Veterans Compensation and Rehabilitation Inquiry

Submission to the Productivity Commission

1. I thank the Productivity Commission for the opportunity to submit this document in relation to Veterans Compensation and Rehabilitation. I make the submission as a Veteran and private individual. The comments within are my view only.

2. I served for some 25 years in the Infantry in locations which cover Borneo in 1964, Malay/Thai Border operations, Confrontation in Malaysia, and in Vietnam. For the last almost 20 years I have been employed as a salaried, full time Advocate for a large ESO. I am a client of DVA.

3. My first point is to provide some comment in relation to the SOP Regime which, it is my understanding, is being called into dispute by some in the legal fraternity mainly. As you would be aware, in 1994 the then Government, after much dismay at what was seen as unfair treatment to current and ex ADF members and/or their widows in relation to the costs involved in appealing or supporting an initial claim, requested the Repatriation Commission to investigate a more equitable and consistent system. This resulted in the Repatriation Medical Authority (RMA) and Statement of Principles (SOP).

4. It has been my experience over my time as an advocate that the SOP has provided, not just a standard of equality, but a consistent level playing field for claims regarding the connection to service. They are based on scientific/medical evidence from world wide sources. Some people may not be able to meet that causal Factor within the SOP to link a condition to service, but that would be based on that RMA investigation of causal effect. In addition some conditions are idiopathic so the condition cannot be accepted as service related.

5. I suggest if the SOP regime were not available many servicemen and women would not have their conditions accepted as service related, as so many specialists that DVA rely on are WorkCover related and, in their opinion, where there is no specific trauma or injury,everything is either constitutional or congenital. An example is lumbar spondylosis which can easily be related to service by the accepted heavy pack loads and equipment that the average serviceman carries or lifts. Indeed, DVA have now accepted the condition as a streamlined condition, along with 31 (depending on legislative cover) other conditions. This means that there is only a requirement for a confirmed diagnosis and a relevant period of service and it is accepted as a service condition. If it were reliant on specialist opinion it would not be accepted, in all probability, due to it being congenital or constitutional according to many specialists.

6. The pre 1994 system resulted in specialist pitted against specialist and DVA had the biggest money bag so they could afford more, and more costly, specialists, to support rejecting any condition as service related. The veteran was left way out of pocket, not just for the cost of any specialist opinion at initial liability and at a later appeal, but for their ongoing medical treatment which under the SOP system, would be an accepted condition.

7. Unfortunately there will always be those who have conditions that just cannot be related to service under the SOP regime. I think it is doubtful that they would have been accepted pre 1994, even with specialist support, as DVA may well have obtained a specialist opinion that differed from the claimants specialist resulting in their rejecting that condition.

8. I support the system of having two different standards of proof related to the cause of a condition. This provides a more beneficial standard to those who have actually been exposed to danger in the service of their country. It allows for just the most minor of causal effect based on the latest medical/scientific evidence. It provides recognition between those who may have faced danger from the forces of the enemy, as compared to those who may never have left the safety of Australia. I see no problem with determining a claim against either SOP as their eligibility is determined by their service. To change to one standard of proof would detract from the accepted and acknowledged comments relating to features of military service and the often exposure to danger from hostile forces.

9. My second point relates to the DVA need to have expensive specialist opinion, particularly under MRCA Legislation, for initial liability and permanent impairment (PI) assessment.

10. Previously under VEA legislation the treating or family GP was asked to provide clinical information and assessment relating to claimed conditions and rarely did a specialist get involved. Under MRCA the use of specialists for opinions relating to liability and assessment have become so stressful, time consuming, expensive and adversarial between client and specialist, particularly in dealing with mental health conditions. Though DVA do have access to a number of medico legal firms who provide these reports within a reasonable timeframe, problems have arisen from those examinations. These problems take a number of forms. One is that, for mental health conditions, clients find it extremely hard to relate to the medico legal doctor who may be in a hurry and only have a specific amount of time to extract necessary information to provide a report. A second problem that occurs regularly is that the specialist will disagree with the accepted condition which has previously been a specialist diagnosed condition which DVA have accepted. The specialist, in changing the diagnosis, removes all right for compensation as it is not an accepted condition under MRCA legislation. This frustrates the client and, in mental health conditions, causes a significant worsening of the accepted condition and may lead to grave concerns for their well being.

11. The answer from DVA is to just raise a claim for the new condition, however, that takes time for a decision, and the new condition may not meet the SOP requirements so it cannot be claimed. Both DVA and appeal bodies appear not interested in trying to fix the problem before it escalates to an appeal or a worse scenario with the veteran and possible self harm. Where a different diagnosis is identified by the medico legal specialist, for instance during PI assessment, the specialist should be provided with the original medical documents used to accept the condition as service related and asked to justify any new or additional condition and why the original specialist was incorrect in the diagnosis. Keeping in mind also that the original diagnosis was also confirmed by their own GP Contacted Medical Advisor (CMA).

12. My third point relates to the manner of claiming under DVA. DVA have enabled claiming for injuries/diseases much easier via the on line claim system, of which there are a couple of different avenues. The Myservice system allows particular current and ex ADF members to claim for conditions in that system. The online claim via the DVA portal and via email submission allows normal claims submission. The main problem appears to be the lack of information as to what is required to have the condition accepted under the SOP Factors and how to link that Factor to service. This has been the expertise of the ESO's so far, however Myservis has no facility for assistance of a representative, thus putting the applicant at a disadvantage immediately. I understand the Myservice success rate is fairly high for claims as it should be with so many conditions accepted under the streamlined conditions system. However there are no statistics relating to the success rate of conditions, other than streamlined ones, under the Myservis system which require investigation of specific SOP requirements. DVA should approve the involvement of representatives for the Myservis claim system.

13. A further problem appears to be the difference between the attitudes of delegates and medical advisers in different locations relating to initial liability. Melbourne has many new delegates and the senior delegates have been dealing with beneficial legislation under VEA so have an approachable attitude. DVA Sydney appear quite the reverse. Their delegates and CMA's are defensive, aggressive and dismissive with a definite workcover attitude. Experience has proved many struggle with English and have their own interpretation of what an SOP requires. Indeed the RMA amended an SOP due to the fact senior delegates and CMA's were failing to understand the written SOP description of the condition.

14. My fourth point is in relation to supporting service medical records. DVA waste so much time on waiting for copies of records from Defence. Under their DVA/Defence system (SAMS) it can take up to 3 months or more to receive those documents. This is so frustrating and not understood by the client who has provided copies from his medical records to support the claim in the first place. In addition DVA Sydney Office are still requesting for medical records via SAMS for streamlined conditions, even though a diagnosis has been provided with the initial claim and service history forms part of the claim. I understand there is to be a system that when people are enlisted into Defence they are asked to allow DVA to access their medical files electronically as required. That is fine for the future but it is the present ADF and Ex ADF members who are suffering currently.

15. My fifth point relates to the Medical Impairment Assessment (MIA) form. This form is required to be completed by a medical professional (GP or Specialist), to assist the delegate to assess accepted conditions for possible compensation payments under VEA or MRCA PI. The questions are supposed to allow the delegate to relate the answers to the Guide to Assessment of Rates of Veterans Pensions (GARP) 5th Edition Tables and provide the relative points allocated for that condition.

16. A number of the questions do not accurately reflect the GARP Table requirements. A number of forms relating to lower limb functionality ask about any restriction in Gait, but the GARP Tables refer to a reduction in Pace. Many medical professionals have different ideas as to what is required. Another problem deals with Resting Joint Pain (GARP Table 3.4.1). This problem has been identified initially about 15 years ago and at various times

since, DVA have been requested to amend it, but DVA have refused to amend their form. The question relates to continuing pain in a joint After any Activity. The actual question on the MIA merely asks if the patient suffers resting pain and mentions nothing about after an activity. Thus the information in most cases is misunderstood by the examining doctor and the client misses out on points for their accepted condition and its impact on the client. A new MIA form has just been released and it still provides the same confusion in relation to resting joint pain and many questions on the new form appear irrelevant to the condition being assessed e.g questions relating to leg length when assessing an accepted lower back condition.

17. My sixth point relates to compensation payments. There have been numerous cases of young veterans with severe mental health accepted conditions being assessed and paid very large sums of compensation. These young damaged veterans are just not capable of understanding about compensation and within a short period of time the money has been wasted. They then are put in a very tenuous situation of having very little income and, due to their accepted mental health conditions, are unable to earn income. This in turn impacts severely on their mental health conditions which may lead to self harm. I am unsure of what, if anything, DVA can do. The compensation is an entitlement under Legislation so must be paid at some stage.

18. My seventh point relates to conditions (injuries or diseases) accepted as conditions caused by, or related to, service under 3 different Legislations. This is so detrimental to a veteran, particularly a long serving one who has cover under 2 or 3 legislations when being assessed for compensation under VEA and/or MRCA PI. Double dipping for compensation is, of course, wrong and should not be accepted, however where a condition accepted under, say DRCA, impacts on a similar functionality under VEA or MRCA PI, this causes a loss to the veteran in assessment under GARP Ch 19. They do not get compensation, or obtain a reduced assessment, but because of the differing methods for compensation in the differing legislation, it is used to reduce the original VEA/MRCA PI assessment and therefore amount of compensation, even though the veteran may not have received compensation under DRCA for that service caused condition previously. If the condition is a service related condition under any legislation, where no compensation has been accepted under differing legislation, it should not be detrimental to the veteran under VEA or MRCA legislation related compensation payments.

19. One question asked in the Issues Paper was "Are there aspects of the claims and appeals process that result in inequitable outcomes for veterans, such as limitations on legal representation". I assume this refers to legal representation when appearing before the Veterans Review Board (VRB) as legal representation is allowed at all other levels (initial claim and AAT). I would refer to the published AAT decisions noted on the AUSTLI site for 2016, but suggest every other year would be similar. Approximately 37 with legal representation were affirmed, approximately 13 were set aside and those with RSL/self representation equally affirmed and set aside. There is, of course, no record of how many were either withdrawn by the applicant or conceded by the Repatriation Commission or MRCC (MRCA appeals only). I suggest that legal representation at the VRB would result in the same figures or worse, plus an increasing cost to the applicant, even under no win no fee agreements as per the AAT cases. No win no fee usually attract some form of administrative

cost. With current estimates of costs for legal representation at the AAT approximating $15,000 I fail to see how having legal representation at the VRB will be cheaper or better. The VRB advise those without representation that it may be beneficial to engage a representative and provide contact details of numerous ESO's.

20. The new ADR system recently introduced by the VRB has been accepted as a success in that more appeals are being finalised in a much quicker manner and time frame. Given that the ADR system currently does not include Queensland, the numbers of successful outcomes would appear to be increased substantially once the system is introduced there.

21. The new advocacy training program (ATDP) from DVA, is just starting to be implemented and should improve the knowledge and experience of those advocates assisting with both claims and appeals. As it is competency based it will require those advocating to reach an accepted level and be mentored by suitably qualified mentors. This in turn will result in a better outcome for claimants. As the government financially support ATDP I would suggest that this scheme is a preferred option for improving the expertise of those advocates who volunteer their time to assist the current and ex ADF members.

Yours Sincerely