Advocacy Program and NDIS Appeals

The National Disability Advocacy Program (NDAP) aims to provide people with disability with access to effective disability advocacy that promotes, protects, and ensures their full and equal enjoyment of all human rights, enabling community participation.

The Department of Social Services provides grants to a range of organisations across Australia to provide advocacy services. These grants are connected to terms in a grant agreement, as well as other legislative and regulatory requirements. Advocacy organisations are certified within 18 months of the initial grant and then every three years after for re-certification. However, individual advocates are not subject to formal training requirements.

Support for appeals of decisions under the National Disability Insurance Scheme (NDIS) at the Administrative Appeals Tribunal are funded by NDIS Appeals, using support persons from the NDAP. Generally, an NDAP advocate (rather than a lawyer) will be used unless there is a question of law, or the matter is novel or complex. In this case, the matter is referred to the local legal aid commission. The commission reviews the matter and can approve funding for legal support services (which is provided by the NDAP, separate to other Commonwealth legal aid funding).

Veterans UK and Legion War Pensions Representatives

Charities assist with appeals against compensation decisions under the Veterans UK armed forces payment systems. The largest is the Royal British Legion, whose War Pensions Representatives are paid employees. They undergo formal internal training and a mentoring program. These representatives confine themselves to the first tier of review — if appeals reach the second tier of review, pro bono legal assistance may be arranged on a case-by-case basis. Public data are not available on the number of cases where the Legion assists.

Canada's Bureau of Pensions Advocates

Established in 1971, the Bureau of Pensions Advocates (BPA) is a Canada-wide organisation of appeals advocates within Veterans Affairs Canada.

The Bureau's main function is to provide free advice, assistance or representation for individuals dissatisfied with decisions rendered by Veterans Affairs Canada in relation to their claims for entitlement to disability benefits or any subsequent assessment. The BPA does this by assisting clients in the preparation of applications for review or for appeals and to arrange for them to be represented by an advocate at hearings before Canada's Veterans Review and Appeal Board.

All BPA advocates are lawyers and members of their respective law societies, with client dealings subject to a solicitor-client privilege relationship. The Cornall review reported that BPA had about 31 lawyers spread across 14 offices, handling about 10 000 cases per year and representing clients in over 95 per cent of cases presented before the Board.

Sources: Australian Government (2018c, pp. 72, 76–80), VAC (2017a).

The potential retirement of existing volunteer advocates provides an opportunity for DVA to enter the space gradually, filling the areas where it identifies the largest gap between demand and availability of advocacy services. As a starting point, DVA collects data on the locations where claims are being made through an advocate and where VRB reviews are being sought. Using the data on advocate location from the Advocacy Training and Development Program (ATDP), it could identify disparities and potentially tender for organisations in those regions to provide claims advocacy services. The National Disability Advocacy Program takes a similar approach, where grants programs have at times focused on assistance in particular coverage areas (DSS 2018c, pp. 6–7).

Importantly, this approach would not be prescriptive about the mix of paid and volunteer advocates providing services. Most important is the number and quality of the advocacy services — whichever organisations can provide those services on a value-for-money basis could obtain funding to provide them with volunteers, paid staff, or a mix of both. Government also has a crucial role to play as stewards of funded claims advocacy services — in particular, monitoring them for quality and effectiveness (PC 2017b, pp. 80–81).

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.

The quality of claims advocacy services varies

The Commission heard that volunteering to help other veterans provides a sense of meaning and purpose for many advocates. For example, John Burrows said:

My last fourteen years as a volunteer veteran pension officer has been a very interesting and immensely satisfying period of my life. Although the commitment and challenges have been exhausting and almost overwhelming at times, the satisfaction of providing assistance, advice and obtaining support for veterans, their families and dependants has provided me with a considerable amount of contentment and happiness. (sub. 27, p. 1)

Volunteering Australia also commented that:

Volunteers are engaged in supporting ex-service officers in a variety of ways, and can play a critical role in their rehabilitation. Advocates play a crucial role in the compensation process, offering advice on what supports and services are available to veterans, and assisting with lodging claims and appeals. (sub. 142, p. 3)

The complexity of the system, however, demands considerable knowledge and some advocates acknowledged that they are not always well placed to provide the advice that

veterans require. The Alliance of Defence Service Organisations (ADSO) noted that ‘legislative complexity is difficult for advocates ... [there is a] persistent aversion of some to undertaking ... training’ in the more recent pieces of veterans’ legislation, namely the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA) (sub. 85, p. 27).

Others also suggested that advocates can be out of their depth:

I’m over three Acts and I’ve got 5 claims under different Acts. I’ve used advocates in the past. The advocates are very well-meaning, very passionate, but because of the complexity the three Acts, I have found, to my detriment, that the advocates were out of their depth. So I was advised to get a lawyer. (Diane Lawrie, trans., p. 351)

Concerns have been raised for several years about the variability of quality of service provided to veterans. The earliest report to consider inadequate representation by advocates was in 1983; concerns continued with this issue through the 1990s and 2000s (SFPARC 2003, p. 47). In the past decade, three specialist reviews by DVA considered the quality and training of advocates (Australian Government 2018c; DVA 2010; Rolfe 2014). The Senate inquiry into suicide by veterans also considered issues relating to advocacy quality in some detail (SFADTRC 2017, pp. 139–143, 152–153).

There has also been a historical focus of practice by advocates on the VEA, leading many veterans to pursue claims under that Act to their detriment:

Their training is almost wholly directed to VEA with some MRCA but no SRCA [*Safety, Rehabilitation and Compensation Act 1986*] ... The lack of any knowledge on SRCA explains their failure to take veterans down that path. Their lack of knowledge on MRCA in part explains the lack of robustness in pursuing MRCA claims, including on appeal. (Allan Anforth, cited in SFADTRC 2017, p. 143)

In some cases, this misguided advocacy leads to overpayments that must be returned to government — putting veterans or their families in financial hardship (Australian Government 2018c, p. 42).

This preference by advocates for VEA claims could also mean that advocates are not examining claims in a holistic manner that considers all possible entitlements. As Maurice Blackburn Lawyers put it:

... we were recently approached by a veteran who had received advice from an Ex-Service Organisation (ESO). The veteran had specifically asked the ESO for assistance in obtaining lump sum compensation for permanent impairment and non-economic loss. Instead, the ESO lodged a claim for a pension. On receiving this pension, the veteran’s ability to access any lump sum compensation (as was the veteran’s preference) was rendered impractical due to offsetting provisions in the legislation. (sub. 82, p. 13)

Beyond questions surrounding the ability of advocates to represent the interests of claimants, concerns were also raised about advocates being expected to be proficient in wellbeing support:

Volunteers in the veterans' sector regularly deal with severely mentally ill clients and often struggle to set and maintain essential professional boundaries to safeguard against causing further harm. Many are DVA clients themselves and have little or no support in their roles. RSL NSW is aware of first responders from small ex-service and other non-government organisations unknowingly enabling and encouraging damaging behaviour, spending days with vulnerable clients without considering the risk or impact on their own health and families, providing emergency housing in their own homes and exhausting their own financial resources, and even starting physical relationships or engaging in violent exchanges with veterans in crisis. The inescapable reality is that volunteers on the ground will always deal with incredibly difficult situations which put both veterans, themselves, and potentially their families at risk. But right now, well-meaning amateurs are all too often worsening the situation vulnerable veterans find themselves in. (RSL NSW, sub. 151, p. 20)

While the volunteer Advocates perform a useful first contact service, where matters become complex their usefulness decreases exponentially. Advocates are generally just not equipped to manage complex or unusual claims alone, nor should they be expected to do so. (Michael Stark, sub. DR159, p. 1)

Training and accreditation of advocates

Advocates are currently accredited under the ATDP. According to the Cornall review, 417 advocates have trained under the program (Australian Government 2018c, p. 39):

- 40 at Level 1 (accredited to prepare a primary claim under supervision)
- 322 at Level 2 (accredited to prepare a primary claim without supervision)
- 48 at Level 3 (accredited to represent a veteran before the VRB)
- 7 at Level 4 (accredited to represent a veteran before the AAT).

Each competency level involves supervised and unsupervised components in and out of the classroom and it is expected that, between coursework and on-the-job mentoring, each competency level will take no more than 12 months to complete (DVA 2018z). There are also continuous professional learning requirements necessary for an individual to maintain accreditation (Australian Government 2018c, p. 82).

The ATDP, with its four levels of competencies, came about following two reviews that identified issues with the previous Training and Information Program (TIP):

- the 2010 *Review of DVA-Funded ESO Advocacy and Welfare Services*, which recommended 'the movement towards the adoption of a level of certification under a Competency Based Training framework' (DVA 2010, p. 6)
- the 2014 *Review of Veterans Advocacy Training* by Brigadier Bill Rolfe, which identified concerns about the previous training program from both DVA (that the quality of primary

claims applications prepared by advocates was low) and by advocates (a lack of ongoing feedback opportunities and formal ‘on the job’ training).

However, formalising the training and accreditation for advocates continues to be a topic of some controversy for existing advocates. For example, John Burrows said ‘the requirement to ‘requalify’ has left some feeling like they know nothing and they need to retrain’ (sub. 27, p. 5) while the Royal Australian Armoured Corps Association described the lack of credit available for prior TIP accreditation as ‘demeaning’ (sub DR203, p. 69).

Although the ATDP incorporates opportunities for the recognition of prior learning, the primary concern seems to be that historical training under the TIP has not been sufficient to maintain accreditation under the ATDP. While the ATDP sets out training programs for advocates in each forum, the VRB and AAT do not require a particular level of accreditation or training. However, current ATDP training is necessary for advocates to be covered for professional indemnity insurance into the future (DVA currently funds professional indemnity insurance at a cost of about \$12 000 per year) (DVA, pers. comm., 9 May 2019).

Formalising expectations of advocates is important in a period of transition

The expectations of advocates have evolved as the veteran support system has changed. The MRCA covers all new injuries and has a focus on rehabilitation; the complexities of that legislation (and its interaction with the other Acts and superannuation compensation) require a sophisticated response by claims advocates, as does the increasing focus on the mental health and wellbeing of today’s claimants.

Volunteers can make a valuable contribution to the quality of public services (by bringing skills or perspectives that are not readily available in the bureaucracy); however, resourcing is necessary to effectively supervise and maintain the quality of volunteer services (Brudney 1993, pp. 285–286). DVA (in its support for claims advocacy through funding BEST and ATDP) has a responsibility to ensure that advocates help their clients rather than hinder them. The establishment of a competency-based training program with continuous professional learning requirements is important in this regard.

Ideally, there should not be a difference between the training and accreditation expectations placed on volunteers and paid advocates, with the aim that veterans who seek advocacy services receive quality and relevant advice. Accordingly, DVA (and in future, the Veteran Services Commission (VSC)), and the VRB should ensure that, going forward, all advocates who act on behalf of an individual in the claims process are appropriately trained and accredited through the ATDP.

It is understandable that the formerly-accredited TIP advocates feel a sense of loss, or that their contribution is not valued if they are unable to engage with DVA or the VRB due to this proposed requirement. However, an expectation of continuous professional development is necessary to maintain the quality of the advocacy services provided by veterans.

ADSO (sub. DR309, pp. 11–12) proposed a new role for TIP-trained advocates as ‘advocacy support officers’, where they would be an initial point of contact, and provide general information and support to claimants. The Commission has not specified a formal role for these advocates, but expects that formerly-accredited advocates will continue to play an important role supporting veterans through veterans’ organisations. The distinction must be that while experienced volunteers who are not accredited can provide useful support, information and assistance, DVA would only recognise and deal with accredited advocates (or legal representatives) as representatives of claimants.

DVA and the VRB should encourage the maintenance and development of the ATDP as the training program for advocates. Although the Commission is not in a position to make a detailed assessment of the program, DVA should continue to monitor and adjust the program based on stakeholder feedback, including considering the relevant recommendations (6.1 and 6.2) of the Cornall review:

That the ATDP give consideration to the course structure and duration that will be most suitable for future applicants.

That the ATDP develop intensive, short accreditation courses at each level in both compensation and wellbeing advocacy in conjunction with ESOs capable of providing the practical experience component. (Australian Government 2018c, p. 85)

In particular, because of the significant time commitment of the current ATDP programs, a more flexible or intensive option for the program should be considered. Any changes to the ATDP’s delivery should also continue to meet the accreditation for vocational training generally (a concern raised by ADSO, sub. DR309, p. 3).

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.

The ATDP can be administered ‘at arms’ length’ by DVA

The Cornall review pointed out that the ATDP has an ‘ill-defined’ legal status. It has:

- a Strategic Governance Board (with members representing ESOs, Defence and DVA), which sets the overall strategic direction of the program
- a Capability Framework Management Group, also with representation from ESOs, Defence and DVA, which ‘drives the definition, development, education and assessment of practitioners’

-
- three Regional Implementation Groups, which cover different parts of the country, focusing on the day-to-day delivery of training (ATDP 2017, p. 3; Australian Government 2018c, p. 82).

An external training organisation undertakes competence assessment and national accreditation (ATDP 2017, p. 3), while the Veterans' Indemnity and Training Association (which is an incorporated association in the ACT) provides professional indemnity insurance and accident cover for advocates (VITA nd, p. 1).

Part of the reasoning behind the development of the ATDP's disjointed structure is about ensuring that it is institutionally separate from DVA, to avoid DVA providing training that advances their interests (rather than the interests of their clients).

Under the new governance arrangements proposed by the Commission (chapter 11), there would be no need for this separation. The body that determines claims in the veteran support system (the VSC) would be institutionally separate from the department that determines policy (DVA). DVA could administer an advocacy training program that adequately explains how to advance an applicant's case, without creating a conflict of interest. The program could continue to have input in its development from Defence and ESOs. DVA could also take on all responsibilities in the training and accreditation of advocates (at the moment, the various responsibilities are split between unincorporated and incorporated bodies).

If the proposed VSC is not established, then it would be desirable to keep the ATDP at arms' length from DVA. In this case, the Cornall review recommendation that the ATDP 'be incorporated as ... a company limited by guarantee' (Australian Government 2018c, p. 85) could be adopted to ensure its independence.

Veterans, advocates and lawyers on appeal

Concerns were also raised about the expectations placed on advocates at the VRB and AAT. Some suggested that lawyers, rather than advocates, were better equipped to take on appeals at the VRB. At the AAT, concerns about veteran representation in an adversarial environment against DVA lawyers have led to calls for greater access to legal aid.

Interaction with lawyers and legal aid in the review path

Lawyers are not permitted to appear with individuals making applications in formal hearings of the VRB (though they may appear at alternative dispute resolution (ADR) conferences and other processes). Claims advocates provide the primary support available to veterans navigating the review.

Traditionally, legal aid services have played a role in supporting disadvantaged claimants through merits review processes. However, the role of legal aid services and community legal centres differs between states (box 12.3).

Box 12.3 The role of legal aid services

Legal Aid New South Wales runs a Veterans Advocacy Service, providing advice to clients claiming under the veteran support system. They also represent veterans in applications for merits review to the Veterans' Review Board (VRB) and Administrative Appeals Tribunal (AAT). Representation is provided by an advocate for cases in the VRB, or a lawyer in the AAT. Funding is also provided for disbursements (such as expert medical reports). In this way, its advice services mirror the advocacy services provided by ex-service organisations (Legal Aid New South Wales, sub. 109).

Legal aid services in other states only provide assistance for veterans seeking review at the AAT from a decision of the VRB, funded by the Attorney-General's Department under the National Partnership Agreement on Legal Assistance Services. This service is not means-tested (COAG 2017, pp. B-2, B-3).

It should be noted that Legal Aid New South Wales is, overall, funded at a higher rate than its interstate counterparts. In 2017-18, its operating revenue was about \$320 million. For comparison, Victoria Legal Aid had an operating revenue of about two-thirds that of Legal Aid New South Wales — even though the overall population of Victoria is only 20 per cent smaller than New South Wales (ABS 2018b; Legal Aid NSW 2018, p. 8; Victoria Legal Aid 2018, p. 93).

The VRB is a tribunal without the full formality of other legal proceedings and this is the historical justification for lawyers being excluded from its proceedings. However, several stakeholders raised that this placed further pressure on veterans navigating a complex system. Although veterans entitlements are widely recognised as a relatively complex area of law, the first and primary actors in the review process are volunteers without a legal background. But there are benefits and costs to these types of tribunals permitting legal representation (box 12.4).

Applicants generally do not represent themselves — 80 per cent of applicants in 2017-18 at the VRB were represented by an advocate (VRB 2018a, p. 37). However, there remains concern about the extent to which advocacy services are able to provide effective assistance to veterans during the claim and review processes.

Box 12.4 **The benefits and costs of legal representation**

There are benefits and costs of allowing legal representation in tribunals. Representation can assist parties who:

- cannot adequately promote their own interests
- are facing an opponent who is a lawyer
- are dealing with complex legal issues.

However, high rates of legal representation can create unintended consequences, such as increased formality and complexity of proceedings. Legal representation is also usually only available to those who can afford it, creating inequity between users of the tribunal. As a result, permitting legal representation may only increase the level of unnecessary legalism in tribunals that are intended to make the involvement of lawyers unnecessary.

Legal costs can also substantially reduce the potential gains from litigation. Where both parties are equally capable of handling the dispute themselves, both parties may be better off if they both elect to self-represent. But where one party chooses to engage a lawyer, it creates an incentive for the other party to do the same.

Source: PC (2014, pp. 368–373).

Non-lawyer advocates should be maintained in the VRB

After a claim is rejected, a claimant can seek review internally at DVA, then at the VRB. If a claim reaches these stages, that could be indicative of its complexity. It may also indicate that necessary information to succeed in the claim was not obtained at the primary claim stage (chapter 10, SFPARC 2003, p. 34). The Commission is recommending (chapter 10) that DVA improve the exchange of information between DVA, the VRB and clients at the primary claims stage, with the aim of reducing the number of reviews. And although these recommendations are aimed at minimising the number of cases that reach the VRB, there is still the issue of ensuring appropriate support to veterans with cases that do reach a higher tier of review.

VRB members can be lawyers or judges (in VRB hearings, at least one of the three members is a lawyer), and some participants indicated that they felt they were at a disadvantage having an advocate without formal legal training representing them.

Veterans should be allowed lawyer representation at the VRB. The Senior Member is one so why not. (Rodney Parnell, sub. 48, p. 1)

I could have an advocate there but not a lawyer, whereas the VRB Board were loaded up with lawyers, so it's a bit intimidating. (Kerry Lampard, trans., p. 55)

... the majority of the members of the VRB are all lawyers. ... there's just no question it is a legal process. ... I'm not saying veterans who appear before the VRB have to be accompanied by legal representation, but why do we deny them the right? (Max Ball, trans., p. 231)

One option is to remove the prohibition on lawyers at the VRB. This change was suggested by some participants, including Legal Aid New South Wales (sub. 109, p. 15), Maurice Blackburn Lawyers (sub. 82, p. 18), Slater + Gordon Lawyers (sub. 68, p. 47) and others.

Compared with the AAT or a court hearing, the VRB is better characterised as an inquisitorial tribunal: the board member carries the responsibility of investigating the circumstances of the case, and can request more information from the applicant or DVA if required to reach a correct decision. In this environment, the applicant should not be ‘fighting’ DVA, and a board member can adjust the complexity of proceedings to suit the needs of the applicant.

Lawyers are already able to participate in the VRB’s ADR processes and the Commission does not see any reason to change this. The Commission’s recommendation to make the VRB an ADR-only forum (recommendation 10.3) effectively removes the prohibition on lawyers.

However, some participants suggested that, because claimants tended to stay with one advocate through the process, there was not much additional value in using a lawyer solely for ADR and the increased availability of ADR has not led to a marked rise in legal representation at the VRB.

Making legal representation the norm at the VRB (rather than advocate representation) could mean the process becomes more adversarial, potentially undoing the progress made through the introduction of ADR processes. Veterans’ organisations said that this could make the process more complicated while others raised concerns about costs:

The opportunity to engage legal representation is provided at the AAT stage of an appeal, for those veterans and families who desire it. AAT cases require significantly more preparation by advocates, and the possibility of facing a lawyer at the VRB would unnecessarily add this workload to all VRB cases, significantly compromising efficiency ... The right to legal representation, even if allowed only under special conditions decided on a case-by-case basis by the principal member, would risk complicating an effective process for little practical benefit. (sub. 151, p. 15)

Legal representation is not the way forward. Paid advocates through ESOs have worked with the client and built trust and rapport to be able to run the case. Legal representation comes at a cost ... (Legacy Club of Brisbane, cited in Australian Government 2018c, p. 59)

The Cornall review also identified benefits to maintaining advocates, rather than lawyers, as the primary representatives of clients in the VRB, including that there are no representatives opposing the veteran, and costs for the veteran are minimised on appeal (Australian Government 2018c, p. 58). And as Cornall pointed out, drawing on the skills of non-lawyer advocates mirrors the approach used in other areas of social policy:

In Australia, the National Disability Insurance Scheme and the Department of Health contract agencies to provide advocacy assistance to their clients at a multi-dollar, government funded annual cost. The situation is the same in the United Kingdom and Canada where Veterans UK

and Veterans Affairs Canada provide a considerable amount of assistance to veterans lodging primary claims. (2019, p. 52)

The Commission's *Access to Justice* report also said that 'legal representation should not be the norm in tribunals' (PC 2014, p. 371).

The Commission agrees with the Cornall review that 'on balance, the arguments against removing the prohibition on lawyers or legally qualified persons representing veterans at VRB hearings outweigh the arguments in support' (Australian Government 2018c, p. 59)

Legal assistance should be targeted to those in need

A number of participants also raised concerns about the relative formality and legality of AAT hearings, observing that they can be a difficult part of the review process. The Secretary of DVA said 'I don't want things going to the AAT. The more I can reduce from the AAT the better, because that's where we're seeing a lot of grief and a lot of costs in that space' (Liz Cosson, trans. p. 471). Others described the AAT as an intimidating place.

... the Administrative Appeals Tribunal. Now that is a scary place. That is a place where the stress is going to increase, and the expense for veterans. In the VRB it's cheap, there is no adversarial approach. (Robert Black, trans. p. 11).

The last place you want to go to is AAT. It's about law then. (Bill Kaine, trans., p. 878)

To resolve as many cases as early as possible, the Commission is recommending expanding the use of alternative dispute resolution at the VRB (chapter 10). Together with the improvements to primary claims decisions outlined above, it is expected that fewer cases will reach the AAT (in the medium to long term).

Issues were also raised about DVA's legal representation at the AAT. Most of DVA's legal matters are dealt with by external lawyers: in 2017-18, it briefed 72 barristers at a total cost of \$487 000. Its total external legal costs were \$9.4 million (DVA 2018g, p. 100). In this environment, it is understandable that veterans want legal assistance.²

There are seven advocates accredited under the ATDP to appear at the AAT (Australian Government 2018c, p. 39). And while a number of TIP-accredited AAT advocates remain, the Commission heard that they are reluctant to appear at the AAT: one veteran whose claim had been through four different advocates said 'the RSL doesn't take claims past the VRB, they don't go even to the AAT as a general rule' (Terence Fogarty, trans., p. 1197). In the absence of any incentive to train in this field, it is not likely that the volunteer AAT advocacy corps will grow.

² The Cornall review recommended that DVA reduce its expenditure on external legal costs (Australian Government 2018c, p. 69). The Commission does not have a particular view on how DVA chooses to engage the legal services necessary to respond to AAT and Federal Court cases.

Almost half of the veterans appearing at the AAT had a lawyer. A further quarter appeared with an advocate and another quarter represented themselves (Australian Government 2018c, p. 10). As more and more cases are resolved at the primary claims level, the level of complexity of cases at the AAT is not likely to decrease, suggesting that the AAT will remain a jurisdiction where legal representation is most appropriate.

The Cornall review argued that the ‘unevenness of legal representation’ (Australian Government 2018c, p. 10) — namely, DVA’s use of barristers and external solicitors in AAT cases — results in a perception that the AAT process is weighted against the veteran and that ‘the lack of legal representation for veterans at the Administrative Appeals Tribunal is a major barrier to veterans accessing their entitlements’ (Australian Government 2018c, p. 67). The Cornall review identified three reasons for this.

- Private lawyers that are available charge excessive rates or use contingency fee arrangements that will ‘take a significant part or percentage of any lump sum payment awarded to the veteran’.
- Costs awards at the AAT do not usually cover the cost of these lawyers.
- Legal aid is not available consistently across states (with Legal Aid New South Wales having the most comprehensive service and other jurisdictions providing support only on an ad hoc basis, in competition with other demands on Commonwealth legal aid) (Australian Government 2018c, pp. 66–67).

The Cornall review proposed that the Australian Government establish a Veterans’ National Legal Service and fund state and territory legal aid commissions to represent, or engage private lawyers to represent, veterans seeking further review of their claim. This would mean a free-of-charge legal service to assist veterans appealing to the AAT. The proposed legal assistance would be subject to a merit test (the legal aid commission would need to determine that the appeal was likely to succeed before offering to assist the veteran) but not a means test.

The problem with this approach is that it does not target assistance to those in greatest need. The Commission’s *Access to Justice* report identified three key justifications for government funding of legal services:

- a positive spillover from preventing or reducing the escalation of legal problems (reducing future costs in the justice and social services systems)
- overcoming market failures such as lack of information and ‘thin markets’ for legal services
- ensuring that access to the justice system is equitable and fair — that is, available for all no matter their means or circumstances (PC 2014, p. 666).

The proposed legal service focuses on AAT and Federal Court cases (Australian Government 2018c, p. 67) — by definition, cases that have already escalated to a hearing. This suggests that the purpose of the proposed service is not to prevent the escalation of veterans’ legal claims.

Further, there is a relatively low number of AAT claims, and no evidence was presented to this inquiry (or by the Cornall review) that lack of knowledge about available legal services was imposing a barrier to access to justice at the AAT for claimants.

As such, the proposed service would primarily be provided as an equity measure. However, a universal legal aid service does not tackle these problems in a targeted manner. The high cost of lawyers in general, does not, logically, imply that the entire costs of legal assistance should be covered. Every other grant of Commonwealth legal aid is ‘targeted at those who do not have sufficient financial means to obtain legal representation before a court’ (PC 2014, p. 672). Veterans’ entitlements cases are specifically exempted from the means test under the current *National Partnership Agreement on Legal Services* (COAG 2017, p. B-3) (and existed in previous Commonwealth legal aid funding arrangements).

Even though veterans are already exempt from the means test, legal aid for veterans is rarely made available through most legal aid commissions.³ The reason appears to be that legal aid commissions are already making do with less. As the Commission noted in 2014, the Australian Government’s contribution to legal aid funding has failed to keep pace with demands for services. The Commission observed evidence in 2014 that:

- resourcing for civil legal aid was already at an inadequate level
- Australia had low levels of funding for legal assistance compared to nations with similar legal systems
- service cutbacks had already resulted from cuts and slow funding growth for many vulnerable groups, including individuals involved in social security, family law, family violence, and consumer credit disputes (PC 2014, pp. 734–736).

The Commission recommended an additional \$200 million in total funding be provided for civil matters (primarily employment, housing, rights and consumer matters), 60 per cent of which was to be funded by the Australian Government (PC 2014, pp. 738–739). The Australian Government did not follow the Commission’s recommendation (Brennan and Murphy 2018).

The Commission also commented in the context of tight funding:

Priority must be given to ensuring that the most disadvantaged Australians have access to legal assistance — this is not happening as well as it should at present. The Commission considers that the [legal aid commissions]’ financial eligibility test is probably too tight. (PC 2014, pp. 720–721)

The primary measure of the need for fully-funded legal assistance should be access to finance.⁴ Already, under the current arrangements, many disadvantaged members of the

³ Excluding New South Wales which has the largest veterans’ entitlements practice of any of the legal aid commissions (box 12.3).

⁴ Though other types of disadvantage are considered in grants for legal assistance – for instance, Aboriginal and Torres Strait Islander clients, people from culturally and linguistically diverse backgrounds, people living with a disability, international students, victims of domestic violence, and homeless persons (PC 2014, p. 716).

community are ineligible for legal aid — as the Commission said, ‘means tests are too mean’ (PC 2014, p. 716).

In this context, a fully-funded and untargeted legal service exclusively for veterans ignores a strong area of community need, instead providing funding in an area where no clear need or disadvantage has been demonstrated (and, in fact, an area where the financial capacity of the claimant is explicitly ignored as a criteria of measuring need). As the Commission said:

Decisions about how to spend limited legal assistance dollars, and who should receive them, should be based on a comparison of benefits relative to costs. That way, resources are deployed where legal needs are greatest and legal problems have the most significant consequences. (PC 2014, p. 704)

The Senate inquiry into review of veterans’ compensation claims also concluded that ‘the issue of legal aid for veterans needs to be considered in the wider context of budgetary costs and government policy on legal aid’ and noted that many other areas of high need remain where legal aid is less easily available than it is for veterans (SFPARC 2003, pp. 55–56).

Finally, Maurice Blackburn Lawyers raised concerns about the level of requisite knowledge required to be an effective representative in the veterans’ space:

I don’t think it would be possible for — just to expand the scope of any Legal Aid practitioner to be just assisting a veteran in the process, because, as we know, it requires that deep dive into the scheme and the veteran’s circumstances, because it’s a very niche expert area of law. (trans., p. 1218)

What is targeted legal assistance?

Better-targeted approaches should be considered to directly respond to the primary issues for veterans at the AAT. These are:

- a perception of adversarialism, imbalance and use of highly-resourced lawyers
- the financial cost of access to justice for veterans disputing claims at the AAT
- the incomplete nature of costs orders at the AAT.

On the first point, the Cornall review suggests that the imbalance between DVA and veterans in the AAT would best be corrected by DVA employing more in-house lawyers and fewer private lawyers. However, there is no evidence or means to measure whether DVA lawyers were any more or less ‘adversarial’ in their approach. Instead, the arguments made to justify this change are primarily focused on other benefits (such as cost and the transfer of expertise from the legal team to DVA).

The question of financial cost is more complex. Given that fully-funded legal aid should be for financially disadvantaged claimants, the reality remains that some people will be expected to pay for legal services. Cost issues can be resolved in the following manner:

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- Veterans may be sufficiently disadvantaged that they have no prospect of affording legal fees, even after receiving a lump sum or other payment.
 - Veterans may be unable to fund the cost of legal representation until after their compensation from DVA has been granted, even if they are not sufficiently disadvantaged to warrant a legal aid grant. This is primarily an issue of *access to credit* — fees can be afforded but appropriate credit in the interim to fund the appeal is not available.

For claimants in the first category, appropriate grants of legal aid should be made (recognising the relative need in the entire community for improved access to civil legal aid). The NDIS Appeals program currently has a method to grant legal aid to ‘novel and complex’ cases, also taking into account overall financial considerations. The Department of Social Services set out criteria for legal aid commissions to determine whether a particular case is novel or complex — in particular, whether the issue has already been addressed by the AAT or a court, and whether the case would clarify uncertainties and improve the administration of the NDIS (DSS 2018b, pp. 3–4).

DVA should consider implementing a similar funding mechanism to ensure that this area of legitimate need is not lost among other civil legal aid priorities. This would be separate from the broader legal aid funding mechanism, but like the NDIS Appeals program, could allow DVA to make an assessment about the level of need of each individual applicant. Funding decisions should also consider the importance of the case to setting general principles that help initial claims decisions to be made with certainty in the future.

For claimants who are not disadvantaged, the legal sector already has a response to the lack of access to credit for individual litigants: conditional billing.

Conditional billing arrangements involve a lawyer’s service fee depending on whether the legal action results in a successful outcome. A ‘no win no fee’ agreement is a type of conditional fee where no fees are charged for the lawyer’s services unless the outcome is successful. The lawyer will often charge an ‘uplift fee’ — a percentage in addition to their regular rate (usually based on hours worked) to compensate for the risk of not being paid at all if the legal action is unsuccessful. The client generally remains responsible for paying disbursements (such as fees for court filing, barristers and experts) (PC 2014, pp. 603–604).

Conditional billing is most commonly used in matters involving monetary claims, such as personal injury and workers’ compensation. Like these areas of law, veterans’ entitlement claims (at least under the MRCA and DRCA) are likely to involve a lump-sum award. A balancing act between full legal aid funding, and encouraging conditional fee agreements, has already taken place in other parts of the world, with the United Kingdom introducing substantial reforms to both, with the aim of extending access to civil justice while targeting fully-funded public support to those who need it most (BBC News 1998). As White put it:

... there are unsuccessful applicants for legal aid, who, if they could retain a lawyer privately, would win their cases. Here is a group who might benefit if they could engage a lawyer on a contingency basis. (1978, p. 295)

Why is there little conditional billing?

There is a lack of clear evidence about why there conditional billing is not readily available for veterans' matters at the AAT. Costs awards in the AAT are awarded only for MRCA and DRCA cases; where they are made, they are capped at a maximum 75 per cent of the Federal Court's Scale of Costs (AAT 2015, p. 2).

Most lawyers in the field charge more than this scale, meaning that claimants who retain a private lawyer are left substantially out of pocket. Maurice Blackburn said:

In some cases, [the costs award] can be as low as 50% of the total costs. As such, the Applicant may be required to pay the balance as solicitor-client costs from their compensation amount, or alternatively, from their pocket if the compensation doesn't result in a lump sum. ... This paucity in cost recovery has resulted in a shortage of firms offering military compensation legal services, or many veterans choosing not to obtain legal representation, or in some cases, not pursue their appeal ... (sub. 82, pp. 19–21)

Slater + Gordon Lawyers recommended that the AAT become a full costs jurisdiction (sub. 68, p. 47), and Greg Isolani observed that the military compensation jurisdiction is 'a hard jurisdiction to run tactically on behalf of a client on a contingency' due to low costs awards (trans., p. 1041).

Given that Federal Court costs scales are already below the market rate for veterans' lawyers, providing 75 per cent of these rates does not help in an environment where the aim is to reduce the costs to the claimant. Changes to cost recovery could encourage more private firms to act in the space, providing better access to justice for veterans. This has the added advantage of placing the risks of an unsuccessful case on private law firms, rather than the legal aid commissions (who face a range of other competing civil law demands).

Full costs orders (that is, both 'party-party' costs reflecting the costs incurred under the Scale of Costs, and additional costs reflecting the additional charges by particular solicitors) are rare in most Australian jurisdictions. They are usually only made when a party behaves poorly in litigation (for example, by refusing to settle for a lower amount sought by a plaintiff, then later receiving a judgment for a greater amount). Any changes to the AAT Costs Rules should reflect this standard approach to costs; it should also recognise the beneficial intent of veterans' legislation.

The Commission recommends that the AAT Costs Rules be amended to comply with the following principles:

- The presumption should be that a veteran whose review application in the AAT succeeds receives costs from DVA at the rate of 100 per cent of the Federal Court Scale of Costs, to reduce the out-of-pocket payment for the claimant and improve incentives for firms to offer conditional billing.
- If DVA has behaved inappropriately in denying an entitlement, or has refused reasonable settlement offers, indemnity costs (that is, all costs incurred by the client for the solicitor) should be considered.

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- As is currently the case, no provision should be made for costs orders against a veteran.

Further, there is no power for the AAT to award costs for claims under the VEA. Because VEA claims do not generally involve lump sums, there is no means for a claimant to be able to immediately pay a lawyer who has been engaged on a conditional billing basis. Costs orders in line with MRCA and DRCA would help to alleviate this issue.

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 delay 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.

Choosing the right level of claims advocacy

Claimants should be able to seek the appropriate level of assistance at different parts of the claim process.

- For primary claims, assistance should mostly be provided in the future by the VSC (either through direct help, or through changing systems to make them more accessible to claimants).
- Advocates would be the primary form of assistance available with veterans at the VRB.
- For AAT appeals, DVA would pay a substantial part of the costs through more permissive AAT costs rules.

Any claimant who wants independent assistance in preparing a claim should continue to be able to receive that assistance from advocates — but it should be as a supplement to direct help from the administrators of the veteran support system.

In brief, the Commission is proposing a model where the role of advocates is primarily left to the area where they provide the greatest value-add — at the VRB — although veterans could still access advocacy services at earlier or later parts of the appeal process.

Responses to the Cornall review

The Commission has considered the Cornall review's recommendations along with the views of participants in this inquiry. Box 12.5 summarises the Commission's responses to the Cornall review's recommendations on advocacy issues.

Box 12.5 Responses to the Cornall review

In December 2018, the Australian Government completed the *Veterans' Advocacy and Support Services Scoping Study*, led by Robert Cornall. Below are the recommendations of the report on advocacy issues and the Commission's response to them.

- **Recommendations 1.1, 1.2, 1.3 and 1.4** (more active assistance with primary claims): Supported. The Commission supports a more active approach to primary claims management from the Department of Veterans' Affairs (DVA), including an outreach process before negative decisions (recommendation 10.2), primary claims advice for veterans and advocates (recommendation 12.2) and active case management by the Veteran Services Commission (section 9.4, section 11.6).
- **Recommendation 2** (retention of prohibition on lawyers at the Veterans' Review Board (VRB)): Supported in principle. The Commission's transition of the VRB to a review and resolution role (recommendation 10.3) would remove board hearings. Legal representatives are already permitted at alternative dispute resolution procedures with the VRB but early evidence suggests that they are not ordinarily used. Claims advocates would remain as the main assistance for claimants at the VRB, maintaining a non-legalistic environment.
- **Recommendations 3 and 4** (increased use of internal legal services at DVA): No view. DVA is entitled to defend claims, may need to defend some claims vigorously, and may procure external legal services as other government agencies do.
- **Recommendation 5** (free Veterans' National Legal Service and Helpline): Not supported. Given the competing priorities for legal aid budgets presently, a universal legal aid service for veterans is not supported. A combination of means-tested legal aid and encouraging conditional billing through better costs awards is preferred (recommendation 12.5).
- **Recommendations 6.1, 6.2, 6.3 and 6.4** (delivery of Advocacy Training and Development Program (ATDP)): Supported in principle. Although the Commission has not undertaken a detailed review of the ATDP, DVA (or an incorporated ATDP) should be responsive to stakeholder feedback about the program (recommendation 12.4), including providing more adaptive delivery options and a greater focus on wellbeing.
- **Recommendation 6.5** (incorporation of Veterans' Advocates Board): Supported in part. Under the proposed governance structure (recommendation 11.1), DVA could administer advocacy accreditation separately from the Veteran Services Commission (VSC). If a VSC is not established, then a separate body may be incorporated to administer the ATDP.
- **Recommendation 10** (establishing a consolidated approach to advocacy): Supported in part. The Commission expects that demand for claims advocacy services will decline over time as more primary claims are automated and as a more proactive approach to resolving claims is adopted. For this reason, the Commission does not seek to establish a new body to coordinate advocacy. However, the Commission does see a role for DVA to strategically procure advocacy services where there is unmet need (recommendation 12.3).

Source: Australian Government (2018c, pp. 19–21).

12.3 Moving towards strategic funding for wellness supports

The focus on claims advocacy by veterans' organisations has had consequences for the government's approach to funding broader wellbeing supports. The Cornall review described claims advocacy as the 'tip of the iceberg' and wellbeing support as 'the hidden mass' (Australian Government 2018c, p. 42).

The broad gamut of services that fall under the banner of wellbeing supports include:

- visits to home, hospital and aged care facilities
- domestic chores
- support during times of grief or other personal difficulty (including addiction, financial difficulties and domestic dysfunction)
- referrals to broader support services available in the community
- administrative support to veterans' organisations
- housing for homeless veterans
- camping facilities for veterans
- 'community shed' style operations where veterans can work on meaningful projects such as furniture assembly (Australian Government 2018c, pp. 23, 44–45).

However, as James Gilchrist from the Woden Valley RSL explained, wellbeing services provided by veterans' organisations often result from advice on an initial claim:

Once people get their claims and appeals done, we then have to help them through, those who are most needy, we help them through the process of acquiring [wellbeing] services ... And the more people need services, we are finding the more they need assistance to negotiate those sorts of issues. ... The welfare side of things, has grown from what ... sub-branches have normally done, which are hospital visits and mates helping mates. What we now do is help people through that system ... (trans., pp. 585)

DVA funding for wellbeing supports

DVA does not directly fund wellbeing services provided by veterans' organisations as they largely fall outside its statutory responsibilities and budget authority (Australian Government 2018c, p. 103) but rather provides indirect support to veterans' organisations that provide these services. It does this through two programs: the V&CG grants

(\$2.17 million in 2017-18), and the SYV grants (\$1 million in 2017-18) (Community Grants Hub 2018c, pp. 6–7; DVA 2018aq).⁵

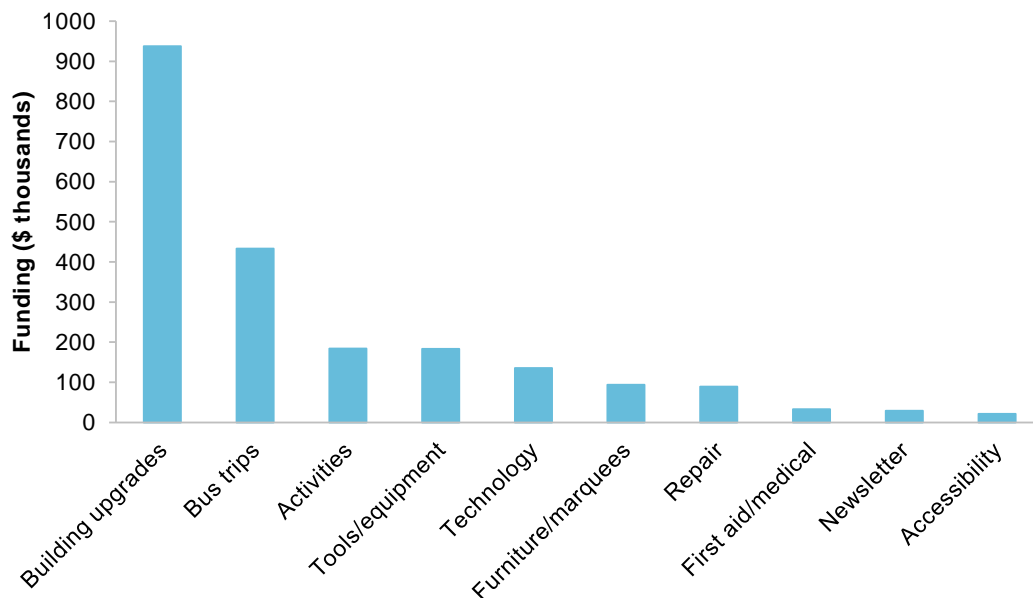
The stated aim of the V&CG program is to fund ‘activities and services which improve the health and wellbeing of members of the veteran community’ (DVA 2018au). However, in practice, the grants offered through this program are not required to be directly connected to services, or to any evidence-based improvement in the health and wellbeing of veterans. Most grants would be better described as discretionary in nature, and are for upgrades of facilities, ‘one-off’ events or activities providing social events for veterans. The 122 V&CG grants issued in 2017-18 included:

- 45 for ‘a series of bus trips to reduce social isolation’
- 31 for building upgrades (and a further three were to make buildings more accessible)
- 16 activities (or grants for equipment to support activities) other than bus trips.

In dollar terms, 44 per cent of funding was for one-off upgrades to facilities, and 18 per cent was for activities or tools or equipment for those activities (excluding bus trips) (figure 12.3).

Figure 12.3 Most funding from the Veteran and Community Grants does not support direct service provision to veterans

Dollar value of grants under the Veteran and Community Grants program by category, 2017-18



Source: Australian Government (2019b).

⁵ Some State and Territory veterans agencies also offer grants funding, largely for restoring and maintain memorial and monument sites. For example, Victoria offers a number of grant programs for ex-service organisations, like the Anzac Day Proceeds fund (Scrutiny of Acts and Regulations Committee 2002; Victorian Government 2019a).

And while these grants may benefit veterans and their families, DVA has no way of assessing the effectiveness of the funding.

The SYV grants program, on the other hand, is more targeted at services. The grant guidelines explicitly set out that grants are to be used to ‘deliver projects and activities’ with the following goals:

- develop the capability to service the unique needs of younger veterans
- support the development of tailored services for younger veterans
- fund organisations that deliver services to younger veterans now and into the future
- increase collaboration among organisations to expand services and harness existing expertise
- increase awareness of younger veteran issues and services, where doing so would benefit younger veterans (DVA 2017r, 2018aq)

The types of grants provided under the SYV program included various activities such as ‘[providing] young disengaged veterans on-the-job training, mentoring and support via a program to restore old “muscle cars”’, a ‘pilot employment program’, a ‘writing program’ and ‘personal coaching and support to unemployed and disengaged veterans’ (Australian Government 2019b). Some grants also supported research on the cohort of younger veterans or facilities that would be used to support veterans.

The Commission sees value in transitioning to more service and outcomes focused funding that meets identified areas of need in the veteran community.

The shift towards a service delivery stewardship role for DVA

In other sectors, governments play an important role in the stewardship of markets for human services — that is, determining ‘what human services should be made available and [assessing] the effectiveness of those services’ (PC 2017b, p. 8). Governments achieve this through effective policy design, regulation, oversight of service delivery, monitoring of provider performance, and system improvement.

The Commission’s *Human Services* study identified three areas where government could improve its stewardship:

- greater coordination (between governments and service providers to overcome gaps and duplication)
- more transparency (providing information to improve accountability and facilitate performance assessment)
- smoother transitions (particularly as new models for funding services replace older ones, aiming to minimise negative effects on service users) (PC 2017b, p. 8).

A future approach to funding veterans' organisations that focuses on useful and innovative services would better allow DVA to properly oversight those activities and assess their effectiveness on:

- quality (of services to users)
- equity (who is affected and how)
- efficiency (encouraging providers to reduce costs while maintaining quality, and allowing users to select services that best meet their needs)
- responsiveness (to the needs of users)
- accountability (of service providers to those who fund the services and use them) (PC 2017b, p. 4).

Towards veterans' hubs

Except for the RSL and Legacy, very few veterans' organisations have a comprehensive national footprint. Most veterans' organisations, such as WithYouWithMe and Soldier On, focus on a much smaller subset of veterans, or on single issues. Some participants claimed that the lack of coordination amongst veterans' organisations could be diluting their effectiveness.

Highly federated structures, robustly protected autonomy at the state and (especially) local levels, and poor information flow between the various organisational levels are issues that many ESOs have yet to resolve. (ADSO, sub. 85, p. 35)

There have been many calls for self-regulation and coordination of activities (including by the then Minister of Veterans' Affairs in 2017) to overcome 'rivalry between organisations ... duplication of effort, misalignment in strategic priorities and ... poor management and service delivery' (DVA, sub. 125, p. 69).

One possible solution is a 'hub' model, where a number of services for veterans by different organisations are made available at a single location or through a single 'front door'. There are also 'virtual hubs', which bring together information on a large number of services and issues relevant to veterans and their families (Australian Government 2018c, p. 33). There are a number of hubs, which generally use existing supports provided by veterans' organisations or clubs associated with them as a foundation (box 12.6).

Box 12.6 Veterans' hubs in Australia

Veterans Centre, Sydney Northern Beaches

The Veterans Centre, Sydney Northern Beaches' was established in 2011 in response to 'disorganised and inefficient' access to support services for veterans and their families in the region. It currently operates from the Dee Why RSL club, but is an independent entity, as an incorporated association with board members appointed from the multiple veterans' organisations providing services through it.

The Veterans Centre provided 2200 hours of social work assistance during rehabilitation and transition for veterans, and referred clients to other services (including primary health networks and medical practitioners). Claims advocacy is also provided, with 255 claims submitted in 2017-18. The Veterans Centre has combined the services of 'traditional' veteran advocates with paid employees, social workers and mental health professionals. Services are mainly provided by volunteers and paid staff from member organisations. Efforts are made to reach out to current and discharging military personnel at Holsworthy Barracks and other military establishments in Sydney, particularly on informing them of transition assistance available from the Department of Veterans' Affairs and veterans' organisations.

The Centre has an operating budget of \$600 000 per year. It is also provided about \$30 000 annually for its claims advocacy services through the Building Excellence in Support and Training grant program.

The Oasis, Townsville

The Oasis is a proposed veterans' centre in Townsville and is designed to bring together services provided by multiple ex-service and other organisations. The driving principle is to provide a single entry point for the services offered by geographically disparate organisations for transitioning members of the Australian Defence Force. The Queensland Government has funding to establish a centre in Oonoonba in Townsville's suburbs. In the meantime, operating out of a donated office in Townsville, the centre is finding project opportunities for veteran volunteer teams (including providing repairs for drought-affected farmers and responding to other disasters).

Hume Veterans' Information Centre

Established in 1998, the Hume Veterans' Information Centre operates in partnership with the RSL and Vietnam Veterans' Association. Services include claims advocacy as well as various wellbeing services such as home help, meals, funeral planning and assistance in times of bereavement. Since it was opened, it has served more than 6000 clients, mainly with claims advocacy. Information on its expenses, revenue and structure are not published.

Sources: Australian Government (2019b); Hume Veterans' Information Centre (nd); Joint Standing Committee on Foreign Affairs, Defence and Trade (2018, pp. 39–41); The Oasis Townsville (2018); Veterans Centre, Sydney Northern Beaches (2018, p. 5).

DVA currently does not systematically fund service hubs, but governments have contributed funding on a discretionary basis for their establishment. The Queensland Government has provided \$2.6 million in funding so far towards the establishment of the Oasis in Townsville, while the Victorian Government has allocated \$200 000 for the development of a business case for a joined-up Veterans' Services Hub (Queensland Government 2018b, p. 114; Victorian Government 2019c). The 2019 federal election also featured proposals to provide

about \$30 million for the establishment or expansion of veterans' hubs in multiple Australian cities (ALP 2019, p. 8; Liberal Party of Australia 2019).

Veterans' organisations appear to be responding to the preferences of veterans for a single coordinated range of services. Although the Commission generally supports coordinated entry points for wellbeing supports, these models are still in their early phases. Governments should ensure that funding is attached to outcome evaluations (in line with the framework outlined above and in chapter 18). Government funding for any hubs should also ensure that appropriate training and information is made available to staff or volunteers that interact with veterans in a service delivery role.

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.

12.4 Improved coordination on policy issues with veterans

Consulting with the 'end users' of government services is an essential part of developing high quality policy. As the Office of Best Practice Regulation put it:

A genuine consultation process ensures that you have considered the real-world impact of your policy options. This is likely to lead to better outcomes and greater acceptance in the community, particularly among any stakeholders who may be adversely affected by the policy. ... Consultation plays an important role in ensuring that every practical and viable policy alternative has been considered. Stakeholders and those closest to a problem can sometimes suggest useful ways to solve it. (2016, p. 1)

The OECD also points to many good reasons for policymakers to consult with stakeholders:

Open and inclusive policy making as promoted by the OECD is a culture of governance that builds upon the idea of opening up policy-making processes to stakeholders beyond the public administration to better design policies by broadening the evidence base.

- It recognises that the public administration does not hold the monopoly of expertise but that other stakeholders ... have valuable information and ought to express their needs and expertise.
- It emphasises the responsiveness of policies and services in actively involving those that will be affected by the policy; it is user-centred.
- It relies on an inclusive approach where all relevant actors are involved and attention is paid to marginalised, disadvantaged or less powerful groups.

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- It can be conducted in different degrees and different modalities, ranging from providing information to consulting and to active engagement in the design, implementation and evaluation stage of a policy. (2016, p. 3)

This inquiry benefited from input from veterans' organisations, members of the veteran community, providers of support services, academics and other government agencies.

DVA has a consultative framework ...

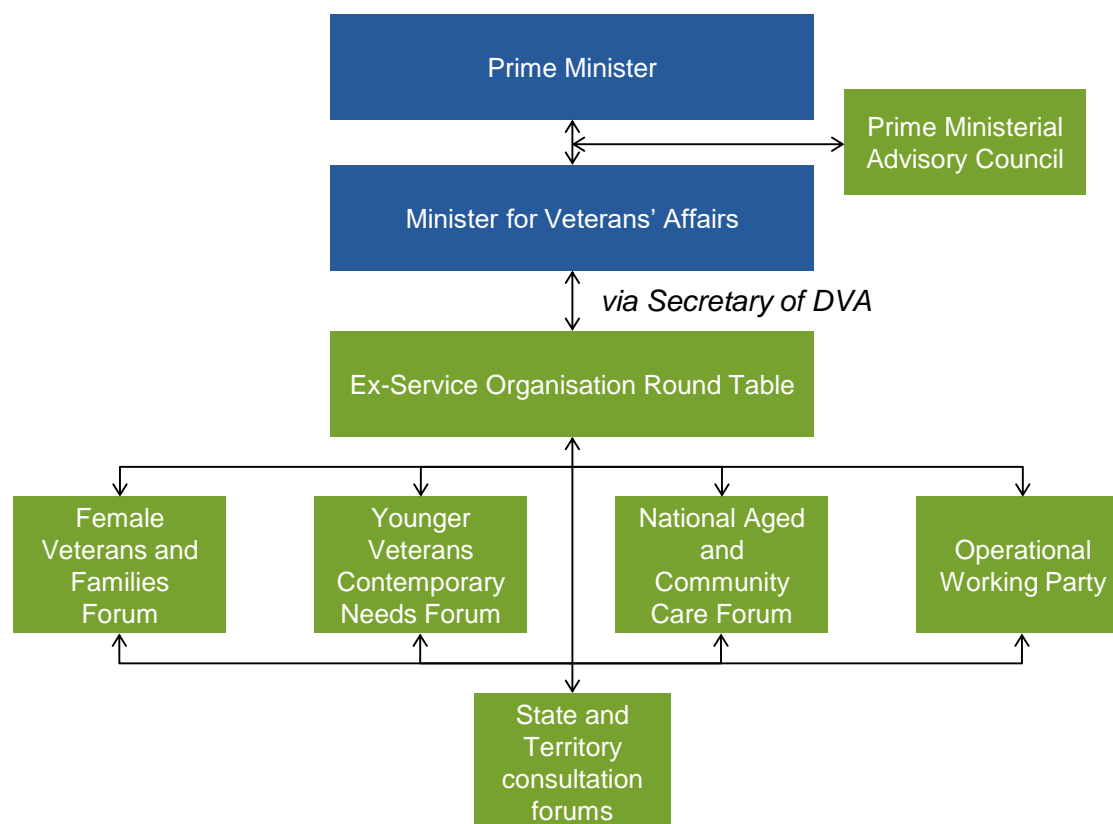
DVA and the Government regularly consult with veterans' organisations during the policy development process to better understand the unique context of military service and the lived experience of veterans and their families. In particular, the Government (including DVA, the Minister for Veterans' Affairs and the Prime Minister) facilitates communication with the veteran community through the National Consultative Framework (NCF, figure 12.4).

The primary consultation body operated by DVA in the NCF is the Ex-Service Organisation Round Table (ESORT), which is consulted for changes to veterans' legislation, as well as issues of strategic importance to the veteran community in the medium to long term, including in the context of ageing members, declining membership and multiplying ESOs (DVA 2018n). Fifteen national veterans' organisations are represented on ESORT, along with the Secretary of DVA and other members of the Repatriation Commission and Military Rehabilitation and Compensation Commission, who can then raise issues of concern with the Minister of Veterans' Affairs.

There are also a number of sub-forums that report to ESORT.

- Younger Veterans — Contemporary Needs Forum — designed to increase engagement and information sharing between DVA and younger veterans outside of existing ESOs. This forum deals with emerging issues in the areas of mental and social health including how they vary by veteran cohort and location, as well as to recommend improvements in DVA's operational policy to promote quality and accountability in service delivery (DVA 2018aw).
- Operational Working Party — a forum for ESOs to discuss concerns about DVA's delivery of services and identify and provide recommendations for improvements in operational policy (DVA 2018ar).
- Female Veterans and Families Forum — to provide an annual platform for female veterans and veterans' families to raise issues directly with the Government and DVA (DVA 2017h).
- National Aged and Community Care Forum — a forum for ESOs, aged care providers and the DVA to discuss current and future health, aged and community care policy and mental and social health policy, including how DVA can better support people at home via community support (DVA 2018ad).
- Each State and Territory has a consultation forum, where veterans' organisations can report issues with DVA services to the local Deputy Commissioner.

Figure 12.4 DVA National Consultation Framework



Source: DVA (2016i).

Separate to ESORT and its sub-forums, the Prime Ministerial Advisory Council (established in 2014) advises the Prime Minister and Minister for Veterans' Affairs on 'matters relating to the mental health of veterans and their families' (Prime Ministerial Advisory Council on Veterans' Mental Health 2018b). The council has 12 members, including veterans, veteran family members, and DVA.

The NCF was last reviewed for its effectiveness in 2016. The review was focused on the types of membership, a future structure for the framework, and administrative arrangements, but did not consider the broader strategic place of the NCF in DVA policy development, as this was not part of its terms of reference (DVA 2016a, pp. 33–37). It recommended that membership of ESORT be extended to Soldier On and Mates4Mates (organisations focusing on younger veterans), and changes be made to membership of the state and territory forums (DVA 2016a, pp. 31–32). The review concluded that 'the NCF remains a highly effective consultation mechanism' (DVA 2016a, p. 4).

... but consultation is often unrepresentative

Despite the findings of the NCF review, many participants to this inquiry were critical of the consultative framework, particularly of ESORT.

Many said that ESORT fails to represent the interests and needs of all veteran groups, particularly the most vulnerable and marginalised. DVA itself acknowledged that:

... changes have often reflected only the specific circumstances of a limited group of veterans and/or their families ... and can ignore the needs of the whole veteran community, or can overlook the circumstances faced by other cohorts of veterans and their families in otherwise similar situations. (sub. 125, p. 29)

Many noted that the membership of the large veterans' organisations is mainly older males who are receiving benefits under the VEA. For example, Max Ball said that ESORT meetings 'do not represent broad consultation with the ESO community' and 'it is a fallacy to think that what is discussed at the ESO round table necessarily represents the views of mainstream veterans' (trans., p. 231).

John Caligari noted a similar lack of full representation across DVA's broader consultation processes:

... in Townsville there are over 25 organisations that would be recognised by [DVA], I'm guessing. Do they represent the entirety of the Townsville veteran community? The answer is no. Their membership, specific to their cause and the people that they bring in for their specific cause, is who they represent ... [DVA is] not necessarily getting to the grassroots of where the problems are, particularly with younger veterans ... particularly those transitioning out of the [Australian Defence Force] now. (trans., p. 1327)

If this is the case, there is a risk that policy decisions end up reflecting the narrow interests of consulted parties, rather than the broader interests of veterans. And it appears that it is the group with the most to lose from decisions about a future system — younger veterans — are not well represented in policy development.

The current approach to consultation in the veteran sector has many organisations, in many forums and sub-forums, at both the federal and state level. This runs the risk of encouraging an ad hoc approach to policy development, where a large number of issues need to be tackled separately (and often inconsistently) to meet the needs of disparate stakeholders. As DVA said 'veterans' military compensation policy has often been developed in reaction to requests advocated by individual veterans or by ESOs', and 'implementing policy responses to specific ad-hoc requests in this way adds to complexity' (sub. 125, p. 29). Other stakeholders agreed, including the War Widows' Guild, who said that the approach to raising formal issues with DVA is 'probably ad hoc and random' (trans., pp. 995–6).

This fragmentation of veteran interests is exacerbated by the funding arrangements that support policy advice from veterans' organisations. Funding is provided through the GIA program, which is for projects and activities that encourage cooperation and communication between veterans, veterans' organisations and the Government, as well as support the

advocacy of veterans in policy issues generally (Community Grants Hub 2018b, p. 6). The program provides between \$8000 and \$10 000 each to fifteen different national veterans' organisations for the travel and other expenses associated with their policy advocacy (Australian Government 2019b).

Some stakeholders also told the Commission that DVA's engagement can often be one-way, with ESORT seldom invited to discuss strategic issues. Instead, ESORT appeared to be primarily used as a means for DVA to disseminate news about decisions that have already been made. For instance, the War Widows' Guild stated that ESORT 'has been a "talk at you fest" ... for many years' (trans., p. 987). Similarly, Max Ball noted that:

... the agenda is often put out very late. Sometimes the items on the agenda are embargoed, in other words the only person that can deal with it is the person attending. (trans., p. 231)

Some veterans said they go around DVA and instead seek to influence with elected officials directly. As one member of a veteran organisation said: 'if we have an issue we take it to ESORT ... But we also take it to the Minister' (Beverley Benporath, Partners of Veterans' Association, trans., p. 281). Legacy Australia suggested that ESORT should include the Minister for Veterans' Affairs as well as DVA bureaucrats (trans., p. 475).

More positively, the Commission heard that the nature of ESORT meetings had recently begun to change, with members now more involved in a fulsome discussion of strategic policy in the veteran support system, including the relative trade-offs and priorities for reform. As the War Widows' Guild noted, ESORT 'is now beginning to change and become much more strategic in their thinking' (trans., p. 987).

Towards a better consultation system

Many of the issues identified with the veteran support system, in this inquiry and others, appear to have come about because of a lack of strategic direction for engagement with the veteran community and broader stakeholders.

Consultation needs to be broader, but does not require consensus

The relationship between DVA and the veteran community has often been much closer than in other areas of social policy with similarly vulnerable client groups. As Lloyd and Rees (1994, p. 318) observed:

... by the early 1960s the ex-service organisations, particularly the RSL, had virtually been absorbed into a cycle of constant improvement of pensions and benefits ... Of course, similar relationships were forged with other client groups who looked to regular improvements in government assistance but in no policy area was the system as sophisticated and assured in what it delivered as repatriation.

However, effective policy development relies on government seeking to take an objective view of issues, informed and moderated by evidence and based on strategic policy and

planning approaches that carefully weigh all aspects of policy design to achieve better long-term outcomes for veterans and the community (OECD 2017, p. 27).

Although governments may see veterans as the best representatives of their own interests, those interests are not always well served by the current arrangements. Indeed, there can be difference between ‘veteran-centric’ policies that emphasise good outcomes, and ‘veteran-driven’ policies that reflect the preferences of the veteran community. For example, the Commission repeatedly heard many veterans express a preference for a pensions-for-life system (as under the VEA), instead of the vocational rehabilitation requirements of the MRCA, despite strong evidence that the latter offers much better life satisfaction and health outcomes over the long run (chapter 6).

Consultation by DVA needs to be much broader. This includes taking steps to communicate more effectively and widely with the veteran community, but also acknowledging that the skills and expertise in developing responses to the many and varied needs of ex-serving personnel are not only known by veterans. They can be known in industries where reducing work health and safety risks is a strong priority and among the medical, legal and actuarial professions, with experience in evaluating early interventions to improve lifetime outcomes.

A ministerial advisory council to provide professional guidance and expertise on veteran services (recommendation 11.4) should go some way towards broadening the scope of consultation. By consulting with leading service providers, not just the recipients of those services, the Government can ensure that services provided to veterans keep up with best-practice design, administration and stewardship.

Relatedly, while it is essential that governments discuss policy issues with veterans to determine priorities and test solutions, a holistic and long-term approach to policy development requires DVA to disagree with some stakeholders and for those stakeholders to accept that the outcome is not as they had hoped. As the OECD warned, ‘engagement and consultation with stakeholders [should not] become erroneously conflated in the public’s mind with consensus’ (2016, p. 26).

The fragmented nature of current consultation (discussed above) can mean there is limited consideration of policy priorities. The separation of policy development and service delivery should help to focus the attention of DVA (or Defence) on the development of long-term policy priorities in the veteran support system, with the administration of the system, and responses to particular individual cases, left largely to the Veteran Services Commission (recommendation 11.1).

The ex-service community is taking steps toward establishing a peak body

Beyond governance changes, the Government still has a vital role to play in improving consultation by seeking to bring together the myriad veterans’ organisations. Other government departments take such an approach to consultation, with funding provided to a peak body that can represent a sector or group of stakeholders, or particular subsectors

(box 12.7). These peak bodies consult with both elected officials and bureaucrats, and are trusted to represent the broad interests of their sector on given issues.

Box 12.7 Peak bodies are funded in other sectors by government

At the federal level, the Australian Government runs a number of grants programs and partnerships to fund peak bodies in multiple sectors.

Australian Council of Social Service

The Australian Council of Social Service (ACOSS) is the peak body for the community services sector in Australia. Founded in 1956, it participates in policy development and debate to reduce poverty and inequality. To support its work, it engages with the lived experience of people affected by poverty and disadvantage and seeks to represent their views. It also collaborates with academics and policy advisors to produce and promote research that contributes to the public understanding of poverty.

The Department of Social Services contributes about \$950 000 each year to the funding of ACOSS, through the Families and Community Service Improvement Activity Grant. This grant is available to ACOSS and five other established representative national community-based organisations. The grant is for organisations that contribute to, and provide feedback on social policy, engaging the broader family and communities sector, and conducting research and evaluations that inform policy development.

Australian Council for International Development

The Australian Council for International Development (ACFID) is ‘the peak body for Australian non-government organisations involved in international development and humanitarian action’ (ACFID 2015). Founded in 1965, it represents the interests of about 120 full members, aiming to improve their influence and create relationships for sharing knowledge between them.

The Department of Foreign Affairs and Trade provides international development funding through a partnership with ACFID. The aim of this partnership is not just to enhance the advocacy of ACFID’s members, but to improve their effectiveness in service delivery through ‘collaboration on ... enhanced policy and practice dialogue’ as well as ‘increased capability, effectiveness and accountability of the Australian [non-government organisation] development sector through standard setting and organisational development’ (DFAT and ACFID 2016, p. 3).

Health Peak and Advisory Bodies Programme

The Department of Health runs a Health Peak and Advisory Bodies Programme (HPABP) to recognise the ‘important role [peak bodies] play in informing and supporting the achievement of positive health outcomes’ (DoH 2015, p. 3). The grant helps peak bodies to engage with their members, the wider health sector and the community and to provide knowledge on their sector to the Government. Funded activities include direct consultation, provision of information, inquiries and investigations, and education and training (DoH 2015, p. 5). In 2018, 23 organisations were granted amounts between \$460 000 and \$2.9 million each under the HPABP (Hunt 2018).

Veterans’ organisations have considered proposals to establish a peak body for some time. Most notably, the former Minister for Veterans’ Affairs publicly challenged the sector to develop a national confederation that would serve as a ‘single voice’ for the views of the veteran community (Tehan 2017c). Many organisations in the sector have recognised that

their efficacy in providing services to veterans and in consulting with government could be improved by consolidation.

Having so many ESOs with, at times, opposing key messages and fractured relationships, ultimately causes confusion for the veteran, their families and the wider community. It is challenging for veterans to know which ESOs offer what and where and how they can be accessed. Understandably this restricts the power ESOs have to advocate to government on behalf of veterans. (Mates4Mates, sub. 84, p. 7)

... collectively ESOs need to re-organise themselves so that there is a national body who is lobbying or advocating on their behalf. (War Widows Guild, trans., p. 986)

Veterans' organisations, other than the RSL and Legacy, have already established a representative body, the Alliance of Defence Service Organisations (ADSO, box 12.8), with the aim of consolidating the views of the ESORT members and facilitating communication between DVA and those organisations:

They formed the Alliance of Defence Service Organisations which were basically ... the round table members having a meeting before they got to DVA to say, "There's no point in us presenting 13 different aspects here. We have to do something a little cleverer about this to make sure that we're providing solid advice", and I think we've seen this happen over probably a couple of decades, but in more recent times where there's been a clearer single voice which I think you would expect the government to be happy with that, and we've done a lot of work to try and bring that voice to be meaningful and helpful to veterans, and to the Department ... (Naval Association of Australia, trans., pp. 634–5).

RSL NSW proposed an alternative model where a peak body is funded by government in the same manner as the Australian Council For International Development (described in box 12.8). As well as co-ordinating policy influence to government (as ADSO currently does for its members), the RSL's proposed peak body would accredit veterans' organisations to provide services to veterans (sub. 151, pp. 16–17).

Box 12.8 Alliance of Defence Service Organisations

The Alliance of Defence Service Organisations (ADSO) is a coalition of veterans' organisations that aims to 'provide a stronger voice on issues impacting the conditions and wellbeing of currently serving and former members of the Australian Defence Force'. It does this by encouraging communication and coordination on policy advice between member organisations. It was established in late 2010 by five organisations; today, it has 18 member organisations representing about 90 000 individuals (ADSO nd; sub. DR247, p. 1). ADSO is not presently incorporated, but intends to incorporate in 2019 (ADSO 2019).

Two of Australia's largest ex-service organisations — the Returned and Services League (RSL) and Legacy — are not members of ADSO. This may reflect the fact that ADSO sees its emergence partly as a reaction to a perceived unwillingness of the RSL to enter the public debate on veterans' issues, and the RSL's federal structure where the national RSL is not influential in policy advocacy (Ryan 2017).

Although many veterans' organisations have joined ADSO, there remains a significant split in the veteran community about the role that a peak body would take in political advocacy and also in managing the broader work of the sector. It remains unclear at this stage whether a representative peak veterans' body will be formed.

Some participants were of the view that the consolidation of diverse veterans' voices to the views of a single body was not possible without sacrificing some viewpoints, particularly for more marginalised groups of veterans or their families:

... asking the sector to speak 'with one voice' through a configuration of lobby groups is counterintuitive to understanding the needs of the community, particularly the vulnerable who are often silenced by the power of politics. Arguably, what is needed is co-ordination and direction by a professional independent body, not unification via the community. The lack of direction and cohesion which haunts the sector can be evidenced in tensions between and within organisations over competition for resources and authority. (Deborah Morris, sub. DR307, p. 11)

In line with this, there is a diversity of views among the state branches and local sub-branches of veterans' organisations (a point echoed by Dennis Martyn, sub. DR168, p. 2 and Ken Chapman, sub. DR305, p. 2). In the conduct of this inquiry, it has been difficult to observe consolidated views of membership on policy issues *within* some of Australia's large veterans' organisations, let alone a single view across the broader community.

Even in sectors where peak bodies exist, they are not expected to fully consolidate the views of their members into one view or be one voice, nor to provide the only means for members to communicate with government. The Australian Council of Social Service, for example, has a number of large members (like the Red Cross and World Vision) that maintain a capacity to independently engage with government. The main aim of peak bodies supported by government funding is to represent the interests of the sector, not necessarily to speak with one voice. They should be able to provide well-developed input, submissions and advice on critical issues. They can be as helpful to government as such bodies are to the sectors they represent.

However, even if the ambition for a 'single voice' may not be the aim, efforts to better consolidate the views of veterans' organisations and to represent them in well-developed submissions could help the Government prioritise policy issues and provide a more co-ordinated stance for a large number of Australia's veterans. If a single peak body does emerge within the Australian veteran community and DVA and the Government are confident that it represents the broad interests of most veterans (including younger veterans), then the Government should give consideration to providing formal funding. Such a body could engage more flexibly with DVA and the Minister, and over time, provide a more functional replacement for ESORT. In particular, it could work with smaller reference groups (which might also contain broader representation from other veterans' organisations) to examine particular topics.

This body would assist DVA on veterans' issues beyond the ministerial advisory council proposed in chapter 11. Specifically, that council would serve to bring expertise from outside of the veterans' sector into the support system. A national peak body would serve to

consolidate to a considerable, but not exclusive, degree the views and voices of veterans on key issues and help the government assess relative priorities.

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.

13 The compensation package

Key points

- Veterans and their families can be entitled to a range of payments across the three veteran compensation Acts. Compensation is paid for: pain and suffering ('impairment') and loss of income ('incapacity'); dependants (including when a veteran dies from a service-related injury or illness); the cost of health care and other services. There are also various supplements and allowances, superannuation invalidity compensation, and the service pension.
- When considered as a package, compensation for veterans and their families is relatively generous compared to other workers' compensation schemes.
 - A veteran with warlike service and an impairment rated at about 20 impairment points would receive lifetime compensation of over \$100 000 under the *Military Rehabilitation and Compensation Act 2004* (MRCA). This is about double what a civilian worker with a similar impairment point rating would receive under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA).
 - A veteran who is totally and permanently incapacitated would receive lifetime compensation of between \$1.5 and \$3.9 million under the MRCA, depending on their age and need for services, such as attendant care. The veteran would receive between \$1.2 and \$2.8 million under the SRCA.
- The veteran compensation system is complex, in part because of the three Acts and the many different payments available under the Acts. The system can be difficult for veterans to access and for the Department of Veterans' Affairs to administer.
- Aligning the compensation provisions of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) with those in the MRCA could reduce complexity and improve equity across claimants, but it would mean a small additional cost for taxpayers.
 - Aligning the two Acts would likely result in a small increase in compensation for most veterans with potential claims under the DRCA — that said, a small number of veterans could receive less because of the age-based lump-sum approach in the MRCA.
 - Current recipients would not see a reduction in benefits as a result of these changes.
 - However, eligibility for the Gold Card would not be extended to veterans with current DRCA coverage. They would continue to receive the White Card.
- Veterans can receive superannuation invalidity pensions through the Commonwealth Superannuation Corporation, which may reduce the Department of Veterans' Affairs compensation veterans can receive. Invalidity pensions cause unnecessary complexity, and the administration of these two schemes should be streamlined.
 - Invalidity pensions result in poor incentives for veterans to return to work. Going forward, there is a case for replacing invalidity pensions with incapacity payments for veterans who are medically discharged.
 - Veterans receiving pensions do not receive rehabilitation. This should be addressed.

In 2017-18, the Department of Veterans' Affairs (DVA) spent over \$7 billion on compensation and income support for veterans, and over \$5 billion on health care (DVA 2018g). This chapter looks at:

- the support veterans and their families may be entitled to (section 13.1)
- the effectiveness of the compensation package as a whole (section 13.2)
- ways to improve the compensation system (section 13.3)
- the interface between DVA compensation and compensation received through military superannuation (section 13.4).

Chapters 14 to 17 explore options for improving the compensation and healthcare system.

13.1 Compensation for veterans and their families

Compensation is one of the key aspects of veteran support. It covers:

- financial payments to veterans and their families to compensate for the pain and suffering associated with an impairment (or death)
- financial payments to compensate veterans for a reduced earning capacity due to an impairment
- healthcare (and other) costs resulting from an impairment
- benefits not linked to an impairment, such as the service pension.






The basic structure of compensation payments for veterans (impairment compensation, income replacement and healthcare costs) aligns with payments in other workers' compensation schemes. However, there are additional payments and allowances which are unique to the veteran support system (figure 13.1).

Compensation needs to be considered as a package as there are many interacting parts. Changes to one aspect of compensation can have implications for other aspects.

Impairment compensation

Impairment compensation is a payment for the 'non-economic' effects of a service-related injury or illness on a veteran's life. That is, the compensation is for the impairment itself, rather than secondary effects, such as loss of income. As the Explanatory Memorandum for the *Military Rehabilitation and Compensation Bill 2003* states, these payments are for 'functional loss, pain and suffering and the effect of the injury or disease on the person's lifestyle' (Vale 2003, p. iv).

Figure 13.1 **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

Impairment compensation is available under all three Acts.

- Permanent impairment payments are provided under the *Military Rehabilitation and Compensation Act 2004* (MRCA) and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA).
- General rate disability pensions are provided under the *Veterans' Entitlements Act 1986* (VEA). While disability pensions are not explicitly considered pain and suffering compensation, their value is estimated in a similar way to permanent impairment payments under the MRCA.

Impairment compensation is calculated in a similar way under all three Acts — it is based on the level of impairment (the 'impairment rating') and the effect of the impairment on the veterans' lifestyle (the 'lifestyle factor') (box 13.1).

Box 13.1 **Measuring the level of impairment**

Military Rehabilitation and Compensation Act 2004 (MRCA)

The MRCA uses the Guide to Determining Impairment and Compensation (GARP-M) to assess the level of impairment of a veteran and the amount of compensation. A veteran's impairment is rated from 0–100, based on the level of functional loss suffered by the veteran. For example:

- five impairment points is associated with conditions such as a lower-level speech impairment, severe skin disorder or amputation of multiple toes (aside from the great toe)
- twenty impairment points are assigned to conditions such as those that result in a moderately reduced walking pace and inability to manage stairs without rails
- a person who is blind in one eye would receive a rating of 25 impairment points, while a person who is blind in both eyes would receive a rating of 85 impairment points.

Impairment ratings for each body part are combined to form the whole-of-person impairment rating, using a table in the GARP-M (rather than adding impairment points for each injury together).

The veteran is also assigned a lifestyle factor of between 0–7, depending on how the impairment affects their lifestyle. A veteran that previously had a more sedentary lifestyle may have a lower lifestyle factor than a veteran who had a more active lifestyle.

The impairment rating and lifestyle factor are combined together to determine the compensation factor, which is the percentage of the maximum rate of compensation the veteran is entitled to. For example, a veteran with warlike service, with an impairment rating of 20 and a lifestyle factor of 2 would have a compensation factor of 0.222. That is, they would receive 22.2 per cent of the maximum rate of compensation available under the MRCA.

Veterans' Entitlements Act 1986 (VEA)

The VEA uses the Guide to the Assessment of Rates of Veterans' Pensions to assess a veteran's level of impairment. The process under the VEA is similar to the process under the MRCA, with one key difference. Impairment ratings and lifestyle factors are combined together to determine the veteran's level of incapacity — a number between 0–100 which reflects the general rate pension that the veteran can receive.

Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA)

The DRCA uses the Comcare Guide to the Assessment of the Degree of Permanent Impairment to estimate the level of compensation available to the veteran. There are some key differences between the approaches used under the VEA and MRCA, and that under the DRCA.

- The DRCA does not use a whole-of-person impairment approach. Impairment ratings and compensation are calculated for each injury separately, and are not combined together.
- Lifestyle factors under the DRCA are on a 0–100 scale. These are not combined with the impairment ratings using a table. Rather, there are three components to the DRCA permanent impairment compensation — two of these are estimated using the impairment rating, and the third is estimated using the lifestyle factor.

Sources: Australian Government (2016c); Comcare (2014); MRCC (2016).

Who is entitled to impairment compensation?

A veteran does not automatically receive permanent impairment compensation under the MRCA or DRCA when DVA accepts liability for a condition.

- The injury or illness must be considered ‘permanent and stable’ to receive permanent impairment compensation. That is, if a condition is expected to improve, either naturally or with rehabilitation, DVA cannot grant permanent impairment compensation at that time. Veterans can receive ‘interim’ permanent impairment compensation while DVA is waiting for a condition to stabilise (box 13.2).
- A veteran must have a minimum level of impairment to receive impairment compensation (5–10 impairment points, depending on the impairment).

Impairments do not have to be permanent and stable for a veteran to receive a disability pension under the VEA.

Box 13.2 What is interim permanent impairment compensation?

Interim permanent impairment compensation is available to veterans under the *Military Rehabilitation and Compensation Act 2004* where an impairment is deemed to be permanent, not yet stable, but it is anticipated that the condition will stabilise in the future. The degree of impairment upon the stabilisation of the condition must be able to be estimated, and it must meet the minimum impairment threshold for payment.

The amount of interim compensation payable is based on the estimate of the final permanent impairment rating that the veteran is likely to have once the condition has stabilised.

Final compensation is paid once the condition has stabilised. However, interim compensation can only be adjusted upwards — the amount of compensation the veteran receives cannot be reduced at the final assessment stage.

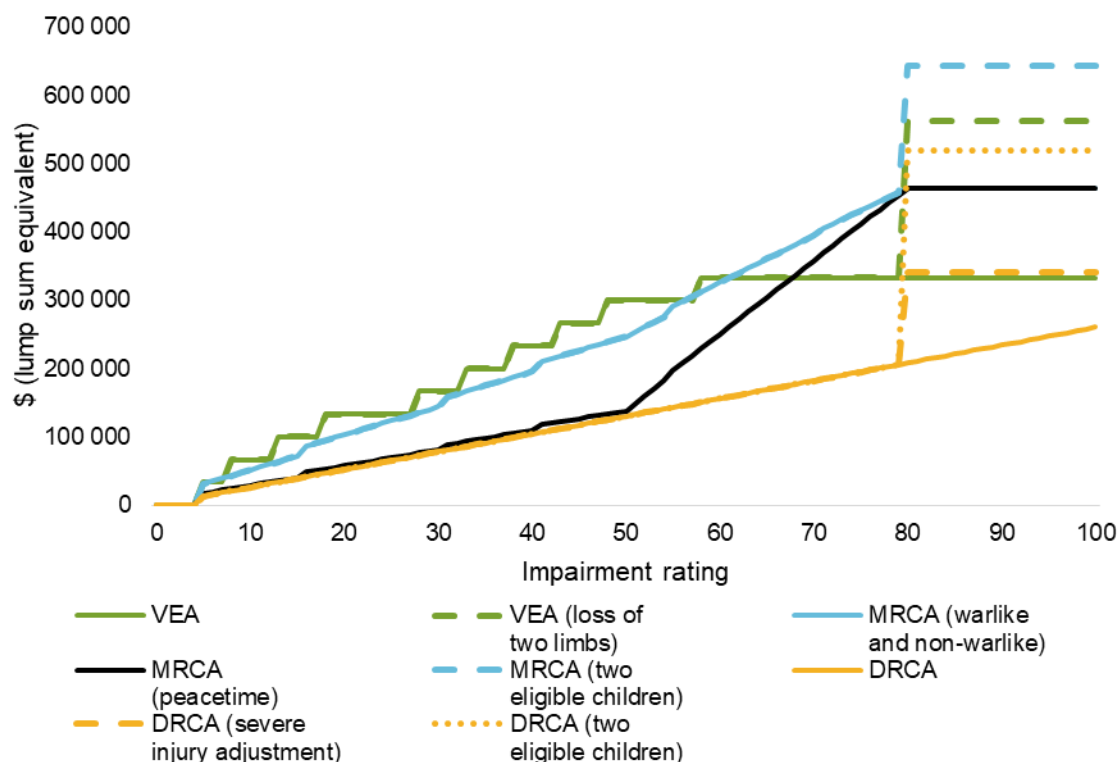
Similar provisions apply under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

Source: *Military Rehabilitation and Compensation Act 2004*.

Impairment compensation — how much is paid?

The permanent impairment compensation amount increases based on the level of impairment up to a maximum amount (figure 13.2). Under all three Acts, additional compensation is also available for severely impaired veterans (table 13.1). In all cases, impairment compensation is not taxable, and does not count as income for the purposes of receiving the service pension. Impairment compensation may be available as a periodic payment (VEA), a lump sum (DRCA) or both (MRCA).

Figure 13.2 **Impairment compensation by level of impairment^{a,b,c}**
May 2019



Sources: Productivity Commission estimates based on Australian Government (2016c); MRCC (2016); *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

^a VEA specific injury payments are only available for veterans on less than the special rate of disability pension. In this example, it is assumed that the veteran receives the specific injury payment once they are over 80 impairment points. ^b For the VEA and MRCA, lifestyle factors reflect the factors most commonly assigned for a given level of impairment. For the DRCA, the lifestyle factor is assumed to be the same as the impairment rating. ^c Periodic payments have been adjusted to lump sums based on the MRCA conversion rates for a 30 year old.

How many veterans are receiving impairment compensation?

Just over 100 000 veterans were receiving impairment compensation (or had received an impairment lump sum) in December 2018, and of these about:

- 84 000 were receiving a VEA disability pension (including those receiving a pension above the general rate)
- 15 000 were receiving DRCA permanent impairment payment
- 14 000 were receiving MRCA permanent impairment payment (Productivity Commission estimates based on DVA unpublished data).

Most veterans receiving permanent impairment payments under the MRCA have relatively low rates of impairment compared to the VEA — about two-thirds have an impairment rating of 35 points or lower. Under the VEA, about half of the veterans received a pension of 100 per cent of the general rate or higher (figure 13.3).

Table 13.1 Impairment compensation

As at June 2019

	VEA	DRCA	MRCA
Maximum amount	\$498.40 per fortnight ^{a,b}	\$260 302 lump sum	\$347.24 per week (can be converted to a lump sum)
Level of impairment for the maximum amount	About 40–65 impairment points ^c	100 impairment points	80 impairment points
Additional compensation for severe impairments	Between \$34.20 per fortnight (amputees below the knee or elbow) and \$688.30 per fortnight (most double amputees).	Severely impaired veterans (generally those with an impairment of at least 80 impairment points) can receive: <ul style="list-style-type: none"> • the maximum compensation • an additional \$80 918 • an additional \$89 302 for each eligible young person in their care.^d 	Veterans receiving the maximum rate of compensation can receive an additional \$89 393 for each eligible young person in their care.

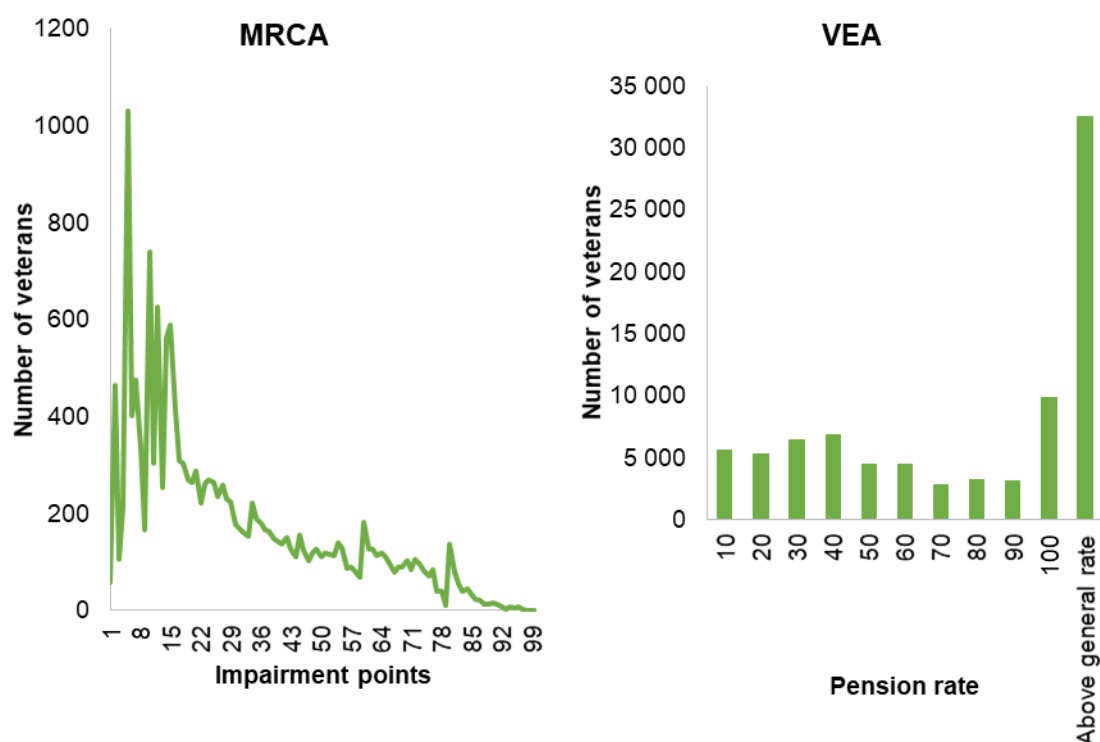
^a 100 per cent of the general rate pension. ^b Rate does not include the energy supplement. ^c Can be reached at a higher or lower level of impairment, depending on the lifestyle factor. ^d DRCA severely impaired provisions are included under the *Defence Act 1903*.

Very few veterans receive the additional payments provided above the base impairment compensation for severely impaired veterans. In December 2018 about:

- 265 veterans were receiving additional disability pension payments for specific injuries under the VEA
- 569 veterans had accessed additional payments for eligible young people under the MRCA
- about 60 veterans had accessed the DRCA severe injury adjustment (as at June 2018) (Productivity Commission estimates based on unpublished DVA data).

Figure 13.3 Level of impairment for veterans claiming impairment compensation^a

As at December 2018



^a Based on the veteran's current disability pension or their impairment rating at the time of their most recent claim.

Source: Productivity Commission estimates based on unpublished DVA data.

Compensation for economic loss (income replacement)

Veterans who cannot work, or have reduced capacity to work, because of a service-related injury or illness can receive income-replacement compensation for their resulting economic loss.

Under both the MRCA and DRCA, incapacity payments are based on the difference between a veteran's actual earnings, and what they were earning in the military (or sometimes in civilian work) when they were incapacitated for service or work.

Compensation for lost income under the VEA is provided in the form of disability pensions set at a rate above the general rate. These include:

- the special rate of disability pension (SRDP) for those who are totally and permanently incapacitated or totally and temporarily incapacitated
- the intermediate rate disability pension for veterans capable of part time or intermittent work

-
- the extreme disablement adjustment (EDA) for veterans age over 65 years.

A version of the SRDP is also available under the MRCA — veterans can elect to receive this payment in lieu of receiving incapacity payments if they meet certain criteria.

Who is eligible?

A veteran may be eligible to receive incapacity payments under the MRCA or DRCA if they are assessed as having incapacity for work or service, and face a loss of income, as a result of their service-related impairment.

Incapacity for work or service is broad. At one extreme, it could mean that the person is unable to work at all. At the other extreme, the person may still be able to work full time, but be restricted in the type of work they are able to undertake, and consequently be forced to work in a lower paying job. In both cases a veteran would be eligible for incapacity payments, although the level of payment received would vary.

A veteran is eligible to receive the SRDP under the VEA if:

- they are receiving a disability pension of at least 70 per cent of the general rate (usually met at 40–50 impairment points)
- they are prevented from undertaking their normal work or other substantive work in their work history for more than 8 hours a week solely because of VEA accepted conditions
- they are suffering a loss of earnings as a result.

For veterans aged over 65 years, they must have been working for a continuous period of at least 10 years which continued past them turning 65 years to start receiving the SRDP. Veterans aged over 65 years who are severely incapacitated but not eligible for the SRDP can receive the EDA.

The criteria for the intermediate rate disability pension are the same as those for the SRDP, except there is a lower threshold for hours worked (20 hours, or 50 per cent of hours normally worked) and the condition does not have to be permanent.

The criteria for the SRDP under the MRCA are similar to, but not exactly the same as, those under the VEA. Veterans are eligible to receive this payment if they:

- have conditions assessed at more than 50 impairment points
- are receiving incapacity payments
- are unable to work for more than 10 hours a week (and cannot be assisted by rehabilitation to do so).

How much compensation?

The amount of compensation payable to veterans receiving income replacement compensation is set out in table 13.2. VEA payments are provided instead of general rate disability pensions, while MRCA and DRCA incapacity payments are provided in addition to permanent impairment compensation.

Table 13.2 Economic loss payments
May 2019

	<i>VEA disability pensions</i>	<i>MRCA incapacity payments</i>	<i>DRCA incapacity payments</i>
Rate of payment	\$1 402 per fortnight (special rate) \$952 per fortnight (intermediate rate) \$775 per fortnight (extreme disablement adjustment)	For the first 45 weeks of payments, veterans receive the difference between normal earnings and the amount they are currently earning. After 45 weeks, normal earnings are reduced to 75 per cent if the veteran is not working, with smaller step downs if they are engaging in some work.	Based on the difference between normal earnings and the amount they are currently earning. After 45 weeks, normal earnings are reduced to 75 per cent if the veteran is not working, with smaller step downs if they are engaging in some work (or study under an approved rehabilitation program). Payments are reduced by a further 5 per cent for veterans receiving superannuation to reflect a notional superannuation contribution.
Remuneration loading	na	Normal earnings are increased by \$165 per week to reflect the non-monetary benefits of military service.	No
Are payments taxed and count towards welfare income tests?	No ^a	Yes (except payments for lost reserve earnings are untaxed)	Yes (except payments for lost reserve earnings are untaxed)
For how long can payments be received?	Pensions are for life	Until age pension age.	Until age pension age
Minimum payment?	na	Normal earnings must be at least minimum wage	\$478.01 per week (higher with dependants)
Maximum payment?	na	No	150 per cent of average weekly ordinary time earnings of full time adults (currently \$2 407 per week)

^a Payments do count towards Centrelink income tests, but reductions in payments as a result of this test are reimbursed to the veteran through the Defence Force Income Support Allowance. **na** Not applicable.

How much compensation are veterans receiving?

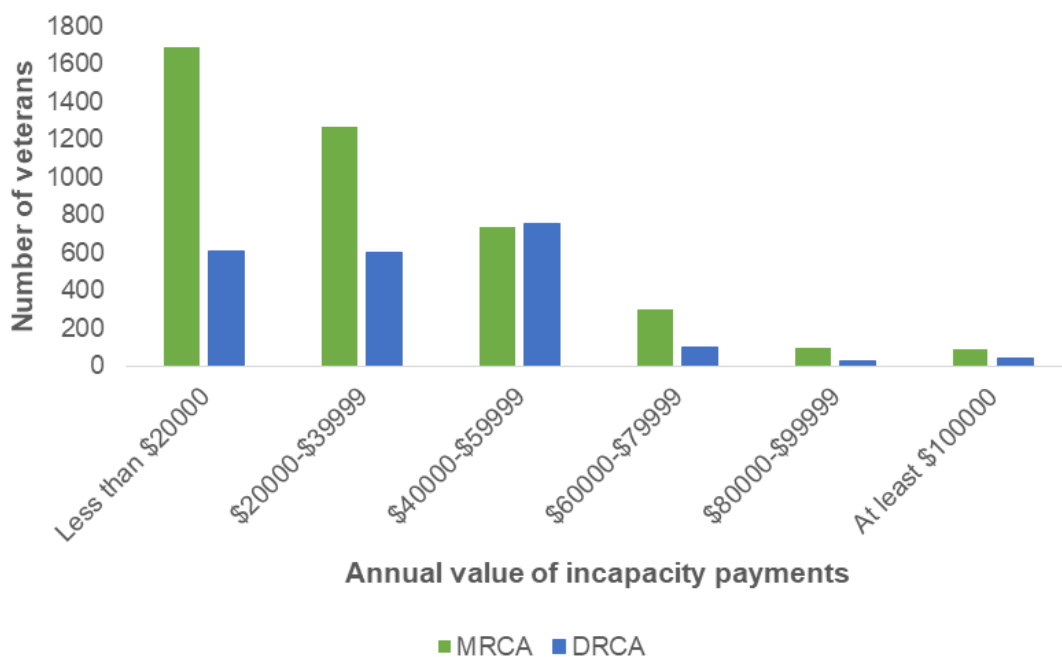
In 2017-18, 4910 veterans received a MRCA incapacity payment, and 2185 a DRCA incapacity payment (DVA 2018g). This represents the total number of veterans who received incapacity payments over the year, and at a point in time, the number of incapacity payment recipients will be lower — on 30 June 2018, 3893 veterans were receiving MRCA incapacity payments, and 1874 veterans DRCA incapacity payments (DVA 2018g, p. 22).

Incapacity payments vary markedly between veterans, depending on their normal earnings, actual earnings, and length of time on incapacity payments (figure 13.4). For example, the Australian Government Actuary found that:

- the average fortnightly incapacity payment varies from \$1700 to \$2700, depending on the veteran's age profile, length of time on the payments and Act they are covered by
- over half of the veterans are not on the payments 12 months after they first receive the payment (2018a, pp. 46, 54).

There were 32 500 veterans on above general rate pensions under the VEA in December 2018. Most of these (about 27 000) were on the SRDP. About 4000 were receiving the EDA, and about 700 were on the intermediate rate (Productivity Commission estimates based on unpublished DVA data).

Figure 13.4 Value of incapacity payments received
2016-17



Source: Productivity Commission estimates based on unpublished DVA data.

Superannuation benefits

Current Australian Defence Force (ADF) members can receive superannuation benefits from one of three funds (chapter 3). The newest scheme — ADF Super — commenced in 2016, although veterans can still receive benefits under the older schemes.

All three schemes offer government-funded invalidity and death insurance. Members of these schemes who are medically discharged from the military may be entitled to a lifetime pension, based on their years of service, salary in the military, and incapacity for civilian work (box 13.3). Under the three schemes, the impairment resulting in discharge does *not* need to be related to service for veterans to receive invalidity or death compensation.

Box 13.3 Superannuation invalidity pensions

The three military superannuation schemes have their own method for estimating the amount of invalidity pension to be paid, but the approaches are similar. This box explains the arrangements under ADF Cover.

A veteran who is medically discharged from service and classed as Class A (at least 60 per cent incapacitated for work) or Class B (30–59 per cent incapacitated from work) can receive an invalidity pension. Eligible veterans receive two types of pension.

- The basic rate of pension is payable for life. The pension is calculated as: salary at discharge, multiplied by prospective years of service to age 60, multiplied by an incapacity factor (0.011 for Class B, and 0.022 for Class A).
- A top-up pension is payable until age 60. This pension is calculated based on years of service in the military times salary at discharge multiplied by an incapacity factor.

Example

Frank joined the military at age 20, and was medically discharged at age 25. Frank was severely impaired and incapable of working, and was classed as Class A.

Frank would receive a pension for life of \$46 200 each year (35 prospective years of service X \$60 000 X 0.022 incapacity factor). He will also receive a top up pension until age 60 of \$6600 annually because of his 5 years of service.

Offsetting arrangements

It is Australian Government policy, established under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA), that it should not pay two sources of income maintenance to the same person (Campbell 2011b). That means that if a person is receiving Australian Government-funded superannuation and incapacity payments under the MRCA or DRCA, their incapacity payments are reduced dollar for dollar by the amount of government-funded superannuation they are receiving. The SRDP under the MRCA is also offset by 60 cents for every dollar of Australian Government-funded superannuation. There is no offsetting under the VEA, nor is there offsetting for the benefits received by dependants.

Offsetting only applies for Australian Government-funded superannuation — this includes the invalidity insurance provided through military superannuation, as well as defined benefit superannuation payments. Benefits from private contributions to superannuation, such as employee contributions to ADF Super, are *not* offset.

Additional allowances and payments for veterans

Veterans can also receive a range of other benefits. There are four broad categories of benefits.

- Benefits to cover the veteran's health and other care costs.
- Payments that supplement impairment compensation.
- Benefits provided as a recognition for service.
- Payments to help veterans navigate the compensation system.

Health and other care

Veterans and their families predominantly receive healthcare support through the veterans' healthcare card system.

- A Gold Card is issued to veterans who are severely impaired under the VEA or MRCA, dependants receiving a VEA war widow(er)s' pension or a MRCA wholly dependent partner payment and veterans with qualifying service over 70 years of age (amongst others). The Gold Card covers the cost of a range of public and private healthcare services, whether the impairment treated was related to service or not.
- The White Card is issued to all veterans, and covers the costs of all clinically necessary health care related to impairments that DVA has accepted liability for. It also covers healthcare costs for cancer, pulmonary tuberculosis and mental health conditions, whether related to service or not.

Veteran-specific healthcare programs are also provided such as Open Arms (a counselling service) and coordinated veterans care. Health care is considered in more detail in chapters 16 and 17.

Veterans can also receive support to help them with daily living, including:

- attendant care services, such as assistance with hygiene, grooming, dressing and feeding
- household services, such as meal preparation, cooking and cleaning.

Under the MRCA and DRCA, eligible veterans are reimbursed for the costs they face, up to a maximum of \$491.67 each week for attendant care and the same amount for household services under the MRCA, and \$473.25 each week per service under the DRCA. Under the VEA, veterans with certain impairments (such as amputees or those who are blind) are entitled to a maximum of \$341 each fortnight to meet the costs of attendant care.

Gold and White Card holders can also access the Veterans' Home Care program, which provides a small amount of support to allow them to continue to live independently in their home.

Compensation supplements

Veterans receiving impairment compensation or with DVA healthcare cards are automatically eligible for payments that supplement their compensation. There are two main payments.

- The energy supplement (introduced to provide financial assistance to cover the cost of the carbon tax), is available for people on MRCA permanent impairment payments, the MRCA SRDP or a VEA disability pension. An additional energy supplement is available for people with a Gold Card or on the service pension. The level of energy supplement varies depending on the type of payment received, but can be up to \$10.75 each week (the energy supplement is usually included in the compensation rate for the other payments).
- The MRCA, DRCA and veterans' supplements replaced the pharmaceutical allowance. These supplements are available to people eligible for the SRDP (MRCA and VEA) and certain other above general rate pensions (VEA), those with more than 80 impairment points (MRCA) or those with a DVA healthcare card (all Acts). It is paid at either \$6.20 or \$12.40 per fortnight, depending on the veteran's eligibility. This supplement is only payable if the veteran is not receiving a pension supplement under the *Social Security Act 1991* (as it includes a pharmaceutical allowance) or through the service pension.

The VEA also includes several other allowances that supplement the base level of compensation provided.

- Veterans with certain impairments that restrict their mobility (for example, amputees) can be entitled to allowances to meet their travel expenses:
 - A maximum of \$91 each fortnight to meet the costs of travel for recreational activities.
 - \$2371 each year to meet the costs of maintaining a motor vehicle.
 - Financial assistance to purchase a new (or modify a) vehicle (a similar program is available under the MRCA that applies for vehicle modifications only).
 - Goods and Services Tax exemptions for motorcycles.
- Veterans with impairments that damage their clothing can receive a clothing allowance of a maximum of \$14.30 a fortnight.
- Veterans who suffer a loss of earnings as a result of undergoing treatment for a service-related impairment can receive compensation to cover this loss of earnings.
- Eligible veterans receive additional payments if they have certain decorations. The rate of this payment is \$2.10 each fortnight, plus an additional \$4541 each year for Victoria Cross recipients.
- Ex-prisoners of war can receive an additional \$569.10 per fortnight.

Benefits as a recognition for service

Veterans with qualifying service (chapter 3) can also be entitled to the service pension. The service pension is similar to the age and disability pensions provided to the general population, and is an income support payment for eligible veterans and eligible partners. The main difference between the service pension and generally available pensions is that the age service pension is available at 60 years old (this is the mandatory military retirement age).

DVA paid about \$1.6 billion in service pensions in 2017-18 (DVA unpublished data).

The Australian Government has also announced a new Australian Veteran Card, which will provide a range of discounts for veterans at participating businesses (Morrison and Chester 2018b). State Governments also often provide discounts for veterans, such as public transport concessions.

Payments to support veterans navigate the system

In 2018, the Australian Government introduced the Veteran Payment to support veterans with a mental health condition who are waiting for their DVA claim under the MRCA or DRCA to be processed. Eligible veterans can receive this payment if they are incapable of working for more than eight hours per week and pass an income test. The payment is \$1002 per fortnight for singles and \$780 per fortnight (each) for couples.

The Veteran Payment ceases six weeks after a decision has been made on the veteran's claim.

In addition, veterans or their dependants can receive compensation for legal or financial advice in certain circumstances under the MRCA. This includes advice to help the veteran make a choice between receiving a lump sum or weekly permanent impairment if they have more than 50 impairment points, advice on whether to choose the SRDP if they are eligible for it, and advice for dependants where they receive a wholly dependent partner payment.

Veterans or their dependants can also receive compensation for financial advice under the DRCA where they are eligible for a payment payable under the *Defence Act 1903*.

Benefits for dependants

If a veteran dies as a result of a service-related impairment (or, in some cases, if they had a severe service-related impairment before their death), their dependent family members ('dependants') are eligible for compensation, either in the form of a pension or a lump sum payment. However, who is a dependant, and the compensation they are entitled to, differs across the three Acts.

Who is eligible for benefits?

Three types of dependants can be eligible to receive compensation.

- Under all three Acts there is compensation available for the veteran's partner.
- Under all three Acts 'eligible children' can receive compensation. Eligible children include children under the age of 16, and those aged between 16 and 25 years who are undertaking full-time education.
- Both the MRCA and DRCA include provisions for other dependants — such as extended family and partly dependent partners — to receive compensation.

Dependants are entitled to compensation where a veteran's death is linked to their service. In addition:

- compensation under the VEA is automatically paid if the deceased veteran was receiving a pension at or above 100 per cent of the general rate, or if they were an ex-prisoner of war
- compensation is automatically payable to dependants under the MRCA if the deceased veteran was eligible for the SRDP at some point in their life, or they suffered impairments of at least 80 impairment points.

How much compensation for dependants?

The level of compensation for dependants varies across the three Acts (table 13.3). Payments are tax free. Widow(er)s receiving VEA or MRCA compensation are not eligible for Centrelink income support payments, but can receive a DVA income support payment (discussed below).

Table 13.3 Compensation for dependants^a
May 2019

<i>Dependant type</i>	<i>VEA</i>	<i>MRCA</i>	<i>DRCA</i>
Wholly dependent partner	\$927.40 per fortnight	\$463.70 per week (can be converted to a lump sum) Additional age-adjusted lump sum of up to \$148 988 ^b	A lump sum of \$550 321.42 to be divided across all dependants based on their level of loss An additional death benefit of \$60 756.25 is payable to the spouse ^c
Eligible child	Double orphan: \$208.30 per fortnight Single orphan: \$104.20 per fortnight	\$148.68 per week Additional lump sum of \$89 393	Additional compensation of \$89 301.98 is payable for eligible children ^c A weekly payment of \$151.34 is payable to eligible children.
'Other' dependant	na	Lump sum of \$89 393	

^a Payment rates exclude the energy supplement. ^b This lump sum is only available when the veteran's death has been linked to service. ^c These payments are included in the *Defence Act 1903*. **na** Not applicable.

Additional allowances for dependants

Dependants can also be entitled to many of the additional benefits and supplements outlined above. Partners and children receiving benefits as a result of a veteran's death under the VEA or MRCA are entitled to a Gold Card. Dependants receiving certain payments can also receive the energy and the MRCA/veterans' supplement.

Eligible partners (or the veteran's estate) can receive a 'bereavement payment' under the VEA and MRCA.

- Under the VEA, the partner receives a lump sum equal to six instalments of the disability pension the veteran was receiving at the time of their death. If the veteran was receiving income support, a lump sum based on this payment may also be paid.

Under the MRCA, this payment is equal to 12 weeks of the incapacity payments, periodic permanent impairment payments or SRDP the veteran was receiving (or entitled to receive) at the time of their death.

Widow(er)s with limited means can receive the Income Support Supplement (ISS) under the VEA and MRCA. This is an income and assets tested payment of a maximum of \$278.50 per fortnight.

There is a funeral allowance to assist with the funeral costs of veterans (provided under all three Acts) where they died as a result of service. And as with other benefits for dependants, it can also be paid out under the VEA and MRCA in other circumstances, such as if the veteran was receiving the SRDP, or died in needy circumstances. A maximum of \$2000 is available under the VEA, while just over \$12 000 is available under the MRCA and DRCA.

Eligible children of deceased or severely impaired veterans can also receive education allowances under the VEA and MRCA, and additional education support, such as tuition. The rate of payment can be up to \$553.10 a fortnight, depending on the age of the child and their living situation. This payment has complex interactions with family tax benefit and youth allowance (chapter 15).

What compensation are dependants receiving?

On 30 June 2018, there were 59 000 war widow(er) pensioners under the VEA, and 124 wholly dependent partners receiving a pension under the MRCA (or who had received a lump-sum payout). In addition, there were 155 dependent children receiving an orphan's pension under VEA and 128 receiving an eligible young person payment under MRCA (DVA 2018g, p. 22).

In 2017-18, \$35 million was paid to 165 dependants under the MRCA, and \$15 million was paid to 72 dependants under the DRCA (DVA 2018g, pp. 225–226).

Support for families of living veterans

Families of living veterans can also be eligible for a range of supports, including financial support and counselling and respite support for those living with impaired veterans.

Financial support for partners

Partners of veterans with qualifying service may be eligible for the partner service pension, along with former partners who are still married to the veteran (pension payments usually stop 12 months after separation) and widow(er)s. The pension is subject to an income and assets test.

The age requirement for partners to access the partner service pension is lower than that of the Centrelink age pension for certain groups. For veterans who are receiving, or who are eligible for, a service pension (or are registered as a member of the pension bonus scheme), the age requirement for their partners is:

- no age requirement or an age requirement of 50 years if the veteran has severe impairments
- no age requirements if the veteran has dependent children
- an age requirement of 60 years otherwise.

For veterans who have qualifying service, but are not yet eligible for a service pension, the age requirement for their partners is the same as that of the Centrelink age pension (65 years of age).

The current maximum payment rate (including the energy supplement) is \$698.10 per fortnight for partners living as a couple, and \$926.20 per fortnight for singles and partners living apart due to illness.

Counselling and respite

Counselling is available to families of all veterans through Open Arms. Families of Reservists can also access counselling through the Reserve Assistance Program and families of veterans in rehabilitation may be eligible for counselling through the Family Support Package.

The Family Support Package is available under the MRCA and provides counselling for family members of veterans participating in an approved rehabilitation program. Up to four counselling sessions each year can be accessed for five years. This program is only available for families of veterans with warlike service after 2004 who are eligible for incapacity payments.

For family members who act as carers for veterans (as well as other carers), respite care is available through the Veterans' Home Care Program subject to threshold limits and other

conditions. This provides carers with a temporary break from their caring responsibilities. Services can include:

- In-Home Respite Care, where care is provided by a substitute carer in the home of the veteran
- Residential Respite Care, where short-term care is provided usually in an Australian Government-funded aged care facility
- Emergency Short Term Home Relief, where emergency care is provided in unexpected circumstances (and when general community services are not available).

Support for children

Short-term child care supports can be provided to families of veterans in certain circumstances:

- through the household services provisions or through a psychosocial rehabilitation plan under the MRCA and DRCA
- as part of the Family Support Package under the MRCA. Up to \$10 000 of funding per year can be provided for children under school age, and up to \$5000 for primary school students.

Children's activities are available through a pilot program by the Australian Kookaburra Kids Foundation (The Australian Government is contributing \$7.6 million to the Foundation over four years from 2019). The program provides children with respite camps, activity days and mental health education.

Education supports can be accessed by eligible children dependent on veterans with severe injuries or service-related deaths (and certain other young persons). These are provided through the Veterans' Children Education Scheme under the VEA or through the Military Rehabilitation and Compensation Act Education and Training Scheme (chapter 15).

Children of Vietnam veterans may be able to access additional funding assistance for post-secondary education through the Long Tan Bursary scheme. They can also access funding for the treatment of certain medical conditions through the Vietnam Veterans' Sons & Daughters Support Programme. Conditions covered are:

- spina bifida manifesta
- cleft lip
- cleft palate
- adrenal gland cancer
- acute myeloid leukaemia.

13.2 Evaluating the package of compensation

An important focus of the veteran support system should be rehabilitation and providing support for veterans to return to work. However, there will be some veterans, because of injury or illness, who will not be able to return to full-time work — adequate and timely compensation is therefore also important. As the Vietnam Veterans' Federation of Australia said:

... experience has shown that many veterans will never again be fit for full-time work, regardless of early intervention and quality of care. That is the situation now, and it is unlikely to change in the face of future operational deployments. These veterans need 'social' not 'economic' rehabilitation, and the most important start for 'social' rehabilitation is the reduction of the debilitating experience of financial anxiety, by the granting of 'compensation' ... Overwhelmingly, veterans would gladly forgo their compensation in exchange for a return to good health. (sub. DR215, p. 8)

And even when a veteran can return to work, compensation provides restitution for the effect of a veteran's impairment on their lifestyle, and is an important part of the support system.

The adequacy, complexity and timeliness of payments, and whether the payments are targeted at the right people, are examined in this section. Hypothetical case studies are used to highlight the compensation package that veterans could be entitled to (box 13.4).

Box 13.4 Estimating lifetime compensation — assumptions used

The case studies in this section include a lifetime value of compensation available to the veteran based on reasonable assumptions. These case studies are intended to be illustrative only and highlight the differences in compensation between the Acts — they are not based on real world examples.

Where payments are provided as periodic payments over time, they are converted to a lump sum based on the formula used in the MRCA.

- Where compensation is available for the veteran or dependant's lifetime, compensation is converted to a discounted lump sum based on the actuarial tables used to convert permanent impairment payments to lump sums in the MRCA.
- If payments are only available for a specified period of time (such as incapacity payments), compensation is converted to a discounted lump sum using the formula in the MRCA.

Payments that are taxed, such as incapacity payments, are converted to an after-tax value based on current taxation arrangements.

Superannuation payments are based on the ADF Cover arrangements.

Where estimates include the Gold Card, this is based on the value of the Gold Card being about \$18 500 per year (the value estimated by the Parliamentary Budget Office as the value of the Gold Card to a person who already had a White Card (chapter 16)).

How does the compensation package compare with other schemes?

Compensation for veterans

Whether a compensation package is ‘adequate’ or ‘fair’ is a difficult judgment to make. It requires calls about the value of a person’s pain and suffering and the potential effect of an impairment on their lives. As noted by the Canadian Veterans’ Ombudsman, in many cases ‘no amount of money can provide full restitution’ (2016, p. 2).

That said, only a few participants raised concerns about the adequacy of the compensation package as a whole (primarily in relation to the SRDP, discussed below). And in fact, many noted the beneficial nature of the supports for veterans. For example:

- Returned and Services League of Australia (RSL) National Office said ‘with regard to compensation in the broader sense, the range of entitlements and benefits offered to Australian veterans compares favourably to those offered to Canadian veterans and New Zealand veterans and superior to those of the US and UK’ (sub. 113, p. 26).
- Alexander McFarlane said that the schemes run by DVA ‘are more supportive and beneficial to the recipients and more equitably administered’ (sub. 69, p. 6) than state-based workers’ compensation schemes.
- EML described the benefits to Australian veterans as ‘well-resourced and largely generous’ (sub. 90, p. 3).

Through consultations, Most ex-service organisations also agreed that, once access to the payments has been granted, the benefits are fair and reasonable.

One approach to assess adequacy is comparisons with other workers’ compensation schemes. The veteran compensation package is generous compared with the workers’ compensation package applying to Commonwealth employees (the SRCA).

- For veterans with a low level of impairment and no incapacity for work, it includes a permanent impairment payment or disability pension, and the energy and veterans’ supplements. For veterans with warlike or non-warlike service, permanent impairment compensation is more generous than a civilian worker covered by the Commonwealth workers’ compensation legislation (box 13.5).
- For veterans with higher needs, the system is more complex. Veterans can receive transport allowances, various supplements, household and attendant care, incapacity payments, special rate pensions, welfare payments, superannuation invalidity pensions and the Gold Card, as well as various other allowances.
 - The MRCA and DRCA offer payments that are generally in addition to, or more generous than, the standard Commonwealth workers’ compensation. Under the MRCA, veterans can be entitled to lifetime compensation in excess of \$3.9 million (box 13.6). Under the SRCA, the equivalent amount is likely to be about \$2.8 million.
 - Determining the generosity of the VEA is less straightforward — as the VEA provides set rate pensions, its relative generosity depends on the veteran’s

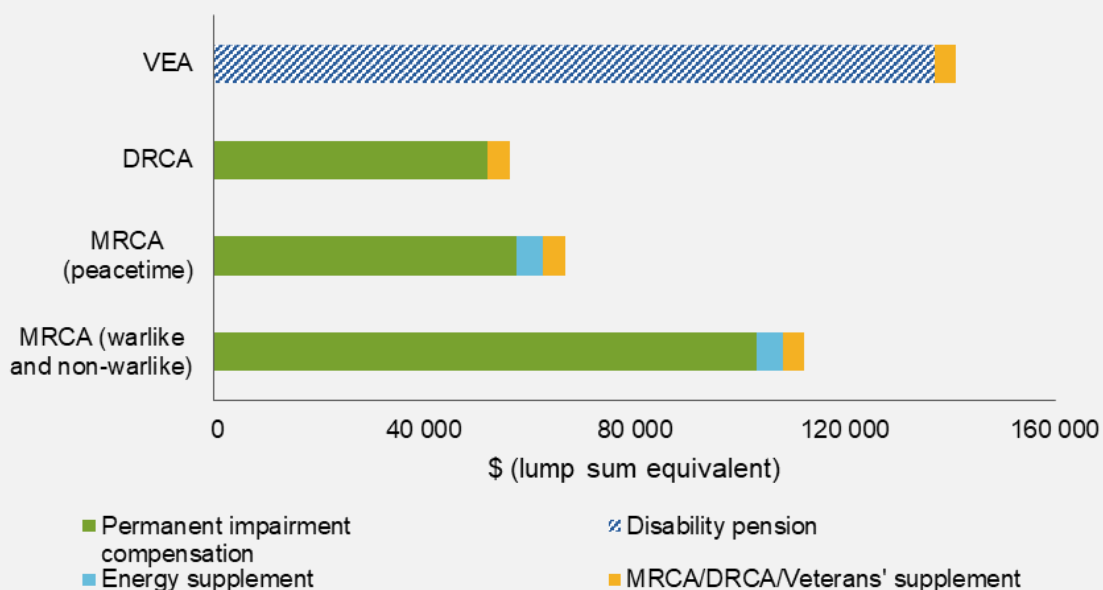
pre-impairment earnings, as well as access to superannuation benefits and various allowances (boxes 13.6 and 13.7). However, in general the level of payments in the VEA is relatively comparable to those provided through the MRCA and DRCA. Some participants suggested that there is a case for an increase in the VEA SRDP, on the basis of comparisons with the minimum wage. This issue is considered in chapter 15 — but it is important to look at the whole package of compensation when making judgments about adequacy, rather than the individual components.

Box 13.5 Case study — low level of impairment

Jane is a 30 year old veteran who has suffered a shoulder impairment graded at 20 impairment points. The amount and type of compensation would vary based on which Act she is covered by and the type of service under which the impairment was suffered. She would be entitled to:

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

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



Jane would also receive treatment for the shoulder impairment through the White Card, and, if she has qualifying service, would receive the service pension at age 60 and the Gold Card at age 70.

Source: Productivity Commission estimates.

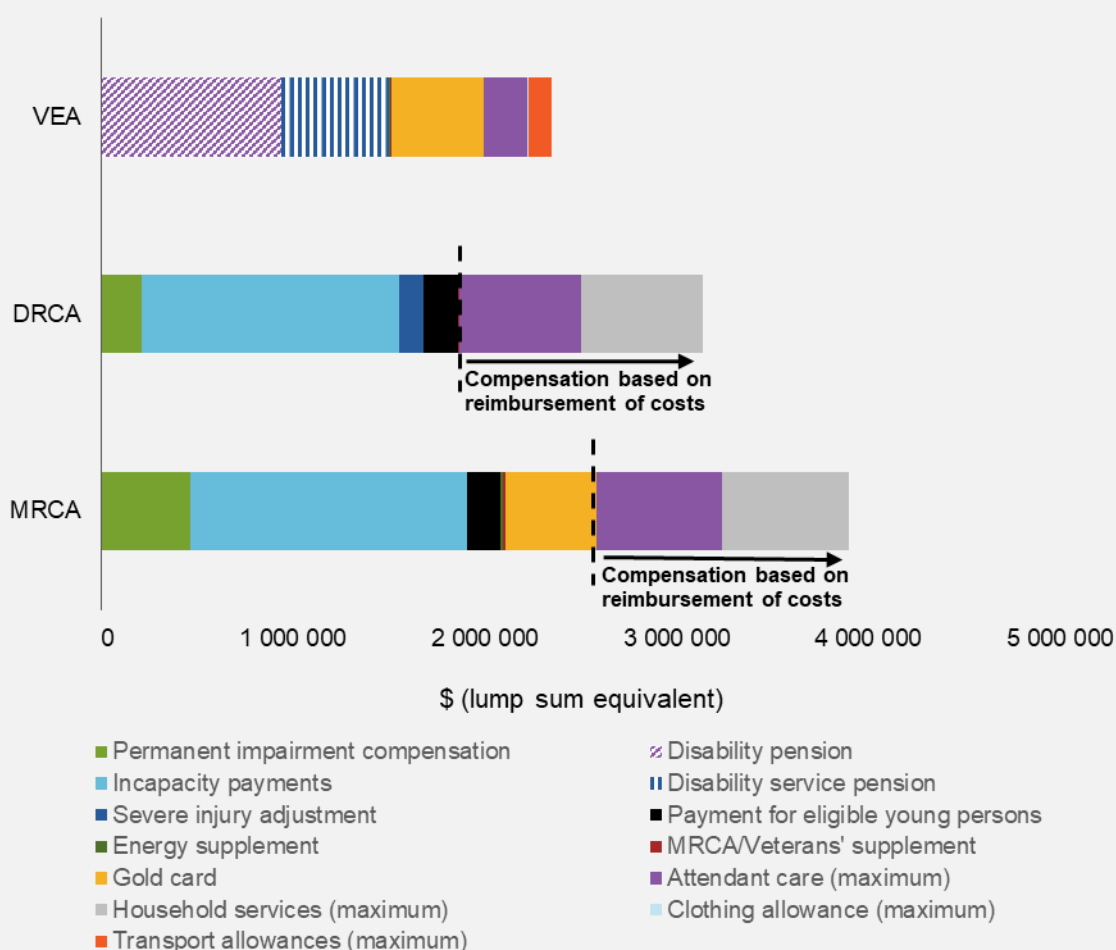
Box 13.6 Case study — totally and permanently incapacitated veteran

Bill is a 30 year old veteran who has suffered a severe impairment graded at 80 impairment points. Bill is unable to work as a result of his impairment and cannot earn his previous salary of \$100 000 per year. Bill's impairment materialised after he left the military, and he is not eligible for compensation from his military superannuation.

Under the MRCA and DRCA, Bill would receive incapacity payments until age 65 as well as a permanent impairment payment. Bill has two children, and would receive an additional lump sum for having eligible young children under the MRCA and DRCA. Under the VEA, Bill would receive the special rate of disability pension for life as well as the invalidity service pension.

Bill's impairment has left him with high needs, and as a result he also claims the maximum available rate of attendant and household care services. Bill would receive immediate access to the Gold Card under the VEA and MRCA.

The total lifetime value of the compensation provided to Bill would be \$2.5–4 million under the MRCA (depending on the level of household and attendant services claimed) and over \$2 million under the VEA.

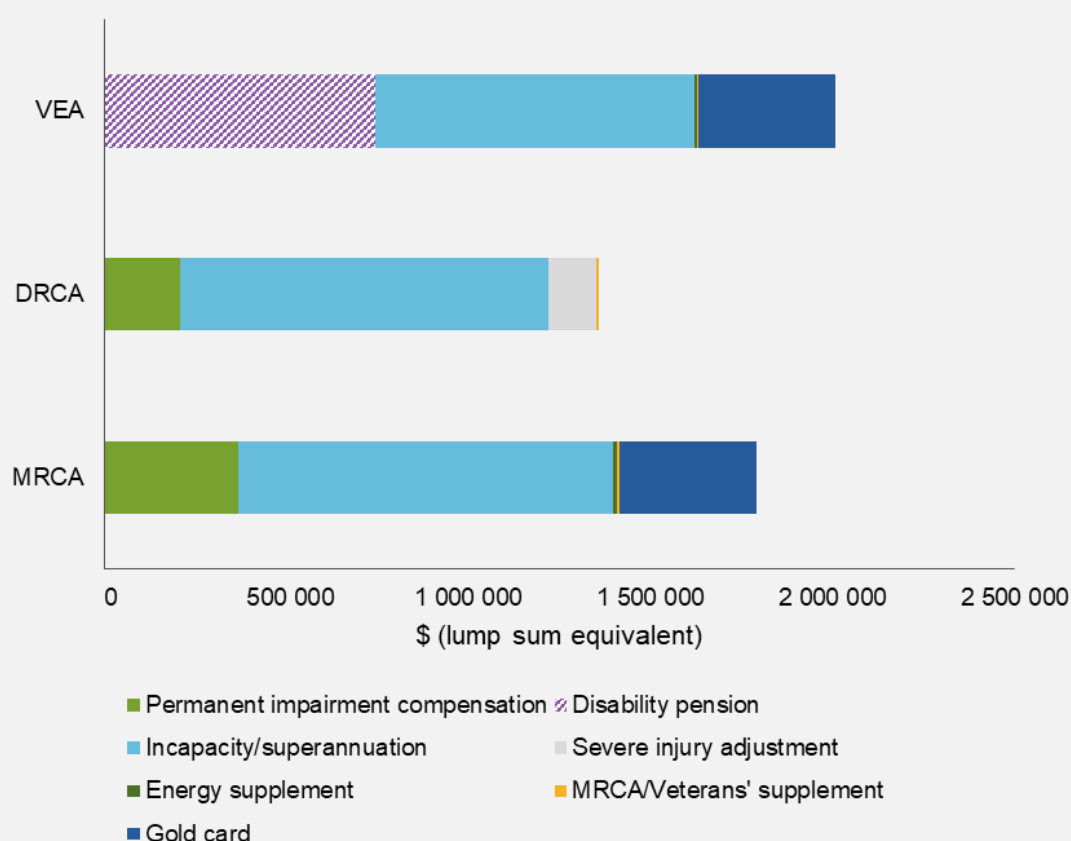


Source: Productivity Commission estimates.

Box 13.7 Case study 2 — totally and permanently incapacitated veteran

Joe is a veteran facing the same circumstances as Bill (box 13.6), with some key differences. Joe is older (50 years of age), has no children and does not have a need for attendant and household services, or other VEA allowances. Joe is also eligible for compensation from his military superannuation (Class A).

Unlike Bill, for Joe the VEA is likely to be the more generous compensation scheme, providing just over \$2 million in lifetime compensation.



Source: Productivity Commission estimates.

Other comparisons are more difficult. For example, when compared to state and territory government workers' compensation schemes, MRCA (and DRCA) incapacity payments step down to the lowest level in the country. However, this is offset by not having a maximum payment rate, a maximum length of time for which payments can be granted and the additional remuneration loading (table 13.4). Permanent impairment payments vary in level across the states and territories, although eligibility for permanent impairment payments can be more restrictive. For example, some states have higher impairment thresholds to be able to claim permanent impairment compensation. That said, the veteran compensation schemes are likely to be more generous in most instances, as workers in state and territory schemes are not paid the range of allowances and benefits available to veterans and their families, such as education payments and the Gold Card.

Table 13.4 Examples of incapacity payments in other workers' compensation schemes

December 2017

	<i>MRCA</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>
Maximum step down	75 per cent from 45 weeks	80 per cent from 14 weeks	80 per cent from 14 weeks	75 per cent from 26 weeks	85 per cent from 14 weeks	80 per cent from 1 year
Maximum length of time on incapacity payments	Payable until age pension age	Five years, except for high- needs workers	Payable until age 5 years (with some conditions)		Payable until age pension age	2 years if not seriously injured (above 30 per cent whole of person impairment)
Maximum weekly payment	No maximum	\$2 043	\$2 150	Maximum total compensation of \$314 920	\$2 667	\$2 946

Source: Safe Work Australia (2017a).

Internationally, the compensation available to veterans and their families is different from the Australian compensation schemes, and comparisons are difficult.

- The Canadian New Veterans' Charter is most similar to the MRCA, and provides a disability award (akin to permanent impairment payments), an earnings loss benefit (akin to incapacity payments) and various other allowances. Lifetime support available for a totally impaired veteran ranges from C\$1.5–\$3.5 million (about A\$1.5–3.5 million) — consistent with the Commission's estimates for the Australian schemes (Canadian Veterans Ombudsman 2017).
- The United Kingdom offers a much higher threshold for permanent impairment compensation — a maximum of £570 000 (just over A\$1 million). However, this is often the only compensation veterans receive — while income replacement is available, only 2 per cent of veterans receiving compensation received the income replacement payment (Brooke-Holland 2017).
- Under New Zealand's scheme 2 (the more modern of New Zealand's two schemes), the level of permanent impairment compensation available is lower than in Australia — a maximum of about NZ\$200 000 (about A\$183 000). New Zealand also offers income replacement, stepping down to 85 per cent of the veteran's pre-injury income after one year.

While comparisons can be instructive, they need to be placed into the context of the broader support available in each country, including both veteran-specific and widely available support. As noted by the Canadian Veterans' Ombudsman:

Assessing the sufficiency of the Disability Award should not be based on a comparison of how other countries compensate for the non-economic effects of disability. For example, the fact that the UK Compensation for Injury benefit is a maximum of £570,000 (CDN\$1,175,277) does not mean that the Disability Award maximum of \$360,000 is insufficient. It simply means that the amounts are different because the UK and Canada decided to support their Veterans in different

ways, through a different suite of benefits that address unique needs, national imperatives and economic realities. (2016, pp. 29–30)

Overall, the compensation available to Australian veterans is beneficial and this reflects the intent of the veteran support system.

Compensation for dependants

As with benefits for veterans, there is little guidance about what compensation a spouse is entitled to in the case of a work-related death of their husband or wife, or what a child should receive upon the death of their parent. There is no generally accepted amount of compensation, and the benefits vary widely across Australia.

- In New South Wales, the compensation most closely reflects the veteran schemes — lump sum compensation of \$760 000 is available, plus a periodic payment for children and funeral expenses. At the other end of the spectrum, in the ACT the available lump sum compensation is about \$210 000, with weekly payments of \$70 available per child.
- In some states, such as South Australia and Victoria, payment based on the amount the worker was earning before they died is available for a period of time (Safe Work Australia 2017a).

The base level of support available for dependants is reasonably consistent with the most beneficial of the state and territory schemes. However, other benefits, including insurance available through the veteran's superannuation and the Gold Card can push the package of benefits available to \$2 million or more (box 13.8).

Easier access to benefits, rather than the amount of compensation, is the most beneficial aspect of the schemes for dependants. The access to benefits available under the MRCA and VEA for dependants of veterans who died while on certain payments is unique to the veteran's system in Australia. This allows some dependants to receive compensation where the veteran's death was not related to service (chapter 14). This means that more dependants of veterans are able to access compensation than in other schemes.

The complexity of compensation

A key concern of participants is the complexity of the system. Veterans state that complexity leads to confusion around entitlements and DVA points to the difficulties administering the scheme (chapter 19). The three Acts are seen as a major contributor to the complexity of compensation. However, having invalidity pensions through superannuation alongside the compensation system also adds to complexity. This leads to a system of compensation offsetting between the Acts, which can be complex and confusing for veterans to understand. Proposals to consolidate and streamline the three Acts are considered in chapter 19.

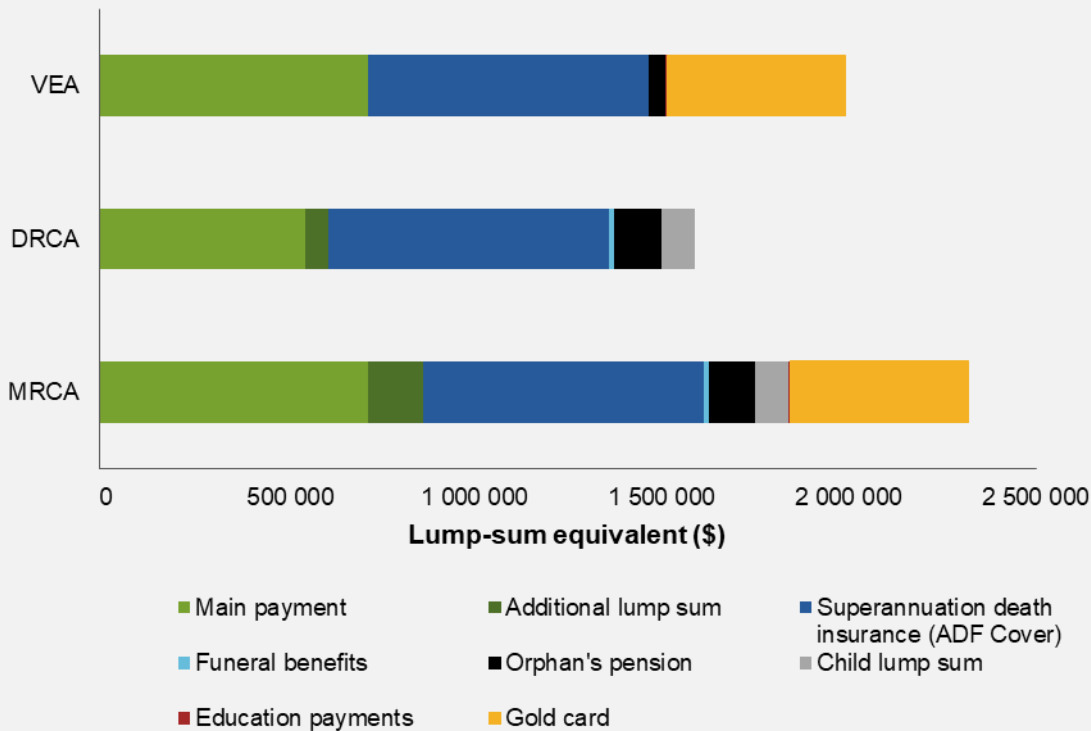
Much of the focus is on the number of Acts, but the complexity of the individual Acts themselves should not be ignored. The main payments of veterans' compensation — disability pensions, widows and orphans' payments, permanent impairment payments and incapacity payments — are generally consistent with the design of payments in workers' compensation schemes. Where the veterans' schemes differ is in the sheer magnitude of smaller allowances and supplements available. This complexity makes it difficult to determine what compensation package veterans are entitled to.

Box 13.8 Benefits for dependants — case study

Mark was a veteran who was killed during service, leaving behind a 30 year old spouse and one child. Mark was previously earning \$100 000 per year in the military.

Under all three Acts, Mark's spouse would receive a main lump sum or pension payment, as well as a payment through superannuation. The spouse would also receive a funeral allowance as well as various other allowances and supplements. The total lifetime support for the spouse is likely to be between \$1.5–2 million, depending on the Act.

Support is also available for Mark's child. This would be in the form of an orphan's pension, a further lump sum (in the MRCA and DRCA) and education payments (in the figure, only education payments up to age 16 are considered).



Veterans may access payments under multiple Acts, sometimes for the same impairment, further increasing the complexity of compensation arrangements. They may also access other payments, such as Centrelink social security payments and superannuation

compensation. RSL Queensland highlighted the complexity caused by the range of payments on offer:

A key shortcoming is the variety of benefits available across the three Acts and the complexity of ensuring the most beneficial legislation is being applied. It is the view of RSL Queensland that the range of benefits is extensive and not necessarily well understood ... Acknowledging the complexity of the range of benefits, it remains difficult for a veteran or his family to feel confident that they have accessed all of their entitlements. (sub. 73, p. 29)

This complexity is in large part the result of payments being added to the system in response to perceived needs or lobbying by veterans, combined with a reluctance to remove any existing benefit for fear of disadvantaging any veteran. As Liz Cosson, Secretary of DVA, said:

... much of the complexity in this system stems from response to the needs expressed by veterans and their support organisations over many decades. We have now a system which does reflect a wide variety of veterans' circumstances and needs but which is complex because each iteration and improvement has been layered upon the previous one. (trans., p. 448)

Many veteran groups expressed the view that the system needs to be simplified but without the loss of any entitlements. For example:

A fair, singular [and] simple to administer and access [system of compensation] is what is required. However the warning here is that this has been tried in the past and resulted in more convoluted arrangements that in many respects reduced entitlements which have harmed many veterans and their families. This must be avoided in any future legislative changes and the veteran community with expert adviser support needs to be fully engaged in any proposal to amend the legislative framework. (David Kelly and David Jamison, sub. DR212, pp. 4–5)

Simply put, this is not possible — a system that does not reassess the existing benefits will continue to become more and more complex. Reform in this area is not possible without affecting some veterans' potential entitlements. And it is the reluctance by governments to remove payments and the grandfathering of compensation benefits that is, at least in part, the root cause of the complexity of the current system.

The existing benefits need to be assessed to determine whether they are well targeted and suitable going forward. The attitude that no benefit can be altered or removed needs to change for the compensation system to work effectively for veterans into the future.

Delays in accessing payments cause distress

The time taken to process compensation claims can be lengthy, although there have been improvements recently (chapter 9). While the length of time to process claims can vary, times taken to process claims can be over a year (ANAO 2018b). Delays can take a toll on veterans' wellbeing (chapter 17).

Many participants to this inquiry commented on the effect delays in receiving compensation can have on veterans, including an overreliance on Centrelink (Peter Alkemade, sub. 66) and a disenchantment with the system (Warren Harrex, sub. 89). Maurice Blackburn Lawyers

(sub. 82) noted that delays in receiving compensation have almost resulted in several of their clients losing their homes, and the RSL (2015) said that the effect of delays can be more pronounced for veterans who were not medically discharged, but find themselves unable to work for an extended period of time. The Australian Psychological Society also highlighted the challenges faced by veterans who are discharged with mental ill-health and no reliable source of income.

[Australian Psychological Society] members who provide mental health services to veterans report that it can often take from six weeks to six months for some veterans to access income from their superannuation or pension. This creates clear barriers for veterans in obtaining accommodation, other important capital expenditure decisions and creates barriers for essential functions of daily living. This interruption in having access to essential funds is a serious issue along with the significant cost of living upon discharge. (APS 2015, p. 13)

There are many reasons why there can be delays in receiving compensation. The Australian National Audit Office (2018b) noted that the two leading causes of delays are due to inactivity during the claims process, and the time taken to receive medical information from specialists. These delays may reflect the complexity of cases — claims may involve multiple impairments covering multiple Acts, all of which need to be processed for the claim to be finalised. They may also reflect the legislative requirements placed on specialists. For example, the Royal Australian and New Zealand College of Psychiatrists noted that:

... it is challenging to meet the requirement of having a ‘permanent and stable’ condition. Often substantial support and treatment will be required before stability is achieved in the field of mental illness ... (sub. 58, p. 8)

The Australian National Audit Office report included several recommendations for DVA, including contracts that prescribe timeliness and quality for specialists engaged by DVA. These recommendations were accepted by DVA — it remains to be seen what effect they will have on decision making.

The targeting of compensation is also important

The compensation system will not be effective if the people with the greatest needs are not receiving adequate compensation or necessary services.

Some payments and services in the veteran support system are not targeted effectively. For example, while the system will pay for health care, there is less of a focus on ensuring that services are available, and veterans are not always able to access the health support that they need. Health services are provided to a wide range of veterans, whereas a tighter focus on high-needs veterans may be desirable (chapter 16). Some payments are provided to all veterans, where higher levels of support to a more targeted group of veterans may be more beneficial (chapter 15).

13.3 Reforming the compensation package

The focus of reforms should be on reducing the complexity of compensation, improving the timeliness of compensation, and ensuring that the right people are targeted by the compensation package.

Some reductions or increases in future entitlements are the byproduct of reform in this area — nonetheless, the Commission’s reform package has been designed such that, with the exception of some very small payments, veterans currently receiving benefits would not lose access to these benefits.

Individual payments that make up the veteran compensation system are assessed in the following chapters. There is also scope to harmonise the DRCA compensation payments with the MRCA as a whole — this is considered below.

Harmonising the DRCA compensation with the MRCA

Compensation provided under the DRCA is consistent in structure with that of the MRCA, and there appears scope to harmonise, and then merge, the compensation received through the two Acts (the reasons for this are outlined further in chapter 19). The following sections illustrate the fiscal costs of change in this area, how veterans may be affected, and some of the transitional arrangements that would be required. Details on changes needed to the MRCA to accommodate harmonisation are discussed in chapters 14 and 15.

What benefits would be harmonised?

By and large, the Commission considers that the DRCA compensation benefits would be almost fully aligned with the MRCA, including with the changes to the MRCA benefits recommended in the subsequent chapters. This includes harmonising permanent impairment compensation, incapacity payments, benefits for dependants and a range of allowances.

Permanent impairment compensation

The Commission sees advantages in the MRCA approach to assessing permanent impairment. Apart from the amount of compensation (section 13.1), there are two key differences between the MRCA and DRCA approaches.

First, the MRCA uses periodic payments that can be converted to an age-based lump sum. The use of periodic payments in the MRCA provides veterans with more choice about how payments are received and provides relatively more compensation to veterans who are impaired early in life — this is fairer and consistent with the principle of providing impairment compensation on the basis of the pain and suffering the person will experience over their lifetime.

The second key difference is that the MRCA uses a whole-of-person impairment methodology and the DRCA uses an injury-based approach (section 13.1). It is the Commission's view that the whole-of-person methodology is more reasonable. In particular, it means that veterans cannot receive compensation above 100 impairment points — the maximum compensation intended to be payable. The Commission also considers it reasonable that veterans are not compensated twice for different injuries that lead to the same functional loss. Adopting the MRCA methodology to DRCA would bring DRCA cases back to the methodology that applied before the High Court found that each condition must be assessed separately.

Current recipients of DRCA permanent impairment compensation should not have their existing compensation recalculated (if the impairment deteriorated over time, additional compensation could be sought using the MRCA). Given the compensation under the DRCA is provided as a lump sum, any change in entitlements would be complex, and it would be difficult and stressful for veterans if an attempt were made to claw back a lump-sum payment. Alternatively, veterans who would be better off under the DRCA could receive large windfall gains. Existing payments would be grandfathered, and offsetting applied where needed.

Incapacity payments

There are also several differences between the MRCA and DRCA incapacity payments (section 13.1). Ultimately, these differences mean that the MRCA incapacity payments provide for a higher level of payment than the DRCA.

Incapacity payments are generally paid as a periodic payment. The Commission considers that it is feasible for all recipients of incapacity payments to move to one system of incapacity payments, including existing recipients. This would be based on the more generous MRCA model — meaning that DRCA veterans would receive a higher level of incapacity payments.

Benefits for dependants

The benefits for dependants in the MRCA and DRCA are similar in total compensation, but have structural differences. Under the DRCA, payments to dependent partners are lump sums that are not age adjusted. The MRCA offers similar compensation either through periodic payments, the option of an age-adjusted lump sum, or a combination of the two. The age adjustment means that those aged under 60 would likely receive more compensation under the MRCA than the DRCA and vice-versa for those aged over 60. It is the Commission's view that an age-adjusted lump sum payment is sensible, particularly when calculating an equivalent periodic payment. This offers dependants additional choice in how they receive their payments.

Existing dependants receiving benefits should not have their entitlements recalculated, as these benefits are often provided as a lump sum.

The MRCA extends automatic eligibility to some groups that do not require liability for death due to service to be accepted, whereas under the DRCA the death must be proven to be service related. This results in considerably fewer people being eligible for benefits. The Commission does not recommend extending this eligibility to the DRCA cohort as there is little rationale for this under the MRCA (chapter 14).

Benefits for families with children are almost identical under the DRCA and MRCA, with the exception that education payments are only available under MRCA — these should be extended to DRCA recipients (the Commission is recommending modifications to education payments in chapter 15 — these should also apply to DRCA recipients).

Eligible DRCA dependants currently access mainstream income support payments and benefits through Centrelink. MRCA dependants are excluded from receiving income support through Centrelink and instead are eligible for the ISS and Rent Assistance through DVA. The ISS is designed to replace income support from Centrelink and the Commission has heard no issues in submissions with the rate of ISS. Therefore the Commission has assumed that these benefits are adequate.

Other benefits

The DRCA should be amended to provide access to the range of allowances under the MRCA. These include:

- access to the MRCA education and training scheme
- the slightly higher payment ceiling for household and attendant services
- the motor vehicle compensation scheme.

If these payments were modified as recommended in chapter 15, increasing their eligibility would not lead to a large increase in fiscal costs or scheme complexity, but there are benefits to veterans and their families in a harmonised approach to these payments.

Existing recipients of DRCA compensation, and future claimants, should be able to access these payments.

However, the Commission does not consider that access to the Gold Card should be extended to veterans and their families who would have been eligible for compensation under the DRCA. The reasons for this are outlined further in chapter 16, but in sum, there is no compelling rationale for extending coverage of the Gold Card. Several veterans expressed a view that DRCA compensation recipients should receive access to the Gold Card (for example, Michael Andrews, sub. DR183; VOA, sub. DR232). However, the Commission has received no compelling evidence to change its view.

What would be the fiscal effect of harmonisation?

The Commission estimates the fiscal cost of harmonisation to be in the range of \$0 to \$37 million per year. The cost would depend on the policy settings adopted (in particular, the rate of permanent impairment compensation). The cost is expected to decline over time, as the number of veterans who would have claimed under the DRCA decreases.

The fiscal effects of harmonising permanent impairment payments are relatively small. If veterans making a claim under the DRCA in 2017 had instead received compensation under the MRCA, total compensation would have been between \$13 million lower and \$17 million higher, depending on how many veterans claimed under the warlike and peacetime rates (Commission estimates based on unpublished DVA data). These estimates take into account the different rate of compensation and age-based lump sums under the MRCA — they do not take into account the whole-of-person methodology used under the MRCA.

The Commission estimates that the effect of introducing the remuneration loading¹ into the DRCA incapacity payments and removing the 5 per cent superannuation step down would have increased the costs of incapacity payments in 2017 by \$12–20 million (Commission estimates based on unpublished DVA data). It is difficult to estimate the effect of other differences between the incapacity payments, including the maximum payment threshold and changes to indexation, but these are unlikely to have large cost effects in practice.

Changes to benefits for dependants and other allowances are unlikely to have a large fiscal effect overall as few dependants qualify for benefits under the DRCA, and the other allowances are relatively small payments. Nonetheless, access to these payments could be a significant benefit to individual veterans.

What would be the effect on individual veterans?

For many current recipients of DRCA compensation, harmonisation would increase the compensation they receive. Recipients of incapacity payments would be immediately able to access the more beneficial MRCA incapacity payments. Compensation recipients may also receive access to MRCA-only schemes, such as the motor vehicle compensation scheme and the education and training scheme.

Those receiving permanent impairment compensation, or widow(er)s receiving lump sum compensation would not have their compensation changed.

The effect on veterans or their families who would have claimed under the DRCA in the future is less straightforward — but many will receive more compensation. They would receive the same access to the more beneficial MRCA benefits as current DRCA recipients. However, they would also make claims under the MRCA permanent impairment payments

¹ The Commission proposes replacing the remuneration loading with superannuation contributions in chapter 15. This would likely lead to similar fiscal effects.

or wholly dependent partner payments. For both of these payments, MRCA compensation is provided as a periodic payment (or age-adjusted lump sum). This means that older veterans can receive less permanent impairment compensation under the MRCA than under the DRCA (and younger veterans more). If the rate of permanent impairment compensation moves toward the warlike rate (chapter 14), the Commission estimates that 75 per cent of veterans making a DRCA claim in 2017 would have received more permanent impairment compensation under the MRCA, while 25 per cent would have received less. Most prominently, those with higher impairment ratings will be much better off under the MRCA (figure 13.2).

In addition, some veterans may be affected by the whole-of person MRCA approach to calculating impairment points. For example:

- veterans who have several impairments below 5 impairment points would receive no compensation under the DRCA, but can combine these impairments to receive compensation under the MRCA
- a veteran with two impairments rated at 20 points would receive compensation based on 40 impairment points under the DRCA (or, more accurately, two sets of compensation based on 20 impairment points would be provided). Under the MRCA the two impairment ratings would be combined using the Guide to Determining Impairment and Compensation to a rating of 36 points
- where two injuries lead to an impairment to the same functional system, under the DRCA the person may be compensated twice for the same impairment — this would not be the case under the whole-of-person methodology.

The bottom line is that most veterans and their families would be made better off by the harmonisation of the DRCA to the MRCA. However, it is not possible to say categorically that no future claimant will face a reduction in their compensation.

Most participants supported harmonising the MRCA and DRCA, but some only did so on the basis that there would be no loss of any benefit (for example, Air Force Association, sub. DR267; Veterans Support Centre and Belconnen RSL Sub-Branch, sub. DR229; VVFA, sub DR215; War Widows' Guild of Australia, sub. DR278). As noted earlier, it is not possible to reduce the complexity of the scheme without affecting benefits, and the change in benefits should not prevent the reform process.

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 a permanent impairment, incapacity and assessing the 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.

13.4 The interface with military superannuation

Veterans who are both medically discharged from service and have a service-related incapacity can receive two sources of income replacement compensation: incapacity payments or above general rate pensions under the VEA, DRCA or MRCA, and invalidity pensions through military superannuation arrangements. Under both the MRCA and DRCA, incapacity payments are offset dollar-for-dollar against invalidity pensions. Often this can result in the veteran losing most or all of their incapacity payment (box 13.9).

Veterans receiving a defined benefit superannuation pension or lump sum under the Defence Force Retirements and Death Benefits Scheme (DFRDB) and the Military Superannuation and Benefits Scheme (MSBS) can also be subject to the offsetting of this payment against incapacity payments.

Box 13.9 **A case study on superannuation offsetting**

Using the example from box 13.3, Frank is a fully incapacitated veteran receiving an invalidity pension of \$52 800 (about \$1015 each week). He was previously earning \$60 000 annually in the military.

If he was not receiving an invalidity pension, Frank would be entitled to an incapacity payment of about \$1294 per week for the first 45 weeks after discharge. This amount is reduced dollar-for-dollar by his invalidity pension, such that Frank would receive a \$279 each week incapacity payment on top of his invalidity pension.

After 45 weeks, Frank's incapacity payments would reduce to 75 per cent of his previous income — \$971 each week. As this is less than his invalidity pension, his incapacity payments would be fully offset by the pension — he would not receive an incapacity payment.

It is important to note that the offsetting arrangements only apply to government-funded superannuation arrangements. Invalidity insurance is provided free-of-charge to members of

the military, in large part because members of the military are likely to find it difficult to obtain cover at a reasonable cost under standard insurance arrangements (Robert 2015). Offsetting arrangements are in place to prevent the Australian Government from paying two sources of income replacement to the same person. If offsetting was not in place, a person could receive income replacement far in excess of their previous income.

Offsetting arrangements should remain between government-funded superannuation and the veteran compensation schemes.

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.

Superannuation arrangements add to the complexity of the system

Decisions about veteran compensation are made by DVA, while decisions about invalidity pensions are made by the Commonwealth Superannuation Corporation (CSC). Several participants commented on the complexity caused by these arrangements. For example:

- the interaction between superannuation and DVA payments can lead to administrative failures, such as overpayments which are later recovered by DVA (with tax implications), placing stress on the veteran and their family (RSL National Office, sub. 113; AVA, sub. 81; DFWA, sub. 118)
- there can be inconsistencies between decisions made by CSC and DVA — for example, Rod Thompson (sub. 116) highlighted a case where DVA decisions have differed from those made by CSC
- uncertainty and delays in the invalidity assessment made by CSC can cause further uncertainty and stress for veterans (DFWA, sub. 118)
- having Defence, DVA and CSC responsible for delivering services for veterans ‘creates risk of confusion, gaps, overlaps and less accessible services’ (DoD, sub. 127, p. 4).

The complexities that can arise from the interaction of the superannuation system and the veteran compensation system were also highlighted in a recent Commonwealth Ombudsman report (box 13.10).

While DVA (sub. 125) noted that recent initiatives (including information sharing) between itself and CSC have had positive outcomes, a system that relies on the goodwill and information sharing between two agencies has the potential for communication breakdowns, which can have significant implications for affected veterans.

Box 13.10 2018 Commonwealth Ombudsman report — superannuation

In 2018, the Commonwealth Ombudsman released a report relating to 'Mr A', a veteran who served from the 1970s until 1997 and between 2002 to 2007. Following his retirement in 2007, Mr A transferred to reserve service.

Mr A was eligible for invalidity compensation under the Defence Force Retirement and Death Benefits (DFRDB) scheme and received a lump sum payment and pension following his initial discharge in 1997, and his retirement in 2007.

Mr A applied to the Department of Veterans' Affairs (DVA) for incapacity payments in 2007. DVA were advised by CSC of the DFRDB lump sum paid in 2007, but not the lump sum payment in 1997. Mr A began receiving incapacity payments in 2008, with offsetting applied for the 2007 DFRDB lump sum.

In 2013, CSC reported the 1997 DFRDB lump sum payment to DVA following a review of Mr A's entitlements. In 2015, DVA sent Mr A a debt notice for over \$50 000 — reflecting the amount that Mr A had been overpaid as a result of offsetting not being applied for the 1997 lump sum.

Following a complaint to the Ombudsman, DVA advised that it had incorrectly applied offsetting. At the time, current members of the defence force (including reservists) did not have offsetting applied to DVA payments as a result of their superannuation payments (this was changed in 2013). As a result, DVA determined that Mr A was in fact owed an additional \$500 000 in back payments — with this new lump sum placing Mr A in the highest tax bracket and leading to a tax liability of over \$200 000.

Source: Commonwealth Ombudsman (2018).

Scope to better integrate the superannuation and compensation systems

Several participants called for the responsibility of the assessment of invalidity pensions to be taken from CSC and given to the body responsible for governing veteran compensation (Robert Shortridge, sub. 76; DFWA, sub. 118; RSL Queensland, sub. 73). For example, the DFWA stated that:

... there is a case for responsibility for military superannuation to be transferred to the [Minister for Veterans' Affairs] ... This would assist the addressing of the governance issue with an initial focus on compensation, inefficiencies regarding medical administration, offsetting payment problems and support timely sharing of information. (sub. 118, p. 29).

The Australian Government accepted a recommendation of the MRCA Review to explore options to streamline the administration of veteran compensation and invalidity and death pensions. It noted:

The legislative and administrative responsibilities of both ComSuper and DVA are unique and complex and there are interactions between the benefits paid by both agencies. This consideration, across government, provides the mechanism to scope opportunities for streamlining the administration of superannuation and compensation invalidity and death

benefits by aligning legislative definitions and consolidating service delivery. (Australian Government 2011)

There has been some progress, although the administration of compensation and invalidity pensions remains separated. A pilot program commenced at Holsworthy Barracks in 2017 to introduce a single medical assessment for DVA, CSC and the Department of Defence. There are also steps being taken to facilitate greater information sharing between DVA and CSC, and amendments in 2017 sought to make it easier for CSC to obtain information from DVA.

In its post-draft submission, CSC highlighted a number of new initiatives to streamline the interface between CSC, Defence and DVA. For instance, CSC now use medical assessments conducted by Defence to make invalidity assessments, eliminating the need for an additional medical assessment in most cases. Both DVA and CSC also have ongoing projects to improve and automate information sharing between them. Finally, CSC have also moved to a new claims administration platform that allows greater oversight and system flags (CSC, sub. DR286). Collectively, these reforms have brought the time taken to process invalidity benefits after point of discharge down to about four days. Pension benefits are available the day after discharge in about 30 per cent of cases (CSC, sub. DR286, p. 2).

Nonetheless, the current arrangements of two agencies managing similar benefits for veterans remains prone to errors and has potential for communication breakdowns. Many veterans are receiving both payments — currently, over half of veterans receiving incapacity payments had offsetting applied for superannuation (Commission estimates based on unpublished DVA data) — and have to apply to both agencies for benefits.

The current system can lead to adverse outcomes for veterans. The potential for errors and overpayments is a serious concern for veterans, as highlighted by the case of Mr A.

In the draft report, the Commission recommended the establishment of a single ‘front door’ for veterans’ income support, with consideration also given to the Veteran Services Commission (VSC) administering invalidity pensions as well as the veteran support system. Participants to this inquiry were mostly (but not universally) supportive of a single front door and all recognised the need for greater simplicity (box 13.11).

The creation of a single front door would be beneficial to veterans who are eligible for both invalidity pensions and veteran compensation would have immediate benefits. A single front door for DVA and CSC veteran income support should aim to achieve at least four outcomes:

1. A single claims process — veterans wanting support from either agencies would only have to submit a single initial claim (whether paper, electronic or oral).
2. A single set of procedures — veterans would only need to undertake a particular process (including medical assessments) once.
3. A single point of contact — veterans have a single contact from whom they can seek information about both invalidity pensions and the DVA-administered component of the veteran support system.

-
4. A single source of information — a single agency is able to give information and support, regardless of which agency administers the process and payment of entitlements.

If these four outcomes were achieved, then it is not important which body administers a particular part of the process. For example, DVA could handle the case coordination (and information collection) for all claims but CSC could still process invalidity pension claims after receiving the information (then relay the result back to DVA).

Having case managers within DVA coordinate claims between DVA and CSC is one method of achieving a single front door. This would aid the flow of information between CSC and DVA and the veteran client. The case coordinator would liaise between different assessors and the client. Having DVA undertake this role places the responsibility with a body that already has heavy contact with the veteran community.

Another method of better aligning the two systems would be allowing claims for CSC invalidity pensions to be feature of DVA's 'MyService' gateway. This would allow veterans to submit (at least simple) claims for both CSC and DVA benefits through a single online form. If this was supplemented with the above mentioned use of a single case coordinator for both agencies, then the veteran would experience little difficulty from, or perhaps even knowledge of, the use of two bodies to administer very similar benefits.

Following this, the question remains whether a single administrator of invalidity and incapacity benefits is necessary. Further integration would have costs and problems. There would be transitional costs with developing new information technology systems and processes. There would also be governance issues — if DVA (or VSC) took over responsibility for invalidity pensions it would be responsible to the Military Rehabilitation and Compensation Commission for part of its operations, and to CSC for another. Finally, there may be issues in having the administration of invalidity pensions separate from the administration of the other parts of military superannuation. This is particularly the case for the older military superannuation schemes, where the line between invalidity pensions and defined benefits superannuation is blurred. The distinction is much clearer in the ADF Super arrangements.

The Commission does not consider these issues to be insurmountable. As shown in box 13.11, veterans and veteran organisations are largely supportive of moving to administration of all veteran income support by a single agency. Further, many of the transition issues experienced by moving administration of invalidity pensions into the VSC are likely to be experienced by the establishment of the VSC itself and so the additional transitional issues may be minor.

Box 13.11 What participants' said about streamlining the administration

Legacy Australia supported the recommendation:

Once a veteran's disability is accepted by either the DVA or Commonwealth Superannuation Corporation (CSC), a veteran should not be expected to prove this disability again. This would require some collaboration between the DVA and CSC. (sub. DR220, p. 13)

The Vietnam Veterans' Federation of Australia Inc also agreed if the establishment of a Veteran Services Commission:

... is not accepted by Government the administration of CSC invalidity pension should become a DVA responsibility. This would effectively bring all veteran compensation and invalidity pensions under one Minister. (sub. DR215, p. 31)

The Air Force Association only agreed with some aspects of the proposal:

Streamlining the administration of superannuation invalidity pensions and veteran compensation as suggested in Recommendation 12.2 is endorsed but not their administration by a VSC. (sub. DR267, p. 9)

The Defence Force Welfare Association suggested establishing a permanent agency within DVA to oversee:

- incremental development of interworking and information sharing requirements among Defence, DVA and CSC
- the establishment, maintenance and on-going management of data dictionaries to facilitate the exchange of information among [information technology] systems
- gathering of data and development of measures to assess efficiency and effectiveness. (sub. DR299, p. 27)

RSL Queensland disagreed with a single front door.

Although RSL Queensland agrees that closer sharing of information between DVA and CSC will benefit veterans in processing any claims for invalidity benefits under CSC, we cannot see how DVA should be given carriage of processing CSC Invalidity Benefits. The business of CSC is superannuation insurance, while the business of DVA is the provision of Military Rehabilitation and Compensation. While the two do share medical similarities, they are exclusively different in their assessment and legislative oversight. (sub. DR256, p. 29)

Brad Campbell agreed on the condition that an adequate retirement income is provided.

I see there's merit in it, as long as there is a mechanism within the total compensation package for you to be compensated for your loss of ability to earn superannuation as well. No one joins the military expecting to hit retirement age living in poverty. So if I had served my 40 years, 45 years out in the Army, I would have had a reasonable standard of retirement. Because my employment was cut short by some 30 years, I now have no – I'm in receipt of my super, but this is only increasing at the rate of CPI. (trans., p. 1087)

The Australian Commando Association believes a single front door would be impractical:

The creation of the PC recommendation of a 'Single Door', whilst understandable for a single point access of both Compensation and Superannuation for exiting ADF Members, may not be practicable in its application, as a result of the differing Legislative and Criterion requirements of both compensation and superannuation. (sub. DR298, p. 6)

Brian McKenzie agreed on the condition that DVA be the body who is the front door:

Consideration should be given to moving assessment of disability claims under DVA and the CSC to a single authority, in this case DVA would be preferred. In any event, a single medical assessment process should be implemented, and any compensation provided by one agency. This should alleviate some of the difficulties associated with offsetting payments. (sub. DR275, p. 8)

That said, if the single front door is working well, a single administration may offer minimal benefits. Once a single front door has been created, policymakers should consider whether there is a case for administration of both invalidity pensions by DVA (or VSC). If the single front door solves most of the interface issues faced by veterans, then administration by a single body would likely be of little additional benefit. In addition, the ‘change management’ reforms already underway in both DVA and CSC may reduce some of the issues that stem from the separation of the two agencies.

Nonetheless, if, following the creation of a single front door and the other reforms underway, there is still significant miscommunication between CSC and DVA and confusion for claimants, then single administration may be necessary.

If invalidity pensions were to be moved into the agency administering veteran compensation, the best time for this to occur would be during the rollout of the VSC and so should occur no later than 2025 if the Commission’s preferred timeline for governance reforms is followed. The rollout of the single front door would serve as an intermediate step before complete integration of the two systems and should be pursued immediately.

What are the necessary legislative changes?

There will need to be legislative amendments to give DVA to collect information relating to claims for CSC benefits and to liaise with CSC about these claims. One way to do this is to give DVA a ‘delegation’ similar to the delegation under section 73B of the SRCA that allowed DVA to process Defence Force SRCA claims between 1999 and 2004. This section states:

Comcare may, in writing, delegate to an officer of, or a person employed by, the Commonwealth or a Commonwealth authority all or any of Comcare’s functions and powers. (s. 73B, SRCA)

Section 36 of the *Governance of Australian Government Superannuation Schemes Act 2011*, which determines CSC’s powers and functions — has a similar function to section 73B of the SRCA. This section states:

CSC may, by writing, delegate to: ... an [Australian Public Service] employee in the Department or in the Department responsible for the administration of the Defence Act 1903 or ... a member of the Australian Defence Force ...

This section may need to be amended to give CSC the power to delegate authority to the DVA (or VSC). This should give the DVA (or VSC) the necessary legal powers to work with CSC towards the creation of a single front door into veteran income replacement.

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*.

ADF Cover may not incentivise work

All three military superannuation schemes provide a proportion of the veteran's previous military earnings (at point of discharge) based on the level of incapacity for civilian work and the age at which they joined the military (except DFRDB which takes account of the former but not the latter). If individuals on the highest level of pension ('Class A') begin working and earning a significant proportion of their previous income, CSC may opt to review their incapacity payment and result in the individual receiving a lower rate of pension. In these circumstances, a veteran returning to work could end up significantly *worse-off* financially, as a result of their decision to work. The potential detriment to their earnings reduces the incentive of an individual to return to work if their level of incapacity becomes lower after being granted an invalidity pension.

Similar income replacement payments through workers' compensation and the MRCA gradually taper-off as an individual's earnings grow to encourage return to work.

If an individual under the three superannuation schemes returns to work, they may lose (or reduce) not only their current invalidity pension, but also the prospect of receiving this pension for life. They accumulate no superannuation entitlements for the time they were on invalidity pensions. As the invalidity pensions are paid into retirement, the detriment to their

retirement income from losing their invalidity pension may not be worth returning to work (even if their income increases in the short term).

Moreover, invalidity assessments under military superannuation are based on a static assessment of the kinds of civilian employment a veteran could undertake with their current experience, qualifications and skills. These assessments also make no allowance for the likelihood or even the possibility that the veteran could retrain or reskill. Such a passive approach to disability goes against the Commission's proposed principles for veteran support (recommendation 4.1) — *ability not disability* — and ultimately undermines the wellbeing of the veterans themselves. As discussed above, return to work has numerous wellbeing benefits and disincentivising a return to work is ultimately detrimental to veterans.

As one participant put it:

It is just money there for pensioning, and the main aim when a person's got a class A is to stay on class A, and if you're on class B, to stay on class B, and don't let them know that you're going to be working or capable of work, because you'll lose everything, and that's a bit of a cynical attitude, but it's what the legislation encourages. (John Lewis, trans., p. 1152)

A potential way to deal with these issues would be to expand access to incapacity payments (under MRCA) to medically discharged veterans and abolish invalidity pensions through military superannuation. These payments have better incentives to return to work, while still providing the veteran a significant proportion of their income.

A common argument against such a change is that incapacity payments and invalidity pensions have different purposes — one is compensation, while the other is superannuation insurance. However, this does not mean that the payments cannot have similar structures.

This may be the case, but in the case of ADF members, the line between the two is heavily blurred. Unlike civilian schemes, military superannuation insurance is provided free of charge, as a government benefit. Both are provided as a form of income replacement. Given that the group of people receiving the benefits heavily overlap, and that the benefits are offset, alignment between the payments would appear to be warranted.

Previous reviews of both veteran compensation and military superannuation have recommended greater integration between the military superannuation and veteran compensation system. The 2011 Review of the MRCA stated:

It is questionable why there are two legislative arrangements and two Australian Government agencies to administer unique invalidity benefits for former ADF members ...

The complexity of a former member receiving military superannuation benefits in full for life and top-up benefits from the [Military Rehabilitation and Compensation Commission] until age 65 under a rehabilitation regime would be reduced if the legislation was more integrated and a single agency held responsible. (Campbell 2011b, p. 171)

The 2007 Podger Review of Military Superannuation noted that there would be benefits in building upon the incapacity arrangements under the MRCA for superannuation invalidity

insurance. Conditions for which liability is accepted by DVA should be compensated by incapacity payments only, with a reduced version of incapacity payments available for non-liability impairments (Podger, Knox and Roberts 2007).

However, such a change would only be desirable under the ADF Cover arrangements. Changes to the MSBS and the DFRDB would affect the accrued rights of veterans, and could make veterans worse off. ADF Cover has only been operating since 2016 and so members have few accrued rights under the scheme.

The effect on veterans is complex

Estimating the effect of this reform on the value of compensation received by veterans is complex.

Once incapacity payments have stepped down to 75 per cent, class A invalidity pensions will generally be more generous for veterans who joined the military at a young age (those under 26 years old, based on the Commission's back of the envelope calculations (box 13.12)). However, this is complicated by the different approaches to indexation — military wages have generally increased at a faster rate than CPI (which invalidity pensions are indexed at). For example, although initially a veteran who was injured at the age of 18 years old would receive 92.4 per cent income replacement, with indexation this proportion of income replacement would fall to as low as 59 per cent (based on assumed growth in ADF wages). However, incapacity payments would provide a constant 75 per cent of their income over their working age (figure 13.5).

Box 13.12 Income replacement by ADF Cover invalidity pensions

Under ADF Cover, invalidity pensions consist of two components:

1. A lifelong (unless reviewed) pension = $(60 - \text{Members' age in years at invalidity exit}) \times [2.2\% \text{ for Class A, } 1.1\% \text{ for Class B}] \times \text{Superannuation salary at exit}$, plus
2. A temporary top-pension payable to age 60 = $\text{Completed years of service at exit} \times [2.2\% \text{ for Class A, } 1.1\% \text{ for Class B}] \times \text{Superannuation salary at exit}$ (sections 4, 16 and 17 of the *Australian Defence Force Cover Act 2015*).

For those under the age of 60, the pension amount can be calculated as

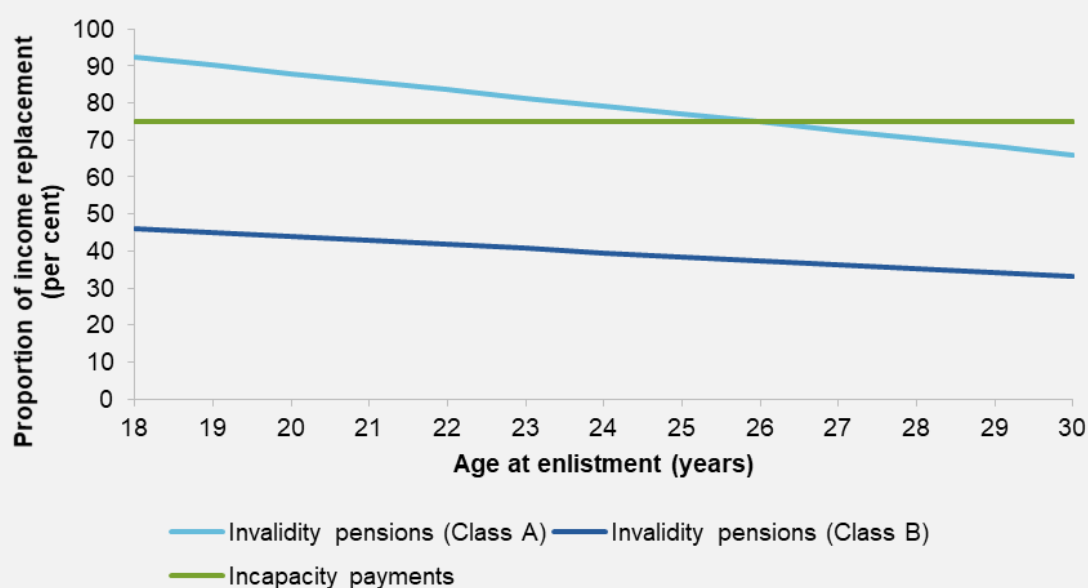
$$= (60 - \text{Age at which the member joined the ADF}) \times 2.2\% [\text{for Class A, } 1.1\% \text{ for Class B}] \times \text{Superannuation salary at exit}$$

This means that the pension replaces a higher proportion of the members salary for those who joined the military earlier in life. It could theoretically replace as much as 92.4 per cent of the members income for those who are classified as 'Class A' and joined the ADF at age 18. However, as shown by the figure below, this would be eroded over time due to indexation.

Incapacity payments, by contrast, replace 100 per cent of the gap between previous military earnings and actual earnings for the first 45 weeks of receiving them followed by a 'step down' after which members receive 75 per cent of the gap (chapter 14).

The Commission's calculations show that a medically member under the age of 60, who is completely unable to work, would be better off receiving incapacity payments in lieu of Class A invalidity pensions depending under particular circumstances. This is the case some of those members depending on combination of the age at which they joined the ADF and the age at which they were injured and it would also be the case for anyone who joined after the age of 26 would always be better-off on incapacity payments.

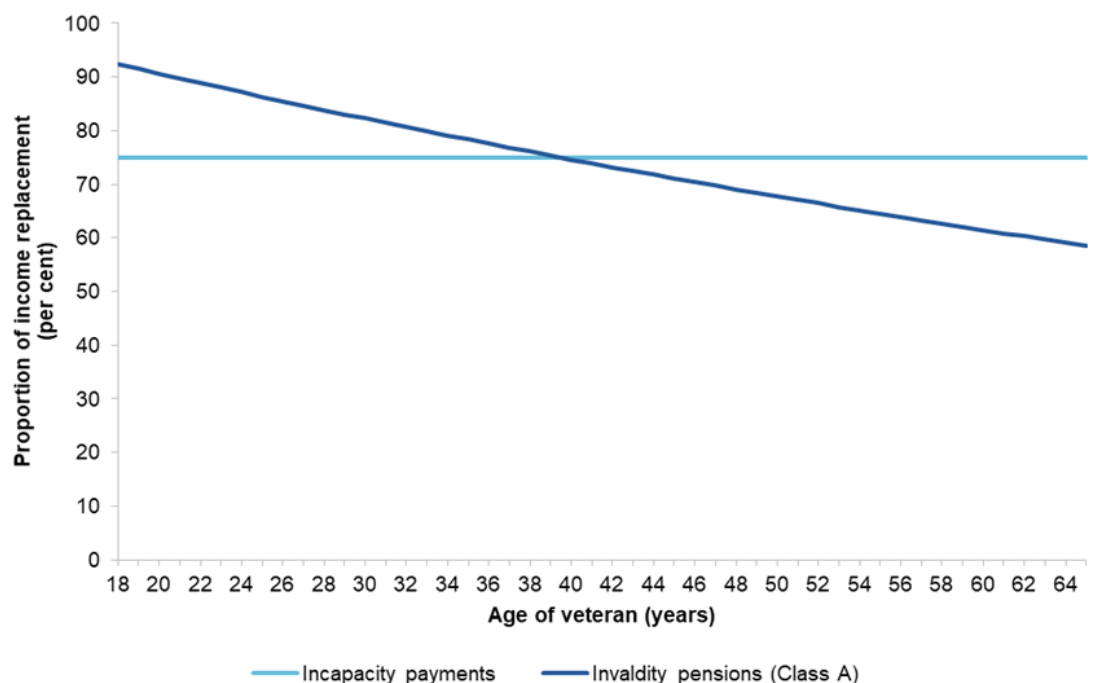
Differences in (initial) income replacement by payment



Source: Commission calculations based on legislative rules.

Figure 13.5 Proportion of income replacement by veteran age^a

Incapacity payments and invalidity pensions (Class A)



^a The proportion of a veteran's income (indexing to general ADF pay increases) replaced by a particular payment over their lifetime.

Source: Commission calculations based on legislative rules.

Incapacity payments are also paid until age 65, while the invalidity pension top-up payment ceases at age 60. While the base invalidity pension is paid for life, the Commission's recommendation on paying superannuation contributions to people on incapacity payments would compensate for this (recommendation 14.6).

All told, this means that:

- Class A veterans who join the military early (before age 26) would be better off on invalidity pensions early in life, before switching to incapacity payments later in life
- veterans who join the military when they are older than 26 years would be better off on incapacity payments.

The amount of financial detriment, however, is likely to be modest. In addition, it assumes that the veteran does not attempt to return to work. Where veterans do attempt to return to work, incapacity payments are likely to be much better for the veteran, as their incapacity payment would be gradually reduced, rather than the veteran facing the large step down to a Class B or Class C pension. This also provides incentives for veterans to return to work, which, as noted earlier, is good for their wellbeing. Moving to invalidity payments is also more consistent with a wellbeing-focused approach to the compensation system.

Finally, there are also benefits in terms of simplification. Putting medically discharged veterans (who joined the ADF post 2016) would mean that veterans only need to access one form of income replacement, rather than the current two, and it would remove the need for offsetting. Veterans would be able to access incapacity payments sooner, as those who are medically discharged would not need to establish liability to receive incapacity payments.

Benefits for dependants

Other complications arise from the other aspects of ADF Cover. This scheme also provides lump-sum payments to dependants of veterans who die during the course of military service and reversionary pensions to dependants of deceased veterans who were in receipt of invalidity pensions (these are paid at a rate equal to two thirds of the invalidity pensions). These benefits create inequities within the system; spouses of veterans who die during and as a result of service receive more compensation than spouses of veterans who die as a result of, but not during service (say for example, as a result of cancer that manifests years after service).

Correcting this inequity would require either extending eligibility for death compensation through military superannuation to those who would only otherwise receive death compensation from DVA, or removing this death compensation through superannuation altogether. The Commission does not see sufficient justification for either of these reforms at this stage.

The reversionary pensions are a source of complication in abolishing invalidity pensions under ADF Cover. Spouses of veterans who were receiving invalidity pensions receive a benefit that is not available to spouses of veterans who were receiving incapacity payments, but there is no clear rationale why one group of dependants should get the benefit while the other does not.

That said, the Commission does not see sufficient justification in either abolishing these pensions or extending them to DVA clients receiving incapacity payments. So if medically discharged veterans were to receive incapacity payments in lieu of invalidity pensions, then the dependants of this group of veterans should also receive reversionary pensions if the veteran dies. These should be equal to two thirds of the incapacity payment the veteran was receiving and, like incapacity payments, should also include a superannuation contribution.

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 recipients would not be affected). Medically discharged veterans (who joined on or after 1 January 2016) should have access to incapacity payments under the *Military Rehabilitation and Compensation Act 2004* if the condition leading to their medical discharge caused their 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.

Rehabilitation

Military superannuation currently lacks support for rehabilitation

Getting access to rehabilitation as soon as possible is a critical component to maximising the chances of a successful recovery and return to work following injury (chapter 6). Because rehabilitation can reduce dependency on benefits, early intervention is also important for ensuring value for taxpayers' money.

Currently, veterans applying for invalidity benefits through military superannuation are not required to undertake any form of rehabilitation before being granted pensions (which in many cases they receive for the rest of their lives). The effects of this are twofold:

- veterans not eligible for DVA benefits (because their impairment is not service caused) are likely to 'fall through the cracks' and not access rehabilitation at all
- veterans who might later obtain rehabilitation through DVA (by being eligible for both DVA and CSC benefits) may face delays in accessing rehabilitation. A medically discharged veteran must apply separately for CSC benefits — which takes on average 4 days after the member has been discharged to process — and apply for liability from DVA — which takes on average 107 days — before they can access rehabilitation (CSC, sub. DR286, p. 2; DVA 2017f, p. 61). The Commission is also recommending changes to the coordination of rehabilitation after discharge (chapter 6.)

Overall, this is likely to inhibit the ability of veterans to return to work — about 30 per cent of recent claimants are in receipt of a Class B invalidity pension and so considered to be capable of returning to civilian work (AGA 2018b, p. 24). Veterans who are granted Class A invalidity pensions might be able to return to work with suitable rehabilitation.

The lack of rehabilitation in military superannuation was criticised in several previous reviews. For example, the Podger review recommended that a new superannuation scheme

be created — this was prior to the introduction of ADF Super — under which invalidity payments could only be obtained after receiving appropriate rehabilitation:

The Review Team considers ... that a stronger rehabilitation approach should be introduced, for the benefit of members as well as Defence, and that superannuation arrangements should draw on the experience and expertise developed by the Department of Veterans' Affairs in managing the MRCA. (Podger, Knox and Roberts 2007, p. 65)

The Campbell review of the MRCA also criticised the lack of rehabilitation in superannuation:

While this Review has not examined the superannuation legislation or operations in any depth, there does appear to be a fundamental gap, in that there is no rehabilitation component after discharge from the ADF. The invalidity benefit level increases with higher incapacity levels. There is little incentive for improving the quality of life through participation in the workforce. (Campbell 2011b, p. 171)

Some participants to this inquiry also highlighted the lack of rehabilitation as being problematic:

If veteran 'wellbeing' is a key objective, then the lack of a rehabilitation element in CSC Invalidity Benefits and the clear financial incentives of the CSC system to stay an Invalid, should be acknowledged and addressed. (DFWA, sub. DR299, p. 6)

Rehabilitation would benefit veterans and the wider community

An important benefit of rehabilitation is that it increases a veteran's chances of obtaining employment. And employment has been found to enhance individual health and wellbeing through a number of mechanisms including: greater income, a sense of community and social inclusion, a sense of purpose, and contribution to society. Early access to rehabilitation is particularly important because chances of returning to work rapidly fall as the length of the employment absence increases (Australasian Faculty of Occupational & Environmental Medicine 2011, p. 12).

The rehabilitation programs offered by DVA would also aid veterans with the medical and psychosocial aspects of their injuries and illnesses. This would be of benefit to those who currently have no or late access to rehabilitation, and may help them adjust better to life in the civilian world.

Providing rehabilitation for medically discharged veterans may also reduce the cost of support. As noted in chapter 3, the Australian Government Actuary estimated the cost of providing ADF Cover to its beneficiaries was approximately 21 per cent of their base salary (or about 18 per cent of ADF payroll) (AGA 2018b, p. 41; chapter 3). If the entire ADF were to receive this cover — in reality most serving members are under MSBS or DFRDB — insurance costs are hard to delineate from the retirement costs, this would make the liability associated with granting invalidity pensions approximately \$1 billion each year. The Commission estimates (based on unpublished DVA data) that DVA rehabilitation costs about \$8380 for each individual — though the cost for each person ranges from about \$20

to nearly \$363 500. If all of the 1581 applicants² for invalidity pensioners were given access to rehabilitation, this would cost about \$13 million each year — or less than 2 per cent of the notional annual liability associated with invalidity pensions. So even a modest increase in return to work rates for those receiving invalidity pensions could yield significant savings.

Rehabilitation is a common feature of ‘temporary incapacity’ insurance (and less commonly a feature of ‘total and permanent disability’ (TPD) insurance) provided through superannuation (box 13.13). This provision of insurance is intended to promote return to work and reduce the costs of the insurance to members. That said, ‘temporary disability’ is not the same as partial (but potentially) permanent incapacity, which is the status of Class B invalidity pensioners; however, rehabilitation may still be beneficial. CSC — as is common in TPD insurance — assesses the level of incapacity with regard to:

- his or her vocational, trade and professional skills, qualifications and experience
- and the kinds of civil employment that a person with those skills, qualifications and experience might reasonably undertake
- the degree to which the physical or mental impairment that is the basis of his or her medical discharge has diminished his or her capacity to undertake those kinds of civil employment. (section 18, ADF Cover Act).³

Such an assessment depends heavily on the *current* skills, qualifications and experience of the individual and, for those with low levels of physical or mental impairment, there is potential to significantly reduce the assessed degree of incapacity through reskilling and vocational rehabilitation.

Rehabilitation is also a feature of the legacy Australian Public Service superannuation schemes which also offer pensions for both partial and full incapacity.

Finally, the current system of having rehabilitation only for DVA benefits and not for military superannuation might create the incentive to seek only the superannuation benefits. Although about half of veterans receiving incapacity payments also receive invalidity pensions, it cannot be determined how many veterans are eligible for both but have chosen to only apply for superannuation pensions (Commission estimates based on unpublished DVA data). Given the payments are offset, it is possible there are many veterans only seeking one of the benefits despite being eligible for both. Therefore, any disincentive to engage with DVA rehabilitation created by the lack of rehabilitation within superannuation could affect a significant proportion of veterans.

² There were 41 applicants under ADF Cover, 1523 under MSBS and 58 under DFRDB (CSC nd, pp. 70,77, 81).

³ Similar provisions are contained in the DFRDB and MSBS Acts.

Box 13.13 **Rehabilitation in civilian superannuation insurance**

The Commission looked at the insurance policies in Australia's ten largest superannuation funds to determine how often rehabilitation is used. Both temporary income protection (IP) — which replaces a portion of the claimant's income if they are temporarily unable to work due to injury or illness — and total and permanent disability (TPD) insurance were covered.

Across the IP policies of the ten superannuation funds, every single one at least offered rehabilitation. Four of the ten funds' TPD policies also offered rehabilitation. In at least one case, the rehabilitation could also include retraining or reskilling.

Of the ten largest superannuation schemes, the insurance arrangements that most closely resembled the military schemes was the Commonwealth Superannuation Scheme (CSS). In this defined benefit scheme, lifelong invalidity (or partial invalidity) pensions are paid to claimants following an injury or illness that prevents them from working (or limits how many hours they can work). However, unlike the military schemes, CSS can require claimants in the public service schemes to undertake rehabilitation.

Sources: AMP (2017, p. 43); AustralianSuper (2018, pp. 23–25); BT Insurance (2018, pp. 16, 53); Colonial First State (2018, p. 23); CSC (2018b, p. 28, 2018c, p. 23); First State Super (2018), MLC Limited (2017, p. 70); QSuper (2018, pp. 16–17, 27); UniSuper (2018, p. 24).

Who should get rehabilitation?

Rehabilitation is of most benefit to those with the greatest chance of returning to work, and with the most time left in their career (as the lifetime benefit is higher). Given this, the Commission considers that those under the DFRDB — who joined the ADF no later than 1991 and hence are at least 45 years old — will not receive sufficient benefit to justify making rehabilitation compulsory. However, rehabilitation services should still be offered to those under this scheme.

Determining if those under MSBS and ADF Cover should be required to attend rehabilitation is more difficult. On the one hand, most of those under these schemes would be young enough to benefit from the use of rehabilitation. And making the rehabilitation compulsory would align with the approach under the MRCA and DRCA, which would further align the superannuation and compensation systems.

On the other hand, rehabilitation tends to not be compulsory for those in civilian superannuation (with the exception of the public service superannuation schemes, box 13.13). That said, the sums of money involved in civilian superannuation tend to be much lower than in the military context — a typical lump-sum payment is between \$100 000–200 000, which is a few years' worth of a typical Class A invalidity pension. With smaller sums of money involved, there is a strong incentive for recipients to maximise their capacity to work, given that they will earn more through working than remaining on their insurance. This is not the case in the veterans' schemes, and the Commission has heard from participants that the current payment structures cause strong disincentives to rehabilitate and return to work.

Some of those under MSBS may perceive the requirement to attend rehabilitation as a dilution of their accrued rights (to receive invalidity pensions if they are incapacitated). The

Commission disagrees. Invalidity pensions would still be available for those that are incapacitated; however, now there would be fewer veterans who are incapacitated over the long term because of the provision of rehabilitation. The Commission does not accept that decreasing the degree of incapacity among veterans is a diminution of their accrued rights to receive support any more than preventing injury and illness is a diminution of a veteran's right to receive compensation.

On balance, it seems reasonable for MSBS invalidity pension claimants — which jointly cover all veterans who joined the military after 1991 and before 2016 — to have a compulsory rehabilitation component. These veterans are younger and more likely to benefit from rehabilitation and they may also have better labour market prospects relative to older veterans. The approach taken should be similar to that under the MRCA where DVA can require the veteran to undertake an assessment as to the appropriateness of rehabilitation and then, if DVA determine it would be beneficial, require the veteran to attend that rehabilitation.

Who should administer the rehabilitation?

There are numerous options for who could administer a rehabilitation program to invalidity pension claimants and what this program should look like. CSC, who currently tender for rehabilitation services for public servants, are one option. However, veterans are likely to have differing needs from public servants and so would be best served by a dedicated rehabilitation program. DVA provides rehabilitation under all three Acts, with the MRCA program being the most holistic.

Of the options available, the rehabilitation program under the MRCA seems the best suited to enhancing the wellbeing of medically discharged veterans. This program covers vocational, medical and psychosocial rehabilitation, while most civilian schemes generally only concentrate on the vocational aspects. There are also likely to be economies of scale in having DVA administer rehabilitation for both those under the compensation Acts and those under the military superannuation Acts. Having DVA, and then VSC, provide rehabilitation would also align with having a single 'front door' approach to aiding injured and ill veterans.

There is little reason why a rehabilitation program cannot be added to military superannuation as soon as a single front door is created.

How would the process work?

Medically discharged veterans would submit a claim to CSC for invalidity pensions who would then assess the veteran's level of incapacity and classify them as Class A, B or C. If the veteran is classified as A or B, CSC would send them to DVA who, if it was deemed appropriate, would design a rehabilitation plan and find a provider — the veteran would be able to attend rehabilitation regardless of whether their condition is service-related. CSC would then pay the veteran either a Class A or B pension depending upon *both* their initial

incapacity classification of the veteran and the degree to which attending rehabilitation would interfere with their ability to work (due to time constraints etc). Following the completion of rehabilitation, CSC would then assess whether the degree of incapacity has changed and reclassify the veteran accordingly.

For those who believe their condition is also service-related, DVA should, while the veteran is being assessed or undertaking rehabilitation, be assessing whether they are liable for the condition and hence have a healthcare card ready for the veteran by the time they complete rehabilitation.

What legislative amendments are needed?

The above recommendations would require at least the following three sections to be amended:

- section 43 of the MRCA — to allow medically discharged veterans to receive rehabilitation from DVA
- section 25 of the MSBS Rules — to make it compulsory for MSBS invalidity pension claimants to attend rehabilitation (if CSC or DVA deem it appropriate) and suspend pensions if the veteran refuses without reasonable ground
- division 2 of part 3 of the MSBS Rules — to allow CSC (or its delegates) to grant interim Class A invalidity pensions to those who have been recommended to attend a rehabilitation program through DVA. This section would also need to be amended to allow the CSC to delay completing an assessment of a veteran's incapacity until after the veteran has completed rehabilitation.

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.

Other issues

Participants to this inquiry raised a number of other concerns about the design, implementation and administration of military superannuation (beyond just the interface with DVA):

- despite being reviewable, invalidity pensions are treated as permanent sources of income for the purposes of family law (David Campbell, trans., pp. 1063–7)
- the taxation of invalidity pensions may have changed retrospectively other similar payments (Australian Veterans' Alliance, sub. 81, attach., pp. 13–4)
- the indexation of DFRDB invalidity pensions may not have been adequate to maintain the purchasing power of these benefits (DFWA 2013)
- there may have been misinformation in the offer of converting periodic retirement payments into lump sums under DFRDB — this has now been referred to a Commonwealth Ombudsman inquiry (Commonwealth Ombudsman 2019a)
- issues with administration of invalidity pensions by CSC (Australian Veterans' Alliance, sub. 81 attach., pp. 18–9).

More fundamentally, the Commission is concerned that the current insurance arrangements through military superannuation may not be the best form of remuneration for contemporary ADF personnel.

When military superannuation for the ADF first began in 1948 (with the Defence Force Death and Retirement Benefits scheme), its insurance arrangements were probably appropriate for the circumstances. At this time, war pensions were not available for those injured in peacetime service, and Commonwealth workers' compensation was probably not

adequate for the unique circumstances of military service. Indeed, in the absence of the invalidity pensions, many peacetime veterans would have been reliant on mainstream welfare or private charity due to the risks inherent in Defence service.

However, now that DVA offers beneficial military compensation suited to the unique risks of military service, it is unclear whether the insurance arrangements offered through military superannuation are needed. The cost of these arrangements is now at least 18 per cent of military wages in gross terms. While much of this offsets similar DVA benefits, the net cost is still likely to be significant. It is worth considering whether many serving members, if given the option, would opt out of coverage by invalidity pensions in return for a, potentially substantial, boost to their pay.

At this point, the Commission is not calling for a broader reconsideration of the insurance arrangements offered through military superannuation. However, further reviews and reforms of military remuneration arrangements should consider whether serving personnel might prefer lower invalidity pensions as a trade-off for better pay and conditions.

14 Compensation for an impairment

Key points

- There are several changes that could be made to permanent impairment payments under the *Military Rehabilitation and Compensation Act 2004* (MRCA) that would simplify the payments, and improve access and equity.
 - Moving to a single rate of permanent impairment compensation across warlike and non-warlike, and peacetime impairments would increase equity between veterans and reduce the complexity of the system. A transition path is needed to ensure that veterans who have already lodged claims are not disadvantaged.
 - While interim compensation payments have reduced concerns about the requirement that impairments are permanent and stable before compensation is paid, the provisions could be improved by limiting the length of time an impairment is considered unstable. Because interim compensation payments are ‘interim’, they should only be given as periodic payments, and on the basis that they could be reduced (or increased) if the impairment stabilises at a level lower (or higher) than what was expected.
 - There is little rationale for additional permanent impairment payments for having eligible young people and the payments add complexity and create inequities between veterans. They should be removed and replaced with an across the board increase in compensation for severely impaired veterans.
- Incapacity payments under the MRCA are generally consistent with those under other workers’ compensation schemes. The *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* should adopt the MRCA incapacity payments.
 - There is a case for some veterans to receive superannuation contributions as part of their incapacity payments, to ensure that these veterans are not disadvantaged in retirement. This provision should replace the remuneration loading which lacks a good rationale.
- The option to take the special rate disability pension under the MRCA is counter to its rehabilitation focus — it provides little incentive for veterans to rehabilitate and return to work. It is also rarely used. The option of taking this pension under the MRCA should be removed.
- The rationale for providing benefits to widows of veterans whose death was not related to service (if the veteran had a threshold number of impairment points before their death) is questionable. Eligibility should be removed from the MRCA, and not expanded to other groups under the *Veterans’ Entitlements Act 1986* (VEA).
- 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.

As a way to simplify the current complex legislative arrangements for veteran support, the Commission recommends that the compensation aspects of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) be aligned with the *Military*

Rehabilitation and Compensation Act 2004 (MRCA) (chapter 13). In this context, this chapter looks at some of the more detailed issues that participants raised about the MRCA in the areas of permanent impairment payments (section 14.1), incapacity payments (section 14.2) and benefits for dependants (section 14.3). The chapter also considers issues raised about the *Veterans' Entitlements Act 1986* (VEA).

14.1 Impairment compensation

Veterans under the MRCA can receive permanent impairment payments to compensate them for the pain and suffering associated with a service-related impairment (chapter 13). This section addresses several issues about permanent impairment payments.

Different rates of compensation in the MRCA

Veterans eligible for permanent impairment compensation under the MRCA can receive a different rate of compensation depending on whether their impairment was suffered during operational (warlike or non-warlike), or peacetime service (figure 13.2). The rates for warlike and non-warlike service are about 80 per cent higher than those for peacetime service, up to 50 impairment points, and the difference narrows to zero per cent at 80 impairment points. At its largest point, the difference can be over \$100 000 in lump-sum terms.

This difference is a result of the way permanent impairment compensation is estimated in the Guide to Determining Impairment and Compensation (GARP-M).

- Table 23.1 of the Guide specifies a set of compensation factors that apply to veterans with operational service.
- Table 23.2 specifies a different set of compensation factors for those with peacetime service (MRCC 2016).
- Section 67 of the MRCA requires that the guide specify different methods of compensation for these groups.

As discussed in chapter 4, the reason for the different rates of compensation is that operational service is more demanding and risky, and veterans injured in such service should be granted special compensation. For example, the 2011 *MRCA Review* stated that:

The retention of higher compensation payments for operational service is in recognition of those who are intentionally exposed to harm from belligerent enemy or dissident elements. This policy objective is as relevant today as it was following the Second World War. (Campbell 2011b, p. 73)

At least in part, the different rates for warlike and non-warlike, and peacetime service reflect the historical genesis of the MRCA — that it was an amalgamation of the VEA and the

DRCA. The different rates of compensation between these two Acts form the basis of the compensation in the MRCA. The explanatory memorandum for the MRCA stated that:

The outcomes in terms of compensation for those whose injury or disease results from warlike or non-warlike service and is up to 50 impairment points will approximate those under the VEA. For peacetime service the results will approximate those under the SRCA [*Safety, Rehabilitation and Compensation Act 1988*]. (Vale 2003, p. 35)

That said, it is not clear why the same impairment should be treated differently depending on where the impairment was suffered. The current approach to compensation raises questions about why a compensation differential is justified at low levels of impairment, but not at 80 impairment points and above (Campbell 2011b). The different rates of compensation also:

- add to the complexity of the system
- require veterans to demonstrate whether their injury was suffered as a result of operational service or not
- create inequities between different groups of veterans.

But some veterans and veterans' groups are strongly opposed to moving to a single rate of compensation. For example, Malcolm Whitney stated:

What a disturbing and disappointing recommendation to suggest that veteran warlike rates of permanent impairment compensation should be the same as those with peacetime service. The veteran's permanent impairment is the result of him or her putting their life on the line for their country. Surely, they are owed a far greater level of compensation to someone whose impairment occurred during peacetime service. (sub. DR173, p. 10)

Similarly, the AATTV Association WA Branch stated that veterans would see a single rate as an 'affront to their service' (sub. DR174, p. 1). Others, such as Legacy Australia (sub. DR220) and the Alliance of Defence Service Organisations (sub. DR247), also did not support a single rate of assistance.

Participants who did support a single rate of assistance, such as Bert Hoebee (sub. DR195) and the Vietnam Veterans' Federation of Australia (sub. DR215), did so on the basis that the higher warlike rate be used for all veterans.

As discussed in chapter 4, an injury is an injury, irrespective of how an injury is acquired. As such, the Commission disagrees that an injury acquired in warlike service should result in a different level of compensation to an injury acquired in another military setting. Different operational settings may require different forms of recognition — such as different levels of pay and allowances — but the compensation regime is not the right vehicle for such recognition.

Moving to a single rate is complex

Selecting a single rate of permanent impairment compensation for all veterans covered by the MRCA is not straightforward and has the potential to have large budgetary implications. As Peter Sutherland (sub. DR192) noted, the cost will be very high if no veteran is to be made worse off.

Moving to the warlike and non-warlike rate would mean that no veteran was disadvantaged. However, the cost could be high. Back of the envelope estimates suggest that moving all MRCA veterans to the warlike and non-warlike rate could increase the costs of permanent impairment compensation by about 25 per cent. This could correspond to an increase in compensation of about \$40 million each year in the short term, rising rapidly as the MRCA becomes the predominant scheme (Productivity Commission estimates).

Prior to setting a rate, the Australian Government will need to weigh up the benefits of the change with the lifetime fiscal implications and the transitional arrangements that will be necessary to implement a single rate. There is an opportunity cost of providing additional benefits to a cohort of veterans (that is, money spent on additional benefits displaces money spent elsewhere) and this needs to be considered before a decision is made about the rate.

Moving to a single rate would also have equity implications. If a higher rate is introduced and veterans who have already put in claims do not have their compensation reassessed, this would mean that veterans who have submitted claims quickly could be made worse off relative to those who have delayed their claim. On the other hand, if existing compensation claims were reassessed, this would add to the administrative burden and the cost of the change.

Because of these equity issues, a transition path is needed. A transition to a single rate could be achieved by adjusting the relevant compensation factors contained in the GARP-M slowly up and/or down each year, until a single rate is achieved. This may take many years — possibly 10 years — but would achieve the benefits of a single rate without the large equity implications of immediately moving to a single rate.

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.

Impairments must be permanent and stable under the MRCA

Under the MRCA (and the DRCA), impairments must be considered permanent and stable for permanent impairment compensation to be granted. Veterans with impairments that are not considered stable are eligible for interim compensation based on what their condition is expected to stabilise to (chapter 13). Interim compensation cannot be clawed back if the assessment is found to be too generous.

Because under the MRCA permanent impairment compensation can be taken as a lump sum, permanent and stable provisions prevent veterans receiving compensation for impairments that are likely to improve naturally or with rehabilitation. For example, a veteran could have an impairment to their shoulder of 50 impairment points, but with rehabilitation it could improve to 20 impairment points. Without permanent and stable provisions, the veteran could receive lump-sum compensation based on 50 impairment points.

Issues raised about the permanent and stable provisions

Several participants to this inquiry said that the permanent and stable provisions are unfair, and they add to the time taken for a veteran to receive compensation. The Vietnam Veterans' Federation of Australia (sub. 34) stated that the provisions cause delays and should be removed, while the Vietnam Veterans' Association of Australia (sub. 78, p. 9) said the provisions were 'unreasonable'. In its submission to the Senate inquiry into suicide by veterans, the Alliance of Defence Service Organisations (2016) also noted that the provisions are known to frustrate veterans awaiting determinations.

The provisions are of particular concern for veterans with conditions that can fluctuate with time, such as mental health conditions. DVA (sub. 125) noted that many conditions have a fluctuation in symptoms as part of their normal manifestation. The Royal Australian and

New Zealand College of Psychiatrists also noted that it can be challenging to meet the permanent and stable provisions for people with a mental illness.

The episodic nature of mental illness, whereby consumers can have periods of wellness and periods with severe symptoms, means that it is challenging to meet the requirement of having a 'permanent and stable' condition. Often substantial support and treatment will be required before stability is achieved in the field of mental illness, and veterans should not be left without compensation during this period if their mental health issues are related to service. (sub. 58, p. 8)

Similarly, the Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women noted that:

A number, if not all, psychological conditions along with a number of physical conditions will never be stabilised but yet the Veteran and their families need to wait until the Claim Delegate decides that they are ready to finalise the claim. (sub. 134, p. 23)

Other participants, however, were of the view that the issues around permanent and stable had been resolved. Peter Sutherland (sub. 108, p. 5), for example, said that the issue had been 'overblown', and mainly arose from a failure to apply interim compensation arrangements effectively. The Returned and Services League (RSL) National (sub. 113) also said that the issue had been resolved by recent amendments and improvements in interim compensation payments.

The 2011 review of the MRCA noted issues with the permanent and stable provisions, and considered that more frequent use of the interim compensation provisions would address the issue (Campbell 2011b). While DVA has always been able to offer interim compensation under the MRCA, it was rarely granted in the initial years (figure 14.1). It has been used more frequently since 2009. In 2018, over 900 MRCA cases led to interim compensation determinations.

What are veterans entitled to while they wait for a condition to stabilise?

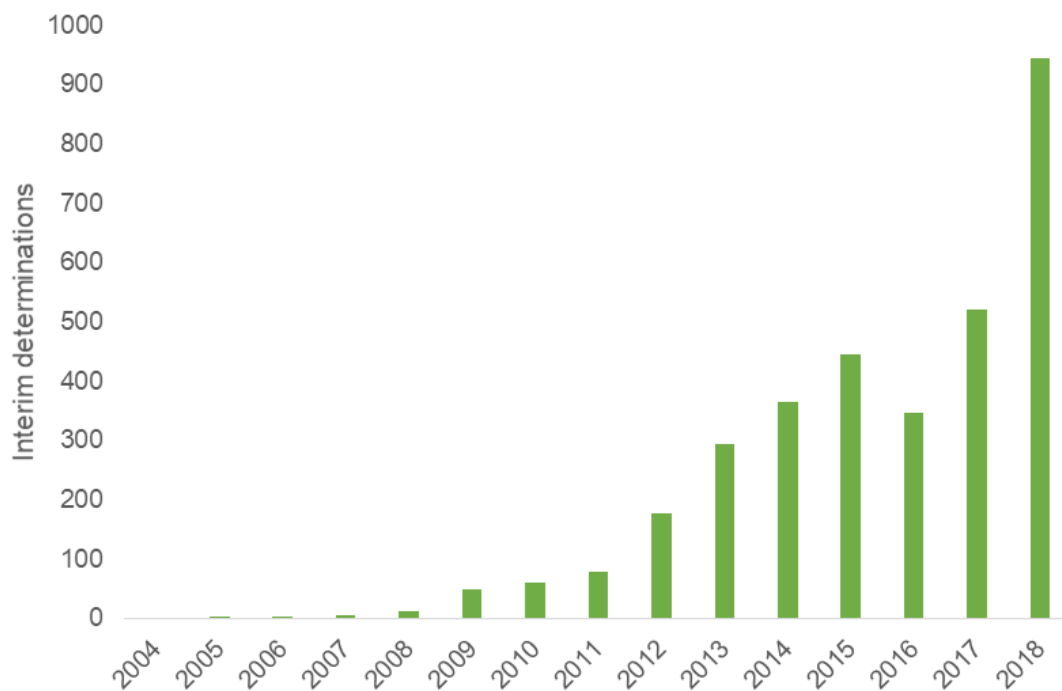
It is important to point out that the provisions around stability only relate to permanent impairment compensation. Veterans can still be eligible for other forms of compensation, including incapacity payments, while waiting for a condition to stabilise. And as noted above, veterans can also receive interim permanent impairment compensation while waiting for their condition to stabilise — and the use of this form of compensation has increased over time.

As a result of recent policy changes, veterans submitting a claim for a mental health impairment may be eligible for two additional forms of compensation.

- First, they can receive the Veteran Payment while waiting for a claim to be determined and six weeks after the claim has been determined (or longer if necessary to transition to another form of income support). This provides an income stream for a veteran while they wait for their payment to be processed.

- Second, DVA will provide interim compensation to people with mental health conditions at a minimum of 10 impairment points, even if the condition is expected to stabilise to less than 10 impairment points (DVA 2018a).

Figure 14.1 **Interim compensation determinations (MRCA), 2004-2018^a**



^a Data for 2018 reflect the number of veterans who started receiving an interim compensation payment in that year.

Source: Productivity Commission estimates based on unpublished DVA data.

The permanent and stable provisions should remain

The permanent and stable provisions should remain in place. A person should not receive a final permanent impairment lump sum on the basis of a level of impairment that is expected to improve over time.

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.

While many of the concerns about the permanent and stable provisions have been addressed by the improved access to interim compensation since 2009, this is not to say that the permanent and stable provisions cannot be further improved.

Interim compensation — weekly compensation or lump-sum payments?

The Commission heard that there is a culture of risk aversion during the claims process in DVA, particularly regarding the payment of interim compensation. While the use of interim compensation has improved, given uncertainty around what impairments may stabilise to, there is likely to remain a bias towards not paying interim compensation, or paying interim compensation at a low level. For example, as discussed below, lifestyle ratings under the MRCA for interim assessments are generally more conservative for a given impairment rating than those for final permanent impairment assessments.

One reason for this may be that interim permanent impairment compensation is not truly interim in nature. Veterans can take interim compensation as a lump sum, which cannot be reduced — even if the condition stabilises at a level lower than expected. Lump-sum payments can be increased following stabilisation of the impairment, and underpayments can be corrected later in the process.

A consequence of this arrangement is that veterans can be overpaid if they have conditions that improve more than expected. This may be exacerbated by the recent policy decision to grant interim compensation of at least 10 impairment points for those with mental health conditions — even if the condition is expected to stabilise below 10 impairment points.

The Commission supports recent moves to increase the availability of interim permanent impairment compensation, particularly for those with mental health issues. Recommendations following the suicide of Jesse Bird note that more needs to be done to ensure that veterans eligible for interim compensation are actually paid it (DVA and DoD 2017). These efforts should continue. However, interim permanent impairment compensation should be interim in nature — that is, compensation should be provided as a periodic payment that can be increased or decreased at a later date depending on the final permanent impairment assessment (compensation already granted should not be ‘clawed back’).

These changes should be combined with a move toward paying interim compensation at the level that best reflects where the impairment is likely to stabilise to, including the lifestyle rating. That is, there should be less risk averse assessments of interim compensation. Veterans on interim compensation should be required to undertake reasonable rehabilitation. Once the condition has stabilised, the level of compensation should be reviewed and veterans would then have the option of taking a lump sum.

Participants expressed some confusion around the intent of this recommendation. Some saw it as a cost-cutting measure (Malcolm Whitney, sub. DR173). Others considered that the reform could be detrimental to veterans (Veterans of Australia Association, sub. DR232, Vietnam Veterans’ Federation of Australia, sub. DR215). The intent of this recommendation

is that, by allowing DVA to more easily correct for mistakes made in the interim assessment, it will allow for a less cautious approach to interim assessments. This will lead to more interim compensation payments made, and at higher levels — to the benefit of veterans.

RSL Queensland (sub. 73) argued that interim permanent impairment payments should be weekly, but be based on the current level of impairment, rather than the level that the impairment is expected to stabilise to. This would simplify the process, however, it could reduce incentives for veterans to participate in rehabilitation. Given the importance of rehabilitation for recovery and veterans' wellbeing, the Commission does not support this proposal.

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.

A time limit for stability?

A key source of concern for veterans is the length of time it can take for an impairment to be determined to be stable. For example, the Commonwealth Ombudsman noted that:

The time frame for potential stabilisation can be many years, and clients are understandably frustrated that their claim for their illness cannot be resolved sooner. This is particularly so when they have psychologically adjusted themselves to a serious and permanent health condition. (2009, p. 3)

Requiring that an injury become stable will lead to some delays. As noted by Hanks in relation to the Victorian Accident Compensation Act:

Some delay due to the instability of a worker's injury or illness is unavoidable. It is important that an injury has stabilised to ensure that the 'permanent' impairment resulting from the injury is appropriately assessed and the entitlement to compensation accurately calculated. (2008, p. 270)

Nonetheless, delays should be minimised. Even with access to interim compensation, delays stretching several years can cause unnecessary angst for veterans, particularly where the veteran is suffering from a mental health condition.

The Commission considers that DVA should have the discretion to offer final permanent impairment compensation in cases where the condition is not stable, but:

- the impairment is permanent — that is, it is likely to have a lasting effect
- a significant length of time has passed since the veteran lodged their claim — at least two years
- the veteran has undertaken all reasonable rehabilitation and healthcare — as determined by DVA.

At this point, the veteran would receive compensation based on their current level of impairment, which could be taken as a lump sum. If the veteran's condition deteriorates further after this point, they could seek a reassessment to increase their compensation.

A similar approach is used under the New Zealand *Accident Compensation Act 2001* — compensation can be paid if two years have passed, and a medical practitioner determines that an impairment is likely to lead to a lasting effect, but is not yet fully stable.

For the majority of cases, this provision is unlikely to have a significant effect, as the veteran's impairment is likely to become stable within two years. The fiscal costs of this change are likely to be relatively small over the long run. However, it would remove outlier cases, particularly veterans with mental health issues, where the impairment can take many years to be considered stable. This change was largely supported by veterans.

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.

Payments for eligible young dependants

Following the Black Hawk disaster in 1996, the 1997 Inquiry into Military Compensation Arrangements recommended that the maximum permanent impairment compensation under the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) be increased by \$150 000. This was to take into account:

- the need to acquire suitable housing and a vehicle
- the additional financial costs incurred by families who forego careers to provide care
- an inability to re-enter the workforce

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- the drop in income brought about by the loss of financial support, such as housing, provided to members of the Australian Defence Force (ADF) (DoD 1997).

In response to the recommendation, the Australian Government increased the maximum compensation under the SRCA by \$49 000, with an additional \$50 750 for each young dependant if the veteran was severely impaired. This payment is retained in the MRCA — with indexation, a severely impaired veteran can receive \$89 393 for each young person dependent on them (chapter 13).

Based on the Commission's research, the MRCA is the only compensation scheme that links the maximum permanent impairment compensation to the number of children a person has, and it is unclear what the rationale is for the payment. Linking a non-economic loss payment to the number of children appears tenuous at best. The economic costs of raising children are met through other payments — including income maintenance through incapacity payments. As noted by the War Widows' Guild of Australia, there are already payments available through the veteran system to help with the costs of raising children.

We are aware that payment (of the same amount) is paid to the dependent children and spouse should the veteran die. This is paid to compensate for loss of a parent and is separate to the initial payment. The Guild questions the necessity of two compensation payments to the same dependents being aware that MRCA is a beneficial legislation. Children of eligible veterans may also access educational payments under the Military Rehabilitation and Compensation Education and Training Scheme 2004. (sub. DR278, p. 21)

Generally available welfare payments, such as the family tax benefit, also assist with the costs of raising children.

Irrespective of whether there is a rationale for the payment, it is poorly designed. It can lead to perverse incentives for veterans. For example, the Commission heard that there can be an incentive for veterans to delay submitting claims that would lead to them exceeding 80 impairment points until they have children and become entitled to the additional compensation. On the other hand, if an impairment stabilises after a child ceases to be an eligible young person, the veteran can miss out on a substantial amount of compensation.

There are also questions of equity between veterans raised by the payment. A veteran with two children can receive about \$180 000 more in compensation than one without — even if that veteran is likely to have children in the future. Similarly, a veteran with two children but with impairments rated at 79 impairment points will receive over \$180 000 less than a veteran in the same situation but with 80 impairment points.

The introduction of the MRCA resulted in a large increase in the maximum rate of permanent impairment compensation — the maximum base rate of lump-sum compensation is about \$200 000 higher than the DRCA rate — but the eligible young person payment has been retained. A severely impaired veteran under the MRCA with two dependent children could receive close to two and a half times the amount of permanent impairment compensation a civilian worker in the same situation would receive under the SRCA.

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.

Most veterans' groups did not support removing the payment, noting that it was a beneficial entitlement that should not be removed (ADSO, sub. DR247; Legacy Australia, sub. DR220; VVFA, sub. DR215). Nonetheless, it is inequitable that veterans with children get a substantially higher amount of permanent impairment compensation than those without. The need for an eligible young person lump sum has been superseded by the substantially higher level of permanent impairment compensation available under the MRCA relative to the DRCA.

While the payment is flawed and should be removed, it is a significant benefit to severely impaired veterans. There is a case for offsetting compensation to ensure that severely impaired veterans are not disadvantaged. This could be achieved by an increase in MRCA permanent impairment compensation of about \$37 per week for those with more than 80 impairment points (equivalent to almost a \$50 000 lump sum for younger veterans), tapering to \$0 by 70 impairment points. This approach would reduce the complexity of the scheme and improve equity between veterans, while retaining the beneficial nature of the scheme.

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.

Guides to assessing impairment

As noted in chapter 13, each Act has its own guide to assess rates of permanent impairment. The use of different guides means that the same impairment can be given a different impairment rating, depending on which Act the impairment falls under. This makes comparisons across the Acts more difficult, increases the complexity of assessing claims, and increases the difficulty of offsetting between the Acts. DVA noted that:

The guides used by DVA are not necessarily the latest assessment guides, and there can be significant differences in the assessment of benefits across each of DVA's Acts depending on which condition is being assessed and under which guide. (sub. 125, p. 104)

This is an area that could be simplified.

The guide used under the DRCA is the most distinct from the other two guides in terms of the impairment ratings assigned to each condition. Simplification would be achieved by assessing future claims that would have been assessed under the DRCA under the GARP-M. While it is not possible to align the Guide to the Assessment of Rates of Veterans' Pensions (GARP) and the GARP-M entirely, given the differences in processes across the VEA and MRCA, where possible these manuals should be aligned to ensure that the same impairment is assigned the same impairment rating across the remaining Acts.

Lifestyle ratings

Under all three Acts, an impairment will be allocated a lifestyle rating depending on its effect on the veteran's lifestyle. This affects the level of compensation that a veteran may receive (chapter 13). Lifestyle ratings are from 0–7 under the MRCA and VEA, and from 0–100 under the DRCA. Slater and Gordon (sub. 68) questioned the use of lifestyle ratings, noting that:

- in the GARP and GARP-M each impairment rating has a range of 1–2 lifestyle ratings associated with it (this range is referred to as 'the shaded area'). Allocated lifestyle ratings rarely fall outside this range
- the factors that affect lifestyle ratings are out of date, and were predominantly developed for World War II veterans
- veterans often do not adequately identify the limitations on their lifestyle, or will over exaggerate the effects
- if claimants seek a lifestyle factor outside the shaded area, this can result in a long, drawn-out process
- increases in lifestyle ratings often result in little gain for the claimant.

It is clear that, at least for the MRCA, most lifestyle ratings fall inside the shaded area for the impairment rating. As of June 2017, about 96 per cent of people who had received a permanent impairment payment had been allocated a lifestyle rating within the shaded area — 73 per cent of people had received a rating at the top end of the shaded area. Of the remaining 4 per cent of veterans, roughly half received a lifestyle rating below the shaded area, while the other half received a rating above the top of the shaded area (Productivity Commission estimates based on unpublished DVA data).

The tendency for veterans to be allocated a lifestyle rating within the shaded area reflects the fact that veterans can opt not to submit a lifestyle questionnaire — which will usually result in a lifestyle rating at the top of the shaded area, or at the bottom of the shaded area for interim permanent impairment assessments. It may also reflect an administrative bias towards granting veterans lifestyle ratings within the shaded area.

It is also the case that changes in lifestyle ratings often do not have a large financial effect in practice, particularly under the MRCA. For veterans with warlike or non-warlike service

under the MRCA, a one point change in lifestyle rating will affect their compensation factor by 0.01–0.02 — a difference of \$4–\$8 per week. Under the VEA, an increase in lifestyle factor may put veterans onto the next highest general rate pension (which can lead to an increase in compensation of \$25 per week), or alternatively not affect the veteran’s compensation at all.

Hilton Lenard and Keith Russell (sub. 13) highlighted the complexity that can occur as a result of the assessment of lifestyle ratings. It noted an example of a veteran who had been assigned a lifestyle rating of two, when they were seeking a lifestyle rating of four (a rating consistent with the top of the shaded area for the veteran’s level of impairment). While after lodging an appeal to the Veterans’ Review Board the veteran received a lifestyle rating of four, the Association noted that: ‘after several years, this veteran received what he was entitled to from the beginning but initially denied and forced into the appeals system due to bad administration’ (sub. 13, p. 3).

There is an in-principle case for retaining lifestyle ratings. Veterans whose impairment leads to a greater effect on their lifestyle should, all else equal, receive a higher amount of compensation. That said, the way they are currently used suggests that they are a ‘tick and flick’ exercise of the compensation process — with little variation in the lifestyle ratings assigned and difficulties for veterans in obtaining a rating that differs from the shaded area. If lifestyle ratings are to remain, they should be treated by veterans and DVA as a more integral part of the process.

Participants to this inquiry largely supported the retention of lifestyle ratings (Bill Kaine, sub. DR197; VOA, sub. DR232; VVFA (ACT) and Belconnen RSL Sub-branch, sub. DR229). Nonetheless, many participants supported an examination of the ratings, to determine if the administration of lifestyle ratings could be improved (Bert Hoebee, sub. DR195; Legacy Australia, sub. DR220; RSL (South Australian Branch) et. al., sub. DR188).

DVA should review its administration of lifestyle ratings, to see if they can be used more effectively to compensate for the effect of an impairment on a veteran’s lifestyle.

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.

14.2 Compensation for economic loss

Incapacity payments

This section considers some of the issues raised about incapacity payments in the MRCA and DRCA. The incapacity payment provisions in these Acts are relatively consistent (with some exceptions) to the provisions that apply in most workers' compensation schemes, and few issues were raised about these payments.

There are two key, and often competing, objectives for economic loss compensation payments.

- Payments should reflect, as close as possible, the true economic cost faced by the veteran as a result of their impairment — the lost wages resulting from a reduced ability to work.
- An incentive needs to remain for veterans to return to work where they are able to do so.

The step downs in compensation in the MRCA are designed to pay a reasonable level of income replacement, while still maintaining an incentive to return to work (PC 2004).

In general, there is a balancing act between the generosity of compensation and incentives to return to work and rehabilitate. The design of the MRCA (and DRCA) incapacity payments mean that compensation will be gradually withdrawn as a veteran returns to work, and that a veteran will be better off financially as they return to work. On the other hand, the VEA has poor incentives for veterans to return to work — as there can be large drop offs in compensation if veterans work more than a specified number of hours. Peter Siminski (sub. DR222) highlighted that the reduction in employment due to Vietnam-era service (compensated by the VEA) could be up to 40 per cent.

This section considers changes to incapacity payments with these key objectives in mind.

Remuneration loading

Veterans on MRCA incapacity payments can receive a remuneration loading — a top up to their normal earnings reflecting the non-monetary benefits of military service (chapter 13). The explanatory memorandum to the MRCA stated that the payment was:

... to reflect and compensate for the lost non-financial components that make up the entire ADF remuneration package, such as free medical and dental and subsidised housing. (Vale 2003, p. 50)

Peter Sutherland raised concerns about the remuneration loading, noting that:

[The remuneration loading] now amounts to more than \$160 pw and has the effect that a junior private will receive about \$50 000 pa in incapacity payments, an amount which they are unlikely to be able to earn in civilian employment. I think the add-on was probably a necessary compromise to get the MRCA Bill passed into law, however its logic is doubtful: the service allowance is already built into normal earnings for discharged veterans (without the

inconveniences compensated for by the service allowance) and many of the non-pay issues are no longer relevant after discharge. (sub. 108, p. 5)

Incapacity payments are designed to cover the economic loss associated with an impairment, and where a person has suffered genuine economic loss, they should be compensated for it. The veteran scheme appears to be the only workers' compensation scheme in Australia to add a remuneration loading-type allowance on to normal earnings. Although this is not the norm, it could be justified where the veteran faces a genuine economic loss as a result of losing access to the services they have available in the military.

Nonetheless, the rationale for introducing the remuneration loading appears weak. Many veterans can receive partial or full health coverage after leaving the military through the DVA healthcare cards system. Veterans can also get access to subsidised home loans to assist with their housing costs through schemes, such as the Defence Home Ownership Assistance Scheme. It is unclear what the other intangible benefits included in the allowance are, and there appears little science behind why the loading was initially set at \$100 per week.

One of the key issues with the remuneration loading is the effect it can have on incentives for veterans to return to work. For example, if a veteran was previously earning \$1000 each week in the military, the step down to 75 per cent combined with the remuneration loading would mean they would be paid 87 per cent of their military salary. The intent of the 75 per cent step down is to provide veterans with incentives to return to work, and the remuneration loading undermines this incentive.

The remuneration loading is not targeted at the economic loss faced by veterans, and reduces incentives to return to work. It should be removed.

Superannuation contributions

Under the MRCA and the DRCA, employer superannuation contributions are not taken into account when estimating the veteran's normal earnings for incapacity payment purposes, nor is a superannuation contribution paid when the veteran is receiving incapacity payments. Peter Sutherland argued that:

In the current environment of retirement savings through accumulation superannuation funds, it is inequitable that veterans on incapacity payments cannot access compulsory superannuation to help them after age 67 when their incapacity payments cease. (sub. 108, p. 5)

Superannuation contributions are not made due to Australian Taxation Office guidance that notes that compensation for workers not working are not salary or wages, and thus no superannuation contribution needs to be made. It is also consistent with all state and territory workers' compensation schemes, with one exception: in Victoria, superannuation contributions can be paid if the worker has been on incapacity payments for at least a year.

The issue of whether superannuation contributions should be made where a person is on workers' compensation payments has been considered for many years.

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- In 1994, the Industry Commission recommended that superannuation contributions should continue while workers are on weekly incapacity benefits, otherwise they would be disadvantaged relative to other workers upon retirement (IC 1994).
 - In 2004, the Productivity Commission noted that ‘inclusion of superannuation contributions could provide for some of the needs of injured workers after the cessation of benefits’ (2004, p. 261).
 - And the Hanks review of the SRCA recommended that consideration be given to amending the Superannuation Guarantee Act so that workers’ compensation payments would be considered ordinary time earnings, and be subject to superannuation contributions (Hanks 2013).

Not paying superannuation is likely to lead to cost shifting from the veteran compensation system to the welfare system, which masks the costs of impairments and may reduce the incentive to minimise injuries. As noted by the Department of Family and Community Services in its submission to the Commission’s workplace relations inquiry:

Long-term unemployment can have significant implications on superannuation for both workers and their families. As injured workers that have not returned to work have a decreased amount of superannuation, many will have increased reliance on age pension in retirement and lower overall income, as age pension only provides a basic level of support. (Cited in PC 2004, p. 270)

For many current veterans, the lack of a superannuation contribution may not be a significant concern. Until 2016, military superannuation was mostly in the form of defined benefits funds, and veterans who are incapacitated while serving would be entitled to invalidity pensions for life through their superannuation. However, going forward, ADF members on the ADF Super accumulation fund may find themselves disadvantaged as a result of their incapacity to work (if they are not receiving an invalidity pension through ADF Cover).

Who should be eligible for superannuation contributions?

Superannuation contribution payments should be paid to long-term incapacity payment recipients — those who have been on incapacity payments for more than a year — who were on the ADF Super arrangements. This would be relatively straightforward as ADF Super is a standard accumulation based scheme. However, these contributions should not be made if the recipient is in receipt of an invalidity pension through ADF Cover, as this includes a pension for life component to replace superannuation.

Going forward, this arrangement could help to streamline the superannuation arrangements and DVA compensation arrangements into one scheme, as it would address a key shortcoming of incapacity payments.

Arrangements for the other military superannuation schemes are less straightforward, as they include large defined benefit components. The MilitarySuper scheme has a partial accumulation component, and consideration should be given to providing members with some portion of the superannuation guarantee to support their retirement. The Defence Force

Retirement and Death Benefits Scheme is a fully defined benefits scheme, and no superannuation payment should be given to incapacity payment recipients who are a member of this scheme.

Finally, it is intended that the superannuation contribution be a replacement for the remuneration loading, not a payment on top of it. Veterans receiving the remuneration loading should not be eligible for a superannuation contribution through their incapacity payment.

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.

Incapacity payments for veterans who are unable to work

While the step down in incapacity payments to 75 per cent of normal earnings after 45 weeks is designed to provide an incentive for veterans to return to work, several participants criticised the use of step downs where a veteran is incapable of returning to work. For example:

My question is, as I am medically unable to pursue any type of paid work, why doesn't the incapacity remuneration package remain equal to my departing salary until retirement age ... As it stands now, I am fortnightly worse off than when I was fully employed by defence. (Dale Canning, sub. DR164, p. 1)

My concern is that I am no longer able to work due to my accepted service related conditions, yet am now required to exist on 75% of my previous wage ... The significant decrease in earnings places a significant psychological burden on members who are medically deemed unable to work. (Rory Patterson, sub. DR238, p. 1)

The Commission does not support increasing the rate of incapacity payments for people who are incapable of returning to work. There are several reasons for this.

- Labelling someone as unfit to ever return to work goes against the wellness principle. The Commission heard that labelling people as unfit to return to work can affect their

self-esteem and self-worth. It would, at least in part, replicate the downsides of labelling veterans as totally and permanently incapacitated under the VEA.

- The veteran schemes are already relatively generous in this regard. Under many of the state and territory schemes, incapacity payments will cease entirely unless a person is severely impaired.
- It is unclear how it would be determined whether a person is unfit to ever return to work. Linking it to permanent impairment ratings is flawed — as impairment is not a good measure of incapacity — and leaving it to the discretion of the scheme administrator is likely to lead to significant inconsistencies between cases.

Nonetheless, there is an in-principle case for veterans who would clearly be unable to ever return to work to receive the full amount of economic compensation — 100 per cent of their prior incapacity payment. The Commission is not opposed to this issue being reconsidered in the future if it is found that the scheme could be competently administered by the Veteran Services Commission to mitigate the downsides of the approach discussed above.

Other differences between the MRCA and the DRCA

There are a number of other differences between the MRCA and DRCA incapacity payments, including that:

- the DRCA increases incapacity payments based on indexation, while the MRCA increases payments based on actual movements in ADF pay
- the DRCA reduces payments by an additional 5 per cent based on a notional superannuation contribution.

The Commission considers that aligning the DRCA with the MRCA approach in these cases is reasonable. Adjusting payments based on actual movements in ADF pay more accurately reflects the economic loss faced by the veteran as a result of their incapacity. The superannuation contribution is outdated. The Hanks review noted that:

That deduction is intended to represent the contribution that the employee would have been making to her or his superannuation scheme if still employed. However, very few superannuation funds now require an employee to contribute to her or his own superannuation. Because most employees are not required to contribute to their superannuation funds, it is inequitable to reduce their incapacity payments in lieu of this assumed contribution. (Hanks 2013, p. 99)

The MRCA approach in these areas should be retained, and applied for veterans currently receiving incapacity payments under the DRCA.

The special rate disability pensions

The MRCA special rate disability pension

Under the MRCA, veterans that meet certain eligibility criteria can opt to take a special rate disability pension (SRDP) — largely equivalent to the special rate of disability pension under the VEA — instead of incapacity payments (chapter 13).

There are several issues with this payment.

- The criteria for the payment runs counter to the rehabilitation focus of the MRCA. Unlike incapacity payments — which provide incentives for veterans to return to work — veterans lose access to their payment entirely if they return to work for more than 10 hours per week. In effect, veterans receiving the payment are labelling themselves as totally incapacitated for life.
- The choice between incapacity payments and the SRDP can create confusion for veterans. Veterans must receive financial advice to make this choice, but this is costly. As of June 2018, the cumulative cost of providing financial advice to choose between the SRDP and incapacity payments was about 15 per cent of the cumulative cost of paying the SRDP over the lifetime of the MRCA (Commission estimates based on unpublished DVA data).

DVA also noted that the SRDP ‘is complex to administer and can act as a barrier to employment’ (sub. 125, p. 32).

The MRCA SRDP is rarely used. In 2018, just over 50 veterans received a SRDP payment (including a SRDP energy supplement). But this exaggerates the true use of the SRDP.

About 37 of the veterans receiving the SRDP in 2018 received less than \$10 000 through the SRDP — due to offsetting from military superannuation and permanent impairment payments. Indeed, for 32 of the veterans, the only SRDP payment they received was an energy supplement payment. For these veterans, the benefit of accessing the SRDP appears to be the higher rate of energy supplement available through this payment (because both their SRDP payment, and their potential incapacity payments, would be offset to zero). This is not the objective of the SRDP.

The remaining veterans are a predominantly older cohort. The average age of these veterans is about 55 years old (compared to the average age of MRCA veteran clients of about 40 years old). Eight of the veterans are 64 years of age or older — at, or nearing the age where incapacity payments will cease. For these veterans, the benefit of accessing the SRDP appears to be accessing the lifetime pension available, rather than incapacity payments which are tightly focused on the economic loss actually faced by the veteran, and thus cease at 65. Again, this is not the objective of the SRDP. There is no rationale for providing economic loss compensation for a veteran who is at retirement age, and has had a full career.

This leaves about 8 veterans who *may* be accessing the SRDP for the reason it was introduced. The SRDP was originally introduced into the MRCA to provide a safety net to ensure that no one would be made worse off in the transition from the VEA to the MRCA — in particular, people in junior ranks in the military (Campbell 2011b; Vale 2003).

The reason for the low uptake of the SRDP is that substantial increases in military wages mean that it is unlikely that veterans will be better off on the SRDP than on incapacity payments. Even the people who have chosen to receive the SRDP are unlikely to be substantially better off on the payment.

While the safety net may have had some rationale at the time of the introduction of the MRCA, its time has now passed. The payment has no rationale, can create costs, cause confusion and reduce incentives to return to work. The option of taking this payment should be closed.

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.

The level of the VEA special rate of disability pension

Several participants raised concerns about the level of the SRDP under the VEA. For example, the Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (sub. 134; sub. 145) used comparisons with the minimum wage and average weekly earnings to state that the level of the SRDP has decreased over time. The Federation noted that the level of the SRDP has declined from 80 per cent of average weekly earnings in the 1950s to about 43 per cent of average weekly earnings in 2018. The Federation called for an increase in the SRDP of about \$400 a fortnight — several other participants supported the assertion that the SRDP was too low (Max Ball, sub. 140; John Reeves, sub. 26).

Such comparisons ignore the other benefits that veterans on the SRDP can receive, including the Gold Card and various allowances and supplements. Veterans on the SRDP can also receive the service pension (or equivalent Centrelink payment) — the SRDP does not count towards the income test for these payments. As noted by Clarke et al. (2003), the amount that special rate pensioners were able to receive increased from about 70 per cent of male average weekly earnings to 90–120 per cent throughout the 1970s, as the SRDP was progressively excluded as income from welfare tests. It remained at this level throughout the period considered by the Clarke Review.

The additional payments received by special rate pensioners cannot be ignored, as most special rate pensioners are receiving some form of additional welfare payment. As of December 2018, over 70 per cent of veterans on the SRDP were also receiving some level of the service pension and a further 7 per cent were receiving a Defence Force Income Support Allowance payment (indicating that they were receiving a Centrelink payment). And, as noted by Clarke et al. (2003), this is the minimum income a veteran on the SRDP should receive — any not receiving the maximum amount of welfare would be receiving a different income source, including potentially an invalidity pension through their superannuation. Veterans are not required to survive on the SRDP alone.

When the SRDP, energy supplement and service pension are considered, a single totally and permanently incapacitated veteran would be receiving about \$2350 per fortnight (not considering benefits such as access to the Gold Card). This is relatively consistent with the figure estimated in the Clarke Review of about 90 per cent of average weekly (after tax) earnings — there does not appear to have been an erosion in the adequacy of the SRDP since the Clarke Review. As noted above, prior to the 1970s, veterans on the SRDP could not access the service pension, and the changes to the service pension access increased the relative generosity of the SRDP.

Participants to this inquiry did not consider the SRDP to be part of a compensation ‘package’, and considered that the above general rate part of the SRDP should be considered as economic-loss compensation. The Commission does not consider that ignoring a substantial benefit of the SRDP — that it is exempt from income and assets tests for welfare payments — would lead to sensible or sound policy making. The logical extension of this approach is that the SRDP should be treated the same as other economic loss compensation payments, and included in income and assets tests for the service pension and Centrelink welfare payments. This approach would make many veterans substantially worse off, in particular those veterans most in need, and is not supported by the Commission. There is no compelling case for an increase in the SRDP.

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.

14.3 Benefits for dependants

There were few issues raised about benefits for dependants — ex-service organisations representing dependants generally considered the benefits available to be reasonable. However, benefits for dependants in the MRCA are an amalgamation of the SRCA and the

VEA, and this has led to some discrepancies and areas where the payments available may no longer be fit-for-purpose.

Benefits for dependants for non-service-related deaths

Under both the VEA and the MRCA, dependants of veterans can receive compensation even if the death was not service related. Dependants of veterans on certain payments, including the SRDP, intermediate rate pension and extreme disablement adjustment, and dependants of veterans eligible for the MRCA SRDP, or above 80 impairment points can automatically receive dependant benefits upon the death of the veteran, irrespective of whether liability for the death was accepted by DVA.

As of June 2018, about 30 per cent of people receiving the war widow(er)s' pension under the VEA were receiving it as a result of the automatic eligibility (DVA unpublished data). It is unknown how many of these would be eligible for the pension in the absence of the automatic eligibility. Most people receiving wholly dependent partner payments under the MRCA were as a result of service-caused deaths — this may be due to the relatively young age of veterans covered by the MRCA, and would be expected to change in the future.

The rationale for the automatic eligibility for benefits for dependants is unclear. The original intent of war widow(er) provisions was to compensate dependants for the service-related death of a veteran. In 1936, automatic eligibility for the war widow(er)s' pension was introduced for dependants of veterans who died while on the SRDP. The Government noted that this was 'a big departure from the generally accepted principles of war pensioning and any additional departures cannot be countenanced' (McLachlan 1935, p. 2415). In 1991, the automatic eligibility was extended to cover the extreme disablement adjustment and widow(er)s of prisoners of war (Clarke, Riding and Rosalky 2003). It was later extended to cover the intermediate rate pension.

The New Zealand Law Commission (2010) considered this issue in the context of the two schemes operating there.

- For scheme one (applying to veterans serving prior to 1974) it recommended that dependants of veterans receiving a disability pension at the time of their death should receive some compensation, but at a reduced rate (50 per cent of the pension the veteran was receiving). This was on the basis that the role the spouse had played during the veteran's life should be acknowledged, but that, because scheme one was for veterans who had served prior to 1974, there was less rationale for a generous payment — the veterans covered by this scheme had not had their life cut significantly short by service.
- For scheme two, it recommended narrower eligibility — dependants would receive benefits only if veterans died during qualifying service, within 10 years of service from a condition that was attributable to service, or more than 10 years from an accepted late onset condition. This is more generous than similar provisions in the United Kingdom system of 5 years and in the case of Canada, 30 days. There is no automatic eligibility under this approach — death needs to be closely related to service. The Law Commission noted:

When non-veterans are dying at a similar age of the same condition, the provision of entitlements, such as compensation, to a surviving spouse does not seem justifiable. Elderly surviving spouses are financially provided for by the Government's income support and disability services. (NZLC 2010, p. 227)

Automatic access to benefits for dependants had a stronger rationale at the time they were introduced. At the time, the welfare and health systems were not as well established, and veterans (almost exclusively men) were often the sole income providers. There is also some evidence to suggest that veterans had a shorter life expectancy than non-veterans (chapter 16). These rationales no longer hold.

The Commission is not proposing removing automatic access to benefits for dependants under the VEA. Under the VEA, benefits are provided almost exclusively as pensions, and the benefits available provide for an extension of (some) pension to a spouse upon the death of their partner. While the rationale for this compensation is weak, the Commission does not see a strong case for its removal. This means that the dependants of the close to 30 000 veterans on the SRDP will become eligible for benefits in the future.

However, the provision of automatic compensation is difficult to justify under the MRCA. Veterans can receive a lump-sum permanent impairment compensation payment, which is intended to cover their pain and suffering over their entire life expectancy. There are no solid grounds for providing an additional lump-sum payment to dependants upon the veteran's death if it is not related to service. Doing so is very beneficial, and results in inequities — for example, less compensation could be provided for a veteran who is killed in service than a veteran with the same circumstances who is impaired in service, and later dies in an unconnected, non-service-related incident.

Many participants suggested that this benefit should be retained, on the basis that it recognises the role of the partner in caring for the veteran. For example:

The reason that dependents may receive these benefits in a non-service related death is to make up for the actual and potential of many years income lost because the veterans receiving these benefits are very often taken out of the workforce prematurely. Solely due to their accepted service related conditions. These small benefits are given to the veteran's dependents as a way of saying thank you for your service from a grateful nation. (RSLA (Queensland Branch) Brisbane North District, sub. DR169, p. 3)

There is a need to provide carers of disabled veterans with support, as with any carer of a disabled person. However, automatic eligibility for dependant benefits is a poor way of providing that support. It does not provide support until the veteran dies, and the need to provide care finishes. It conflates the support needs of carers with those who have lost their partner as a result of service — two groups with different needs. A carer who dies before their partner would not receive the assistance, which appears inequitable.

In addition, there are already a range of initiatives that recognise and support carers of veterans (chapter 14). For example, the partner service pension provides beneficial access to the age and disability pension for partners of veterans with severe impairments. There is

access to services such as carers' respite. And there are a range of supports available through the general welfare system, such as the Carer Allowance, Payment and Supplement.

There is a case for more targeted supports for these dependants, to address their identified needs. The Commission has recommended an expansion to the Family Support Package to provide these supports (chapter 19).

The automatic eligibility for benefits for dependants should be removed from the MRCA — dependants should only receive benefits if DVA accepts liability for the veteran's death. Some support would still be available to other widow(er)s, including bereavement payments, the funeral allowance, and potentially superannuation reversionary pensions or lump sums.

This reform would be designed to target payments towards those most in need of support. The effect of the reform is likely to be minimal in the short term — as noted above, the majority of dependants under the MRCA are receiving benefits due to service-related deaths. The effect would be higher in the long-term, as MRCA veterans begin to die from age-related diseases.

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.

The additional death benefit

The benefit received by wholly dependent partners upon the service-related death of a veteran (or the death of a veteran on certain benefits) under the MRCA has two components.

- First, the partner can receive a weekly payment based on the VEA war widow(er)s' pension, which can be converted to a lump sum.
- Second, partners can receive an additional lump sum if the veteran died due to a service-related death. This MRCA lump sum is age adjusted if the partner is over 40.

The MRCA Review considered the rationale for these two separate payments, and recommended that they be combined, noting that:

The Committee recognises the beneficial nature of the MRCA's death benefit package when compared with other statutory compensation schemes. However, the complicated nature of the package means its value is not always readily apparent or easily understood. The Committee believes that a single lump sum payment to wholly dependent partners would be more easily understood than the existing, complicated arrangement. (Campbell 2011b, p. 96)

The Commission agrees. Having two separate payments adds needless complexity to the system, and obscures the true value of the benefits for dependants available under the MRCA. Combining the payments would also provide greater flexibility for veterans — it would allow them the option of taking the whole package as either a weekly benefit or a lump sum, rather than being required to take a component of the package as a lump sum.

The current additional lump sum is equivalent to between \$90 and \$130 per week, depending on the age and gender of the partner — likely to be about \$115 per week for most people. The wholly dependent partner payment where DVA has accepted liability for the death of the veteran should be increased by this amount to compensate for the removal of the additional payment.

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.

Funeral allowance

When a veteran dies, or in some cases, where the dependant of a deceased veteran dies, their dependants may receive assistance to help pay for the costs of the funeral. There is a substantial difference in the funeral allowance payable between the VEA and the other two Acts (\$2000 and \$12 000 respectively) — which some participants saw as inequitable.

The cost of the veterans' funeral to their family is not related to their compensation arrangements, and the requirements for death related to service are equivalent. It is unclear why this disparity has been continued, to the disadvantage of WW2, Korea and Vietnam veterans and their families. (War Widows' Guild of Australia, sub. 87, p. 9)

In principle, there is little reason why these payments should not be aligned across the Acts. However, in practice, aligning the payments is less straightforward. While the MRCA eligibility requirements for the funeral allowance closely mirror the requirements for a dependant receiving a wholly dependent partner payment, the VEA criteria are much broader, and include for example, where a veteran was receiving treatment in an institution at the time of their death (irrespective of the cause of death). In many cases, the VEA benefit is an automatic grant of \$2000, while the MRCA is a reimbursement of the reasonable funeral costs (up to the maximum allowed). This was noted by the MRCA review:

The VEA funeral payment is intended to subsidise funeral costs, and is paid to a range of claimants, including automatic grant to the estate of certain deceased veterans. In comparison, funeral benefits under the [DRCA] and the MRCA are intended to approximate the full costs of a funeral, but are paid in more restricted circumstances ... simply matching the amount of funeral benefits would not be equitable — both the rate of payment and the circumstances in which it is paid need to be considered. (Campbell 2011b, pp. 322–323)

The Commission does not support raising the funeral allowance to MRCA levels for VEA clients who would not be eligible through the MRCA — the rationale for providing these groups with support is less strong. And removing eligibility from these groups would disadvantage many dependants of veterans. Nonetheless, some harmonisation of funeral benefits should be undertaken, to improve equity and reduce complexity.

The funeral allowance should be harmonised for dependants of the group under the VEA who receive automatic access to the funeral allowance — veterans, who at the time of their death, were receiving a SRDP, an extreme disablement adjustment pension, an allowance as a multiple amputee, or a former prisoner of war. In addition, harmonisation should be extended to those veterans who died from a service-related incident. Claimants would receive reimbursement for reasonable funeral expenses up to a maximum of just over \$12 000. All other groups eligible to receive the VEA funeral allowance would continue under the existing arrangements.

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.

15 Streamlining and simplifying additional payments

Key points

- There is scope to streamline and simplify additional compensation payments to better target benefits (so they are based on need) and remove inefficiencies.
- Payments that are in addition to general compensation should have a good rationale and achieve their stated objectives without giving rise to unnecessary complexities.
- Some payments add unnecessary costs and needless complexity to the support system. These payments should be removed or consolidated with underlying payments.
 - The Defence Force Income Support Allowance should be removed and the Department of Social Services should exempt qualifying compensation payments from income tests for welfare payments. This is an administrative change — it will not affect the amount paid to veterans.
 - The education schemes should be extended to those students currently covered by the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*. The education allowance arrangements for children younger than 16 years should be extended to children between 16 and 19 years and in secondary school, to align the payments with family tax benefits. For other children 16 years and older, the payments should be consolidated with their equivalent youth allowance.
 - The pension supplement subsidiary payments should be consolidated with permanent impairment payments, disability pensions and dependant benefits through a proportional increase.
- Some of the additional payments made to veterans and their families lack a clear objective or the coverage is wider than what is necessary to achieve its objective.
 - The energy supplement for compensation payments should be removed. It was put in place to cover the additional cost of the carbon tax (that is no longer in place) for income support recipients.
 - The vehicle modification scheme under the *Veterans' Entitlements Act 1986* is overly generous (eligible veterans can purchase a new car every two years) and it is not needs-based. It should be aligned with the modern *Military Rehabilitation and Compensation Act 2004* equivalent which is needs-based.
- Some payments are poorly targeted and inconsistent — these should be changed to improve their effectiveness and equity through harmonisation across Acts. For example, the *Military Rehabilitation and Compensation Act 2004* attendant and household services should replace the outdated *Veterans' Entitlements Act 1986* attendant allowance.
- Going forward, the veteran support system should not have additional payments added unless there is a clear objective that cannot be met by general compensation payments.

Veterans and their families can be entitled to ‘additional’ payments — that is, payments that go beyond the main income replacement (economic loss), impairment compensation (non-economic loss) and dependant compensation. As outlined in chapter 13, additional payments can cover educational costs for children, allowances for damaged clothing and vehicle modifications. This chapter looks at the benefits and costs of the range of additional payments, and ways to simplify and better target these payments.

15.1 The benefits and costs of additional payments

Additional payments are typically provided to cover extra costs that some veterans and their families face that are not covered by general compensation. Some people in particular circumstances can require different levels of support and face additional costs. Amputees, for example, can have additional care and assistance needs (their vehicles may need to be adapted and they could require assistance with cooking and cleaning) that are not covered by general compensation (box 15.1). As the Pension Review Report background paper of 2009 said:

Supplementary payments provide a way of ensuring that people with additional costs achieve a similar standard of living.

Supplements recognise specific costs faced by particular groups which have not otherwise been met through direct services and which cannot reasonably be met out of the basic payment alone. (Harmer 2009, p. 10)

As discussed in chapter 13, there are numerous payments that make up the compensation package for veterans.

While additional payments can help people meet the costs of additional supports, these payments can also increase complexity and costs, including administrative costs, and can make the system more difficult for veterans and their families to navigate. As the Returned & Services League of Australia (RSL) National Office said:

When looked at in their totality, the range of entitlements and support available to veterans is overwhelming and confusing ... (sub. 113, p. 30)

The RSL National Office’s observation underscores the point that the system can be so difficult to navigate that veterans and their families need a trained advocate to help them manage a claim.

Additional payments also have budget implications. It is therefore important that the benefits of any additional payments outweigh the costs (including the cost of complexity) and that any compensation is paid in the most efficient way (figure 15.1).

Box 15.1 Additional needs of amputees

Amputees are a cohort of permanently impaired veterans who can have specific needs. And while anyone who is permanently impaired can face additional costs because of their impairment, amputees can face several big-ticket items because of their impairment that go beyond incidental living costs.

Modifying vehicles

Amputees can face additional costs to modify their vehicles so they can drive themselves (steering aids, hand controls and pedal adjustments that need to be fitted by an approved engineer and endorsed on their driver's license) or be transported by family and friends (lower floored minivans and equipment to secure a wheelchair). These modifications can be a large expense.

Attendant care and household services

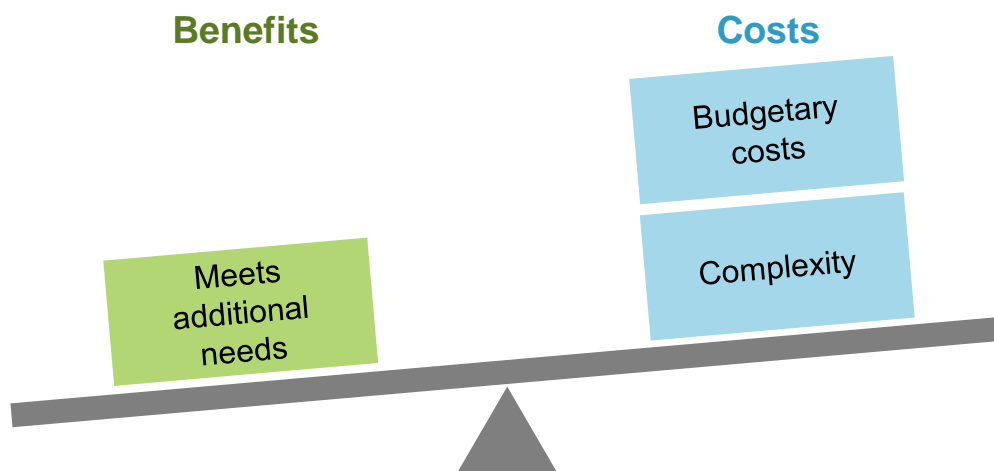
Amputees may need additional assistance to manage their own personal care. This can be simple and short-term assistance — such as recovering after minor surgery — or more complex and ongoing assistance that can vary with the individual's circumstances. It can include assistance with personal hygiene, grooming, dressing, feeding and general assistance for living with a severe injury.

They may also require help with the running and maintenance of their household. This can include meal preparation, cleaning, laundry and shopping. Again, these services may be required for a short period or ongoing.

These services are highly variable in both needs and costs and so require a highly targeted approach.

Figure 15.1 Weighing up the costs and benefits

The benefits should be substantial enough to outweigh the costs



Some participants called for the additional allowances to be rationalised. For example, RSL Queensland noted that ‘the range of benefits is extensive and not necessarily well understood’ and that:

The various allowances available under the VEA [*Veterans’ Entitlements Act 1986*] should be reviewed and rationalised using a ‘better off overall’ methodology. (sub. 73, p. 29)

Many of the payments available to veterans are outdated (often having remained unchanged since the 1920s), do not meet their intended objectives, and result in another layer of complexity in the veteran compensation system. These payments are in need of reform through simplification, streamlining or updating to better meet their objectives.

Questions we asked when assessing additional payments

The Commission’s assessment of the range of additional compensation payments available to veterans and their families involved asking the following questions:

1. What is the rationale for the payment and is it still relevant?
2. Does the payment achieve its objectives?
3. Could the costs of the payment (including the costs of complexity) be reduced or the benefits increased (including by improving targeting) (figure 15.2)?

Based on the answers to these three questions, the Commission identified eight additional payments (from the full list of additional payments) that should be reformed (table 15.1).

Figure 15.2 A framework for assessing additional payments

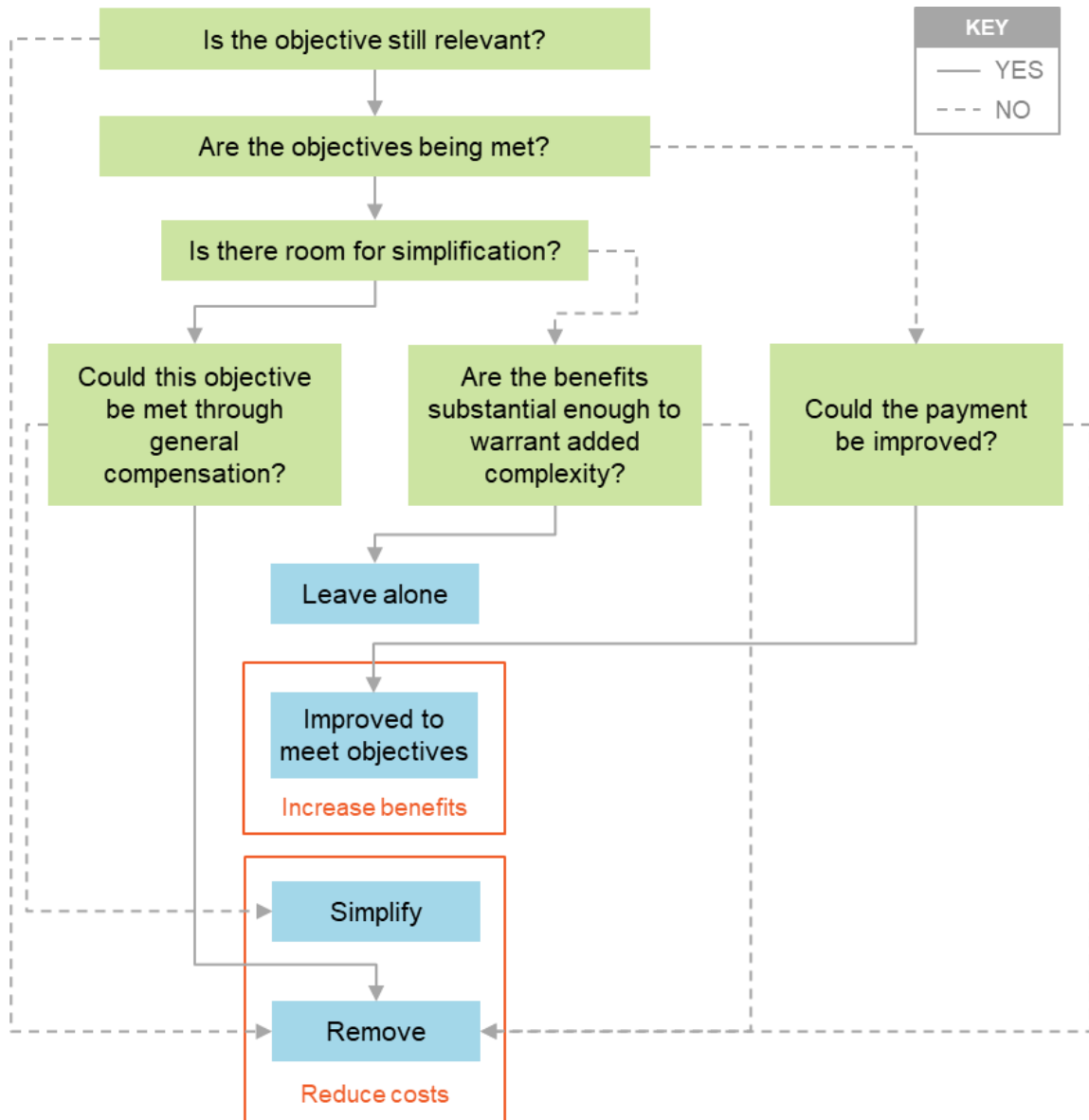


Table 15.1 **Summary of additional payments assessment**

<i>Payments</i>	<i>Needs simplifying</i>	<i>There is justification for removal or consolidation</i>	<i>Needs better targeting</i>	<i>Increases harmonisation across Acts</i>
Defence Force Income Support Allowance	✓			
Education payments	✓			✓
Supplements	✓	✓	✓	
Decoration allowance		✓		✓
Clothing allowance		✓		✓
Recreation transport allowance		✓		✓
Attendant and household care			✓	✓
Vehicle modification			✓	✓

15.2 Options for reform

There are two broad reform options for additional payments:

- simplifying and streamlining payments (and removing payments that no longer have a strong rationale)
- better targeting of payments based on need.

Simplifying payments

The Defence Force Income Support Allowance (DFISA), DFISA Bonus, and DFISA-like payments

The Department of Social Services (DSS) treats Department of Veterans' Affairs (DVA) payments as income and can reduce a person's income support payments if they are also receiving DVA payments. For economic loss payments (replacement of income), this is the

end of the process. However, impairment compensation has a more complex arrangement with how it interacts with DSS payments.

Veterans' Entitlements Act 1986 (VEA) and *Military Rehabilitation and Compensation Act 2004* (MRCA) disability pensions, and MRCA permanent impairment payments ('adjusted disability pensions') attract reimbursement through the Defence Force Income Support Allowance (DFISA) (box 15.2). This is essentially a roundabout way of exempting adjusted disability pensions from DSS income tests (figure 15.3). The service pension income test directly exempts adjusted disability pensions.

Box 15.2 An example of how DFISA works in practice

A veteran receiving the age pension

A 65 year old veteran is receiving a special rate of disability pension of \$1423 a fortnight under the *Veterans' Entitlements Act 1986* and does not have any other income. He does not have qualifying service and therefore cannot apply for the service pension (which exempts adjusted disability pensions from its income test), but instead, is eligible for the age pension (which includes adjusted disability pensions in its income test).

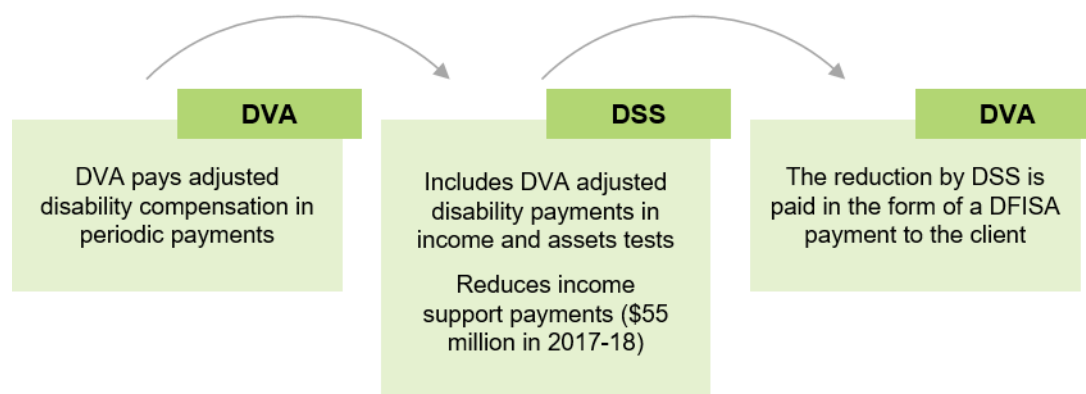
His special rate of disability pension is included in the income test for the age pension which reduces the rate for a single person from the maximum rate of \$926 to \$301 a fortnight. The difference of \$626 is then calculated by the Department of Social Services (DSS) and the figure sent to the Department of Veterans' Affairs (DVA). DVA then pays this amount out in the form of a DFISA payment along with the special rate of disability pension. DSS, usually on a different day, will pay the reduced age pension of \$301 to the veteran.

There are similar payments for veterans claiming the age pension bonus under DSS, called the DFISA Bonus. There is also a DFISA-like payment which covers payments in a similar way that are not technically under DSS legislation. For example, the Farm Household Allowance is administered by the Department of Agriculture and Water Resources, rather than DSS and is excluded from DFISA, but is covered instead by DFISA-like payments.

DFISA also allows those who have their payment under DSS reduced to nil, but are paid greater than nil through DFISA, to receive fringe benefits such as concession cards and supplements.

About \$55 million was offset by DSS and then paid out by DVA in 2017-18. As of December 2018, there were about 14 000 people receiving periodic DFISA payments (Productivity Commission estimates based on unpublished DVA data).

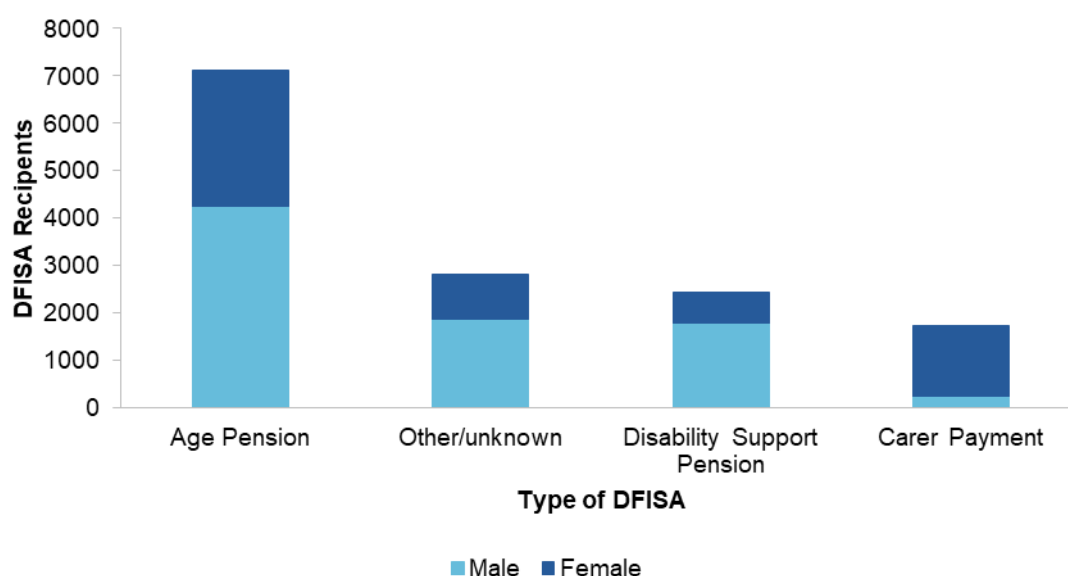
Figure 15.3 The DFISA process



Most income support payments, including the age pension, the disability support pension and carer payments, attract DFISA (figure 15.4). Recipients of the age pension are by far the largest group of DFISA recipients. A substantial portion of this group are women who receive no other payments from DVA except the DFISA payment (because their partner is receiving an adjusted disability pension). They would also be receiving a reduced age pension from DSS.

Figure 15.4 Who receives DFISA payments?

The most common income support payments that attract DFISA (Dec 2018)



Source: Productivity Commission estimates based on unpublished DVA data.

What is the rationale for DFISA payments?

The DFISA payments have their genesis in the treatment of war pensions (the precursor to disability pensions) in income tests for the service pension. While initially war pensions were regarded as income for the purpose of receiving a service pension, this was relaxed progressively over time. In 1973, the service pension exempted 25 per cent of the war pension from income assessment. This was increased to 50 per cent in 1975, and then to 100 per cent in 1982 following a recommendation of the Toose Report. This recommendation reflected the fact that compensation payments were not regarded as income for taxation purposes and therefore should not qualify as income for the purpose of a means tests (Toose 1976, p. 404). However, war pensions were still considered as income for the purposes of Commonwealth rent assistance payments paid by DVA.

The exemption created an anomaly because disability pensions were not considered as income for the purpose of the service pension, but were considered as income for the purpose of DSS payments, such as the almost identical age pension. In 2003, the Clarke Review recommended extending the exemption of disability compensation from income tests to all income support payments.

In the Committee's view, disability compensation payments under either scheme should not be assessed as income in any means tests applied under the VEA or the social security system. (Clarke, Riding and Rosalky 2003, p. 629)

The Australian Government accepted this recommendation and created DFISA to effectively exempt this compensation. However, although the Clarke Review explicitly recommended rent assistance be included, it was not adopted, and rent assistance is currently not covered by DFISA. The rationale for excluding rent assistance but including other forms of income support is unclear and appears to be inconsistent with the principles of DFISA.

While the exemption of workers' compensation payments from welfare income tests is unique to the veterans' compensation scheme, there is some rationale for DFISA.

- First, there is an argument that impairment compensation should not be considered as income because it is for pain and suffering, rather than economic loss. This is similar to the argument made by Toose and the Australian Government at the time to exclude this compensation from the service pension income test.
- Second, the periodic payment of impairment compensation, as opposed to a lump sum, is unique to the veterans' compensation scheme. Lump sum payments are subject to the assets test only, which is considerably looser than the income test that applies for periodic payments, especially if the lump sum payment is used to purchase a family home. Veterans taking a periodic payment could be substantially worse off without DFISA because of their reduced income support payments compared to those who take a lump sum.

However, there are also arguments against the full exemption of adjusted disability pensions from income tests. First, unlike payments under the MRCA, the special rate of disability pension under the VEA does not explicitly distinguish between permanent impairment and

incapacity payments (chapter 13). There is some justification for the exemption from income tests for this payment (the permanent impairment part), but not all (the incapacity part). As the special rate of disability pension is presumed to be a mix of these two payments, it is hard to decipher how much of it is permanent impairment compensation that should be excluded from income tests, and how much is income replacement that should be included. The MRCA and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) explicitly distinguish between these forms of payments. The Commission is not proposing a change in this area.

Second, there may be cases where someone who takes a lump-sum payment could be left worse off than someone who takes a periodic payment under the current arrangements. This would be the case where the level of the lump sum results in a person exceeding the assets tests for income support payments, or where the person invests the lump sum to generate a periodic income stream, which would then be considered in the income test. Again, the Commission is not proposing a change in this area.

DFISA achieves its objectives, but the costs of administering it could be reduced

While DFISA achieves its objectives, the way it is implemented creates a layer of confusion and adds unnecessary administrative burden. The current arrangements mean that costs are simply passed from one government agency to another. As RSL Queensland (sub. 73, p. 33) said, DFISA is ‘confusing and apparently difficult to administer’.

The Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women of Australia went further and described some of the complications that can arise from an inefficient exemption system:

There is also an issue where a non-operational DVA client who HAS to deal with Centrelink is advised by them that there is an overpayment. This needs to be repaid via the Centrelink Disability Pension. Because there was an overpayment with this payment then the DFISA from DVA also has an overpayment. This has to be recovered from the DFISA payment. If a DVA client wants to query this overpayment, then Centrelink advise that DVA should be contacted and then DVA advise that Centrelink should be contacted. There is never a resolution. (sub. 134, att., p. 4)

Similarly, RSL Queensland said that:

... the importance of not requiring a veteran to deal with two separate Government Departments in order to obtain basic benefits should be foremost in the focus of those responsible for veterans’ wellbeing. (sub. 73, p. 33)

Veterans may also not know which department to talk to about their DFISA payments as different departments handle different parts of the processes (including debt recovery from overpayments that need to be made to both departments) depending on the circumstances.

People receiving income support from DSS can receive their income support payment on any of the 10 working days in a fortnight. DVA’s payments, however, are only paid on one

of those days. This can mean someone receives their reduced age pension one week and their DFISA payment another week. This can create a confusing payment situation and could make it more difficult for recipients to plan ahead (because of uncertainty about when they will receive their payments) and to repay overpayment debt.

Options for reform

There is room to simplify the system for veterans, their families, advocates and for DVA administration by removing a layer of complexity that does not add any benefits.

The first option is to remove DFISA without adding any exemptions. However, as noted above, there are some rationales for exempting adjusted disability pensions from means testing. This option would also see many veterans worse off — and in the case of veterans currently receiving the special rate of disability pension and a welfare payment, substantially so. It would also create inequities and an inconsistency between the age and service pension, with the former including the adjusted disability pensions in its income test and the latter exempting them.

The second option is for DSS to exempt all income support payments currently covered by DFISA directly. This would achieve the same result as the DFISA payment without the added complexities. The main difference would be that the payments would be made by DSS in full rather than DVA paying the difference.

While many participants supported this option, others did not on the grounds that it would disadvantage veterans (for example, Veterans Support Centre and Belconnen RSL sub-branch, sub. DR229; VOA, sub. DR232). However, it is important to note that this change is administrative in nature — affected veterans would still receive the same amount of compensation.

These changes may have an effect on rent assistance eligibility for people receiving adjusted disability pensions. Rent assistance eligibility through DSS is tied to receiving a DSS income support payment. As adjusted disability pensions would now be exempted from income tests for DSS payments, more veterans may be eligible for rent assistance. This may result in a small increase in assistance for veterans.

Paying DFISA is a complicated way of exempting periodic adjusted disability pensions from income tests by DSS. DSS should add an exemption for these payments to help streamline the existing system.

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*.

Education schemes

Financial assistance, student support services, and guidance and counselling services are available for eligible students (dependent children of veterans who are either permanently impaired or who have died as a result of service). These are available through the Veterans' Children Education Scheme (VCES) under the VEA and the Military Rehabilitation and Compensation Act Education and Training Scheme (MRCAETS) under the MRCA.

There are different rates of payment for students in primary school, secondary school, and tertiary education. Education payments are not income tested, unlike youth allowance under DSS (although MRCAETS requires that the student is not working full time). The rates for tertiary education students are equivalent to those of the income-tested youth allowance under DSS (which students of veterans covered by DRCA have to apply for).

As at June 2018, there were about 2600 dependants receiving payments under VCES and MRCAETS. Dependants received about \$11 million through these allowances in 2017-18, while the additional support, such as scholarships, cost a further \$3.5 million (DVA 2018g, pp. 22, 217).

Do the education payments achieve their objectives?

VCES replaced the Soldiers' Education Scheme in 1986 and rates were aligned with youth allowance in 1989 for students 16–25 years old (the current arrangement). The income test for students over 16 years was abolished in 1993 as the scheme was seen as compensation rather than income support for those studying. While initially straightforward, the Australian Government extended the full rate of family tax benefit (FTB) in 2012 to those aged 16–19 years and still in full-time secondary school, which complicated the arrangements.

For dependants under 16 years, the education schemes provide additional support in a relatively straightforward manner. These dependants can receive education payments in addition to other income support, such as FTB. For these dependants, the scheme appears to be meeting its objectives.

However, this is not the case for dependants over 16 years old. The only additional benefit that eligible students can receive is not being subject to the income test. Therefore, this

payment is only benefiting high-income families that would not qualify because of the income test under youth allowance (youth allowance is covered by DFISA).

When a dependant turns 16 years, the *Social Security Act 1991* precludes the person from receiving both the education payment and the FTB payment. This means that families are faced with a complex choice between an education payment or the FTB once the eligible young person turns 16 years old (box 15.3).

Box 15.3 Example of complex pathways

John, a dependant of a permanently impaired veteran on the special rate under the *Veterans' Entitlements Act 1986* (VEA), has just turned 16 years old. He currently lives at home and is enrolled in secondary school. Up until this point, John's family had been receiving an education payment of \$57 each fortnight under the VCES and the maximum rate under FTB Part A of \$238 each fortnight.

Once John turns 16 years old, he must be studying full time to be eligible for VCES. In addition, the FTB and education payments cannot be paid together so the family must make a choice. This choice is a difficult one to make. John would likely remain at home while in secondary school and the family would opt for the FTB, as it can be more beneficial (because of other benefits such as rent assistance). When the FTB cuts out at 19 years old, if John goes to tertiary education he is able to collect the education payment from DVA. This would be the better option as there is no income testing, but it would mean that John and his family have to go back and forth between agencies depending on their circumstances for no clear benefit (unless John's family has a higher income, in which case it would be beneficial to have the exempted payment).

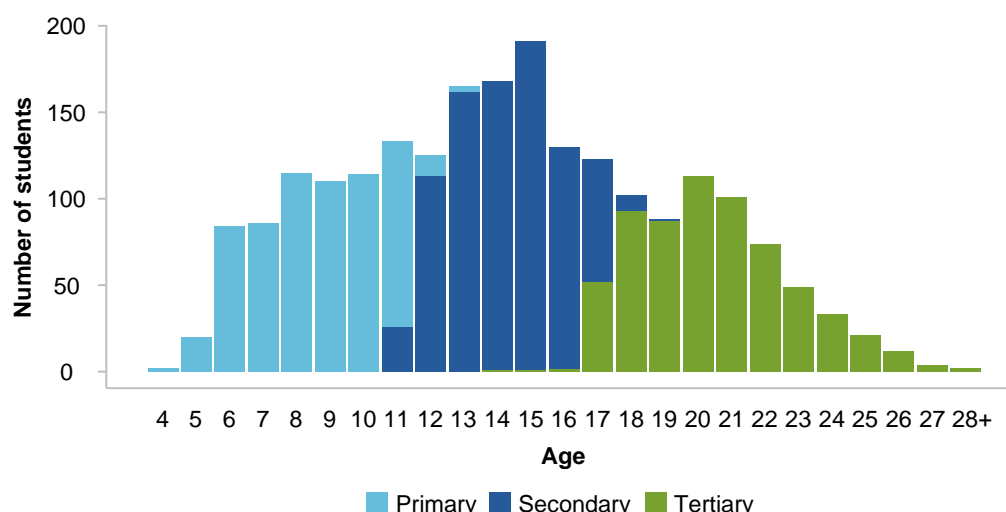
Participants to this inquiry said the arrangements were confusing and that people are switching to FTB when dependants reach 16 years of age then switching back to education payments when FTB eligibility ends at 19 years of age or the dependant begins tertiary education (figure 15.5). The Partners of Veterans Association of Australia, for example, said:

There are an additional unknown number of high school students in this age group who have opted for Centrelink's Family Tax benefits instead of DVA's education allowances. It is thought there are probably another 250-280 students who might return to the Scheme as tertiary students once they finish year 12 and the Family Tax Benefit cuts out. (sub. 77, p. 3)

After the recipient reaches 16 years of age, the education schemes mirror youth allowance with the exception of income testing. Therefore, any additional support would be going to those families who are relatively better off (that is, those that would not pass the income or assets tests). Youth allowance also offers additional support for those under 22 years and looking for work that the DVA education schemes do not. Given the complexities involved, it is not clear that these schemes are well targeted, or have net benefits. The confusion for veterans and their families is amplified when dependants receive an orphan's pension under the VEA, or its equivalent under the MRCA. Before 16 years of age they can receive education, FTB and orphans' pension payments all at the same time. After 16 years of age, it becomes more complex. A dependant can receive the education payment and orphans' pension at the same time under the MRCA, but not under the VEA. The DRCA adds more

complexity with all three Acts paying different rates of orphan's pensions at different times and with different eligibility rules.

Figure 15.5 Eligible young people receiving education payments^a
December 2018



^a Education payments can continue for those over 25 years if their course has not yet been completed.
Source: Productivity Commission estimates based on unpublished DVA data.

Options for reform

The complex education payments are largely because the Government expanded the full rate of FTB to children aged 16–19 years (and in secondary school), but did not adjust the education payment system — leading to a complex range of decisions for families once the child turns 16. The Vietnam Veterans' Federation of Australia noted that:

The solution to keep the eligible child better off than his civilian counterpart, and to simplify this unnecessarily complex system, is to continue the same payments and conditions for the 16-year-old as applied for the 15-year-old. (sub. DR215, p. 11)

The Commission agrees that children eligible for education payments should be on the same arrangements as children under 16 years while they are eligible for FTB. This would require:

- changing the rate of education payment for children between 16 and 19 years and in secondary school to the under 16 rate — currently \$56 under the MRCA
- allowing families to take both this education payment and the FTB when the child is between 16 and 19 years and in secondary school (which is likely to require amendments to the Social Security Act).

The net result is that these families are likely to receive a higher level of compensation. The education payment would be more consistent with the intent of the scheme — to provide an additional level of support to children in recognition of the difficulties of living with an impaired veteran — and provide an incentive for children to complete their secondary school education.

On the other hand, providing a payment that is almost identical to the youth allowance to children over 19, or over 16 and not in secondary school, is needlessly complex. Removing payments for these students in favour of youth allowance would better target those in need of education assistance and simplify the process.

As noted by Barbara Wheatley and Eric Wheatley (sub. DR274), there is a range of additional assistance, like counselling and tuition, that is available through the education payments but not youth allowance. The Commission is not proposing to remove this assistance. Indeed, students not receiving an education payment under the VCES or MRCAETS can still apply to receive additional assistance (if eligible). These services are also currently available to students of veterans covered by DRCA, who would have to apply for youth allowance.

While removing this payment would reduce access to education payments for some families (those who are more financially well off), this could be offset by an increase in compensation to some other families. Currently, dependants of veterans covered under DRCA do not get access to education payments. There are reasons — such as equity and harmonisation across the Acts — to allow access to education payments for these students.

While some participants supported the proposed adjustments to education payments in the draft report (Bill Kaine, sub. DR197; Peter Sutherland, sub. DR192), others rejected the draft recommendation on the grounds that it would make veterans and their families worse off (Claude Palmer, sub. DR179; RSL (SA Branch) et, al., sub. DR188; Stephen Ager, sub. DR162). However, the net result of these reforms is that many families of veterans would be better off — both by receiving more compensation while the children are in secondary school, and increased access to compensation through the DRCA. Some families would lose access to compensation as the children enter tertiary education — these would be families with higher income or more assets that do not meet the income test for youth allowance, while families with lower income and less assets would retain their benefits through youth allowance. On balance, these reforms would remove complexities, harmonise benefits between Acts, and better target those in need.

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.

Supplements

The two main supplements available to veterans and their families are the energy supplement and the various pension supplements (chapter 13).

The energy supplement (formerly the Clean Energy Supplement), was introduced in 2013 when the carbon tax was introduced with the *Clean Energy Act 2011* to assist income support recipients with the increased energy costs. The rates have been frozen since 2014 since the repeal of the carbon tax with the *Clean Energy Legislation (Carbon Tax Repeal) Act 2014*. In September 2016, the Government closed the energy supplement to new recipients of FTB Part A and FTB Part B, and to new recipients of the Commonwealth Seniors Health Card.

There are different rates of the energy supplement attached to a number of DVA payments and benefits — namely income support payments and impairment compensation (disability and permanent impairment payments). DVA clients can only receive more than one energy supplement if they are receiving an income support payment and a DVA impairment compensation payment.

The pension supplements have a different genesis. In September 2009, DSS payments were changed to consolidate the pension supplement (intended in 2000 to account for the effects of the GST) with other smaller payments to help simplify the system. The former telephone, internet, utility and pharmaceutical supplements were merged into the pension supplement. And while this simplified DSS payments, it added complexity to the veteran support system. This is because some DVA clients who were previously entitled to the pharmaceutical allowance were not eligible for the pension supplement. To account for this discrepancy there were three additional supplements, one for each Act, put in place: the MRCA Supplement, DRCA Supplement and Veteran Supplement. These essentially replaced the

pharmaceutical allowance to help cover the cost of medication co-payments for those who cannot receive the pension supplement.

The rationale for supplements

The energy supplement was put in place to help clients with higher energy costs as a result of the carbon tax. The carbon tax, however, is no longer in place.

The pension supplement, and the subsequent additional supplements, aimed to consolidate a range of supplements designed to help with the cost of living.

The rationale for the additional veteran supplements is weak.

- First, if supplements are needed to assist with the cost of certain expenses, it is unclear why this could not be achieved through an increase in the underlying payment, rather than as a separate payment.
- Second, while there is some rationale for attaching cost of living compensation to income support payments — such as the service pension — there is no rationale for attaching such supplements to impairment compensation. These payments are not designed to cover living expenses — rather, they are compensation for pain and suffering.

Separate supplements add to administrative burden without benefiting veterans and their families. For example, someone who receives a permanent impairment lump sum under MRCA will continue to have their fortnightly MRCA supplement paid at the low rate of \$6.20 or the high rate of \$12.40 for the rest of their lives — this makes little sense. Similarly, those who access the White Card for non-liability health care and do not receive any other payment are also entitled to this supplement of \$6.20 a fortnight.

The supplements are needlessly complex.

- The supplements are sometimes included in the underlying payment and sometimes not.
- Supplements can be subject to different levels of indexation than their underlying payments that can result in extra complications when trying to remove or roll-in the payment.

In 2015, the report of the Reference Group on Welfare Reform to the Minister for Social Services summed up the current state of supplements in the Australian welfare system:

Some supplements have a strong rationale while others have remained in the system long after the rationale has passed. In some cases, more than one supplement is performing equivalent roles. In many cases, there is no reason why the supplement cannot be rolled into the primary payment. (2015, p. 48)

The Commission agrees with this analysis and finds little rationale for the structure of these payments, which add to the complexity of the system and can cause confusion without providing additional benefits.

Options for reform

These supplements should be rolled into their underlying payments or removed. This would:

- address the issue of different indexation and supplements being paid on their own
- make the compensation arrangements simpler for veterans to use and for DVA to administer.

The Reference Group on Welfare Reform to the Minister for Social Services noted on the broader welfare system:

In the current system, it is not clear why some costs or activities are supported through supplements and others are supported through the payment system or through services. In some cases, the costs of certain goods or services are covered in part by both payments and supplements.

For example, some supplements cover general costs of living such as telephones or utilities. In moving to a simpler and more coherent system, it would make sense for the main payments rather than supplements to cover general costs of living.

Other supplements that go to the majority of income support recipients such as the Energy Supplement should be rolled into the five main payments. (2015, p. 92)

This logic should be followed in the veteran support system going forward. As the Reference Group points out, this is a broader system issue that needs to be addressed. However, there are some specific changes that can be made within the veteran support system.

First, the pension supplements should be rolled into their underlying payments. There is little justification for having a complex array of supplements that cover general living costs and even less rationale for having them attached to impairment compensation. The DRCA, MRCA, and veteran supplements should be removed and the underlying payments increased by their respective amounts. This would simplify the system for veterans and their families, and also ease administrative burden for DVA. It should be noted that those with non-liability health care cards who do not meet the threshold for permanent impairment compensation or a VEA disability pension would miss out on this payment as there is no underlying payment to attach it to. This would leave this group worse off by a small amount. Those with any claim above non-liability coverage would have it included in their underlying payment and some groups would be receiving an extra supplement, as this amount is already included in the main Pension Supplement. Overall, it is likely that this change would result in an increase in compensation for veterans.

Many participants supported rolling in the pension supplements to the underlying payments (including Bill Kaine, sub. DR197; Legacy Australia, sub. DR220; RSL (SA Branch) et. al., sub. DR188).

Second, the energy supplement should be removed. While participants were less supportive of this proposal, noting that it is a beneficial entitlement for veterans that should not be removed (Bert Hoebee, sub. DR195; RSL (SA Branch) et. al., sub. DR188; VVFA,

sub. DR215), there is no rationale for an energy supplement for impairment compensation (non-economic loss payments) which are not designed to help with the cost of living. This should be confined to income support payments, which *are* designed to help with the cost of living. There is also no rationale for veterans receiving two energy supplements. Those who are receiving an impairment compensation payment and are eligible for income support would be able to access this payment (but not twice). Those who do not qualify for income support but receive impairment compensation would no longer receive this supplement.

About \$30 million in compensation was paid through the energy supplement attached to impairment compensation in 2017-18 (DVA unpublished data).

Going forward, supplements should be carefully considered, factoring in their complexities. The Australian Government should follow the recommendation by the Reference Group on Welfare Reform to the Minister for Social Services that supplements ‘should be for clearly defined purposes and specific extra costs’ (2015, p. 93).

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 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.

Consolidation of small and outdated VEA payments

There are a number of outdated payments under the VEA that have a long history dating back to the 1920s. They include the decoration allowance, the recreation transport allowance and the clothing allowance. Some of these payments are small — for example, the decoration allowance is \$2.10 each fortnight and has only been indexed once since its inception. And some of these payments require additional individual applications (where many eligible may not apply).

Although not a significant source of complexity by themselves, they do add another layer to the system and inconsistency across the Acts. As RSL Queensland said:

Consideration should be given to making lump sum payments available if requested by the veteran for allowances such as Decoration Allowance, Victoria Cross Allowance and Recreational Transport Allowance. (sub. 73, p. 29)

These payments were not retained under the MRCA.

Participants' views on these payments were mixed. Several participants, including Bill Kaine (sub. DR197), Claude Palmer (sub. DR179), Peter Sutherland (sub. DR192) and the Veterans Support Centre and Belconnen RSL sub-branch (sub. DR229) supported simplification of these payments. For example, the Veterans Support Centre and Belconnen RSL sub-branch noted that the change would 'tidy up administration' (sub. DR229, p. 13) and Bill Kaine said 'outdated payments should be paid out and removed' (sub. DR197, p. 10). Other participants disagreed that the payments were outdated, and did not support their removal (Legacy Australia, sub. DR220; VOA, sub. DR232; VVFA, sub. DR215).

The Commission maintains that these allowances no longer have a clear rationale and should be removed to facilitate a simpler system and one that is closer aligned with the modern principles of the MRCA. The added complexity caused by these payments is for little benefit, as the payments are poorly targeted and outdated. While the budgetary impost is low — the Commission estimates, using unpublished DVA data, that the cost of payments is \$1.4 million each year — there is little case for their retention.

That said, current recipients of these payments should not be made worse off. The Commission considers that these recipients should receive a one-off, age-adjusted, lump-sum payment instead of receiving the periodic allowances. The payments would be closed for new recipients.

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.

Targeting and streamlining services

There are payments and services under the veteran support system that require improvements in the targeting of compensation to better meet their objectives, rather than simplification. This section outlines how a better targeted approach can help meet the complex requirements of veterans with extra needs.

VEA attendant and household care

Under the VEA, attendant and household care is provided through an attendant allowance and a program offering home care services.

- The attendant allowance is paid to eligible veterans to assist them with the cost of attendant care (feeding, bathing, dressing and other activities of daily living). Under the

VEA, there is a higher rate of \$341 and a lower rate of \$170 each fortnight for incapacity from war- or defence-caused conditions arising from service before 2004. The lower rate is paid for blindness, certain amputations, or for injuries or diseases that affect the brain and/or spinal system. The higher rate is paid to a veteran who is both totally blind and suffers from a loss of speech or total deafness, or has both arms amputated. The attendant allowance is paid fortnightly once eligibility has been determined, with no follow-ups for assessing changes in needs. As at June 2018, 273 people were receiving an attendant allowance (DVA 2018g, p. 22). The cost of the attendant allowance was about \$1.3 million in 2017-18 (unpublished DVA data).

- The Veterans' Home Care (VHC) program provides a range of household and attendant services for veterans who have a White or Gold Card. The service is not intended for complex care needs, but rather to assist with smaller duties so that ageing veterans can remain at home rather than be moved into care. The veteran does not need a service-related impairment to receive access to these services. Co-payments can be required for these services.
- There are no household services available for VEA clients beyond what is covered under the VHC program, which is limited to basic household needs.

The MRCA and DRCA approach is different — household services and attendant care are provided to veterans with service connected injuries on a needs basis through reimbursement. Veterans can receive a maximum of \$491.67 each week under the MRCA for household services, and the same for attendant care.

The DRCA rates are similar to the MRCA (but not the same due to indexation) and both caps are far higher than under the VEA, which does not offer household services. Veterans under the MRCA and DRCA can also access the VHC program, but cannot access specific services under the VHC program if they are receiving a reimbursement for household services or attendant care to avoid overlap in services. In general, the range of services that can be accessed through the MRCA and DRCA attendant care and household services are much broader than those offered through the VHC program and far more suitable for those with complex needs. These needs are assessed by a suitably qualified professional, most often an occupational therapist. When determining the reasonable requirements for care the following issues are among those considered:

- the nature of the injury, disease or illness
- the ability for the veteran to care for themselves and their household
- the need to avoid disruption to employment and other activities
- the extent to which other services are already providing support
- the extent to which a relative may be able to help (MRCA, s. 215; s. 219).

These requirements are regularly reviewed and DVA makes a decision based on how many hours of care are appropriate. The household and attendant care services are generally paid through reimbursement and they encourage the use of professionally qualified service

providers. This allows choice and control for those claiming the services to seek out their desired services with reimbursements made on a needs basis.

Household and attendant care services can be provided through either DVA or through the National Disability Insurance Scheme (NDIS) with an individual care plan, but not both.

Does the attendant allowance achieve its objectives?

The attendant allowance is designed for those who have additional care needs such as amputees (box 15.1). People with more complex needs require a targeted and flexible approach that cannot be met by general compensation. That is, increasing general disability payments would not reach those with attendant needs as effectively as possible without raising all disability payments up to the rate of the most complex case. Therefore, targeted attendant and household care services are appropriate and consistent with other schemes (such as the NDIS).

The attendant allowance was created in 1922 for veterans who were double amputees, blind or had spinal injuries. These conditions were gradually expanded over time with little change since the allowance's inception. The modern day approach to attendant care has evolved since then with needs-based assessments, individualised care and consumer-directed markets. This type of care is most prominent in the NDIS principles.

The NDIS promoted the need for consumer choice and control, rather than an allocated amount that is intended to cover the entire cohort who all have individual and differing needs. The Commission, in the 2011 Disability Care and Support inquiry, said:

Even small degrees of decision-making power can lead to large improvements to a person's quality of life. Increasing the degree of choice available to people may not even require more funding – in some cases, it can lead to more efficient choices which can reduce costs. (2011a, p. 151)

The evidence strongly suggests a wide range of positive wellbeing outcomes from self-directed funding for people with disabilities and their carers, including higher satisfaction with life, more independent living, better continuity of care and lower levels of abuse and neglect. (2011a, p. 343)

The current VEA attendant allowance allows for choice in provider and spending, but only at two fixed rates (a low and a high rate). These rates are far below the maximum allowances under the MRCA and DRCA. The MRCA and DRCA services provide for a needs-based approach as well as allowing the veteran to have choice and control of the service providers they use. These offer greater flexibility of funding allocations without the constraint of an arbitrary allowance amount. Therefore, although the attendant allowance achieves some of its objectives (giving choice and control through cash payments) it does not adjust funding levels to the needs of veterans — which would allow a better-targeted approach.

The lack of household services available under the VEA can also cause problems for veterans. For example, Josephine Couper noted:

As Veterans age, many experience difficulty in managing their garden maintenance and mowing. Veterans' Home Care does not provide assistance here (except for occasional safety related garden maintenance) ... The lack of assistance with mowing/yard maintenance is definitely the area I receive the most complaints from Veterans. (sub. DR291, p. 1)

Options for reform

Alignment of the outdated VEA attendant allowance with the MRCA attendant and household services would simplify the system through harmonisation and make a more equitable system by providing greater access for those with higher needs. This change was largely supported by participants (for example, Bill Kaine, sub. DR197; Claude Palmer, sub. DR179; Legacy Australia, sub. DR220; VVFA, sub. DR215). The DRCA payment rates should also be aligned with those in the MRCA.

The budgetary effect of this change is likely to be small — given that the total cost of these allowances and services was about \$13 million in 2017-18 (DVA unpublished data). The cost is likely to decrease over time, as the number of veterans on the VEA decreases.

The change would mean that those on the attendant allowance under the VEA would have to change programs. This could be done in two ways.

- Grandfathering those currently on the attendant allowance, but requiring new claims be made through the new MRCA equivalent. This would be a simple approach but would allow the payment with few people to remain for years to come.
- Alternatively, those on the old attendant allowance could be automatically transferred to the same level of payment (rounded to the nearest beneficial hourly rate) on the new MRCA model. This would create harmonisation immediately but would lead to a small amount of disruption for those receiving the VEA allowance. Some of these people may be able to access a higher level of payment, if they have higher needs. As there were only 273 veterans on this payment in June 2018 (DVA 2018g), disruption is likely to be minimal, and this is the Commission's preferred option.

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.

Vehicle modifications

Vehicle modifications can be required to enable a veteran with a severe impairment to access or operate a vehicle. These can include additional requirements for wheelchair entry, exit and being able to be transported safely. They can also include specialised controls to allow operation of a vehicle.

There is a different, but similar, vehicle modification assistance scheme operating under each of the VEA, DRCA and MRCA. In addition, there is a similar assistance program under the NDIS — these schemes are all mutually exclusive (and the schemes cannot be accessed by those receiving a recreation transport allowance).

The Vehicle Assistance Scheme is a VEA-only scheme intended to help veterans with severe impairments (including having both legs amputated or having one leg and both arms amputated):

- purchase a motor vehicle (and a replacement vehicle every two years)
- running and maintenance costs
- make driving modifications to that vehicle (DVA 2018p).

At the end of June 2018, there were 43 people receiving a payment under the Vehicle Assistance Scheme (DVA 2018g, p. 22).

There are similar programs under both the MRCA and the DRCA, but with some key differences. The Motor Vehicle Compensation Scheme that covers the MRCA does not include running costs or the purchase of a motor vehicle (or a replacement vehicle) unless there are special circumstances. The DRCA program is mostly aligned with the MRCA program.

The NDIS motor vehicle modification scheme, like the MRCA and DRCA schemes, does not provide funds for the purchase of the motor vehicle itself or the running costs, but does provide funding for the necessary modifications of the vehicle. The exception to this is when it is necessary or more cost effective to purchase a vehicle outright that has been modified rather than modifying an existing vehicle (NDIA 2019).

What is the rationale for covering the cost of vehicle modifications?

There is a strong rationale for using a targeted approach to cover the additional cost of modifying a motor vehicle. Modifying a motor vehicle is a significant additional cost to those who cannot drive or be transported in an unmodified vehicle. It does not make sense to cover this cost in general compensation as only a small number of veterans need their vehicles modified, and to varying degrees.

However, the cost of the unmodified vehicle and the normal running costs should be incurred by the veteran. These are costs that are incurred by the broader cohort of veterans and economic compensation and/or income support are designed to cover general living

expenses. Eligible veterans, and people in the general community with certain types of disability, already have access to cheaper motor vehicles and parts through the GST exemption provided by the Australian Taxation Office (ATO 2018).

Options for reform

The differences between the schemes adds extra and unnecessary complexity to the veteran support system. This could be easily solved by harmonising the schemes. The Military Rehabilitation and Compensation Commission has already agreed in-principle to align the assistance for motor vehicle modifications under all three Acts (DVA 2018c), and participants to this inquiry were broadly supportive of harmonisation (APPVA, sub. DR270; Bill Kaine, sub. DR197; Legacy Australia, sub. DR220; War Widows' Guild of Australia, sub. DR278).

The Motor Vehicle Compensation Scheme under the MRCA provides similar services to other schemes, but with a more sensible and needs-based approach than the VEA. Unlike the VEA scheme, it only funds the purchase of a vehicle if an existing vehicle cannot be modified. This system removes the incentive to claim the purchase of a new car every two years while still providing compensation based on the additional individual needs. The DRCA has a very similar program to the MRCA and could be aligned easily.

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.

Additional payments going forward — what needs to be considered

There should be good processes in place for considering any additional compensation payments going forward. Questions that should be addressed before making any changes are:

- What is the problem being addressed or why are additional payments required?
- Why are existing compensation payments inadequate to deal with the problem?

Where there is a clear case for an additional payment, the costs and benefits of alternatives (including costs of complexity and administration) should then be assessed.

Additional payments should not be added to the system unless there is a clear rationale, and the benefits of the payments clearly exceed the costs to the community as a whole.

16 Health care

Key points

- The Department of Veterans' Affairs (DVA) fully funds health care for eligible veterans and dependants at public and private providers, including private specialists and hospitals. Access to health care is via the Gold Card (for all conditions) and White Card (for service-related and specified other conditions including for mental health). In 2017-18, about 191 000 DVA clients were eligible for treatment via a Gold or a White Card, at a cost of \$5.3 billion.
 - The Gold Card is highly valuable to veterans, yet costly: the average cost is about \$24 000 per cardholder each year. While some of this funding would have been provided through Medicare, Gold Card holders can access many benefits not available in the public health system.
 - The White Card is generally well-targeted.
- While many veterans spoke highly of DVA-funded health care, there are several problems:
 - The Gold Card can lead to perverse incentives for some veterans to remain unwell, and it may result in over-servicing. There has been little assessment of the outcomes DVA is getting for its healthcare expenditure. An overreliance on its healthcare cards is likely to be getting in the way of more effective and targeted approaches.
 - The Gold Card is not needs based. Many Gold Card holders do not have severe impairments — they are dependants of veterans or veterans over 70 years of age.
 - The Coordinated Veterans' Care program, which funds coordinated care for Gold Card holders at risk of hospitalisation, is a good initiative that could be improved by better targeting and measuring of outcomes.
 - Some of the fees that DVA pays health providers are below market rates and below those paid by other workers' compensation schemes. DVA needs to find the right balance between paying fees that mean health professionals provide services to veterans, containing healthcare costs and ensuring quality services. DVA should commission an independent review into its fee-setting arrangements.
 - The Commission's proposed Veteran Services Commission would take a lifetime, person-centred (holistic view of health and wellbeing), evidence-based approach (including greater use of data) to health care. It would have greater oversight of providers (including potentially rewarding healthcare providers that get better outcomes for their clients).
- Over time, the overriding rationale for the Gold Card appears to have become more one of compensation — providing the Gold Card as gratitude for service — than health care. And the context for health care has radically changed since the Gold Card was introduced.
 - The Gold Card should not be used as a form of compensation — it should be tightly targeted towards highly-impaired veterans. Eligibility for the Gold Card should also not be extended to any *new* categories of recipients (this will not affect any current Gold Card holder).

Health care is a key component of the veteran support system — one of the key objectives of the veteran support system is to restore wounded, injured and ill veterans to health so they can participate in employment and life (chapter 4). The health of a veteran can also be affected by the quality and timeliness of the health care they receive.

Health care for serving Defence Force members is provided by Defence through Joint Health Command. Once a member transitions to civilian life, health care is available through the public health system. As the Department of Veterans' Affairs (DVA) said 'post-transition, most veterans are only supported by the national health system, and most are unknown to DVA' (sub. 125, p. 43).

Veterans may also be entitled to support administered or funded by DVA. In 2017-18 it spent \$5.3 billion on health services for about 191 000 clients (DVA 2018g, p. i). Eligible veterans, war widows and widowers and their dependants can access a wide range of DVA-funded services and other benefits.

This chapter looks at:

- who is entitled to DVA-funded health care (section 16.1) and what services DVA funds (section 16.2)
- how the veteran health care system is performing against the objectives and underlying principles for a future veteran support system (section 16.3)
- reforms to improve health outcomes for veterans (section 16.4)
- the appropriateness of funding health care as a form of compensation or recognition for service (section 16.5).

Mental health care is covered in chapter 17.

16.1 Health care — an original feature of veterans' support

One of the original goals of the veteran support system was to provide treatment for the war-caused injuries and illnesses of returned service members and to return them, as far as possible, to good health. The intention was to make up for the effect that war service had on the veterans' health and, in doing so, ease their re-establishment into civilian life (chapter 2 has a more detailed discussion on the history of the veteran support system). Over time, the Australian Government extended the veteran health system to cover dependants as well as more categories of veterans, and treatment for health conditions that are not service-related (box 16.1).

Box 16.1 **A brief history of eligibility for health care**

Over the past century, eligibility for veterans' health care has widened.

Treatment of injuries and illnesses accepted as related to eligible military service (and pre-existing conditions aggravated by service) has been provided since the enactment of the *War Pension Act 1914*.

In 1924, limited access to medical treatment was expanded to include widows and orphans of deceased soldiers and for widowed mothers of unmarried deceased soldiers.

In 1943, health care was widened to include treatment for conditions that were not related to war service for veterans receiving either the full general rate or the special rate war pension. Some types of treatment were specifically excluded, including alcoholism, drug addiction, chronic or incurable diseases requiring prolonged treatment in institutions, and 'conditions for which the member was entitled at law to receive free treatment from another source' (Toose 1976, p. 390). These exclusions were relaxed in 1972.

In 1959, treatment coverage for war widows, orphans and widowed mothers was extended. And in 1961 eligibility for treatment for veterans was widened again, this time to include treatment for all conditions for service pensioners. In 1969, a new means test extended eligibility for the service pension but the Government did not allow those made newly eligible to become eligible for health care. Eligibility for the war widow(er)'s pension, and hence eligibility for health care coverage for all conditions, was extended to defence widows in 1972.

In 1973, eligibility for treatment for all conditions was widened to include all Boer War and World War I veterans. In 1974, free medical treatment was extended to all Australian prisoners of war, and to all veterans with cancer, whether or not their disease was service-related.

In 1988, full medical entitlements were extended to World War II ex-servicewomen with qualifying service. This was to recognise that women had been paid less than men for their war service and had not been eligible for the same level of repatriation benefits after the war. In 1991, eligibility for the war widow's pension was widened again. In 1996, service pensioners who were excluded from the 1969 change to eligibility were granted the Gold Card. In 1999, eligibility was extended to all male World War II veterans over 70 with qualifying service.

From 2002, eligibility was further extended to post-World War II veterans over 70 with qualifying service. Eligibility for mental health care was widened in 2016 to all current and former Australian Defence Force members, irrespective of their date, duration or type of service. In 2017, eligibility for the Gold Card was extended to participants in the British nuclear test program in Australia and veterans of the British Commonwealth Occupation force. In 2019, eligibility for the Gold Card was extended to civilian doctors and nurses who provided aid, training and treatment to local Vietnamese people during the Vietnam War.

Sources: Australian Government (2017c); Bell (2002); Clarke et. al (2003); Frydenberg and Chester (2019); Toose (1976).

The veteran health system is currently organised around two main health cards — the Gold Card and the White Card (there is also a third card, the Orange Card, box 16.2). DVA issues health cards to eligible veterans, war widows and widowers and their dependants. The health cards identify eligible people and the type of health care coverage they are entitled to.

Box 16.2 **Healthcare cards, some history**

The health care card system began in 1979. It allowed eligible people to visit dentists and general practitioners of their choice, without first needing approval from the Department of Veterans' Affairs (called the Repatriation Department at the time).

In 1987, a four coloured card system was introduced:

- the yellow card was for treatment for all conditions
- the white card was for treatment for specific conditions
- the lilac card was for widows and children
- the red card was for service pensioners.

The lilac and red cards did not allow access to the same travel or pharmaceutical benefits as the yellow card.

In 1996, the yellow card became the Gold Card and those with the lilac and red cards were given Gold Cards. The White Card remained the same.

The Orange Card was created in 2002 to give access to pharmaceuticals for Commonwealth and other allied veterans living in Australia.

Sources: Bell (2002); Clarke et al (2003); Repatriation Commission (1979).

About the Gold Card

The Gold Card entitles the card holder to DVA funding for all clinically necessary health care needs for all conditions, irrespective of whether they are related to military service. (Section 16.2 covers the types of services a Gold Card holder is entitled to.)

Gold Cards are issued to:

- veterans aged over 70 with qualifying service (chapter 3) (about 7000 cardholders)¹
- veterans receiving the service pension who satisfy a means test (about 11 000 cardholders)¹
- veterans with service-related impairments
 - veterans receiving a *Veterans' Entitlements Act 1986* (VEA) disability pension paid at 100 per cent of the general rate or higher (about 43 000 cardholders) — 50 per cent or above if they are also receiving a service pension (at any amount) (about 6000 cardholders)
 - veterans with conditions accepted under the *Military Rehabilitation and Compensation Act 2004* (MRCA) at above 60 impairment points — above 30 points if they are also receiving a service pension (about 1500 cardholders)

¹ These estimates exclude veterans who would qualify for the Gold Card through any other means.

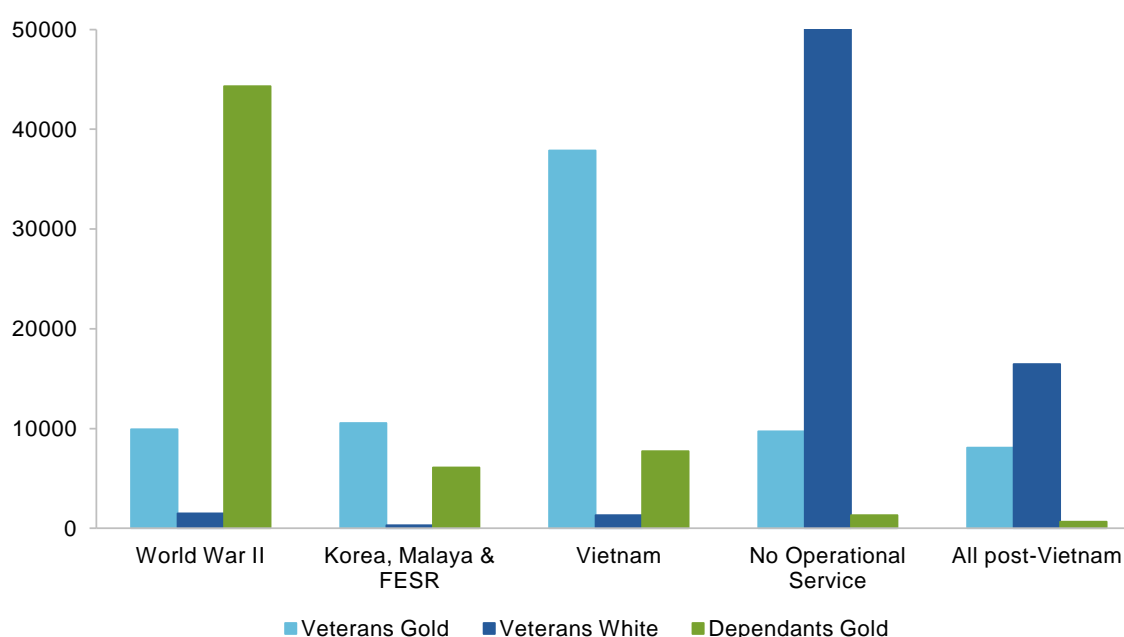
- dependants of deceased veterans who qualify for a VEA war widow(er)'s pension or orphan's pension, or a MRCA wholly dependent partner or child payment (about 62 000 cardholders)
- ex-prisoners of war (140 cardholders), British nuclear test participants and members of the British Commonwealth Occupation Force (650 cardholders).

Gold Cards are not available for impairments covered under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA).

As at March 2019, about 124 000 DVA clients have a Gold Card (DVA 2019i, p. ii). About half of these are over 80 years of age and 36 000 (or 29 per cent) are over 90 years of age. The largest cohorts are:

- dependants of World War II veterans (about 43 000 women)
- Vietnam War veterans (about 39 000 men)
- World War II veterans (about 10 000 men and 7500 women) (figure 16.1).

Figure 16.1 Gold and White Card holders by conflict^a
March 2019



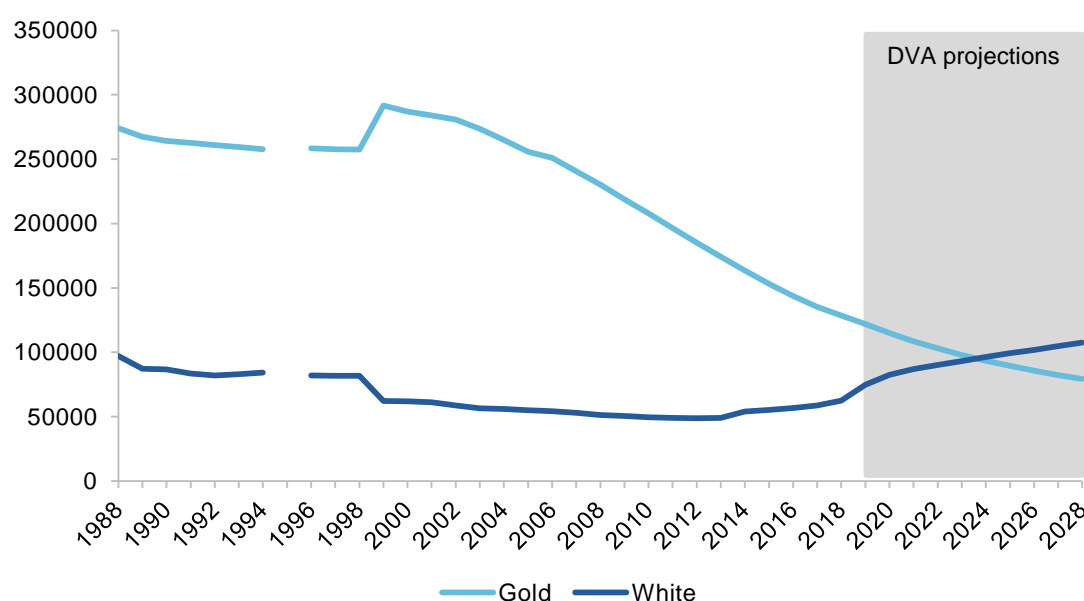
^a There are also 59 World War I dependants with Gold Cards. Peacekeeping forces are included in the post-Vietnam data.

Source: DVA treatment population statistics.

The number of DVA clients with a Gold Card peaked in 1999, following a spike in eligibility because of the Government's decision to provide the Gold Card to all World War II veterans

over 70 (figure 16.2). Since then, the number of Gold Card holders has halved, reflecting a decline in the number of living veterans from the World Wars. The share of Gold Card holders² aged over 85 increased from 5.6 per cent in 1994 to 48.4 per cent in 2016. Over the next decade (to 2028), DVA projects the number of Gold Card holders to continue to fall.

Figure 16.2 Gold and White Card holders^a
1988 – 2028



^a Prior to 1997 Gold Cards include Personal Treatment Entitlement Card, Service Pensioner Benefits Card and Dependant Treatment Entitlement Card and White Cards include the Specific Treatment Entitlement Card. The data for 1995 are not available.

Source: DVA Treatment Population Statistics, various years.

About the White Card

A DVA Health Card — Specific Conditions, commonly known as the White Card, covers treatment for:

- accepted service-caused injuries or diseases under the VEA, DRCA or MRCA
- mental health conditions, without the need to prove a link to service (known as non-liability health care)
- malignant cancer and pulmonary tuberculosis, without the need to prove a link to service for veterans with certain types of service (war, operational, warlike, non-warlike, peacekeeping or hazardous, and others).

² Before 1997, those holding a card which would become the Gold Card, as outlined in box 16.2

Commonwealth and other allied veterans living in Australia can also be issued a White Card for service-caused conditions.

About 75 000 people hold a White Card — about 57 000 of these have no operational service and about 3000 are issued to Commonwealth and other allied veterans living in Australia (DVA 2019i, p. 15). The average age of a White Card holder is 51 years old.

The number of DVA clients with a White Card fell from 1988 until 2013 but has risen since then (figure 16.2). DVA projects the number of White Card holders to increase strongly over the next 10 years (reflecting the automatic granting of a White Card to transitioning Australian Defence Force members to provide non-liability mental health care) and overtake the number of Gold Card holders in 2025.

16.2 What does the veteran health system cover?

DVA funds a wide range of health and other care services. Most of the funding pays for enhanced access for DVA clients to mainstream services, like public and private hospitals, but there are also veteran-specific programs and entitlements. An individual DVA client's entitlement is uncapped (although there are annual limits for some services).

Most of the veteran healthcare spending is on residential aged care, medical consultations and services, and hospital stays (table 16.1). DVA also spends about \$110 million administering its healthcare programs (about \$580 per cardholder) (DVA 2018ah).

Table 16.1 Health expenditure
2017-18

<i>Area of expenditure^a</i>	<i>Amount (\$ million)</i>
Residential aged care	1 014
General medical consultations and services including GP, specialist and dental visits	791
Private hospitals	795
Public hospitals	658
Pharmaceuticals	336
Veterans counselling and other health services	319
Community care and support	255
Travel for treatment	170
Rehabilitation appliances	145
MRCA/DRCA medical services	178
Total	4 661

^a Excluding program support.

Source: DVA (2018ah).

In 2017-18, DVA funded just over 30 million health services — this equates to 162 health services per cardholder (DVA 2018g). DVA funded 220 services per Gold Card holder and about 30 services per White Card holder. By way of comparison, Medicare funded about 17 services per person in 2017-18 and about 44 services per person aged 85 years and over (DoH 2018a).

In 2017-18, the average cost per Gold Card was \$24 400 and \$3100 per White Card (DVA 2019d, p. 2). It is unclear how much of this cost is over and above what would be covered by the public health system (box 16.3). While many of the services funded by these cards are funded by governments for all Australians — such as public hospitals and pharmaceuticals — DVA cardholders are also able to access many services — private hospitals, private specialists, dental services and travel for treatment — that are not available to other Australians without a charge. For example, in 2016-17 DVA funded more than twice as many private hospital separations as public hospital separations (DVA 2017f, p. 78).

Box 16.3 The cost of the health care cards

There are several estimates of the net additional cost of the Gold Card, that is, the cost of the Gold Card taking into account services funded by the public health system.

One estimate of the net additional cost of the Gold Card comes from the Australian Institute of Health and Welfare (AIHW). The AIHW calculated that the Department of Veterans' Affairs' expenditure per cardholder in 2015-16, excluding residential aged care, was \$15 612. This was more than double the \$6671 spent per person for the total Australian population (all sources of funds) (AIHW 2018f, p. 6).

The Parliamentary Budget Office also costed a proposal by Senator Jacqui Lambie to extend Gold Card eligibility to all veterans with qualifying service (discussed in section 16.5). It estimated that the proposal would increase the average annual cost by \$21 000 for each veteran who previously did not have a health card, and by \$18 500 for veterans who previously had a White Card (PBO 2016, p. 6). This includes estimates of offsetting savings to the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule.

The much higher average age of the cardholding population compared to the general population may explain some of the apparent additional cost of the Gold Card. Various sources show that older people have higher health expenditure.

- For example, in 2012-13, the AIHW found that hospital expenditure per person for men aged 75–79 was more than six times higher than for men aged 40–44, and expenditure for women aged 75–79 was about five times higher than women aged 40–44 (AIHW 2017a). Expenditure per person aged 85–89 was 50 per cent higher than for people aged 75–79.
- Medicare statistics also show higher expenditure for older people. Medicare expenditure per person aged over 85 was 2.6 times higher than the average for all age groups (DoH 2018a).

As the National Mental Health Commission said 'In effect, the Gold Card is a substitute for private health insurance' (NMHC 2017b, p. 27). And while that is true to some extent, Gold Card holders do not (like other Australians with private health insurance) pay a premium for health insurance and they do not incur out-of-pocket expenses.

Gold Card holders are also exempt from paying the Medicare levy (this is not captured in the expenditure or cost estimates). Treasury estimated the cost of this exemption for both veterans and serving Defence Force personnel to be \$115 million in 2018-19, but are not able to identify Gold Card holders specifically (Treasury 2019, p. 28). Most veteran pensions and some compensation payments are tax exempt, so many Gold Card holders would not need to pay the Medicare levy. In turn, however, this means that the Medicare levy exemption would tend to benefit higher income Gold Card holders (that is, those with taxable income).

DVA cardholders are also entitled to a range of additional services and benefits not available to the general population.

- DVA requires private hospitals to nominate a veteran liaison officer. This officer coordinates with hospital staff to enhance the treatment and care provided to veteran patients and provides pre-admission and discharge planning support. DVA also fund private hospitals to provide better discharge planning to people who are at risk of an unplanned readmission.
- DVA provides a pre-booked taxi or hire car service for some cardholders. A cardholder who is aged over 80, legally blind or suffering from dementia can contact DVA to book a car with a driver to take them to their medical appointments. Cardholders under 80 years with certain conditions, such as arthritis that severely limits their independence, can use the booked car scheme, but only to travel to some types of providers, such as hospitals or diagnostic services. There were about 1.3 million booked trips in 2017-18, far outnumbering the 170 000 or so claims for reimbursement for other travel types (DVA 2018g, p. 227).
- DVA will pay a supplement for the home care or residential aged care for veterans who have a mental health condition accepted as related to their service. It is designed to ensure a veteran's mental health condition does not act as a barrier to accessing care. The supplement for veterans in residential aged care is \$6.69 per day, and the supplement in home care is 10 per cent of the basic subsidy amount.
- DVA's rehabilitation appliances program funds aids or appliances to help a person maintain independence in their home; in 2017-18 the program's expenditure was about \$145 million (DVA 2018ah, p. 46). A wide range of aids and appliances are available, including home modifications, Continuous Positive Airways Pressure machines for sleep apnoea and personal response alarm systems.
- Cardholders are entitled to a wide range of pharmaceuticals at a concessional rate through the Repatriation Pharmaceutical Benefits Scheme. Cardholders can get all the items on the Pharmaceutical Benefits Scheme and about 500 additional items, including a wider variety of wound dressings. Items not listed on either schedule can be prescribed by a doctor, with DVA approval. Cardholders' pharmaceuticals are subsidised in a variety of ways.
 - Subsidies include a pharmaceutical payment (paid as part of the pension supplements or the MRCA/DRCA/veteran supplement), a safety net (after which DVA will pay

the full cost of prescriptions and the cardholder will face no co-payment), and reimbursement for some cardholders³ which leaves them with no out of pocket costs.

Providers are generally prohibited from charging DVA clients a co-payment (except for pharmaceuticals and some dental services).

16.3 How is the veteran health system performing?

As in any health care system, a well-functioning veteran health system will deliver high quality services to veterans that improve their health outcomes at a reasonable cost. High-quality health care provides strong prospects for better lifetime outcomes for veterans. And this is the stated objective of the veteran health system (as set in in several places, including in legislation, in DVA's Budget Statements and other policy statements, box 16.4). DVA also outlines a high-level vision in its Social Health Strategy, which is for:

Improved quality of life for the veteran and ex-service community, achieved through preventing illness where possible, fostering social connectedness and enhancing health and wellbeing. (DVA 2015f, p. 4)

Box 16.4 The goals of the veteran health system

The goal of the veteran health system is defined similarly in several places.

The VEA and MRCA state that an eligible veteran or dependant is entitled to 'treatment' (VEA part V, s. 80-93J and MRCA s. 278-287A), which encompasses:

- (a) restoring a person to physical or mental health or maintaining a person in physical or mental health;
- (b) alleviating a person's suffering;
- (c) ensuring a person's social wellbeing (VEA s. 80 and MRCA s. 13).

The MRCA Treatment Principles, which are the legislative instrument that set out the rules under which DVA will arrange or fund treatment for an eligible person, describe the aim of DVA-funded medical services as being 'to ensure that as far as is practicable entitled persons have access to free, safe and cost-effective treatment' (s. 4.1.3).

DVA describes its policy intent as being 'to provide a universal service offer across Australia, to ensure that all eligible persons have access to the full range of services with minimal travel required' (sub. 125 p. 46).

DVA has three overarching outcomes in its Budget Statements (and Annual Report), one of which relates to health:

Maintain and enhance the physical wellbeing and quality of life of eligible persons and their dependants through health and other care services that promote early intervention, prevention and treatment, including advice and information about health service entitlements. (DVA 2019f)

³ Veterans with qualifying service who also have a Gold or White Card and are receiving a disability pension under the VEA or permanent impairment compensation under the MRCA. Veterans who have a permanent impairment under the DRCA are also eligible if they also have qualifying service under the VEA or MRCA.

Because DVA funds such a broad range of services it is connected to every part of the Australian health system. As the only single funder of healthcare in Australia it has the potential to promote comprehensive, effective and efficient health care for its clients, in a way that is virtually unparalleled in Australia.

Based on the principles for a modern veteran support system (chapter 4), health care for veterans should be provided in a way that it is:

- wellness focused — promoting access to services that positively contribute to wellbeing
- veteran or patient centred — patient-centred care gives prominence to the preferences, needs and values of consumers. It is about getting the outcomes that matter for a person (that is, giving veteran's and their families a say when planning care and treatment) and ensuring that patients' experience of health care, subjective as they may be, are positive
- administratively efficient — waste is avoided, health care is coordinated and harmful delays are avoided. This requires the right incentives for both clients and providers of health services
- equitable and needs based — veterans are not disadvantaged (compared to other Australians) in terms of accessing care and health care is targeted to those with the greatest need
- evidence based — health care provided is effective (treatments are based on the latest evidence and expert consensus) and sufficient attention is paid to health outcomes of veterans. Quality data are collected, analysed and fed back for improvement (including improving patients' experiences)
- financially sustainable and affordable — the system has adequate funds for health care (today and in the future), and health care is affordable for veterans and taxpayers.

The question is, given the objectives of the veteran healthcare system, and the underlying principles for a future system, how is it performing?

Wellness focused?

Social insurance schemes (chapter 4) and some veteran health care systems have shifted the focus away from illness and injury to wellness. The United States Veterans Health Administration, for example, has shifted from a healthcare system focused primarily on treating disease to one focused on supporting the veteran to achieve their greatest overall wellbeing (box 16.5).

While many participants to this inquiry spoke highly of the health care support they receive under the current scheme and some argued that the current arrangements are wellness-focused (box 16.6), the veteran healthcare system is not focused on promoting health, wellness or the prevention of illness.

Like most other healthcare systems, the veteran system is designed around addressing injury and illness and relies on veterans contacting the health system when they experience symptoms. A system that unduly focuses on illness and incapacity, rather than wellness, can inhibit recovery and work against the goal of returning a veteran to health.

Box 16.5 Whole health – patient-centred care in the United States

The United States Veterans Health Administration has been undergoing a transformation from a medical and disease-based system of care to one that addresses the whole patient. The goal is to change the conversation from ‘what is the matter with you?’ to ‘what matters to you?’. This ‘whole health’ approach starts with the veteran at the centre and explores their values, goals and vision of health.

The core characteristics of the whole health approach are that care is:

- personalised – tailored to an individual’s characteristics
- proactive – including preventive and non-invasive or non-pharmacological approaches
- person-driven – care is based on and driven by what really matters to the person in their life.

The whole health approach is also intended to support veterans self-care. Self-care can promote important lifestyle changes, such as improved diet and exercise, and improve the effectiveness of medical treatment (such as by encouraging adherence to prescribed medicines). The whole health approach has also led the Veterans Health Administration to fund complementary and alternative therapies such as yoga, tai chi and acupuncture.

The effectiveness of the whole health approach has not yet been evaluated. Because it is a whole system approach that employs multiple treatments and health promotion strategies as opposed to isolated complementary therapies, studying outcomes is more challenging than evaluating an isolated pharmaceutical or other type of intervention. As two proponents argued:

Because the primary conceptual framework of medicine is disease oriented, medical research generally focuses on the notion of deficits. We have a conception of normal function and decrements off that, and because our clinical approach relies on this, we have well-developed tools for measuring those decrements and how a given intervention does or does not change them. We are not typically looking at well-being or positive outcomes. We ask how much pain people are in, but not how good they feel in their bodies. ... At best, the patient gets back to the zero state, where the deficit is gone ... If one outcome we seek for veterans is life-long well-being, should we be putting more emphasis on measuring positive emotions in daily living? On life meaning and purpose? On the quality of relationships? Do we ask them whether they feel more engaged and activated in their lives and toward their health? (Gaudet and Kliger 2019, p. S9)

Sources: Krejci et al. (2014); Gaudet and Kliger (2019).

There are, however, some positive aspects to the card-based system operated by DVA. It could be argued that having access to a healthcare card means that DVA clients who would otherwise not have been able to afford to access healthcare can do so. Also, healthcare cards give cardholders choice of provider (that is, if providers accept the cards, discussed below). As RSL Queensland said:

The Card system has been effective in ensuring veterans have access to treatment. Most veterans feel an enormous sense of security knowing that their health needs will be taken care of into old age. (sub. 73, p. 33)

Box 16.6 **Many participants spoke highly about healthcare support**

Bill Denney (combined SA ex-service organisations):

We believe that a Gold Card system, or something very similar to it, remains the best way to ensure that those who have suffered in the service of their nation are adequately cared for. (trans. p. 6)

Liz Cosson (Secretary, Department of Veterans' Affairs):

But if I can ... just offer a personal reflection, my father with his Gold Card, that's what takes him to the doctor. He wouldn't be going to the doctor without that Gold Card. He wouldn't be going to have his eyes checked because I just know him. ... He is so proud of it, and to me it's about what is the purpose. It's about getting you into health care. It's about making sure that you're getting timely treatment and response, and that it's appropriate for your needs, and as early as possible; that you're not sitting at home. And it's also keeping him at home. Through that Gold Card he gets the support to stay at home ... (trans, p. 466)

Angela Rainbow:

The DVA gold card communicates lifetime support, care and an importance and value on an individual's wellbeing. ... The benefits of the Gold Card are aligned with and fulfil the intention of the instruments of The Veterans Entitlement Act 1986 and Repatriation Private Patient Principles Legislation enabling free and enhanced treatment to be provided to veterans and therefore promotes their right to health. The Gold Card has a tremendous influence and positive outcome on wellbeing. (DR244, p. 2)

Terrance Makings (Naval Association of Australia):

The cards are universally recognised and provide considerable comfort to veterans' families. They understand what they're for and at the end of the day, the issue with the Card is that it provides a small premium to some medical practitioners, and most importantly, it probably recognises where the Federal Government's primary role is the defence of Australia and the veterans are the instrument by which that happens, that they may in fact be elevated somewhat, moved up the queue a little bit because they've got a Gold Card and we think that that's more than apt. (trans., pp. 625–6)

James Brown (RSL NSW):

... the Gold Card does acknowledge that the holder has been particularly severely impacted by their service. It is most importantly an attempt to limit the obstacles a veteran might have in receiving whatever care is required to manage the pain they've been left with ... (trans., p. 899)

The Gold Card is considered one of the most desirable benefits of the veteran support system. The Clarke Review said it 'is a valuable benefit and one that is highly prized by the veteran community' (Clarke, Riding and Rosalky 2003, p. 500). This may reflect its generosity — while there are annual limits for some services, overall a person's entitlement is uncapped (the highest spend on a Gold Card in 2015-16 was more than \$1 million). But it also reflects the Gold Card's symbolic value in providing recognition for service.

However, there are aspects of the card-based system that run counter to the principle of the wellness. The Gold Card provides a strong incentive for some veterans to increase their level of assessed impairment so that they qualify for it (and veterans will respond to the incentives of the system). A veteran with service-related impairments can substantially increase their compensation package by reaching the Gold Card eligibility threshold.

And as pointed out by a number of participants, the Gold Card can discourage people from seeking treatment (which can result in the need for more expensive treatment).

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. (NMHC 2017b, p. 35)

So vets at the moment are working towards getting that Gold Card and so they are getting more and more broken and proving how broken they are rather than having a system that works towards getting them better. (Rosemary Mountford, trans., p. 1321)

Peter Reece suggested that the Gold Card could ‘breed hypochondria’ (trans., p. 563).

The Gold Card can also encourage over-servicing of clients by providers. This could mean that veterans receive treatments that are unnecessary or ineffective. As Dr Kenneth O’Brien argued, the focus on the system should be:

... to support the individual health-seeker, not on the individual’s ability to attend a multitude of appointments that assess their ability to attend appointments. This in itself is meaningless to long-term optimal outcomes and is frankly ridiculously costly to taxpayers, unproductive, punitive to the Veteran and only contributes to the problem, not the solution. Only the provider benefits. (sub. DR302, p. 3)

There is a tension between whether the Gold Card is in place to improve the health outcomes for veterans and their families, or whether it is a tool to compensate veterans or provide recognition for their service. The unclear purpose of the Gold Card was highlighted by RSL NSW. It said that the card system ‘encourages a view of the system as a contest to be won, with the Gold Card as the prize’, and that:

The outcome sought for veterans should be rehabilitation, not monetary settlement. The ‘gold card’ nomenclature utilised by DVA reinforces a negative entitlement culture where success for veterans is the extraction of cash from the government, not their rehabilitation and return to being a productive member of civilian society. (sub. 151, p. 7)

Other participants also acknowledged that the Gold Card is more about providing benefits (in recognition of service) than encouraging wellness, a return to functionality or better health outcomes (section 16.5).

Veteran-centric?

Providing healthcare centred on the needs and expectations of patients (or veterans) is a key attribute of quality healthcare. A veteran-centred health system revolves around the veteran, giving them agency through choice, shared decision making with medical professionals and the capacity for self-management where feasible (PC 2017e). But, as is the case in Australia’s general health system, the veteran health system is not built around a patient-centred model of care.

An additional complication for the veteran health system is that veterans may have healthcare needs that differ from those of the general population.

Choice and shared decision-making

In theory, the veteran health system enables a high degree of choice — health card holders can use a wide range of services in both the public and private sectors, with very few restrictions. However, the relatively low rates that DVA pays for some services, together with restrictions on user co-payments, may be reducing veterans choice of provider (section 16.4).

People are not always able to make informed decisions about health care and treatment. As GO2 Health said:

The Veterans themselves are not educated enough in their own rehabilitation goals and needs to be able to make good decisions. This needs the proper team of health professionals to help them make those decisions. (sub. 98, p. 8)

A patient-centred approach brings the patient and medical professionals together through a process of shared decision-making. Shared-decision making involves the integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to achieve appropriate health care decisions (ACSQHC nd).

DVA puts GPs in charge of a veteran's care. DVA attempts to promote some shared decision-making by requiring GPs to have a written care plan for clients which sets out the presenting conditions (including diagnostic results), the planned treatment regime (including the anticipated type, number and frequency of services) and the expected outcomes or results of the treatment regime (DVA 2016j, p. 13).

But DVA do not monitor GP's care plans to drive patient-centred care (or track health outcomes). Because of this, some veterans may not be getting the right care at the right time. As RSL Queensland pointed out, under the current arrangements there is no way of knowing what treatments veterans are receiving or if they are getting good outcomes:

... the system does not provide good feedback in relation to the effectiveness of treatment programs that are being accessed through DVA Cards. ... There is no system to check on the type of treatment being provided, nor on its effectiveness. The treatment being provided may not be best practice and may not achieve any discernible improvement, but DVA has no process to identify and address this with the veteran to assist them in gaining more effective treatment. (sub. 73, p. 33)

Provider groups also pointed to problems with putting the onus for coordination on GPs. The Australian Medical Association, for example, observed that:

... current referral arrangements do not encourage AHPs [allied health providers] to report back to the GP and may, in some circumstances, encourage treatment by an AHP to persist beyond what is clinically indicated.

We are concerned that feedback from members suggests that it is quite common for AHPs to fail to collaborate effectively with the patient's GP and this means that important aspects of clinical management such as continuity of care and clinical accountability are lost. (AMA 2016, p. 1)

GO2 Health also noted that current fee arrangements do not support shared decision-making:

The current financial model allows for medical practitioners to charge for case management time. It does not pay for psychologists, physiotherapists and other essential treating professionals to attend these meetings. In private practice, this financial constraint prevents teams from discussing treatment, assessing outcomes and goal planning with the veteran. (sub. 98 p. 2)

DVA does have plans to introduce a new 'treatment cycle' to improve GP's oversight of allied health treatment. However, this initiative stops short of being an active, patient-centred, approach. Currently, GPs can write a referral for allied health services which is valid for 12 months, as well as an ongoing referral, and there are no limits on the number of services that can be supplied during this period. DVA considered that 'both quality and efficiency of the arrangements needed to be improved' (DVA 2018a, p. 19).

The new treatment cycle restricts referrals to 12 sessions (after 12 sessions the patient needs to return to the GP for another referral). Totally and permanently impaired veterans will be exempt from service limits for physiotherapy and exercise physiology (Liberal Party of Australia 2019). But DVA have not put in place measures to support the treatment cycle becoming a vehicle for promoting more veteran-centred care (such as outcomes measures, or increased oversight by DVA).

The healthcare card system is in many ways a 'set and forget' arrangement for DVA. That is, veterans are given a card that allows them to spend health dollars, but what DVA does not have is a health plan with a focus on achieving particular health outcomes for clients or a case manager to help them achieve those outcomes. DVA described the current arrangements as 'open-ended health care available through White and Gold Cards' (sub. 125, p. 145). Such an arrangement can encourage a reactive rather than a coordinated approach to health care.

That said, DVA has made some steps towards achieving better coordinated care for some clients with the Coordinated Veterans' Care (CVC) program. This program, which funds GPs to provide coordinated care for Gold Card holders with chronic conditions and complex care needs and those at risk of unplanned hospitalisation, has had some success with program participants having fewer hospital stays than those not participating in the program (section 16.4).

DVA also takes no role in the clinical content of hospital care despite being a large funder of services. There is some evidence in the area of palliative care to suggest that there would be benefits for patient's wellbeing as well as savings from a more person-centred approach to care (box 16.7).

Box 16.7 Palliative care

Palliative care is provided to people who have a medical conditions that means they are likely to die within the next 12 months. Access to specialist palliative care services in hospital can reduce the symptom burdens of people at the end of their lives and can benefit families through this period. Palliative care services for terminal hospital patients can also lead to substantial cost savings.

A recent study of Department of Veterans' Affairs clients aged over 70 years found that only one-third of those who died in hospital received palliative care during the admission in which they died (Ireland 2017, p. 551). The study also found that the cost of providing end of life care in a designated palliative care bed was significantly lower than the cost of a hospital episode (ending in death) for those with no recorded palliative care access (Ireland 2017, p. 552).

Veterans' unique needs

A veteran-centric health system would recognise and address ways in which veterans' health needs are different to those of other Australians, and support the mainstream health system in dealing with these needs. War service can expose people to a large number of environmental risks, including harsh climates, hazardous substances and infectious disease risks (chapter 2). Military service can also have an effect on a person's mental health (chapter 17).

Within the current card-based system, DVA has several methods to inform health providers about the needs of veterans. These include various ways to communicate the effects of military service, such as online training about understanding the military experience (a two-hour program) and a plethora of material about veterans mental health. Outside of the card system, DVA has other ways to meet veterans' health needs. Open Arms, for example, is a veteran-specific counselling service (chapter 17).

The Gold Card could be getting in the way of DVA developing more effective veteran-specific health strategies because it provides for a range of fully funded services. It could therefore provide a mirage that veterans' healthcare needs are being well met. But without evidence on health outcomes it is difficult to know.

Some State governments are using the sites of their former repatriation hospitals to develop new facilities for veterans' health.

- The redevelopment of Concord Hospital in Sydney (scheduled to be completed in 2021) will include the country's first National Centre for Veterans' Healthcare. It is being billed as a comprehensive care centre that will integrate a range of specialist outpatient services in a one-stop shop.
- The Jamie Larcombe Centre in Adelaide, opened in October 2017, is a veterans' mental health precinct that provides acute, sub-acute and rehabilitative mental health care for veterans. It also runs post-traumatic stress disorder programs for emergency service personnel.

Administratively efficient?

DVA appears to administer the veteran health system well. Most payments to medical providers are processed through Medicare, and DVA has well-established processes for payments for other services. In 2004, the Australian National Audit Office (ANAO) found that DVA had a sound set of administrative practices around the issuing, replacement and cancelling of health cards, and made only minor recommendations for DVA to improve claims processing (ANAO 2004b, pp. 15, 22–23).

While the ANAO review is somewhat dated, it is to be expected that DVA has maintained its good performance — the department prioritises output and process-based metrics in its performance reporting. That said, submissions to a review of DVA’s dental and allied health arrangements raised a number of minor administrative issues, including delays in notifying providers of a cardholder’s entitlements and delays in processing claims for prior approval for services or appliances not covered by DVA (Australian Physiotherapy Association 2016, pp. 15–16; Optometry Australia 2016, p. 6).

Nonetheless, there is still room for improvement. DVA itself identified a number of immediate opportunities to improve efficiency, including the automatic transfer of the full Defence Health digital record into the new whole-of-population My Health record, and collaboration between DVA and Defence on shared purchasing arrangements (to help align health care across agencies, assist veterans’ continuity of care and support contract and delivery efficiencies) (sub. 125).

Needs-based and equitable?

The White Card for specific conditions is clearly needs-based where a veteran has an impairment that is directly linked to service. The Australian Government, as the former employer of the veteran, is also liable to pay for health care for service-related conditions as part of workers’ compensation.

The Gold Card, on the other hand, covers a range of public and private health care services, irrespective of whether the impairment is service related (and covers a wider range of health care than other workers’ compensation schemes). There are a number of historical rationales why coverage was extended to non-service related health care, including:

- concerns about the long-term health effects of military service
- concerns about the ability to access comprehensive health care
- difficulties distinguishing between service and non-service related conditions
- potential benefits from considering the health needs of severely impaired veterans holistically (box 16.8).

Box 16.8 **History provides some insights on health coverage**

The decision to cover treatment of non-service-related conditions dates back to World War II. Commenting on the rationale behind eligibility for veterans' health care, including the extension to non-service-related treatment, the Clarke review of veteran compensation said:

Although no clear rationale is discernible, it would appear that, initially, the need to provide generous health care cover for veterans who were severely incapacitated by service-related disabilities was the primary factor in providing full health care benefits. (2003, p. 501)

Clarke et al (2003, p. 501) also noted that the original decision to extend coverage to non-service-related health care was understandable at the time given it was before universal basic health cover was available and it was considered difficult to distinguish between service-related and non-service-related conditions.

The 1976 Toose report also noted the desirability of considering the health needs of severely impaired veterans holistically:

... it seems to me quite proper that the nation, having assumed the responsibility for the treatment of their service related disabilities, which would constitute a significant proportion of their treatment requirements, should take the next logical step of assuming responsibility for the treatment of the whole man. In so doing it prevents the development of a situation where failure, because they cannot afford it, to obtain treatment for a disability, unrelated to service prejudices the effect of treatment being given for service-related disabilities. (Toose 1976, p. 448)

Some of these rationales are now out-of-date. A number of studies have found that veterans have lower mortality than the general community (chapter 2), and Australia's health care system is now considered world-class. However, some of the rationales, such as taking a holistic view of severely impaired veterans' health, may continue to be relevant. James Brown (RSL NSW), when relaying a story of a special forces soldier who had suffered a gunshot wound to his abdomen and had difficulty getting a claim for irritable bowel syndrome accepted, said:

That's where the Gold Card really comes into play for those who have been severely impaired. It reduced the friction in the system, the moral insult and the frustration that can arise from normal bureaucratic activities which can be really crippling in its own right. (trans., p. 900)

While there are likely to be benefits from taking a holistic view of a severely impaired veteran's health (and hence funding a wide range of health care) this does not mean that a Gold Card is the best vehicle for achieving good outcomes or that the range of services covered by the Gold Card (such as travel for treatment) is the best way to spend the health dollars.

Most Gold Card holders also do not have severe impairments — about 60 per cent are dependants or veterans who qualify through age or because they are receiving the service pension. For these Gold Card holders, health care is a form of compensation or recognition for service. As Malcolm Whitney said:

The Gold Card to a war veteran is more than just a card for health-related services. It is a form of recognition that the country expects these veterans to be entitled to a special level of care and benefits following their service. (trans., p. 946).

The Australian Commando Association also said that the Gold Card is a ‘recognition for the holder’s sacrifice to Australia (sub. DR298, p. 6).

One of the problems with using the Gold Card as a form of compensation is that some cardholders will use the healthcare system more intensely than others making the amount of non-monetary compensation higher for some than others. The appropriateness of funding health care as a form of compensation or recognition for service is discussed in more detail in section 16.4.

Evidence-based?

Despite spending \$5.3 billion in 2017-18 on health care, DVA has little outcomes data to show that the money spent has improved their clients’ health.

DVA’s regulation and contracts with service providers⁴ are not focused on promoting quality care or achieving good outcomes, but are instead focused on facilitating payment, setting eligibility and codifying the parameters of the service, such as what can be provided. That said, DVA does have a provision in the ‘notes for GPs’ that allows it to conduct audits of GPs to, among other things, monitor the quality of health care being provided and the health care outcomes of cardholders. But DVA does not appear to provide any guidance to GPs about what it considers sufficient quality of care or expected outcomes. Commenting on measuring performance in health care, DVA told the Commission that:

As a purchaser of services, DVA maintains robust performance requirements and standards for the services it buys. However, it can be difficult to determine the outcomes of all health care interventions. (sub. 125, p. 47)

Margaret Jenyns, RSL Queensland also commented that:

There’s no outcomes driven look at how the general provision of treatment is establishing wellness. So when a person is provided with a White Card or a Gold Card they are entitled to get treatment for that condition that’s been accepted or for all conditions, and there’s no real monitoring of that and no real effort to ensure that the treatment they’re getting is best practice. (trans., pp. ,1101–2)

And EML, based on its experience as an injury claims manager, said:

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)

DVA does take an evidence-based approach to some policy areas. The Veterans’ Medicines Advice and Therapeutics Education Service (Veterans’ MATES) program, for example, aims to improve the use of medicines and related health services of cardholders. This program uses DVA administrative health claims data to identify the prevalence of

⁴ DVA’s regulation comprises the Treatment Principles and the ‘notes for providers’ which are legally binding documents setting out the conditions for DVA payment for services and other accountability requirements.

medication-related problems in the cardholding population. The program then identifies cardholders with these potential problems and notifies their GP that their medicines may need reviewing. Information is sent to the cardholder to act as a prompt for discussion with their GP, such as suggesting bone density tests for those at risk of osteoporosis.

There is some good evidence that the program's interventions make a difference. Based on Veterans' MATES research which showed that antipsychotic medicines can cause serious harm in older persons, including a higher risk of hospitalisation for pneumonia and hip fracture and a higher risk of death, the program delivered a range of initiatives, including:

- highlighting the limited role of antipsychotics in the management of dementia
- promoting non-pharmacological alternatives
- providing guidance on how to taper and cease antipsychotics.

The program led to reduced use of antipsychotics in patients with dementia and was estimated to avoid over 200 hospitalisations for pneumonia, 70 hospitalisations for hip fractures and about 40 premature deaths (Veterans' MATES 2017, p. 23). Other successful interventions have reduced the use of sedatives that increase the risk of falls among older people (avoiding an estimated 80 hospitalisations).

The Commission is recommending DVA develop outcomes and performance frameworks that provide robust measures of the effectiveness of services (chapter 18). These frameworks are critically important to improving DVA's stewardship of the veteran health system. Performance reporting requirements can improve transparency and accountability while also providing an added incentive to effectively manage the system. It is especially important that the Australian Government and the community have sufficient oversight through an effective performance monitoring mechanism given the billions of dollars spent on veteran health each year.

Financially sustainable?

DVA has relatively few controls over its health expenditure or service usage. In effect, DVA relies on general practitioners (GP's) to act as gatekeepers. But the fee-for-service model of healthcare means that GPs do not have a financial incentive to reduce the number of future consultations (health services are paid for by DVA regardless of the impact they have on the client's health). Indeed, because DVA's health entitlements are largely uncapped and clients face few co-payments there is the potential under current arrangements for over-servicing and wasteful expenditure⁵. In the general health system co-payments help reduce some of the risk of over-servicing. Wasteful expenditure means that resources are being used with little or no effect on the health and wellbeing of veterans.

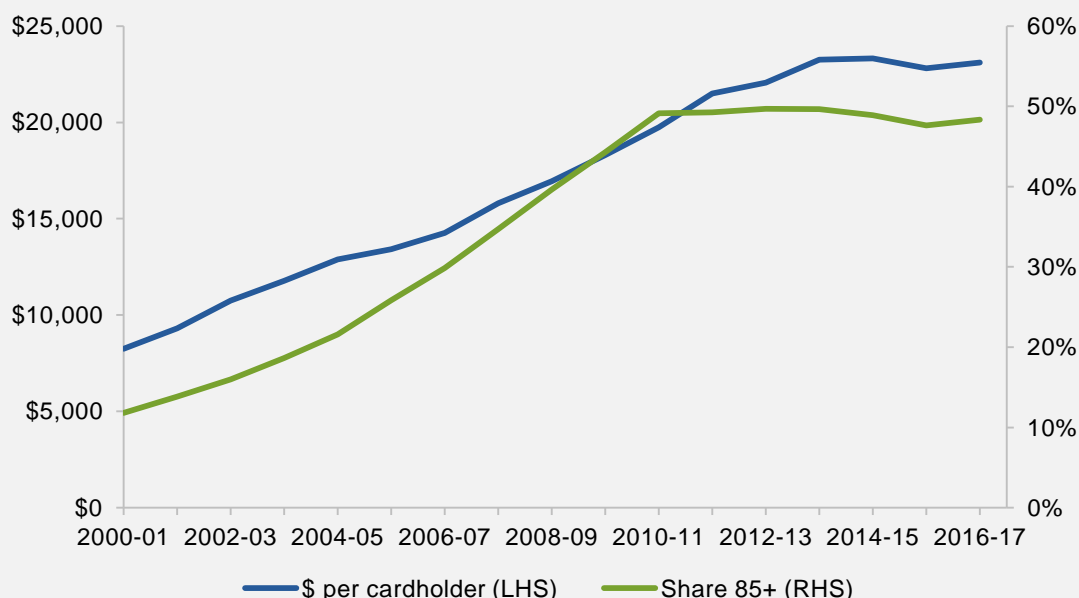
⁵ Over-servicing means providing (and paying for) unnecessary medical interventions. Wasteful expenditure, in this case, refers to paying for other services that are unnecessary or poor value-for-money.

As noted above, clients of these cards are high users of healthcare services (220 services per person in the last year). This has increased rapidly in recent years — and some, but not all, of this increase can be explained by the ageing of the Gold Card population (box 16.9).

Box 16.9 The rising cost of Gold Cards

The cost of the Gold Card has risen since 2000, in part due to an increase in service usage by DVA cardholders. Some of this can be explained by an ageing population — spending per cardholder has increased with an increase in the share of the population aged over 80 years.

But there are other indicators that suggest health service usage is not fully explained by ageing. Since 2010 the age profile has not changed much — as shown in the figure below, the share of the population aged over 85 has remained just below 50 per cent — but from 2011-12 until 2016-17, the average number of dental and allied health services per patient increased by nearly 50 per cent (DVA 2018an, p. 11). Over the same period, mental health services per patient increased by about 150 per cent (this may reflect non-liability access).



A number of participants pointed to the lack of accountability under the current healthcare arrangements and the potential for over-serving or ‘waste’. For example, EML, said they:

... did not observe any line of sight within DVA of its overall treatment expenditure. There is an inadequate focus on managing individual veteran treatments and scheme costs (i.e. a passive approach), resulting in over-servicing, as well as the regular administration of concurrent, ineffective and/or potentially harmful treatments. (sub. 90, p. 6)

GO2 Health also said:

It is important that accountability processes are in place for health care providers (esp allied health) to ensure over treatment or inappropriate treatment is minimised, or does not occur. DVA is not an ‘ATM’. There has been recent focus on exercise physiology and it is important that

‘cowboy’ providers are held accountable. Linking them back to the referring GP is the key, provided the GP has the time to actually case manage or monitor. (sub. 98, p. 9)

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).

16.4 Reforms to improve health outcomes for veterans

This section looks at reforms to improve health outcomes for veterans, including the Veteran Services Commission (VSC) and the approach it would take to health care, improvements to the CVC program, and updating the fee arrangements for the healthcare cards.

A Veteran Services Commission

The Commission’s proposed VSC, with its focus on lifetime costs, would take a far more active approach than DVA currently does to managing clients’ health care. Based on the experiences of workers’ compensation and social insurance schemes, the VSC would:

- take a patient-centred approach to the health care of clients, including coordinating care of those clients with chronic health conditions and complex needs. 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. (sub. 90, p. 2)

- take a data-driven and evidence based approach to healthcare (chapter 18). The VSC would need to collect utilisation (services and costs) and outcomes data. It would use the data to track clients and identify high users of healthcare and look at the reasons of the high use. The information collected could be used to customise healthcare plans (including potentially making more use of preventative health measures) to improve

health outcomes for veterans and reduce healthcare costs over the life of the veteran.⁶ The VSC's actuarial modelling and analysis would also mean a focus on evaluating specific health services and treatments that it funds.

- have an active provider management framework. This would involve proactively engaging with medical providers, monitoring their performance (including potentially rewarding healthcare providers that get better outcomes for its clients), and demanding evidence-based approaches to treatment and care (EML sub. 90, p. 6).

The VSC's approach to healthcare would be based on decisions about its role in the wider public health system, including where it would be more efficient and effective to rely on mainstream services compared to it commissioning tailored services. It would be able to better respond to individual needs, taking account of the special characteristics of military service and its impacts on veterans and their families.

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.

Targeting Coordinated Veterans' Care

The Coordinated Veterans' Care (CVC) program provides ongoing, planned and coordinated primary and community care, led by a GP with a practice nurse, to eligible Gold Card holders. The program is aimed at reducing unplanned hospitalisations for people with chronic conditions, namely:

- congestive heart failure
- coronary artery disease
- pneumonia
- chronic obstructive pulmonary disease
- diabetes.

About one in six Gold Card holders have enrolled in the CVC program since it commenced in 2011 (DVA 2017i). As at February 2015, about 28 000 people had enrolled in the program (BUPA 2015, p. 2).

⁶ Some participants proposed a new healthcare card, a 'silver card', be created to promote earlier access to health care that would support veteran wellbeing and reduce healthcare costs in the long run. The VSC would be in a position to judge the merits of such an approach (noting that a card-based approach has numerous problems, as articulated earlier).

GPs are paid an initial incentive payment to enrol a participant in the program and a quarterly care payment for ongoing care. GPs that use a practice nurse get a higher payment. A GP with a practice nurse will be paid about \$2200 in the first year for each participant and then about \$1800 each year after.

The program has had some success. A review of the CVC program found that:

- participants of the program had fewer hospital episodes, although the cost savings were more than offset by the costs of additional medical services provided under the program (Grosvenor Management Consulting 2015, p. 65)
- while the number of overnight hospital episodes were lower for high-risk CVC program participants (compared to non-participants), this was not the case for the other risk groups
- there were no differences in the average length of stay or cost per episode (program participants had similar hospital care to non-participants).

To achieve its goal of reduced hospitalisations, CVC targets people with a high risk of hospitalisation (those with risk ratings in the 80th to 95th percentile). However, the program review found that about 27 per cent of enrollees did not meet the risk threshold or have one of the specified chronic conditions (Grosvenor Management Consulting 2015, p. 32). This is the result of GPs having discretion to enrol people into the program. The review recommended the eligibility criteria be narrowed to increase participation of people at the highest risk of hospitalisation.

The payment model for CVC provides an incentive to enrol people in the program. The usual concern with a model that pays a periodic amount for each enrolled person, called capitation, is that providers will avoid high-risk or high-need people. There is no evidence of this behaviour for CVC, although the enrolment of low-risk people may be the other side of the same coin. DVA pays GPs at a rate that is about the same as the highest tier payment for Health Care Homes (HCH), a similar scheme being trialled by the Department of Health (HCH has three tiers of payments based on level of risk and care needs).

Keeping people out of hospital is a good outcome regardless of cost savings and CVC may also be resulting in other positive health and wellbeing outcomes for participants — and GPs and patients reported positive qualitative benefits (Grosvenor Management Consulting 2015, p. 6).

High levels of enrolment in the program would be a positive development if GPs were taking a broader view of their patient's health than required by the eligibility criteria. For example, a patient may not have one of the specified chronic conditions, but be overweight or smoke (and so at risk of developing a chronic condition). However, an implementation review of the CVC found that GPs assessments were subjective and unstructured, and found variation in how GPs were selecting patients for enrolment (Discipline of General Practice Flinders University 2015, p. 5). And the CVC is not set up to encourage general health promotion by GPs. It is aimed at keeping people at risk of hospitalisation out of hospital and on this front, given the current enrolment pattern, while a good initiative, it is less effective than it could be.

The ideal reform should then strike the right balance between targeting groups who:

- are likely to have positive health outcomes and cost savings due to lower hospitalisations (high risk people)
- have positive health outcomes from CVC but who are lower risk.

Capitation incentives for enrolling low-risk people (with some flexibility) should be removed.

There is a range of options for improving the targeting of CVC.

1. Stricter enrolment criteria. DVA could narrow the eligibility criteria to not allow enrolment in CVC unless the patient meets all the criteria (having a named chronic condition and being in the risk range). This was recommended by one set of consultants who reviewed CVC.
2. DVA could advise GPs about a patient's risk rating. If a GP recommends a patient be enrolled in CVC, but they fall outside the desired range for enrolment, DVA could go back to the GP with the risk rating and ask them to reconsider their recommendation. The weakness with this proposal is that the GP will still face the financial incentive to enrol the patient regardless of DVA's advice.
3. Vary the CVC payment based on a patient's risk rating. The Commission has previously recommended a risk-weighted payment model for public dental services. HCH also allows a GP to request an override of the risk classification where they can provide clinical evidence that they have a higher risk. This allows for some discretion and also allows a feedback loop to update the risk weighting tool in the future.

The last option would better target groups with different risks, needs and cost savings. It would retain the ability to enrol people at any point on the risk rating scale, reflecting the expected benefits. This is the Commission's preferred option.

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.

Fee arrangements for good health outcomes

As discussed earlier, some healthcare providers are not accepting DVA cardholders.⁷ GO2 Health, for example, said:

⁷ See, for example, the Commonwealth Ombudsman (sub. 62); VVCS National Advisory Council (sub. 72); the Prime Ministerial Advisory Council on Veterans' Mental Health (sub. 99); RSL Queensland (sub. 73), Victims of Abuse in the Australian Defence Force Association (sub. 133).

There is much evidence of both private medical and allied health professionals closing their books to DVA. The loss of fees is part of the issue. Without a review of this error, we will lose more therapists who simply cannot spend the time to look after our veteran community, or deal with the often onerous and non-sensical paperwork requirements of DVA. (sub. 98, p. 5)

The Commonwealth Ombudsman said that based on information it had, this issue is of particular concern for DVA clients requiring psychiatric, neurological and orthopaedic services (sub. 62, p. 5). In the context of psychiatrists and clinical psychologists, the VVCS National Advisory Council said:

The remuneration gap between seeing veterans versus private patients from the general community or Defence members is now so significant that clinical providers are prioritising other clients over DVA referrals. In some cases, providers are refusing to accept clients with DVA white or gold cards because of the poor remuneration offered. (sub. 72, p. 4)

The question is, how widespread is the problem? DVA's latest annual report states that the:

... number of clients making a complaint in relation to un-met access or quality is very low when considered in the context of the overall number of health services accessed by DVA clients ... This is an indication that there is currently no widespread issue impacting DVA clients' ability to access clinically necessary treatment. (2018g, p. 82)

But only reporting the overall average could be misleading (it could be obscuring more concentrated problems). Access could be very good for, say, GPs, dentists and optometrists in major cities (these are the bulk of funded services), but there may be access issues in particular locations or for particular services that do not show up in the average measure.

Some of the experiences of veterans and their families that the Commission heard about suggests that access to some specialists is problematic. The mother of David Finney, a veteran who suicided in February 2019, told the Commission that David's rehabilitation provider was not able to find a psychiatrist in Canberra accepting DVA clients. RSL Queensland also commented that:

... there is a lack of availability of mental health practitioners in some regional areas, and that an increasing number of veterans are reporting that psychiatrists, particularly in regional cities with less market competition, will no longer accept DVA clients as they can bill private clients at a higher rate. (sub. 73, p. 33)

DVA does, however, have a number of contingency arrangements if a cardholder is refused treatment by a particular service provider.

Providers can seek prior approval from DVA to charge a higher fee before undertaking any treatment or consultation. DVA considers requests for prior approval on a case-by-case basis, taking into account clinical need and the patient's ability to reasonably access another provider (DVA 2018an). On this issue, the Commonwealth Ombudsman said:

While DVA does have the discretion to pay above the repatriation rate, it can only do so where there are exceptional circumstances, and these situations must be applied for in advance of any

treatment. This becomes problematic for veterans who have paid for the treatment and seek reimbursement of out of pocket costs. (sub. 62, p. 5)

Data on prior approvals would give some insights on accessibility and potentially highlight any emerging access problems. However, DVA recently told the Senate Standing Committee on Foreign Affairs, Defence and Trade that it does not hold data on how many applications have been made requesting prior approval (DVA 2019h). It is unclear why DVA does not hold this information, given it should be able to collect it easily and because it is potentially a useful indicator of accessibility. DVA should collect and report on the number of requests for, and approval of, prior approvals by providers to charge higher fees.

Another contingency arrangement that DVA can use is to pay for the cardholder's travel to an alternative provider. However, while DVA travel assistance may be available, the distance and logistics required to arrange travel can present a barrier to some services and could be a particular concern for people with mental health problems (NMHC 2017b, p. 46). That said, the Prime Ministerial Advisory Council on Veterans' Mental Health (2018a, p. 1) looked at the issue of accessibility of mental health services at its March 2018 meeting and concluded that the contingencies were adequate, but also said it would continue to monitor the situation.

The other contingency arrangement is for DVA cardholders to use Medicare or private health insurance and be treated like any other patient.

Concerns about access for DVA clients are not new. In 2004, the ANAO reported that DVA was aware of a shortage of certain specialist services for veterans in particular regions of Queensland (ANAO 2004b, p. 70). There were also reported cases of specialists indicating that the cardholder would be asked to pay for the initial consultation as a private patient and they would only accept the health card if subsequent treatment was deemed necessary. Some specialists also reported asking for co-payments, which are not permitted for health card holders. The ANAO, however, concluded at that time that cardholders had a reasonable level of access to medical services and that DVA acted to provide alternative solutions to any who encountered difficulties.

DVA reported to the ANAO in 2004 that they were aware of about 300 specialists who had notified DVA that they were no longer accepting DVA cardholders as clients. However, there does not appear to be a more recent estimate. According to RSL NSW, DVA do not currently have information on health care providers in particular areas.

... the Department necessarily must maintain a register of health care providers who have advised they will accept the DVA fee as full payment for health care services, and therefore an externally distributable list or database should be relatively simple to produce. DVA should make a list of registered providers publicly accessible on their website. (sub. 151, p. 12)

There are three ways DVA could improve its reporting of access to services:

- more disaggregated information on complaints
- reporting on the use of contingency arrangements

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- recording and reporting on the number of providers who have told DVA that they will not accept cardholders as clients.

DVA could also look into the issue of how many cardholders use Medicare, private health insurance or other sources to pay for their health care.

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.

Fee levels

When looking at the issue of fees, it is important to distinguish between medical fees and allied health fees.

Medical fees

DVA pays medical fees that are higher than the Medicare fee schedule:

- 15 per cent higher for GP consultations
- 35 per cent higher for specialist consultations
- 40 per cent higher for procedures (DVA 2018an, p. 9).

There is also another payment of between \$7 and \$11, called a Veterans' Access Payment, for GPs.

The fees the government pays under the Medicare Benefits Schedule (MBS) and the fees that DVA pays under its scheme have not been indexed since 2013. The Australian Government recommenced indexing fees in 2018. Fee indexing for GPs and specialists recommenced in 2018, specialist procedures will recommence in 2019 and fee indexing for diagnostic imaging will recommence in 2020.

While Medicare and specialist bulk billing rates for the general population have not deteriorated during the indexation pause (there is no comparable statistic for DVA cardholders as providers cannot charge co-payments, discussed below), DVA clients could

be finding it more difficult to access clinicians because there are higher overhead costs for providers than other patients. For example, the Royal Australian and New Zealand College of Psychiatrists suggested that DVA's burdensome paperwork requirements discourage providers from accepting DVA patients:

... RANZCP members have indicated that time-consuming paperwork requirements are directly impacting the availability of clinicians for clinical assessment and treatment. Such requirements discourage medical practitioners from taking on veterans that require engagement with DVA. (sub. 58, p. 5)

DVA acknowledges the administrative burden it places on providers. The Treatment Principles concede that the legally-binding notes for GPs may be 'exacting' (and hence require remuneration higher than the Medicare fee schedule) but claim that medical specialists 'are not prepared to submit to the same level of regulation' as GPs (s. 4.1.3). There is no set of legally-binding notes for psychiatrists or other specialists (aside from the Treatment Principles).

DVA's fees may be higher than Medicare but they are lower than other comparable schemes.

- Comcare and NSW icare pay fees for medical practitioners, including GPs, psychiatrists and specialists, based on a list prepared by the Australian Medical Association.
- Worksafe Victoria pays medical fees that are, on average, twice the MBS rate. GP consultations are 50–75 per cent higher than the MBS rate.
- Workcover Queensland pays medical fees that are, on average, three times the MBS rate. GP consultations are double the MBS rate.

And the cost to providers of treating a DVA patient, relative to another patient, could have increased over the period of the indexation pause.

Allied health

Allied health industry groups claim that DVA fees are below market rates and below the rates paid through other workers' compensation schemes. Allied Health Professions Australia said:

Feedback from practitioners across a range of professions and across a range of locations and settings suggests that the low rates paid by DVA are a genuine barrier to access to high quality services, provided by experienced practitioners. Our view is that current rates are not sustainable and result in providers either refusing to provide services, using less experienced staff to deliver care, or to effectively subsidise services by charging lower than appropriate rates. None of these options are conducive to ensuring the best outcomes for veterans or supporting genuine choice. (sub. DR261, p. 7)

Other participants also noted gaps between DVA and other fees.

- GO2 Health said that that DVA fees are around 40 per cent lower than private fees.

- Under the current DVA payment scheme, the majority of the expected community health care team are poorly remunerated for their hard work supporting the veterans. As a centre that specialises in the care of veterans, GO2 Health is keenly aware of the financial hardship taken on by practitioners who choose to serve the veteran community. Across the entire practice, GO2 health is aware of a 40% reduction in revenue as a direct result of treating veterans, with certain services (psychology) working on a 41% of normal fee model. (sub 98, p. 4)
- David Tymms (sub. 79) also estimated that physiotherapists, occupational therapists and psychologists can earn as much as 50 per cent more for treating non-DVA clients.

Allied health fees are indexed the same way as medical fees, and indexation was paused between 2013 and 2018.

It is difficult to come up with a true like-for-like comparison of the fees paid under different schemes. For example, some schemes pay an hourly rate, others pay per appointment. And some schemes pay different fees for consultations at the practitioner's office or elsewhere (in or out of rooms), while others do not (paying a travel allowance instead). Having said that, some comparisons can be made.

- DVA's fees for an initial physiotherapy consultation are somewhat below those paid by other schemes, but the in-room standard consultation rate is above the Transport Accident Commission and Worksafe Victoria rates and slightly below the Comcare rate (table 16.2).
- DVA's fees for psychologist consultations are below other schemes, except for very short appointments where they are above Transport Accident Commission and Worksafe Victoria, but still below Comcare (table 16.3).

Table 16.2 Physiotherapy fee comparison
\$ per consultation

	<i>Initial consultation (in rooms)</i>	<i>Initial consultation (out of rooms)</i>	<i>Standard consultation (in rooms)</i>	<i>Standard consultation (out of rooms)</i>
DVA	64.25	69.05	64.25	64.25
Transport Accident Commission	71.55	102.12	54.51	81.70
Worksafe Victoria	103.71	103.73	54.46	56.97
Comcare (Victorian rate)	103.71	NA	54.46	NA

Sources: Comcare (nd); DVA (2018af); TAC (nd); Worksafe Victoria (2018a).

Table 16.3 Psychology fee comparison
\$ per consultation (length)

	20 minutes	30 minutes	45 minutes	60 minutes
DVA	72.95	72.95	72.92	102.95
TAC	54.26	81.39	122.08	162.78
Worksafe Victoria ^a	55.78	83.67	125.50	167.33
Comcare	119.00	119.00	166.00	218.00

^a Commission estimates - pro rata based on the hourly rate.

Sources: Comcare (2018b); DVA (2018ak); TAC (2018); Worksafe Victoria (2018b).

There are some other significant differences that work against the DVA fees. For example, the differences in travel allowances can lead to big discrepancies for services that are largely provided in a client's home, such as occupational therapy. DVA's out-of-rooms loading for occupational therapy is \$22.10, compared with Worksafe Victoria's travel payment of \$132.71 per hour — meaning Worksafe's payment will be higher than DVA's if the provider needs to travel more than 10 minutes (return). Occupational therapists providing services under the DVA Rehabilitation Appliance Program also commented that the legally binding documents that set out the expectations on the way allied health services under this program:

... do not translate to a fair and workable day to day system ... As a consequence of this poor administration, it has led to and will continue to, result in a decrease in a veterans' ability to access allied health services in general, and in particular quality allied health services. (Angela Rainbow, sub. DR244, p. 5)

Co-payments

Providers cannot generally charge DVA cardholders a co-payment (except for pharmaceuticals and some dental services). Other schemes do not restrict the use of co-payments; workers compensation, transport accident and disability insurance schemes all allow co-payments, as does Medicare.

User co-payments can be a significant source of funding for some services — only 31 per cent of Medicare specialist attendances were bulk-billed in 2017-18 (DoH 2018a). The restriction on co-payments may exacerbate the problems with low fees for some services outlined earlier.

If the DVA fee schedule is set too low and providers cannot charge co-payments then they can respond by either cross-subsidising from other patients (or their own income) or not treating DVA clients. Some participants suggested that DVA cardholders are being treated by less-experienced clinicians or recent graduates (Occupational Therapy Australia, sub. 71; VVCS National Advisory Council, sub. 72) and a participant to a recent Senate inquiry said that psychiatrists who tend to see veterans are those with a special interest in veterans' issues,

young inexperienced psychiatrists or those who cannot otherwise maintain a full client load (JSCFADT 2019, p. 63).

Where to from here?

DVA needs to find the right balance between paying fees that mean there are sufficient for providers to be willing to provide services to veterans, while containing costs and ensuring cardholders have access to quality services. DVA's task is similar to that faced by workers compensation authorities, transport accident insurance authorities and the National Disability Insurance Agency. The RANZCP said that DVA could learn from other workers' compensation fee arrangements:

... the RANZCP encourages DVA to review remuneration rates and schedules for psychiatric consultations, and consider options to encourage mental health services to accept veterans as patients. The administrative burden of patient care with compensable injuries is more reasonably reflected in the workers compensation systems reimbursement schedule which is a direct competitor for clinicians' time. (sub. 58, p. 5)

There are, however, also some important differences between DVA's health care arrangements and other workers' compensation schemes.

Most workers' compensation schemes use various means to control costs and they typically are more focused (than DVA) on outcomes. For example, to claim medical treatment from Comcare the claimant must submit a treatment plan for approval. The treatment plan must set out the types of treatment needed, how often and for how long. Costly treatment, such as surgery, require prior approval from Comcare. And importantly, workers' compensation schemes only pay for treatment of work-related conditions.

At the moment, DVA's balancing act is made all the more difficult because of the differences between groups of cardholders — particularly the differences between cardholders with service-related conditions and those without. The VSC with a more active approach to managing clients and providers will be better equipped (than DVA currently is) to adjust fees (the VSC could also pay different fees based on health outcomes).

Of less concern is the effect of the current fee arrangements on clients accessing health care for non-service related conditions. One element of the Gold Card's ostensible value as compensation is that users cannot be charged co-payments, but with this is the potential downside of reduced access to some services. But if there is an expectation that Gold Card holders be able to visit any healthcare provider of their choice, then providers should not be restricted from charging co-payments. As discussed below, it is the Commission's view Gold Cards should not be the vehicle for compensating people (section 16.5).

Fee-setting arrangements, however, should not be allowed to affect service quality and access to health care for those with service-connected conditions. An independent review into fee setting arrangements should be commissioned to look at DVA's fee setting arrangements and how they can be set to promote accessible and high quality care for

veterans with service-related conditions, while maintaining financial sustainability. The review should explicitly consider the merits of adopting workers' compensation fee setting arrangements. Drawing on the experiences of workers' compensation schemes (and other insurance schemes, such as those for transport accidents, where relevant), the independent review should consider the following issues:

- the role fees play in promoting access to quality services — this should cover the standards of services that DVA expects (including provider travel and preparing notes) and appropriate fee levels to support this
- ongoing fee setting arrangements to ensure adequate fees over time
- how DVA can increase its oversight of the effectiveness and appropriateness of treatment and better
- how to monitor the quality of care and health outcomes.

DVA recently conducted a review into its dental and allied health fee arrangements. This review, which was not independent, did not address all the issues mentioned above. It also explicitly did not consider proposals that were not cost neutral to government. A more substantive review is required.

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 of fees over the longer term. The review should also consider and advise on future governance arrangements for the ongoing setting of fees.

16.5 Should compensation be a feature of veteran health care?

Health care — part of a beneficial compensation package

As discussed earlier, for some groups receiving the Gold Card there is little healthcare rationale — dependants and veterans who are eligible because of age or because they are receiving the service pension. For these groups, the Gold Card is primarily a means of non-monetary compensation or recognition.

History provides some insights into the rationales for providing the Gold Card as a form of compensation. For example:

- In 1975, the Toose report concluded that dependants should be eligible for medical treatment because 'the bread-winner has been lost and ... the nation, in terms of

compensation obligations, should assume responsibility for the welfare of the dependants' (Toose 1976, p. 450).

- Clarke et. al. considered the Gold Card to be part of a dependant's compensation package for the death of the veteran (2003).
- And in 2004, the then Veterans Affairs Minister, the Hon Danna Vale MP, said the earlier decision to grant the Gold Card to all veterans over 70 with qualifying or warlike service was a 'benefit granted in recognition of incurring danger from an enemy' (Vale 2004, p. 5).

This sentiment was echoed by one Member of Parliament who spoke about the recent decision to extend the Gold Card to civilian medical personnel who provided assistance in the Vietnam War (as part of the South East Asian Treaty Organisation, or SEATO), saying the decision was 'not just about medical care but also about recognition and acknowledgement of the service and sacrifice that the SEATO officers made' (Flint MP 2019, p. 14242).

Clarke et. al. and Toose both disagreed with earlier decisions to grant the full treatment benefits to non-seriously-impaired veterans as a compensation measure. Toose said:

There is no justification in pure Repatriation terms for any further extension of entitlement to full medical and hospital treatment at departmental expense.

While full treatment benefits for other persons presently eligible [World War I and Boer War veterans, among others] ... cannot be justified as a compensation measure, I am of the view that practical considerations require that this entitlement, in respect of past service, be continued. (1976, p. 462)

And Clarke et al. said:

... the recent extensions of Gold Card entitlement irrespective of means have imbued qualifying service with an additional significance — in a sense, it is seen as a reward for serving in a theatre of war. The Committee considers that these extensions of eligibility for the Gold Card were inconsistent with a needs-based approach ... (2003, p. 503)

A number of participants put forward the view that severely impaired veterans, or veterans with war service, deserved the Gold Card in recognition of their service and hardship. And yet, even accepting those viewpoints (which the Commission does not), it remains the fact that nearly half of all Gold Card holders today are dependants and not veterans, and one-third of veterans with a Gold Card do not have severe impairments. The Gold Card is also in addition to various other types of financial compensation (chapter 13). Indeed, some participants noted the superiority of financial compensation over the Gold Card — the TPI Federation, for example, said 'Remember a Gold Card does not put bread on the table' (sub. DR290, p. 11).

Does the veteran health system cover the right people?

Taking into account the health care (section 16.3) and compensation rationales for the Gold Card, eligibility for some groups is questionable.

Dependants

The Commission accepts, as some participants submitted, that the hardship of living with or caring for a severely-impaired veteran can lead to health problems for their partner and sometimes children. Importantly such dependants need support while the veteran is living.

Some dependents need support for long term health problems associated with the care of their veteran relative that may persist after the death of the veteran. The question is what is the most effective way to deliver support to dependants whose health is adversely affected by their care of impaired veterans?

DVA recently increased support for partners, including increasing access to mental health care through Open Arms, funding child care so partners can attend counselling, and increasing access to respite care. It is the Commission's view that these supports are better targeted to need than providing the Gold Card if they can directly address the causes of stress for dependants, and should be extended (chapter 19).

The Gold Card is also flawed as a way to compensate dependants of veterans who have died from service-related causes. It is not based on health needs, and it can be inequitable as a form of compensation — its 'value' depends on how much a person uses it (so dependants who are heavy users of health care will be compensated more than those who do not use the health system very much).

Participants supported compensation for dependants, but did not put forward any arguments that would justify the Gold Card as the most appropriate form of compensation. The War Widows' Guild, for example, said:

... the system of coloured card should not be examined from a purely economic rationalist point of view. There must be recognition of the important compensatory component inherent in them. (sub. DR278, p. 28)

Increasing compensation payments to dependants in lieu of providing the Gold Card would be simpler and fairer. However, this is not straightforward.

- Increasing underlying payments (such as the wholly dependent partner payments) could be inequitable, as the increase would also go to people receiving the Gold Card, potentially doubling their compensation.
- Limiting increased payments to new applicants would add additional complexity to the system by creating two rates for these payments, or adding in an additional supplement to the system. This goes against the Commission's findings in other areas (chapter 15).

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- The Commission is recommending compensation in the DRCA be harmonised with the MRCA, but that the Gold Card should not be extended to the DRCA. DRCA dependants are not losing entitlement to the Gold Card and therefore should not be eligible for increased compensation.

The Australian Government would need to decide on the amount of compensation that it deems to be fair. It would also need to balance the benefits and drawbacks of adding to the complexity of the compensation system. Changes in compensation should also take into account the full package of support available to veterans' families (chapter 13) and other potential ways to use that funding that may be more beneficial to wellbeing.

The Commission is recommending removing access to wholly dependent partner payments for dependants of veterans who had not died as a result of service under the MRCA (chapter 14). By extension, this means they would also not get access to the Gold Card.

Veterans without severe impairments

Veterans with qualifying service can get the age service pension from age 60 and the Gold Card if they meet an additional means test. Veterans with moderate impairments can get the Gold Card if they are also receiving the service pension. At age 70 all veterans with qualifying service are issued a Gold Card.

Tying eligibility to the age service pension, and means testing it, suggests that the Gold Card is provided to these groups as a form of additional assistance by way of an in-kind benefit rather than a payment. The age service pension was created in 1935 in response to concerns that war service had intangible effects that may result in premature ageing of the veteran, necessitating early retirement. Clarke et al. reasoned that the Gold Card was provided to this group as 'an attempt to provide greater assistance to veterans who were needy and "burnt out" due to their service in combat' (2003, p. 501). The means test targets these benefits towards veterans who have reduced earning capacity.

As discussed earlier, this 1930s rationale for providing the Gold Card to this group is now out-of-date. A number of studies have found that veterans have lower mortality than the general community (chapter 2) and Australia's general healthcare system is also much more developed than it was 80 years ago. In any case, financial payments are a more appropriate way to compensate for reduced working capacity. The Gold Card is also not an appropriate a form of additional welfare assistance — it is essentially an uncapped benefit, unlike other forms of assistance.

At age 70 the means test is essentially removed for the Gold Card — removing the connection to financial need. Removing the means test implies that this category of Gold Card recipients are relatively better off financially, which is not needs based or equitable.

There may be some administrative efficiencies from deeming large categories of veterans to be eligible for the Gold Card and reducing the volume of claims that DVA has to process.

Removing the requirement to submit a claim may also mean less burden on veterans to navigate a potentially complicated and difficult process. At the same time, it is incumbent upon DVA to handle its given claims volume efficiently and effectively — removing a source of potential claims could have the unintended consequence of reducing DVA's incentive to perform well (chapter 9). That is, if DVA were faced with high claim volumes and long processing times, the initial response would logically be for DVA to improve its performance. Instead of undertaking such necessary and important process improvements, DVA was given the easier option to simply deem large categories of people, with associated increased healthcare costs.

Dealing with high claim volumes and long processing times by extending Gold Card eligibility could also be an example of how policymaking in the veteran support system has, for many decades, been reactive in nature and driven by external events (chapter 11).

There is no healthcare or compensation rationale for providing the Gold Card to veterans without service-related health conditions. These veterans have access to the generally available healthcare system and this funding could be better targeted towards more effective means of support and towards veterans with greater needs.

Veterans with severe impairments

It may be onerous for a veteran with severe impairments to continue to make claims for additional health conditions in order to access treatment. That said, some veterans who qualify for the Gold Card by way of having high impairments would still face an incentive to make additional claims for financial compensation.

- Under the VEA, the Gold Card is available for veterans receiving 100 per cent of the general rate disability pension. But these veterans could substantially increase their financial compensation if they are able to advance to the special rate disability pension.
- Under the MRCA, the Gold Card is available for veterans at above 60 impairment points, but permanent impairment compensation continues to increase up to 80 impairment points.

To justify the Gold Card in terms of reducing the burden of making additional claims, it would be logical to restrict its eligibility to the maximum rate of compensation — the special rate disability pension under the VEA and 80 impairment points under the MRCA.

Another argument put forth in favour of the Gold Card is that it can be difficult to determine the exact causality of a condition for veterans with complex health needs. This may be so, but it does not necessarily mean that the Australian Government should therefore presume liability for all conditions. The initial liability system has a number of elements that are intended to favour the veteran in the case of close-run decisions, including beneficial standards of proof. Where a new claim may be difficult to prove, even in light of the beneficial nature of the compensation system, it might mean that the claim is not substantiated.

The Commission acknowledges that there may also be health and wellbeing gains from taking a holistic approach to treatment, which would support extending coverage to a wide range of services and is not recommending removing the Gold Card from veterans with severe impairments. That said, it should not be presumed that the Gold Card is the *best* way to promote the wellbeing of severely-impaired veterans, and the Commission supports DVA (and the VSC) investigating other approaches that may prove to be better.

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.

Calls to further expand access to Gold and White Cards

Historically, DVA (and government) has faced pressure to widen eligibility, regardless of how that measures against the objectives of the system. The Clarke Review faced calls to widen eligibility for the Gold Card and generally recommended against it. In one significant case the Clarke Review recommended narrowing eligibility — that the VEA be amended so that there would be *no* further grants of the Gold Card to post-World War II veterans with qualifying service at age 70, unless the veteran satisfied some measure of financial need. This recommendation was rejected (DVA nd). The Government at the time said that a ‘benefit granted in recognition of incurring danger from an enemy should not discriminate among veterans on the basis of wealth or income’ (Vale 2004, p. 5).

Clarke et al. also recommended that the Gold Card *not* be extended to all veterans of the British Commonwealth Occupation Force, and that participants in the British nuclear tests only be made eligible for the White Card, giving them access to treatment for cancer. Both groups were granted the Gold Card in the 2017 Budget (Australian Government 2017c).

In 2019, the Gold Card was extended to civilian doctors and nurses who provided aid, training and treatment to local Vietnamese people during the Vietnam War. Clarke et al. had

also recommended against such an extension. And, as recently as October 2017 the Government position had been consistent with Clarke et al., namely that these doctors and nurses were not under ADF command and control and so were covered by civilian Commonwealth workers' compensation arrangements. In announcing the extension, the Treasurer explicitly framed the decision as being about recognition and gratitude for service (not need or compensation for harm):

It may have taken nearly 50 years, but today justice is being done as a group of brave Australian doctors and nurses are duly recognised for their selfless contribution as members of the Southeast Asia Treaty Organization (SEATO) surgical civilian medical teams that served in Vietnam. (Frydenberg and Chester nd)

Other groups also called for access to the Gold or White Cards. For example:

- the Partners of Veterans Association argued that partners of disabled veterans should be issued a White Card that would give them access to a range of services including psychology, exercise physiology, massage, hospital stays and specialists services (sub. DR280)
- the War Widows Guild said that the Gold Card should be extended to widows aged 80 or older to recognise the widows of veterans 'lifetime of support to their family and country' and assist them in managing their health in later life (sub. 87, p. 8)
- the ACT branch of the Defence Force Welfare Association argued for all ADF members with war or war-like service to be granted a Gold Card on discharge and those with peacetime service be given a White Card for all conditions listed on the final discharge medical (sub. 13).

Senator Jacqui Lambie (herself an ex-Army servicewoman) introduced a Bill on 11 November 2015 that sought to grant the Gold Card to all veterans who have served in war or war-like operations. Senator Lambie said:

By making access to the Gold Card a tick and flick exercise — or a simple bureaucratic process, for those members of the ADF who had served in war or war-like conditions — it will allow vulnerable and often damaged people to bypass a traumatic and further damaging administrative process and immediately receive the medical care they need to get well (Lambie 2015, p. 8306).

The Senate voted on the Bill in February 2016 and it was defeated (the two major parties, the Liberal-National coalition and the Labor party, both voted against the Bill). Senator Linda Reynolds (an ex-Army reserve officer) spoke for the Government and cited a number of reasons for not supporting the measure. They included that:

- it would be costly
- it was not targeted
- it would spread the entitlement 'too thin' and end up meaning that those who need assistance the most would end up losing out
- some in the veteran community supported the current arrangements (Reynolds 2016).

Given all the problems with the Gold Card, it is the Commission's view that eligibility should not be widened any further. No current Gold Card holder or person who is entitled to a Gold Card under current legislation would be affected.

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.

What about the DRCA?

As discussed above, the Gold Card is not well targeted to those most in need and it is the Commission's view that it should not be extended further, including to veterans with impairments covered by the DRCA only. The White Card for service-related conditions is a more appropriate vehicle for funding veterans' healthcare needs and DRCA clients already have access to it. There is also no need to give the Gold Card to DRCA clients from a compensation perspective as the compensation package is already beneficial (chapter 13).

Some veterans with impairments covered by the DRCA will also have impairments covered by the VEA or the MRCA, which means they may have access to the Gold Card. A veteran with a high impairment rating under the DRCA and a small impairment under the MRCA (or VEA) could be eligible for the Gold Card.

17 Mental health and suicide prevention

Key points

- Australian Defence Force (ADF) personnel are recruited and trained to be physically and mentally resilient, and to display strength and perseverance. While serving, protective factors, including a strong sense of purpose, camaraderie and easy access to health care, reduce the risk of mental ill-health and suicide. But there are also risk factors, such as exposure to trauma and extended time away from family. Transitioning to civilian life can also be a risk factor.
- Mental ill-health places a heavy burden on affected individuals, their families and the community more generally. Individuals with mental ill-health and their families can have reduced quality of life and for those with reduced capacity to participate in the workforce it can mean lower household income.
- Supporting veterans' mental health better is not just about providing access to treatment — all aspects of the veteran support system have a role to play in supporting mental health and wellbeing throughout veterans' lifetimes.
- There is some evidence that mental illness is more prevalent in ex-serving personnel than in the general population. The age-adjusted rate of suicide for male ex-serving personnel is also significantly higher than the rate in the general population. Between 2001 and 2016, more ADF personnel died by suicide than in operations overseas.
- Serving and ex-serving members and their families can access generally available mental health and support services, and additional services through the Department of Veterans' Affairs (DVA).
 - Open Arms is run by DVA and provides counselling, case coordination and an after-hours telephone counselling service for veterans and their families.
 - DVA funds mental health care for veterans on a non-liability health basis through the White Card (veterans are eligible for treatment without having to prove a link to service).
- Veterans seeking help for mental ill-health should have access to quality mental health treatment and be confident that the health professional provides the best available treatment (or can refer them to someone else who can). While easier access to treatment is important, so too is access to treatment that is evidence based, patient centred and effective.
 - The non-liability White Card was designed to improve access to mental health services for veterans. However, it is not clear that it has increased the number of veterans who can access quality treatment. Open Arms does not publish outcomes data, so the effectiveness of its services is not clear. DVA should develop outcomes measures for Open Arms and then use these to ensure that services are accessible and high quality.
 - 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 focus on building the evidence base on the causes of, and treatments for, mental ill-health, and on monitoring services provided to veterans and families to help ensure that those with most need can access quality services.

Mental health care is a key area of need for veterans. There has been a heightened focus on veterans' mental health and suicide in recent years and a number of inquiries and reviews (box 17.1). This follows a number of veterans taking their own lives while seeking support from the Department of Veterans' Affairs (DVA). And as discussed in chapter 1, the genesis for this inquiry was a recommendation by the Senate inquiry into suicide by veterans (SFADTRC 2017).

Improving veterans' mental health is not just about better mental health services. Each of the life stages — recruitment, in service, transition and ex-service — of a veteran and all aspects of the veteran support system are important for getting better mental health outcomes. Earlier chapters of this report considered the role that effective rehabilitation (chapter 6), transition support (chapter 7), claims management (chapter 9) and health care (chapter 16) play in supporting veterans' mental health. The Commission's proposed changes in these areas, as well as the proposed governance changes (chapter 11), will be critical to preventing and minimising harm from mental ill-health (including suicide).

This chapter is focused on mental health programs and initiatives. It looks at: what is known about the mental health needs of veterans (section 17.1); the mental health services available to serving and ex-serving personnel and their families (section 17.2); problems identified with the current arrangements (section 17.3); how improvements across the veteran support system will improve the treatment of mental ill-health (section 17.4); why an increased focus on outcomes is required to improve veterans' mental health and wellbeing (section 17.5); and the role for a new Veteran Mental Health Strategy (section 17.6).

17.1 About the mental health of veterans

Military service and how it shapes mental health

The (mentally) healthy soldier effect?

Australian Defence Force (ADF) members are recruited and trained to be strong and resilient. As the *Mental Health in the ADF* study¹ said:

The military is an occupation where personnel are selected, trained and prepared to face adverse, stressful and potentially traumatising situations. To meet these demands, an approach that focuses on strengthening resilience and enabling recovery is essential. (McFarlane et al. 2011, p. xxxi)

The physical health screening required to enter the ADF, together with military training, means serving members are physically healthier than the general population. This is known as the 'healthy-soldier effect' (chapter 2). However, whether serving members are mentally healthier than the general population is less clear. While there is mental health screening for

¹ The study was conducted between April 2010 and January 2011. It covered nearly half of the ADF, which at that time was about 50 000 full-time members (McFarlane et al. 2011, p. 5).

ADF recruits, the effectiveness of recruitment screening assessments and the regular mental health screening of members (such as those following deployments and other operations), has been questioned (NMHC 2017b, p. 32). Because these tools are used on a regular basis, it is said that personnel learn responses to avoid detection, and this makes it difficult to track the mental health of personnel while they are serving (NMHC 2017b, p. 33).

This is supported by findings in the international literature. A study summarising the mental health screening used in the United States found that the major limitation of the screening tools was that they relied on self-reporting and personnel could learn responses to avoid detection which makes the screening ineffective (Lee, Warner and Hoge 2018, p. 125). A study conducted in the United Kingdom also found that post-deployment screening did not reduce the prevalence of mental illnesses (including post-traumatic stress disorder (PTSD), anxiety, depression and alcohol misuse) or increase help seeking (Rona et al. 2017).

Box 17.1 Reviews, inquiries and research on veteran mental health

Increasing concerns about the mental health of veterans have led to a number of inquiries, reviews and research programs. Defence and the Department of Veterans' Affairs (DVA) have responded to the recommendations with a program of new initiatives (these are discussed throughout the chapter).

2013 — Care of ADF Personnel Wounded and Injured on Operations (Joint Standing Committee on Foreign Affairs, Defence and Trade, Defence Sub-Committee inquiry)

This inquiry looked at the treatment of wounded personnel including return to work arrangements, repatriation arrangements and management of personnel who cannot return to work. It made six recommendations specific to mental health concerns. Three were supported by the Government. They were that: Defence publish periodic assessments on how it was implementing the recommendations of reviews on Australian Defence Force (ADF) personnel mental health; Defence, with input from DVA, assess the effectiveness of psychological first aid; and establish strategic research priorities to address suicide attributable to defence service. Two recommendations were supported in principle and the last one noted.

2016 — Mental health of Australian Defence Force members and veterans (Foreign Affairs, Defence and Trade References Committee inquiry)

This inquiry focused on the mental health supports provided by Defence and DVA. The inquiry made 17 recommendations. The Government agreed to three recommendations:

- allowing medical officers access to members' records of potentially traumatic events after deployment
- extending eligibility of Open Arms to serving personnel
- emphasising the benefit of early identification and treatment of mental ill-health in Defence mental health programs.

Six others were partly agreed to, four were agreed to in-principle and four were noted.

(continued next page)

Box 17.1 (continued)

March 2017 — Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families

The National Mental Health Commission's review investigated the prevalence of self-harm and suicide, the type and efficacy of self-harm and suicide prevention services (through a survey of serving and ex-serving members and their families) and potential barriers to care. It made 23 recommendations and in response the Government announced funding for pilots of innovative approaches to suicide prevention.

August 2017 — The Constant Battle: Suicide by Veterans (Foreign Affairs, Defence and Trade References Committee inquiry)

The Senate Committee made 24 recommendations and 13 of these were for further reviews, studies or trials. The Government released its response in October 2017, and agreed to 22 of the recommendations (agreeing 'in-principle' to recommendations to support the provision of alternative therapies and to establish a Bureau of Veterans' Advocates). This inquiry came about following a recommendation from this Committee.

October 2017 — Joint inquiry into the facts surrounding the management of Mr Jesse Bird's case (Department of Veterans' Affairs and Department of Defence)

This inquiry was in response to Jesse Bird's death by suicide. The inquiry made 19 recommendations, nine of which were priority actions, including putting in controls to ensure that complex case management is initiated and identifying indicators for at-risk veterans to develop case management models. In 2018, an independent review of the implementation of these recommendations commenced and will report in 2019.

2018 to 2019 — Transition and Wellbeing Research Programme

The Transition and Wellbeing Research Programme, which is jointly funded by DVA and Defence, examines the health and wellbeing of ADF personnel during service and following their transition back into civilian life. The programme will have ten reports, seven of which were released over the course of 2018 and 2019 (box 18.7 has more details on this programme.)

2019 — Inquiry into transition from the Australian Defence Force (Joint Standing Committee on Foreign Affairs, Defence and Trade inquiry)

This review looked at the barriers preventing ex-service organisations from effectively engaging with ADF members, the model of mental health care while in ADF and through the transition period, and the supports to facilitate an effective transition. It recommended mandatory online veteran-specific training and professional development for clinicians and a register of clinicians, a sustained funding model for veterans' mental health research and a coordinated strategy to improve treatment outcomes for post-traumatic stress disorder. The government is yet to respond.

Sources: Australian Government (2013, 2016a); DVA (2018a); Chester (2018a); NMHC (2017b); SFADTRC (2017); JSCFADT (2013, 2019).

Recruits also typically enter the ADF at an age when there is a lot of mental development and identity formation. The first signs of mental ill-health typically occur at the age most recruits enter the ADF. It can therefore be difficult to determine whether individuals entering the ADF have (or do not have) pre-existing mental ill-health and because of that, the effect

that military service has on ADF members (NMHC 2017b, p. 33). An inquiry into mental health and the armed forces conducted in the United Kingdom concluded that:

It is very difficult to prove whether the mental health conditions that some serving personnel and veterans develop are caused by their military service. Non-military factors or underlying mental health conditions exacerbated by military service could all contribute to an individual's mental health. (House of Commons Defence Committee 2018, p. 10)

What are the protective and risk factors for serving and ex-serving members?

For serving members, there are a number of protective factors that are likely to reduce the risk of mental ill-health — they include a strong sense of camaraderie, purpose and belonging, and easy access to health care (NMHC 2017b, p. 20). But there are also risk factors for serving personnel, including exposure to trauma, moral injury², extended time away from family, frequent moves, and aspects of military culture, such as bullying and harassment.

A number of inquiry participants raised concerns about the effects of ADF culture on mental health (box 17.2). The Defence Abuse Response Taskforce report found evidence of a culture of harassment and physical and sexual abuse within the ADF (box 17.3).

In the context of organisational culture, it is interesting to note that a study looking at the mental health of police and emergency workers found 'poor workplace practices and culture ... to be as damaging to mental health as occupational trauma' (Beyond Blue 2018a, p. 17).

Military culture can also be a barrier to seeking help for mental ill-health. 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 help seeking, and in the absence of support, mental ill-health can become worse (NMHC 2017b, p. 43).

Another aspect of military culture that can impede help seeking is the belief that disclosing a mental illness will mean missing out on deployments and promotions. As John Cantwell (a Major General in the Australian Army) said in his book *Exit Wounds*:

For two decades I hid my problems because I felt they were a sign of weakness. I was afraid to tell anyone, other than my wife, in case I looked foolish or soft. I was also afraid it would damage my chances of promotion in a job I loved. I suffered in private. (2012, p. 2)

² Moral injury can be defined as 'being confronted with events and experiences associated with perpetuating, failing to prevent, or bearing witness to inhumane or cruel actions, or learning about acts that transgress deeply-held moral beliefs and expectations' (DoD 2017h, p. 35).

Box 17.2 **Participants' comments on the effects of military culture on mental health**

Deborah Morris:

... it is the day-to-day effects in military socialisation and the systems of power coupled with no foreseeable end in sight that breaks the person more than the actual trauma or the injury that has occurred. (trans., p. 1250)

Brian McKenzie:

To ensure that new recruits will follow all orders and kill their opponents in war, Army training indoctrinates unconditional obedience, stimulates aggression and antagonism, overpowers a healthy person's inhibition to killing, and dehumanises the opponent in the recruit's imagination. Recruits are taught that stressful situations are overcome through dominance, and that soldiers are superior to civilians.

The available evidence points to appreciable changes to the recruit population once they are enlisted: to personality (more antagonistic and conformist, and less emotional); to attitudes (more authoritarian and militaristic); to mental health (more anxious, depressed, and suicidal); and to behaviour (more likely to drink heavily and behave violently, including the sexual harassment of women by men). Traumatic war experiences typically reinforce these changes. (sub. DR275, p. 1)

Rosemary Mountford:

... it's almost like a Stockholm Syndrome. You are taught not to question and you're taught to like the person that is abusive to you. And Stockholm Syndrome is the closest thing that I can ever relate that to. So these soldiers become dependent on the people above them to care for their needs and express what their belief is. They're not allowed to have an opinion. They are a soldier. (trans., p. 1319)

Ben Walker:

Immediately following my [mental health] diagnosis, my colleagues and superiors in the [Air Force] treated me with contempt and what, at best could be described as ignorance and at worse bullying and harassment due to their naivety and perhaps fear of the unknown around mental health. Unfortunately this wasn't in the 1920s or 1940s, this was 15 years ago. I commend the ADF for making deliberate steps to remove the stigma around mental health over the last decade, however I do believe there is still room to do more. (sub. DR216, p. 1)

The *Pathways to Care* report found that one of the most common barriers to seeking help for serving and transitioned personnel were concerns over career (Forbes, Van Hooff and Lawrence-Wood 2018). The National Mental Health Commission (NMHC) also heard that these concerns resulted in serving members withholding information about their health and wellbeing (2017b, p. 43). Other barriers to seeking help, such as stigma, are discussed in more detail in chapter 5.

When serving personnel transition to civilian life, some of the protective factors associated with military service can become risk factors (for example, the loss of identity and social connections). This is also a time when veterans can face other risk factors, such as unemployment and reduced income. As the *Mental Health Prevalence* report said:

Changes brought about by the transition process can lead to the development and/or exacerbation of existing service-related mental and physical symptoms resulting in psycho-social adjustment issues ranging from employment difficulties and family/relationship conflict, to mental health and substance abuse problems. (Van Hooff et al. 2018a, p. 1)

Box 17.3 Abuse in the Australian Defence Force

There have been a number of reviews investigating abuse in the Australian Defence Force (ADF). The Defence Abuse Response Taskforce (DART) was established in 2012 and released its final report in 2016. The terms of reference for the DART only considered complaints of sexual and other forms of abuse by Defence personnel alleged to have occurred prior to 11 April 2011 or complaints from women who experienced sexual abuse at the Australian Defence Force Academy during the period 1991 to 1998.

The DART received 2439 complaints — 1751 were found to be in scope and plausible. Of the complainants, 73 per cent were male and 27 per cent were female.

The DART analysed a sample of cases from 2000 to 2011 and found that:

- the Navy had the highest number of sexual abuse and sexual harassment cases
- there were high levels of abuse of young people at recruit and training establishments
- women were significantly overrepresented as complainants.

The Commonwealth Ombudsman is able to receive reports of serious abuse within the ADF under its Defence Force Ombudsman jurisdiction (serious abuse includes sexual abuse, serious physical abuse or serious bullying or harassment). The total number of reports of abuse received by the Defence Force Ombudsman from 1 December 2016 to 30 April 2019 was 1031. Of these:

- 76 per cent were made by males and 24 per cent by females
- 15 per cent were made by serving members of the ADF and 82 per cent by former members
- the Army had the highest number of reports (457), followed by the Navy (370) and then the Air Force (165).

Sources: DART (2016, pp. viii, 1–2, 21, 28); Commonwealth Ombudsman (2019c, pp. 1, 5).

Orygen (The National Centre of Excellence in Youth Mental Health) also said:

A range of protective factors have been identified for serving personnel. Ex-serving personnel may be at risk of losing these factors or their being weakened upon leaving the ADF, which may result in the following:

- a loss of social support, belonging, identity and purpose, especially among ex-serving personnel who are involuntarily discharged
- the challenge of adapting to a civilian context in which traits suited to active service can potentially add to an individual's vulnerability to mental ill-health
- having to learn 'life skills' following the structured environment of service life.

The potential loss of protective factors needs to be considered in the development of new and innovative approaches to supporting young serving personnel in transition and ex-serving personnel. (sub. 67, p. 2)

Protective and risk factors for suicide

The risk factors for suicide (and self-harm) are 'complex and varied, and can relate to individual, social and contextual factors' (NMHC 2017b, p. 19). And while suicide is

multi-determined in nature, the risk factors are not well understood in the general population, let alone in the veteran population. As the NMHC said ‘there is no clear “checklist” to determine whether a person is likely to attempt or die by suicide, or engage in self-harming behaviour’ (2017b, p. 19).

That said, there are clear links between mental ill-health and suicide (and the risk factors for suicide are thought to be similar to those for mental illness). For example, the *Mental Health in the ADF* study found that 90 per cent of those who attempted suicide had a mental disorder (McFarlane et al. 2011, p. 89). Self-harm is also considered to be a risk factor for suicide (2017b, p. 19).

The identified risk factors associated with suicide in the general community include:

- mental ill-health (depression, severe anxiety, PTSD, substance abuse, recent discharge from an inpatient mental health unit)
- social factors (social isolation, loss of relationship, financial difficulty, having access to means for suicide and media coverage of suicide)
- physical health problems
- historical factors (suicide attempts, past abuse, family history of suicide, family history of mental health problems)
- demographics (males, divorced or widowed, age) (NMHC 2017a, pp. 35–41).

For the veteran community, additional military-related risk factors include combat or other operational experience, disciplinary action, reduction in rank or medical employment classification status with loss of status and identity, separation from unit or service and difficulties with post-deployment adjustment (Phoenix Australia 2016).

However, recent studies found that commonly thought risk factors for suicide are not good predictors of whether someone would later suicide.

- A recent study analysed risk factors for suicidal thoughts and behaviours and found risk factors only had a slightly better chance at predicting suicidal thoughts and behaviours than chance (Franklin et al. 2017).
- A meta-analysis by McHugh et al. (2019) found that suicidal ideation was not a good predictor of whether someone would later suicide.

As the NMHC put it:

Despite decades of research, the pathways to suicide and self-harm are only partially explained by models of behaviour. Suicide and self-harm is intensely personal, and while numerous risk factors have been identified, the [consolidations] of these factors and an individual’s personal vulnerability and characteristics increase complexity. For similar reasons, few studies can identify strong protective factors regarding suicide and self-harm. (2017b, p. 19)

This uncertainty over risk factors for suicide makes developing prevention and early intervention strategies difficult (section 17.3).

Is there a link between deployment, mental ill-health and suicide?

A number of recent Australian studies have looked at whether mental ill-health varied by deployment status.

- The *Mental Health in the ADF* study found *no* significant difference between the twelve-month prevalence³ of mental disorders between ADF personnel who had deployed and those who had not (McFarlane et al. 2011, p. 47).
- The *Mental Health Prevalence* report also found that there was no significant difference in the twelve-month prevalence of affective disorders, alcohol disorders or suicidality between those who had deployed and those who had not (Van Hooff et al. 2018b, p. 91 and 108).
 - However, it found that those who had deployed had greater twelve-month prevalence of anxiety disorders than those who had never deployed (39 per cent compared with 25 per cent). And the twelve-month prevalence of PTSD was considerably greater in the deployed group (20 per cent) compared with the group that have never been deployed (4 per cent) (Van Hooff et al. 2018b, p. 66).

These different results may be explained by the fact that the *Mental Health in the ADF* study only included currently serving personnel and members with mental ill-health may have transitioned out of the ADF (such as through medical discharge). The *Mental Health Prevalence* report, on the other hand, included members who had transitioned, and this would have included those who had transitioned due to mental ill-health.

The *Impact of Combat* study looked at the mental health of those who had deployed to the Middle East Area of Operations between June 2010 and June 2012, and found that the majority of deployed personnel did not report mental disorder symptoms, but the proportion who did report mental disorder symptoms increased over time. The study also found that exposure to traumatic events while on deployment was associated with both increased psychological distress and post-traumatic stress symptoms (Lawrence-Wood et al. 2019, pp. iii, 65–66, 104–105, 108–109).

These results are similar to those found by international studies. For example, a recent systematic review investigated the odds of mental ill-health in a deployed population compared to a non-deployed population. The review (which covered studies from the United States, United Kingdom and Australia) concluded that the odds of screening positive for mental ill-health in the longer term (greater than 24 months) were higher in the deployed group compared to the non-deployed group (Bog, Filges and Jorgensen 2018, p. 9).

The *Mental Health Prevalence* report analysed the relationship between different types of traumatic events and PTSD prevalence. It found that some of the most common traumatic

³ Twelve-month prevalence is meeting the diagnostic criteria for a mental illness/disorder and having reported symptoms in the previous twelve months.

events experienced by transitioned ADF members were those that were more likely to occur while on deployment, including:

- being in combat
- being a peacekeeper in a warzone or place of ongoing terror
- seeing atrocities or carnage such as mutilated bodies (Van Hooff et al. 2018b, pp. 76, 77).

And experiencing these events was associated with PTSD prevalence. For example, of the 42 per cent of transitioned ADF members who reported being in combat as a traumatic event, 28 per cent met criteria for PTSD (Van Hooff et al. 2018b, pp. 78, 80).

While it is not possible to eliminate members' exposure to certain traumatic events while in the ADF, higher PTSD prevalence has also been found to be associated with non-combat related traumatic events. For example:

- 6 per cent of transitioned ADF members reported being raped and 39 per cent of these members had PTSD
- 13 per cent of transitioned ADF members reported being sexually assaulted and 26 per cent of these members had PTSD (Van Hooff et al. 2018b, pp. 78, 80).
 - 84 per cent of transitioned ADF members in the study were men (Van Hooff et al. 2018b, p. 30) and they report sexual assault at much higher rates than the general community — about 5 per cent of men and 18 per cent of women are reported to have experienced sexual violence (sexual assault and/or threats) since the age of 15 (AIHW 2018e, p. x).

And while the study did not identify when these events occurred, as discussed above, these events are risk factors for a number of mental disorders (not just PTSD) and potentially suicide. The prevalence of these experiences highlight the importance of prevention and early intervention support services for personnel (chapter 5).

What role do families play in mental health and suicide prevention?

Families can play an important role protecting serving and ex-serving members from suicide. On reviewing the literature, the NMHC found that families can be:

... part of the fabric of protective factors that reduce the risk of suicide for members of the military, can assist in recognising signs that a member may be at risk, and can play a supportive role in assisting members in treatment and recovery. (2017b, p. 22)

Family members are often the ones who search out information on mental health services and help the veteran access care. The *Pathways to Care* report found that transitioned personnel who had sought help for mental ill-health received help seeking care mostly from their general practitioner or medical officer (41 per cent), followed by their partner (28 per cent) (Forbes, Van Hooff and Lawrence-Wood 2018, p. 87). Transitioned personnel

who received help for mental ill-health also reported that seeking help was most commonly suggested by partners (47 per cent) (Forbes, Van Hooff and Lawrence-Wood 2018, p. 80).

This is consistent with the international literature. A United States study of veterans with PTSD, for example, found encouragement and support from friends and family increased the likelihood of a veteran seeking care (Spoont et al. 2014). Another United States study found that veterans undergoing PTSD treatment were more likely to discontinue treatment if they lacked social support (Gros et al. 2013).

Families of veterans with mental illness, however, often also require support themselves to be able to provide effective support for family members (NMHC 2017b, p. 23). Family members can suffer significant harm, including through vicarious trauma and directly from the stresses associated with the care of an injured or unwell veteran.

Prevalence of mental ill-health among veterans

The evidence on how military service affects mental health is not conclusive and each individual responds differently to risk and protective factors. However, there is research on how the mental health of serving personnel compares to the general population and the prevalence of mental ill-health among veteran groups. This research gives an indication of how serving personnel and veterans are faring and their mental health needs.

Prevalence of mental ill-health among serving personnel

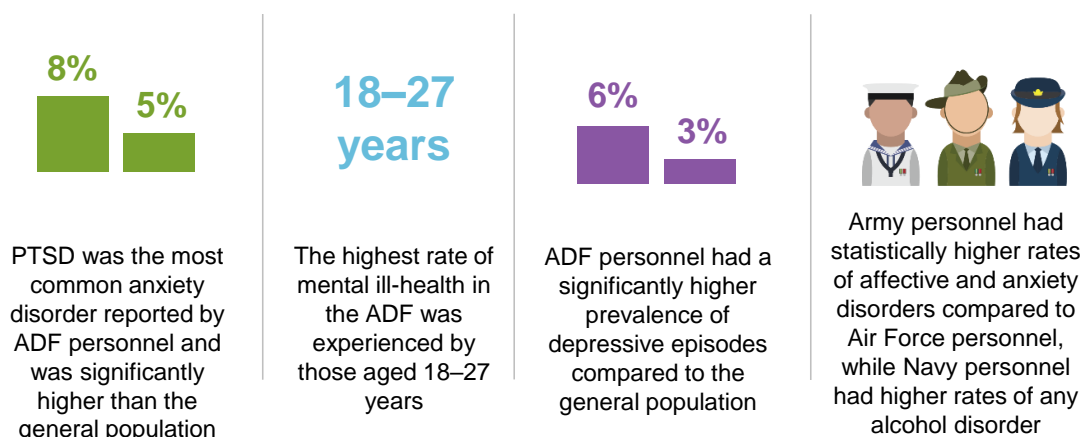
The *Mental Health in the ADF* study found that:

- one in five of the ADF population had experienced a mental disorder in the previous 12 months. This is similar to the rate in the Australian community
- ADF personnel were more likely to report a mental illness in their lifetime (54 per cent) compared to the general population (49 per cent) (McFarlane et al. 2011, p. 15)
- ADF males had higher rates of any affective disorder and both ADF males and females had lower rates of any alcohol disorder.

Other findings are shown in figure 17.1.

One of the conclusions of the *Mental Health in the ADF* report was that ‘there are still significant barriers to seeking care and untreated mental disorders are affecting capability’ (McFarlane et al. 2011, p. 211). The prevalence of mental illness suggests that any healthy soldier effects in Defence may be counterbalanced by the impact of occupational stressors.

Figure 17.1 **Mental health in the ADF**



Source: McFarlane et al. (2011).

Prevalence of mental ill-health among transitioned personnel and veterans

Transitioning can be difficult for individuals as they leave military service and adjust to civilian life (chapter 7). Transition can be particularly difficult for members who are medically discharged, as they may be discharging because of mental ill-health, or physical injuries (which increases the risk of mental ill-health).

The *Mental Health Prevalence* report found that 46 per cent of transitioned ADF reported having a mental disorder in the last 12 months (Van Hooff et al. 2018b, p. 54). This report found that ex-serving members had higher rates of mental illness compared to reservists (table 17.1).

Table 17.1 **Transitioned personnel (twelve-month prevalence)**

	<i>Affective disorders</i>	<i>Anxiety disorders</i>	<i>Alcohol disorders</i>
	%	%	%
Ex-serving members	32.9	44.6	18.7
Inactive reservists	17.0	29.5	8.7
Active reservists	12.5	31.9	7.3

Source: Van Hooff et al.(2018b).

This study, however, did not compare veterans' prevalence rates to the general population, but rather compared prevalence rates between different subgroups of the veteran population. Not being able to compare prevalence rates to the general population means it is unclear if transitioning veterans have higher prevalence of mental ill-health compared to the general population, and therefore require additional support.

The study was limited in terms of what it could do with comparisons because of a lack of national data on the prevalence of mental ill-health. To rectify this, the study used data from the *National Health Survey* which has some limited information on mental health. These data show that four times more transitioned ADF personnel reported high psychological distress compared to the general population (20 per cent compared with 5 per cent) (Van Hooff et al. 2018b, p. 203).

There are two other limitations of this study.

- First, only recently transitioned members were included. Symptoms of mental ill-health can be delayed and may not appear in recently transitioned personnel.
- Second, the response rate for the study was low which means the results may not accurately reflect the true prevalence of mental disorders in the total transitioned population (chapter 18).

DVA has also commissioned health studies of veteran groups. These studies, which compared a group of deployed veterans to a sample from the general population, found that veterans have higher rates of anxiety, depression and alcohol disorder compared to the selected comparison group (box 17.4).

Suicide

In response to a recommendation from the Senate inquiry into suicide by veterans, DVA commissioned the Australian Institute of Health and Welfare (AIHW) to report annually on the suicide rate of full-time serving personnel, reservists and ex-serving personnel, who joined the ADF on or after 2001 (Australian Government 2017b, p. 7).

The latest AIHW data show that the age-adjusted suicide rate for serving male ADF personnel is lower than the general population, however the age-adjusted rate of suicide for ex-serving personnel is significantly higher. Between 2001 and 2016:

- the age-adjusted suicide rate for serving and reserve men was lower than for all Australian men (51 per cent lower for men serving full time in the ADF and 47 per cent lower for men in the reserves)
- the age-adjusted suicide rate for male ex-service personnel was 18 per cent higher than the rate for Australian men
- male ex-service personnel under the age of 30 had a rate of suicide about twice the Australian average for the cohort of the same age and gender (AIHW 2018g).

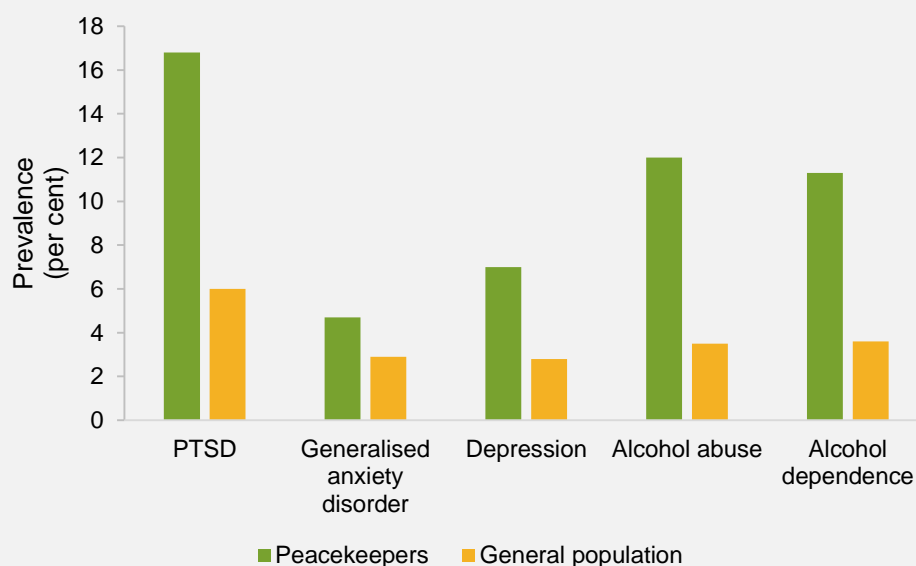
Box 17.4 Evidence from studies of veterans' mental health

Australian Veterans of the Korean War (2005)

This study compared male Korean War veterans to a sample of men from the general population. It found that Korean War veterans were three times more likely to report hazardous alcohol consumption compared to the general population, and report higher levels of anxiety, depression and post-traumatic stress disorder (PTSD).

Peacekeepers' Health Study (2013)

This study compared the health of a sample of Australians who deployed on peacekeeping missions between 1989 and 2002 to a sample from the general population. It found that 30 per cent of the peacekeepers in the study met the criteria for a mental illness, which was higher than the general population sample (12 per cent). The peacekeeper sample had significantly higher prevalence of mental illnesses compared to the general population (figure below).



Sources: Hawthorne et al. (2014, pp. 1–2, 63); Sim et al. (2005, p. 12).

These findings are similar to those found in other countries. For example, currently serving male personnel in the United Kingdom have lower rates of suicide than the general population (Ministry of Defence (UK) 2018), but male veterans aged under 24 years have two to three times higher rates of suicide than the general population. Other age groups of male veterans were found to have comparable rates of suicide to that of the general population (Kapur et al. 2009). In the United States, veterans had a suicide rate 1.5 times higher than non-veterans (Office of Mental Health and Suicide Prevention 2018).

The factors identified in the *Mental Health Prevalence* study that were associated with higher rates of suicidal thoughts and behaviours included:

- having completely left the ADF (reservists had lower rates of suicide)
- being medically discharged

-
- being a DVA client (the study does not explain why DVA clients have higher rates of suicidal thoughts and behaviour, but it also found that DVA clients had higher rates of mental ill-health than non-DVA clients) (Van Hooff et al. 2018b, pp. 121, 135–136).

The AIHW also found that younger age, involuntary discharge (particularly medical discharge) and less than one year of service to be associated with higher suicide risk (AIHW 2017b).

And as noted in chapter 1, more contemporary veterans have died by suicide than on operational service — between 2001 and 2016, there were 59 deaths⁴ of ADF personnel on deployment and 373 suicides in serving, reserve and ex-serving ADF personnel. Of these, 198 (or 53 per cent) occurred in ex-serving personnel (AIHW 2018g, p. 7; AWM 2019). These numbers are likely to be underestimates as the AIHW data only capture veterans who were in the ADF on or after 1 January 2001 (AIHW 2017b, p. 15).

Statistics on the number of deaths by suicide should be used with caution as they are unlikely to capture all deaths by suicide. Hospitalisations due to intentional self-harm are currently the best measure of suicide attempts, however not everyone who intentionally self-harms intends to end their life, and others may use other methods, such as drug overdose, which may not be captured in these data. Changes in the numbers of deaths by suicide over time also need to be interpreted in the context of changes in the size of the ex-serving group over the analysis period.

One area where the evidence base is thin is the incidence of suicide among female veterans. The AIHW was unable to report on the incidence of this group because of small sample sizes. The *Mental Health in the ADF* study, however, reported on suicidality (includes ‘felt so low thought about committing suicide’, ‘made a suicide plan’, or ‘attempted suicide’) and found that females in the ADF population had higher rates of any suicidality compared to the general population (5 per cent compared to 3 per cent), as did males in the ADF population (4 per cent compared to general population rate of 2 per cent) (McFarlane et al. 2011, p. 22).

A study looking at suicide rates of United States female veterans from 2004 to 2007 found that female veterans, excluding current serving personnel, were over three times more likely to die by suicide than the non-veteran female population. The study found that those aged 18–34 years had the highest rate of suicide compared to non-veterans (McFarland, Kaplan and Huguet, 2010). Another United States study found that the female veteran suicide rate was about one-third that of the male veteran rate. However, the difference in suicide rates between female veterans and the female general population was greater than the difference between male veterans and the male general population (Kang et al. 2015, pp. 97–98).

⁴ The number of deaths as a result of service with Australian units between 2001 and 2016, based on the Roll of Honour.

Comorbidities

There are high rates of mental ill-health comorbidity (multiple health conditions) within the veteran population. The *Mental Health Prevalence* report found that about a quarter of transitioned ADF had two or more mental disorders (Van Hooff et al. 2018b, p. 115).

There is also a link between physical conditions and mental disorders.

- Severe pain can lead to depressive symptoms (Scott and Sullivan 2012). The link between pain and mental health was highlighted by the Ex-military Rehabilitation Centre:

Pain causes you to become tired ... the flow-on effects from pain to mental health are massive ... and a lot of people don't seem to understand that one sort of goes hand in hand with the other. (trans., p 108)

- There is a long established link between stress (such as that from PTSD) and physical health. For example, PTSD is associated with negative physical health outcomes including chronic rashes and eczema, arthritis, asthma and hypertension (O'Toole and Catts 2008).

Comorbidities can add complexity when creating a treatment plan and make it more difficult to diagnose mental disorders (Phoenix Australia 2015, p. 27). As Allied Health Professions Australia said:

Separating the approaches used to address mental health issues and those related to physical health issues can be an impediment to coordinated and effective care for a veteran. (sub. DR261, pp. 8–9)

The compensation process and mental health

In addition to the effects of service and pre-existing conditions, the process by which veterans seek compensation for their service-related conditions can affect their mental health. Many inquiry participants discussed the negative effect of the claims process on mental health (chapter 9).⁵ One inquiry participant described getting assistance from DVA as 'like going through a minefield' (Owen Bartrop, sub. 20, p. 2), while another referred to the system as 'byzantine, sluggish and at-times adversarial' (RSL NSW, sub. 151, p. 10). And the Royal Australian and New Zealand College of Psychiatrists (RANZCP) said:

It is ... concerning to note reports of DVA staff who have exhibited hostility and derogatory attitudes towards veterans and ex-service personnel. Insensitive communications are distressing for veterans and ex-service personnel and can result in feelings of rejection, stigma and hopelessness, which may contribute to suicidal ideation and/or the non-pursuance of justified claims for compensation. (sub. 58, p. 5)

⁵ Brendan Dwyer (sub. 15), Gary Vincent (sub. DR163), Hilton Lennard and Keith Russell (sub. 13), Hugh Baldwin (sub. 10), Maurice Blackburn Lawyers (sub. 82), Michael Longford (trans., p. 42), Neil Robson (sub. 146), Owen Bartrop (sub. 20 and sub. DR165) and Richard Coathup (sub. 124).

Karen Bird, the mother of Jesse Bird who died by suicide in June 2017, said:

... Jesse was unable to navigate the systems that were in place from when he left the Army ... Because it was so claims based and in their own words, a web to navigate ... it's well known, if you're not in a good mental state, it's very difficult to navigate very much of anything. (trans., p. 604)

A recent review looking at the DVA compensation process and its effect on the mental health of claimants found that the literature consistently reported that people who go through a compensation process have poorer mental health compared to people with similar injuries who did not go through the compensation process. Specific aspects of the compensation process that may affect the mental health of claimants included:

- slow and complex processes that can mean long processing times
- poor communication between DVA and veterans
- vulnerable veterans not being recognised and supports for these veterans not being provided (Collie 2019, p. 25).

On reviewing previous reviews and inquiries into the DVA compensation process, the review concluded that:

First ... psychological harm does arise in some veterans who have been involved in DVA compensation claims. Second ... while DVA compensation claims processes are unlikely to be the sole cause of psychological ill health in these cases, the consequences may be catastrophic and include multiple reported cases of suicide and self-harm. (Collie 2019, p. 25)

These findings apply to all claimants, regardless of whether they have a mental illness, but are particularly concerning because a high number of claims are from people who are already experiencing mental ill-health. Mental illnesses are among the most common conditions claimed for under the *Veterans' Entitlements Act 1986* (VEA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA)⁶. Three of the top fifteen conditions claimed for under the VEA and four of the top fifteen conditions claimed for under the MRCA were mental illnesses (DVA 2018g, pp. 225, 227).

The current focus on simplifying the claims process through MyService and decision-ready processing is important to help alleviate stress for all claimants and potentially improve health outcomes. As Collie noted, compensation processes are largely modifiable and DVA has a number of action items it could take to improve these processes, including further expansion of MyService, investment in claims teams through additional training and better use of available data (Collie 2019, p. 7). Additional reforms to the claims process that alleviate known areas of stress for veterans will further improve veterans' mental health (chapter 9).

⁶ Data are not available for claims under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

The consequences of veteran mental ill-health and suicide

Mental ill-health results in pain and suffering for those individuals, as well as their families and friends.

Many of the costs of mental ill-health are intangible. They include psychological distress, unpleasant side effects of medications, social isolation, lower social participation and discrimination. Vicarious trauma, as mentioned above, can also contribute to adverse mental health conditions of family members. Sometimes they are referred to as secondary victims. A number of participants spoke about the pain and suffering of mental ill-health (box 17.5). For example, the wife of one ill veteran said:

I'm living a nightmare and I never enlisted in the military, literally all I did was wave my husband off to a warzone (and in return I got back a broken, angry stranger). (Fiona Brandis, sub. DR295, p. 1)

Box 17.5 Participants described some of the effects of mental ill-health

Claude Palmer:

Prior to his one year with 1 ATF, including patrol duties, R had a promising Army career—highly regarded by superiors, peers, and subordinates. On return, R could not settle back in the Army, secured a senior civilian position, but became withdrawn, unsettled, resigned and moved interstate, cutting off his erstwhile mates. He sought psychiatric help, diagnosed PTSD. R sadly suicided. (sub. 18, p. 2)

Fiona Brandis:

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 mentally ill spouse who often presented extreme symptoms and behaviours ... I struggled on until my husband's second psychiatric hospitalisation for suicidality earlier this year, when I basically cracked under the pressure. ... 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. (sub. 103, p. 1)

David Coffey:

... I think, three times since 2012, I've got to the point where I think, 'Well, I don't need [counselling] anymore.' And then something else has happened, or you get a bad decision, or an unexpected decision from DVA, and before you know it, you're sort of falling apart and you're back — you're back to them. (trans., p. 315)

Connie Boglis, partner of Jesse Bird:

The reason I fell in love with Jesse, because he had emotions and he cared. I lost him two years later. I lost him to being numb of emotion, because he was heavily medicated and that was the answer. That was the outcome for him for the rest of his and our life. (trans., p. 606).

Mental ill-health also imposes costs on the community more broadly. This includes the direct cost of providing health care, social services, housing and other services, as well as the reduced economic participation and productivity of people with mental ill-health and

their caregivers. As Defence said in its *Defence Mental Health and Wellbeing Strategy 2018–2023*:

Mental illness is costly to the organisation, sometimes forcing highly-skilled people out of their roles and causing lost productivity. (DoD 2017h, p. 15)

The costs of mental ill-health to the Australian economy are being considered in more detail in another inquiry that is currently being undertaken by the Commission — an inquiry into the social and economic benefits of improving mental health (PC 2019).

The significant burden of mental ill-health on individuals, carers, families and society highlights the importance of taking a whole-of-life approach to veterans' mental health.

- When members are serving, preventing mental ill-health is critical to minimising the harm to veterans from service and the lifetime costs of mental ill-health.
- Timely and effective transition support that mitigates known risk factors, such as unemployment and social isolation, is important to reduce the likelihood of the individual experiencing mental ill-health.
- Access to effective post-service supports is crucial to help those who develop mental disorders or have ongoing mental ill-health.

This view was supported by inquiry participants. For example, Orygen said:

At every stage, recognition of a young person's wellbeing and the potential need for mental health support must be identified and provided. (sub. DR206, p. 4)

Mental health needs of families

While there is only limited evidence on the mental health effects of a veteran's military service on their family members, there is no doubt that mental ill-health can have ripple effects on others. As RSL NSW pointed out:

When veterans suffer from serious mental health conditions, their family members can live in a traumatic environment, and often endure domestic violence and controlling behaviour, experience feelings of isolation, exhaustion and chronic sorrow, and/or begin to mirror the symptoms of the veteran (e.g. hyper-vigilance, anxiety, depression, anger, frustration, social isolation). (sub. 151, p. 23)

The NMHC also received the following feedback:

- The routine of military life creates a set of unique stressors for families, including the anxiety and concern about the safety and wellbeing of the person who is in service, particularly when they are away from home, and especially when they are away on deployment.
- Incidents of domestic violence, and drug and alcohol abuse, and the impact on the family of living with a service person who has a physical injury or mental illness but cannot or will not access treatment services. (NMHC 2017b, pp. 22–23)

The *Vietnam Veterans Family Study* found that children of Vietnam veterans had higher rates of mental ill-health compared to the children of ADF personnel of the same era who did not deploy (DVA 2014e, p. 9).

The recent *Family Wellbeing Study* (FWS) found similar results (although findings from this study should be used with caution as the participants were not completely representative of the *Transition and Wellbeing Research Programme* population). The FWS surveyed families of serving and ex-serving ADF members and found that:

- rates of psychological stress in adult children were 9 per cent higher than the general population of the same age and gender
- dependent children aged 2 to 17 years ‘may have been faring less well than children in general community samples’ (Smart, Muir and Daraganova 2018, p. 243)

The findings from the FWS and the *Vietnam Veterans Family Study* align with other studies of the general population that find that children of parents with mental ill-health are at higher risk of mood disorders, anxiety disorders and alcohol and substance abuse (Klasen et al. 2015; Ramchandani and Psychogiou 2009; Sweeney and MacBeth 2016).

The FWS also found that rates of psychological distress for the spouses, partners and parents of those included within the FWS were similar to the general population (Smart, Muir and Daraganova 2018, p. 243).

17.2 What mental health supports are available to veterans and their families?

Supports while in service

Serving personnel

Defence provides health care to ADF personnel, including mental health care. Many of these services will, from 1 July 2019, be provided under contract by Bupa Health Services (chapter 6). Dedicated mental health and psychology services are currently located on 23 bases around Australia, and provide both mental health assessments and treatment and/or occupational psychology assessments. There are also nine on-base regional mental health teams which conduct mental health training and promotional activities and provide support to commanders (DoD 2017c).

Mental health services available to ADF personnel were described by the NMHC as ‘the same as — if not better than — those available in the general community’ (NMHC 2017b, p. 24).

There are also a range of mental health activities within the ADF (chapter 5).

- As discussed earlier, the ADF undertakes screening for mental ill-health at the recruitment stage and at various points during a person's career, such as around deployment and after a critical incident. (O'Donnell et al. 2014).
- There is a Suicide Prevention Program for both ADF personnel and ADF mental health professionals. ADF personnel are able to attend workshops that cover: identifying at-risk individuals, initial treatment and where to access mental health treatments. Mental health practitioners can attend training aimed at standardising suicide risk assessment in the ADF (DoD 2019b).
- ADF personnel have access to a resilience program called BattleSmart. This program was developed after evidence showed that individuals benefited from having a broad range of coping strategies. The program focuses on four coping strategies: adapting physiological response, adapting thoughts about a stressful situation, adapting behaviour and managing emotions (Cohn, Hodson and Crane 2010).
- NewAccess Defence is currently available to employees of Defence (ADF personnel and public servants). NewAccess is an early intervention program developed by Beyond Blue that uses low-intensity cognitive behaviour therapy (CBT) delivered by specially-trained coaches (EY 2015).
- ADF personnel also have access to rehabilitation services (chapter 6), transition support services (chapter 7) and other online services available to veterans such as At Ease (box 17.6) and Open Arms (discussed below).

Box 17.6 At Ease

At Ease is the Australian Government's health and wellbeing portal for the serving and ex-serving community. It has resources on mental health for health professionals, veterans, transitioning personnel, current serving personnel and their families. There is an extensive list of support services that are available to each group including social programs and employment services available to transitioning personnel and veterans, as well as links to the Defence for currently serving personnel.

The portal also provides advice to someone who may be experiencing mental ill-health, from recognising symptoms of mental ill-health to finding help with any problems. Stories of others who have experienced mental ill-health or who have cared for a veteran with mental ill-health are also included on the website.

Source: DVA (2019a).

Families

Families of serving personnel have a number of supports available to them.

- The Defence Community Organisation (DCO) provides targeted supports for families of ADF personnel who are on deployment, this includes support calls, social work and

assistance with emergencies. DCO also runs programs for families including an employment assistance program and resilience programs for partners, teenage dependents and child dependents (DoD 2018c).

- Defence Families of Australia (DFA) provides a forum for ADF personnel and their families to raise issues affecting them and advises government about matters that affect ADF personnel and their families. DFA also provides information to ADF personnel and their families about services and benefits provided by Defence (DFA 2018).
- ForceNet is a secure online portal which provides information on serving personnel to their families. It also provides links to both DCO and DFA (DoD 2019h).

Supports for ex-serving personnel

Ex-serving personnel have access to mental health services that are available to the general population as well as supports provided by DVA.

Many ex-service organisations also provide mental health assistance to veterans. 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 ESOs [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, sub. DR245, p. 5)

The Oasis Townsville is another initiative which is developing a 'community hub' that will provide a concierge service for the veteran community and include advocacy services and job placement and support (The Oasis Townsville, sub. 92).

Some State and Territory Governments also provide some mental health support for veterans, such as:

- the redevelopment of Concord Hospital in Sydney (scheduled to be completed in 2021) which will include the country's first National Centre for Veterans' Healthcare. It is being billed as a comprehensive care centre that will integrate a range of specialist outpatient services in a one-stop shop
- the Jamie Larcombe Centre in Adelaide, opened October 2017, which is a veterans' mental health precinct that provides acute, sub-acute and rehabilitative mental health care for veterans (SA Health 2017; Sydney Local Health District nd).

Supports provided by DVA include:

- Open Arms counselling service for serving and ex-serving personnel and their families

-
- non-liability access to mental health care provided through the White Card (this includes free treatment for mental health conditions without the need to provide a formal medical diagnosis)
 - the Veteran Payment (a new payment for veterans who have a mental disorder that prevents them from working while waiting for liability claims to be processed)
 - online resources and apps such as the At Ease portal, Operation Life, High Res, The Right Mix and PTSD Coach Australia (boxes 17.6 and 17.7)
 - PTSD trauma recovery programmes in selected hospitals
 - a trial of the use of assistance dogs to help veterans with PTSD.

Box 17.7 **Health and wellbeing portals for veterans and families**

The **Operation Life** initiative helps people to understand warning signs and provides information and resources to help keep people safe from suicide.

The **High Res** portal and app provides techniques on dealing with stress and building resilience. Techniques cover physical reactions to stress, thoughts, behaviour and emotions.

The **Right Mix** portal and the **On Track with the Right Mix** app provide information about the implications of alcohol use and allows for tracking of alcohol consumption.

The **PTSD Coach Australia** app provides information on PTSD and treatments, as well as information on services available to serving and ex-serving personnel.

Sources: DVA (2019e, 2019g, nd); DVA and DoD (nd).

In 2017-18, DVA spent approximately \$200 million on mental health support services and treatments (DVA 2018g, p. 56).

Following the release of the Government's responses to the Senate report *The Constant Battle: Suicide by Veterans* and recommendations tabled following the joint DVA-Defence review into the management of Mr Jesse Bird's case, an additional \$31 million was allocated to the 2017-18 Budget for veteran mental health support to cover five measures:

- \$16.1 million over four years to fund the Veteran Payment
- \$7.1 million over four years to extend support to families of veterans
- \$2.1 million over four years to provide annual health assessments for former ADF members in the first five years after their discharge
- \$4 million over two years to pilot a case management service for transitioning and recently discharged ADF members, and veterans requiring additional support
- \$1.7 million over one year to undertake a scoping study to professionalise veterans' advocacy (DVA 2018g, p. 7).

Open Arms — Veterans and Families Counselling

DVA runs a counselling service for veterans and their families that is known as Open Arms (until September 2018 the service was known as the Veterans and Veterans Families Counselling Service). Open Arms describes itself as ‘the cornerstone’ of the veterans’ mental health system (sub. 72). It provides services to current and former ADF personnel with at least one day of continuous full-time service and to their families.

Through its employees and network of providers, Open Arms provides the full spectrum of care, from early intervention services to services for those with a mental disorder. Open Arms is able to pay market rates for mental health services through contract arrangements with their provider network. This enables them to link in with a range of providers who are able to meet the varied needs of Open Arms’ clients.

Services provided by Open Arms include:

- counselling for individuals, couples and families
- case coordination for clients with complex needs
- group programs to develop skills and enhance support
- an after-hours telephone counselling service (including 24-hour crisis support: 1800 011 046)
- referrals to other services or specialist treatment programs
- a network of outreach counsellors (psychologists and mental health accredited social workers) who deliver services to Open Arms clients unable to access an Open Arms centre.

Open Arms is also running several trials of initiatives designed to improve services to veterans (box 17.8).

Box 17.8 **Open Arms' trials**

Open Arms' trial of peer workers

The National Mental Health Commission review found that there was a lack of peer workers within the veteran mental health system. Peer workers can be effective first points of contact for veterans with mental ill-health. After the review, Open Arms began a trial called the Community and Peer Program in Townsville. The program involved:

- community engagement — such as attending community meetings and giving presentations
- direct client services — including outreach services and helping with case management
- peer network — providing group programs and organising monthly educational meetings.

This program will be rolled out to other parts of Australia and already has sites in Townsville, Sydney and Canberra.

Project Synergy

Project Synergy is about finding ways that technology can support the counselling work undertaken by Open Arms. Workshops were undertaken with Open Arms staff, veterans, clinical staff and families to develop a user friendly online platform. This online platform is used to facilitate communication between the client and their counsellor and provide options for how clients want to engage with their mental health treatments.

Source: Open Arms (2019).

In 2017-18, Open Arms supported clients across 28 locations through a network of more than 1300 outreach providers. In the same period, Open Arms delivered over 106 350 counselling sessions, which was a 12 per cent increase on the previous financial year (DVA 2017f, p. i, 2018g, pp. 56, 62). The estimated actual budget for Open Arms in 2017-18 was approximately \$41.9 million (DVA 2018ai, p. 46).

Inquiry participants had varying views on Open Arms. Many were happy with the services provided by Open Arms and considered it to be a crucial component of the veterans support system. Others had concerns about shortages in Open Arms' resources and that some veterans and their families were unaware of the services provided by Open Arms (box 17.9).

Box 17.9 Participants' views about Open Arms' services

Royal Australian Armoured Corps Corporation:

The Corporation considers the operation of Open Arms ... to be a vital link in the chain of support to veterans and their families. Its value to veterans — both current and former service personnel and their families is incalculable. (sub. DR203, p. 81)

Partners of Veterans Association of Australia WA:

Open Arms is a wonderful organisation, and our one here in WA run excellent programs, and I have the highest regard for them, because it's so easy for us to say, hey, we've got a problem, and they're there to help. (trans., p. 275)

Darren Thompson:

Open Arms provides a two-day [course], I actually did it before I was discharged, it was extremely helpful and partners could go along and it looked at everything, how to integrate back in life. I remember doing a trauma recovery program and there was a digger on there, and the one thing that's always stuck in my mind is, 'The Army taught me how to kill. The Army has not taught me how to be a civilian', and I think that's a very valid point. (trans., p. 840)

John Pilkington:

Open Arms needs to be better funded ... after hours. Veterans will not wait on the phone for any length of time when they are in distress. During the normal 9.00 to 5.00, Monday to Friday, that's fine. On weekends and public holidays, it's a disaster. Over the Christmas period I had to deal with one of those — it wasn't very nice and I — I waited on the phone for 15 minutes, a veteran won't do that. The wife was distressed, police were called, yeah, it was a — on Christmas it was a disaster. I don't know who they actually assist or how many they've got working, but we can't get any information. It's not the — 'works fine' from all the reports I've seen, but having dealt with it over Christmas, no. (trans., p. 708)

Partners of Veterans Association of Australia SA:

She's not getting any support in any way. Most of them don't even realise that they can go to Open Arms; they've never even heard of that. (trans., p. 87)

Veterans of Australia Association:

There's an issue there, Open Arms providers are overwhelmed. (trans., p. 1145)

Vietnam Veterans' Federation of Australia:

- access to [Open Arms] is often delayed;
- access may not easily be available to would-be clients;
- continuity of psychologist/counsellor is not guaranteed; and
- telephone counselling does not meet all needs. (sub. 34, p. 21)

There is limited information on the effectiveness of Open Arms services. Data are not collected on Open Arms outcomes. That said, a study conducted from 2009–10 with a sample of 312 Open Arms participants found that the counselling practices used by Open Arms resulted in a significant reduction in depression, anxiety, stress and alcohol misuse severity (O'Donnell et al. 2013).

The NMHC also conducted a survey of serving personnel, ex-serving personnel and their families on the perceived effectiveness of services (rated as either high or low). Just over half of serving and ex-serving personnel rated the perceived effectiveness of Open Arms counselling services as high, as did 39 per cent of family members of current serving

personnel and 44 per cent of family members of ex-serving personnel (NMHC 2017c, p. 22). And while these rates appear to be low, Open Arms counselling services had higher rates of perceived effectiveness than other services in the survey. Open Arms had the highest rating amongst current serving members, second highest amongst ex-serving personnel, third amongst family of current members and second amongst family of former members (NMHC 2017c, p. 22).

Treatment funded by the non-liability White Card

A person holding a White Card can seek treatment from (or be referred to) a general practitioner, psychologist, social worker, occupational therapist, psychiatrist or hospital and DVA will pay for the mental health treatment.

Non-liability access to the White Card allows all current and former members of the ADF with at least one day of continuous full-time service and any mental disorder, malignant cancer or pulmonary tuberculosis access to the White Card without the need to establish a link between the disorder and a veteran's service (chapter 16). For mental disorders, DVA will also fund treatment without the need for a diagnosis.

The non-liability White Card eligibility and treatment coverage has been extended on multiple occasions over the past few years. Changes since 2016-17 include:

- the extension of the non-liability White Card to cover PTSD and depressive disorders and eventually extended to cover all mental disorders
- the removal of the non-liability White Card eligibility requirement to serve three years or more of continuous peacetime service
- the extension of eligibility to some reservists
- all transitioning personnel automatically receiving a non-liability White Card. (Australian Government 2016b, 2017c).

The extension of non-liability access to mental health care in the 2017-18 Budget was, in part, a response to the NMHC review (DoD, DoH and DVA 2017). The NMHC recommended the Australian Government:

... consider whether there are superior models for supporting optimal health and wellbeing of current and former members and their families, including models that separate compensation, liability and health care provision. (NMHC 2017b, p. 52)

Non-liability health care separates the treatment of mental ill-health from compensation and liability processes. Another intention of the non-liability White Card was to increase the number of veterans who were able to access appropriate mental health treatment.

The DVA White Card will be a physical indicator of the availability of support for each discharged ADF member that they can carry with them into civilian life (SFADTRC 2017, p. 129).

Many participants supported the decision to provide non-liability access to the White Card for mental disorders. Some of the terms used to describe the initiative included ‘life-saving’, ‘exceptional’ and ‘most positive’ (box 17.10). The Royal Australian Armoured Corporation pointed to a number of advantages of the automatic issuing of a White Card to veteran:

- no stress and trauma for a veteran in navigating the legislative claims process to establish initial liability and a number of known conditions related to military service
- reduced instances of self-harm or worse
- eliminating unnecessary and lengthy delays in waiting for a liability and decision ready determinations for a service-related injury, illness or disease
- reinforcing the requirement for veterans to tell DVA only once will eliminate the soul-destroying requirement for veterans and their families to continually have to repeat one’s experience to a new Determining Officer due to staff changes
- reduce the requirement on veterans to litigate through the appeals process
- provision of ongoing treatment of a service related illness, injury or disease for life
- formal acknowledge[ment] by the Government as represented by DVA that they did incur, accelerate or aggravate an illness, injury or disease on service be it operational or non-operational service. (sub. 29, pp. 9–10)

About 75 000 people hold a White Card — 57 000 of these have no operational service and about 3000 are issued to Commonwealth and other Allied veterans living in Australia (DVA 2019i, p. 15). This number has been growing over the past few years and is set to continue to grow as all eligible transitioning ADF personnel are issued a non-liability White Card. It is unclear how much the White Card costs as the numbers reported are often combined with mental health service costs from other DVA health care cards.

Box 17.10 Support for the non-liability White Card for mental health treatment

The Royal Australian Armoured Corps Corporation:

The White Card is automatically generated and sent to the veteran to enable early mental health treatment. The Corporation considers this move to be a major factor in enhancing early intervention for vulnerable veterans and contends this measure to be a life-saving initiative. (sub. 29, p. 9)

Defence Force Welfare Association:

The experience of our Advocates and the feedback from Veterans on social media has all been positive, especially the speed with which the approval is given and the White Card is issued. It has facilitated quick arrangement of treatment without administrative and delay stress which exacerbated the mental condition. (sub. 118, p. 73)

GO2 Health:

The non-liability coverage for mental health is probably the most significant positive change in recent years — this has made it much easier for veterans to access almost immediate mental health support. (sub. 98, p. 9)

Mates4Mates:

The experience of ADF personnel in their 'workplace' is inherently different to the general population. Amongst a myriad of other differences, military service involves higher risk of exposure to physical and emotional trauma. Non-liability coverage of any mental health through the White Card is one of the most positive initiatives DVA has introduced in recent times. It acknowledges that veterans, by the very nature of their work, are entitled to receive mental health support when needed and without the burden of having to prove causality to military service. (sub. 84, p. 4)

Royal Australian and New Zealand College of Psychiatrists:

One element of the legislative framework that is strongly supported by the RANZCP is the extension of the non-liability health care to all mental health conditions. In allowing veterans to access appropriate treatment with minimal administrative burden, DVA has demonstrated significant commitment to more effectively supporting those veterans with mental illness. (sub. 58, p. 7)

The Senate inquiry into suicide by veterans also noted that it had heard 'almost universal praise from stakeholders' regarding the decision (SFADTRC 2017, p. 113).

Coordinated care pilots for veterans

There are three coordinated mental health care pilots currently underway. The first is a DVA-commissioned pilot called the Veteran Suicide Prevention Pilot (also called the Mental Health Clinical Management Pilot). It provides veterans who have experienced a suicide crisis and required hospitalisation with a support coordinator for up to three months (DVA 2018av). The pilot is being delivered by Beyond Blue in Brisbane for up to 100 veterans (DVA 2017g, 2018av).

Support coordinators work with the veteran to:

- develop a personalised safety plan that is aimed at safely re-engaging the veteran in everyday life
- assist with access to follow-up care (including tracking appointments with other services)

-
- link the veteran with other support services, including Open Arms.

Beyond Blue has run a similar service, called The Way Back, since 2014 and in the 2018-19 Budget the Government allocated nearly \$38 million to expand the service (Beyond Blue 2018b).

The second pilot, also a DVA-commissioned pilot, is an early intervention measure for people in the Coordinated Veterans' Care (CVC) program — participants complete a short CBT based self-help course using an app on their phone or other device. This pilot is being run for up to 250 participants and specifically targets rural and remote regions where mental health services may be harder to access (or unavailable) (DVA 2018k).

Despite being delivered to CVC participants, the pilot appears to be focused mainly on trialling the self-help app (rather than coordinated mental health care). When the trial was announced in the 2017-18 Budget, DVA said that the pilot would trial an expansion of the CVC program to support veterans with chronic mental and physical conditions (DVA 2017g). Such an expansion would be worth trialling, given the effectiveness of CVC in keeping people out of hospital (chapter 16).

The third pilot is called Operation Compass and is being funded by the Department of Health and run by the Northern Queensland Primary Health Network. Operation Compass has six campaigns, led by local expert teams, and is expected to be completed by June 2020. The campaigns include projects to:

- provide training in suicide awareness and prevention
- improve after-hours primary care, mental health and alcohol and other drug services
- create and promote a range of community support groups
- engage veterans in volunteering, through The Oasis Townsville
- gather more detailed information at a local level about the veteran community through surveys and focus groups (Northern Queensland Primary Health Network nd).

All three pilots have the potential to improve mental health care, and this points to the importance of good evaluation and an implementation plan (if they are found to be successful). DVA said that its intention is that the Suicide Prevention and CVC pilots will identify barriers and success factors, health outcomes and evidence for further expansion and it will collect the evidence necessary to support a national scale-up, if either or both of the pilots are found to be successful (DoD, DoH and DVA 2017).

Support for families

Families of veterans have access to a number of support services provided by DVA, on top of services available to the general population.

- In response to a recommendation by the 2016 Senate inquiry into the mental health of ADF members and veterans, Open Arms eligibility was extended to families of veterans who have a non-liability White Card.
- DVA provides respite care for individuals providing ongoing care to a veteran who has a White Card or Gold Card. DVA will pay for up to 196 hours of in-home respite care (or 28 days of residential respite care) each year (DVA 2018r).
- There is also a Family Support Package (this was provided in response to a recommendation by the Senate inquiry into suicide by veterans). The package provides eligible veterans and their families access to childcare funding (complementing existing Australian Government childcare entitlements). It also provides family members of eligible veterans access to counselling support (in addition to Open Arms). Counselling support can be provided by any appropriately qualified professional and covers drug and alcohol counselling, resilience training, parenting skills and personal and relationship counselling. A veteran's family can have four counselling sessions a year for five years (DVA 2018w). Reforms to the Family Support Package are discussed in chapter 19.

A number of supports for families are also provided by veterans' organisations. Some, such as Mates4Mates provide counselling services (box 17.11), while others, such as Legacy, provide advocacy support during the claims process. As Legacy noted in its submission to this inquiry, it 'will forever champion the needs of families and dependent children' (sub. DR220, p. 19).

Box 17.11 **Mates4Mates**

Mates4Mates provides a range of services to current and former ADF personnel and their families including:

- rehabilitation services such as equine therapy, yoga, massage, and strength and conditioning programs
- psychological services such as counselling services
- family recovery centres which house a number of services but also provide a place for social activities.

Mates4Mates said it places a strong focus on the family unit because they are:

... acutely aware that 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. When the family unit isn't functioning well due to a veteran's injury or illness, the veteran can feel significantly more vulnerable and responsible, which can negatively impact their rehabilitation and put them at increased risk of suicidal ideation. (sub. 84, p. 7).

Source: Mates4Mates (2018a).

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.

17.3 Problems identified with current arrangements

Concerns about ADF's assessments

A number of participants raised concerns about the mental health assessments undertaken by the ADF, with some claiming they were not done at all. Alan Sisley, for example, said:

Neither of my two sons who have been to Afghanistan, Middle East, neither of them and one who is still in the Army — neither have ever had a psych test. The other one got out of the Army because, like me, PTSD hit him and he was going to — he had to get out because he couldn't stay there. We're not angry ... we're angry with the fact that we never got, like the Army even says to my son, 'We will look after you by giving you a psych evaluation.' They don't even bother doing it. (trans., pp. 1436–1437)

And David Thomas:

When I got discharged, and I think it would probably be the same for veterans today, all our physical needs were checked — you know, you've got a bad back or you're deaf or whatever, but there was nothing with our mental checks ... we see now that if police or fires go to an accident everybody comes back and get counselled. With discharged people out of the forces, and there's no — as far as I'm aware — there's no counselling provided. We're recognised at your death and we recognise all these other things, but that's minuscule compared to your mental health. (trans., p. 1424)

Screening is about facilitating early intervention and addressing symptoms before mental illness develops to cause significant problems for the veteran. Keeping track of where personnel are at, and intervening early, is critical to minimising harm. This is particularly important given what is known about ADF culture and the value placed on strength, ability to cope in the face of adversity and an ethos of teamwork and not wanting to let your mates down (NMHC 2017b).

The RANZCP also told the Senate inquiry into suicide by veterans that while the risk of developing PTSD and other mental disorders increases with cumulative exposure to trauma, the likelihood of detection and treatment may lessen with higher numbers of deployments.

More experienced personnel may become reluctant to express their distress due to increased expectations placed on them, and commanders may be less attentive to the needs of their more experienced recruits ... many individuals exposed to trauma will exhibit a progressive increase in PTSD symptoms over time ... highlighting the need to recognise the early signs of distress among military personnel while they are still in service. Robust protocols to detect early signs of distress should therefore be regarded as critical operational assets during times of deployment. (RANZCP 2016, p. 7)

Mental health screening can improve members' awareness about their own wellbeing (and that of their colleagues), and reduce stigma around mental ill-health by making the monitoring of mental health more routine (similar to physical health check-ups) (O'Donnell et al. 2014). As the RANZCP said:

Prioritising early identification and injury prevention will help to minimise the number of veterans requiring serious interventions later in life ... (sub. 58, p. 6)

In the context of early identification and prevention, the RANZCP also suggested looking at the needs of particular groups, such as the Special Forces (sub. 58).

However, given the questions raised around the effectiveness of mental health screening (discussed above), it is important the screening methods used are based on what is known about best practice in this area and any mental health screening undertaken is subject to an evaluation process.

Services vary in quality

Variable quality in the services and treatments provided by mental health practitioners was an issue raised by participants in this and other inquiries, and by health care professionals who provide services to emergency services personnel.

I'm a senior sessional mental health clinician with [a regulatory organisation]. We do peer-to-peer contact, talking to treaters about what they're actually doing and we talk to more than 950 a year. What strikes me is the enormous variability in what goes on out there. At least 50 per cent of psychologists are not up to the job of providing competent PTSD treatment. At least 50 per cent . That's pretty shocking. (Barratt, Stephens and Palmer 2018, p. 46)

... the training in most undergraduate and postgraduate degrees, including psychiatrists and Masters in Clinical Psychology are completely inadequate for managing post-traumatic stress disorder ... (Alexander McFarlane, trans., p. 141)

Mental health plans are also not always in place.

There is little validity or reality to the concept of a mental health treatment plan. Psychologists don't generally make contracts with people with mental health issues in regards to goals or how many sessions, it is a continuous process with little thought or plans for the relationship to end.

If we look at the experiences with the Vietnam Veterans, many of them are still in psychological counselling and are in most cases worse rather than better for all the hours sat talking about their issues. (RSL & Services Club Association 2018, p. 4)

The NMHC found that veterans and their families generally had poor perceptions of service effectiveness, particularly for mental health or suicide prevention support programs, PTSD treatment services and support for families (NMHC 2017b). Veterans and their families may be reluctant to continue treatment if they are concerned about the quality of the practitioners and/or the effectiveness of the support they are receiving.

When a veteran seeks help for mental ill-health, they should be confident that the professional they are seeing is either equipped to give them the best available treatment or can refer them to someone else who can. While easier access to mental health treatment is important, so too is access to treatment that is evidence-based, patient-centred and effective.

The process of seeking and receiving care has multiple steps — while initial rates of engagement are high, there is the potential to increase the extent to which evidence-based treatment is provided and the degree to which veterans remain engaged in care long enough for treatment to be effective (best practice treatments are discussed in box 17.12).

Box 17.12 Best practice treatments for mental ill-health

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has treatment guidelines for mood disorders.

- First-line treatment for patients with mild to moderate depression should be psychotherapies, including cognitive behaviour therapy (CBT), interpersonal psychotherapy and dialectical behaviour therapy.
- First-line treatment for patients with moderate to severe depression or chronic depressive disorders should be combined psychotherapy and pharmacotherapy (therapy using pharmaceutical drugs).
- The evidence shows that 54 per cent of individuals recover within 6 months, 70 per cent within one year but 12–15 per cent fail to recover.

The RANZCP also has treatment guidelines for anxiety disorders. Recommended initial treatment options for these disorders are CBT, pharmacotherapy, or the combination of CBT and pharmacotherapy. There is little information about the proportion of people who do not recover from panic disorder, generalised anxiety disorder or social anxiety disorder.

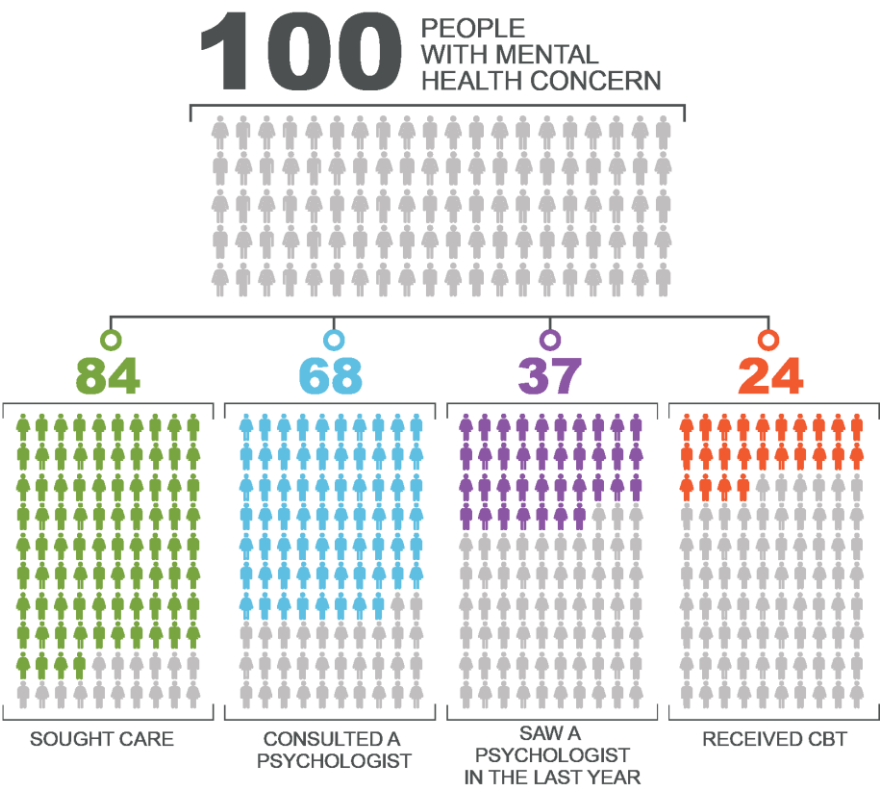
The Australian Guidelines for the Treatment of Acute Stress Disorder & post-traumatic stress disorder (PTSD) were developed by Phoenix Australia. The best practice treatment for adults with PTSD is trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. The rates of those who do not respond to best practice treatment for PTSD are double those of depression. As noted by Phoenix Australia:

... it is reasonable to assume that around one-third of patients will make a good recovery following effective treatment, one-third will do moderately well, and one-third are unlikely to benefit. (2013, p. 28)

Sources: Andrews et al. (2018); Harvey et al. (2015); Malhi et al. (2015, p. 13); Phoenix Australia (2013).

The *Pathways to Care* report found that while initial rates of engagement with mental health care among veterans was relatively high, only a small proportion of veterans were receiving best practice care (Forbes, Van Hooff and Lawrence-Wood 2018). Only about 24 per cent of veterans with a mental disorder had seen a psychologist in the past year and received CBT, which the researchers used as a proxy for evidence-based best-practice treatment (figure 17.2).

Figure 17.2 **Veterans seeking and receiving mental health care**
Per cent



Source: Forbes et. al (2018).

The RANZCP (sub. 58) also raised concerns about the quality of care and lack of continuity of care under the current purchaser-provider model. As discussed in chapter 16, the current healthcare card system can encourage a reactive rather than a coordinated approach to care. Workers' compensation schemes typically have case managers working with clients and health professionals to coordinate care and help clients achieve particular outcomes (and coordinated care can be critical to achieving good outcomes for clients). Providers under these schemes are also usually required to report on outcomes.

Others said that an important element of service quality for veterans is that providers understand veterans' military experience. Mates4Mates, for example, said that unless service providers 'understand the context from which veterans will operate, they will have little hope

of developing positive therapeutic relationships with veterans' (sub. 84, p. 4). The NMHC also said:

... some service providers are perceived to have no/limited understanding of military culture and military service, which can be exacerbated by turnover amongst health service providers. This lack of understanding can have adverse consequences for the quality of treatment and the willingness of current and former serving members to seek help and assistance. (2017b, p. 32)

Veterans should receive support to find high-quality service providers who have some understanding of veteran's military experience (discussed below).

Limited choice

Inquiry participants raised concerns about the limited choices for mental health services within the current veteran support system. This was also a concern raised in the Senate inquiry into veteran suicide (SFADTRC 2017, p. 40). The importance of incorporating veterans' preferences, needs and values was discussed by Ben Walker:

The many different cohorts of veterans that require compensation and rehabilitation is complex. Some require surgery, medicine, mobility aides and/or constant care. Some like me need to access services from time-to-time, some may never actually access the service but would like to have the cover there for the eventuation that they do (a safety net if you will). One size doesn't fit all, one system doesn't fit all ... (sub. DR216, p. 2)

Consumer choice can lead to better outcomes — it can empower consumers to have greater control of their lives and to make decisions that best meet their needs and preferences.

Within the veteran support system, all veterans are able to access Open Arms and the non-liability White Card. Families of veterans also have access to Open Arms. However, some veterans and their families may prefer not to engage with DVA services. For example, Connie Boglis said:

There needs to be an offer of alternative therapeutic interventions. Not just Open Arms counselling in a clinical based setting, nor the PTSD program which is 13 weeks. You know, heavily paper based ... Not everybody responds to that. If we are talking about DVA transforming ... it is about the holistic well-being of an individual's needs. (trans., p. 605)

The rollout of Open Arms' peer worker trial to other parts of Australia is a positive step towards increasing the choice of services available to veterans, as are the current coordinated care pilots.

To address families' concerns about a lack of choice, the Commission, in chapter 19, sets out reforms to provide families with additional options for mental health services. These reforms will provide families with an alternative to Open Arms.

A lack of support and awareness of services

A concern raised by some family members was the lack of contact and support they received from Defence and DVA when their partners/children were dealing with mental ill-health. Fiona Brandis, for example, said:

I'm the wife of a critically ill veteran. ... in the past, and ongoing, I've had no agency and nobody has engaged with me at any point during my husband's deployment, pre-deployment, when he was returned early to Australia from deployment for medical reasons. At no point did anyone from Defence engage with me. I didn't even know that he had landed back in the country. I got this critically ill man back in my life and at no point have I had any support. He's had multiple hospitalisations for both treatment and suicidality and at no point has anyone engaged with me. I wrote to DVA and I wrote to Defence. I don't get answers. (trans., p. 1184)

Some participants also said that once members were discharged from the ADF, Defence washed its hands of any responsibility.

When I write to these Ministers of Defence or DVA I just get passed around to each department of defence personnel, 'Your husband's no longer serving so these people are going to deal with you. This is not our responsibility'. (trans., p. 1188)

Timely access to support is crucial for a person at-risk. David Stafford Finney, a veteran who died by suicide in February 2019, requested help from DVA and in October 2018 was told there were no psychiatrists in the ACT taking on new clients. Instead, he was told of other services that had waiting lists up to April 2019. This is not a unique story, as noted earlier, Jesse Bird faced similar issues when trying to access care, and there have also been reports of calls to Open Arms going unanswered (Greene 2019).

We also heard about a lack of awareness among veterans and their families about the mental health services that were available. Connie Boglis, partner of Jesse Bird who died by suicide in 2017, for example, said:

.... when I met Jesse, I guess I wasn't aware of what services were available. And especially in Melbourne, it wasn't Townsville that we lived that was very well-resourced. It was in Melbourne, where we knew of two PTSD clinics that were not fit for veterans ... But I guess what I'm trying to say is that we didn't – we didn't have any avenue to pursue anything other than advocates through RSL, or [Open Arms]. (trans., pp. 603–604)

And as mentioned earlier, some participants were not aware of the services provided by Open Arms (Partners of Veterans Association of Australia SA, trans., p. 87). RSL NSW also said:

In reality, the range of benefits available mean that even amongst those aware of their veteran status, few are fully aware of their entitlements, such as free mental health treatment without acceptance as service related under the Non-Liability Health Care programme. Much of the negative perception of DVA across the veteran community is attributable to poor understandings of Departmental programmes and processes, and could therefore be combated with a joint DVA-Defence campaign highlighting the breadth of veteran status, specific entitlement programmes and the progress of Veteran Centric Reform. The participation of Defence in this

project would help to reach current-serving members, including Reservists, before they discharge and begin transition. (sub. 151, p. 13)

If a veteran or their family is not aware of the services provided by DVA they might rely on information provided by their general practitioner, or search commonly used websites. However, these websites provide limited information on services available to veterans. For example, the Lifeline and Beyond Blue websites do not have information on Open Arms. The Black Dog Institute also has a page on PTSD and where to find help for PTSD, but does not list Open Arms or other DVA services as a place for help.

Providing a link on commonly used mental health services to veteran-specific services will help veterans and their families find appropriate services, especially as veterans have a preference for service providers who understand their military experience.

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).

The need for more research

It was also brought to the attention of the Commission how much is still not known about what strategies are effective at preventing suicide and self-harm. Despite extensive research, programs and trials on suicide prevention, a meta-analysis of 41 suicide prevention strategies found only three were successful:

- reducing access to lethal means
- the continuation of contact with people discharged from an acute mental health unit
- implementation of emergency call centres (du Roscoat and Beck 2013).

There is still a need for more research to develop effective suicide prevention strategies.

There is also an ongoing need for more research on mental health treatments, as evidenced by the rates of unresponsiveness to best practice treatments for PTSD and depression (box 17.12).

The need for further research into mental health services delivered during transition was also highlighted by the Joint Committee inquiry into transition from the ADF:

Further research into the transition from military to civilian life would inform the provision of the most effective support to ADF personnel as they transition from ADF service, and help to

ensure that mental health services in the community are able to provide for clients with previous military experience. (JSCFADT 2019, p. 62)

17.4 System-wide reforms will improve mental health outcomes

The Commission is recommending a number of reforms that will improve mental health care for veterans and their families.

The Veteran Services Commission (VSC) (recommendation 11.1), with a focus on the lifetime costs of supporting veterans, will have much closer and effective engagement with veterans. It will identify and respond to the individual needs and situation of veterans (including taking into account the needs of a veterans' family in supporting a veteran dealing with mental ill-health). This includes supporting families of veterans who have died where the effects on families persist. It is also expected that the VSC will proactively seek out at-risk veterans and offer them early rehabilitation and treatment before their conditions worsen. The VSC's approach to health care (chapter 16) and rehabilitation services (chapter 6) will have flow-on effects to mental health by improving the physical health and independence of veterans.

Levying a premium on Defence (recommendation 11.2), so that it is responsible for the lifetime costs of ADF members, will encourage Defence to reduce the harm to members during their service. This could include Defence having in place more regular and effective assessments of the mental health of personnel, better training on mental health awareness and suicide prevention, strategies to encourage early reporting of injuries and illnesses, placing a greater focus on early intervention, and more effective transition support. As the RANZCP said:

Prioritising early identification and injury prevention will help to minimise the number of veterans requiring serious interventions later in life and create efficiencies in the veteran care system. (sub. 58, p. 4)

Centralising transition support within Defence (by establishing a Joint Transition Authority), together with more transparent reporting on transition outcomes for veterans will also encourage the adoption of more person-centred, effective transition support (chapter 7).

On claims administration, DVA reforms, such as MyService and decision-ready processing, should alleviate stress points. Ensuring recommendations made by the Australian National Audit Office and Commonwealth Ombudsman are implemented (chapter 9) will also improve claims-processing times and help identify vulnerable veterans. Providing additional training to DVA staff to manage claims made by vulnerable veterans will also help facilitate communication between DVA and veterans. 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 (chapter 9; SFADTRC 2017).

Simplifying the system is a key component of the Veteran Centric Reform program and initiatives such as MyService should continue to be built on. The front end of the system should be made simpler for clients, as a complex system does not need to be complex for veterans and their families. Veterans and their families should be able to understand the system, including the claims process, why claims are accepted or rejected, and what package of supports they may be entitled to. Harmonisation across the three Acts in terms of: the initial liability process (chapter 8); the appeals process (chapter 10); and payments (chapters 13, 14 and 15) will also simplify the system for veterans and their families making it easier for them to navigate.

17.5 An increased focus on outcomes is required

While both Defence and DVA have recently put in place an extensive array of initiatives aimed at improving the mental health of serving and ex-serving personnel and their families, the outcomes from these initiatives are not known.

The NMHC said ‘independent evaluation of suicide prevention and self-harm services within ADF and DVA is good practice and should be embedded’ (2017b, p. 53). The Commission agrees. There should be independent monitoring and evaluation of ADF and DVA mental health and suicide prevention initiatives, including efforts to improve early identification of mental ill-health and injury prevention — two areas identified as being key to improving outcomes for trauma-exposed populations (RANZCP, sub. 58, p. 4).

As stewards of the veteran support system, DVA has a responsibility to ensure that veterans are accessing quality mental health care. This is not restricted to the services provided by DVA as veterans have access to all of the mental health services that are available to the general population. However, because these services are primarily used by the general population the quality of these services is a system-wide consideration. DVA should thus focus on ensuring the quality of its mental health services, such as Open Arms, and that the White Card provides access to quality care. However, information on outcomes delivered by Open Arms and services purchased through the White Card is not currently collected, and there is limited evidence that either are improving outcomes for veterans.

Data gaps and the non-liability White Card

It is unclear whether the non-liability White Card has increased the number of veterans who are able to access quality treatment. As discussed in chapter 16, DVA’s fees for psychologists are below those paid by Comcare. If DVA’s fees are below the market rates, this could be a barrier to veterans accessing care. This was noted by inquiry participants:

So even though everybody is issued with a White Card or a Gold Card and non-liability mental health care, we have numerous psychiatrists, psychologists that do not accept DVA patients. So therefore when they come into a clinic like ours and we see them, there’s a higher demand on our psychology because there isn’t the availability and not only that, when we have somebody in

an acute crisis, which happens quite regularly, we call around to the private hospitals to admit them and there's up to a four week wait to get in for an acute mental health disorder. (GO2 Health, trans., p. 1168)

The Senate inquiry into transition from the ADF also noted that:

A disincentive for specialists, including psychiatrists, is that DVA has frozen the remuneration to psychiatrists, and so some will not see veterans because they know they will be paid less, and there are onerous reporting and administrative requirements. Specialists who do see veterans are: those who will continue to see them regardless because they have a special interest in them; young inexperienced psychiatrists who are trying to build a practice but do not have the appropriate skills or experience to meet veterans' needs; or psychiatrists who cannot keep a client load for whatever reason. (JSCFADT 2019, p. 63)

In addition, it is not clear that supports are being accessed by those with the greatest need and that treatments that are accessed are based on the latest evidence. Limited data are collected on what is purchased through the White Card and there is no analysis of whether it is best practice care, whether the White Card is improving access to mental health care or if veterans' outcomes are improving. This was noted by RSL Queensland:

There's no outcomes-driven look at how the general provision of treatment is establishing wellness. So when a person is provided with a White Card or a Gold Card they are entitled to get treatment for that condition that's been accepted or for all conditions, and there's no real monitoring of that and no real effort to ensure that the treatment they're getting is best practice ... (trans., pp. 1101–1102)

There is limited performance information included in DVA's annual report. Although the annual report measures how DVA is ensuring 'arrangements are in place for the access and delivery of quality mental and allied health services for DVA Health Card holders' (DVA 2018g, p. 81), the measurement used for this is the number of clients accessing services versus the number who have registered a complaint in relation to un-met access and/or quality. As discussed in chapter 16, this measure is not a sufficient indicator for whether those in need can access services.

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.

Open Arms — information about outcomes should be collected and published

Current performance information on Open Arms

DVA does not publish outcomes data for Open Arms, which makes assessing its effectiveness difficult. The only performance information released are measures of timeliness, client satisfaction and complaints.

Open Arms attempts to have client needs identified and supports in place within 14 days of the initial intake. In 2017-18, counselling was provided within 14 days for about two-thirds of clients (DVA 2018g, p. 81). Of the 30 complaints Open Arms received in 2016-17, most were about the responsiveness of their services (DVA's 2017-18 annual report did not report complaints for Open Arms) (DVA 2017f, p. 88).

The timeliness measures could be more informative and include:

- mean, median and maximum wait times
- wait times by State and Territory (or for each of Open Arms' centres) — to gauge whether services are more accessible in some locations than others
- wait times by priority group — even a short wait for someone in crisis would be a problem
- length of time taken for the initial intake.

On satisfaction, DVA's 2017-18 annual report noted a client satisfaction rate of more than 94 per cent (DVA 2018g, p. 81). Similarly, Open Arms was one of the highest-rated services in the NMHC survey, particularly for current serving and former ADF members (NMHC, sub. 107). However, these rates were not broken down by age and gender of clients so it is unclear whether subgroups report different satisfaction levels.

Outcomes measures for Open Arms

Open Arms has a central role in the veterans' mental health system. Given the role it plays, it could make a significant contribution to both ensuring high-quality mental health care and the coordination of care for veterans with complex problems. Open Arms is also currently participating in a number of pilots and trials which, if successful, could further expand its role. For all these reasons, it is critical that its performance is measured and evaluated in terms of clinical or other mental health-focused outcomes. An outcomes framework is a valuable way for Open Arms to fundamentally embrace a culture of performance improvement, and allow DVA more broadly to consider the position of Open Arms in the veterans' mental health system.

Open Arms is nationally accredited against the *National Standards for Mental Health Services*. These standards require some degree of safety, quality and outcomes measurement.

However, these standards do not provide information about whether a service is improving outcomes for clients. Instead they focus on:

- how services are delivered
- whether they comply with policy directions
- whether they meet expected standards of communication and consent
- whether they have procedures and practices in place to monitor and govern particular areas — especially those which may be associated with risk to the consumer, or which involve coercive interventions. (Australian Government 2010, p. 2)

The broad range of services that Open Arms provides raises the question of what the most informative and practical outcomes measures would be. State and Territory mental health services are required to collect outcomes data for their consumers, called the Mental Health National Outcomes and Casemix Collection (NOCC). Nine clinician-rated and consumer-rated measures are reported to the Australian Government through the Australian Mental Health Outcomes and Classification Network (some data are reported in the annual Report on Government Services) (box 17.13). The data are also shared among the services, so mental health services can be benchmarked. This assists clinicians and others to better understand outcomes and any variability in mental health services across the public sector. By participating in this network Open Arms could have its performance compared with other services and learn from what is working or not working in other mental health services.

It may be the case that not all of the outcomes measures used by the States and Territories are applicable to Open Arms services. However, even if Open Arms only used some measures, the process of adopting routine outcomes measurement is likely to foster a culture of benchmarking and contribute to a process of ongoing quality improvement, as required by the National Standards for Mental Health Services.

Findings from a 2013 review of the outcomes measures used by the States and Territories could help inform the development of outcomes measures for Open Arms (NMHIDEAP 2013).

- Any outcomes measures for Open Arms should consider taking into account non-mental health outcomes. One identified gap in the NOCC is that it does not measure factors that affect mental health such as social participation, employment, quality of life and satisfaction with services (NMHIDEAP 2013, p. 80).
- Service provider and consumer-completed outcomes measures are important to provide insight into the two perspectives on the effectiveness of services (NMHIDEAP 2013, p. 17).
- Implementation of outcomes measures was helped by strong leadership and management, training of clinicians to collect data, fit-for-purpose information and reporting systems, and a culture that values outcomes measurement and does not see it as an administrative burden (NMHIDEAP 2013, pp. 53–66).
- Ongoing review of outcomes measures is important to ensure the collection of relevant and reliable information.

Box 17.13 **The Mental Health National Outcomes and Casemix Collection**

Of the nine measures reported to the Australian Government through the Australian Mental Health Outcomes and Classification Network, five are specifically for adults and older persons and the remaining four are for children and adolescents. The five outcomes measures for adults and older persons are discussed below.

3. Health of the Nation Outcome Scales (HoNOS). The HoNOS consists of 12 items and is completed by the clinician. The HoNOS measures the severity of mental ill-health and includes questions on suicidal thoughts or behaviour, problem drinking and supportive social relationships.
4. Abbreviated Life Skills Profile. This questionnaire consists of 16 items and can be completed by family members, as well as professional staff. This measure does not address clinical symptoms like the HoNOS, instead it assesses the basic life skills of an individual such as how the individual is functioning in day-to-day tasks.
5. Resource Utilisation Groups — Activities of Daily Living. This measures the ability of a person to undertake tasks that usually become more difficult with age (eating, mobility etc.), and is normally completed by nursing staff.
6. Focus of care. This provides a context for outcomes measurement as it refers to the goal of care. An individual may have different goals when they access care or even within the same period of receiving care. This is a single item measure with only four options: acute; functional gain; intensive extended care; and maintenance.
7. Consumer self-report outcomes measures. These measures vary across states and territories as there is no agreed upon national measure. These capture the individual's perspective on their own mental health.

Source: Department of Health and Ageing (2003).

In the United States, an interagency taskforce on military and veterans' mental health, comprised of the Department of Defense, Department of Veterans Affairs and the Department of Health and Human Services, recommended that outcomes be collected on five core measures of mental health: a general patient health questionnaire; generalised anxiety disorder; PTSD; frequency of heavy drinking; and frequency of tobacco use. In response to this recommendation, the Department of Defense, Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration started to collect these data (Interagency Task Force on Military and Veterans Mental Health 2016). It is unclear how this data collection process is tracking, as the last annual report from the interagency taskforce was released in 2016.

If Open Arms is not able to use the States and Territories' measures, its National Advisory Committee should lead the development of an outcomes framework. The goals of the outcomes framework should be to:

- measure mental health and wellbeing
- use indicators that are useful for informing practitioners and others in the service
- use indicators that allow benchmarking against other providers, where possible

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- use data sources that minimise the cost of collecting outcomes measures.

Open Arms collects clinical outcomes of feedback from clients. Open Arms told the Commission that it is in the process of developing an efficiency framework which will allow monitoring of this feedback. Once all outcomes measures are in place, Open Arms' performance should be evaluated.

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.

17.6 Improving the veteran mental health system — a new Veteran Mental Health Strategy

The mental health policy landscape is changing

As discussed earlier, 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 17.1). The myriad of policy changes in the mental health landscape mean that DVA's role in the system needs to evolve. DVA retains ultimate responsibility for the effectiveness of veteran mental health services, such as Open Arms and those purchased through the White Card, regardless of the service delivery arrangements. DVA's responsibility over the system involves oversight of all the functions of the veteran mental health system and directly or indirectly affects all the outcomes. DVA's decision to expand access to non-liability mental health care means its stewardship responsibilities have widened.

A number of participants observed shortcomings in DVA's stewardship of mental health care.

- RSL Queensland (sub. 73) said that DVA had no process to identify where treatment was not working and where a veteran could be assisted to gain more effective treatment.
- Dr Warren Harex (sub. 89) noted that DVA should be evaluating mental health services to ensure quality and cost-effectiveness.
- RANZCP said:

... DVA rely on a purchaser-provider system, whereby health services are contracted from external providers ... Veterans are required to source their own services, and there is little incentive to build specialised service areas related to veterans. This leads to a number of issues,

including the possibility of market failure whereby certain services may simply not be available. In addition, the services which do exist cannot benefit from the advantages of consolidated clinical knowledge. Thus fragmented, services offer varying models of care at varying levels of quality with no guaranteed continuity of care ... Instead of improving care, this system creates issues that can exacerbate mental ill-health, and clearly does not prioritise the needs of veterans. (sub. 58, p. 3)

As discussed earlier, the VSC will have an increased focus on improving veterans' mental health outcomes and will actively evaluate services to ensure they are effective. This will include ensuring quality of care and coordinating care.

However, there is currently no strategy for coordinating the range of reforms undertaken and assessing whether they are improving outcomes for veterans. The usefulness of DVA's 10-year *Veteran Mental Health Strategy*, which was released in 2013, is questionable — it is telling, for example, that recent initiatives have been driven by community concerns and related inquiries and not by the Strategy.

The Strategy also does not have any tangible goals, commitments or indicators to measure progress. This is despite the DVA *Social Health Strategy 2015–2023* stating that DVA would set indicators to measure progress (DVA 2015f). However, no indicators were mentioned in either the *Mental and Social Health Action Plan 2015 and 2016* or the *Implementation Report of the Mental and Social Health Action Plan 2015 and 2016* (DVA 2015d, 2016l).

In the *Report on Implementation of the Mental and Social Health Action Plan 2015 and 2016*, DVA acknowledged a need to update its mental health strategy:

... 2017 presents an opportunity to consolidate and consider the findings and recommendations from the significant range of reviews, inquiries and research currently underway and ensure future focus in this area is evidence-informed, current and relevant. The next Action Plan will be informed by this work. (2016l, p. 8)

It is not clear what action DVA is taking on updating the Action Plan or if it is developing a new one. DVA told the Commission that it had commenced a review of its mental and social health strategic framework (sub. 125, p. 44). Defence and DVA are also undertaking a mapping exercise of all mental and social health services to identify weaknesses or gaps in treatment options (DoD, DoH and DVA 2017). However, this mapping exercise was originally mentioned in the Government response to the NMHC review in 2017 and the progress of this exercise is unclear.

In light of the changes to the policy landscape, it is the Commission's view that a new Veteran Mental Health Strategy should be developed. The Strategy should focus on maintaining, and building on, the efforts of recent years and making sure that the responses to the NMHC and Senate inquiry into suicide by veterans are followed through. It will need to consider the findings from recent research and the results from the pilot programs.

Information is needed to support the strategy

Developing an effective mental health strategy or plan is an involved process (box 17.14). There is an interim step between recognising the need for a strategy and commencing development of a strategy — identifying information that should form the basis of the new strategy (and seeking out such information).

Box 17.14 Good practice health strategy development

One example for the Department of Veterans' Affairs to follow in developing a new Veteran Mental Health Strategy is the Department of Health's (DoH) development of the National Women's Health Strategy for 2020 to 2030. To develop this strategy, the DoH:

- gathered information and data for policy development — the DoH commissioned a review of the evidence
- consulted — a National Women's Health Forum was held with organisations and individuals from the women's health sector to inform priority areas and areas for action. There was also a questionnaire on the DoH's website for interested parties to provide feedback on the draft strategy
- set out the purpose, principles and objective — the strategy has a clearly set purpose, principles and objectives along with determined areas for action.

All these processes and characteristics align with the World Health Organization's guidance on essential steps to develop a mental health policy.

Sources: DoH (2018b); World Health Organization (2005).

One common theme among the recent reviews of veterans' mental health is that DVA needs to build the evidence base in a number of areas, as a necessary precondition for both filling service gaps and making services more effective. The NMHC found that it was not able to empirically assess the effectiveness of suicide prevention services because there was insufficient information (while noting a lack of evidence around effectiveness was not uncommon for mental health and suicide prevention services more broadly). But the NMHC pointed out that the lack of information had been previously recognised by the Dunt Review in 2008, which explicitly recommended rigorous evaluation of all programs. That this did not result in ongoing improvements in the quality of information available suggests a new approach is needed to translate ideas and commitments into practice which is sustained over the long-term.

Recent research and reviews (including the forthcoming service-mapping exercise) will no doubt contribute, but before developing a new Veteran Mental Health Strategy, DVA should pause to consider the information it needs. This includes considering what outcomes, and subsequently data, should be used to both measure the progress of the new Veteran Mental Health Strategy and to be used to publicly report on the progress of the Strategy. That said, perfect information (which will never exist) is not a prerequisite to developing the Strategy. It would also be counterproductive to delay the Strategy unnecessarily, or to let the development of the Strategy delay the progress of other policies and programs.

A lifetime perspective

The Veteran Mental Health Strategy should take a lifetime perspective. This is important for getting the best outcomes for veterans and their families (chapter 4).

A Strategy that takes a lifetime perspective would cover the mental health services in place at recruitment, in service, transition and ex-service. At each of these stages, the risk factors and protective factors of mental health change, and each individual reacts differently to these factors. Therefore, the needs of individuals at each stage, and subsequently the services designed to meet those needs, might differ.

The majority of individuals will be mentally healthy during their lifetime, but there will be some who do go through a period of mental ill-health and some who may be severely mentally ill. As a result, each stage should incorporate a range of services to meet the needs of individuals, including:

- prevention and promotion services in place for those who are mentally healthy
- early intervention services for at-risk groups
- treatments for those with mental ill-health (which would also vary by the severity of the disorder). (DoH nd)

Defence currently has its own *Mental Health and Wellbeing Strategy 2018–2023* that was published in 2017 (chapter 5). Having a Defence strategy and a DVA strategy splits the veteran mental health system. Taking a whole-of-life perspective will require DVA and Defence to work together to develop and implement a new Veteran Mental Health Strategy. As the Prime Ministerial Advisory Council on Veterans' Mental Health highlighted:

This would provide veterans with a clear narrative of support from the day of enlistment, through their period of service and on to their wellness needs following transition back into the civilian environment. Importantly, this strategic model could, and indeed should be reinforced with focused plans from the contributing agencies aligned to the single strategic plan with a focus remaining on the agencies' operational outcomes. (sub. DR276, p. 3)

The Prime Ministerial Advisory Council on Veterans' Mental Health could also provide input into the development of the new Strategy. This Council advises government about the mental health needs of veterans and their families. It is comprised of representatives from the veteran community, ex-service organisations, Defence and DVA.

An independent body with expertise in mental health should have oversight of the new Strategy. This body would annually report on the progress of the new Veteran Mental Health Strategy which will provide transparency and hold DVA accountable for the mental health outcomes of veterans.

The NMHC is well placed to provide oversight of the new Strategy.

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- The NMHC has expertise in mental health and Australia's mental health system. One of the key areas of work of the NMHC is to provide advice and evidence to government about ways to improve Australia's mental health system.
 - It also aims to increase 'accountability and transparency through credible and useful public reporting and advice informed by collaboration' (NMHC 2014). In this role, the NMHC releases an annual report on mental health and suicide prevention outcomes, it also monitors the progress of reforms in the mental health system. The NMHC recently released its *Monitoring mental health and suicide prevention reform: National Report 2018* (NMHC 2018).

Oversight responsibility of the new strategy sits within NMHC's role to increase transparency and accountability. In this role, the NMHC should publicly report on the Strategy's implementation and outcomes.

What should the priorities for the new strategy be?

While there is a lot of work underway that should inform a Veteran Mental Health Strategy, there are also potential priority areas identified in recent reports, including:

- the quality of mental health care that veterans have access to
- coordination of care for veterans with complex needs
- access to mental health care for families of veterans.

The Veteran Mental Health Strategy should also acknowledge the heightened risk of suicide for younger veterans and include dedicated strategies to address the needs of this cohort and prioritise injury prevention and early intervention (Baker et al. 2017).

Access to high quality mental health care

Further research is required

Previous reviews have recommended that consideration be given to funding and developing specialist mental health 'centres of excellence' to:

- build the evidence base through high-quality research and service evaluation as well as use specialist multi-disciplinary teams to provide services (NMHC 2017b)
- identify services and practitioners with competence in addressing veterans' mental health problems, and promote high levels of connectedness between services (Forbes, Van Hooff and Lawrence-Wood 2018).

In response to the NMHC review, the Australian Government noted the existence of the Centenary of Anzac Centre (discussed below), which conducts research, and Open Arms, which provides services (DoD, DoH and DVA 2017).

DVA's most significant effort to promote quality treatment and understanding of PTSD is funding to Phoenix Australia, the Centre for Posttraumatic Mental Health. DVA funding for the 2016-17 financial year was \$1.3 million (Phoenix Australia 2017, p. 30). Phoenix Australia conducts research, provides education and training and publishes evidence-based treatment guidelines for PTSD. For example, Phoenix Australia is currently trialling whether an intensive form of one of the most effective treatments for PTSD (prolonged exposure therapy) is as effective as the standard form. The current form of treatment comprises one session a week for ten weeks, while the new intensive form that is being trialled will comprise daily sessions for two weeks. If the trial is successful it could make an effective therapy more accessible.

The Government also funded Phoenix Australia to establish the Centenary of Anzac Centre, which is intended to bring together research on treatment for veterans' mental health problems and provide expert guidance and support for practitioners working with veterans with mental health problems. The Centre's practitioner support service provides free consultations with veteran mental health experts for health practitioners, organisations that provide clinical services for veterans and other veteran-specific organisations (such as ex-service organisations).

These organisations play an important role in driving research on mental health treatments. As discussed in section 17.3, there is an ongoing need for more research on mental ill-health. The high rates of unresponsiveness to best-practice treatments for PTSD and the lack of effective suicide prevention strategies are key areas of research need. Inquiry participants argued DVA should play a more proactive role in commissioning research into PTSD. As Stephan Rudzki said:

Defence and DVA should be at the forefront of conducting research studies examining the effectiveness of novel therapies. The current default position is one of passive waiting for other nations or organisations to develop the evidence. (sub. 40, p. 6)

To help research efforts into treatments for mental disorders, particularly PTSD, DVA should make mental health a research priority in future research plans (chapter 18). This was suggested by the RANZCP:

Recent research clearly highlights the need for further investigation into the high rates of mental illness in former ADF cohorts, as an estimated 46% of former ADF members, transitioned within the past five years, met diagnostic criteria for a mental illness in the past 12-months. There is a clear need for studies which observe the level of impairment and disability that follows on from those diagnoses, and emphasise quality of life, satisfaction with family life and any other relevant measures. (sub. DR225, p. 3)

Training for providers

Training modules are available to clinicians to improve their understanding of the military experience and their skills in delivering mental health treatment.

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- DVA provides a two-hour online training program to help mental health providers understand the military experience and a one-hour online training program for general practitioners to help them understand common mental disorders among veterans (DVA 2019c).
 - Phoenix Australia runs one- to two- day training programs on anger, trauma-focussed therapy and cognitive processing therapy (Phoenix Australia 2019).

Concerns about clinicians' lack of understanding of veterans' mental health issues led the Senate inquiry into suicide by veterans to recommend that the Government improve veteran-specific online training programs (SFADTRC 2017). The Australian Psychological Society told the inquiry that DVA:

... currently provides the opportunity for upskilling of providers of psychological services to veterans to support quality service delivery. The current DVA suite of eLearning online training such as 'understanding the military experience' modules are important in building a cohort of providers informed in the military experience. Such training is vitally important for clinicians to be able to effectively translate clinical best practice to the particular issues confronting veterans. However, there is no requirement for DVA providers to undertake this training and there are currently no incentives for health practitioners to complete the training. Additionally, there is no mechanism for referrers or consumers to identify service providers who have undertaken the DVA training. (APS 2016, p. 1)

The Australian Psychological Society (2016) made three suggestions.

4. That training be enhanced.
5. A system for identifying practitioners who have undertaken the training be introduced.
6. Incentives to undertake the training and demonstrate clinical outcomes be introduced.

The Government agreed to the Senate inquiry's recommendation for a review of its training but did not provide a commitment to actually introduce incentives or a way for identifying practitioners who have completed the training (Australian Government 2017b, pp. 7–8).

It would be in veterans' and DVA's interest to know whether DVA's training material is effective in promoting quality care. Do practitioners find it useful? Can veterans tell if a practitioner has undertaken such training — do they provide noticeably better care? Do practitioners who have undertaken the training also have better treatment outcomes? This training material is a key way that DVA seeks to enhance the quality of care for veterans and so it is important to get right and should be a goal for DVA.

As a first step, veterans should have access to a list of practitioners who have undergone training programs delivered by Phoenix Australia. Practitioners could opt into having their details listed once they have completed the training course. This would help guide veterans when seeking mental health care.

The list should be made available on a website that is used as the first point of contact for veterans seeking mental health care. However, there are many websites to select from. The

DVA website has a mental health page with links to other websites such as Open Arms, At Ease, High Res, Operation Life and the Right Mix website. Phoenix Australia also has some information for people who are undergoing a period of mental ill-health. DVA needs to determine which website is the most widely used and post the list on this page.

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).

Coordination of mental health care

Veterans with complex or serious mental disorders would benefit from coordinated care. As Phoenix Australia put it:

the care system is a complex one, often difficult for the veteran to navigate, and hence there is the potential for veterans with elevated risk or complex problems to fall through the cracks. (Phoenix Australia 2016, p. 6)

Coordinated care can help a person with mental ill-health access a range of different services they may need to aid in their recovery and, importantly, aims to bring the multiple agencies and professionals involved together, so they can work towards improving the person's mental health. A designated care coordinator has the responsibility of coordinating, facilitating and integrating a person's treatment, care and support (WA Department of Health nd).

As noted earlier, many veterans have complex mental health problems due to the high rates of comorbidity with other mental disorders as well as physical conditions. The *Pathways to Care* report observed problems with the coordination of care for veterans:

The service system available to Transitioned ADF compared with that of Defence is that it is provided largely by a broad array of private services, tertiary- and community-based services, and private health and mental health practitioners across the country ... There is little systematic coordination across the full array of services, between levels of care and between providers of care. As such, there is considerable risk that individuals may fall out of care or into gaps between services. (Forbes, Van Hooff and Lawrence-Wood 2018, p. 225)

DVA has a complex task ahead of it in responding to the three pilots mentioned above. They do not appear to be part of a cohesive strategy and indeed look to be at risk of overlapping in some areas. It is also not clear how DVA plans to build on the Operation Compass trial, which could have profound implications for service delivery and, if successful, suggests that

Primary Health Networks could play a greater role in commissioning mental health services for veterans.

The VSC will also provide individualised support to veterans, including case management for those veterans with complex needs.

Families

As discussed in section 17.1, supportive families can help veterans with their mental health, including encouraging them to seek help for mental health concerns (families are often the first to notice symptoms). A veteran's mental disorder can also affect their family.

Many family members affected by veterans suffering from mental illness called for more support. For example, Fiona Brandis said:

I'm not saying that I deserve a Gold Card or even a White Card; however I believe that I should receive some kind of subsidy for my own medications and medical appointments. Surely DVA has a duty of care to spouses who've suffered mental illnesses as a result of the veteran's service-related illnesses and injuries. Why shouldn't we receive some assistance? (sub. DR295, p. 1)

RSL NSW also listed a number of areas where carers and families of vulnerable veterans would benefit from support. This included additional transition support (chapter 7), financial support, respite care and:

- clear, understandable, and readily accessible information about the veteran's condition, how best to manage it at home, and support services available
- access to programmes to build resilience in families of veterans to cope with trauma
- practical impact-minimisation support including cleaning, maintenance, and safety in the home. (sub. 151, p. 24)

And Vietnam Veterans' Federation of Australia:

There is an immediate need for spouses/partners to have early, targeted intervention to address potential mental health issues, and early access for psychological and/or psychiatric services. (sub. DR215, p. 19)

Many inquiry participants — including Deborah Morris (sub. DR307), the Partners of Veterans Association of Australia (sub. DR280) and the Vietnam Veterans' Federation of Australia (sub. DR215) — suggested that this type of psychological support for families should be provided through some type of White Card for families.

The Senate inquiry into suicide by veterans also heard concerns about a lack of support for families and recommended that DVA review the support for partners of veterans to identify further avenues for assistance (SFADTRC 2017, p. xvi).

The NMHC recommended the ADF and DVA consider a strategy for supporting families that would focus on ‘known stress points for families’ (NMHC 2017b, p. 52). The NMHC also recommended the ADF review its current approach to implementing family-sensitive practices. This review should be included within the service-mapping exercise that is currently being undertaken and the results fed into the new Veteran Mental Health Strategy.

As mentioned above, families have access to a number of mental health supports, such as Open Arms and respite care. The FWS study found that most families who were concerned about their own mental health knew where to get help for their needs (87 per cent) and were seeking help (80 per cent). When those who had not sought help were asked about perceived barriers to accessing services, 77 per cent said ‘they preferred to handle problems independently’ and only a small proportion reported cost as a barrier (22 per cent) (Daraganova, Smart and Romaniuk 2018, p. 7). The study concluded that:

Given that the great majority of FWS participants knew where to obtain help and had done so, there did not seem to be a substantial unmet need for mental health services among FWS family members. (2018, p. 7)

However, whether these supports are effective or sufficient for families of veterans is unclear. Participants to the Senate inquiry into the mental health of ADF serving personnel commented:

Despite previous inquiries and reviews into these issues, there does not appear to have been any major changes at the coal face. The only changes seem to be to add another layer within the already multi-layered systems. Defence Community Organisation for example, has been reviewed and restructured and had more money put into it, however the services at a local level have diminished. The money appears to go into more bureaucracy and more restricting rather than the person-centred approach that is required. (AFOM 2015, p. 2)

One suggestion made by inquiry participants was to make mental health first-aid training available to families.

Providing opportunities for veteran’s partners and family members to access accredited training such as Mental Health First Aid training and suicide awareness training is vital. Often family members can feel helpless and inadequate when faced with a loved one experiencing physical, emotional or psychological pain. However, being provided with training in areas such as recognizing the signs of mental health problems or suicidal ideation and skills in how to respond in crisis situations can provide family members with increased confidence and can assist in veterans being linked with supports sooner. (Mates4Mates, sub. 84, p. 8)

This training could benefit families by teaching them how to provide support to their veteran, teach them about mental ill-health and services available and potentially help them manage their own mental health. However, it is unclear whether this training improves the wellbeing of families. Families would have also had the option to receive similar training while their veteran was serving, such as resilience training through the DCO. Additional support for families is considered in chapter 19.

As discussed in section 17.4, the VSC will also approach family support differently from DVA. The VSC will address the needs of families under a client-focused case management system. Those needs include their carer role for the veteran, as well as specific needs resulting from the effect of the veteran's condition on the family, including after the death of a veteran, where necessary. In addition, the VSC should have discretion to assist families who wish to access services other than Open Arms. The VSC should monitor the effectiveness of these services and implement additional support services if required.

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 of 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.

18 Data and evidence

Key points

- Good-quality data and evidence are critical to:
 - achieving good outcomes for veterans and their families
 - knowing which services and interventions are cost-effective
 - managing the performance of service providers
 - understanding the lifetime costs of supporting veterans and managing the long-term costs of the veteran support system
 - informing and improving the design of services and policies.
- Data are a key component of contemporary workers' compensation and social insurance schemes. They are lacking in the veteran support system. And where data are collected, opportunities are lost because they are not used as well as they could be. This inquiry was limited by the lack of data, and by poor practices in the collection and linking of data.
- Good-quality evaluation of the supports that Defence and the Department of Veterans' Affairs (DVA) provide to veterans and their families is also lacking, despite recent improvements in information-sharing processes between Defence and DVA.
- The future veteran support system, with its stronger focus on outcomes for veterans and their families and financial sustainability, will demand better collection and analysis of data.
- Action is needed to build the evidence base on veterans and their families in four main areas.
 - *Performance and outcomes frameworks.* These frameworks are a feature of best practice workers' compensation and social insurance schemes. They will help address the data gaps highlighted throughout this report, and set up a system that allows ongoing monitoring of data (to help identify emerging trends and outcomes). When developing outcomes measures, existing data holdings should be leveraged so the cost of data collection is minimised. Developing robust performance and outcomes frameworks should be a priority.
 - *High-quality reviews and evaluations.* Reviews and evaluations are essential for generating evidence about what works, for who and in what circumstances. To minimise the costs of reviews and evaluations while also delivering high-quality evidence, the methodology of (and subsequently the resources devoted to) reviews and evaluations needs to reflect the characteristics of the services or programs being assessed.
 - *Strategic approach to research.* There needs to be a research plan which sets out research priorities on issues affecting veterans, and timeframes for research completion and publication. Updating the research plan annually will help DVA and Defence track progress and provide transparency about research outcomes and remaining evidence gaps.
 - *Research governance.* Establishing an Expert Committee on Veteran Research will help ensure the research plan facilitates the development of high-quality research. Members of the Expert Committee should have a diverse range of skills and expertise.

The veteran support system, like any good workers' compensation or social insurance scheme, requires good-quality data and evidence. Data and evidence are essential to:

- help deliver good outcomes for veterans and their families, by informing and improving the design and delivery of supports and policies
- monitor the performance of the system (including understanding clients' experiences, analysing error rates, and ensuring the system is financially sustainable)
- monitor and manage the performance of service providers.

This chapter looks at the role of data and evidence in the veteran support system. Section 18.1 looks at the gaps in data and evidence on veterans and veteran supports. Sections 18.2 and 18.3 set out why data, evidence and performance measurement are important for the future veteran support system. Section 18.4 describes how to better use the data to build an evidence base, and section 18.5 looks at the role of policy trials, evaluation and research in improving veterans' wellbeing.

18.1 Persistent gaps in data and evidence on veterans and veteran supports

Inadequate data on many aspects of the veteran support system

Basic data on veterans is missing

The gaps in information about veterans are significant. A number of inquiry participants raised concerns about the lack of data.¹ The Defence Force Welfare Association, for example, said:

Before one can fix a problem, one has to be able to quantify the problem. To measure the success or otherwise of service delivery, or an intervention, the definition of success must be identified and ways of measuring it decided. There is a dearth of statistics in many areas. (sub. 118, p. 33)

This inquiry identified and was limited by gaps and poor practices in the data collection on veterans.

- There is very little information on the veteran population. The number of living Australian veterans is not known. The Department of Veterans' Affairs (DVA) estimates that about a quarter of the estimated living veteran population are DVA clients (chapter 2). This means that the health and welfare status of three quarters of living veterans is largely unknown to DVA.
- DVA only collects limited information to evaluate the effectiveness of the services it provides to veterans and their families. DVA does not measure and publicly report

¹ They included the Defence Force Welfare Association (sub. 118), Giselle Fleming (sub. 33), the National Mental Health Commission (sub. 107), RSL Queensland (sub. 73), Robert Shortridge (sub. 76) and the Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia (sub. 96).

meaningful information on the health and wellbeing of its clients. DVA should be able to demonstrate the effectiveness of the activities it funds. It cannot currently do this.

- Data are not collected in a consistent and comparable manner, and incorrect coding of data is prevalent within the DVA system. DVA rehabilitation data contain numerous instances of ambiguous classification, and are difficult to interpret as a result.
- There are gaps in the information about veterans, including in the areas of education, employment, justice and safety, income and finance. There are also substantial gaps in the understanding of women's experiences in the Australian Defence Force (ADF) (reflecting in part the historically small number of women in the ADF) (AIHW 2018b, p. 297).
- There are notable gaps in the data on the aspects of the veteran support system for which Defence is responsible. Gaps noted in previous chapters of this report include in the areas of preventing illness and injury (chapter 5), rehabilitation services for serving members (chapter 6) and transition preparation and support (chapter 7). These gaps are exacerbated by the dispersed nature of Defence records (chapter 8).

Each of these gaps would, on its own, merit concern, but taken together they point to significant shortcomings in the administration of the veteran support system (chapter 11). This view was shared by the Returned and Services League (RSL) Queensland.

The failure to understand the overall outcomes of the supports being provided is really the key to the problems [DVA] are currently facing. (sub. DR256, p. 36)

No whole-of-client analysis

DVA should be well placed to understand and respond to the needs of its clients. It provides (and has provided for decades) a range of supports to veterans and their families, and supports are often provided over an extended period of time. As the Australian Public Service Commission (APSC) said:

DVA has a long, close relationship with its unique client base which allows the department to collect a wealth of data relating to health and social wellbeing, such as income support, compensation and rehabilitation information. This data in many cases spans the entire life of a veteran. (APSC 2013, p. 27)

But in practice, DVA does not put together the data it collects to gain a whole-of-client view. Each process undertaken by DVA has its own dataset, and these datasets are not linked to each other. For example, DVA's claims data has the type and severity of a veteran's service-related injuries. The value of these data was discussed in a recent review into the mental health impact of claims assessment processes.

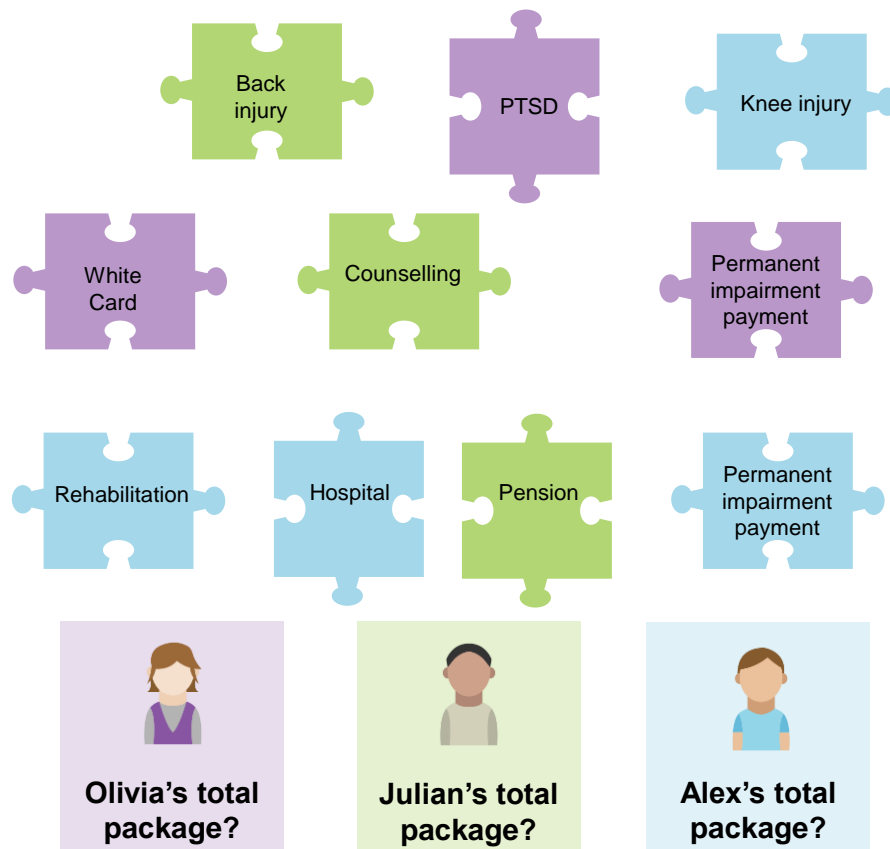
The DVA claims processes produce vast amounts of data, but this is currently not exploited to its full potential. There is a clear opportunity to better use data to support strategy and claims operations. (Collie 2019, p. 63)

But claims data are not linked to the veteran's rehabilitation or healthcare data. What this means is that DVA does not have an overall picture of the total package of services it

provides to individual veterans, and so it cannot assess the effect of those services on veteran wellbeing (figure 18.1).

In addition, very little of the data that Defence collects about veterans from the day of enlistment (including information about their training, service, deployments and health care) are shared with DVA, nor are they used by Defence and DVA in a joined-up way to achieve a whole-of-client picture. The Commission's proposed changes to the governance of the veteran support system (including establishing a new Veteran Services Commission (VSC) (chapter 11)) should help to achieve a greater focus on the lifetime wellbeing of veterans.

Figure 18.1 **DVA holds lots of data about veterans, but does not connect the data in meaningful ways**



Inadequate publication of data held by DVA

DVA only publishes a snapshot of the data it holds and there is a lag in updating this information. This leads to a lack of transparency which reduces veterans' trust in the system. For example, Connie Boglis (partner of Jesse Bird) said:

... DVA and Defence needs to be really clear with their statistics and I think that needs to be part of the conversations, moving forward, I think that's something that they need to highlight, you

know, what is the feedback, what is the data, what is the statistic on mental health recovery and how they're progressing. Because it is a cultural shift and there's no trust within the veteran community ... around these changes. (trans., p. 606)

And the Australian Federation of Totally and Permanently Incapacitated Ex Servicemen and Women said:

... we don't know how many special rate people there are under MRCA. ... 14 years to gather this data and we can't get it. Believe me I've tried many times, and they can't keep blaming the computer systems, there's something wrong. (trans., p. 510)

Limited action to improve evidence

Shortcomings in DVA data have been evident for many years

Concerns about the lack of data, and the failure to make optimal use of the data that are collected, are not new. For example:

- an Australian National Audit Office (ANAO) performance audit on the quality and integrity of DVA's income support records in 2008-09 found that 'key fields in many electronic records were not accurate, complete or reliable' (ANAO 2009, p. 17)
- another report by the ANAO on the administration of rehabilitation services under the *Military Rehabilitation and Compensation Act 2004* (MRCA) found that neither Defence nor DVA reliably measured, monitored or reported on rehabilitation outcomes (ANAO 2016, p. 8).

DVA also makes very little use of its extensive health and social care data — this is a lost opportunity (chapter 16). Unlike other government agencies involved in funding health and social care services, DVA is in the unique position of having access to data on many aspects of a person's care — their use of public and private hospitals, general practice, allied health, pharmaceuticals, aged care and more. The value of these comprehensive data was highlighted by the APSC.

DVA has one of the most valuable health datasets in the country. While this dataset has been used to achieve positive health initiatives, greater whole-of-client analysis would inform future service provision. (2013, p. 24)

DVA has plans to improve the use of data — one of the strategic pillars of the Veteran Centric Reform (VCR) program is to embed the use of data and data analytics into day-to-day functions (chapter 9). But DVA is a long way from being as effective as contemporary workers' compensation and social insurance schemes when it comes to the use of data and data analytics, the monitoring of service delivery and provider performance, and its focus on client outcomes.

Long overdue upgrades to DVA ICT architecture

One reason for the gaps in data about DVA clients is that DVA is still in the early stages of addressing concerns about the reliability and efficiency of its information and communication technology (ICT) systems. Many of DVA's ICT systems remain archaic and not fit-for-purpose. This issue was flagged as far back as 2009 when the ANAO found that:

A key challenge for DVA is managing the risks associated with maintaining the department's heritage IT systems, while developing new system capabilities. (2009, p. 21)

And then in 2013 the APSC said:

... there are some 200 individual ICT systems operating in the department with a dated desktop. Typically a client facing employee or assessor may need to open three or four separate applications, none of which 'talk to the other', in order to deal with a single client request or claim. Furthermore, staff or assessors may need to access additional separate applications (likely through another staff member) to determine if a client had a transport booking, or to check a client's eligibility for glasses or dental treatment. (2013, p. 8)

The APSC considered that DVA's 'multiple ageing ICT systems pose a significant threat to its data holdings' (2013, p. 28). The systems are so outdated that paper-based claims are only just being phased out.

Until 2015, some 25 tonnes of paper were being moved around the country each month, as part of usual DVA operations, with more than a million files taking up space in three warehouses and other storage facilities. (DVA 2017q, p. 12)

DVA also told the Commission that its programs rely on multiple systems, 'some dating back more than thirty years' (sub. 125, p. 16).

It was not until the 2016-17 Budget that significant funds were allocated to develop a business case to improve DVA's ICT infrastructure (this was the first business case for the VCR program) (DHS 2017).

But even with the VCR program underway, improvements to ICT systems have been slow and in some cases led to a decrease, rather than an improvement, in DVA's ability to derive meaning from the few data it does collect. For example, DVA told the Commission that the VCR program created a discontinuity in client data — this means that in some DVA datasets information collected by DVA prior to December 2017 cannot be matched with information collected after, and so DVA may not know which services it provided to the same person before and after that date.

So despite ICT upgrades, significant issues remain. As Renee Wilson pointed out:

... significant amounts of money and time are spent to synchronise the ICT systems, and data collection enabling DVA to become more proactive yet we are still nowhere near where we should be. (sub. DR257, p. 2)

Recent initiatives hold some promise

Some recent initiatives, while overdue, are promising in the context of improving the evidence base about veterans. For example, DVA has entered into a partnership with the Australian Institute of Health and Welfare (AIHW) to develop a profile on the health and welfare of the veteran population (box 18.1).

Information-sharing processes between Defence and DVA have also improved. Under the Early Engagement Model, members who joined the ADF from 1 January 2016, and those who separated from the ADF after 27 July 2016 are registered with DVA (DVA, sub. 125, p. 37). (Prior to this, Defence did not always notify DVA when a veteran left the ADF.) Defence has also provided DVA access to eHealth records and has begun to digitise other health records (DoD, sub. 127, pp. 11–12).

Box 18.1 **A partnership to profile the health and welfare of veterans**

In 2017, the Department of Veterans' Affairs and the Australian Institute of Health and Welfare commenced a 4-year program of work 'to build a comprehensive profile of the health and welfare of Australia's veteran population' (AIHW 2018a, p. vi). There are a number of recent publications from this partnership.

- *Incidence of suicide in serving and ex-serving Australian Defence Force personnel: detailed analysis 2001–2015*. This report analysed the incidence of suicide in serving and ex-serving personnel, along with characteristics that may be associated with suicide risk.
- *Development of a veteran-centred model: a working paper*. This paper set out a model to support holistic analysis and reporting of veterans' health and welfare.
- *Australia's health 2018*. This publication included a chapter on veterans' health, including data limitations and information from the incidence of suicide study.
- *Causes of death among serving and ex-serving Australian Defence Force personnel 2002–2015*.
- *National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2018 update*.
- *A profile of Australia's veterans 2018*. This report sets out what is known about the health and welfare of veterans, the gaps in information about veterans and how to address these gaps.

Sources: AIHW (2017b, 2017c, 2018a, 2018b, 2018c, 2018d, 2018g).

Gaps in research

High-quality research into issues affecting veterans can help build an evidence base on what does and does not work in improving outcomes for veterans and their families. Research can also inform the design and delivery of effective services, and can reduce costs or make better use of the money spent on veteran support (programs that are found to not be cost effective can be replaced with more effective services).

The importance of research is reflected in the MRCA. Under section 362 of the MRCA, the Military Rehabilitation and Compensation Commission is required to promote research into:

- the health of members and former members
- the prevention of injury and disease
- the rehabilitation of persons from injury and/or disease.

To this end, DVA undertakes a number of research projects. However, despite having worthwhile aims, the benefits of some of these initiatives have not yet eventuated. One example is DVA's MRCA Rehabilitation Long-Term Study which will examine the effectiveness of rehabilitation arrangements under the MRCA. The study came about following a recommendation in the 2011 MRCA review (Campbell 2011a, p. 46). To date, all that has been produced is a proposed study design framework (dated November 2016, but not publicly available). And DVA advised that work has now been delayed to 2019-20.

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 has been deferred until 2019-20. (sub. 125, p. 133)

However, it is unclear why this activity inhibits the collection of outcomes of people in the rehabilitation system. The delay is particularly concerning as the intention of the study is to measure long-term outcomes, so any further delays to the start of the study will delay the results of the study. With these current timelines it would take at least until 2029-30 for the results of this study, which is 19 years after the need for the study was identified.

Many inquiry participants called for more research on veterans, noting that many questions remain unanswered. Olivia Pursey, for example, advocated for:

... more academic research, encouraged by fellowships, funding honours theses and further study, particularly into the kinds of mental illness suffered by veterans, and how best to treat and rehabilitate veterans of modern warfare. (sub. 51, p. 6)

The Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia noted benefits in conducting:

... research on the causal aspects/drivers behind why the majority of serving and former serving personnel are healthy and view their military service with fondness and positivity, including those exposed to significant stress and trauma during service. Such research may improve recruitment procedures and/or assist to identify individuals at risk earlier. (sub. 96, p. 4)

Australian War Widows Queensland recommended:

Further research around war widows and their unique needs to enable government and industry to respond meaningfully to their needs. (sub. DR187, p. 4)

And Stephan Rudzki said more research was needed into novel therapies for post-traumatic stress disorder.

Defence and DVA should be at the forefront of conducting research studies examining the effectiveness of novel therapies. The current default position is one of passive waiting for other nations or organisations to develop the evidence. (sub. 40, p. 6)

Participants also expressed concern about DVA's inability to provide strategic guidance on research. For instance, the Royal Australian and New Zealand College of Psychiatrists said that:

Recent research into veterans' health has suffered from fragmentation from a variety of directions. DVA has lost much of its technical capacity to act as a coordinating research body as well as corporate memory, meaning that much of what was learned from its earlier post-deployment research has not been directly utilised in more recent studies. (sub. 58, p. 6)

RSL NSW commented on the poor dissemination of research funded by DVA.

DVA funding for research should be made conditional upon the inclusion of 'clinical applications' as a research outcome. This research should then be distributed to major [ex-service organisation] service providers (for forwarding on to advocates, etc.) and made easily available online ... More thought needs to be given to the way DVA-funded expert research is communicated to non-expert audiences. (sub. 151, pp. 12–13)

In addition to these gaps in research and in research translation, there are cases of DVA declining requests for much-needed research in the veteran support system. As discussed in chapter 8, the Repatriation Medical Authority (RMA) is prohibited from carrying out any new research work. Instead, the RMA can request that DVA carry out research on its behalf. This has happened twice in 24 years and both times DVA declined to undertake the research, despite it having been requested by the agency responsible for assessing medical-scientific evidence about diseases, injuries or deaths that could be related to military service (RMA, pers. comm., 11 October 2018).

Too few high-quality reviews and evaluations

Over the years, DVA has conducted a number of evaluations and reviews of some of its programs and services, such as the Coordinated Veterans' Care program (Grosvenor Management Consulting 2015). These evaluations are important sources of information for how DVA services are working to improve veteran outcomes.

However, DVA's evaluation activity is nowhere near as transparent as it should be. It does not publish all of the evaluations that it commissions or undertakes. Publishing evaluations is important for building an evidence base, informing future policy development and sharing information with researchers and veterans and their families. DVA has not published:

- the PTSD Coach mobile app evaluation which, according to the DVA 2017-18 Annual Report, was conducted in 2017-18 and will be used in 2018-19 to shape a redesign of the app (DVA 2018g, p. 64)

-
- the Veterans' Assistance Initiative evaluation which is mentioned in the DVA 2015-16 Annual Report (DVA 2016c, p. 31)
 - a review of its Strategic Research Model
 - a review of its online professional development offerings for health professionals treating veterans. It is especially concerning that this review is not publicly available as it was commissioned in response to a recommendation made by the Senate inquiry into suicide by veterans.

DVA's evaluation activity is also not sufficiently strategic, with current evaluation activity focused on smaller programs and not on larger, strategically significant programs. For example, DVA has two major activities to ease the burden of veteran mental ill-health — Open Arms and the non-liability White Card. Eligibility for these services has been extended to more veteran groups and their families in response to recommendations from inquiries and reviews. But DVA has not evaluated the effectiveness of Open Arms nor does it have plans to evaluate the non-liability White Card, so DVA does not know if these services are improving the mental health outcomes of veterans and their families. Previous chapters highlighted a lack of evaluation of other strategically significant services, including health services (chapter 16), rehabilitation services (chapter 6) and transition preparation and support (chapter 7).

The current lack of rigorous, open and transparent evaluation is a barrier to understanding how services work for veterans and to improving service design and delivery.

A focus on outputs limits performance reporting

Like all government entities, DVA and Defence report on department performance in accordance with the reporting requirements of the *Public Governance, Performance and Accountability Act 2013*. Under this Act, entities must publish statements about their performance in their annual reports. Comprehensive and reliable data and evaluation are key to meeting the spirit of, not just the letter of, this requirement.

DVA's performance statements are output focused. This type of reporting provides little insight into whether supports provided are improving veterans' health and wellbeing. For example, performance measures include claims processing times and the number of clients accessing various payments and services (but no direct measures of clients' wellbeing, or even of the financial wellbeing of clients receiving pensions). On health outcomes for veterans, DVA mostly reports outputs such as the 'number of clients accessing services versus the number who have registered a complaint in relation to un-met access and/or quality' (DVA 2018g, p. 80, 2018l, p. 30).

DVA's focus on outputs, rather than outcomes, was highlighted by inquiry participants. For example, the National Mental Health Commission said:

There are no direct measures of effectiveness (i.e. achievement of outcomes) for the mental health services provided by the ADF and DVA. The only data that is available relates to outputs (e.g. the

number of services provided, and the number of people attending training), which does not provide meaningful information about whether a service has achieved its intended outcome for its client (e.g. higher resilience) or client group (e.g. lower rates of mental illness or suicide attempts). (sub. 107, p. 4)

DVA also acknowledged that its focus is on outputs rather than outcomes.

... most of DVA's performance assessments have tended to measure *delivery* (or *outputs*), rather than *effect* (or *outcomes*). (sub. 125, p. 148)

In some cases DVA has not only neglected to consider outcomes but has omitted basic output measures before committing further resources. For example, there is no published information on the uptake and effectiveness of the ADF Post-discharge GP Health Assessment. But DVA has announced that eligibility for the health assessment will be substantially expanded — instead of being available to each veteran on a once-off basis, it will be offered in each of the first five years after leaving the ADF. The rationale for such an expansion is unclear (chapter 7).

Better performance reporting is needed across the entire veteran support system, including the parts of the system that Defence are responsible for (particularly in the areas of injury prevention and rehabilitation).

FINDING 18.1

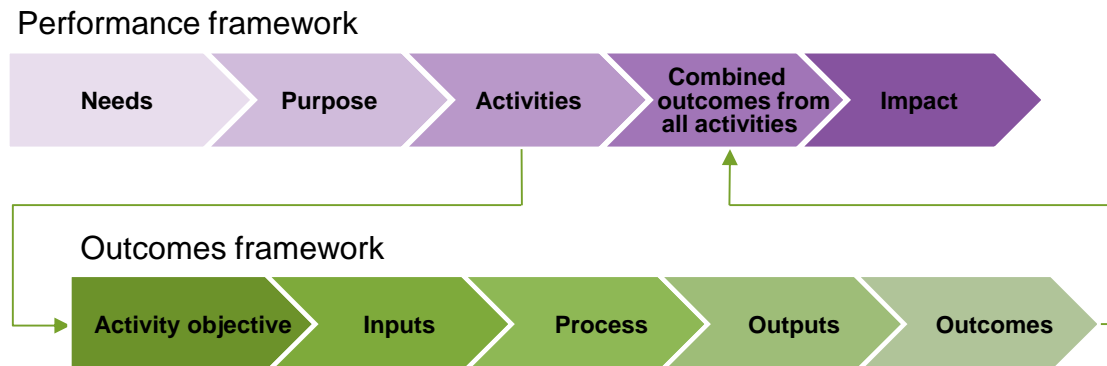
There is a lack of robust data, evidence and research on many crucial aspects of the veteran support system. This impedes the design and delivery of effective supports for veterans and their families.

18.2 Collecting data on the effect of veterans' programs

Insights (and data) on outcomes are an important element of any evidence base and are crucial for accountability and performance reporting. Any effective organisation should have performance and outcomes frameworks to guide measurement of the effect of its actions.

- Performance frameworks provide a holistic view of performance.
- Outcomes frameworks are a subset of performance frameworks and are unique to each activity (program or service). An outcomes framework identifies the relevant data (outcomes measures) which quantify how an activity contributes to specific outcomes, and how the data are collected (figure 18.2).

Figure 18.2 **Outcomes and performance frameworks**



Source: Adapted from Department of Finance (2015b).

There are a number of examples of outcomes frameworks of potential relevance to the outcomes of the veteran support system. They include the National Disability Insurance Scheme Short Form Outcomes Framework and Veterans Affairs Canada's wellbeing framework for veterans' services (box 18.2). The domains of wellbeing discussed in chapter 4 (health, employment, income and finance, housing, education and life skills, social support and integration and recognition) could also be used to inform the development of outcomes frameworks.

Box 18.2 **Examples of outcomes frameworks**

National Disability Insurance Scheme Short Form Outcomes Framework

The National Disability Insurance Scheme Short Form Outcomes Framework is an approach to measure the outcomes of National Disability Insurance Scheme support. It includes eight indicators of participant experience (known as participant domains) as well as outcomes related specifically to families and informal carers. It was piloted in the first three months of 2015 and is now being rolled out scheme wide.

Participant domains

Choice and control — improved choice and control, and planning and delivery of supports
Daily activities — increased ability to undertake the daily activities with adequate levels of support
Relationships — increased levels of social inclusion and reduced experiences of loneliness
Home — improved satisfaction with home environment now and five years into the future
Health and wellbeing — improved health and wellbeing and increased ease of access to health services
Lifelong learning — increased opportunities to learn new things
Work — increased uptake of paid employment (and the associated social inclusion)
Social, community and civic participation — increased participation in community activities chosen by the participant, and reduced negative experiences associated with being excluded

Family and carer domains

Families have the support they need to care
Families know their rights and advocate effectively for their family member with disability
Families are able to gain access to desired services, programs and activities in their community
Families have succession plans
Parents enjoy health and wellbeing

The framework will allow tracking of participant and scheme progress over time, and demonstrates how participants are faring relative to other Australians and to those with similar needs in other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Veterans Affairs Canada wellbeing framework

Veterans Affairs Canada developed a wellbeing framework comprised of seven domains of wellbeing (employment or other meaningful activity, finances, health, life skills and preparedness, social integration, housing and physical environment, and cultural and social environment). Good wellbeing across the seven domains is used as an ultimate strategic objective for veterans' policy and programming and as a measure of successful transition for veterans.

Measurement of the domains is used to segment the veteran population along a continuum ranging from those doing well to those in crisis. The population segments that are doing well might meet all seven criteria, or be at low risk of experiencing difficulty. On the other end, the in-crisis segment may be veterans with severe problems in one or more domains.

This framework takes a lifetime view, focusing on particular points in the life cycle of a veteran, such as during transition or post discharge.

Sources: NDIA (2017) and Thompson et al. (2016).

Collecting data on outcomes, however, is not without some challenges — outcomes data can be difficult to collect and quantify. Attributing outcomes to particular services can also be difficult, particularly if a veteran or family member is receiving many services.

And while more data provides the benefit of a stronger evidence base, collecting data involves costs, and the benefits must be weighed against these costs. There are also costs associated with establishing and supporting effective ICT systems and modifying programs to enable information to be recorded.

Several participants² commented on the costs of monitoring outcomes. But others noted that improvements to data were ‘essential for the effective delivery of services to clients’ (Rory Patterson, sub. DR278, p. 31). And the Defence Force Welfare Association said:

There is no doubt that there are overheads in collecting statistics and that, unless carefully considered, the information put together may not be effective measures. This should however, not stop attempts to define what success would look like when committing funds to Veteran support. (sub. 118, p. 34)

Some cost minimisation strategies include leveraging existing data collection processes and reviewing data collection processes to ensure they are streamlined and effort is not duplicated. While outcomes measurement is the ‘gold standard’, in light of the costs and challenges of collecting these data, ‘second-best’ metrics, such as measures of outputs that proxy outcomes (combined with appropriate caveats) and used in concert with other means, can be useful alternatives.

DVA could also draw on the experiences of other organisations when it is developing and implementing outcomes measures. For example, DVA could consider the use of patient-reported measures in its healthcare services. Patient-reported outcome measures and patient-reported experience measures are emerging as a useful addition to indicators traditionally used to monitor the performance of healthcare providers. In particular, patient-reported outcome measures, which ask patients about their health and health-related quality of life, have been shown to lead to improved patient–provider communication and improved patient satisfaction (PC 2017c).

Implementing performance and outcomes frameworks is a vital step for DVA to improve data collection, performance reporting and, ultimately, veteran wellbeing. It will also promote transparency and accountability about how the veteran support system has performed in light of the resources invested in it, reveal where weaknesses in the system lie and guide resource allocation.

² Brian McKenzie (sub. DR275), Malcolm Whitney (sub. DR173) and William Kane (sub. DR197).

18.3 Alignment with the design principles

As outlined in chapter 4, the overarching objective of the veteran support system should be to improve the lifetime wellbeing of veterans (and their families), and the Commission is proposing a number of governance changes (including establishing a new VSC) to help achieve this objective.

In the future veteran support system, good data and evidence will be essential to knowing whether the supports veterans and their families receive are improving their wellbeing. Two of the principles that should underpin the future veteran support system rely heavily on the collection and analysis of data.

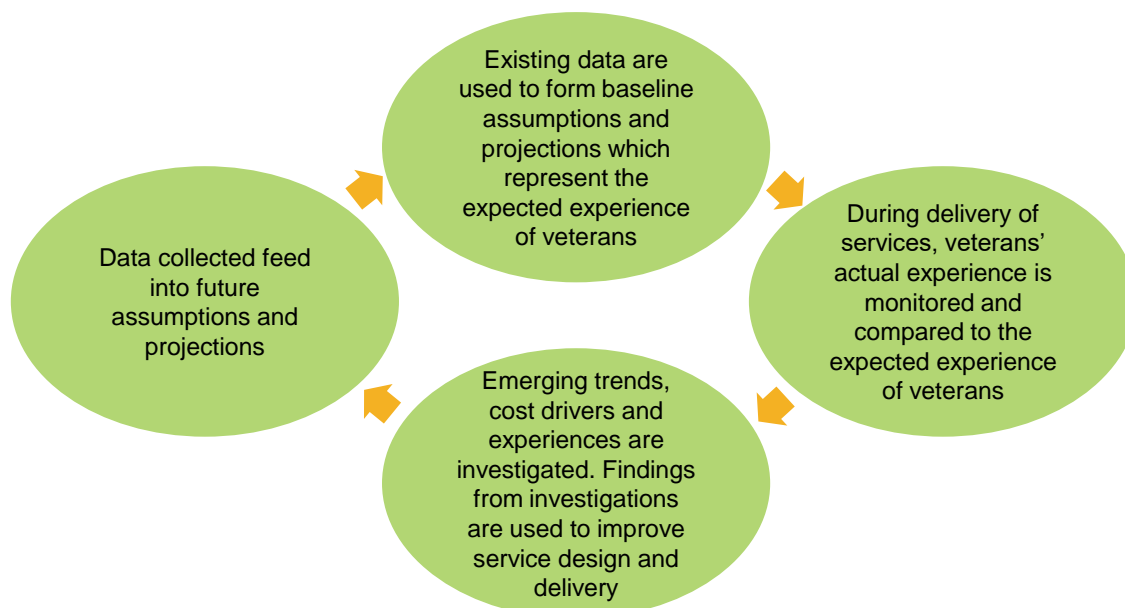
- A financially sustainable and affordable system requires information on costs and outcomes.
- An evidence-based system requires evaluation of the effectiveness of services, interventions and policies, as well as high-quality research.

Data to ensure a financially sustainable system

Good-quality data are needed to estimate the long-term costs of the veteran support system and to understand the cost drivers and emerging risks. As in workers' compensation and social insurance schemes, actuarial modelling will play a key role in monitoring and evaluating the performance of the future veteran support system (actuarial modelling will be needed to ensure that the income the VSC receives from the premium is aligned with scheme costs). This will require data to estimate the annual costs of the scheme over future years (and to estimate liabilities) which will be supported by continuous monitoring and evaluation of clients' outcomes and costs. The cycle involves:

- establishing a baseline by estimating the long-term costs of the system and long-term outcomes of clients (or the 'expected' experience of clients in the system)
- continuously collecting data on the actual experience of clients
- using the data collected to monitor clients' outcomes, identify factors that contribute to the achievement of outcomes and investigate cost drivers
- using the data collected to update the 'expected' experience of clients (figure 18.3).

Figure 18.3 **A monitoring framework for ensuring financial sustainability**



The continual monitoring will mean that any changes in costs and liabilities can be identified early and addressed. And because monitoring ensures that the system is continuously improved, and the cycle is repeated, the approach should become more refined over time as more data are collected on client supports, lifetime costs and outcomes. As EML said, ‘successful schemes aim to continuously improve in order to provide fit-for-purpose services and value for money’ (sub. 90, p. 3).

Building the evidence base

Building the evidence base about what works and does not work (and what is cost effective and what is not) will support the monitoring of progress against the objectives of the scheme, and will help DVA and the VSC to find new and innovative ways to improve outcomes for veterans and their families. It will also improve transparency and accountability (including about the performance of service providers and client outcomes) and give taxpayers confidence that money spent on veterans and their families is money well spent.

The monitoring and evaluation required under the financial sustainability monitoring framework is an important first step in building an evidence base on veteran services and policies. However, investing in research is also important for building the evidence base. Research builds the capacity and capability for innovation, outcomes analysis and evidence-based decisions on policy, services and programs. Disseminating research findings can also help inform services provided by other organisations.

The remainder of this chapter focuses on areas of reform for improving veterans data and building an evidence base. These reforms reflect the escalating data needs of the future veteran support system and should be commenced immediately.

18.4 Making better use of existing data

As noted earlier, a component of the VCR program (chapter 9) is to improve the data analytics capability of DVA. This will include ‘connecting data sources to create a consolidated veteran view and embedding data analytics in the service delivery environment’ (DVA, sub. 125, p. 78). As part of this process, DVA has been working with the Department of Health ‘to develop an integrated DVA–Health dataset and a partnership on analytics work’ (DVA 2018g, p. 88). These are positive steps in the move to link and analyse data to support improvement in the veteran support system.

Linking and analysing existing data

While DVA has taken small steps to link data, it (and veterans and their families) would benefit from much larger strides on linking its datasets to provide a whole-of-client picture. Linking claims data, especially information about injuries and illnesses, to information about an individual’s healthcare use and rehabilitation services would allow DVA to assess how well the services provided to that person are meeting their needs (figure 18.4).

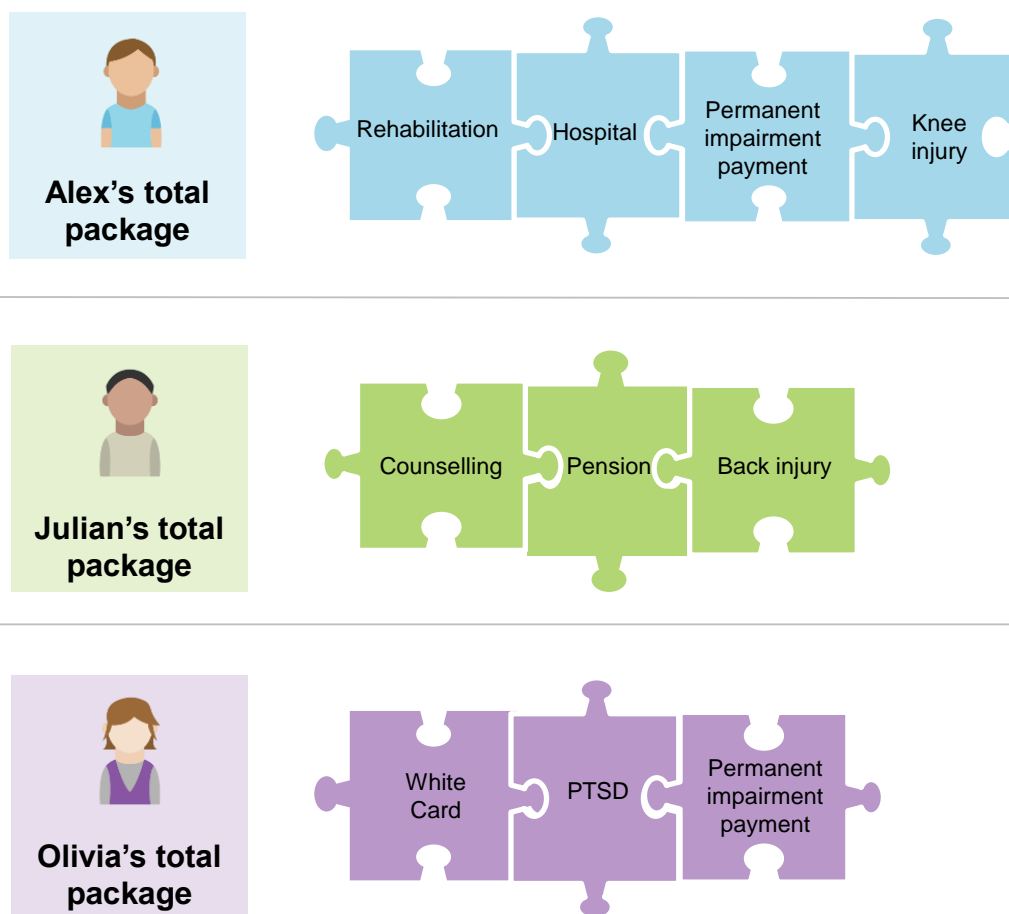
DVA also holds longitudinal data, that is, data about the same individuals over a period of time. These data are highly valuable as they allow for analysis of how a program, or an event, might affect individuals over time. Given veterans’ conditions may take time to manifest, having long-term data on veterans would allow for identification of ‘trigger events’ and could provide insight into why and how certain conditions affect veterans.

... the ability to obtain information about multiple dimensions of the life course as it unravels is invaluable. The longitudinal nature of such data also makes it easier to assign causal ordering to a series of life-course events by allowing analysts to place them in sequence. Finally, longitudinal data pay attention to time and place by allowing the effects of military service to vary across the life course. As indicated earlier, the effects of military service may wane or grow as time passes. Longitudinal data collection will capture these shifts in the relationship between military service and various outcomes at different points in the life course. (Burland and Lundquist 2013, p. 284)

The benefits of longitudinal data were also highlighted in a report from the Transition and Wellbeing Research Programme (section 18.5).

Longitudinal surveillance presents an opportunity to use the data collected to date to examine broader impacts of policy change, interventions and cultural shifts. (Lawrence-Wood et al. 2019, p. 189)

Figure 18.4 Putting the picture together



DVA also needs to consider the publication of data holdings. Releasing data, with appropriate safeguards around what data are released and the use of data, can have many benefits.

- Enhanced transparency of government decisions can incentivise governments to improve governance structures and policy outcomes.
- When data are used to analyse government services and compare similar services, this can help make services more efficient and reduce costs.
- When researchers have access to data, this can stimulate research and facilitate knowledge transfer (PC 2017a).

Building data capability

Initiatives in the VCR program that are focused on improving the data analytics capability of the department are still in the early stages and it is unclear when the projects will allow for linkage and analysis of DVA data.

There are three actions that DVA can take to maximise the success of these projects and build data capability. First, it should incorporate principles for data integration into data linking projects (box 18.3). Adhering to these principles would improve data quality through good data management, including the use of standard definitions and classifications and the maintenance of datasets. It would also help ensure DVA maintains adequate controls over the use of veterans' data in data integration projects.

Box 18.3 High-level principles for data integration

- *Strategic resource.* Responsible agencies should treat data as a strategic resource and design and manage administrative data to support their wider statistical and research use.
- *Custodian's accountability.* Agencies responsible for source data used in statistical data integration remain individually accountable for their security and confidentiality.
- *Integrator's accountability.* A responsible 'integrating authority' will be nominated for each statistical data integration proposal.
- *Public benefit.* Statistical integration should only occur where it provides significant overall benefit to the public.
- *Statistical and research purposes.* Statistical data integration must be used for statistical and research purposes only.
- *Preserving privacy and confidentiality.* Policies and procedures used in data integration must minimise any potential impact on privacy and confidentiality.
- *Transparency.* Statistical data integration will be conducted in an open and accountable way.

Source: Cross Portfolio Statistical Integration Committee (2010).

Second, to enhance the quality and consistency of data collection processes, DVA should develop standard definitions of key terms, and collate those definitions into data dictionaries. Data dictionaries are used to set out data definitions and act as a guide on data. They contain information such as:

- what values the data can take on, such as if values are set or free text
- what values might mean if the data has been coded
- units of measurement
- relationships between different data fields collected in the same dataset
- relationships with other datasets.

In the absence of data dictionaries, data are unlikely to be collected in a consistent and comparable manner. For example, in the data on claims made under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, claims submitted by veterans who have both depression and anxiety were listed in ten different ways, including 'depression anxiety', 'anxiety/depression', 'anxiety & depression' and 'depression and anxiety' (this does not include any variations involving other words such as major, severe or

disorder). Irregularities such as these, particularly when there are many, severely inhibit data analysis, but could be avoided with the use of data dictionaries.

The Commission's inquiry into *Data Availability and Use* noted the importance of setting out data definitions.

Consistent use of standard definitions and units of measurement are necessary to achieve coherence. Information that could assist interpretation include the variables used, the availability of metadata, concepts, classifications, and measures of accuracy. (PC 2017a, pp. 160–161)

It is important to minimise changes to data dictionaries wherever possible to help ensure data recording remains consistent over time, permitting data analysis over these periods. Once data dictionaries are established they should only be updated when there is a clear need to do so, such as to take into account changes in policy or legislation. Changes should be made in batches rather than changing one component at a time and should be scheduled so that data users and collectors have clarity about what data is comparable to what and what data should be collected.

The third component to improving DVA's data capability is to build the capacity of its staff to make the most of data. Data dictionaries will assist in this regard, as using data dictionaries in staff training will provide a guide to data collectors in what data should be entered into systems. Data dictionaries should also be made available to staff members who wish to analyse the data, and have permission to do so, to ensure staff have complete understanding of what information is being recorded in the data. Retaining the skilled staff involved in current improvement projects will also be essential (chapter 9).

Another way to build the capacity of DVA staff is to leverage the knowledge of other organisations. Partnerships with organisations such as the ABS, AIHW and universities could play an important role in developing data analytics capability. Similarly, other workers' compensation schemes and the National Disability Insurance Agency have expertise in actuarial modelling that could be relevant to the future veteran support system.

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.

18.5 Action is required to improve evidence

As the government agency responsible for the veteran support system, DVA's role does not end once services are designed and delivered — it should also be looking for ways to continually improve services and policies and guard against poor outcomes. In the veteran support system, this means building an evidence base on what works and does not work to improve the wellbeing of veterans and their families. This can be done by:

- undertaking high-quality policy trials, reviews and evaluations
- taking a strategic approach to research.

Policy trials

Reforms can be costly and time consuming, and testing policies prior to system-wide implementation is important. Testing can be in the form of policy trials which can be used to minimise costs, reduce wasted efforts and smooth transition to new policy. Policy trials allow the testing of ideas, including simultaneous testing of variations of a program, such as different contract structures or delivery models at different trial sites.

Policy trials need a sound methodology, as this helps ensure results can be used to form evidence-based policy. A range of methodologies can be used in policy trials, and the most appropriate methodology depends on the policy topic and when the trial is being designed (whether it is an ex-ante or ex-post assessment of a policy). However, there are common features of all good trial methodologies (box 18.4).

DVA is currently conducting and funding trials that have a sound methodology. For example, DVA funds the Rapid Exposure Supporting Trauma Recovery trial which is testing whether intensive treatment for post-traumatic stress disorder (daily sessions for two weeks) is as effective as the standard form of treatment (one session a week for 10 weeks). The trial is currently recruiting volunteers from across Australia. Although this trial is still in the early stages, it already contains a number of good features of trial methodologies including a clearly outlined theory and counterfactual (Phoenix Australia 2018).

However, not all DVA trials are founded in a robust methodology. For example, DVA recently conducted a trial of methods for increasing awareness of the services and programs available to veterans and their families. The trial involved placing information about DVA services in Australia Post stores. But it was conducted for a very limited period — two trial sites opened in April 2018 and one site opened in December 2017 with the pilot ending in June 2018 (Chester 2018b; DVA 2018a). A longer trial would have been more in keeping with the good trial methodologies shown in box 18.4.

Box 18.4 **Features of good policy trials**

Well-designed policy trials have the following features. They:

- *are designed to test a theory* — about why the policy will be effective in meeting the needs of the service users
- *capture baseline data* — taking stock of the current situation before a policy is implemented allows for analysis of the impact of the policy over time
- *clearly specify a counterfactual* — what would have happened in the absence of the policy. A trial needs to have a counterfactual so the effects of the policy can be compared to the counterfactual
- *consider direct and indirect effects* — although a policy is designed for a particular purpose, there might be wide-ranging and unintended effects. A trial needs to consider both direct and indirect effects, and quantify both where possible
- *are conducted at an appropriate time* — trials should take into account that effects of a policy may take time to appear. But, there is also concern that at times a trial report may take too long to be developed to add any input into policy development. People undertaking trials need to strike a balance in the timing of undertaking and delivering trial results
- *set out uncertainties* — be aware of and take steps to control for any influences on outcomes where possible
- *are designed to avoid errors* — trials need to take steps to reduce the risk of biases. Examples of where bias may come from include:
 - self-selection. If trial participants choose whether or not to be involved in the trial, this can skew results
 - attrition. There are a range of reasons why individuals could drop out of a trial. If they drop out due to a particular effect of the policy, not capturing their information would bias results
- *include sensitivity tests* — to take into account factors that may influence results, testing should be made on these factors where possible to determine the effect they have on conclusions
- *incorporate learnings* — findings from the trial are incorporated into policy development. Feedback mechanisms could also be built into the trial
- *can be tested and replicated by third parties* — any data from the trial should be made available (with appropriate safety precautions in place) so that others may test results to determine the robustness of the analysis.

Sources: ANAO (2018c); Banks (2009); Hallsworth et al. (2011).

Reviews and evaluations

Reviews and evaluations are a key part of a financially sustainable and affordable system because they identify any issues within processes or programs and generate evidence about what works, for who and in what circumstances. Reviews and evaluations can be conducted for many different purposes. For example, one-off reviews may be carried out when responding to an identified or emerging problem with a service. Evaluations are often planned well in advance, during the design of a program or service, in order to test its effects.

Both reviews and evaluations can also be embedded within a framework for constant improvement and can assist in proactively identifying issues.

It is crucial that high-quality evaluation of programs and services are conducted so that DVA can build an evidence base to inform policy development, improve planning decisions and help DVA and the VSC provide more targeted and effective services for veterans, including for those who do not currently have contact with the veteran support system (box 18.5).

Inquiry participants recognised the importance of increasing the frequency of evaluation to build an evidence base to design future services. For example, the National Mental Health Commission said that independent evaluation of suicide prevention and self-harm services within the ADF and DVA should be routinely conducted and used to inform further service development (chapter 17) and that:

Any new program to reduce the incidence of suicide and self-harm in the ADF or DVA, including services commissioned through ESOs, must be evidence based and have a clearly defined program of evaluation before the program commences. (NMHC 2017b, pp. 53–54)

Similar to policy trials, reviews and evaluations require a sound methodology so that findings can be used to build a robust evidence base. And because reviews and evaluations can be costly, the methodology of (and subsequently the resources devoted to) reviews and evaluations should reflect the size, complexity and other characteristics of the services or programs being assessed (box 18.6).

Regardless of whether they are identified through monitoring or reviews, potential improvements to services will only improve outcomes for veterans if they are implemented. An effective veteran support system would incorporate a learning system — findings from evaluations and reviews should inform changes to system planning and program design. This means not only should DVA disseminate the lessons from evaluations and reviews within the organisation, it should publish evaluations and learnings to increase uptake of research on veterans' wellbeing throughout the veteran community.

Reviews and evaluations should identify problems and consider if the solutions lie in direct service reforms or broader system reforms. Importantly, reviews should identify means of 'checking' (such as types of data or information to collect) that the reforms are progressing as intended towards their objective, and that unintended consequences are not emerging. Ultimately, the financial sustainability monitoring framework is a continuous cycle, as the trends identified when comparing veterans' expected experience to actual experience can trigger further changes to the design and delivery of a service.

Box 18.5 **What about the veterans not known to DVA?**

The total number of veterans is not known. To address this gap, several inquiry participants (including the Alliance of Defence Service Organisations (sub. 85), Rod Murray (sub. DR189), RSL NSW (sub. 151), Robert Shortridge (sub. 76) and the Veterans' Advisory Council and the Veterans' Health Advisory Council South Australia (sub. 96)) suggested that a question related to military service should be included in the *Census of Population and Housing*.

In its submission to the review of Census topics, DVA described a number of potential benefits of including a question related to military service on the Census. A question on the Census could:

- provide a better estimate of the number of veterans in Australia
- help DVA to understand the changes in the veteran population over time
- provide information on the location and age distribution of veterans, to better target services
- overcome many of the issues that make other data sources incomplete (excluding particular categories of veterans, for example) or unreliable (because the data were collected many years ago or only include small sample sizes).

Census results could also be used to compare some aspects of the wellbeing of the veteran population to the broader Australian population (although the Census does not collect data on all the domains of wellbeing, so this would provide only a partial picture).

Adding a question to the Census is also costly. Some of the costs include:

- increasing the time taken for the Australian population to complete the Census
- increasing Census processing time and costs
- displacing another question from being included on the Census. For example, the current review of Census questions is assessing whether questions on long-term health conditions should be included in the Census. (While not veteran-specific, such a question could provide more insight into the needs of veterans with long-term health conditions and help facilitate the provision of targeted services that meet their needs.)

And these costs presuppose that it is possible to add a question to the Census. However, as the ABS noted, 'there is a limit to the number and type of questions that can be reasonably asked through a Census due to the burden on respondents in answering questions and the cost of collecting and analysing the information collected' (ABS 2018a).

One of the arguments put by DVA was that Census information will help it provide more targeted and effective support strategies for veterans. However, as noted earlier, the effectiveness of many DVA services is not known and this is a more significant impediment to the design and delivery of effective support strategies for veterans (whether or not they are currently known to DVA) than information on the total number of veterans.

It is also unclear why the community should pay for information to be collected in the Census, when much of that information was collected by Defence throughout veterans' military service and should already be available in Defence data holdings.

Taken together, these factors suggest that the rationale for adding a question on veterans to the Census is far from clear. A better strategy would be for DVA to focus on improving the evaluation of its services. Not only will evaluating current DVA services help veterans known to DVA by improving those services, it will also put DVA in a stronger position to help the veterans not currently known to it.

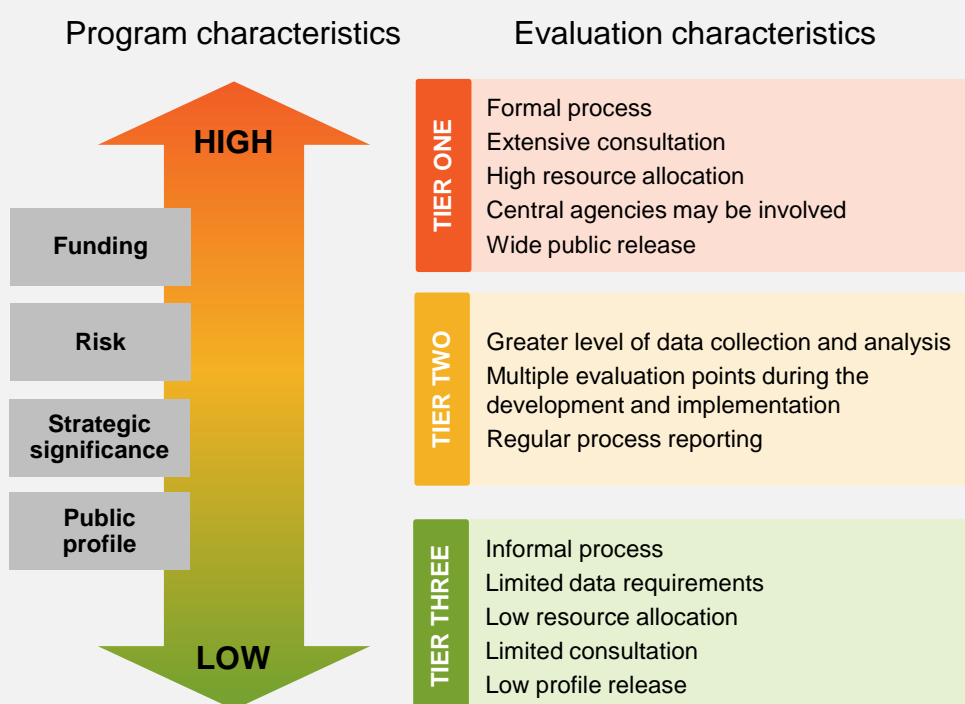
Sources: ABS (2018a, 2018c) and DVA (2018am).

Box 18.6 A strategic approach to evaluation

The decision to conduct an evaluation should be made strategically because evaluations involve costs, and these costs can be substantial.

There should be a deliberate and strategic decision about what the evaluation is intended to assess. The evaluation should seek to measure the impact of an intervention (or set of interventions) on a specific outcome (not just describe the program or intervention).

Decision makers should also consider the manner in which evaluation is to be undertaken. The evaluation method chosen should be appropriate to the particulars of a given program — a ‘one size fits all’ approach will not be as effective as a more tailored approach. One promising way to select the most appropriate evaluation method is to use a tiered approach. For example, the Department of Industry, Innovation and Science (2017) has developed a tiered approach to program evaluation which ranks programs based on their level of funding, risk, strategic significance and their public profile.



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.

Taking a strategic approach to research

Research priorities and a research plan

Some worthwhile research is underway ...

DVA has a number of research initiatives that are building the evidence base about veterans' needs and outcomes. They include:

- a partnership with the AIHW (box 18.1) to develop a comprehensive profile of the health and welfare of Australia's ex-serving population and to report annually on the incidence of suicide among serving and ex-serving ADF personnel (AIHW 2017c)
- the veterans' medicines advice and therapeutics education services (Veterans' MATES) program. This program uses data from the Repatriation Pharmaceutical Benefits Scheme to identify and address common medication-related problems among veterans and war widows, and has led to successful interventions that have improved veteran health and reduced costs by lowering hospital admissions (chapter 16)
- the Transition and Wellbeing Research Programme (box 18.7).

DVA also funds a number of other research organisations. For example, it provided \$1.3 million in 2016-17 to Phoenix Australia (the Centre for Posttraumatic Mental Health) (Phoenix Australia 2017, p. 30). Phoenix Australia conducts research, provides education and training and publishes evidence-based treatment guidelines for post-traumatic stress disorder. The Government also funded Phoenix Australia to establish the Centenary of Anzac Centre, which is intended to bring together research on treatment for veterans' mental health problems and provide expert guidance and support for practitioners working with veterans with mental health problems.

Box 18.7 **Transition and Wellbeing Research Programme**

The Transition and Wellbeing Research Programme (TWRP) is a joint initiative by the Departments of Veterans' Affairs (DVA) and Defence to examine the health and wellbeing of Australian Defence Force (ADF) personnel, ex-personnel and their families. Describing the TWRP, DVA said:

Almost \$6 million has been invested over five years by DVA and Defence to conduct research through the Transition and Wellbeing Research Programme to continue to develop a better understanding of individual veterans' needs, particularly around mental health. This is the largest and most comprehensive study undertaken in Australia on the impact of contemporary military service on the mental, physical and social health of serving and ex-serving military members and their families. (sub. 125, p. 37)

Most TWRP results were obtained in the second half of 2015, primarily from surveys and interviews of ADF members who transitioned from the regular ADF between 2010 and 2014 (transitioned ADF) and from a random sample of regular members of the ADF. Some results also come from a survey of family members nominated by ADF members. Comparisons to the Australian community were made using a matched sample from the National Health Survey, which was conducted by the ABS in 2014-15.

The response rate for the study was low, particularly among transitioned ADF and Other Ranks (that is, ADF members who were not officers). While results were weighted to account for low responses rates from these groups, in several cases response rates were so low that it may affect the reliability of TWRP results.

The TWRP will lead to the publication of eight reports and two papers — seven reports were released over the course of 2018 and 2019.

- The *Mental Health Prevalence* report investigated the twelve-month and lifetime prevalence of mental illnesses in a sample of transitioned ADF personnel.
- The *Pathways to Care* report looked at the use of mental health services by transitioned ADF personnel. This included the services used, barriers to care and perception of services.
- The *Family Wellbeing Study* reported on the experiences of families of serving and transitioned ADF personnel, in particular the physical, mental and social wellbeing of families.
- The *Technology Use and Wellbeing Report* looked at the use of technology by serving and transitioned personnel and how this may help in the delivery of future services.
- The *Mental health changes over time: a longitudinal perspective report* was a longitudinal study of the mental health of a sample of ADF personnel. It assessed the relationship between potential predictors of mental ill-health and mental health over time.
- The *Impact of Combat Report* looked at the mental health of ADF personnel before deployment, immediately after deployment and a number of years after deployment.

The remaining three outputs will:

- look at the health and wellbeing of reservists
- examine the psychosocial predictors of health
- summarise the key findings from the TWRP.

Source: DVA (2018as).

... but a more considered approach to veteran research is required

There remain many gaps in research on issues affecting veterans (section 18.1) and little research that takes a whole-of-life perspective by spanning the four life stages of military personnel (recruitment, in-service, transition and ex-service). To address these gaps and provide strategic direction to future research efforts, DVA and Defence should work together to set priorities for veteran research.

The research should be focused on finding out what works best, for who, and when (in what circumstances). The research should not only establish best practices, but also determine how to turn best practice into common practice in the veteran support system.

Defence and DVA should develop the research priorities in consultation with both the VSC and the RMA. The VSC will be well placed to identify gaps in the evidence base because of the key role it will place on collecting and analysing data about veterans and their supports. Consulting the RMA will help drive high-quality epidemiological research into medical causality that the RMA relies on for its role.

Research priorities are used in other sectors to assist with allocating research funding. For example, in housing, national research priorities guide the research program administered by the government-funded Australian Housing and Urban Research Institute.

International research on issues affecting veterans covers a broad and diverse set of topics and this research could also be used to inform the research priorities (box 18.8). However, as issues affecting overseas veterans are not necessarily the same as in Australia, given the different social and institutional settings, research priorities developed by DVA and Defence need to reflect the needs of Australian veterans.

Box 18.8 **International research on issues affecting veterans**

The United States

For over 90 years, the US Department of Veterans Affairs has run a research and development program into issues affecting the health and wellbeing of veterans. There are four research divisions within the program: biomedical laboratory, clinical science, health services and rehabilitation. High-priority research areas currently include chronic disease, homelessness, Iraq and Afghanistan veterans, mental health, pain management, precision medicine, women's health, and prosthetics and amputation (VA 2017).

RAND is a think tank that undertakes research on issues affecting veterans and serving personnel. It is an international research organisation, but has done extensive research on US veterans, particularly on veterans' health, employment, education and on military caregivers (RAND 2019).

Canada

Veterans Affairs Canada established a Research Directorate in 2001, with the aim of supporting decision makers by providing evidence related to veteran health and wellbeing. Its primary activities include conducting and funding research into veteran health, building partnerships which enable research and monitoring of veteran health, interpreting and monitoring veteran health issues, providing methodological expertise and transferring and exchanging knowledge both within Veterans Affairs Canada and with other parties. Recent publications include analysis of income for veterans after transition from military to civilian life, a suicide mortality study and a profile of personnel deployed to Afghanistan (VAC 2018).

The United Kingdom

Military research in the United Kingdom is primarily undertaken by non-government organisations.

- The King's Centre for Military Health Research describes itself as a centre of excellence for military health research. The objectives of the Centre relate to three main areas: war and health; war and psychiatry; and personnel issues and social policy (King's College London 2019).
- The Forces in Mind Trust is a charity that aims to build the evidence base on veterans which can be used for policy development. The Trust has six areas of interest on which it funds research projects — housing, employment, health and wellbeing, finance, criminal justice system and relationships (FiMT 2017).

To formalise the national priorities for veteran research, a research plan should be developed and published. The plan would provide a formal platform for embedding evidence into future planning and policy direction and identify priority areas for generating further knowledge in a systematic and coordinated way. The plan could also be used to communicate research findings to other organisations that provide services to veterans.

The research plan should also set out how data collected through research will be managed, and what data held by Defence and DVA will be shared with universities and other institutions for research. (One of the ways the risks around sharing data with external researchers can be managed is to use the 'five safes' approach, which focuses on providing

data to trusted researchers in safe settings and protecting the privacy of individuals (PC 2017a).)

Other important features of a research plan are:

- consulting with veterans and researchers on potential research priorities
- setting long-term goals and priorities for veteran research
- establishing timeframes for research completion and publication
- focusing on action that will result in research deliverables and new knowledge, rather than statements of vision, mission, objectives or principles (and certainly not all four)
- frameworks for routinely releasing information held by Defence and DVA to external researchers.

The research plan should be updated annually to reflect the research activities undertaken under the priorities and insights from the research conducted over the year. It is important to have a transparent system for monitoring research progress.

In addition to annual updates of the research plan, the research priorities should be reviewed periodically, perhaps every three to five years, to ensure they are still relevant to the strategic direction of the veteran support system. This will provide adequate time to undertake research under each priority and for findings to be communicated, but also for the research priorities to remain relevant for veterans' policy.

The Commission understands that DVA is developing a strategic research framework. While publishing a framework is a positive step in addressing gaps in veteran research, it would be a complement to, rather than a replacement for, a veteran research plan.

- Frameworks typically take a high-level perspective and set out visions that are underpinned by a set of principles to help achieve a vision.
- Frameworks may set out steps for implementing the framework, but they rarely provide details or have time frames attached to them.

Research plans, on the other hand, provide detail on how to close evidence gaps (including identifying what is currently missing and detail action plans on how to address the gaps) and timelines for action as well as progress measures.

For example, the Queensland Department of Education has in place an evidence framework which sets out principles that the department uses to evaluate whether research is good quality. The department has another document with priority research themes. These themes align with the strategic direction of the department. Each theme also has priority research questions that are directly related to policy development. External researchers can use these questions to consider potential projects that will be funded by the department (Queensland Government 2017, 2018c, 2018d).

Another example is New Zealand's *Veterans Rehabilitation Strategy 2018–2021*. This is a high level document that sets out 'themes' that should underpin the future rehabilitation system (VANZ 2018a). New Zealand also has a companion rehabilitation *Work Plan* which sets out actions, timelines and measures of success (VANZ 2018d).

The funding of veteran research also needs to be considered when developing the veteran research plan. If the veteran research plan outlines a more ambitious research agenda designed to underpin broader improvements to the veteran support system, Defence and DVA will need to ensure that the resources devoted to research are sufficient for those benefits to be realised.

The Commission understands that DVA's Applied Research Program currently has a budget of just under \$4 million per year. This equates to less than 0.03 per cent of the DVA budget being dedicated to research on all aspects of the health and wellbeing of veterans and their families. To put this in perspective, the Australian War Memorial has about \$7.6 million a year (or 12 per cent of its budget) to spend on 'research and information dissemination of knowledge and understanding of Australia's military history' (DoD 2019f, p. 95). This suggests that there may scope to, and benefit from, devoting a larger share of DVA's budget to research.

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.

Building research capability within DVA

The veteran research plan would set out a pathway for the development of high-quality research that would address current gaps in the evidence base. An external advisory group could help facilitate this outcome in the short term and build long-term research capacity.

The Commission recommends that DVA and Defence establish an Expert Committee on Veteran Research, made up of professionals with experience undertaking multidisciplinary applied research across government, academia and the private sector. Seeking advice on veteran research from a diverse range of experts would help ensure that there is input from a range of perspectives and disciplines and that a broad view is taken when developing research priorities. The committee could also provide up-to-date insights from all of the research fields that affect veterans' wellbeing.

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

- providing input into the development of the research priorities and the veteran research plan

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- monitoring the outcomes of the veteran research plan
 - promoting the use of research in the veteran support system
 - ensuring DVA and Defence publicly report on the research outcomes and progress towards the goals outlined in the veteran research plan.

The Committee should be made up of a small number of members with extensive expertise in their fields. It is essential that members are appointed on the basis of their skills and experience, not as representatives of any organisation.

The research priorities and plan should take a whole-of-life perspective and build evidence on what improves veterans' wellbeing; this covers the four life stages of military personnel and also the domains of wellbeing set out in chapter 4 and this covers many different fields. Collectively, the members of the Committee should have skills and experience in the areas of:

- the military and veterans' affairs
- injury and illness prevention, including work health and safety
- mental and physical health care
- rehabilitation
- education and employment
- other compensation systems and social insurance schemes.

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.

19 Bringing it all together

Key points

- To simplify the veterans' compensation and rehabilitation legislation, the Commission is proposing a 'two-scheme' approach.
 - Scheme 1 is based on the *Veterans' Entitlements Act 1986* (VEA), and will continue to provide benefits to older veterans (and their families) who are currently receiving benefits under the VEA. Younger veterans covered by the VEA will be offered a one-off choice to switch their benefits to scheme 2.
 - Scheme 2 is based on a modified *Military Rehabilitation and Compensation Act 2004* (MRCA). It will provide benefits for veterans (and their families) who are not covered by scheme 1, including:
 - ... those with current MRCA or *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) benefits
 - ... those without a current or accepted claim (including under the VEA) at the commencement of the two-scheme approach.
 - Veterans currently receiving benefits under multiple Acts will be placed under the scheme that best reflects their current range of benefits. Where this is unclear, they will be offered a choice about which scheme they are placed under.
 - Dependants of veterans will receive benefits under the same scheme as the veteran.
- A two-scheme approach will reduce confusion around eligibility and minimise/remove the need for offsetting, and it will effectively abolish the DRCA. However it is not a panacea for the issues facing the veteran support system — the system will remain complex to some extent and moving to one Act is not possible at this stage.
- Families of veterans may face challenges that stem from the veteran's military service. The Family Support Package should be expanded to provide more support to more families.
- It is important that the reforms are rolled out over time so veterans and other stakeholders can adjust to the changes, and so the Veteran Centric Reform process is not interrupted. That said, it is also essential that the proposed new veteran support system is fully implemented and operationalised within a reasonable period.
 - Simplifying payments, improving claims processes, and undertaking reforms in the areas of rehabilitation, transition and data and evidence will cause minimal disruption and should be undertaken as soon as practicable.
 - The governance changes and the two-scheme approach are more fundamental and should be implemented in the medium to long term (with all recommendations implemented by 1 July 2025).
- All the proposed reforms seek to place an increased focus on the wellbeing of veterans and their families, and will result in a simpler, fairer and more accessible system of support.

The recommendations set out in this report are designed to transform the veteran support system so it is better suited to meeting the needs of veterans and improving their lives. This chapter sets out the long-term pathway for implementing the recommendations. Section 19.1 outlines in detail the Commission's two-scheme approach to simplify the legislation. A detailed timetable for reform is set out in section 19.3 and the benefits of a modern system of veteran support are discussed in section 19.4.

Supports for families of veterans are mentioned in various chapters throughout this report. Section 19.2 documents the supports available to families and looks at reform options.

19.1 Addressing legislative complexity

As discussed in chapter 1, one of the key drivers of this inquiry was the legislative complexity that arises from multiple Acts for veteran support. There are up to six different pieces of legislation covering the veteran support system. These include:

- the three main veterans' support Acts
- two older pieces of Commonwealth workers' compensation legislation that are included in the *Safety, Rehabilitation and Compensation Act (Defence-related Claims) Act 1988* (DRCA) through transitional arrangements
- the *Defence Act 1903* that supplements some DRCA claims.

Other compensation systems, including the generally available welfare system and superannuation invalidity pensions, operate alongside this framework. When recommending that the Productivity Commission undertake this inquiry, the Senate inquiry into veterans' suicide said:

The committee considers that a system which is as complex and challenging to navigate as the current arrangements will compromise any efforts to make claim processes 'veteran centric'. (SFADTRC 2017, p. 68)

Earlier chapters have made recommendations designed to simplify the legislation. This section looks at broad approaches to legislative reform, and sets out an indicative timeline for legislative reform.

Why is the veteran support system so complex?

Multiple and overlapping Acts

Several decisions led to the complex array of overlapping Acts that is in place today. As discussed in chapter 3, notable decisions included:

- the 1973 decision to allow veterans injured in peacetime service access to the repatriation Acts, while continuing to allow them to make claims under the Commonwealth workers' compensation legislation

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- the 1994 decision to close off dual eligibility for veterans injured in peacetime service and open it up for those with operational service — allowing them to claim under either the *Veterans' Entitlements Act 1986* (VEA) or the then *Safety, Rehabilitation and Compensation Act 1988* (SRCA)
 - the introduction of the *Military Rehabilitation and Compensation Act 2004* (MRCA). A decision was made, based on the recommendations of the Tanzer Review (Tanzer 1999), to base eligibility under this Act on the timing of the service the impairment was related to, rather than the time of enlistment, or close off new claims under the old Acts.

These changes were made with the intention of moving towards a new system of support and improving equity between veterans. But priority was given to ensuring that veterans' existing entitlements were not affected. For example, in the context of closing off the existing VEA and SRCA schemes at the time the MRCA was introduced, the Tanzer Review stated:

Although the new scheme incorporates the best features of the SRCA, and relevant aspects of the VEA, there will be some people, depending on their age and other circumstances, who will feel disadvantaged if at the time they claim they no longer have dual entitlement. (1999, p. 79)

The net effect of these decisions is that veterans can be eligible for compensation under multiple Acts, whether for the same impairment or different impairments over time (chapter 3). Over 30 000 veterans have had liability accepted under more than one of the three main Acts (chapter 3). And this understates the true extent of the problem — many of the veterans who have only submitted claims under one Act would have been eligible to lodge a claim under one of the other Acts at some point, which can lead to confusion in itself. Furthermore, as noted by the NSW Returned and Services League (RSL), this is expected to become more of a problem:

[The three Acts] makes the system for veterans' compensation intimidating and stressful for veterans to navigate. Under this complex system, veterans can seem to be effectively rewarded or punished for the timing of their service. As individuals with service covering all three Acts begin to reach their 60s and come out of the shadows, the complexity of claims will continue to increase. (sub. 151, p. 4)

One of the consequences is the need for the offsetting of compensation between Acts, to ensure that veterans are not being over or under compensated. For example, if a veteran has a claim accepted under the VEA, and later lodges a claim for the same impairment under the DRCA, the veteran's VEA compensation will be reduced (or offset). The Department of Veterans' Affairs (DVA) noted that 'the clearest manifestation of complexity from having three Acts is that veterans can have eligibility under more than one Act, requiring offsetting of compensation payments for the same incapacity or death' (sub. 125, p. vii).

Offsetting creates confusion for veterans — the Commonwealth Ombudsman said offsetting was one of its largest areas of complaints (sub. 62, p. 5). The Defence Force Welfare Association noted:

... another set of policies and processes had to be developed to cater for the complexities introduced when a veteran's incapacity spanned 2 or 3 Acts. This area remains a mystery to

veterans and advocates as applicable policies and processes are not available to them. There are probably still more complexities being discovered. (sub. 118, pp. 42–3)

Offsetting can also lead to errors in estimating compensation, and this can have serious financial consequences for the veteran. For example, the Australian Veterans' Alliance (sub. 81) noted that offsetting can often result in overpayments, with tax implications for the veteran when they are required to repay the payments.

Multiple Acts can cause inequities between groups of veterans — with different veterans receiving different levels of compensation for the same impairment. This was brought to light in the Black Hawk Helicopter crash in 1996, where the compensation available for veterans who were severely impaired, or dependants of deceased veterans, varied depending on whether they were covered by the VEA or the SRCA (or both).

These differences remain — compensation is heavily dependent on whether the veteran is eligible under the MRCA, DRCA or VEA (chapter 13). DVA noted that 'there can also be different outcomes for veterans who are in similar circumstances, depending on their eligibility under the different Acts, and the order in which claims are made' (sub. 125, p. vii).

Ultimately, the multiple Acts create confusion for veterans about which Act they should claim under, and what they are entitled to. As Olivia Pursey put it:

... determining which Act to claim under and the exact expectations of how the veteran should go about applying for compensation can be a daunting, even insurmountable, first challenge to the majority of veterans who are attempting to claim entitlements without legal advice, especially in circumstances where they suffer more than one injury, served in different conflicts and were deployed at home and overseas (these cases are not rare). (sub. 51, p. 2)

The complexity of individual Acts

While much of the focus of legislative reform is on the multiple Acts, the individual Acts are also complex. The Acts feature numerous payments, over and above what is usually provided by workers' compensation schemes. The eligibility for compensation and rehabilitation can vary depending on whether the impairment was suffered during operational service or not. The net result is that it can be unclear to veterans exactly what they are entitled to.

The complexity of the individual Acts is not the focus of the discussion below — the Commission has made recommendations throughout the report that will simplify the Acts. That said, even if it was possible to move to one veterans' support Act, some degree of complexity would remain.

The difficulty of legislative reform

This section looks at some of the barriers to reforming the veterans' support legislation.

The first point to make is that legislative reform is not a panacea for the issues ailing the veteran support system. By its nature, workers' compensation and support is a complex area, so while it is possible to simplify the system, it will remain complex to some extent. The largest gains from reform are likely to come from improving the governance structures and claims processes, rather than legislative reform. RSL NSW, while noting the benefits from simpler legislative arrangements, agreed it was not the highest priority.

There are clear, strong arguments for some level of legislative simplification. Merging the three Acts would be ideal and would greatly improve the well-being of veterans as well as claims advisors and advocates. However, RSL NSW believes there are significantly higher priorities for reform than legislative merging, especially considering the gargantuan task this may present. (sub. 151, p. 6)

That said, many participants called for simpler legislative arrangements and some called for a single veterans' support Act. For example:

Commence the process to merge the three pieces of legislation (VEA, DRCA and MRCA) to create a single Act, like the NZ Veterans' Support Act 2014 ... This is not only 'the right thing to do', it will simplify the claims and advocacy environment and decrease dependence on the letter of the law and place more emphasis on natural justice. (The Oasis Townsville, sub. 92, p. 1)

Legislation in a consolidated, omnibus form would simplify administration and enable the best elements and most beneficial aspects of existing Acts to be combined, while eliminating the inconsistencies and anomalies of the current range of veteran legislation. (VVFA, sub. 34, p. 18)

The Acts can be vastly different

The MRCA and DRCA are the most similar of the veterans' support Acts — they have similar compensation structures and a focus on rehabilitation. However, there are also many differences between the two, including:

- the amount of compensation
- access to the Gold Card
- the use of the Statements of Principles (SoPs).

But there is scope for some harmonisation between these Acts.

While the MRCA has retained some aspects of the VEA, the VEA is fundamentally different to the other Acts in many other aspects. The VEA offers set-rate pensions to disabled veterans and dependants for life, with no requirement for the veteran to participate in rehabilitation. The MRCA has a greater focus on rehabilitation, and also structures compensation to be more consistent with the loss (both economic and non-economic) faced by the veteran as a result of their impairment.

Some of our recommendations will partially harmonise the VEA and MRCA. However, given the fundamentally different objectives and focuses of the Acts, achieving full

harmonisation between the VEA and MRCA would require a significant change in veteran benefits and would have large financial implications.

Benefits for some veterans would need to change

It is not possible to simplify the veteran compensation legislation without changing the benefits that some veterans would receive (either upwards or downwards) in the future.

Some participants called for one Act that would effectively provide veterans with the most generous benefits of the three Acts, or would not lead to any reduction in benefits for veterans. For example, the Victims of Abuse in the Australian Defence Force Association (sub. 133) stated that all veterans should be covered under the VEA, with a no-disadvantage test. Similarly, Kerry Lampard (sub. DR180), the Royal Australian Armoured Corps Corporation (sub. 29) and the Vietnam Veterans' Federation of Australia (sub. 34) called for a single Act that contains the best or most beneficial provisions of the three Acts.

This type of single Act is not practical (or necessarily desirable). It would likely lead to a large increase in expenditure on veteran compensation. But more fundamentally, it would not lead to a reduction in complexity. Working out which Act is most 'generous' to the veteran is not easy, and depends on the veteran's circumstances, such as their age, other income and welfare payments. Providing veterans with the most generous compensation would require detailed assessments of the benefits available under each Act, either by DVA or the veteran, which would be no simpler than the current situation.

Simplification requires trade-offs, and one of these is that there will be a change in benefits for veterans — in some cases downwards. This needs to be undertaken in a way that is fair and reasonable, both for veterans and the community as a whole.

VEA — well supported, but not suited for future generations

In the future, the MRCA should be the predominant piece of veteran compensation legislation. It is a more modern Act than the VEA, and reflects modern workers' compensation principles, such as a focus on rehabilitation and return to work where possible, rather than simply providing pensions for life. Any legislative simplification should be focused on speeding up the transition to the MRCA.

That said, many veterans, particularly Vietnam veterans, prefer the VEA. For example, the Vietnam Veterans' Association of Australia stated that it is 'opposed to any consolidation or amalgamation of the VEA 1986 and to any amendments to that Act that removed or diluted current benefits under that act' (sub. 78, p. 5). In part, this reflects a familiarity among this group of veterans with the VEA, rather than an assessment of the benefits available to veterans (as noted in chapter 13, the MRCA is often the more beneficial Act) or what will improve the wellbeing of veterans.

A pathway forward

Simplifying the legislation is not straightforward, and there is the risk of unintended consequences (including creating further complexity). Nonetheless, there has been a strong push for simplification following the Senate inquiry into veterans' suicide, and many participants saw simplification as important. And some degree of simplification is possible.

Moving to one Act is not possible at this stage

Moving to one Act covering all veterans is the ultimate objective of simplification. In particular, the MRCA and its focus on rehabilitation is likely to have benefits for many veterans. And eventually, even without simplification, the MRCA is expected to become the sole Act, although this could take many decades. As RSL NSW said:

A veteran of the peacekeeping operation in Somalia in early 1993, for example, could be covered under VEA until the 2060s, and DRCA could be relevant for another decade beyond that. (sub. 151, p. 6)

However, moving to one Act is not possible at this stage. There remain many veterans on the VEA — either with current benefits or likely future claims. And many of these veterans are older, for whom a focus on rehabilitation and return to work is less beneficial. The costs of moving these veterans on to the MRCA is unlikely to outweigh the benefits.

This view was supported by several participants. For example, Hilton Lenard and Keith Russell said that replacing the existing Act, 'with their complex trail of amendments dating back a century, with a single Act, would be an administrative nightmare and definitely a step too far'. Instead, they contended that 'it would be most beneficial to concentrate [on] updating MRCA to improve the efficiency and operation of that Act' (sub. 13, p. 2). Similarly, Peter Sutherland said:

The simple answer is to make 'One New Act'! The real outcome of this simplistic answer would be to worsen the complexity because there would then be six Acts rather than five, and a whole new set of transitional and application provisions. (sub. 108, p. 3)

And the Vietnam Veterans' Association of Australia doubted that 'it would be practical to consolidate the entitlements into one Act' (sub. 78, p. 5).

In the short term, the focus should be on achieving some degree of harmonisation between the Acts.

A two-scheme approach

The Commission sees merit in a two-scheme approach where the majority of older veterans claiming benefits under the VEA remain in a VEA-based scheme (scheme 1) and all other veterans receive support under a modified MRCA-based scheme (scheme 2).

The MRCA and DRCA are similar enough that harmonisation of these Acts is feasible and desirable, and can be achieved within a short period of time. Once harmonisation is achieved, the DRCA could be rolled into the MRCA to create one Act. This would underpin scheme 2 and be the predominant scheme going forward.

For the VEA (scheme 1), the Commission's focus is on retaining the benefits for veterans where moving them to the MRCA is unlikely to be beneficial, while allowing or requiring some veterans to receive benefits under the MRCA-based scheme. Scheme 1 will eventually cease, but not for some time.

Aspects of scheme 1 and 2 would be harmonised where possible, including initial liability, reviews, and many of the smaller compensation payments. The key differences would be in the core compensation payments for impairment, incapacity and dependants (table 19.1).

This approach is similar to that taken in New Zealand following the Law Commission Report in 2010. A group of veterans remained on an older, pension-based scheme, while younger veterans were placed into a more modern scheme. Moving to a system where eligibility is based on the date of service, as in New Zealand, is unlikely to be feasible in Australia given the existing complex eligibility arrangements, but some clarification of eligibility would be needed. This would lead to fewer veterans having dual eligibility or being confused about which scheme they are covered by.

There was support for this approach from some participants. Peter Sutherland said:

In my opinion, a satisfactory solution to this policy dilemma can be achieved by a detailed remake of the overall scheme which focuses on improving outcomes for veterans and consigning the complexity to the back end — the administration of the scheme by DVA. Features of this 'harmonisation' approach are:

- MRCA is recognised as the one new Act and is amended to reduce its complexity and enhance its suitability for harmonisation with the other four Acts (VEA, 1930 Act, 1971 Act, SRCA/DRCA)
- DRCA is brought more and more in line with MRCA over time, and the VEA is harmonised with MRCA where compatible
- Cohorts currently under the VEA and DRCA are moved into MRCA coverage through a combination of measures such as outright transfer, irrevocable election and grandfathering. (sub. 108, p. 3)

The Air Force Association said:

Legal opinion is a single veterans' support Act would be difficult to draft but not impossible. A possible more immediate achievable pathway is to harmonise the three Acts. DRCA would appear to be the easiest to modify. (sub. 93, p. 2)

And many participants supported the two-scheme model.¹

¹ Participants supporting the two-scheme model included — APPVA (sub. DR270); Deborah Morris (sub. DR307), DFWA (sub. DR299), Legacy Australia (sub. DR220), Peter Sutherland (sub. DR192), RSL

What would be included under each scheme?

Scheme 1

Scheme 1 would be based on the current VEA. Most veterans and dependants who are receiving benefits through the VEA will remain eligible under scheme 1. The core benefits received through the VEA will remain largely unaltered.

Given its historical basis, the Commission does not see a lot of scope for reform to the VEA. However, it has made some recommendations to:

- harmonise important aspects of the VEA with the other Acts
- improve the administration of the VEA
- streamline and harmonise some of the small payments available under the VEA.

These changes would not affect the beneficial nature of the VEA, and scheme 1 would retain the lifetime pension focus of the VEA. Benefits would be predominately delivered through disability pensions, including the special rate of disability pension, and war widow(er)s' pensions (figure 19.1). Beneficial access to dependant benefits would remain.

The Act itself is an unnecessarily complex piece of drafting, and there is room for updating the legislation without changing the outcomes for claimants — although the Commission has not made recommendations in this area.

Scheme 2

Scheme 2 would be based on the MRCA. Veterans not eligible under scheme 1 and veterans who took up an opportunity to switch into scheme 2 (discussed later) will claim through scheme 2.

Victorian Branch (sub. DR273), Veterans' Advisory Council SA (sub. DR266), Veterans Support Centre and Belconnen RSL Sub Branch (sub. DR229), VVFA (sub. DR215), War Widows' Guild of Australia (sub. DR278), William Kaine (sub. DR197).

Table 19.1 The two schemes — what would be harmonised?

<i>Area</i>	<i>Harmonised?</i>	<i>Scheme 1</i>	<i>Scheme 2</i>	<i>Relevant recommendations</i>
Initial liability assessment	Mostly	Heads of liability and other liability provisions would be harmonised across the schemes. While a single standard of proof would apply to clients with service after 2004, this would not be the case for pre-2004 clients.		8.1 and 8.4
Reviews and appeals	Yes	A single review process, based on internal reconsideration by DVA in the first instance, followed by alternative dispute resolution by the Veterans' Review Board and merits review by the Administrative Appeals Tribunal.		10.2
Rehabilitation	No	Veterans have voluntary access to the Veterans' Vocational Rehabilitation Scheme.	Veterans would be required to participate in rehabilitation to receive incapacity payments.	
Impairment compensation	No	Veterans can receive general rate disability pensions, with additional pensions for specific disabilities.	Veterans would receive permanent impairment compensation based on the current MRCA approach. A single rate of impairment compensation would be introduced over time.	13.1, 14.1
Income replacement	No	Veterans can receive above general rate pensions, including the special rate of disability pension.	Veterans would receive incapacity payments based on the current MRCA approach. Superannuation contributions would replace the remuneration loading.	13.1, 14.6
Dependant benefits	No	Dependants can have access to the war widows' pension, orphans' pension, income support supplement and bereavement payments. Eligibility remains as under the current VEA.	Dependants would receive wholly dependent partner payments, payments to eligible young people and other dependants based on the MRCA approach. Dependants could have access to the income support supplement and bereavement payments. Dependants of veterans who die from non-service-related causes would not be eligible for compensation.	13.1, 14.8, 14.9
Other allowances	Mostly	Other payments in both schemes include the funeral allowance, education allowance and motor vehicle compensation scheme — these are mostly harmonised across the schemes. Veterans on scheme 2 can also access the Veteran Payment.		14.10, 15.1, 15.2, 15.3, 15.4, 15.6
Health care	Mostly	The Gold Card would be available to severely impaired veterans (excluding those who would have been covered under the DRCA). Access to the White Card and household and attendant care would be based on the MRCA approach.		15.5, 16.4

As a starting point, changes would be made to the MRCA and the DRCA to harmonise the benefits received under these Acts (consistent with the recommendations made throughout this report). Eventually, the DRCA would be rolled into the MRCA to form one Act — the basis of scheme 2. Recommendations to harmonise the two Acts are contained throughout this report.

Combining the MRCA and the DRCA was considered by the 2011 review of the MRCA (Campbell 2011b). However, combining the Acts was not recommended at that time — in large part because of the sizeable potential increases in costs involved in moving current DRCA recipients onto the MRCA. Chapter 13 assesses in detail the costs involved with harmonising the MRCA and the DRCA, but some points are worth making here.






- While there is likely to be an increase in costs involved with the switch, the cost will be lower than it was in 2011 due to the age-based lump sums that apply in the MRCA, and because the group of people claiming under the DRCA are now likely to be older.
- The MRCA Review noted that simplification of the MRCA and DRCA could be achieved in the future — the Commission considers that now is the time.
- The MRCA Review also noted that some people could be made worse off under the MRCA than they would be under the DRCA. This continues to be the case (chapter 13), but some trade-offs need to be made if there is to be a simpler system.
- The MRCA Review suggested that such a change could lead to calls for previous recipients of DRCA benefits to have their compensation reassessed under the MRCA. The Commission sees merit in DRCA compensation recipients moving to the MRCA model of incapacity payments (chapter 13). However, reassessing permanent impairment payments would be complex, and the Commission does not support reassessments of past DRCA claims.

Scheme 2 would retain the beneficial nature of the MRCA, although the Commission has proposed streamlining some of the payments and provisions that reflect the historical nature of the scheme, but have little rationale in modern society — including the MRCA special rate disability pension and eligible young person payments.

Scheme 2 would be a simpler scheme, with compensation based around:

- permanent impairment payments
- incapacity payments
- wholly dependent partner payments and orphans' pensions
- health care, attendant and household service allowances (figure 19.1).

Figure 19.1 Compensation available under the schemes

	Scheme 1	Scheme 2
 Impairment compensation	General rate disability pensions Additional payments for specific disabilities	Permanent impairment payments
 Income replacement	Above general rate disability pensions Superannuation invalidity pensions	Incapacity payments Superannuation invalidity pensions (offset)
 Dependant benefits	Widow(er)'s pension Orphan's pension Funeral allowance Bereavement payment Income support supplement Education allowance (under 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

Who would be covered by what scheme?

The eligibility criteria for each scheme should be revised to avoid the confusion caused by the current injury-based approach to eligibility. The Commission's proposal to change eligibility is based on the following principles:

- veterans should only be eligible to make claims under one scheme — that is, all future claims for each individual veteran would be processed under either scheme 1 or scheme 2
- veterans should not have their current benefits affected, unless they elect to switch their current benefits to the other scheme
- veterans should be placed into the scheme that most reflects the current range of benefits they receive.

Applying these principles would reduce the need for compensation offsetting and confusion among veterans, and speed up the transition towards scheme 2 becoming the predominant scheme. In practice, however, implementation and transitional issues need to be carefully considered.

The simplest way to determine eligibility would be to base it on the Act that the veteran has claims under at the date of the implementation of the two-scheme approach (the implementation date) (table 19.2; figure 19.2).

For veterans with accepted claims under only one Act, the process would be relatively straightforward. Veterans with claims under only the VEA would be placed into scheme 1 for all future claims. Those with accepted claims under only the DRCA or the MRCA would be placed into scheme 2. About 110 000 veterans would be covered by these provisions.

For veterans with claims under the VEA and at least one of the MRCA and the DRCA (about 25 000 veterans), determining which scheme they should be placed under for future claims is more complex. However, for many of these veterans, a straightforward solution is possible.

- Many veterans with accepted claims under multiple Acts are actually only currently receiving payments under one Act. They should be placed on the scheme that relates to the Act they are receiving payments under. This covers about 17 000 veterans.
- The largest differences between the payment structures under the Acts relate to the income replacement for veterans with incapacity for work, and veterans can only receive one source of income replacement. Their future claims should be processed under the scheme that relates to their source of income replacement — scheme 1 for those receiving an above general rate VEA pension (1700 veterans) and scheme 2 for those receiving a DRCA or MRCA incapacity payment, or MRCA special rate disability pension (1100 veterans).

Table 19.2 Eligibility under the two schemes

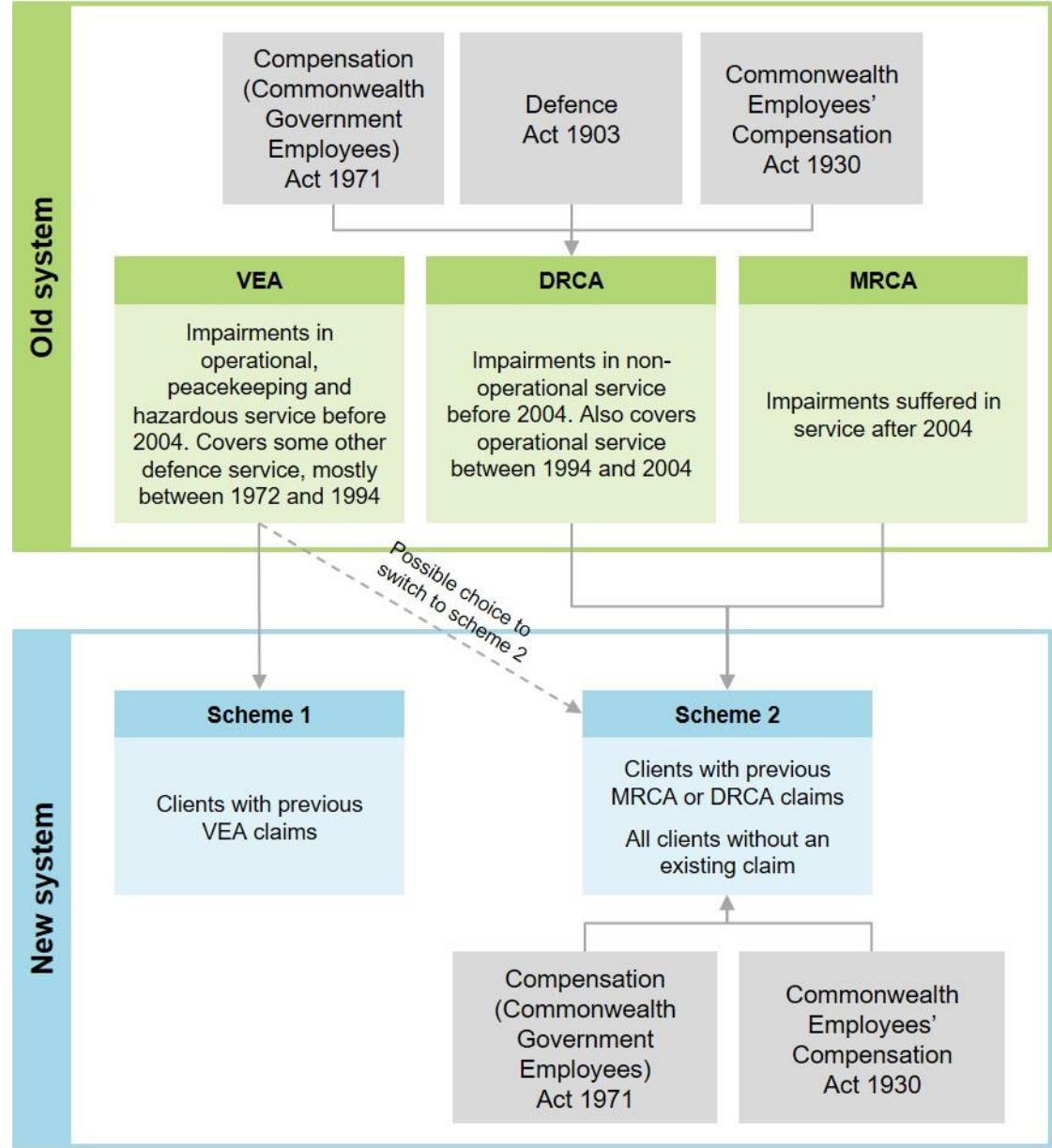
<i>Type of client</i>	<i>Future claims processed under:</i>	<i>Number of veterans who would meet these criteria</i>
Clients who only have VEA claims	Scheme 1 (with option to switch benefits to scheme 2 if under 55 at implementation date)	61 911
Clients who only have DRCA or MRCA claims	Scheme 2	51 761
Clients with VEA and either a MRCA or DRCA claim, but are only receiving a VEA payment	Scheme 1 (with option to switch benefits to scheme 2 if under 55 at implementation date)	16 490
Clients with VEA and either a MRCA or DRCA claim, but are only receiving a MRCA or DRCA payment	Scheme 2	514
Clients receiving both VEA and either a MRCA or DRCA payment, who are on an above general rate disability pension	Scheme 1 (with option to switch benefits to scheme 2 if under 55 at implementation date)	1 683
Clients receiving both VEA and either a MRCA or DRCA payment, who are on an incapacity payment	Scheme 2	1 110
Other clients with VEA and either a MRCA or DRCA claim	Veterans will choose their scheme upon their next claim	5 870
Clients without a claim	Scheme 2	na

na Not available.

Source: Productivity Commission estimates based on unpublished DVA data.

This would leave about 6000 veterans for whom eligibility is unclear. Participants suggested that these veterans should be able to choose which scheme they would be covered under going forward (Deborah Morris, sub. DR307; DFWA, sub. DR299). The Commission agrees that this is the fairest way to determine which scheme the veteran would be covered by. This choice would be made at the time of the veteran’s next claim, and they would be provided with support to help them make this choice.

Figure 19.2 Two schemes — the eligibility



It is important to note that, irrespective of which scheme the veteran is placed on, their current benefits would *not* be affected. For example, there was some concern that veterans could lose their current disability pension and Gold Card if they were placed on to scheme 2 (Michael Andrews, sub. DR183). This would not be the case.

Veterans without a current or accepted claim at the implementation date should be covered under scheme 2 going forward. This would speed up the transition towards scheme 2. There would be one exception to this. As noted by the United Nations and Overseas Policing Association of Australia (sub. DR196), police peacekeepers have access under the VEA, but not under the MRCA or DRCA. That means police peacekeepers who have not yet made a claim would retain their eligibility to make a claim under the VEA if they were previously eligible to do so.

Enough time should be given before the reform is implemented to provide veterans with time to adjust to the new approach. Veterans without an existing claim who wish to be covered by scheme 1 would have the opportunity to submit a VEA claim if they have current eligibility under that Act prior to the implementation date.

A choice to switch schemes for some veterans

As noted earlier, scheme 2 is the scheme better suited for the modern veteran, and it would be desirable to transfer veterans to this scheme where there would be no detriment to the veteran.

There are unlikely to be benefits from switching older veterans to scheme 2. It is expected that these veterans will be better off on the lifetime pension provided by scheme 1, and are unlikely to benefit from the rehabilitation focus of scheme 2. Veterans older than 55 years of age when the change is implemented who have been allocated to scheme 1 should have all their future claims processed under this scheme, with no option to switch.

However, younger veterans *may* be better off with the rehabilitation and income replacement focus of scheme 2. Veterans 55 years of age or younger at the implementation date should be given the option to switch to scheme 2 prior to, or at the time of, their next claim. If they elect to switch, the current benefits they are receiving would be recalculated based on scheme 2, and all future claims would go through scheme 2. They would receive support to help them make this decision, but the decision would be irrevocable.

Most veterans receiving benefits under the VEA will be over 55 at the implementation date. About 4000 veterans receiving a VEA disability pension in December 2017 will be under 55 in 2025, and this is expected to decline over time. Offering financial advice and processing requests to switch schemes for this group should therefore be manageable.

How would dependants be covered?

When a veteran dies, dependants would receive compensation based on the scheme the veteran was covered by. However, there are two cases where this may be unclear.

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- If the veteran has not yet had an accepted claim, their dependants should receive compensation under scheme 2. The quantum of compensation available under scheme 2 is more generous than scheme 1, and these dependants would not be automatically eligible for benefits.
 - If the veteran was entitled to choose which scheme they would be covered by, but had not yet made that choice, that choice would transfer to their dependants upon their death. These dependants are likely to be better off under scheme 2, but in some cases may be better off under scheme 1, and should therefore be given this option.

An exception — the pre-1988 Commonwealth workers' compensation legislation

One difficulty with the two scheme approach is that there are two pre-1988 pieces of Commonwealth legislation — the *Commonwealth Employees Compensation Act 1930* and the *Compensation (Commonwealth Government Employees) Act 1971*. While these Acts have been repealed, transitional provisions mean that veterans with impairments that stabilised prior to 1988 can still receive compensation based on these Acts. About 26 per cent of DRCA permanent impairment claims determined in 2017 were based on injuries that occurred prior to the assent of the SRCA in 1988 (Productivity Commission estimates based on unpublished DVA data).

The compensation received under these Acts is very different in nature to that received under the three veterans' compensation Acts. For example, in the 1971 Act, compensation for permanent impairment is based on a table of maims approach, which only covers a limited number of impairments. Conditions such as mental health and back pain are not included as compensable conditions. The maximum amount of compensation available is substantially less than under the DRCA.

Rolling these veterans in to scheme 1 or scheme 2 would potentially provide a large windfall gain to some veterans, purely as a result of them delaying their compensation claim. The Commission does not consider this reasonable. Veterans who would receive compensation under the pre-1988 Commonwealth workers' compensation Acts should remain covered by these schemes for those injuries. These provisions would be included in the modified MRCA.

Some criticisms of the two-scheme approach

While many participants supported the two-scheme approach, there were two key criticisms put forward against the approach.

First, some participants did not see the need for change, given that the VEA and the DRCA will eventually end, leaving the MRCA as the sole Act. For example:

The Commission needs to allow the current Acts to remain in force. For example, the VEA ... will eventually die out due to the ages of those veterans now and as there is a cut-off date for this

Act. The numbers under this Act will dwindle over the coming years. (AATTW WA Branch, sub. DR174, p. 1)

As it now stands, a single Act scenario will develop with all veterans eventually being assessed under MRCA. The number of VEA and DRCA claims is reducing, while MRCA claims are increasing. (RSL Queensland, sub. DR256, p. 37)

It is true that there would eventually be one Act under the status quo, but as noted earlier, this will not occur for decades. Given the complexity of the current system, and the stress many veterans experience trying to navigate the system, it would be irresponsible to delay simplifying the system.

Second, some participants were also of the view that a two-scheme approach would add more complexity to the system. For example:

To suggest another two-scheme approach on top of that is just creating more complexity into an already too complex situation. This would then mean that there are too many legislative Acts to navigate for the younger Veteran. (TPI Federation, sub. DR290, p. 31)

The proposal to move to two schemes does not negate any impacts across the schemes; in fact it creates a more confusing situation depending on a person's date of birth, under which scheme the majority of their claims is accepted or predominate of the current benefits, or their age at date of implementation. (RSL Queensland, sub. DR256, p. 36)

For some veterans, the two-scheme approach may initially be complex, as they may need to choose which scheme they wish to be covered by, or they could be uncertain about which scheme they are covered by. However, this would only apply to a small number of veterans — for most veterans the eligibility will be clear. And this complexity would be dwarfed by the complexity that currently arises, where veterans can be covered under multiple Acts depending on their service time, type of service and when the injury occurred.

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.

19.2 Support for families

The impacts of military service extend to the families of veterans. During service, frequent relocations, the veteran's irregular hours and their extended periods away from home can all take a toll on families. Post-service, there can also be challenges for families who live with or care for a veteran with mental health issues and/or physical injuries.

Studies that looked at the effects of a veteran's military service on their families have mixed findings. However, in general they pointed to adverse effects on families' mental health and employment (with these effects found for partners and/or children) (chapter 2).

The recent *Family Wellbeing Study* found higher rates of psychological distress (than the comparable Australian population) for adult children (and greater behavioural issues for young children), but rates of psychological distress for partners and parents of veterans were similar to the comparable population. The study also found that most families who were concerned about their mental health sought help, and few family members were unable to do so because of financial barriers (chapter 17).

Supporting families of veterans is important not only because of the issues they face, but also because they can play an important role supporting veterans, including when they are undertaking rehabilitation and when they are transitioning back into civilian life (chapters 2, 6, 7 and 17).

As discussed throughout this report, families of veterans have access to a number of supports provided by DVA (in addition to those provided by Defence and those available more generally). The supports include the partner service pension, counselling, respite care, child care and various education supports (chapters 13, 16 and 17). Supports for families are also provided by veterans' organisations (including counselling, claims advocacy and wellbeing support, chapter 17). However, many participants in this inquiry argued for more support for families of veterans.

The Commission's proposed Veteran Services Commission (VSC) (recommendation 11.1) would have close engagement with families (including providing them with assistance) as this can be important for supporting veterans on a more individualised basis. Many of the other reforms outlined in this report — including those in the areas of injury prevention, rehabilitation, transition and health — will help improve the wellbeing of veterans, which in turn should lessen the support load on families (such as by reducing caring duties). Improving veteran outcomes rather than relying on families to support veterans is important, particularly as some veterans do not have family members who can support them.

The Family Support Package

In 2018, and in response to the Senate Committee report *The Constant Battle: Suicide by Veterans*, the Family Support Package (FSP) was introduced. The FSP provides counselling and other support to a narrow group of veteran families — it is available to families of veterans who have undertaken warlike service on or after 2004. This section looks at the case for expanding the eligibility criteria to support a broader range of families, as well as relaxing the limits on counselling supports for families.

Box 19.1 **The Family Support Package**

Eligibility

The Family Support Package (FSP) is available to:

- families of a veteran participating in an approved rehabilitation program. The family member must have an identified need for support where this helps the veteran achieve their rehabilitation goals. Family members include partners, parents or step-parents, grandparents, children or step-children, grandchildren, siblings, in-laws and persons who 'stand in the position' of a parent or child. The veteran must have undertaken warlike service on or after 1 July 2004, and be eligible for, or receiving, incapacity payments
- widow(er)s who were the partner of a veteran at the time of their death. The veteran must have undertaken warlike service on or after 1 July 2004, and their death must be a service death or a suicide related to their service.

Counselling services

The FSP provides brief intervention counselling to help families 'manage challenging life circumstances that military service may have contributed to' (DVA 2018w). This is provided in addition to services available through Open Arms. Types of counselling may include grief and loss counselling, parenting skills and support counselling, and a Mental Health First Aid course.

Counselling services covered must offer the client benefits within a discrete number of sessions. Clinical treatment of ongoing issues or diagnosed conditions such as chronic anxiety or depression cannot be covered under the FSP (but may be accessed through alternate avenues such as Open Arms and DVA health cards).

Services can be provided by any qualified provider but are subject to threshold limits:

- For families of veterans in a rehabilitation program, up to four counselling sessions per year can be accessed for five years (shared between the family members of a veteran).
- For widow(er)s, up to four counselling sessions per year can be accessed for two years following the veteran partner's death.

Childcare support

Financial assistance with childcare is provided for the veteran's child. The maximum amount is \$10 000 a year per child under school age and \$5000 a year per child in primary school. This is intended to cover any gaps (partial or full) in child care fees after Commonwealth funding has been applied.

Home Help Assistance

The widow(er) may select providers for household services such as cooking, cleaning, gardening and minor repairs. A maximum of \$491.67 can be paid per week and can be accessed for two years following the veteran partner's death.

Sources: DVA (2018w, 2018x, 2018y); Military Rehabilitation and Compensation (Family Support) Instrument (No.2) 2018.

Should only families of veterans with warlike service be eligible?

Excluding families from the FSP based on the type of service goes against the principle that an injury is an injury (chapter 4). Families caring for veterans are likely to face the same issues and associated stressors irrespective of the type of service the veteran have undertaken. This is also the case for families of veterans who have died from service-related injuries or illnesses. The Commission recommends removing the requirement for veterans to have undertaken warlike service for families to access this support.

Should families be eligible only if the veteran is undertaking rehabilitation?

A current requirement for families of living veterans to access the FSP is that the veteran must be on a rehabilitation plan. The rationale is that:

Research shows that a person's family unit is integral to their rehabilitation success. Where a person experiences challenging family circumstances such as illness, financial problems and relationship breakdown, the effectiveness of their rehabilitation can be affected. (DVA 2018y)

However, veterans with impairments who are not in rehabilitation may also need additional support from their families. The Government, in its response to the National Mental Health Commission Review on suicide-prevention services for veterans and their families, noted that 'the role of family can be particularly important in the treatment and recovery of ill or injured individuals throughout their lifetime' (DoD, DoH and DVA 2017, p. 5). The Royal Australian and New Zealand College of Psychiatrists also stated that:

Family-centred approaches to treatment may also be useful considering the potential effects of mental ill health on the families of veterans and ex-service personnel suffering from [post-traumatic stress disorder] ... a lack of sufficient spousal/ familial support may contribute to the breakdown of these relationships which can have catastrophic consequences for the mental health of veterans and ex-service personnel. (2016, p. 12)

The current requirement that living veterans must be receiving (or be eligible for) incapacity payments should already cover veterans who suffer impairments and need a carer (unless they are beyond retirement age). As such, there is a case for counselling under the FSP to be extended to families of veterans who are not under rehabilitation but are receiving incapacity payments. However, childcare under the FSP should not be extended as it is provided on top of the childcare already available under household services provisions and through a psychosocial rehabilitation plan.

Extending to families of veterans who are receiving the veteran payment

In 2018, the veteran payment was created to provide support to veterans with mental health issues while they are waiting for their claims to be processed (chapter 13) (with a requirement that the veteran must participate in rehabilitation if they are capable of doing so). However, families can still face delays before receiving support. To provide more timely

support, the Commission's view is that FSP should be extended to families of veterans who are eligible for or in receipt of the veteran payment.

Extending counselling services for immediate family

While Open Arms already provides the full range of counselling services, many veterans and families expressed a preference for choosing their own providers (with some not wanting to have anything to do with support provided by DVA, chapter 17). As the Commission highlighted in its report on competition and choice in human services, some of the benefits of providing greater choice include the intrinsic value of 'empowering people to have greater control over their lives', allowing users to 'satisfy their individual preferences' (PC 2017c, pp. 313–314) and improved services. The Commission sees value in providing families with an alternative to Open Arms. The scope of counselling services under the FSP should be extended to mimic Open Arms, but still allow sessions to be accessed from any qualified provider.

The full range of counselling services should only be made available to partners (or widow(er)s), eligible young children and parents (immediate family members). Parents should be covered as many veterans do not have partners or children (chapter 2). This change will also help to fill the gaps in mental health support for immediate family of deceased veterans who do not receive the Gold Card. Other family members would continue to have access to brief intervention counselling provided by the current FSP and may also access counselling through Open Arms.

The advantage of extending counselling services through the FSP (instead of, for example, providing a White Card for families — chapter 17) is that it allows for flexibility to provide targeted services to families who need them the most (which aligns with the needs-based principle, chapter 4). Families covered after implementing the proposed changes to FSP will be those with the greatest needs: families of incapacitated veterans and veterans waiting on a claim for a mental health condition, and families of veterans who have suffered a service death.

Relaxing the limits on access to counselling for immediate family

Requiring an identified need for families of living veterans adds a layer of bureaucracy into the process of accessing counselling through the FSP. As equivalent counselling is already available through Open Arms, families who seek alternate providers are likely to be those who want an alternative that is separate from the veterans' system.

The current session limits may also be too restrictive. Another option is to place a cap on the value of counselling that can be accessed. This is consistent with other schemes that offer counselling for families of injured and deceased workers — Victoria's workers' compensation scheme, for example, offers counselling services up to the value of \$6470 (as of 1 July 2018) (WorkSafe Victoria nd). As with the existing FSP, families of veterans with service deaths should be provided with access to this counselling for two years after the

veteran's death. Any extensions to the payment cap or time limit should be provided at the discretion of DVA if special circumstances apply. These changes would provide families with flexibility to access the services they need when they need them, but impose safeguards on overuse.

Expanding to other schemes

On fairness grounds, veterans with the same impairments should receive the same level of support for their families regardless of which Act they are covered under.

While incapacity payments are also provided under the DRCA, the VEA operates a different system of entitlements. Under the VEA, the special rate and intermediate rate of disability pension are provided to veterans with incapacity for work, and veterans covered under these approximate the cohort covered by incapacity payments under the MRCA and DRCA.

The cost of expanding to families of living veterans covered under other schemes could be high, due to the large number of VEA veterans who would fulfil the incapacity eligibility criteria (chapter 13). For families of veterans with service deaths, the costs of expanding counselling to the VEA may be low as many widow(er)s and dependent children (along with some mothers) already have Gold Cards (which provides the full range of mental health treatment). There may be more costs associated with expanding counselling to the DRCA and expanding childcare and home care to the DRCA and VEA.

What does this all mean?

These changes would lead to a focused package of support for families of veterans who need support the most. They would provide benefits to a broader range of families than previously, and counselling support more consistent with that available through Open Arms — providing families with a viable alternative to Open Arms (greater choice).

Importantly, these reforms promote fairness — a family should not be denied the benefits it needs simply because of the Act the veteran is covered by, or the type of service the veteran undertook.

Of course, these reforms would not be without costs, but some of the costs will be transferred from other schemes operated by DVA, including Open Arms. By enabling the family unit to provide greater support to the veteran, costs may also be reduced in other parts of the support system.

Further research should be conducted to better understand the impacts of military service on families and how to best support them. The FSP should also be evaluated for its effectiveness (including comparisons against other services, such as Open Arms).

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.

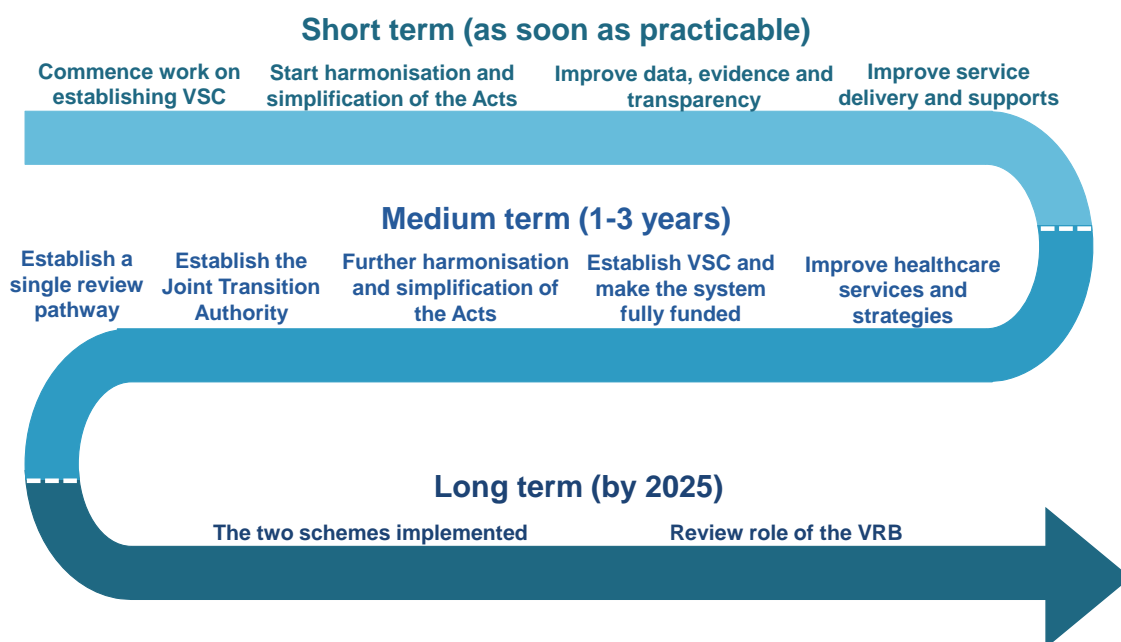
The Department of Veterans' Affairs should amend the Family Support Package to extend:

- 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.

19.3 Implementing the reforms

While some of the reforms proposed by the Commission could be implemented relatively quickly, some will need to be implemented over the longer term to allow stakeholders time to adjust, allow consultation with relevant groups, and so existing processes are not disrupted (figure 19.3). This section outlines an indicative timeline for the reforms, and outlines the potential costs and benefits of the reforms. The timetable allows current Defence and DVA reforms to continue to be rolled out, while also ensuring the proposed new veteran support system is fully implemented and operationalised within a reasonable period.

Figure 19.3 Timeline for reform



Legislative simplification

Unwinding the complexity of the veterans legislation will take time. Nonetheless, the benefits to veterans are likely to be significant. A simpler system will reduce the scope for delays and errors in decision making, which have caused so much difficulty for veterans. It will be easier for veterans to understand the benefits they are entitled to. By extension, this will reduce the stress that the system places on veterans. The reforms should therefore take place as soon as practical (table 19.3).

The starting point for reform should be simplifying and streamlining the Acts. This includes many of the recommendations in chapters 14 and 15 that are designed to simplify the range of payments available (predominantly in the MRCA). At the same time, some simple harmonisation between the DRCA and the MRCA could be achieved, such as aligning the incapacity payments between the Acts (recommendation 13.1), and SoPs in the DRCA (recommendation 8.1). These reforms would set the framework to roll the DRCA into the MRCA.

Table 19.3 Legislative simplification recommendations — implementation

<i>Description</i>	<i>Recommendation no.</i>	<i>Notes</i>
Implemented as soon as practicable		
Harmonising the initial liability process across all Acts. Remove the distinction between types of service when determining causality between a veteran's condition and their service under the MRCA	8.1 and 8.4	
Alignment of the DRCA with the MRCA, including incapacity payments, and allowances such as the education payments	13.1 (in part)	These are priority reforms that should be implemented to simplify the system and make it fairer
Removing access to, streamlining, or merging various payments, supplements and allowances across all Acts	14.4, 14.5, 14.7, 14.10, 15.1, 15.2, 15.3, 15.4, 15.5 and 15.6	
Provide access to rehabilitation for veterans receiving invalidity pensions.	13.4	
Medium-term reforms (2–3 years after the reform process commences)		
Remaining alignment of the DRCA and MRCA, including permanent impairment payments and dependant benefits	13.1 (in part)	
Introduction of one rate of permanent impairment compensation in the MRCA covering peacetime, non-warlike and warlike service	14.1	
Changes to permanent and stable provisions in the MRCA — limit the length of time an impairment can be considered unstable, and interim compensation paid as periodic payments only	14.2 and 14.3	These reforms are likely to be more complex, and require stakeholder negotiation as to how they should be implemented. Time should be given to allow these reforms to proceed as smoothly as possible
Changes to dependant benefits to limit eligibility under the MRCA, and provide for one, simpler, payment.	14.8 and 14.9	
Replace the remuneration loading in incapacity payments with a superannuation contribution	14.6	
Close off access to invalidity pensions under ADF Cover, and expand eligibility for MRCA incapacity payments	13.3	
Longer-term reforms (by 2025)		
Adoption and full implementation of the two-scheme approach	19.1	Longer-term reform that should only be implemented after other reforms. Time is required to allow veterans to adjust to the new schemes

By 1 July 2025, the two-scheme approach should be implemented. This would involve rolling the DRCA into the MRCA, as well as assigning veterans to each scheme and providing some veterans with the option to switch (although switching need not take place immediately). The Commission has chosen this time period to:

- allow time for other reforms to be implemented
- allow veterans time to adjust to the new approach and consider their options.

The reforms proposed will not be without costs. It is likely that they will lead to an increase in government expenditure on compensation, at least in the short term, as veterans move to different compensation arrangements. In particular, harmonising the DRCA and the MRCA is likely to increase expenditure on compensation, as will moving to a single rate of permanent impairment. It should also be noted that, while many veterans will receive more compensation as a result of reform, it is inevitable that some may receive less in the future. Given the substantial benefits to veterans as a result of reform, these costs should not hold up the reform process.

Governance and responsibilities reform

Overarching system governance

The Commission is recommending fundamental changes to the governance arrangements of the veteran support system (table 19.4). The governance structure proposed will ensure that the system has the right incentives to meet the lifetime needs of veterans efficiently and effectively. The potential benefits from the governance changes should not be underestimated.

The VSC would take a proactive approach to veteran support with a focus on reducing clients' reliance on supports through early intervention and building clients' skills and capabilities for independence. The approach is very much about minimising harm and reducing long-term costs to veterans and their families and Australian taxpayers (with a focus on total future costs of support and financial sustainability).

Levying a premium on Defence would also have substantial benefits. It would sheet home financial accountability for the veteran support system directly to Defence, and create an incentive for Defence to reduce the risk of injuries while training or serving. A fully-funded system will create incentives for the VSC to manage the needs of veterans within a funding envelope. This will lead to incentives to reduce the burden of impairments on veterans — by improving rehabilitation and health care. It will also lead to incentives to fix issues in the system effectively and efficiently, rather than simply throwing more money at the problem.

While the benefits from the governance changes are expected to be substantial, there are also transitional costs associated with the large-scale changes. Because of the scale of the recommended changes, there is a risk that such disruption could undermine DVA's existing

reform program, particularly the continued rollout of the Veteran Centric Reform (VCR) program (chapter 9), which is currently expected to be completed by about 2021.

Table 19.4 Governance and responsibilities recommendations — implementation

Description	Recommendation no.	Notes
Short term (as soon as practicable)		
Streamline the administration of superannuation invalidity pensions and veterans' compensation	13.2 (in part)	Recommendation is a continuation of existing processes
Commence work on establishing the Veteran Services Commission	11.1 (in part)	Work should commence early to enable a smooth transition
Provide additional resources to the Repatriation Medical Authority to conduct reviews and investigations. Abolish the Specialist Medical Review Council	8.2 and 8.3	Reforms will involve minimal disruption.
Formalise Defence responsibility to support its members	5.4	
By 1 July 2020		
Establish the Joint Transition Authority and prepare members better for civilian life	7.1 and 7.2	These reforms will involve minimal disruption to existing processes, and can be undertaken relatively quickly
Establish a single review pathway and modify the role of the Veterans' Review Board	10.2 and 10.3	
Establish an advisory council and give primary responsibility for the Office of Australian War Graves to the Australian War Memorial	11.4 and 11.5	
By 1 July 2022		
Establish the Veteran Services Commission. Reform DVA to improve its strategic policy capability	11.1 and 11.3	These reforms involve major reorganisation of the roles and responsibilities for veterans' support. Time is needed to avoid disruption of existing processes
Make the veteran support system a fully-funded compensation system	11.2	
By 2025		
Review the role of the Veterans' Review Board	10.4	Longer term to allow time for other reforms to become established
Consider transferring responsibility for the superannuation invalidity pensions to the Veteran Services Commission	13.2 (in part)	

While the work to establish the VSC should commence as soon as possible, it should not disrupt the rollout of the VCR program. Once the VCR program is completed, the changes to DVA's governance structures should be implemented. This should allow the VSC to begin operating no later than 1 July 2022, and earlier if possible. Any delays in the rollout of the VCR program should not delay the establishment of the new governance and administrative arrangements.

Managing transition

Other governance changes could be put in place more quickly. The proposed Joint Transition Authority (JTA) would provide a single point of access for veterans leaving the military, based in Defence. This will improve the coordination of transition, and give it greater prominence. It will improve the service available to veterans during a potentially stressful period of their lives. The JTA is based on an existing model and many of its functions are already the responsibility of Defence. This means that the JTA should be able to be operating by 1 July 2020, and earlier if possible.

Reviews and appeals

The Commission is recommending changes to the roles and responsibilities of the Veterans' Review Board and DVA processes, to allow for a single review pathway. As the Commission is not recommending that new bodies be established, the single review pathway could be put in place relatively quickly with amendments to legislation and DVA processes where relevant — the Commission suggests no later than 1 July 2020.

Improving service delivery and supports

DVA services

DVA provides many services to its clients, including the assessment of claims for compensation, rehabilitation to veterans who need it, and healthcare programs to improve the wellbeing of veterans and their families. DVA is attempting to improve its service delivery, notably through the VCR program, however, there remains room for improvement (table 19.5).

In the long term, the VSC will have the structure and incentives to deliver services to veterans and their families that improve their wellbeing. But there are several steps that DVA can take to improve its service delivery in the short term. The Commission has made recommendations to improve the claim assessment, rehabilitation and transition programs that could be undertaken alongside the VCR reforms.

Changing the way that health services are provided will take longer. There is currently a culture of providing health services through DVA cards, which provide funding for healthcare services. There is little monitoring of these cards, including whether the health services are achieving positive outcomes for veterans or whether veterans are accessing high quality services.

In the longer term, the Commission envisages the card-based approach being replaced by a more proactive client-based healthcare case management model delivered by the VSC. In the medium term, the card-based system should be reformed to be tightly focused on veterans with severe impairments — those most at need of support.

Advocacy and support services

Veterans' organisations play an important role in delivering services to veterans, including claims advocacy, wellbeing supports and services and policy input. The Commission's reforms in this area should occur as soon as possible, to improve the quality of advocacy and support services available to veterans and their families.

Table 19.5 Improved service delivery — implementation

<i>Description</i>	<i>Recommendation no.</i>	<i>Notes</i>
Commence as soon as practicable		
Better engagement with rehabilitation providers and better coordination of rehabilitation for transitioning personnel	6.3	
Trial a new education allowance for veterans undertaking full-time study	7.3	
Better claims administration — better staff training in trauma and reassessment of claims assessment batches with excessive error rates	9.2 and 9.3	These reforms can commence immediately, alongside the Veteran Centric Reform program
Funding advocacy services where there is an unmet need. Ensuring accreditation of advocates	12.3 and 12.4	
Funding legal advice for claims on a means and merit-tested basis	12.5	
Commission a review into fee-setting arrangements for health care	16.3	
Better advertising of DVA mental health services	17.1	
Improved Family Support Package	19.2	
Medium term reforms		
Amend the payments for Coordinated Veterans Care to better reflect the risk rating of patients	16.1	These reforms require better evidence and consultation, and may take 2–3 years to implement fully
Target the Gold Card to those veterans with severe service-related impairments	16.4 and 16.5	
Update the Veteran Mental Health Strategy	17.4	

Data, evidence and transparency

Improving the services available to veterans requires an investment in data and evidence. The Commission has made several recommendations designed to improve the data and evidence base for veteran support (and injury prevention), and ensure that this evidence is publicly available. These reforms are intended to underpin longer-term reform to the veteran support system, and should commence as soon as practicable (table 19.6).

Improving the data and evidence base within the veteran support system will require development of competencies in information technology, data management and analysis — encompassing both software and people — with many more resources than currently allocated to this function.

The increasing focus on data and evidence will require staff with specialist knowledge in data analytics as well as outcome measures. And from a whole-of-system view, staff capability in actuarial modelling will be needed to implement a financially sustainable model.

Table 19.6 Data, evidence and transparency — implementation

<i>Description</i>	<i>Recommendation no.</i>	<i>Notes</i>
Commence as soon as practicable — ongoing processes		
Investigating augmenting the Sentinel database with information from the Defence e-health system	5.1 and 5.2	
Piloting injury prevention programs		
Publishing a report that estimates notional workers' compensation premiums for the Australian Defence Force	5.3	
Reporting on outcomes from the Australian Defence Force Rehabilitation Program	6.1	
Better use of data to evaluate the effectiveness of rehabilitation services	6.2	
Reporting on the progress of implementing recommendations from recent reviews	9.1	These reforms should commence as soon as practicable to underpin longer term reform and change
Reporting on the Veterans' Review Board's reasons for varying decisions	10.1	
Reporting on the accessibility of healthcare services accessed through the Gold and White Cards	16.2	
Monitoring, reporting on, and reviewing the performance of Open Arms	17.2	
Publish a list of practitioners who have completed Phoenix Australia's trauma-focussed therapy and cognitive processing therapy training	17.3	
Development of outcome measures to assess service effectiveness. More trials, reviews and evaluations, and an annual research plan	18.1, 18.2 and 18.3	
Establish an expert committee on veteran research	18.4	

19.4 How will reform affect the future veteran support system?

While the Commission has not quantified the benefits of its reforms, they are likely to be significant and across multiple domains (table 19.7).

One of the key objectives of the Commission's reforms is an increased focus on the wellbeing of veterans over their lifetime, including through improved rehabilitation, work health and safety and transition support. Ultimately, this should mean that:

- fewer veterans and families need to deal with injury, illness or death
- when impairments do occur they are managed better and more veterans are able to return to work
- veterans and their families are better prepared to manage their lives post service, and veterans are provided with the skills needed to have a post-military career.

Injuries and illnesses will still occur, and compensation will be needed to provide restitution and support for veterans and their families. The Commission's recommendations aim to reduce the complexity through the liability system, from the initial liability process right through to the reviews and appeals process. Along with the changes to the structure of compensation, this will result in a simpler, fairer, and more accessible and timely system of compensation.

The Commission's recommendations seek to set up the veteran support system so that it is not only a better system in the short term, but it continually improves and remains effective well into the future. The Commission has made several recommendations designed to create a better evidence base to inform improved design and delivery of services, programs and policies. The new governance structures should also facilitate better decision making, ultimately leading to improved outcomes for veterans and their families.

There will also be efficiency gains from the proposed changes, including by placing a greater focus on accountability and lifetime costs of support and reducing duplication. A greater focus on wellness and lifetime costs should also translate into increased economic and social participation of veterans and reduced reliance on income support.

Reform to the veterans system are not without cost. It is likely that there will be an increased fiscal cost to the taxpayer in the short term, as better approaches to prevention, rehabilitation and transition are introduced, new governance structures are established and services are improved. Many veterans will also be entitled to an increased level of compensation. In the long run, the cost of the system may reduce, as prevention and rehabilitation lead to a reduced reliance on the compensation system, to the benefit of both veterans and the taxpayer.

Table 19.7 What benefits for current and future veterans?

<i>What the Commission proposes</i>	<i>What will it achieve</i>
Provide support for trial injury prevention programs at Lavarack and Holsworthy barracks	Better evidence base to support a service-wide rollout of new approaches to injury prevention
Augmenting Defence work health and safety incident reporting with other health and claims data	Better information on the incidence and lifetime costs of harm, improved safety and prevention
Extension of rehabilitation to discharging members	Better and more continuous rehabilitation services, potentially increased economic participation
Evidence-based services and evaluation of outcomes	
More transition support for veterans and families	Veterans and their families are better prepared to cope with the practical, psychological and social challenges of transition
Creating a new authority within Defence to centralise responsibility for preparation and support	
Changing governance structures by introducing a new independent statutory agency (the Veteran Services Commission) to administer the veteran support system	Achieving the objectives of the system in the most cost-effective manner possible
Fully funding the long-term costs of the system via a premium collected from Defence	Make the long-term cost implications of future policy decisions affecting veterans transparent
	Sharper incentives to reduce harm and rehabilitate injured veterans
Harmonise the initial liability process across all three Acts, including moving to a single standard of proof	Less complexity and increased consistency of claims assessments
Single review pathway across the veteran support Acts, with internal reconsideration	A quicker and simpler review process
Better feedback to DVA claims assessors	Less time and cost spent pursuing reviews
	More accurate initial decision making by DVA
Improved accreditation and funding of advocacy services	More effective support to help veterans and their families navigate the claims system
Better support offered by DVA to help clients lodge claims	
Streamlining the compensation package, by removing payments that are poorly targeted or have little rationale, simplifying payments, or rolling them into underlying payments	A simpler, fairer and more accessible system of compensation
Harmonising compensation in the MRCA and DRCA, and eventually moving to a two scheme approach	Some changes in the levels of compensation received by veterans making claims in the future. Existing benefits would be largely unaffected
Changing the eligibility for the Gold Card to target veterans most in need of support	Targeting health care to veterans most in need
Reviewing fee-setting arrangements for healthcare cards	Sharper incentives to design healthcare programs that meet the needs of veterans and their families
	Improved accessibility of services through the Gold and White Cards
Updated veteran mental health strategy	More veterans could access mental health care and receive evidence-based treatment
Reporting on outcomes of Open Arms services	
Improving data and evidence by introducing more high-quality evaluations and trials, and a strategic direction for veterans' research	A better evidence base to inform the design and delivery of effective services

A Conduct of the inquiry

The Commission received the terms of reference for this inquiry on 27 March 2018. It subsequently released an issues paper on 3 May 2018 inviting public submissions and highlighting particular matters on which it sought information. A draft report was released on 14 December 2018, and further public submissions were invited.

In total, 313 public submissions were received and placed on the inquiry website. A list of all public submissions is contained in table A.1. The Commission also received brief comments, and selected comments are available on the website.

During the course of the inquiry, the Commission held informal consultations, roundtable discussions and public hearings with veterans and their families, ex-service organisations, service providers and academics, as well as a number of government departments and agencies. Tables A.2, A.3 and A.4 list these participants.

The Commission would like to thank all those who contributed to this inquiry.

Table A.1 Submissions^a

<i>Participants</i>	<i>Submission number(s)</i>
AATTW WA Branch	DR174
Abilita Services	DR191
Ablong, Anthony	DR230
Administrative Appeals Tribunal (AAT)	DR258
Advanced Personnel Management (APM)	DR219
Ager, Naomi	DR254
Ager, Stephen	DR162
Air Force Association (AFA)	93, DR267, DR300
Alkemade, Peter	66, DR283
Alliance of Defence Service Organisations (ADSO)	4, 85, DR247, DR309
Allied Health Professions Australia (AHPA)	DR261
Anderson, Julie	152 *
Andrews, Michael	DR183
Ashmore, Alan	55, 95, 102, DR268 *#
Association of Totally and Permanently Incapacitated Ex-Service Men and Women (South Australia)	DR310
Atkinson, Rob	DR210
Australian Acupuncture and Chinese Medicine Association	80
Australian Commando Association (ACA)	DR298
Australian National Veterans Arts Museum (ANVAM)	DR296
Australian Peacekeeper and Peacemaker Veterans' Association (APPVA)	DR270
Australian Rehabilitation Providers Association (ARPA)	DR249 #
Australian Veterans Alliance	81 #
Australian War Memorial	DR226 *
Australian War Widows Qld	DR187
Bak, Bob	DR262 * #
Baker, Terence	132 *
Baldwin, Hugh	10
Ball, Max	140
Barbara Wheatley and Eric Wheatley	DR274
Bartrop, Owen	20, DR165
Bauer, Brad	DR302
Beezley, John	DR233
Benton, Ross	63
Berg, Chris	52, 105 *
Black, Robert	45
Brandis, Fiona	103, DR295
Brown, William	110
Browne, Neville	DR246
Browning, Avelon	136 * #
Bucci, Ronald	126
Burrows, John	27
Burton, Phillip	DR243 #
Bysouth, Peter	DR308 #
Caligari, John	DR253

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<i>Participants</i>	<i>Submission number(s)</i>
Campbell, Angus	DR172
Campbell, Christopher	DR292
Canning, Dale	DR164
Carers NSW	DR264
Cartner, Steven	21
Central Queensland TPI Association	DR287
Chapman, Ken	DR305
Chesterfield, Timothy	24, DR228* #
Coathup, Richard	124
Coghlan, Rebecca	DR198
Commonwealth Ombudsman	62
Commonwealth Superannuation Corporation (CSC)	DR286
Community and Public Sector Union (CPSU)	94, DR284
Cornish, John	64
Couper, Josephine	DR291
Craft, Wayne	DR252* #
Crossley, Matthew	83
Dabovich, Paula	DR242
Danes, Kerry	DR160
Defence Force Welfare Association (DFWA)	118, DR299
Defence Force Welfare Association WA Branch	DR279
Délboux, Brad	60
Department of Defence	127
Department of Veterans' Affairs (DVA)	125
d'Hagé, Adrian	54
Disabled Veterans of Australia Network	DR288#
Doctors on Demand	139
Duncan, John	DR207
Dwyer, Brendan	15
Edwards, Robert	5
Eglinton, Ian	123
Employers Mutual Limited (EML)	90
Enno, Keith	147, 150
Evans, Paul	DR218
Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (TPI Federation Australia)	134, 145, DR290#
Fielding, John	130
Fielding, Marcus	DR201
Fisher, Petrina	75
Fleming, Andrew	1*
Fleming, Giselle	33
Fogarty, Terry	32
Foley, Daniel	19
Fordyce, Jack	DR214#
Forsbey, William	3
Foster, Larry	DR213
Fraser, Ian	DR155
Fry, Robert	DR282
Fuller, Brian	11
George, John	DR281, DR184

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<i>Participants</i>	<i>Submission number(s)</i>
GO2 Health	98
Gore, William	97
Gray, Aaron	DR202 * #
Green, D	50, DR312
Greenhalgh, Rick	DR241
Griffin, John	DR182
Griffiths, Anthony	DR181
Griffiths, Geoff	104
Hampson, Alan	DR239
Harkness, Harry	91 #
Harrex, Warren	89
Harrison, David	129
Hauptmann, Almuth	DR161
Hawes, Peter	30, 47
Hayes, Peter	8
Hemburrow, Keith	17 #
Hermans, Carol	DR185
Hewitt, Chris	38
Hoebee, Bert	DR195
Hogan, Harold	DR190 #
Horner, Christopher; Chandler, Jarrod; Allen Hine, Scott; Jones, Gareth; Newell, Steven; Kirkels, Brad; Kendall, Kenneth; Stamp, Catherine; Sullivan, Kieron; Harding, John; Inglis, Jane Megan and Dennerley, Michael	28
Hume Veterans' Information Centre	121
Janz, Stephen	65
Jones, Roy	135, DR227 #
Kaine, William	DR197
Kaleta, Christopher	DR170
Kearney, Bill	DR285
Kelly, David and Jamison, David	DR212
Kelly, Michael	DR304 #
Kemp, Ray	37, DR240
Kirkwood, Neil	44, DR224
Lampard, Kerry	DR180
Legacy Australia	100, DR220
Legacy Club of Brisbane	DR272
Legal Aid Commission of New South Wales (Legal Aid NSW)	109, DR263
Lehman, Peter	DR166
Lenard, Hilton and Russell, Keith	13
Liberal National Party of Queensland (Warwick Branch)	DR301
Linden, Mattheus	41
MacNeill, Neil	DR156
Manning, Robert	43 #
Martinson, Ole	DR294
Martyn, Dennis	DR168
Mates4Mates	84
Matthews, Gary	DR167 * #
Maurice Blackburn Lawyers	82

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Table A.1 (continued)

<i>Participants</i>	<i>Submission number(s)</i>	
McFarlane, Alexander	69	
McKenzie, Brian	DR275	
McLean, Neil	DR154	
McLeod, Sydney	DR158	
Medhealth	DR176	*
Meehan, Terence	35	
Melandri, David	61	
Menhinick, Richard	DR236	* #
Miller, Russell	138	* #
Mollison, Charles	14, DR175	
Moore, Kathleen	DR221	
Moore, Leslie	7	
Morris, Deborah	DR307	
Muldoon, Ian	22	
Murray, Rod	DR189, DR269	
Name withheld	9, 12, 36, 57, 70, 101, 112, 122, 128, 141, 119, DR217, DR248, DR255	*#
National Mental Health Commission (NMHC)	107, DR208	
Nelms, Peter	6	
New, Brent	153	
Newstead, Graham	DR186	
O'Brien, Kenneth J	DR302	
Occupational Therapy Australia (OTA)	71, DR289	
Orygen - The National Centre of Excellence in Youth Mental Health	67	
Palmer, Claude	18, DR179	
Park, Kenneth	2	
Parnell, Rodney Kenneth	48	
Partners of Veterans Association of Australia	77, DR280	
Patterson, Rory	DR238	
Petersen, David	DR223	
Piccolo, Tony	DR260	
Pike, Melanie	56	
Portbury, Matthew	DR171	
Prime Ministerial Advisory Council on Veterans' Mental Health	99, DR276	
Pursey, Olivia	51	
Rainbow, Angela	DR244, DR306	#
Reading, Warwick	88	
Redenbach, R P	31	
Reece, Peter	49, DR194	#
Reeves, John	26	
Rehabilitation Counselling Association of Australasia (RCAA)	74	
Repatriation Medical Authority	111, DR209	#
Returned and Services League (RSL) of Australia — National Office	113	
Returned and Services League (RSL) of Australia (New South Wales Branch)	151	
Returned and Services League (RSL) of Australia (Queensland Branch)	73, DR256	

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Table A.1 (continued)

<i>Participants</i>	<i>Submission number(s)</i>
Combined SA Ex Service Organisations (Returned and Services League (RSL) of Australia (SA Branch), Vietnam Veterans Association of Australia (SA Branch), Vietnam Veterans Federation of Australia (SA Branch), RAAF Association SA, National Servicemen's Association (SA Branch), National Malaya-Borneo Veterans Association of Australia (SA/NT Branch), Korea Veterans Association of Australia (SA Branch), Military Brotherhood Motorcycle Club (SA Branch))	DR188
Returned and Services League (RSL) of Australia (Tasmanian Branch)	DR205 #
Returned and Services League (RSL) of Australia (Victorian Branch)	DR273
Rewko, Peter	DR204
Rhone, Warren	DR211
Ridge, Garry	25 #
Robson, Neil	146
Rollins, Martin	23 *
Royal Australasian College of Physicians (RACP)	DR234 #
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	58, DR225
Royal Australian Armoured Corps Corporation	29, DR203#
RSL Veterans' Centre East Sydney	114
RSLA (Queensland Branch) Brisbane North District	DR169
Rudzki, Stephan	40#
Salcole, Richard	DR293
Saul, Edward	DR297
Shafran, Geoffrey	115, 120, 144* #
Shortridge, Robert	76
Sim, William	148#
Siminski, Peter	DR222
Slater + Gordon Lawyers	68
Soldier On	DR245
Specialist Medical Review Council	DR200
Stark, Michael	DR159* #
Sullivan, Don	53
Sutherland, Peter	108, DR192#
Taylor, Lisha	DR311
The National Centre of Excellence in Youth Mental Health (Orygen)	DR206#
The Oasis Townsville	92
Thomas, Rustyn	39#
Thompson, Rod	116#
Tongue, Susanne	DR259
Totally and Permanently Disabled Ex Servicepersons Association (Townsville Branch)	DR250
Totally and Permanently Disabled Soldiers Association (Queensland)	86
Townsend, Helen	46
Tymms, David	79
Uildriks, Kim	131
United Nations and Overseas Policing Association of Australia (UNOPAA)	DR196
Veterans Advice and Social Centre — Hervey Bay	DR231
Veterans' Advisory Council South Australia	DR266
Veterans' Advisory Council (VAC) and the Veterans' Health Advisory Council (VHAC) of South Australia	96
Veterans and Veterans Families Counselling Service (VVCS) National Advisory Committee	72

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Table A.1 (continued)

<i>Participants</i>	<i>Submission number(s)</i>
Veterans Care Association	DR178
Veterans' Health Advisory Council (South Australia)	DR251
Veterans of Australia Association (VOA)	DR232
Veterans' Review Board (VRB)	117, DR277
Veterans Support Centre, Belconnen and Belconnen RSL Sub Branch	DR229
Victims Of Abuse in the Australian Defence Force Association	133, 137, DR157, DR265 #
Vietnam Veterans and Veterans Federation ACT and Belconnen RSL Sub Branch	42
Vietnam Veterans Association of Australia (VVAA)	78, DR271
Vietnam Veterans' Federation of Australia (VVFA)	34, DR215
Vincent, Gary	DR163
Volunteering Australia	142
Walker, Ben	DR216
War Widows' Guild of Australia	87, DR278
Watson, Campbell	143 *
Watts, David	DR177
Welch, Kerri-Ann	DR235
Westphalen, Neil	149 * #
Whitney, Malcolm	DR173
Wickham, Roger	DR199
Wilson, Renee	DR257
Withdrawn	106
Woden Valley RSL Sub-Branch and Veterans Support Centre	DR193
Wombold, Raymond	16 #
Wood, Ross	59
Work Rehab	DR237

^a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 **Consultations**

Participants

Administrative Appeals Tribunal
Ambulance Victoria
Attorney-General's Department
Australian Federation of Totally and Permanently Incapacitated Ex Servicemen and Women
Australian Government Actuary
Australian Institute of Health and Welfare
Australian National Audit Office
Australian National University - National Centre for Epidemiology and Population Health
Australian Peacekeeper and Peacemaker Veterans' Association
Australian War Memorial
BHP
Baker, Don
Bird, Karen and John
Blackman, Deborah
Boeing Defence Australia
Bravery Trust
Comcare
Commonwealth Ombudsman
Commonwealth Superannuation Corporation
Creyke, Robin
Defence Force Welfare Association
Department of Defence
Department of Finance
Department of the Prime Minister and Cabinet
Department of Veterans' Affairs
Employers Mutual Limited (EML)
Finney, Julie-Ann
Hickie, Ian
Konekt Australia
Lee, Rob
Legacy Australia
Legal Aid NSW
Maurice Blackburn
McFarlane, Sandy
Medibank Health
Morris, Deborah
Murdoch, Paul
New Zealand Accident Compensation Corporation
New Zealand Defence Health Directorate
New Zealand Veterans' Affairs
O'Flynn, Janine
Palmer, Geoffrey
Papamau, Talissa

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Participants

Paterson, Ron
Phoenix Australia
Pope, Rod
PwC Australia
Queensland Department of the Premier and Cabinet
Queensland Veterans' Advisory Council
Rayner, Kathryn
Reece, Peter
Repatriation Medical Authority
Returned & Services League of Australia – National Branch
Returned & Services League of Australia – New South Wales Branch
Returned & Services League of Australia – Queensland Branch
Returned & Services League of Australia – South Australia Branch
Returned & Services League of Australia – Victorian Branch
Ridges, Garry
Rolling, Martin
Royal Australian Air Force Association
Royal New Zealand Returned and Services Association
Rudzki, Stephan
Schulze, Jason
Siminski, Peter
Slater + Gordon Lawyers
Specialist Medical Review Council
State Insurance Regulatory Authority (NSW)
Sutherland, Peter
Taylor, Lisha
Tharwa Valley Forge
Topperwien, Bruce
Travers, Mark
Treasury
Tune, David
Veterans' Affairs New Zealand
Veterans' Review Board
Vietnam Veterans' Federation of Australia
War Widows' Guild of Australia
WithYouWithMe
WorkSafe Victoria

Table A.3 Roundtables

Organisations

Brisbane – 18 July 2018

Alliance of Defence Service Organisations
Australian Peacekeepers and Peacemakers Association (Queensland)
Australian War Widows (Queensland)
Defence Force Welfare Association (Queensland)
Defence Welfare Organisation (National)
Jamie Whitehead
Karen Bird
Legacy (Brisbane club)
Mates4Mates
Peta Miller
Queensland Advisory Committee for the Commemoration of the Anzac Centenary
Queensland Forensic Mental Health Services
Queensland Veterans' Advisory Council
Returned and Services League of Australia (Queensland)
Royal Australian Regiment Association (Queensland)
Slater + Gordon Lawyers
The Australian Federation of Totally and Permanently Incapacitated Ex-Servicemen and Women (Queensland)
Toowong Specialist Clinic
Vietnam Veterans Federation of Australia (Queensland)

Townsville – 19 July 2018

Operation Compass
Returned and Services League of Australia (Queensland, Townsville sub-branch)
The Oasis (Townsville)
Totally and Permanently Disabled Ex-Servicepersons Association
Trojan Trek

Hobart – 6 August 2018

Australian Peacekeeper & Peacemaker Veterans' Association
Jon Lane
Mates4Mates (Ex-Officio)
Royal Australian Air Force Association (TAS Division)
The Partners of Veterans Association of Australia Inc. — (Tasmania)
Vietnam Veterans' Association of Australia

Melbourne – 8 August 2018

Carry On
Defence Families Australia
Defence Force Welfare Association
Defence Reserves Association
Department of Premier & Cabinet — Veterans Branch
Michael Quinn
Returned and Services League of Australia — Victoria
Royal Australian Air Force Association
Totally and Permanently Incapacitated Ex-Servicemen & Women of Victoria Inc.

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Table A.3 (continued)

Organisations

Darwin – 13 August 2018

Legacy Northern Territory
Naval Association of Australia
Returned and Services League Darwin
Returned and Services League Katherine
Returned and Services League Palmerston
Veterans Australia Northern Territory

Adelaide – 16 August 2018

Adelaide Legacy
Defence Force Welfare Association
Ex-Military Rehabilitation Centre
National Malay & Borneo Veteran's Association Australia
Soldier On
The Road Home
Veterans South Australia

Perth – 17 August 2018

Australian Federation of Totally and Permanently Incapacitated Ex-servicemen and Women
Australian Special Air Service Association
Defence Force Welfare Association
Definitiv
Returned and Services League of Australia
Royal Australian Air Force Association
Vietnam Veterans' Association of Australia
War Widows' Guild of Australia

Sydney – 5 October 2018

Alex Collie
Employers Mutual Limited
Generation Health
Konekt Australia
MedHealth Group
Transport Accident Commission Victoria
Work Health Group

Canberra – 16 October 2018

Australian Institute of Family Studies
Defence Families Australia
Legacy
Partners of Veterans Association of Australia
Veterans and Veterans Families Counselling Service
War Widows' Guild of Australia

Table A.4 Public hearings

<i>Participants</i>	<i>Transcript page nos.</i>
Adelaide – 4 February 2019	
Returned and Services , Returned and Services League of Australia, Vietnam Veterans Association of Australia, Vietnam Veterans Federation of Australia, RAAF Association, National Servicemen's Association, National Malaya Borneo Veterans Association, Korean Veterans Association, Military Brotherhood Motorcycle Club and War Widows' Guild	2–18
Veteran's Advisory Council	19–30
Robert Schahinger	31
Returned and Services League (SA/NT)	32–40
Michael Longford	40–52
Kerry Lampard	52–59
Daniel Foley	59–71
Rod Murray	71–80
Partners of Veterans Association of Australia (SA)	80–88
Raymond Kemp	89–99
Ex-military Rehabilitation Centre	99–108
Les Smith	108–118
Claudia Cream	118–123
Robert Black	123–128
George Mikajlo	128–138
Centre for Traumatic Stress Studies - University of Adelaide	138–149
Lee-Anne Norrey	150–151
Perth – 5 February 2019	
Aaron Gray	153–162
Harold Hogan	163–175
V360 Australia Ltd	175–189
AATTV Association WA Branch	201–213
Geoff Shafran	213–227
Max Ball	227–236
Angela Rainbow and Lisa Smith	236–251
Rebecca Coghlan	251–262
Marc Jones	262–272
Partners of Veterans Association of Australia	272–285
Darwin – 7 February 2019	
Dan Tellam	286–301
David Coffey	301–317
Abilita Services	317–326
John Kennedy	326–336
Phillip Sutherland	336–348

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<i>Participants</i>	<i>Transcript page nos.</i>
Terry Sirianni and Diane Lawrie	348–362
Leonard Anderson	362–367
 Wagga Wagga – 11 February 2019	
Hume Veterans Centre	369–387
Rod Pope	388–400
Judy Emberson	401–408
Integrated Service People's Association of Australia	408–426
Contemporary Veterans Wagga Wagga	426–442
Integrated Service People's Association	443–446
 Canberra – 12 February 2019	
Department of Veterans' Affairs	447–471
Legacy Australia	472–488
Vietnam Veterans Federation of Australia Inc	488–508
Australian Federation of Totally & Permanently Incapacitated Ex Servicemen & Women	508–524
Peter Sutherland	526–540
Mack Weller	540–550
Peter Reece	551–565
Jack Fordyce	565–568
Royal Australasian College of Physicians	568–584
RSL Woden Valley Sub-Branch	584–601
Connie Boglis and Karen Bird	601–615
James Gilchrist	616–619
Kathleen Moore	619–621
 Melbourne – 13 February	
Naval Association of Australia	623–638
Defence Reserves Association	638–648
Victims of Abuse in the Australian Defence Force	648–663
Julie Anderson	663–672
Alan Ashmore	673–683
Robert Manning	683–692
David Tymms	692–706
John Pilkington	706–714
Doug Steley	714–729
Returned and Services League of Australia (Vic Branch)	730–750
United Nations and Overseas Policing Association of Australia	751–762
Peter Fitzpatrick	763–782
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<i>Participants</i>	<i>Transcript page nos.</i>
Carl Schiller OAM	782–785
Jillian Wilmott	786–788
 Hobart – 15 February 2019	
Cygnnet RSL Sub-branch	791–815
Partners of Veterans Association (Tasmania branch)	815–826
James Haw	826–839
Darren Thompson	839–850, 893
Returned and Services League Tasmania	850–864
Tasmanian Ex-Service & Serving Support Association	865–883
Brian McKenzie	883–892
 Sydney – 26 February 2019	
Returned and Services League of Australia (NSW Branch)	896–913
Alliance of Defence Service Organisations	913–929
Royal Australian Amoured Corps Corporation	929–943
Roseville RSL Sub Branch	944–955
Paula Dabovich	955–966
John George	966–979
War Widows' Guild of Australia	980–997
Partners of Veterans Association of Australia	998–1013
Kathleen Moore	1014–1029
Greg Isolani	1029–1044
William Red	1044–1047
 Brisbane – 27 February 2019	
Australian War Widows (Qld)	1050–1063
Australian Veterans Alliance	1063–1078
Royal United Service Institute (Qld)	1078–1085
RSL (Qld)	1085–1107
RSL Qld Brisbane North District	1107–1121
Royal Australian and New Zealand College of Psychiatrists	1121–1131
Veterans of Australia Association	1131–1148
Defence Force Welfare Association (Qld)	1148–1165
GO2 Health	1165–1176
Neil Robson	1176–1183
Fiona Brandis	1184–1191
Terence Fogarty	1191–1197
Kathy and Steve Barton	1197–1206
Neil Clancy	1206–1208
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Table A.4 (continued)

<i>Participants</i>	<i>Transcript page nos.</i>
<i>Brisbane – 28 February 2019</i>	
Maurice Blackburn Lawyers	1210–1221
Angela Rainbow and Lisa Smith	1222–1232
Deborah Morris	1232–1245
4 Aussie Heroes Foundation	1246–1255
Liberal National Party of Queensland	1255–1269
Naval Association of Australia (Qld)	1269–1280
David Petersen	1281–1291
John Heney	1291–1298
Australian Rehabilitation Providers Association (Work Rehab & Easesec)	1298–1318
Rosemary Mountford	1319–1322
<i>Townsville – 1 March 2019</i>	
John Caligari	1324–1342
Phillip Burton	1342–1356
TPDESA Townsville/RSL Townsville	1357–1369
Ray Martin	1370–1379
Lawrence Charles White	1380–1386
John Ernest Williams	1386–1390
Peter Hindle	1390–1397
Sarah Molloy	1397–1404
<i>Rockhampton – 21 March 2019</i>	
Alan (Jack) Parr	1407–1417
David Thomas	1417–1424
Brad Bauer	1425–1433
Alan Sisley	1433–1444
Central Queensland TPI Association	1445–1458
Josephine Couper	1459–1466
Christopher Campbell	1466–1472
More Than Normal (PTSD Support Services)	1473–1485
Terry Kerlin	1485–1487
Unidentified Speaker	1488–1489

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