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RACP submission to the draft Productivity Commission report 'A Better Way to Support Veterans'

February 2019

About the Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of nearly 16,000 physicians and 7,000 trainee physicians throughout Australia and New Zealand. It represents a broad range of medical specialties, including addiction medicine, cardiology, general medicine, geriatric medicine, neurology, occupational and environmental medicine, oncology, paediatrics and child health, palliative medicine, public health medicine, rehabilitation medicine, respiratory medicine, and sexual health medicine.

As part of its drive for medical excellence, the RACP is committed to developing health and social policies that bring vital improvements to the wellbeing of all patients. These include current and ex-serving members of the Australian Defence Force (ADF).

Purpose

The RACP notes the Productivity Commission is conducting an independent inquiry as to whether the compensation and rehabilitation system currently available for current and ex-serving ADF members is fit for purpose now, and whether it is likely to effectively and efficiently support them and their families in the future. We also note the inquiry reviewed the governance arrangements, administrative processes and service delivery of the Department of Veteran's Affairs (DVA). Finally, we note the Commission is seeking feedback submissions regarding the inquiry's draft Report 'A Better Way to Support Veterans'[1] (the draft Report) by 11 February 2019, with the final Report due for release in June 2019.

This submission has been led by the Australasian Faculty of Occupational and Environmental Medicine (AFOEM). AFOEM is a RACP Faculty, representing nearly 500 specialist occupational and environmental physicians (OEPs) in Australia and New Zealand. It is committed to establishing and maintaining the highest standards of practice in occupational and environmental medicine (OEM) through training, continuing professional development and advocacy.

To this end, OEPs use their specialist knowledge to ensure healthy and productive workforces, while connecting workplaces with the diverse range of health services necessary to optimise employee health and wellbeing. Their role regarding occupational medicine entails taking a preventative approach to workplace health and safety, by looking at how people's work can affect their health and how their health affects their work. In addition, the OEPs' environmental medicine role pertains to the health impacts of workplace practices on communities beyond workplace sites.

As RACP Fellows, OEPs have the professional qualities as medical specialists and are specifically trained and experienced to undertake:

- Clinical and population-based practice with specific reference to the chemical, physical, biological, psychological, emotional, environmental and psychosocial hazards pertaining to work-related illness and injury as follows:
    - Assessment and treatment of work-related illnesses and injuries.
    - Conducting fitness and return to work assessments.
    - Providing specialist workplace rehabilitation advice.
    - Providing specialist workforce health promotion advice.
- Conducting workplace hazard assessments.
- Undertaking critical appraisal of information with respect to the relationships between workplace hazards and employee health.
- Conducting research regarding the relationships between workplace hazards and employee health.

- Working with governments, regulators, employers, workers and other stakeholders to ensure positive health outcomes for workers and employers.

- Providing specialist advice regarding the relationships between medicine and workplace health, safety rehabilitation and compensation legislation.

- Providing specialist health advice regarding workplace environmental hazards affecting the general community for governments, regulators, employers, workers, affected community members and other stakeholders.

We therefore believe the skills and expertise of OEPs are directly germane to the Report, especially regarding the health services required for current ADF members, and the vocational rehabilitation and compensation arrangements for current and ex-ADF members.

While the Commission has previously received independent submissions from two ex-ADF OEPs,[2,3] this submission represents the RACP's formal response to the draft Report since its release for comment.

Definitional Clarification

We note the draft Report currently uses the term 'veteran' to refer to both currently serving and ex-serving ADF members. However, this submission uses the terms 'current and ex-serving ADF members' (CXSM), 'currently serving ADF members' (CSM) and 'ex-serving members' (XSM).

The reasons for doing so firstly reflects important differences as to who provides their health care: CSM receive theirs from the ADF for all medical conditions (including accepted compensable conditions), while XSM receive theirs from DVA for primarily service-related compensable medical conditions. XSM may also receive treatment for conditions without liability having to be determined, such as mental health disorders and in some cases, malignant conditions. All other non-service-related conditions are managed as for the most of the civilian community, i.e. Medicare, private health insurance, or self-funded.

We therefore recommend the final Report likewise clearly differentiate CSM from XSM, particularly for the benefit of cursory readers who may not realise that its current use of the term 'veteran' refers to both.

Key Points

- The RACP concurs with the draft Report's findings that the current processes within both the Department of Defence ('Defence') and DVA fail to focus on the lifetime wellbeing of CXSM. It also concurs that these processes are legislatively and administratively complex, difficult to navigate and frequently inequitable, and that this combination places unacceptable stress on claimants.

- We therefore commend the overall intent of the draft Report with respect to reducing the preventable harm from service-related injury and illness and investing in CSM so that they are more likely to fulfil productive lives when they separate from the ADF. In particular, we concur that a lifetime focus on the health and wellbeing of CXSM will not only result in better outcomes for them and their families but also for the broader Australian community.

- The Report's intent is entirely consistent with the RACP *Consensus Statement on the Health Benefits of Good Work*,[4] and the RACP *National Vocational Rehabilitation Policy*.[5]

- We also commend the draft Report's recognition that compensation and rehabilitation cannot be addressed in isolation. It is likely that it is the first-ever comprehensive, detailed and organisational assessment, regarding the importance of Work, Health and Safety (WHS) in the ADF and its consequences to individuals.

- We also note that, while the Report refers to the need for a range of 'wellness', 'rehabilitation', 'collaborative',' governance', 'funding', and other 'enabling' models, it does not incorporate any of these into an overarching strategic model for CXSM health and wellbeing.

- To enhance the usefulness and acceptance of the final Report, we therefore recommend it considers a systems approach to WHS, rehabilitation and compensation for CXSM in order to develop a consistent strategic model which consolidates the various administrative issues raised in the draft Report. There are clear principles for the planning, development and implementation of an occupational health (or WHS) service that can and should be applied to the ADF.

- Other large organisations in Australia have responsibilities for provision of an occupational health service for their workers. The ADF is unique in that it also provides or funds full health care for its members, and not just health care related to work related illness and injury. Identifying the rates and costs of work-related illness and injury from other health and treatment services is important if there is to be a significant improvement in Work, Health and Safety in the ADF.

- We consider the ADF is potentially the most hazardous working environment in Australia. Members of the ADF have potential exposure to a broad range of physical, chemical, biological, psychological, environmental hazards, as well as those hazards associated with combat. Using the limited information available, we estimate the incidence of workplace illness and injuries in the ADF is at least ten times greater than any other organisation in Australia. Only a small proportion of these are classified as 'battle casualties'. We consider that at least twenty percent of presentations to ADF health services are work-related, compared to only two percent in general practice, suggesting there is plenty of scope for prevention.

- We also note that in the past, particularly in the RAAF, there has been emphasis on developing and training uniformed medical officers as OEPs. This appears to have diminished over the past two decades, with increasing emphasis on the costs of health treatment, rather than preventing the causes of illness and injury. Although medical administration expertise is certainly required for efficient and effective treatment services, as previously indicated, the ADF requires an effective occupational health service, as well as its treatment services. The costs of work-related illness and injury as identified in the draft Report, cannot be addressed solely by competent medical administration.

- This submission is premised on addressing best practice management for the prevention, monitoring, early intervention, treatment and rehabilitation of work health and safety issues in the ADF. Reducing the costs of preventable illnesses and injuries in the ADF is likely to reduce significantly the high incidence of disability borne by CXSM and result in a major reduction in the costs of compensation to DVA, and the taxpayer, in the longer term. We therefore advocate for a best practice occupational-health-system to improve the health status of *all* CXSM as a *workforce / post workforce* population.

ADF Demographics

- Compared to the civilian workforce, the ADF population is younger, predominantly male (but also with a small but increasing female population of predominantly childbearing age), has high turnover, has very high training commitments, is highly geographically dispersed (often including remote locations even within Australia), and highly geographically mobile (even without deploying).

- These factors, as well as the operational and other workplace hazards to which they are exposed, and the command structure and emphasis on task execution, places the ADF's workforce at greater risk of workplace illness and injury compared to other Australian workforces. This assertion is supported by the ADF's high rates of workplace-related injuries and illness, despite the fact that it is also probably one of the most highly medically selected workforces in Australia.

- We therefore consider OEPs have an essential role regarding the provision of strategic level advice on development, implementation and sustainment of an occupational-health-based systems model, targeted for CSM during their ADF service and also for an effective and efficient compensation and rehabilitation process, and to enable continuity of care for XSM for their service-related conditions after they leave the ADF.

ADF Workplace Hazards

- Although we agree with the attributes of military service referred to in the draft Report, we add that the key attribute that makes it unique pertains to its primary function: the potential *controlled infliction of lethal force* in pursuit of Australian national objectives, against similarly inclined opponents.

- Military service can be further characterised by the fact that when CSM are not actively applying controlled lethal force, they are either training to do so, or supporting those who do. In the operational setting, *all* are susceptible to often unpredictable and potentially lethal threats from their opponents.

- It is therefore appropriate to acknowledge the likelihood of physical, medical, dental, mental, spiritual, social and other consequences of highly selected but otherwise ostensibly ordinary Australians being required to *deliberately* inflict harm on other human beings, with or without risking their own lives in return.

- Even so, although Battle Casualties (BCas) receive high media attention, the rates of rarely media reported Disease and Non-Battle Injury (DNBI) far exceed the rates for BCas. The overwhelming majority of ADF clinical presentations are for DNBI.

- While there is no enabling comparison data, we consider the ADF is potentially and probably the most hazardous working environment in Australia, with respect to both the variety of hazards, and the potential of each to cause harm.

- Another attribute of military service is that junior CSM in particular lack the protections provided in the civilian workforce by unions and other employee welfare organisations. We contend that the demands on ADF commanders to achieve their mission(s) continues to result in lower-profile yet exceptionally common musculoskeletal and mental health conditions, with the former in particular being regarded as 'business as usual' rather than generally preventable. CSM therefore need to rely heavily on the ADF's health services to protect their interests, for which the latter require direct access to the relevant authorities in the command chain as a means to reduce preventable illnesses and injuries.

- In addition to the requirement for direct access to commanders and supervisors, we also acknowledge that Defence health personnel also require *military* as well as health experience and expertise, for them to act effectively with respect to acting as WHS advisors to safeguard the health and wellbeing of a military workforce.

- Given the breadth and depth of hazards encountered during military service, best practice is for the ADF health services to utilise the skills, knowledge and expertise of OEPs using a systems approach to develop, implement, monitor and evaluate and sustain an occupational-health-based model, not only for the health and wellbeing of CXSM as an end unto itself, but also enabling ADF operational capability.

ADF Illness and Injury Rates

- We suggest Defence has minimal visibility as to the extent to which its work-related illness and injury rates are compromising operational capability, because accurate enabling data simply does not exist.

- Nevertheless, the limited information that *is* available suggests that:

    - The per capita cost of service-related injuries and illness *alone* to DVA, could be more than twice that expended by the Australian government on the general civilian population.

    - The Defence compensation claim incidence rate could be up to 12 times the *average* civilian serious claim incidence rate, and up to five times the *highest* civilian serious claim incidence rate.

    - The per capita CXSM compensation cost could be up to twice the average civilian rate.

- The magnitude of these differences makes it highly unlikely that they can be solely ascribed to different compensation eligibility criteria and/or entitlements. There is ample scope for improvement.

- To that end, we consider OEPs have an essential role with respect to preventing ADF injuries and illness, via:

    - Conducting workplace hazard assessments.

    - Undertaking research, and critical appraisal of information, with respect to the relationships between workplace hazards and employee health.

- We also consider OEPs have an essential clinical role regarding the management of ADF workplace-related injuries and illness. Besides workforce primary health care, this includes:

    - Conducting fitness and return to work assessments.

    - Working with governments, regulators, employers, workers, health professionals and other stakeholders, to ensure positive health outcomes for workers and employers.

    - Providing advice regarding the relationships between medicine and workplace health, safety rehabilitation and compensation legislation.

- In addition, OEPs can also provide health advice regarding ADF workplace environmental risks and incidents affecting the general civilian community.

ADF Illness and Injury Data Collection and Reporting

- While other large organisations in Australia have responsibilities for providing an occupational health service for their workers, the ADF is unique in that it also provides or funds full health care for its members, beyond that related to work related illness and injury. Separating the rates and costs of work-related illness and injury from operational requirements and routine treatment services is essential in order to improve ADF WHS.

- We therefore believe collecting health information regarding the work-relatedness of CSM injuries and illness *at the point of treatment* is essential in order to:

    - Monitor the effectiveness of the ADF with respect to preventing workplace-related illness and injury.

    - Account for the health care costs incurred by the ADF health services.

    - Account for the compensation and veteran health care costs incurred by DVA.

    - Document the work-relatedness – and therefore compensation eligibility – of each member's illness or injury.

- To this end, OEPs have skills and expertise that can facilitate the development, implementation and continuous monitoring, sustainment of a comprehensive workplace injury and illness reporting system, as part of the aforementioned occupational-health-based model.

- In addition, OEPs can also provide advice to all management levels regarding compliance with the *Work, Health and Safety Act 2011*, thereby preventing compensable workplace illness and injuries in the first place.

ADF Rehabilitation

- One of our specialists has advised there has been a threefold increase in the number of Navy members with medical restrictions, and a fourfold increase in those deemed medically unsuitable for

deployment since 1996. If confirmed, this suggests that the introduction of the ADF Rehabilitation Program (ADFRP) in 2006 and its subsequent iterations have not been particularly effective with respect to actually returning ill and injured Navy (and by extension other ADF) members to normal duties.

- Among other reasons, we believe both in the civilian and military settings, General Practitioners (GPs) need access to specialist advice, skills and expertise in order to provide the full range of clinical vocational rehabilitation services. We also note the current Australian Defence Force Rehabilitation Program (ADFRP) model does not reflect the RACP *National Vocational Rehabilitation Policy*.

- In particular, OEPs provide specialist advice on the pace and direction of workplace-based rehabilitation, and, as medical specialists, are also able to negotiate with employers and other stakeholders to achieve optimal return-to-work outcomes or advise on alternate duties.

ADF Compensation

- We note that at present, DVA does not specify either occupational medicine or military skills, knowledge, experience or training as even desirable criteria when contracting clinical advisors in their compensation sections.

- We advocate utilising the considerable experience of OEPs with a wide range of civilian workers' compensation systems throughout Australia and New Zealand. The formation of an expert medical advisory panel (EMAP) might be considered as a means of providing strategic level health advice regarding the proposed best practice client-centred ADF rehabilitation and compensation scheme to review and or replace the current DVA compensation schemes.

- OEPs also have skills and expertise that can complement Defence GPs and DVA compensation medical advisors, with respect to facilitating compensation and well as supporting primary health care for the ADF workforce.

Governance

- We note the draft Report's recommendation regarding a single Minister within Defence being responsible for both CSM and XSM. We also note the proposal to form a 'Veteran's Services Commission' (VSC) replacing DVA in its current form, under the proposed single Minister.

- We also note the proposal to transfer DVA's current policy responsibilities to a new Veterans Policy Group within Defence, contingent on its purpose being to act as a bridge between the proposed VSC and the ADF / single-Service personnel directorates.

- We do not consider transferring the current DVA responsibilities to Defence necessary. With the exception of self-insurers, compensation organisations are separate from the enterprises they support.

- We also have concerns that the responses from both the ADF and DVA to the recommendations on organisational restructuring may predominate, at the expense of focussing on the function of improving the WHS, rehabilitation and compensation system for the benefit of CXSM. As an aside, we also do not consider this will improve the ADF's ability to conduct its primary role in the defence of Australia.

- We note the Defence WHS Committee does not have any OEP representation and has not been provided with this expertise for over two decades. Best practice in industry occupational health services requires OEM advice to have direct access to the highest levels of management.

- We also note the Defence Work Health and Safety Strategy 2017-2022[6] and the statement that "Importantly, work health and safety is everyone's responsibility". However, there does not appear to be an implementation plan, and unlike the Airworthiness Board[7], no individual(s) appear to be accountable for its performance.

- However, we note the response of the ADF to the Sea King Board of Inquiry[7] and other incidents and accidents in the 1990s. A review of ADF Aviation Safety Management resulted in the appointment of the Chief of Air Force as the ADF Airworthiness Authority tasked to establish, manage and monitor an ADF Airworthiness Management System for aircraft and aviation systems. Since this was implemented, ADF aircraft accident rates are reported to have reduced significantly.

- Although we agree that the Chief of the Defence Force (CDF) and the Service Chiefs should be more accountable for the health and wellbeing of their personnel (beyond their obligations per the *Work Health and Safety Act 2011*) we suggest CDF may be in the best position to determine the appropriate governance arrangements. We recommend the establishment of EMAPs, similar to the specialist engineer expertise per the current independent ADF airworthiness, seaworthiness and other engineering Boards, to provide the specialist occupational health strategic knowledge and advice.

- We note the recommendation for an annual premium levied by Defence Group. We consider that however the financing is determined, the accurate and timely reporting of costs and injury rates is essential if ADF commanders and supervisors are to be held accountable for the health and well-being of their members.

- We also consider that the formation of the proposed 'JTC' is not an essential requirement, as transition can in many ways be considered a mirror or inverse of the detailed, comprehensive, thorough and often extended recruiting process. We therefore suggest that the current emphasis on improving transition would be better able to meet the needs of separating members. More emphasis should be placed on transitioning those who are separating for administrative and medical reasons, as these CSM are likely to be of increased risk.

Transition from the ADF

The RACP has developed a Consensus Statement on addressing the harms to health from both unemployment or being employed in 'toxic workplaces'. The RACP *Health Benefits of Good Work* sets out the economic and social imperatives to ensure that everyone who is capable of working should be supported to do so. It reflects the fact that employment has been widely recognised (including by the World Health Organisation) as *the* major social determinant of health. The nature of that work is discussed in the companion AFOEM position statement *What is Good Work?*[8]

Additional evidence since the publication of the Consensus Statement reinforces its assertion that work is good for optimising people's health and wellbeing, and work absence because of illness or injury is not.[9] Furthermore, it also documents emerging evidence demonstrating the growing adverse effects that a lack of 'good' work has on mental health. The Consensus Statement also highlights the need to promote recovery at work practices, which requires better integration between health services and employers.

These statements are supported by the fact that for example, suicide rates among unemployed males is over four times that of employed males, and is about eight times worse for unemployed females compared to their employed peers.[10] *We contend that a focusing on gaining employment, or skills to enable employment, should be a key focus during transition from the ADF, as a far more effective measure for promoting mental health and well-being than the current emphasis on the provision of mental health services.*

To date, the Consensus Statement has over 200 Australian signatories. Besides various health organisations, these include entities such as Allianz, the Australian Federal Police, the Australian Life Underwriters and Claims Association, the Business Council of Australia, Comcare, the Financial Services Council, Fire & Rescue NSW, KPMG Australia, the Police Federation of Australia, Qantas, SafeWork Australia, SafeWork NSW, the NSW State Insurance Regulatory Authority (SIRA) StateCover Mutual Limited, Thales Australia, WorkCover Queensland, WorkCover South Australia, WorkCover Tasmania and WorkCover WA.[11]

We believe it would be entirely consistent with the Report's recommendations if Defence and DVA, or the latter's successor, either adopted the principles of, or even became signatories to the RACP Consensus Statement.

Vocational Rehabilitation

The RACP *National Vocational Rehabilitation Policy* describes how vocational rehabilitation is an idea and an approach as much as a formal intervention or service, based on the concept that being at work can be therapeutic and have a positive impact on health. Hence, the barriers to vocational rehabilitation do not pertain to particular impairments, but to the lack of guaranteed access to customised plans of timely support and development. The draft Report confirms the extent to which such barriers exist within both Defence and DVA.

As participation in the workforce requires ongoing good health and management of illness, injury and disability, the *National Vocational Rehabilitation Policy* states that treatment services have an essential but not isolated role alongside vocational rehabilitation programs, as an enabler for workforce participation and productivity.[12] This submission will show how this statement pertains to the health services provided by JHC.

The *National Vocational Rehabilitation Policy* also states that the principles and practice of vocational rehabilitation are fundamentally the same for work-related and other comparable health conditions, irrespective of whether they are classified as injury or disease. Work is not only a goal: it is generally therapeutic and an *essential* part of rehabilitation.

Finally, the *National Vocational Rehabilitation Policy* refers to the urgent need to improve vocational rehabilitation interventions for mental health conditions, which have become the largest and fastest growing cause of long-term civilian incapacity. Promising approaches include health care that incorporates a focus on return to work, workplaces that are willing to accept such cases, and early intervention to support workers to stay in work in order to prevent long-term incapacity. We note the draft Report highlights the need for better support for CXSM with mental health conditions.

Best practice in vocational rehabilitation entails utilising the expertise available from specialist rehabilitation physicians and specialist OEPs, for both a strategic planning role as well as for the individual management of more complex cases.

ADF Population Demographics

This submission is premised on the principle that to be efficient and effective, health services should reflect the population(s) they serve. Civilian examples include the indigenous, LGBTIQ and prisoner communities.

Size

The draft Report indicates that the ADF currently has about 58,000 CSM who require health services, while DVA supports about 166,000 CXSM and 117,000 dependants (mainly widows or spouses). It also refers to a lack of detailed demographic information regarding XSM and their dependents.

The lack of additional demographic information makes it very difficult to ascertain the qualitative and quantitative attributes of the health services required for both CSM and XSM. Even so, we note the combined CXSM population (excluding dependants) may be up to 741,300 people, consisting of 80 000 permanent and active reserve CSM, about 20,000 inactive reservists, and an estimated 641,300 XSM (the latter including 145,800 with peacetime-only service).[13,14,15]

With respect to the permanent ADF population, the RACP notes that the ADF has averaged 60,763 members since 1950, and that it had 57,475 permanent members in 2017-18.[16] Comparison with civilian workforces indicates that in 2017-18, the Australian Public Service comprised 136,175 permanent and 14,419 non-ongoing (contract) employees,[17] while the three largest Australian private employers were Wesfarmers (217,000),[18] Woolworths (201,000)[19] and Rio Tinto (47,000).[20] However. Unlike the ADF, none of these employers provide clinical health services for their employees; furthermore their employee's medical conditions usually do not require the same level of assessment or monitoring of their capacity to work.[21]

The ADF population requiring health services therefore constitutes one of the largest workforces in Australia. It is comparable to urban centres such as Wagga Wagga NSW (population 48,263), Melton VIC (54,455),

Rockhampton QLD (61,213), Bunbury WA (71,014), the SA Fleurieu Peninsula including Murray Bridge, Bridgewater-Crafers, Mount Barker, and Victor Harbour (total 63,827), and Launceston TAS (75,328).[22]

The relevance of the ADF's population numbers pertains to the overall size of its supporting health services (hence resources required) to undertake the numerous roles and functions. However, the wide distribution of this workforce around the many Defence establishments in Australia (see below) also means the ADF's health services cannot achieve the economies of scale of large co-located populations.

Age

As ADF members, by definition all CSM are over 17 years of age and virtually all are under 65, compared to 66 per cent of the Australian civilian population who were within this age range in 2018.[23]Furthermore, 22 per cent of CSM were aged under 25,[24] compared to 12.8 per cent of the Australian population who were aged 15-25 at that time.[25]

The fact that its health services do not provide care for family members or XSM therefore means that the ADF is not only a workforce population, but predominantly a *young* workforce population. Compared to the aforementioned civilian communities, this negates the need for health services such as paediatrics or geriatrics (both of which constitute a large component of civilian general practice) and reduces (but does not eliminate) the need for other health services such as those that may be required for some humanitarian aid / disaster relief operations.

However, their relative youth *increases* the demand for other health services, such as those related to workplace- and sports-related musculoskeletal injuries, domestic- and workplace-related mental health issues, and risk-taking behaviours such as horseplay, driving habits, and alcohol and other drug use.

Gender

We note the ADF had 10,483 female members (18.1 per cent) in 2017-18,[26] compared to 47.0 per cent of the Australian civilian workforce.[27] We also note that Defence is committed to increasing the proportion of female ADF members to 19.8 per cent by 2023.[28]

Among their anatomical, psychological, and other differences, males and females have their own illness and injury profiles.[29] Combined with the relative youth of ADF members, this affects the nature and severity of their workplace- and sports-related musculoskeletal injuries, mental health issues, risk-taking behaviours, and (especially) how and when they present to health staff.[30]

The majority of female CSM are of childbearing age, and potential hazards must be appropriately managed to ensure their workplace health and safety, and that of any unborn children. To this end, it should be noted AFOEM recently published a *Guide for Pregnancy and Work*.[31]

Health Standards

The recruiting health standards for each of the ADF's three Services are intended to facilitate operational capability by ensuring that entrants can perform their expected duties. Some require specific standards: for example, the importance of visual tasks for aircrew means that, compared to other ADF members, they require a higher visual standard. Similar issues pertain to Army and Navy divers and Navy submariner candidates regarding their airway and lung function.

In addition, current ADF members should also meet the relevant retention health standards. This facilitates personnel operational capability with respect to promotions, courses, career transfers and postings.

Hence, the ADF probably has one of the most highly medically-selected populations in Australia. This not only reflects the limited health services available in remote or austere environments: it also stems from their normal duties usually requiring high levels of medical, dental and mental health, often even when not deployed.[32]

Conversely, the ADF's high rates of workplace-related injuries and illness (see below) confirms the extent to which high health standards do not of themselves prevent such conditions if the hazards to which employees

are exposed are not properly managed via systematic prevention, early intervention, treatment, rehabilitation and compensation.

Workforce Complexity

Taking Navy as an example, there are 50 Permanent Navy (PN) and ten Australian Navy Reserve (ANR) entry-level jobs.[33] Furthermore, the workforce composition per Figure 1 indicates the extent to which the notional numbers of PN members for each rank / Primary Qualification (officer) or rank / branch (sailor) permutations are quite small.

Figure 1: PN Workforce Composition, 2017-18

PN Member Type	Number of Ranks	Number of Primary Qualifications (PQs) / Branches	Number of Rank / PQ or Rank / Branch Permutations	Members per Rank / PQ or Rank / Branch Permutation
3,362 Officers[34]	Ten (MIDN to VADM)	25 PQs	~150 from MIDN to CAPT	~23
10,288 Sailors[35]	Nine (RCT to WO-N)	33 Branches	~231 from RCT to CPO	~47

If every officer and sailor rank has up to ten skill-level-based pay rates,[36] Figure 1 gives a notional 2.3 officers per rank per PQ per pay rate, and 4.7 sailors per rank per branch per pay rate. While these figures clearly do not reflect the actual PN workforce, they do indicate why the smaller PQs / branches in particular frequently lack depth with respect to their skills base.

Moreover, over 1,814 Navy members (13.2 per cent) were under training in 2017-18,[37] a proportion that is probably higher than most civilian employers. Navy also conducted nearly 2000 courses in 2017, many of which were for its *trained* force, including those at sea.

Navy (hence the broader ADF) therefore probably also has one of the most complex workforces in Australia. Keeping this workforce medically, dentally and mentally employable and deployable creates major challenges for supporting health staff, especially for CSM with skills that are rare but essential to their units' mission. For example, if a safety-critical 'ship-stopper' Navy crew member is medically landed ashore, their ship cannot sail until they are fit for sea, or replaced by someone else with the same 'ship-stopper' skills (if available).

Hence, any failure to keep CSM medically, dentally and mentally employable and deployable can have major impacts on ADF operational capability.

Duration of Service

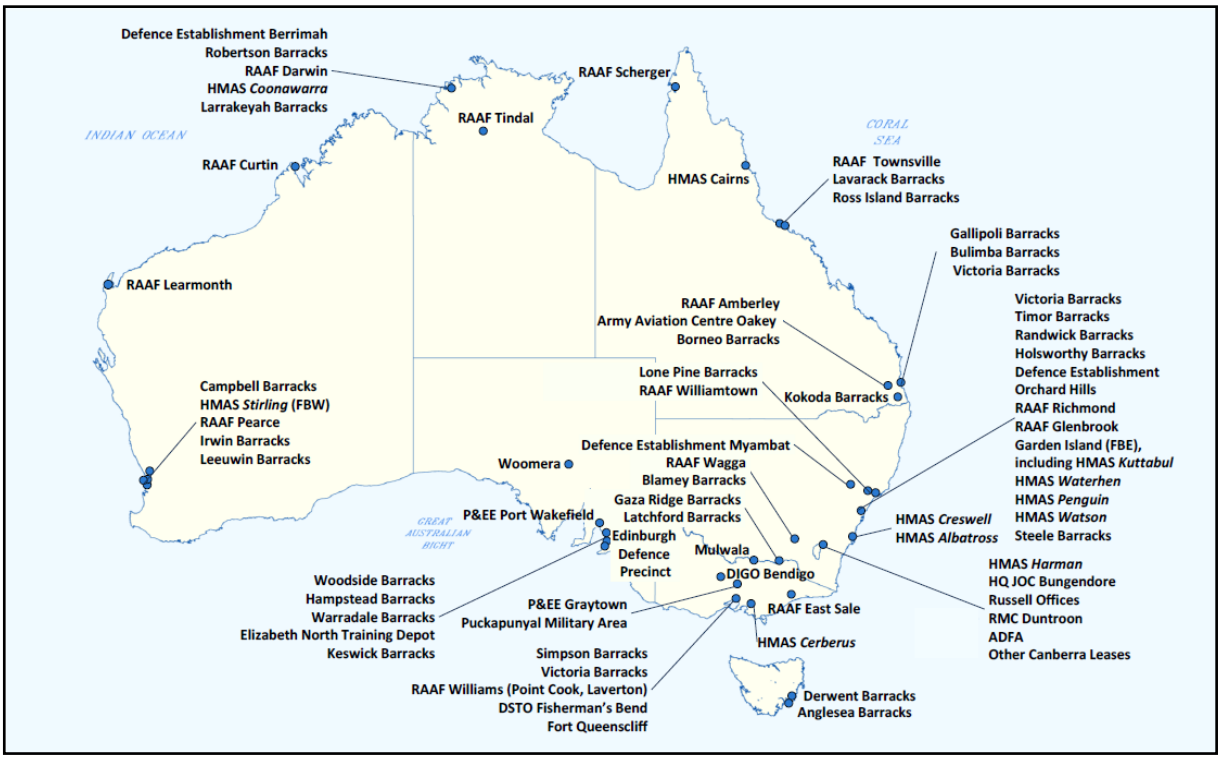
The draft Report indicates that the median length of service is seven years for Navy and Army members, and 10 years for Air Force members. However, it also indicates that the 12-month ADF separation rate to 30 Jun 2015 was 9.1 per cent, and that of those ADF members who transitioned in 2015, 45 per cent had served four years or less.[38] We also note that in 2015, nine per cent of CSM had served less than one year, and 38 per cent for less than five years.[39] These figures imply a high-turnover population, particularly if a median length of service of seven years for all ADF members is applied to an average Australian lifetime of 80.3 years for males (8.7 per cent) and 84.4 years for females (8.3 per cent).[40]

The relevance of these numbers firstly stems from high-turnover workforces generally having higher rates of workplace injury and illness compared to those with lower turnover.[41] Furthermore, it is likely that most early separations are for various medical and other involuntary reasons, which the draft Report confirms can have a range of mental health and broader societal implications for the affected XSM.

Workforce Distribution

Using Navy again as an example, about two-thirds of the PN population (9300 personnel) are posted to 14 shore establishments, or to more than 40 non-Navy ADF bases throughout Australia (Figure 2).[42]

Figure 2: ADF Base and Establishment Locations, 2016-17[43]



The remaining third (4700) are distributed among 50 seagoing Fleet units and non-commissioned vessels.[44] When not at sea, they are alongside one of five homeports, two of which are in Sydney. Of these, up to 800 (17.0 per cent of all seagoing PN members) are force assigned to Joint Operations Command, while the remaining 3900 undertake a range of Navy-led activities in Australian waters, and various regional and other deployments. While the turnover between being alongside and at sea varies considerably, an average of one third (1600) who are physically at sea at any one time appears reasonable.[45]

Hence, the Navy (and by extension the broader ADF) population requiring health services is widely distributed, not only whilst deployed but also within Australia. As previously indicated, the wide distribution of this workforce around Australia means the ADF's health services cannot achieve the economies of scale of large co-located populations. Furthermore, locations such as Darwin and Cairns for Navy, (as well as Darwin and Tindall for Air Force, and Darwin and Townsville for Army members) have limited access to many specialist health services that are more readily available in southern Australia's major urban centres.

Workforce Mobility

All ADF members are subject to posting cycles of two to three years' duration, which in Navy's case (as an example) amounts to at least 4700 planned postings per year. This excludes unplanned postings for compassionate, disciplinary, medical and other reasons. Although many Navy shore postings can be 'back-to-back' at the same location, this is often not possible for various Service and career development reasons.

Furthermore, Navy's minimum crewing policy for Fleet units means seagoing Navy members deemed non-deployable must be posted ashore pending replacement. This contrasts with non-deployable Army and Air Force members, who can remain posted to a deployable unit unless it actually deploys.[46]

As previously indicated regarding 'ship-stopper' Navy personnel, the ensuing 'crash postings' to sea of erstwhile shore-based members drives their need to maintain a high level of medical and dental fitness. Yet, the fact that they themselves may have only just been posted ashore after extensive sea time has considerable potential for creating a range of retention, welfare, mental health and other issues.

Figure 3 summarises the composition, distribution and mobility of the Navy population: the other Services are likely to be comparable.

Figure 3: Navy Population Composition, Distribution and Mobility

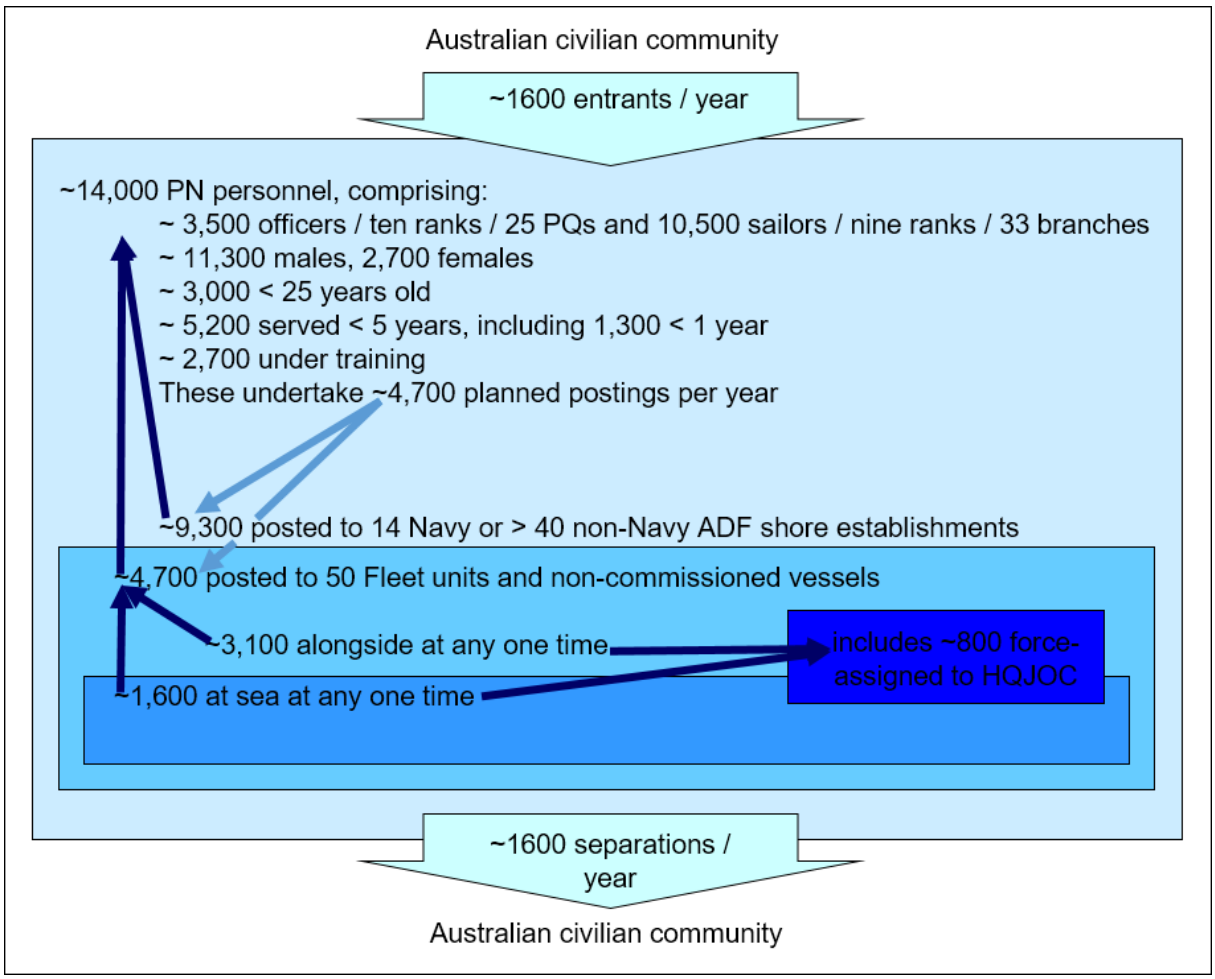


Figure 3 therefore demonstrates the extent to which Navy (and by extension, the broader ADF population requiring health services) is not only very complex and widely distributed, but also exceptionally mobile.

Implications

Compared to the civilian Australian workforce, the ADF workforce is younger, more complex, predominantly male (but also with a small but increasing female population of predominantly childbearing age), has high turnover, has very high training commitments, is highly geographically dispersed (often including remote locations even within Australia), and highly geographically mobile (even without deploying).

Even without considering the operational and other workplace hazards to which CSM can be exposed, these demographics result in a higher risk of workplace illness and injury compared to the general Australian workforce. The fact that they are highly medically selected does not of itself protect them from these hazards.

We therefore believe OEPs have an essential role regarding the development, implementation and sustainment of an occupational-health-based model, targeted for CSM during their ADF service, and for XSM for their service-related conditions after they leave.

Although not directly germane to the Report, we also believe OEPs also have a role regarding ADF requirements with respect to the same occupational-health-based systems model approach to enabling operational capability.

ADF Workplace Hazard Management

We note that the draft Report describes military service as a unique occupation, in that it involves a requirement to follow orders, frequent relocations and long and irregular hours. It also notes that CSMs are also frequently placed in high-risk environments, including in war or operational service and while in training or on peacetime service.

While generally true, we suggest that the draft Report might add the key point as to what makes military service truly unique: unlike other disciplined government-sanctioned uniformed services such as police (and to a lesser extent fire, ambulance, and other emergency services), its primary function entails the *controlled infliction of lethal force* in pursuit of Australian national objectives against similarly inclined opponents. We believe this must not be glossed over, given the physical, medical, dental, mental, spiritual, social and other consequences of ostensibly ordinary Australians *deliberately* inflicting harm on other human beings, with or without risking their own lives in return.

Military service can be further characterised by the fact that if members are not actively applying controlled lethal force, they are either training to do so, or supporting those who do. In the operational setting, *all* are susceptible to lethal force (much of which is somewhat less-controlled) from their opponents.

Battle Casualties (BCas) are typically caused by physical hazards such as blade- and club-type weapons, small arms, grenades and other explosive devices, artillery rounds, sea-, land- and air-launched missiles, and sea mines and torpedoes. These cause penetrating wounds, blunt trauma, blast injuries and/or burns. Nuclear and radiological weapons pose additional hazards, as do biological and chemical agents.[47] We therefore accept that the ADF clearly requires a targeted and scalable range of deployable and non-deployable surgical and related allied health BCas treatment services.

Even so, although BCas receive high media attention, the rates of rarely media reported Disease and Non-Battle Injury (DNBI) far exceed the rates for BCas. Consistent with military history,[48,49,50] the overwhelming majority of ADF clinical presentations continue to be for DNBI. This is because even when not deployed, CSM can still be exposed to a wide range of workplace hazards compared to civilians, such as:

- Physical, including heat, cold, noise, vibration, and radiation (ionising and non-ionising);
- Chemical, including solids, liquids, dusts, fumes, mists and gases;
- Biological, including vermin, parasites, protozoa, fungi, bacteria, rickettsia and viruses;
- Ergonomic, in particular personnel/machine interfaces, and
- Psychological factors, including trauma, work load, shift work / fatigue, circadian dysrhythmia, and bullying / harassment.

While there is no enabling comparison data, we believe it is highly likely that CSM are exposed to the greatest variety of such hazards of any Australian workforce. Furthermore, the ADF's workplace injury and illness rates per below suggests in many cases, *each* of these hazards are presently causing more harm to CSM compared to civilian employees.

We note that ADF members in particular lack many of the protections provided in the civilian workforce by unions and other employee welfare organisations. The demands on ADF commanders to achieve their mission(s) has previously led to high-profile failures to ensure the health and wellbeing of their people.[51] We contend this remains the case regarding lower-profile yet exceptionally common musculoskeletal and mental health conditions (see below), with the former in particular being regarded as 'business as usual' rather than generally preventable.

We also contend that many Defence health personnel presently require both the *military* as well as health experience and expertise required, in addition to (in particular) direct access to their commanders, for them to act effectively as *military* health and wellbeing advisors.

We agree that the introduction of the *Work Health and Safety Act 2011* has been instrumental in improving WHS outcomes in the ADF. However, we do not agree that Defence's incentives to prevent service-related injuries and illnesses at present include maximising operational capability: evidence per below indicates that accurate enabling data for it to do so simply does not exist.

Rather, the only incentives at present pertain to reputation management (and even then, not necessarily as an employer of choice), and to meet its obligations under WHS legislation and the related enabling regulations and codes of practice.

We also note that the existence of appropriate legislation, regulations, policies and codes of practice does not ensure protection of the health and safety of individuals in an organisation. Workplace cultures, methods of conducting work and compliance with rules and regulations invariably change over time and may result in departures from required procedures, as indicated by the 'black lung'[52] and accelerated silicosis[53] issues widely reported over the past two years in Queensland. Such deviations from requirements are more likely given the task focus, population demographics of the ADF and the absence of union support. Ongoing expert monitoring and early intervention is essential to contain and respond to developing issues.

We note that the responsibility for whole-of-Defence WHS compliance (including its civilian public service workforce) is a Defence WHS Branch responsibility, with very limited engagement by JHC. We believe the current lack of OEM engagement by the latter is in no way counterbalanced by that provided by the former.

This assertion is supported by media articles reporting significant preventive management shortfalls for ADF environmental hazards in the base setting, such as asbestos, fuel, diesel exhaust fumes, surface finishes and fire-fighting foam.[54,55,56,57] While Defence's responses to each of these high-profile events is generally effective, we believe its overall approach can be improved via an occupational-health-based systems model with continuous monitoring and evaluation.

Regarding the latter, we suggest that the focus by the Defence WHS Branch on these higher-profile workplace exposures does not address the lower (and at present often absent) profile yet far higher volume (and cost) of preventable workplace-related musculoskeletal and mental health conditions being treated by JHC health staff. As a result, JHC's current role with respect to facilitating Defence WHS compliance can best be described as 'The Ambulance Down in the Valley'.[58]

This assertion is further supported by the fact that at present, JHC has only two OEPs (of which one is not currently employed in an OEP role), while the Defence WHS Branch has only one. We believe their efforts to influence ADF WHS, rehabilitation and compensation policy at a strategic level are often overwhelmed by other matters considered higher political priority.

We believe EMAPs with OEP representation on the Defence and single Service WHS committees would benefit *all* committee members, *including* the current *non*-OEP Service health representatives.

ADF Workplace Injury and Illness Rates

This submission has previously noted that Defence has minimal visibility as to the extent to which its work-related illness and injury rates are compromising operational capability, because of the shortfall in timely, accurate and contemporaneous records and data.

We note a 2009 study of DVA compensation claims in 2006 and 2007 for Chondromalacia Patellae (CMP), a painful degenerative condition of the patella (kneecap).[59] This study indicated that the rate of new cases (incidence) of this condition *alone* within the ADF was 0.62 per cent (639 cases) per annum, with the incidence in Army (0.85 per cent) being about twice that of Navy (0.33 per cent) and Air Force (0.45 per cent). Most of these cases developed in the first few years of service. Hence, if the median duration of service per the draft Report for Army personnel is seven years, *every* Army member has a 5.95 per cent likelihood of developing compensable CMP *alone* during their service.

Furthermore, if, as seems likely, CMP is one of the five most common musculoskeletal disorders in the ADF, and if the incidence of the other four conditions are comparable, the ADF would sustain *at least* 3,200 *new* cases with musculoskeletal disorders resulting in DVA claims *alone every year*. If one applies the median duration of service per the draft Report of seven years to all CSM, *each* would have a minimum **21.7 per cent** likelihood of developing a compensable musculoskeletal condition during their service.

This submission has previously noted that Australia had about 741,300 CXSM in 2017-18, including 150,200 with peacetime-only service. Of the total, 190,967 (29.8 per cent) were receiving health care services from DVA for service-related conditions (Gold and White Cards),[60] costing $5.3 billion (**$7,149** per CXSM, or $27,753 per CXSM with an accepted claim).[61] By comparison, the Federal Government spent $74.6 billion[62] on health services on a total Australian population of 24,511,800 people in 2016-17[63] (**$3,043** each).

This suggests that the per capita cost of service-related injuries and illness *alone* to DVA, is more than **twice** that expended by the Federal Government on the general civilian population.

These figures exclude another $7.4 billion spent by DVA on *non*-health disability services and compensation in 2017-18.[64] To this end, 85,811 CXSM received a disability pension via the *Veteran's Entitlements Act 1986* (VEA), while another 5,767 CXSM received a weekly incapacity payment per the *Safety Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA) or the *Military Rehabilitation and Compensation Act 2004* (MRCA), while between12,414 and 26,564 CXSM received one-off permanent impairment payments from either the DRCA, the MRCA, or both.[65]

Hence, between **140** and **159 per 1000** CXSM received some form of compensation payment for at least one service-related medical condition in 2017-18, at a per capita cost (*additional* to the treatment costs above) of **$9,982** per CXSM (total **$17,131**).

Comparing this DVA claim data with civilian worker's compensation claim data is difficult for various reasons, noting in particular that the latter are subject to multiple federal, state and territory jurisdictions. Collating the civilian data is also not straightforward: for example, Safe Work Australia stated that in 2012-13, Australia had 10.599 million employees,[66] while the Australian Bureau of Statistics' Work-related Injuries Survey infers there were 12.367 million employees.[67]

Even so, the most recent data from SafeWork Australia indicates that the median cost[68] of civilian claims in 2012-13 was $8,900,[69] while the Work-related Injuries Survey showed that the total economic cost was estimated to be $61.8 billion (4.1% of GDP),[70] or **$5,000** to **$5,800** per civilian employee.

The Work-related Injuries Survey also indicated that during that time, an estimated 531,800 workers (4.3%) had experienced a work-related incident. 348,600 workers did not receive compensation, either because no application was made, or the application was rejected.[71] Of the remaining 183,200 workers, Safe Work Australia showed that 117,815 were for serious worker's compensation claims (requiring a work absence of one working week or more), or **11.1 claims per 1000** employees.[72] Employees working as labourers had the worst serious claim incidence rate of all civilian occupations (**27.0 per 1000** employees), followed by machinery operators and drivers (**24.4 per 1000** employees).

Hence, the current Defence compensation claim incidence rate could be at least **12 times** the *average* civilian serious claim incidence rate, and **five times** the *worst* civilian serious claim incidence rate. Furthermore, the per capita cost of compensation for CXSM could be **up to twice** the Safe Work Australia median civilian rate and the average Work-related Injuries Survey civilian rates.

The magnitude of these disparities makes it highly unlikely that they can be solely ascribed to different compensation eligibility criteria and/or entitlements.

We also note data from the ADF's Health Surveillance System (EpiTrack), which showed that in 2007-08 and 2008-09, the five most common medical conditions were injuries and musculoskeletal disorders, respiratory tract conditions, skin conditions, ill-defined conditions, and ear, nose and throat disorders, while the five most common medical conditions resulting in sick leave were injuries and musculoskeletal disorders, respiratory tract conditions, mental health disorders, stress reactions, ill-defined conditions, and intestinal infectious disease.[73,74]

By comparison, the five most common Australian civilian clinical presentations in 2013 were hypertension, (childhood) immunisations, upper respiratory tract infections, (non-work-related) depression, and diabetes.[75]

We also draw attention to Table 1, which lists the 15 most frequently claimed conditions under the VEA in 2015.[76] These claims were based on the Repatriation Medical Authority's Statements of Principles, and made up 61.5% of all conditions claimed under the VEA.

Table 1: 15 most frequently claimed conditions under the VEA in 2014–15

Disability	Claims accepted	Acceptance rate	Claims rejected	Total claims
Osteoarthritis	1 623	76%	514	**2 137**
Sensorineural hearing loss	1 372	99%	14	**1 386**
Tinnitus	1 307	98%	26	**1 333**
Lumbar spondylosis	930	84%	181	**1 111**
Solar keratosis	640	99%	9	**649**
Post-traumatic stress disorder	472	76%	151	**623**
Non-melanotic skin cancer	533	99%	7	**540**
Depressive disorder	270	56%	211	**481**
Alcohol use disorder	218	55%	176	**394**
Hypertension	100	31%	219	**319**
Cervical spondylosis	82	28%	211	**293**
Ischaemic heart disease	154	53%	139	**293**
Acquired cataract	223	100%	1	**224**
Rotator cuff syndrome	70	32%	150	**220**
Chronic bronchitis	124	60%	84	**208**
Totals	**8 118**	**79%**	**2 093**	**10 211**

Table 1 suggests that at least 22 per cent of all VEA claims were for musculoskeletal conditions, while at least another nine per cent were for mental health issues (including alcohol use disorder). Other conditions for which a relatively straightforward relationship to ADF employment exists include hearing disorders secondary to workplace noise (16 per cent), skin disorders secondary to sun exposure (seven per cent), and a small number of eye disorders secondary to ultraviolet-light exposure (e.g. arc welding).

Table 1 also confirms this submission's previous advice that the overwhelming majority of ADF clinical presentations are *not* combat-related.

Pending better data collection (see below), we therefore suggest it is likely that:

- About 30-40 per cent of clinical presentations to typical Australian located JHC 'garrison' facilities, may be for generally preventable musculoskeletal injuries. About half could be workplace-related (typically related to manual handling or slips/trips/falls); the remainder would mostly be sports-related.

- Another 30-40 per cent of 'garrison' clinical presentations may be for generally preventable workplace mental health issues. Perhaps half of these cases lack psychological robustness for whom the ADF has been a poor career choice; the rest are psychologically robust but are not coping with excessively demanding or otherwise dysfunctional ADF workplaces or personnel management practices.

  It should be especially noted that the former such cases in particular would not be eligible for civilian workers' compensation. It should also be noted that for various reasons (see below), it is likely that many Defence GPs are not distinguishing between the two.

- Hence, it seems likely that pending better data, **60-80 per cent of JHC primary care presentations** could be for work-related conditions. These estimates should be compared with data that *does* exist, which indicates that only **2.4 per cent of civilian GP presentations** in 2013-14 were work-related.[77]

We therefore consider OEPs have an essential role with respect to facilitating local command compliance with the *Work, Health and Safety Act 2011*, by helping to prevent compensable workplace illness and injuries in the first place via:

- Conducting workplace hazard assessments.

- Undertaking critical appraisal of information with respect to the relationships between workplace hazards and employee health.

- Conducting reviews and research regarding the relationships between workplace hazards and employee health.

In addition to prevention, we also consider OEPs also have an essential *clinical* role managing the chemical, physical, biological, psychological, emotional, environmental and psychosocial hazards pertaining to ADF workplace-related injuries and illness, in order to either return CSM to normal duties as soon as possible or facilitating their timely and empathetic transition from the ADF.

ADF Workplace Injury and Illness Recording and Reporting

We note that current OEH legislation imposes a duty of care obligation on ADF commanders to minimise personnel exposures to workplace hazards.[78] Although the *Work Health and Safety Act 2011* does permit granting exceptions for hazards that cannot be adequately controlled for operational reasons, doing so can later become an emotive political issue.[79,80] From an OEM perspective, preventing or limiting BCas in particular while in pursuit of their mission(s) can be considered a normal – if admittedly at times extreme – 'business-as-usual' function that is already conducted by ADF operational commanders.

Yet at present, the ADF appears unique in that, unlike other employers that provide employee health care, its health services do not ascertain whether their clinical presentations are work-related. For example, at present JHC health staff routinely record CSM patient details such as their Service and rank, but only rarely their rate (Navy), corps (Army) or mustering (Air Force) that indicate the jobs they perform. We also note that although JHC recently added an 'occupational aetiology' checkbox to the Defence e-Health System:[81]

- No guidance was provided for its primary health care providers to ensure consistency as to what should and should not be considered work-related. Ascertaining work-relatedness is not often

easy to determine as it entails considering multiple factors, in particular awareness of the patient's workplace and associated activities where and when the injury or illness occurred.

- Workplace- and sports-related injuries are not recorded separately, thereby precluding differentiating work- versus sports-related treatment costs or Lost Time Injury Frequency Rates.

- It does not initiate the compensation claims process (which still has to be done separately).

Hence, JHC remains generally unable to collect or report work-related illness/injury data, or record lost time or restricted duties, or identify the ensuing health care costs.

Although some – but by no means all – of this information is provided via Defence's Work Health and Safety Compensation and Reporting (WHSCAR) System ('Sentinel'), a recent study indicates that only 11 to 19 per cent of all Army Reserve and Regular work-related injuries and illnesses are being reported.[82] It seems likely that workplace illness and injury reporting by the other Services is probably comparable.

The most likely reasons pertain to the fact that such reporting is currently conducted separately via 'Sentinel', from when CSM present for treatment, even though health staff should be ascertaining much of the same information for clinical reasons. The fact that the first presentation for a service-related medical condition does not *automatically* initiate the compensation process means it does not even commence unless or until the member submits their claim (often years later).

We believe collecting this information *at the point of treatment* is essential, not only to document the work-relatedness – and therefore potential compensation eligibility – of each CSM's illness or injury (thereby addressing the deficiencies of the 'Sentinel' system per the draft Report), but also to:

- Monitor the effectiveness of the ADF's OEH services with respect to preventing workplace-related illness and injury.

- Account for and appropriately categorise the health care costs incurred by JHC.

- Account for the compensation and veteran health care costs incurred by DVA.

We note the recommendation in the draft Report to integrate Sentinel and the JHC electronic health record. We have some concerns regarding this, as this is not required in other organisations who run effective WHS programs. In addition, unless the medical condition is work-related, there are potential risks to privacy.

To this end, OEPs have skills and expertise that can facilitate the development, implementation and sustainment of a comprehensive population based workplace injury and illness reporting system, as part of the aforementioned systems approach using an occupational health model.

We also consider the need to improve workplace exposures and health status recording for CSM during their service, via a systematic periodic health assessment process as follows:

- On entry for 'baselining' purposes. This already occurs at present on recruitment, albeit for purposes associated with assessing their health suitability for service on entry, rather than recording their health status at that time for future rehabilitation and compensation purposes (which may only occur years after the member has left the ADF).

- Pre-deployment, in order to 're-set' each CSM's health status 'baseline' since entry. We note although JHC conducts pre-deployment health assessments, these are more-or-less 'healthy lifestyle checks', per the Royal Australian College of General Practitioners (RACGP) 'Red Book',[83] which are of limited value for actually assessing their health-related suitability for deployment, and generally cannot be used for rehabilitation and compensation purposes.

- Post-deployment, for comparison with each CSM's pre-deployment 'baseline', and to re-set' their health status 'baseline' on their return. As the current JHC post-deployment health assessments are another 'health lifestyle check' per the RACGP 'Red Book' and are otherwise only intended to assess their health suitability for treatment purposes, they cannot be compared with the

member's pre-deployment 'baseline' or become the next 'baseline' for future health assessments, for rehabilitation and compensation purposes.

- Periodic (we suggest five-yearly intervals unless it is less than 12 months since their previous 'baseline' health assessment). At present, the JHC periodic health assessments are likewise essentially 'health lifestyle checks' per the RACGP 'Red Book' and cannot be compared with any other health assessments for rehabilitation and compensation purposes.

- At separation ('re-baselining' for DVA/VSC purposes). The current JHC Separation Health Assessment can be compared (more-or-less) with any suitable previous health assessments for rehabilitation and compensation purposes, where the latter exist (which at present, per above, is usually not the case).

Again, OEPs have the skills and expertise which can facilitate the development, implementation and sustainment of a comprehensive and systematic health assessment process as part an occupational health based model.

Rehabilitation

Civilian Rehabilitation

As previously indicated, the RACP's *National Vocational Rehabilitation Policy* states that, as common health problems account for about two-thirds of civilian long-term sickness absence and incapacity benefits, these cases should receive high priority. Among other considerations, this could be interpreted to imply *all* health professionals such as GPs, who treat patients with common health problems such as musculoskeletal and mental health conditions, should assume responsibility for their rehabilitation and occupational outcomes.

However, this submission has previously noted that only 2.4% of all presentations to civilian GPs in 2013-14 were work related. Furthermore, studies indicate medical fitness-for-work certification can be challenging for civilian GPs because of a combination of confidentiality issues inherent to the doctor-patient relationship, the GP's patient advocacy role, consultation time pressures, a lack of occupational health expertise, and a lack of knowledge of their patient's workplace.[84,85] In addition, other studies indicate that some civilian GPs do not consider they have responsibilities for the management of long-term work absence, work disability and unemployment.[86,87] Furthermore, we note that the RACGP website has only limited references to GPs having a role with respect to workplace rehabilitation (without any guidance as to the actual skills required),[88] while the Australian College of Rural and Remote Medicine (ACRRM) website has no workplace rehabilitation references.[89]

Hence it seems reasonable to assert that even in the civilian setting, GPs need access to the skills and expertise of OEPs and rehabilitation physicians in order to provide the full range of clinical vocational rehabilitation services. This particularly refers to assessing the limitations posed by workplace hazards when returning ill and injured workers to work and assessing and monitoring their patient's return to normal employment, or if this is not possible, ascertaining their suitability for alternative employment. *As previously noted, these limitations are particularly relevant with respect to assessing the work-relatedness of CXSM with mental health conditions*.

We therefore suggest that, whilst fully accepting GP skills and expertise with respect to clinical primary health care, it seems reasonable to expect that these cannot be further expanded to include vocational rehabilitation without substantial additional training. We also note in any case at present, no such training is provided by JHC or its contracted service provider for its GPs (service or civilian).

Hence the most practical option, and current best practice, is to provide access to the services of specialist rehabilitation medicine physicians and OEPs. These could be provided either by JHC or through its contracted service provider(s).

As previously indicated, OEPs are not only trained to provide strategic advice on the pace and direction of workplace-based outpatient rehabilitation, but as medical specialists, are also able to negotiate with civilian employers and other stakeholders to achieve optimal return-to-work outcomes.

In addition, the mission of the RACP Australasian Faculty of Rehabilitation Medicine (AFRM) is to train, accredit and support medical practitioners in the management of functional loss, activity limitation or participation restriction arising out of illness and injury.[90]

Adult rehabilitation medicine physicians diagnose and treat patients from adolescence and young adulthood through to the very elderly, a demographic that includes CXSM. They have an essential role in the hospital in- and outpatient setting, with respect to maximising CSM functionality and quality of life of, not only for BCas but also DNBI from motor vehicle and similar accidents.[91] They also have a comparably essential role for XSM with long-term service-related medical, musculoskeletal, neurological and neuromuscular disorders.

Adult rehabilitation medicine physicians can provide these services via a variety of means such as 'prehabilitation' (for example prior to surgery), in-reach rehabilitation, early supported post-hospital discharge, rehabilitation in the home and other community rehabilitation and integrated care models, reablement and restorative models of care, ambulatory care services, and tele-rehabilitation.[92]

We suggest the DVA rehabilitation program would benefit from provision of both policy and clinical advice from an EMAP consisting of specialist rehabilitation medicine physicians and OEPs, as per current best practice in many workers compensation organisations.

The ADF Rehabilitation Program (ADFRP)

We note that the ADF's *Defence Health Manual* has extensive policy guidance for the provision of rehabilitation services for currently serving ill and injured ADF personnel. These describe the ADFRP,[93] the relevant governance arrangements,[94] the health procedures for its delivery,[95] and the management processes for entitled ADF reservists.[96] They indicate that the attributes of personalised rehabilitation plans for ADF members may include one or more of the following:

- Case management, utilising a Rehabilitation Activities Schedule, which is an agreement between the member, a Program Case Manager (PCM), and a Workplace Rehabilitation Representative (WRR).
- Functional capacity evaluations.
- Vocational assessment and rehabilitation.
- Clinical and psychological measures, such as in- and out-patient clinical services, aids and appliances, physical training, physiotherapy, counselling and psychosocial training.

However, a striking characteristic of these references is that although they all describe the ADFRP as an *occupational* rehabilitation program, none refer to a role for OEPs or rehabilitation medicine physicians. This implies the ADFRP is premised on GPs providing clinical rehabilitation services, despite their aforementioned limitations.

We understand the current ADFRP was developed from the adoption of a civilian model, where allied health professionals were appointed as rehabilitation coordinators, acting as conduit between GPs and employers. However, the fact that the ADF has uniformed medical officers who have dual responsibilities to both ADF commanders, personnel authorities as well as ADF personnel they treat, indicates that this has led to an unnecessary duplication of services. We also suggest outcomes might be improved if the ADFRP routinely involved specialist OEPs and rehabilitation medicine physicians.

Furthermore, rather than conceptualising vocational rehabilitation as an idea and an approach as much as a formal intervention or service per the *National Vocational Rehabilitation Policy* document, these references are almost exclusively process-driven, and thereby reliant on large numbers of PCMs and WRRs. These processes are not only highly bureaucratic (and therefore expensive): they also preclude giving common health problems sufficient priority, even though they may account for about two-thirds of preventable long-term sickness absence and incapacity benefits, in this case funded by DVA.

Regarding the latter, we have previously noted DVA spent $7.4 billion in 2017-18 on non-health disability services and compensation. The *National Vocational Rehabilitation Policy* document therefore implies that effective rehabilitation services for CXSM could save DVA up to $4.9 billion per year.

The ADFRP and Assessing Medical Suitability for ADF service

We note that before 2000, each Service had their own processes for assessing their members' medical suitability for employment and deployment. These were replaced by the ADF Medical Employment Classification (MEC) System, which was last revised in 2011. ADF members with medical restrictions for more than 28 days now undergo a MEC Review in accordance with the relevant joint and single-Service references.[97,98,99,100]

Comparing the medical deployability status of Navy personnel as of 30 June 1996 with that on 01 March 2018 indicates that the proportion deemed not medically suitable for sea for more than 28 days increased from 4.8 to 13.0 per cent, while the proportion with at least one medical restriction for more than 28 days increased from 9.4 to 39.4 per cent.[101,**102**] Although comparable historical data has not been found for the other Services, it seems likely that their medical deployability figures during this time would be similar.

While the reasons for these increases require further elaboration, it appears that the introduction of the ADFRP in 2006 and its subsequent iterations since have not of themselves been particularly effective with respect to actually returning ill and injured CSM to normal duties.

The ADFRP and the ADF's 'Garrison' Health Services

We note that JHC provides primary care and other health services for non-deployed CSM in accordance with the extant 'garrison' health Service Level Agreement (SLA) between the Vice-Chief of the ADF, and the single-Service Chiefs. Although variations to the ADF's treatment services can be authorised by the Defence Minister (in order to maintain fitness for duty while reflecting the facilities available), all SLAs to date have otherwise only specified compliance with the *Health Insurance Act 1973*, and the *National Health Act 1953*. This ensures that the standard of non-deployed care for ADF members remains comparable to that provided for the civilian community.

However, the current JHC 'garrison' health service contract does not include OEPs as part of their multidisciplinary rehabilitation teams: in fact, it specifies that all civilian primary care physicians require either a RACGP or ACRRM Fellowship. Yet as previously indicated, OEPs are not only trained to set the pace and direction of workplace-based outpatient rehabilitation, but also to negotiate with civilian employers and other stakeholders to achieve optimal return-to-work outcomes. Furthermore, as also previously indicated OEPs can facilitate local command compliance with the *Work Health and Safety Act 2011*. Given the estimated high rate of work-related illness and injury in the ADF compared with civilian general practice, this appears to be a significant oversight.

Proposed New CXSM Compensation Scheme

We note the draft Report advocates replacing the three current DVA compensation schemes (per the *Veteran's Entitlements Act* 1986, the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act* 1988, and the *Military Rehabilitation and Compensation* Act 2004), with two schemes as follows:

- The proposed 'Scheme 1' would cover CXSM under a modified VEA. This scheme is intended for largely an older cohort of CXSM with operational service who have injuries before 2004, which will continue until natural attrition removes the need for this scheme.

- The proposed 'Scheme 2' would cover all other CXSM underpinned by a modified MRCA (incorporating the DRCA) and is intended to become the dominant scheme over time.

We commend the intent of the draft Report with respect to developing a best practice client-centred ADF rehabilitation and compensation scheme. To this end, we advise OEPs have considerable experience and expertise with a wide range of civilian worker's compensation systems in Australia and New Zealand.

We therefore recommend that eminent OEPs be engaged to provide strategic level planning and health advice for developing the proposed new scheme and offer the following initial comments.

- This submission has previously noted that the ADF appears unique in that unlike other employers who provide employee health care, its health services do not ascertain whether CSM clinical presentations are work-related. We have also previously noted that collecting this baseline health information at the point of treatment is essential for several reasons, including documenting the work-relatedness – and therefore compensation eligibility – of each member's illness or injury in the first place. We believe this is absolutely essential with respect to reducing claim processing and appeal timeframes.

- Consistent with other compensation schemes, the ADF should implement a policy requiring claims to be submitted as soon as practicable (i.e. within weeks) following a work-related illness or injury. This will enable liability for claims to be determined by DVA using contemporaneous information, rather than incurring significant costs and delays in trying to establish liability for compensation years afterwards during transition or following separation from the ADF.

- In addition to health advice regarding the proposed new scheme, the same OEP skills and expertise can also complement Defence GPs, with respect to facilitating providing specialist assessment of compensation claims. This should complement the provision of primary health care for the ADF workforce. We believe this is also absolutely essential with respect to reducing claim processing and appeal timeframes.

- We note that the co-existence of the three Acts, VEA, DRCA and MRCA has resulted in a level of complexity particularly as entitlements vary depending on the period of ADF service. This can lead to exclusion of compensation for a similar illness or injury, or application of outdated medical concepts of disease to compensation claims. We therefore support a review of the legislation with the aim of removing anomalies as the first step in what is likely to be a complex legislative environment.

- We consider that restriction on the hours of employability for access special rate pensions (TPI and equivalent) be removed with increased support being provided to those who require assistance with activities of daily living (ADL). Current health care, disability support combined with employment practices and legislation means that many individuals retain a capacity for employment. Policies restricting the hours of employment in order to obtain benefits are counterproductive as they contribute to worse outcomes as detailed in the RACP publication *Health Benefits of Good Work* referred to earlier

- We agree that DVA should be primarily concerned with compensation and supporting entitled veterans. We consider that dependents should continue to receive appropriate benefits on their CSXM's death, especially if that death occurred during service, is service-related or occurred before retirement.

- We note that all CSM are exempt from paying the Medicare Levy. If there were to be a change in entitlements, we suggest consideration could be given to exempting XSM, and dependants of deceased CXSM as a result of service, from the Medicare Levy, and/or that they be funded for the cost of private health insurance.

Governance Issues

We note that the draft Report correctly refers to the need for revised governance and funding arrangements for reducing the preventable harm from service-related injury and illness, and providing a lifetime focus on the health and wellbeing of current and ex-ADF members. In particular:

- We agree that a single Minister within Defence who would be responsible for both CSM and XSM would help facilitate a lifetime focus on their health and wellbeing.

- We also note the proposal for replace DVA with a VSC and for the establishment of the proposed 'JTC' does not reflect the fact that CSM personnel management is a CDF / Service

Chief responsibility, which is exercised via their respective personnel directorates. Noting the extent to which transition from the ADF is an iterative rather than an 'either-or' process, we believe that the proposed 'JTC' would further complicate how the ADF manages its CSM.

Rather, we believe the intent of the Report would best be achieved by incorporating its outcomes into a 'business as usual' approach by the personnel directorates, with improved accountability by CDF and the Service Chiefs via appropriate legislation, on comparable terms as has already been achieved per the *Work Health and Safety* Act *2011*. The ADF's organisational structures to comply with the legislation should then take whatever configuration(s) required to do so, on the principle of 'structure following function'.

With respect to the latter, the RACP has recently been consulted on the development of an EMAP to the Queensland Department of Natural Resources, Mines and Energy (DNRME). The purpose of the DNRME EMAP is to provide independent strategic level policy and other health advice on a range of matters pertaining to the early detection, diagnosis, rehabilitation and prevention of lung disease in Queensland coal mine workers. Its membership includes OEPs and other medical specialists on fixed (three-year) appointments.

Noting the scope of such EMAPs are generally comparable to the intent of the Report, we believe that the purpose of the proposed 'JTC' would be better met by CDF and the Service Chiefs having their own EMAPs, provided they also possess the necessary military knowledge and experience.

To that end, we note that the ADF already has a range of independent airworthiness, seaworthiness and other engineering Boards that report to CDF and the Service Chiefs. These Boards are responsible for ensuring that the relevant assets are fit for purpose, beginning with their design and followed by their construction, maintenance and operation. We believe that, as a 'through life' approach therefore already exists within the ADF for its technical assets such as ships and aircraft, a similar approach can be applied for its personnel, thereby complying with the intent of the Report.

We also reiterate that OEPs are specialist health advisors regarding the 'through life' workforce wellbeing cycle from prevention, workplace hazard assessment, control of workplace hazards, workplace monitoring, early treatment, rehabilitation, compensation and legislation. We therefore consider OEPs to be essential members to the proposed CDF/Service Chief EMAPs, as a first step to implementation of a successful WHS program.

Conclusions

The RACP concurs with the draft Report's findings that the current processes within both Defence and DVA fail to focus on the lifetime wellbeing of CXSM. It also concurs that these processes are legislatively and administratively complex, difficult to navigate and frequently inequitable, and that this combination places unacceptable stress on claimants.

The RACP therefore commends the overall intent of the draft Report with respect to reducing the preventable harm from service-related injury and illness and investing in CSM so that they are more likely to fulfil productive lives when they leave the ADF. In particular, we concur that a lifetime focus on the health and wellbeing of CXSM will not only result in better outcomes for them and their families but also for the broader Australian community.

To enhance the usefulness and acceptance of the final Report, we consider a systems based approach to WHS, rehabilitation and compensation would enable development of a consistent strategic approach that would consolidate the various administrative issues raised in the draft Report. There are clear principles for occupational health (or WHS) services which can and should be applied to the ADF and DVA.

We also reiterate our opinion that compensation and rehabilitation cannot be addressed in isolation but should be regarded as integral components of Work, Health and Safety (WHS) in the ADF.

Recommendations

The RACP advocates introduction of a systems approach to develop a best practice occupational health-based model that reflects the status of CXSM as a *workforce / post workforce* population. We request the following issues be considered for inclusion in the Report:

1. We request the Report use the terms 'current and ex-serving ADF members' (CXSM), 'currently serving ADF members' (CSM) and 'ex-serving members' (XSM), in lieu of 'veteran' to include CSM as well as XSM.

2. We request the Report recommends the ADF and DVA adopt the principles in the RACP *Health Benefits of Good Work* Consensus Statement.

3. We suggest the Report refers to the RACP *National Vocational Rehabilitation Policy*.

4. We recommend the ADF and DVA utilise expert medical advisory panels of OEPs and specialist rehabilitation medicine physicians, to assist with the design, development and implementation of best practice, fit-for-purpose occupational health, rehabilitation and compensation policies and systems for CSM and XSM.

5. We recommend the ADF record and monitor all work-relatedness of illnesses or injuries *at the time of presentation*, and use population-based statistics of incidence rates, severity and costs to advise senior management as is usual practice in most large industries.

6. We recommend the ADF should implement a policy requiring claims to be submitted *as soon as practicable* (i.e. within weeks) following a work-related illness or injury. This will enable liability for claims to be determined using contemporaneous information, rather than incurring significant costs and delays in trying to establish liability for compensation years afterwards during transition or following separation from the ADF.

7. We recommend the Defence WHS Committee includes OEP as expert advisors, as well as OEPs being included on each of the Service Chief WHS Committees.

8. We request the Report specifically refer to the role of OEPs with respect to:

    a. Utilising their extensive experience and expertise with respect to civilian worker's compensation schemes, to provide health advice regarding best practice client-centred ADF rehabilitation and compensation scheme in order to modernise the current DVA compensation schemes.

    b. Conducting ADF workplace assessments to help reduce preventable workplace-related illnesses and injuries, in conjunction with other occupational and environmental health professionals.

    c. Undertaking clinical practice with particular reference to the medical, chemical, physical, biological, psychological, emotional, environmental and psychosocial factors pertaining to workplace-related illness and injury.

    d. Setting the strategic priorities, pace and direction of workplace-based *outpatient* rehabilitation for currently serving ill and injured ADF members, via negotiating with ADF commanders, workplace managers, personnel agencies and other stakeholders in order to achieve optimal return-to-work outcomes.

    e. Conducting health and medical assessments for current and ADF members, in order to ascertain work-relatedness for compensation purposes.

9. We recommend the ADFRP include OEPs and specialist rehabilitation medicine physicians as essential members of multidisciplinary/interdisciplinary healthcare teams.

Further Support

The RACP is willing to facilitate access to our members' expertise with respect to providing further advice prior to release of the final Report, as well as facilitating its recommendations thereafter. We are also willing to disseminate the final Report to our members.

Appendices

1. RACP Consensus Statement *Health Benefits of Good Work*

2. RACP *National Vocational Rehabilitation Policy*

References

1 Productivity Commission [Internet]. 'A Better Way to Support Veterans', 2018, Draft Report, Canberra [cited 2019, 30 Jan]. Available from: https://www.pc.gov.au/inquiries/current/veterans/draft.

2 Harrex, WH [Internet]. Productivity Commission Submission [cited 2019, 30 Jan].. Available from: https://www.pc.gov.au/__data/assets/pdf_file/0003/229440/sub089-veterans.pdf.

3 Westphalen, N [Internet]. Submission – Compensation and Rehabilitation for Veteran's Inquiry [cited 2019, 30 Jan].. Available from: https://www.pc.gov.au/__data/assets/pdf_file/0005/231737/sub149-veterans.pdf.

4 Australasian Faculty of Occupational and Environmental Medicine [Internet]. 'Consensus Statement on the Health Benefits of Good Work', [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=baab321a_14.

5 Royal Australasian College of Physicians [Internet]. 'National Vocational Rehabilitation Policy', [cited 2019, 30 Jan]. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/racp-national-vocational-rehabilitation-policy.pdf

6 Department of Defence [Internet]. 'Defence Work Health and Safety Strategy 2017-2022' [cited 2019, 30 January]. Available from: http://www.defence.gov.au/whs/_Master/docs/policy/Final_WHS-Strategy_FAweb_Oct2017.pdf

7 Department of Defence [Internet]. 'Defence Publications Sea King Board of Inquiry, Board of Inquiry [cited 2019, 30 January]. Available from: http://www.defence.gov.au/Publications/BOI/SeaKing/Chapters.asp

8 Australasian Faculty of Occupational and Environmental Medicine [Internet]. 'Position Statement: What is Good Work?', 2013, Oct [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/pa-what-is-good-work.pdf?sfvrsn=4

9 Australasian Faculty of Occupational and Environmental Medicine [Internet]. 'Realising the health benefits of work – An evidence update', 2015, Nov [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/pa-health-benefits-of-work-evidence-update.pdf?sfvrsn=4

10 Milner, A, Morrell, S, LaMontagne, AD. 'Economically inactive, unemployed and employed suicides in Australia by age and sex over a 10-year period: what was the impact of the 2007 economic recession?' International Journal of Epidemiology, 2014, 26 Jul, pp1–8,

11 Royal Australian College of Physicians [Internet], 'Health Benefits of Good Work, [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work

12 UK Department of Health [Internet]. 'Invisible Patients: Summary report of the Working Group on the health of health professionals', 2010, 5 Mar [cited 2019, 30 Jan].. Available from: http://www.champspublichealth.com/writedir/4344Invisible%20patients%20-%20The%20Working%20Group%20on%20the%20Health%20of%20Health%20Professionals%20-%20Report.pdf

13 Department of Veteran's Affairs [Internet]. 'DVA Annual Reports 2017-18', Table 4: Estimated numbers of living veterans 2013–14 to 2017–18, p23, [cited 2019, 30 Jan].. Available from: https://www.dva.gov.au/sites/default/files/files/about%20dva/annual_report/2017-2018/annrep2017-18.pdf.

14 Department of Defence [Internet]. Defence Issues Paper 2014 [cited 2018, 15 Jan]. Available from: http://www.defence.gov.au/Whitepaper/docs/DefenceIssuesPaper2014.pdf.

15 Australian Bureau of Statistics [Internet]. Year book Australia, 2009-10 [cited 2019, 30 Jan].. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/6D4CD661FDBA3226CA25773700169C59?opendocument.

[16] Department of Defence [Internet]. 'Defence Report 2017-18', Table 7.11: Defence workforce headcount as at 30 June 2017 and 30 June 2018 p 85, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/17-18/Downloads/DAR_2017-18_Complete.pdf.

[17] Australian Public Service Commission [Internet]. 'State of the Service Report 2017–18: Appendix 3 – APS workforce trends', [cited 2019, 30 Jan].. Available from: https://www.apsc.gov.au/state-service-report-2017-18-appendix-3-aps-workforce-trends.

[18] Wesfarmers [Internet]. 'Wesfarmers Annual Report 2018' p 60, [cited 2019, 30 Jan].. Available from: https://www.wesfarmers.com.au/docs/default-source/reports/wes18-044-2018-annual-report.pdf?sfvrsn=4.

[19] Woolworths Limited [Internet]. 'About Us', [cited 2019, 30 Jan].. Available from: https://www.woolworthsgroup.com.au/page/about-us.

[20] Rio Tinto Group [Internet]. 'Our Business', [cited 2019, 30 Jan].. Available from: http://www.riotinto.com/our-business-75.aspx.

[21] For example, only 1.6 per 100 patient presentations to civilian general practitioners were for sickness certificates in 2015-16. See Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Pan Y, Charles J, Pollack AJ, Wong C, Gordon J, 2016, General practice activity in Australia 2015–16. General practice series no. 40, Table 10.3. Sydney: Sydney University Press.

[22] Town sizes reflect those closest to the ADF population for each State, per the 2016 Census. See City Population [Internet]. 'Australia', Commonwealth of Australia [cited 2019, 30 Jan].. Available from: https://www.citypopulation.de/Australia.html.

[23] Index Mundi [Internet]. 'Australia Age Structure 2018' [cited 2019, 30 Jan].. Available from: https://www.indexmundi.com/australia/age_structure.html.

[24] Defence Census 2015 Fact Sheet 1.

[25] See 'Index Mundi [Internet]. 'Australia Age Structure 2018' [cited 2019, 30 Jan].. Available from: https://www.indexmundi.com/australia/age_structure.html.

[26] Department of Defence [Internet]. 'Defence Report 2017-18', Table 7.17: ADF permanent (Service Categories 7 and 6), Gap Year (Service Option G) and Reserve forces (Service Categories 5, 4 and 3) and APS by gender, as at 30 June 2017 and 30 June 2018, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/17-18/Downloads/DAR_2017-18_Complete.pdf.

[27] Workplace Gender Equality Agency [Internet]. 'Gender workplace statistics at a glance, August 2018', [cited 2019, 30 Jan].. Available from: https://www.wgea.gov.au/sites/default/files/Stats_at_a_Glance.pdf.

The 47 per cent figure represents all women in the Australian workforce (including part-time).

[28] Department of Defence [Internet]. Women in the ADF Report 2016–17, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/annualreports/16-17/Downloads/WomenInTheADFReport2016-17.pdf.

[29] For an overview of the different injury and illness profiles between males and females, see, Australian Institute of Health and Welfare, [Internet]. 'Australia's Health 2016' pp. 379-432 [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx?inline=true,.

[30] Disclaimer: the existence of different illness and injury profiles between males and females does not mean that one medically is more suited for ADF service than the other. It simply means that their supporting health services should reflect their different profiles. For example, see White, T (editor), 2013, *Winning at Sea: The Story of Women at Sea in the RAN*, Canberra: Defence Publishing Service.

[31] See Australasian Faculty of Occupational and Environmental Medicine [Internet]. 'Guide to pregnancy and work', [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/the-australasian-faculty-of-occupational-and-environmental-medicine-guide-to-pregnancy-and-work.pdf?sfvrsn=85c3031a_12

[32] This submission is written to reflect the medical, dental and mental health of ADF personnel as being within its remit. While their importance with respect to operational capability is acknowledged, physical suitability in the

absence of a medical diagnosis is a non-medical Command issue, while spiritual suitability is likewise a non-medical chaplaincy issue.

[33] Department of Defence [Internet]. 'Defence Recruiting Centre job finder' [cited 2019, 30 Jan].. Available from: https://www.defencejobs.gov.au/jobs?page=1&perPage=6&query=&jobStates=full-time&tab=view-all-jobs.

[34] Department of Defence [Internet]. 'Defence Report 2017-18', Table 7.17: ADF permanent (Service Categories 7 and 6), Gap Year (Service Option G) and Reserve forces (Service Categories 5, 4 and 3) and APS by gender, as at 30 June 2017 and 30 June 2018, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/17-18/Downloads/DAR_2017-18_Complete.pdf.

[35] Department of Defence [Internet]. 'Defence Report 2017-18', Table 7.17: ADF permanent (Service Categories 7 and 6), Gap Year (Service Option G) and Reserve forces (Service Categories 5, 4 and 3) and APS by gender, as at 30 June 2017 and 30 June 2018, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/17-18/Downloads/DAR_2017-18_Complete.pdf.

[36] Department of Defence, [Internet]. 'ADF Permanent Pay Rates - 01 November 2018' [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/PayAndConditions/ADF/Resources/WRA.pdf.

[37] Department of Defence [Internet]. 'Defence Report 2017-18', Table 7.17: ADF permanent (Service Categories 7 and 6), Gap Year (Service Option G) and Reserve forces (Service Categories 5, 4 and 3) and APS by gender, as at 30 June 2017 and 30 June 2018, [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/17-18/Downloads/DAR_2017-18_Complete.pdf.

[38] Department of Defence [Internet] 'Defence Report 2015-16', [cited 2019, 30 Jan].. Available from: http://www.defence.gov.au/AnnualReports/15-16/Downloads/DAR_2015-16_Vol1.pdf.

[39] Defence Census 2015 Fact Sheet 1.

[40] Australian Institute of Health and Welfare, [Internet]. 'Australia's Health 2016', p7 [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx?inline=true.

[41] For example, see Burt C.D.B. 'New employee safety: Risk factors and management strategies', 2015, Switzerland: Springer International Publishing, pp. 9-22.

[42] Wikipedia, [Internet]. 'List of Australian military bases', [cited 2019, 30 Jan].. Available from: https://en.wikipedia.org/wiki/List_of_Australian_military_bases.

[43] Department of Infrastructure, Regional Development and Cities, [Internet]. 'Defence: Investing in Regional Growth—2016-17'[cited 2019, 30 Jan].. Available from: https://infrastructure.gov.au/department/statements/2016_2017/ministerial-statement/defence.aspx.

[44] Wikipedia, [Internet], 'Royal Australian Navy' [cited 2019, 30 Jan].. Available from: https://en.wikipedia.org/wiki/Royal_Australian_Navy.

[45] A single deployed amphibious task group, consisting of one *Canberra* class Landing Helicopter Dock (~1300 personnel), one *Hobart* class Guided Missile Destroyer (~200), and two *Anzac* class frigates (~170 each), may therefore have over 1900 Navy and other embarked ADF members alone.

[46] This difference in posting practices has posed some challenges for the Landing Helicopter Dock ships. These each have 400 crew, including up to 100 Army and RAAF members. Their operational capability is seriously impaired if the latter's non-deployable members are not replaced on the same terms as their Navy personnel.

[47] For example, see Zajtchuk R., Jenkins D.P, Bellamy R.F, and Ingram V.M, 1996, *Textbook of Military Medicine, Part 1, Volume 2: Medical consequences of nuclear warfare*, TMM Publications: Falls Church; also Emergency Management Australia, 2003, *Australian Emergency Manuals Series, Part 3, Volume 2, Manual 3: Health aspects of chemical, biological and radiological hazards*, Paragon Printers: Canberra.

[48] Chretien, J-P [Internet]. 2012, 'Protecting Service members in war: non-battle morbidity and command responsibility', New England Journal of Medicine. Volume 366 Number 8 pp 677-679 [cited 2019, 30 Jan].. Available from: http://www.nejm.org/doi/pdf/10.1056/NEJMp1112981.

[49] Lacina, B and Gleditsch N.P, 'Monitoring trends in global combat: a new dataset of battle deaths', *European Journal of Population*, Issue 21, 2005, pp. 145-66

[50] Writer, J.V, DeFraites, R.F, and Keep, L.W, Non-battle injury casualties during the Persian Gulf War and other deployments', *Preventive Medicine*, Vol. 18, Issue 3, Supplement 1, 2000, pp. 64-70

[51] For what is probably the most egregious recent ADF example when this requirement was not met, see Clarkson JW, Hopkins WA, and Taylor KV. 'Chemical exposure of Air Force maintenance workers: report of the Board of Inquiry into F-111 (fuel tank) deseal/reseal and spray seal programs', 2001 29 Jun, Canberra: Air Force Headquarters.

[52] See Australian Broadcasting Corporation [Internet]. Mellor, L, Riga R, and staff, 'ABC News: Black lung inquiry finds 'catastrophic failure' in public administration in Queensland, 29 May 2017, [cited 2019, 30 Jan]. Available from: https://www.abc.net.au/news/2017-05-29/black-lung-report-catastrophic-failure-qld-public-administration/8568000.

[53] See Australian Broadcasting Corporation [Internet]. Atkin, M, '7:30: The biggest lung disease crisis since asbestos: Our love of stone kitchen benchtops is killing workers', 10 October 2018, [cited 2019, 30 Jan]. Available from: https://www.abc.net.au/news/2018-10-10/stone-cutting-for-kitchen-benchtops-sparks-silicosis-crisis/10357342.

[54] See, for example, Australian Broadcasting Corporation [Internet]. Murphy, S, 'Landline: Williamtown', 2 July 2016 [cited 2019, 30 Jan].. Available from: http://www.abc.net.au/landline/content/2016/s4493433.htm.

[55] See, for example, Sydney Morning Herald [Internet]. Doherty, B, 'Pressure builds on Defence Force to remove deadly asbestos', 8 January 2009, 2016 [cited 2019, 30 Jan].. Available from: http://www.smh.com.au/national/pressure-builds-on-defence-force-to-remove-deadly-asbestos-20090108-7cwb.html.

[56] See, for example, Australian Broadcasting Corporation [Internet]. Oakes, D, 'RAAF jet fuel damaged ground crews' body cells; long-term consequences unknown, says groundbreaking research', 30 April 2015, [cited 2019, 30 Jan].. Available from: http://www.abc.net.au/news/2015-04-30/raaf-personnel-exposed-to-jet-fuel-suffered-cell-damage/6433360.

[57] See, for example, Australian Broadcasting Corporation [Internet]. Jones, A, 'Abuse in the military: running with a pack of wolves', 23 January 2012, [cited 2019, 30 Jan].. Available from: http://www.abc.net.au/news/2012-01-23/jones-abuse-in-the-military3a-running-with-a-pack-of-wolves/3786652.

[58] See 'The Ambulance Down in the Valley' [Internet]. [cited 2019, 30 Jan].. Available from: https://www.justice4all.org/wp-content/uploads/The%20Ambulance%20Down%20In%20The%20Valley.pdf.

[59] Harrex, WH, Wilkins, PS, 'A review of compensation claims for chondromalacia patellae decided by the Department of Veteran's Affairs in 2006 and 2007', June 2009 (unpublished).

[60] Department of Veteran's Affairs [Internet]. 'DVA Annual Reports 2017-18', Table 2: Numbers of benefit recipients by type of benefit 2013–14 to 2017–18, p 22, [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/6b21b4dc-5fd6-4077-8c75-7a6bab09416d/15405.pdf.aspx?inline=true.

[61] Department of Veteran's Affairs [Internet]. 'DVA Annual Reports 2017-18', p 56, [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/6b21b4dc-5fd6-4077-8c75-7a6bab09416d/15405.pdf.aspx?inline=true.

[62] Australian Institute of Health and Welfare [Internet]. 'Health expenditure Australia 2016–17' p 31, [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/e8d37b7d-2b52-4662-a85f-01eb176f6844/aihw-hwe-74.pdf.aspx?inline=true.

[63] Australia Bureau of Statistics [Internet]. 3101.0 - Australian Demographic Statistics, Mar 2017, [cited 2019, 30 Jan].. Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Mar%202017?OpenDocument.

[64] Department of Veteran's Affairs [Internet]. 'DVA Annual Reports 2017-18', p 47, [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/6b21b4dc-5fd6-4077-8c75-7a6bab09416d/15405.pdf.aspx?inline=true.

[65] Department of Veteran's Affairs [Internet]. 'DVA Annual Reports 2017-18', Table 2: Numbers of benefit recipients by type of benefit 2013–14 to 2017–18, p 22, [cited 2019, 30 Jan].. Available from: https://www.aihw.gov.au/getmedia/6b21b4dc-5fd6-4077-8c75-7a6bab09416d/15405.pdf.aspx?inline=true.

[66] SafeWork Australia [Internet], 'Australian workers' compensation statistics, 2012–13'[cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/australian-workers-compensation-statistics-2012-13.pdf.

This reference excludes compensation claims by ADF personnel.

[67] SafeWork Australia [Internet], 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

[68] SafeWork Australia [Internet]. 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

Safework Australia explains that, because a small number of uncharacteristically long absences or high payments can skew the average (mean), median payment and median time lost from work of serious workers' compensation claims approximate to a 'typical' claim.

[69] SafeWork Australia [Internet]. 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

Safework Australia explains that payments include compensation paid to claimants for: benefits paid to an employee or the employee's surviving dependents; outlays for goods and services such as medical treatment, funeral expenses, rehabilitation services; non-compensation payments such as legal costs, transport and interpreter services; and common law settlements, which may incorporate estimates of future liability and indirect costs such as loss of productivity.

[70] SafeWork Australia [Internet]. 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

[71] SafeWork Australia [Internet], 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

[72] SafeWork Australia [Internet], 'The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community 2012–13', [cited 2019, 30 Jan].. Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf.

Safework Australia explains that the definition used for the term 'serious worker's compensation claim' is:

"A workers' compensation claim for an incapacity requiring an absence from work of one working week or more, lodged in the reference year, and accepted for compensation by the jurisdiction by the date the data are extracted for publication.

Claims in receipt of common law payments are also included.

Claims arising from a journey to or from work or during a recess period are not compensable in all jurisdictions, and are excluded."

[73] The ADF Health Surveillance System (EpiTrack) website is only available on the Defence Intranet. As it is primarily designed for land-based operations and deployments, EpiTrack is not consistently applied by all ADF health facilities. The data, therefore, is substantially incomplete.

[74] Australian Institute of Health and Welfare [Internet]. 'Australia's health 2010', *Australian Institute of Health and Welfare*, pp. 275-8, [cited 2018, 15 Jan]. Available from: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442452962

[75] Cooke, G, Valenti, L, Glasziou, P, and Britt, H, 'Common general practice presentations and publication frequency', *Australian Family Physician***,** Vol. 42, No. 1/2, January/February 2013, pp. 65-8.

[76] Department of Veteran's Affairs [Internet]. DVA Annual Reports 2014-15 [cited 2019, 30 Jan].. Available from: https://www.dva.gov.au/sites/default/files/files/about%20dva/annual_report/2014-2015/annrep2014-15.pdf

[77] Sydney University Family Medicine Research Centre [Internet]., 'General practice activity in Australia 2014-15', [cited 2019, 30 Jan].. Available from: https://ses.library.usyd.edu.au//bitstream/2123/13765/4/9781743324530_ONLINE.pdf

[78] ADF commanders are deemed 'persons conducting a business unit' (PCBU) in accordance with the *Work Health and Safety Act 2011*. See Federal Register of Legislation [Internet]. Work Health and Safety Act 2011 [cited 2019, 30 Jan].. Available from: https://www.legislation.gov.au/Details/C2015C00472.

[79] See Smith FB, 1994, Agent Orange – The Australian Aftermath, in O'Keefe, B. 'Medicine at War: Medical Aspects of Australia's Involvement in Southeast Asian Conflicts 1950-1972', *The Official History of Australia's Involvement in Southeast Asian Conflicts 1948-1975,* Allen and Unwin: Australian War Memorial.

The sensitivities of this issue are such that even this reference is being revised: see Australian Broadcasting Corporation [Internet]. Grimm, N 'Australian War Memorial to revise official record of impacts of Agent Orange use in Vietnam War', 01 March 2016, [cited 2019, 30 Jan].. Available from: http://www.abc.net.au/news/2015-07-14/australian-war-memorial-to-revise-agent-orange-record/6619118.

[80] For a more recent example, Australian veterans have raised concerns regarding the use of the antimalarial drug mefloquine in East Timor. See Australian Broadcasting Corporation [Internet]. Lloyd, P, 'Mefloquine: RSL backs veterans' calls for review over use of controversial anti-malaria drug', 22 December 2015, [cited 2019, 30 Jan].. Available from: http://www.abc.net.au/news/2015-12-17/soldiers-call-for-a-review-over-the-use-of-anti-malaria-drug/7038890.

This is despite mefloquin's inclusion on the WHO Model List of Essential Medicines: see 'Wikipedia, [Internet]. WHO Model List of Essential Medicines', [cited 2019, 30 Jan].. Available from: https://en.wikipedia.org/wiki/WHO_Model_List_of_Essential_Medicines.

[81] JeDHI Helpdesk email Defence eHealth System - Occupational Aetiology - Quick Reference Guide dated 1503 12 July 2018 (only available on Defence intranet).

[82] Journal of Military and Veteran's Health [Internet]. Pope, R, and Orr, R. 'Incidence rates for work health and safety incidents and injuries in Australian Army Reserve vs full time soldiers, and a comparison of reporting systems', April 2017, Volume 25 Number 2; pp 16-25, [cited 2019, 30 Jan].. Available from: https://jmvh.org/wp-content/uploads/2017/07/Original-Artical-Incidence-rates.pdf.

[83] Royal Australian College of General Practitioners [Internet]. 'Guidelines for preventive activities in general practice', [cited 2019, 30 Jan].. Available from: http://www.racgp.org.au/your-practice/guidelines/redbook.

[84] Australasian Faculty of Occupational and Environmental Medicine [Internet]. 'Australian and New Zealand consensus statement on the health benefits of work - position statement: realising the health benefits of work', [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/realising-the-health-benefits-of-work.pdf

[85] Society of Occupational Medicine [Internet]. Richards, T, Keay A.J, and Thorley K, 'Do GPs record the occupation of their patients?', *Occupational Medicine*, Vol. 63, No. 2, 2013, pp. 138-40, [cited 2019, 30 Jan].. Available from: https://academic.oup.com/occmed/article/63/2/138/1375749.

[86] Society of Occupational Medicine [Internet]. Cohen, D, Marfell, N, Webb, K, Robling, M, and Aylward, M, 'Managing long-term worklessness in primary care: a focus group study', *Occupational Medicine*, Vol. 60, No. 2, 2010, pp. 121-6 [cited 2019, 30 Jan].. Available from: https://academic.oup.com/occmed/article/60/2/121/1422483.

[87] Society of Occupational Medicine [Internet]. Beaumont, D, 'Rehabilitation and retention in the workplace: the interaction between general practitioners and occupational health professionals: a consensus statement', *Occupational Medicine*, Vol. 53, No. 4, 2003, pp. 254-5, [cited 2019, 30 Jan].. Available from: https://academic.oup.com/occmed/article/53/4/254/1442934.

[88] Royal Australian College of General Practitioners [Internet]. 'Curriculum for Australian general practice: CS16 Core Skills Unit CS1.2: General practitioners use effective health education to promote health and wellbeing to empower patients' [cited 2019, 30 Jan].. Available from: https://www.racgp.org.au/Education/Education-Providers/Curriculum/2016-Curriculum/Core-skills-unit/CS16/CS1.2/gp-lifelong-learning/promote-health-and-wellbeing

[89] Australian College of Rural and Remote Medicine [Internet]. [cited 2019, 30 Jan].. Available from: https://www.acrrm.org.au

[90] Royal Australasian College of Physicians [Internet]. Rehabilitation Medicine Physician Scope of Practice: Adult Rehabilitation Medicine, June 2018, [cited 2019, 30 Jan].. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/afrm-scope-of-practice-statement-adult-rehabilitation-medicine.pdf?sfvrsn=94d6021a_12.

[91] For example, see De Gelder, P. *No Time for Fear: How a Shark Attack Survivor Beat the Odds*, 2013, Australia: Penguin Books. Able Seaman Clearance Diver Paul De Gelder lost his right arm and right leg when he was attacked by a bull shark while undertaking Service-related diving in Sydney Harbour in February 2009.

[92] Royal Australasian College of Physicians , 'Rehabilitation Medicine Physician Scope of Practice Adult Rehabilitation Medicine'. 2018, June [cited 2019, 14 Jan]. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/afrm-scope-of-practice-statement-adult-rehabilitation-medicine.pdf

[93] Australian Defence Force, 'Health Manual' Volume 1 Part 13 Chapter 1 'Australian Defence Force Rehabilitation Program' (only available on Defence Intranet)

[94] Australian Defence Force, 'Health Manual' Volume 2 Part 13 Chapter 1 'Governance of Australian Defence Force Occupational Rehabilitation Service's (only available on Defence Intranet)

[95] Australian Defence Force, 'Health Manual' Volume 2 Part 13 Chapter 2 'Health Procedures for Delivery of the Australian Defence Force Rehabilitation Program' (only available on Defence Intranet)

[96] Australian Defence Force, 'Health Manual' Volume 2 Part 13 Chapter 3 'Procedures for the Treatment and Occupational Rehabilitation of Reservists Not on Service Option C' (only available on Defence Intranet)

[97] Australian Defence Force, 'Military Personnel Manual (MILPERSMAN)', Part 3, Chapter 2 'Australian Defence Force Medical Employment Classification (MEC) System', (only available on Defence intranet)

[98] Australian Defence Force, 'Health Manual (HLTHMAN)'. Volume 3 Retention Standards, Chapter 1 'Medical Employment Classification System' (only available on Defence intranet)

[99] Royal Australian Navy, 'Australian Book of Reference 1991 *RAN Health Services Manual'*, Chapter 8 'The Australian Defence Force Medical Employment Classification System and the Maritime Environment' (only on Defence intranet, last revised c2013, presently undergoing revision)

[100] Australian Army, 'Army Standing Instruction (Personnel), Part 8, Chapter 3 The Application of the Medical Employment Classification System and PULHEEMS Employment Standards in the Australian Army', (only available on Defence intranet)

[101] Royal Australian Navy, 'Medical Classification Data 30 Jun 1996 – 1 July 2000', undated.

[102] Defence e-Health System (DeHS) data search 'Confirmed MEC and SPEC Counts' 2018, 01 Mar, [accessed 2018, 04 Apr] (only available on Defence Intranet)