RETURNED & SERVICES LEAGUE of AUSTRALIA LTD
(ABN 63 008 488 097)
National Office

Productivity Commission into Compensation and Rehabilitation for Veterans

Returned and Services League of Australia Ltd

Response to the "Issues Paper"

Executive Summary

The RSL has concerns that, as time passes and the number of conflicts in which Australia is involved, government commitment to veteran support will wane and that, increasingly, the focus will be on the economic costs and benefits of the veteran support systems in place, without consideration of the social benefits of the system and costs of undermining the system of supports in place.

Whilst there have been a number of criticisms levelled at DVA over recent years, some admittedly justified in light of certain high-profile failures, the RSL acknowledges that DVA has made significant inroads to improving service delivery and quality of service via initiatives such as Veteran Centric Reforms. However, the full effects of these changes will take time to manifest, and these changes are far from complete.

There are a number of areas where improved communication and liaison between ESOs, Defence and DVA, and even within ESOs provide opportunities to improve the level of support and care provided to our veterans and, given the complexities of the system in place, these opportunities must be seized. Whilst the system is complex, there are some opportunities to harmonise at least some elements, and there are opportunities to improve the quality of information and interfaces with information available for veterans to ease their access to the knowledge they require to confidently engage with the system. The existence of professional, quality advocates who are appropriately accredited and maintain their professional knowledge and development, in the same way as other service professionals do, also serves to ease the passage through the system for veterans, as a good advocate alleviates the need for the veteran to have detailed knowledge of the system.

The greatest challenge facing ESOs is recruiting new advocates into training and accreditation and engaging with each other and working collaboratively with DVA and Defence to improve outcomes for all.

Recommendations

The RSL recommends that the Productivity Commission Inquiry into Compensation and Rehabilitation for Veterans find that:

- A purely economic approach to veterans' support and compensation is an unacceptably narrow view of the issue and that a broader, socio-economic view is more appropriate.
- An effort to harmonise some aspects of veterans' support legislation be made, with the following being a priority:

- Implementation of an two-step version of the Statements of Principle liability process across the VEA, DRCA and MRCA:
  - Step One: Does the claim satisfy an existing factor within the SoP? If yes, accept liability, otherwise proceed to Step 2,
  - Step Two: Does the medical evidence available, in the expert medical opinion of the evaluator indicate that, on the balance of probabilities, in the circumstances of the injury or disease, the veteran's service significantly contributed to the injury or disease? If yes, accept liability, if no, the claim fails.
- Align DRCA with MRCA for method of assessment of level of impairment (impairment points);
- Align DRCA with MRCA for method of assessment of amount of permanent impairment quantum and provide for weekly payments.
- Expand the application of the "reasonable hypothesis" standard of proof to cover peacetime activities where the level of risk of injury, disease or death is of a level similar to that experienced on an operational, hazardous or warlike/non-warlike deployment (e.g. high level chemical exposure, severe incident, live-fire exercise, wargames, etc.).

- The ATDP be separated from DVA and set up as a separate entity with responsibility for training advocates, maintaining register of advocates, maintaining continuous professional development of advocates, overseeing quality control of advocates and service delivery and setting of professional standards for advocates.
- Expand non-liability health care for mental health conditions to all Reservists.
- Improvements to the interface for Factsheets on the DVA website be made to adopt a workflow or knowledge tree interface whereby factsheets are accessed by stage of claim and relevant entitlement or process at each stage through a more intuitive and graphical flow diagram interface.

1. Introduction

1.1. The Returned and Services League of Australia (RSL) has operated for over 100 years as a member-driven organisation seeking to represent current and ex-serving members of the ADF, returned service men and women and the families and dependants of the men and women of the ADF in accessing and advocating for their support, welfare and wellbeing in Australian society.

1.2. RSL advocates around the country continue to engage with members of ex-service and current serving community and their families and dependants to ensure appropriate support and access to entitlements is available to all who need and qualify for the same.

1.3. This submission attempts to address all key issues raised in the issues paper, based upon the experience of RSL advocates in their dealings with a wide demographic of claimants and in light of past reports produced into veterans' support and entitlements.

1.4. As with the Alliance of Defence Service Organisations (ADSO), the RSL is also concerned that many of the issues raised in the issues paper seem to imply that a purely economic focus is intended in the Commission's review, ignoring the broader socio-economic impact of ADF service.

1.5. It is noted that the ADSO submission discusses the socio-economic impact of ADF service in greater detail, and the RSL fully supports the ADSO position on this issue and, rather than replicate work, endorses this aspect of the ADSO submission.

2. Priorities for Veterans' Support

2.1. *What should the priority objectives for veterans' support be?*

2.1.1.1. It is the view of the RSL that the principle priorities for veterans' support be as follows:

2.1.1.2. In the event of incapacity of members of the Defence Force (as defined in the *Military Rehabilitation and Compensation Act 2004* (MRCA) s 5), provide whatever medical, rehabilitative, vocational and social rehabilitation required to "*maximise the potential to restore [the member] .. to at least the same physical and psychological state, and at least the same social, vocational and educational status and he or she had before the injury or disease*" (MRCA s 37);

2.1.1.3. In the event that a member's service results in death, whether from warlike service, non-warlike service, hazardous operations, or peacetime service, provide a "*grant of pensions*" and other entitlements as, or similar to those provided in the *Veterans Entitlements Act 1986* (VEA), *Safety and Rehabilitation Compensation (Defence-Related Claims) Act 1988* (DRCA) and MRCA to the member and their family;

2.1.1.4. Reduce the complexity of the entitlements available and the associated claims process where possible; and

2.1.1.5. Improve access to medical ADF information for the assessment and processing of claims by DVA for the delegate within DVA and the member's advocate to assist in the timely preparation and resolution of claims.

2.2. *Why?*

2.2.1. There are several aspects to this question that must be considered, and it must be considered to be more than a simple economic inquiry into costs and an opportunity to increase efficiency in application of economic resources. The management of veteran entitlements and veteran welfare has both an economic and a social dimension, and these cannot be readily separated. While certain aspects of the priorities can, indeed, achieve economic efficiency dividends, the temptation to focus on these and ignore the social dimension must be resisted, as this will undermine over a century of work in this area, as highlighted by ADSO in their submission (4.1B).

2.2.2. The primary objective for an ADF member who has suffered an injury or disease should always be a return to health and a return to work, as this is the best outcome for the member's physical and mental health, their family, the ADF and any future employers, and the majority of injuries and diseases may allow a return to work relatively quickly after initial recovery. However, there are a significant number of circumstances where and injury or disease results in an incapacity for work in the short or long term.

2.2.3. Within the civilian employment sector, serious workplace injury or illness resulted in a median time off work of 5.6 weeks in 2013-14[1], with a median compensation amount of $10,100 and the most common injury type in 2014-15[2] was traumatic joint/ligament and muscle/tendon injuries. Injuries suffered in the ADF are often more severe than those suffered in the civilian workforce and injury rates are relatively higher:

[1] Safework Australia Workers' Compensation Data: national dataset for compensation-based statistics (https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/disease-and-injuries/disease-and-injury-statistics).
[2] Ibid.

2.2.3.1. In 2015-2015 there were 11.9 million Australians employed[3], with 104,770 claims for serious injury or disease lodged under worker's compensation legislation Australia wide – a rate of 0.009%. This is significantly lower than the rates of veterans in receipt of incapacity payments for serious injury or disease resulting in an incapacity for work, indicating that either the rate of injury or disease, or the severity of injury or disease may be significantly higher, or both;

2.2.3.2. By comparison, best estimates for the veteran population in Australia are between 300,000 and 500,000, of which approximately 165,000 are existing DVA clients with recognised injuries or diseases (Issues paper p. 5);

2.2.3.3. Taking Departmental data for claimants under MRCA, in September 2017, there were 26,455 MRCA veterans registered with DVA, of whom 3,304 were in receipt of incapacity payments (and thus injured severely enough to be unable to work), a rate of 12.5%, and 2,039 undergoing active rehabilitation, a rate of 7.7%[4];

2.2.3.4. Similarly, there were 52,163 DRCA clients at the same period in time, of whom 1,724 were on incapacity payments, a rate of 3.3%, and 552 were undergoing rehabilitation, a rate of 1.1%[5]. It is likely that the lower rates under DRCA are due to members who have previously been in receipt of incapacity payments having been successfully rehabilitated to a return to work of some kind, though it is possible that many may have aged to beyond retirement age and ceased to be eligible for incapacity payments.

2.2.4. Whilst it is always preferable to provide treatment, rehabilitation and financial support to return an injured or sick member to work, it must be recognised that, in some circumstances, this may not be possible. Some injuries, in particular some injuries to mental health, make a return to work either unlikely, or extremely protracted and costly to manage. It must also be recognised that "return to work" must be more than just a return to simply any kind of work regardless of other factors.

2.2.5. Whilst there is a requirement to ensure that any return to work takes into account the experience, background and skills of the member who has been injured, it must be remembered that there may be skill gaps between skills and trades acquired in the ADF compared to an equivalent civilian qualification, due to the specialised nature of the ADF and the compartmentalisation of roles within the ADF based on rank structures, among other factors.

2.2.6. It must also be remembered that members of the ADF are compensated for their services on a different scale to civilians, with rates of pay for relative skills often significantly different to rates of pay for similar roles in the civilian sphere. This becomes a significant factor when an injured member has family to consider, as return to work rehabilitative programs may prepare the member for roles of similar skills to those performed in the ADF, but with significantly lower remuneration, resulting in a significant drop in finances for the member and their family when incapacity payments cease, which may place added strain on the member to work additional hours or

[3] Australian Bureau of Statistics (http://www.abs.gov.au/ausstats/abs@.nsf/lookup/6202.0Media%20Release1May%202016).
[4] Department of Veterans' Affairs: Statistics About the Veteran Population, Statistics at a glance (https://www.dva.gov.au/sites/default/files/files/about%20dva/SaaG_Sep2017.pdf).
[5] Ibid.

undertake additional work to make up the difference, potentially aggravating an injury or disease that they would otherwise have been considered to have recovered from.

2.2.7. When a member has died as a result of their service, it is incumbent on us, as a society, to recognise this sacrifice, whether it be in a warlike, non-warlike or hazardous setting or in a peacetime setting and provide support for their family. This extends to more than mere financial support via the vehicle of pensions. Families of ADF members are often not significantly recognised for the sacrifices that they themselves make:

2.2.7.1. Families of ADF personnel frequently move from location to location, following the ADF member on their postings, often over significant distances;

2.2.7.1.1. This causes disruptions in the education of their children, as they move from school to school and State to State, and frequently disrupts their circle of friends as new relationships need to be established in each location;

2.2.7.2. Similarly, partners of veterans need to establish new friendships and social circles in new locations, not always certain how long they will remain in a particular location;

2.2.7.3. Current practice in the ADF places the families of personnel within the general community, which provides some advantages in terms of integration in wider society, however, it has disadvantages in the form of reduced access to families and partners of other ADF personnel who understand the nature of ADF life and the life of ADF families;

2.2.7.3.1. ADF personnel may often be away from their families for extended periods due to deployments, exercises or other work arrangements, and may engage in irregular hours, and are on call at all hours of every day, placing added strain on the family, particularly in long absences;

2.2.7.4. It is not uncommon for ADF personnel to be absent for births of their children, which can place strain on themselves and their partners.

2.2.8. Given that families of ADF personnel themselves face a number of challenges from ADF life, support for a bereaved family should extend to social support, via mental health support, educational support and access to treatment cards in addition to pensions. Some of this exists currently, however, many are unaware of the degree of support available, and there are limits on the criteria which are complex for many to navigate.

2.3. *In what way does the current legislation support or hinder achievement of those priority objectives?*

2.3.1. The underlying principles of the VEA, DRCA, MRCA and the previous *War Pensions Act 1914* (WPA) and *Australian Soldiers Repatriation Act 1920* (ASRA) (other than the differences between WAP, VEA and ASRA having a compensation focus and DRCA and MRCA having a rehabilitative focus) are fundamentally sound and represent over 100 years of work on the part of governments and society to accept and reflect the unique nature of service.

2.3.2. However, these Acts are hindered by their complexity and their general inconsistency – veterans do not have a “level playing field”. The RSL agrees with ADSO that the fundamental underlying principles of all of the legislation is generally consistent and does not require change, however, the way in which the Acts approach the issue of addressing compensation and rehabilitation becomes unnecessarily complex, unwieldy and (at times) contradictory – one question that many advocates face from veterans who have cover under multiple Acts is why a condition that was rejected under one can be accepted under another, especially if the two Acts cover the same time period (e.g. VEA and DRCA). Another is why two people with essentially identical injury

circumstances, but slightly different circumstances of service, will achieve two different outcomes.

2.3.3. The issue of complexity of legislation becomes particularly vexatious when dealing with veterans who are covered by VEA, DRCA and MRCA, which is an increasingly common occurrence as many ADF personnel with 40+ years of service are moving to retirement.

2.3.4. Some of these issues relating to complexity, as noted by ADSO in their submission at 4.2 (g), this complexity has been partially addressed via various initiatives by DVA through its Veteran Centric Reforms (VCR) program, however, the full extent of the impact of these reforms is yet to be determined and it is the RSL's view that further reductions in complexity and levelling of the playing field could be achieved.

2.4. *What principles should underpin the legislation and administration of the system?*

2.4.1. It is widely acknowledged, as noted by the High Court in *Roncevich v Repatriation Commission [2005] HCA 40* that veterans' legislation is of a beneficial nature, and this is carried through, in particular, to the beneficial "reasonable hypothesis" test applied in VEA and MRCA to injuries or disease sustained during warlike, non-warlike and hazardous operational service. As was noted by the High Court, this principle has carried through from the original provisions in the WPA of 1914. As this has been a constant for over a century, it would be inappropriate for this to be overturned now.

2.4.2. Given the current world climate, it is not unreasonable to expect that the ADF will be called upon to be involved in future engagements, and it must be remembered that, unlike many other nations, all of the military force within this country is engaged on a voluntary basis – there are no conscripted forces in this country, so it is appropriate to continue applying the beneficial approach to veterans' legislation to recognise that ADF personnel are volunteering to put their lives at risk for the nation when assessing their access to government provided entitlements for their service.

2.4.3. As society progresses and becomes increasingly immersed in new technologies, the expectations of each generation of government, society and each other change over time. Globally, trust in institutions has been declining and, in Australia, the general population in 2018 was assessed as having only 35% trust in government, down 2% from 2017[6]. This lack of trust means increased expectations of government to provide services and entitlements in a timely and effective manner and using effective technologies, especially among younger veterans.

2.4.4. Younger veterans are also likely to be engaged with social media, have higher expectations of professionalism and are focused on their families, based on experiences from advocates within the RSL, and this is supported by experiences relayed in the ADSO submission (4.3 (d)).

2.4.5. Because of this, any changes to legislation and administration of the veterans' support system should reflect this focus on family, professional and timely delivery of service and use of effective technologies within a beneficial framework that recognises the unique nature of service and the risks and challenges faced by the veteran and the challenges faced by their families.

[6] 2018 Edelmen Trust Barometer – Australia Results (https://www.slideshare.net/EdelmanInsights/2018-edelman-trust-barometer-australia-results), accessed 30 June 2018.

2.5. *Is the current system upholding these priority objectives? What are the key deficiencies of the system?*

2.5.1. While distrust in government is high, and has been growing for a number of years, more concerning is that Australians have also come to distrust NGOs, including charitable organisations, with trust in these institutions falling to 48%, down from 52% in 2017 for the first time in 2018[7]. This is concerning, as the advent of social media means that any concerns with any organisation, justified or otherwise, have the ability to proliferate rapidly and become difficult to control or overcome.

2.5.2. Reduced trust in government and other institutions means that the effectiveness of any system to deliver veterans' support suffers a serious blow as all channels for delivery of the system require considerable work to overcome this distrust. Whilst it is not clear from the data available which NGOs are most affected, nor to what extent, it is a trend that ESOs must be aware of and work to overcome. Similarly, government must be aware of the negative perception of agencies such as DVA and work to overcome this and achieve cultural changes, all of which take time.

2.5.3. The RSL acknowledges the changes that have been introduced as part of the VCR programs, and note that some improvements have resulted from these, however, it is difficult to assess the extent of these improvements as yet, as these reforms are relatively new and the degree of change required in perceptions takes time to achieve, often many years.

2.5.4. The current legislation achieves the basic principles relating to provision of some form of monetary and/or rehabilitative compensation and support to veterans and their families in many cases, however, the complexity of the system represents a substantive barrier for many veterans and their families. Many veterans, either of their own volition or encouraged by DVA's messaging regarding self-service attempt to lodge initial claims on their own, and very often these claims fail for want of correct preparation or for want of adequate information being provided due to a lack of understanding of the requirements of either the legislation or instruments such as the Statements of Principles relevant to a claim.

2.5.5. Such failure at the initial claim can be disheartening to the veteran, if not outright damaging in the case of a veteran with fragile mental health or physical health, and often discourages the veteran from appealing or attempting to claim a second time and disengaging from the system. This can cause the veteran to suffer unnecessary hardship in their life by failing to access assistance they are entitled to due to lack of faith in the system or, in some cases, by simply being unaware they are entitled to assistance.

3. Recognition of Military Service

3.1. *What are the key characteristics of military service that mean veterans need different services or ways of accessing services to those available to the general population? How should these characteristics be recognised in the system of veterans' support?*

3.1.1. The RSL shares similar concerns to ADSO with the nature of these questions (ADSO submission 6.1A & 6.1B). The nature of military service is fundamentally different to other occupations in which the person performing their duties places their life in danger. Whilst emergency services personnel certainly place themselves at risk and are to be commended and recognised for doing so, they are not trained and expected, in

[7] Ibid.

the line of duty, in the application of lethal force in as humane as possible a manner on behalf of, and in the protection of, the State. Nor does their failure in the performance of their duties place the State or its citizens and their freedom in jeopardy.

3.1.2. This places a higher burden upon ADF personnel in the performance of their duties, higher expectations upon them in active service, and greater responsibilities in their applications and use of force and the consequences for failure in their duties.

3.1.3. As such, any access to services required for their support and entitlements should be as easy as possible, even if this requires some overlap and duplication with the way that the same services are accessed by the general population.

3.1.4. Given the relatively small number of ADF personnel compared to the general population, the added cost of providing an easy mode of access for veterans to services compared to the general population should be relatively small.

3.2. *What is the rationale for providing different levels of compensation to veterans to that offered for other occupations, including people in other high-risk occupations such as emergency service workers?*

3.2.1. Whilst there are some similarities between emergency services workers and ADF personnel on the surface, there are many differences that warrant the differing levels of compensation for veterans.

3.2.2. ADF personnel are, voluntarily, ready for deployment to war zones and disaster response immediately, and irrespective of their domestic circumstances and their daily life is focused on preparation for such roles.

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

3.2.4. Whilst some emergency services workers may deploy to some of these operations, particularly peace keeping operations and some disaster responses, where these are done in conjunction with the military and under the same conditions, these personnel are usually recognised as being covered by military compensation legislation for the relevant period by the Minister to reflect the heightened deprivation and risk of injury or death.

3.3. *Are the differences in support and ways of accessing support based on different types of service (such as operational, peacetime and Reserve service) justified?*

3.3.1. This is a fraught question open to many levels of interpretation which is difficult to answer definitively, as the answer varies depending upon the interpretation applied to the question. At its most basic level, all veterans, as defined in this inquiry, should be able to access support, however, exactly what that means, depends on a range of variables and circumstances.

3.3.2. Irrespective of the type of service that a veteran has, be it operational, peacetime or reserve service, all veterans may access the same support services and have the same means to access those services. However, the veteran's location, access to providers, IT, advocates, DVA and other physical factors may affect the practical access to these services.

3.3.3. With regard to whether a particular injury or disease is provided with medical treatment, pharmaceutical services and compensation, is subject to two factors:

3.3.3.1. Medical diagnosis – this is determined at the reasonable satisfaction (or balance of probabilities) standard of proof, irrespective of type of service; and

3.3.3.2. Determination of liability – this is determined at either the "reasonable hypothesis standard of proof (for those with operational service, whether reservists or full-time service) under VEA and MRCA or reasonable satisfaction/balance of probabilities for peacetime service.

3.3.4. Level of compensation will vary by Act once liability is determined and, for VEA and DRCA, compensation is the same, irrespective of how the injury or disease arose and is based upon the level of impairment and the non-economic loss or lifestyle impact. Under MRCA, the level of compensation varies between warlike or non-warlike service and peacetime service. Rehabilitative services differ between each piece of legislation, irrespective of type of service, but quite different between Acts.

3.3.5. Similarly, non-liability health (NLHC) care for mental health is available to reservists only if they have rendered one day of continuous full-time service, and access to NLHC for tuberculosis and cancer depends on the nature and dates of service.

3.3.6. Access to treatment is provided with either a White Card (for NLHC conditions or accepted conditions only) or the Gold Card (for all conditions, accepted or otherwise), and the fee schedule is regulated and providers may not charge a gap. However, some providers either do not accept patients with treatment cards, or "ration" the number of patients they take in a given period on treatment card arrangements.

3.3.7. This high degree of variability of access, for a wide range of variables, makes it difficult to give a definitive answer to this question. For the most part, at is most basic level, the RSL believes that all veterans should have equal ease of access to support, subject to some caveats. This will become clearer further into the submission.

4. Complexity of Veterans' Support

4.1. *What are the sources of complexity in the system of veterans' support?*

4.1.1. Complexity in the system of veterans' support arises from the existence of multiple pieces of legislation covering veterans' service, with coverage depending upon types of service and the dates during which service occurred.

4.1.2. Whilst the use of advocates trained and accredited via the ATDP training program reduces the complexity for the veteran as this training requires all advocates to be competent in all three Acts, there still arises a layer of complexity where a veteran is covered by more than one piece of legislation.

4.1.3. This arises because the type of entitlement offered by each Act is different, and the interaction of these Acts can be complex and it is ultimately the veteran's decision as to which entitlements they choose to pursue, it is not the place of the advocate to make that decision for the veteran, as the advocate may not be aware of all aspects of the veteran's life necessary to make an informed decision in the best interests of the veteran.

4.1.4. There are also ramifications if the veteran chooses to pursue claims for the same injury under more than one piece of legislation which mean that, in some circumstances it is beneficial to do so, while in others it is less beneficial to do so, and these interactions can be complex as the offsetting rules and calculations are largely opaque even to advocates.

4.1.5. Additional complexities arise from the interactions between MRCA and DRCA entitlements with the superannuation entitlements of veterans, which do not apply to veterans' entitlements under the VEA.

4.2. *What are the reasons and consequences (costs) of this complexity?*

4.2.1. The primary reasons for the complexity arise from the poor understanding of the interactions between legislation for veterans who are covered by multiple pieces of legislation, or who are entitled to claim the same injury under multiple Acts. This is because the offsetting rules that are applied by the Department are largely opaque to advocates and cannot be reasonably estimated in advance to assist in assessing the impact of multi-Act claims, or in the preparation of appeals against determinations where multi-Act claims have been subjected to what often seem arbitrary and arcane rules that are not understood well by those outside the Department.

4.2.2. When claims and appeals are prepared by the veteran themselves or by an advocate (voluntary or paid) via an ESO, there is no financial cost to the veteran for the claim or appeal for even the most complex appeal, other than perhaps incidental transport to and from appointments. However, if the veteran engages a lawyer, typically in a "no win-no fee" arrangement, the costs can be high on a successful claim, typically of the order of approximately 40% of settlement plus $10,000-$15,000 in administrative fees. This is sufficient to significantly erode a successful claim, and administrative costs may apply even on an unsuccessful claim.

4.2.3. Further, non-economic costs of this complexity are that the navigation of the system takes additional time to prepare the claim or appeal, and to process the claim or appeal within the Department or appellate body. This may delay the outcome for the veteran, who may be in financial stress at the outset, further adding to this situation as the claim or appeal drags on.

4.2.4. Multi-Act claims, or claims for a significant number of physical or mental conditions concurrently are at increased risk of delays in preparation or processing, adding to the risk of additional stress or strain on a veteran who is already likely to be in a poorer state of health at the beginning of the claim.

4.2.5. Some of these concerns have been partially addressed by the VCR program implemented by the Department, and by the introduction of the Case Coordinators, however, the full impact of these initiatives has yet to be fully realised.

4.3. *What changes could be made to make the system of veterans' support less complex and easier for veterans to navigate?*

4.3.1. Whilst the RSL supports, in part, the ADSO position that the complexity of the system has been addressed somewhat since the recent Senate Inquiry, there are still some elements that may be improved further.

4.3.2. The VCR initiatives implemented have addressed some aspects of the complexity and may, over time, have significant impact, however, these have not yet fully had time for their impact to be assessed.

4.3.3. Further reduction of complexity may be achieved by providing greater clarity to advocates in how offsetting rules operate and greater transparency as to how interactions between Acts are handled by the Department. Current information available to advocates is unclear and often seems contradictory to results observed in decisions received.

4.3.4. Further complexities are only likely to be reduced by a combination of improved ICT systems and a process of harmonisation of legislation to the extent that it is possible to do so.

4.4. *Can you point to any features or examples in other workers' compensation arrangements and military compensation frameworks (in Australia or overseas) that may be relevant to improving the system of veterans' support?*

4.4.1. Whilst there have been improvements in service delivery within the system of veterans' support recently and at various points in the past, the RSL supports the ADSO position that the current legislative system is not world's best practice.

4.4.2. However, the temptation to systematically revise the current system on the basis of a system in place in another legislature based wholly on that country's cultural and historical context, including their military conflict context in the past and its influence on national cultural character must be resisted. The nature of Australia's military, its historically voluntary nature and its impact on the evolution of Australian culture and identity is central to much of Australia's perception of and treatment of veterans and how we see the future of veterans' support in this country. It would seem better to work within the system that we have, that has grown around our cultural and historical context, to repair the shortcomings in the system, than to adopt a system based on a different cultural identity and context that may prove wholly inappropriate for the Australian context.

4.4.3. Similarly, the degree of sacrifice expected of military personnel, combined with the expectation of personnel to apply lethal force in the service of the nation and expose themselves to situations of high risk during service makes most worker's compensation systems, which are typically characterised by an insurance model often focused on avoiding liability, wholly inappropriate for this context.

4.5. *Is it possible to consolidate the entitlements into one Act?*

4.5.1. There are considerable problems with unifying the three Acts into one harmonious piece of legislation, just as there are several benefits from doing so. The current landscape of legislation does not present a "level playing field" that is fair and equitable to all veterans, both in terms of establishing liability for injury or disease, or in terms of outcome of a successful liability determination.

4.5.2. Currently there are two distinctly different approaches to determination of liability, one quite rigid, if standard and relatively fair and equitable in its application, and one much more flexible, if somewhat less predictable in its application.

4.5.3. Under the VEA and MRCA, the Statements of Principle (SoP) provide a standardised approach to determining whether liability for an injury or disease arising during or from service rests with the Commonwealth, based on sound medical evidence, as determined by the Repatriation Medical Authority. However, this system has become quite rigid and inflexible in its application, which does not seem to fit with either the concept of beneficial legislation articulated by the High Court or the drafters of the initial WPA in 1914.

4.5.4. Under the DRCA, liability is determined to the reasonable satisfaction standard on the basis of sound medical opinion of medical assessors on the claim who evaluate the claimant and the medical evidence available from medical records, current medical evidence and scans or reports, and the available reports as to the circumstances of the injury or disease and determine if they are reasonably satisfied that the claimant's military service contributed significantly to their claimed condition. This is much more open and flexible than the SoP method, and allows conditions to be accepted that may not meet a factor within the Statements of Principle in some circumstances if the evidence is strong, while under the VEA and MRCA, no amount of medical evidence will

allow a claim to succeed if the circumstances of injury or disease do not fit within an accepted factor within the Statement of Principle.

4.5.5. Further differences arise in the manner of assessing level of impairment between the Acts, the MRCA and the VEA use similar tables for determination of impairment points, but once tallied and combined, these are treated differently under each Act. Under the VEA, they are rounded to the nearest 5 and combined under a matrix with a Lifestyle Rating to give a percentage of pension. Under the MRCA, the exact total is combined with a Lifestyle Rating using one of two matrices (depending on type of service) to determine a multiplier, which is then combined with the claimant's age to determine a compensation factor, which is then used to determine a weekly compensation rate that can be used to provide a weekly payment or converted to a lump sum using an actuarial table.

4.5.6. The DRCA uses a fundamentally different impairment guide which is arguably less sensitive than the impairment points system to arrive at a percentage of whole person impairment (WPI) for the claimed injury, and a non-economic loss (lifestyle impacts) factor is used to determine the non-economic loss portion of the pay-out and a lump sum is offered.

4.5.7. Incapacity payments under the MRCA and the DRCA are different again, and are based on the rate of pay of the veteran at either date of injury or date of discharge and either indexed by CPI (DRCA) or paid at today's rate of pay (MRCA), subject to offsetting rules.

4.5.8. Given these fundamental differences, there are several challenges to harmonising legislation, and full harmonisation is likely to be impossible at this point in time, however, partial harmonisation may be possible.

4.6. *If so, how would it be done?*

4.6.1. The legislation most open to harmonisation is DRCA, since it is the legislation with the most differences at the liability and assessment stages (which are broadly similar, if not identical in most cases, between the VEA and MRCA).

4.6.2. One approach to harmonisation in liability determination would be to combine the SoP process with certain elements of the DRCA process. While the SoP process has the advantage of providing a standard approach to claims and predictable outcomes, this strength comes packaged with a weakness of rigidity in that there are situations in which medical opinion strongly indicates that a veteran's service has significantly contributed to their injury or disease due to particular or unusual circumstances which nonetheless do not fit any of the available SoP factors. This rigidity does not permit the claim to be accepted, while the DRCA process would permit it to be so, provided that the medical evidence and opinion was supportive of that outcome.

4.6.3. An approach where the first pass was to apply the SoP and capture claimants who fit the SoP and accept those claims and then more closely evaluate those that do not fit the SoP factors and pass them to specialist medical review to determine whether medical opinion supported their service contributing to their injury or disease in spite of the existing factors not being met due to either unusual circumstances or strong evidence supporting that conclusion would provide a more fair and equitable and less rigid process that would provide a "level playing field" across all Acts.

4.6.4. With respect to assessment of impairment, harmonisation could be achieved by adopting the same process to assess medical impairment. The process adopted under the VEA and the MRCA is arguably the more sensitive and flexible system as it provides for a wider range of results in otherwise similar cases compared to the WPI system used

under DRCA currently. Adopting this system, as implemented under MRCA, across both MRCA and DRCA would provide consistency in assessment and would allow greater clarity in MRCA claims for permanent impairment where whole of body assessments are undertaken and conditions under all Acts are taken into account, and would not require "conversion" of the WPI system into the impairment points system as they would already be assessed in the same manner.

4.6.5. With regard to levels of compensation offered, the legislation least open to harmonisation is the VEA, as this is based on an entirely different concept of compensation – the disability pension. This does not readily lend itself to adaptation to the permanent impairment payment and incapacity payments system utilised (albeit with differences) under the DRCA and MRCA. This likely cannot be harmonised while claimant able to claim entitlements under this legislation remain.

4.6.6. Permanent impairment payments under the DRCA and MRCA can be harmonised by allowing the DRCA payments to be taken as incremental (weekly) payments in the same manner as MRCA (this is currently not possible) with little modification to the legislation.

4.6.7. Incapacity payments between the DRCA and MRCA are currently worked out differently in that one is based on the original rate of pay at a certain date and indexed (DRCA), while MRCA uses the current rate of pay and is thus paid at a higher rate. This disadvantages DRCA claimants, however, there are additional elements available under some circumstances to DRCA claimants that do not apply to MRCA claimants (though these are complex and not always readily known).

4.6.8. Further opportunities for harmonisation are best left for the current Legislative Forum considering avenues for legislative reforms to consider.

4.7. *What transitional arrangements would be required?*

4.7.1. Currently there is a Legislative Forum considering legislative reforms, and this question is best left to that to consider.

4.8. *How might these be managed?*

4.8.1. Currently there is a Legislative Forum considering legislative reforms, and this question is best left to that to consider.

4.9. *Are there approaches, other than grandfathering entitlements, that can preserve outcomes for veterans receiving benefits or who may lodge a claim in the future?*

4.9.1. The RSL supports the ADSO position that, in the spirit of Australia's cultural adherence to the "fair go" and the complex interactions between the various pieces of veterans' support legislation and superannuation legislation, that grandfathering is the only fair option for existing entitlements to be preserved in the event of harmonisation of legislation, and that this issue be canvassed by the Legislative Forum and considered by DVA, ESOs and interested stakeholders.

5. Claims & Appeals Process

5.1. *How could the administration of the claims and appeals process be improved to deliver more effective and timely services to veterans in the future?*

5.1.1. As has been submitted by ADSO in their submission to the Commission, much of the criticism levelled at the claims and appeals process during the Senate Inquiry was characteristic of previous experiences and is increasingly less valid as the effects of

initiatives such as VCR on the claims process and the Veterans' Review Board's (VRB) ADR process are felt over time.

5.1.2. That is not to suggest that problems do not remain, however, many of the criticisms of the past are becoming less valid and the problems that remain are becoming characteristic of problems with resourcing and ICT issues within the Department, the VRB or a lack of advocates within ESOs equal to the demand within the veteran community.

5.2. *Are there diverging areas of the claims and appeals process under the different Acts that could be harmonised?*

5.2.1. Whilst noting and endorsing the comments of the ADSO submission, the RSL does note that there is one area of primary difference in appeal paths between the three Acts currently in place. This is the appeal path under DRCA, which currently does not have an appeal pathway via the VRB, but rather via an internal review, and then via the Administrative Appeals Tribunal (AAT).

5.2.2. The RSL would submit that harmonisation of the three Acts to a single appeal path via the VRB as the first port of appeal, as was undertaken with the MRCA previously would assist with many appeals, especially if the DRCA was harmonised with the VEA and MRCA in terms of liability determination and level of impairment assessment, as currently the difference in appeals process preparation and format can add extra time to cases, as the ADR process with the VRB is now quite streamlined since its initial introduction.

5.3. *Are there aspects of the claims and appeals process that result in inequitable outcomes for veterans, such as limitations on legal representation*

5.3.1. In the past, there has been historical advocacy from a subset of advocates who have been of the opinion that primary claims should be prepared by advocates and that appeals to the VRB and AAT are the purview of lawyers rather than advocates.

5.3.2. Like ADSO, the RSL rejects this proposition and takes the position that an appropriately experienced advocate who has been accredited under the ATDP training program and appropriately mentored is an effective person to represent a veteran at both the VRB and AAT levels of appeal, and there are many examples of such successful advocates in practice who are professional and successful in handling even complex and difficult appeals for their clients.

5.3.3. Further, if DVA subscribes fully to its stated model litigant provisions and undertakes to abide by the principals laid out therein, there should be no imbalance in representation between the Department and a veteran in a hearing at the AAT, as the Department under such rules should undertake not to pit a volunteer advocate against a barrister in such a setting. Such representation on behalf of the Department, which sadly has happened on numerous occasions in the past, is not in keeping with the spirit or provisions of the model litigant policies that the Department purports to abide by.

5.3.4. The changes adopted within the Department under the VCR and within the VRB with the ADR process have also improved claims and appeals processes, making these processes more equitable for veterans in the time that they have been in place, though there are still areas of progress to be made.

5.3.5. Currently, one of the largest challenges is the limited number of advocates available and the difficulty in attracting new advocates to roles to assist veterans with claims and

appeals, particularly attracting younger advocates and female advocates for training and mentoring.

5.4. *Will the Veteran Centric Reform program address the problems with the administration of the veterans' support system?*

5.4.1. The RSL believes that the VCR will address, and has begun to address, many of the current problems with the administration of the veterans' support system, in conjunction with the VRB's ADR process and the ATDP advocacy training, provided that resourcing challenges can be addressed.

5.4.2. Currently there are resourcing challenges for ESOs in that there are too few accredited advocates to meet current demand for claims and appeals in most areas of the country, with some areas experiencing this problem more acutely than others. This includes a lack of existing advocates trained under the TIP system undergoing RPL accreditation under ATDP and a lack of new advocates undergoing training and mentoring. Within those undergoing accreditation, there is an underrepresentation of younger advocates and female advocates in particular, which will become increasingly important into the future, as the number of female clients increases.

5.4.3. The RSL shares the view of ADSO that the current level of appropriations for the Department and VRB is not sufficient for the needs of the veteran community. This is reflected in the inability of the Department to meet the processing times they are committed to meet under their stated targets, and the delays in the ADR process currently experienced in 2018 as complexity of claims and appeals increases.

5.5. *Are advocates effective?*

5.5.1. There have been a number of reviews into advocacy effectiveness in the past[8], and these have highlighted a number of instances where TIP-trained pensions or welfare officers or Level 3 or 4 advocates failed to deliver advocacy services of a high standard, for a variety of reasons. Many of these reasons related to the TIP model, which was focused on classroom learning, lack of assessment and accreditation, lack of mentoring and a BEST funding model which was focused on claims volume rather than claims quality.

5.5.2. It was these very reviews and findings, as well as a push from groups within the ESO community for an accreditation-based model that lead to the development of the ATDP model, which significantly alters the training approach and introduces an accreditation and adult-learning approach to advocacy training services.

5.5.3. Among the key initiatives of ATDP that offer advantages over the TIP model are the requirement for all advocates to display competencies in all three Acts, rather than being able to choose to practice in a single Act, introduction (from 1 July 2018) of ongoing professional development, planned rollout of quality assurance measures and a fundamental change of perspective to compensation support being an episodic step in ongoing wellbeing support.

5.5.4. ADSO has noted in their submission that they have identified the need for VRB and AAT training to incorporate units of legal studies to provide understanding of legislation and legal reasoning and argue that this is advantageous at the VRB and mandatory at the AAT. The RSL's experience is that those advocates who have had legal training or undertaken legal studies in addition to their advocacy training are typically more

[8] Review of DVA-Funded ESO Advocacy and Welfare Services, December 2010, Report of the ESORT Working Party on TIP Accreditation (2013), and Review on Veteran's Advocacy Training – Summary Paper (2015).

successful in appeals than advocate who have not undertaken these studies and supports this proposal for future development of training for VRB and AAT advocates.

5.6. *How could their use be improved?*

5.6.1. Use of advocates across the ESO community has been piecemeal and patchy at best. Even within the RSL, use of advocates has varied by State and even within States the approach to advocacy has been inconsistent.

5.6.2. Some of the States within the RSL (particularly Tasmania, Victoria and Queensland) have adopted a "hub and spoke" model either informally or via Veteran Support Centres (VSC), sometimes in conjunction with other ESOs. However, even within these States, some Sub Branches housed their own advocates, even with a VSC in the area, whilst others, with no accessible VSC did not host an advocate, leaving veterans to travel considerable distances to access an advocate or to attempt to access one remotely via telephone or via systems such as Skype.

5.6.3. Many of the difficulties that ESOs have faced in adopting effective advocacy and coordinating their services have arisen from several factors. First, there are a profligate number of ESOs available today, many of whom seem to overlap in a manner that can be confusing for the veteran, and many of whom duplicate some services but also are similar in the services they do not offer. Other ESOs are highly federated and suffer from strict State protections based on their incorporation status in each State or Territory, and even strict local autonomy and restricted communication and information flow between levels of the organisation.

5.6.4. Despite these challenges, there are strong opportunities for ESOs to collaborate, and for the ADF, DVA and ESOs to collaborate and communicate to obtain the best outcomes from the VCR, ADR and ATDP initiatives.

5.6.5. Advocacy funding is a prime concern that will remain into the future, in light of current reviews of the ACNC legislation and the Senate inquiry into Charity Fundraising. This will become particularly pertinent if we wish to see an increase in younger advocates, as younger veterans increasingly have careers and may not have the time to volunteer as advocates and may seek to be paid advocates. This raises the question of where funding to pay advocates comes from, especially in States with smaller fundraising incomes.

5.7. *Are there lessons that can be drawn from advocates about how individualised support could be best provided to veterans?*

5.7.1. The RSL fully endorses the views expressed in the ADSO submission on this point. The RSL position is that it is unlikely that high quality, high performing advocates would not be providing such individualised support at this time.

5.7.2. However, it is easy to understand that such high quality and high performing advocates would be significantly discomfited at the level of disinterest among the Executive of many ESOs in advocacy.

5.8. *Have the Statements of Principles helped to create a more equitable, efficient and consistent system of support for veterans?*

5.8.1. In general, it is the position of the RSL that SoPs appear to have introduced a level of consistency to the determination of claims to which they apply, when they are correctly used in the determination of the claim. However, there have been a number of instances of claims that have been rejected at primary determination and overturned at appeal on the basis of incorrect application of the SoP.

5.8.2. Further, we draw attention back to comments made at point 4.5.3, where it was noted that, whilst the SoPs generally improved consistency of decision making and introduced a more level field of play for claims to which they applied, they have become very rigid in their application and interpretation, which does seem somewhat in conflict with the concept of "beneficial legislation" to some degree.

5.8.3. As such, we also draw attention to comments made at points 4.6.2 and 4.6.3 where proposed suggestions were made as to a possible means of harmonising the liability schemes of the VAE & MRCA (which use SoPs) and the DRCA (which does not) were discussed.

5.9. *Are there ways to improve their use?*

5.9.1. The principle method of improving the use of SoPs, as highlighted in the submission by ADSO is via increased training in their application and use. This was an optional course in TIP training to enhance skills for VEA and MRCA advocates, but is a compulsory component of ATDP training. There may also be value in ensuring that DVA delegates receive adequate training in their application, given previous comments at 5.8.1 regarding primary decisions being overturned at appeal due to incorrect application of SoPs by delegates of the Department.

5.9.2. Further, we draw attention again to comments at 4.6.2 and 4.6.3 about possible avenues for harmonising the VEA and the MRCA with the DRCA with regard to the use of SoPs and increasing their flexibility somewhat.

5.10. *What is the rationale for having two different standards of proof for veterans with different types of service?*

5.10.1. The primary rationale for the two standards of proof lies in two concepts:

5.10.1.1. The first is the concept that ADF personnel on warlike/non-warlike, operational, peacekeeping or hazardous service is inherently at significantly increased risk of injury, death or exposure to disease by way of their service and thus deserves the benefit of any doubt in the determination of liability for an injury, disease or death; and

5.10.1.2. A particular incident, exposure or injury may, according to epidemiological evidence be *associated* with a particular condition or disease without the epidemiological evidence being sufficient to establish, on the balance of probabilities, *causation* of the condition or disease.

5.10.1.3. Because of the benefit of any doubt of the first presumption, the association supported by the evidence in the second presumption is sufficient to provide evidence of liability provided that the circumstances of the injury or disease raise a *reasonable hypothesis* that the service caused the injury or disease – i.e. if it cannot be shown beyond reasonable doubt that service did not cause the injury or disease, then liability is established.

5.10.2. On the whole, the RSL is of the position that the existence of two standards of proof is fair and reasonable, and that providing this benefit of the doubt to personnel with combat exposure is also fair and reasonable.

5.10.3. However, the RSL is also of the position that:

5.10.3.1. Some personnel on operational deployment are deployed in non-combat roles in non-hazardous locations and do not suffer increased exposures or risks over and above what might be expected in non-operational foreign locations;

5.10.3.2. Some peacetime activities (e.g. exercises with live fire, wargames, etc.) can entail risks equal to some combat situations or other operational hazardous locations;

5.10.3.3. These points bring into conflict the long-standing practice based in societal values, legislated practice and case law of the "relaxed" standard of proof for operational service, with the concept that deployed personnel whose service does not put them in immediate danger should be subject to the same standard of proof as another who did not deploy but who was prepared to do so;

5.10.3.4. To further confound the issue, there is evidence of clustering of conditions in deployed personnel suggesting exposure to diseases and/or toxins that were not present in Australia at the time[9], however, there may not yet be enough epidemiological evidence to provide a link on the balance of probabilities, making the reasonable hypothesis standard the only one available to provide a link to service.

5.10.4. Much like ADSO, the RSL takes the position that the "reasonable hypothesis" standard of proof is necessary, fair and equitable, and is appropriate for warlike/non-warlike, peacekeeping, operational and hazardous service.

5.10.5. The RSL also endorses the ADSO position that certain types of peacetime activity that entail heightened risk of injury or exposure also warrant the application of the lowered standard of proof. Examples of such cases would include live fire exercises, wargames where there is heightened risk of accident or injury, major accidents or incidents such as the Black Hawk accident in 1996 and activities involving increased exposure to toxic chemical (e.g. entry to F-111 fuel tanks, heightened exposure to aviation fuel, high-level exposures to PFOS/PFAS and other firefighting chemicals, etc.).

5.11. *Are there alternatives to recognise different groups of veterans?*

5.11.1. The RSL supports the position put forward by ADSO in their submission on this issue. While some veterans have expressed the opinion in the past that the existence of two standards of proof runs counter to the Australian way of a "fair go", and highlight their willingness to deploy in a period where Australia engaged in no conflicts for an extended period ("the long peace"), the RSL largely does not support this position.

5.11.2. The position of the RSL is that the lower standard of proof is appropriate for service which is inherently more hazardous to the ADF personnel engaged in that service than typical peacetime service. In general terms, this include the currently defined warlike/non-warlike, peacekeeping, operational and hazardous service. However, the RSL would see this extended to particularly hazardous types of peacetime service as outlined in 5.10.5 above, which we feel is more reflective of the true level of hazard in some aspects of peacetime service and is more truly in keeping with the Australian concept of a "fair go"- that the level of hazard be fairly reflected in the way that the claim is assessed.

5.11.3. This is consistent with the position adopted by ADSO, and consistent with past exceptions to normal provisions in veterans' legislation that government has made, such as the SHOAMP creation for DSRS participants, extension of Gold Cards to surviving British Nuclear Testing veterans and special provisions after the Black Hawk incident of 1994. Recognition of the extra hazards posed by certain peacetime activities is not new, however, past efforts have been piecemeal and ad hoc rather than consistent and clearly focused.

5.11.4. As noted by ADSO, past examples of extensions to veterans' benefits that make the approach truly beneficial seem to highlight a trend for these changes to only occur when

[9] For example, exposure to dioxins in drinking water distilled in RAN ships from sea-water off the Vietnamese coast, or the "Gulf War syndrome", which has not yet been properly defined or accepted on the basis of available scientific-medical evidence.

either the magnitude of a situation or incident is sufficient to attract public attention and require action (such as the Black Hawk incident), or death has reduced the number of beneficiaries to the point that the quantum of benefit is sufficiently small to be encompassed within the existing DVA appropriations (such as the extension of Gold Card entitlements to British Nuclear Testing veterans). Sadly, this trend has been noted with a certain cynicism by commentators outside the veteran community.

5.12. *What would be the costs and benefits of moving to one standard of proof for all veterans (for example, would it make the claims process easier)?*

5.12.1. A cost/benefit analysis for this change is largely meaningless from an ESO perspective. This is because such a change is largely irrelevant to an advocate, and the impact on a veteran is variable, but again, largely not relevant except under MRCA and then only indirectly and is undefined in this circumstance due to unpredictable variables.

5.12.2. For an advocate under the current regime, the SoP is only used as a reference to determine what factor is used to rely upon to lodge the claim and to help determine what evidence must be advanced to support the contention in relation to causation of the injury or disease. At present, the advocate has a choice of two for each condition, based upon type of service. Even then, for some conditions, the SoPs ("reasonable hypothesis" (RH) and "balance of probabilities" (BoP)) are virtually identical save that the threshold of exposure may be lower in one (RH) than the other (BoP). However, for DRCA claims, SoPs are largely irrelevant as DVA may be "guided by" the SoP, but is not bound by it.

5.12.3. Use of the ESO Portal means that the differences between claim forms for the three Acts are now gone, unless the advocate chooses to lodge a paper form for some reason. The ESO Portal uses the Single Claim Form process where the questions are uniform and the Portal uses information entered to determine the likely Act the condition(s) claimed fall under and includes an option allowing the advocate to permit the delegate to transfer to another Act if it is determined that the Portal has assigned it to the wrong Act in the first instance. Thus, the existence of one or two SoPs largely only affects decisions as to whether the claimant meets the thresholds or factors to claim and what evidence to advance in support of the claim.

5.12.4. Under MRCA, the type of service also impacts the amount of Permanent Impairment payment as the tables for peacetime service and warlike/non-warlike service progress to 100% compensation at different rates. Thus, the existence and use of a BoP SoP to advance a claim indirectly affects level of compensation based on the type of service, but this does not impact the ease of the claim or have any cost or benefit to the advocate, and the cost or benefit to the veteran is undefined and variable (and indirect).

5.12.5. Compensation under the VEA is unaffected by the type of SoP used, as SoPs are only used for liability and compensation is unrelated to type of service. Similarly, SoPs have no impact whatsoever on DRCA claims at present.

5.12.6. From the perspective of economic cost to government, the question is more simply answered, although it is difficult to accurately predict whether adopting a single standard of proof will actually have the effects outlined here – it is logical to assume they would, however, it is possible that no change would result. If one standard of proof is used, costs to government are likely to either go up or down, depending on the standard chosen. If the RH standard is adopted across the board, the logical assumption is that more claims would succeed due to the reduced standard of proof used. This would mean increased levels of compensation, through increased pensions under the VEA, increased permanent impairment payments and incapacity payments under the MRCA and associated medical,

pharmaceutical and rehabilitation and other associated costs. However, a move to the BoP standard should logically result in a slight reduction in successful claims (though it must be noted that many claims that succeed on the RH standard would succeed on the BoP standard in any case) and therefore a reduction in costs to government via a reduction in the costs noted earlier.

5.12.7. However, it should be noted that a switch to a single standard would need to balance the expected shift in costs to government with the nation's security and Australia's cultural traditions when it comes to veterans and their support.

5.12.8. On balance, the RSL supports retaining the two standards of proof currently in place, subject to the changes noted earlier in 5.11.2.

6. System Governance

6.1. *Do the governance arrangement for the veterans' support system encourage good decision making – from initial policy development to its administration and review?*

6.1.1. The RSL takes the position that much of the governance and administration of the veterans' support system lies in the hands of DVA and that this has been the subject of much criticism and several reviews and inquiries over recent years.

6.1.2. However, DVA has made a number of positive attempts to improve upon aspects identified within these criticisms over recent years, giving rise to initiatives such as VCR and ATDP.

6.1.3. It should also be noted that many of these reviews have occurred in relatively short spans of time (e.g. the recent Senate inquiry and the most recent Australian National Audit Office review and now the ongoing Productivity Commission Review) and DVA has, in some cases, been the subject of multiple reviews concurrently, which begs the question of whether opportunities have been provided for the Department to properly implement outcomes identified in each of the successive reviews, whether sufficient time for outcomes of changes to be realised has been allowed and whether sufficient resources or appropriations have been made to adequately address the recommendations made in these reviews.

6.2. *If not, what changes could be made?*

6.2.1. Outside the Department, it is acknowledged that, aside from the relatively loose regulatory regime of the ACNC, ESO delivery of veterans' support is relatively unregulated. Quality assurance of advocate performance and decision-making is self-monitored within each ESO and is often left to the individual advocate to manage with little to no supervision, depending on the ESO and the circumstances in which the advocate works. Very often the Executive within the ESO has little to no understanding of the advocate's role or skillset and cannot provide meaningful oversight.

6.2.2. Stricter regulatory oversight via improvements in the ACNC legislation and regulatory model and improved governance within ESOs could result in better quality control of advocates, especially once ATDP rolls out its quality assurance measures in 2019.

6.3. *Are incentives sufficiently aligned between agencies, or are there areas of conflict that could be better managed?*

6.3.1. In general terms, the RSL is not aware of any specific areas of conflict between government agencies that would cause concern in governance over the administration of veterans' support.

6.3.2. However, one concern that has been flagged to the RSL by some younger veterans in relation to training for advocates relates to ATDP and the association between ATDP and DVA.

6.3.3. As was highlighted in the Senate inquiry, there is a perception among some younger veterans that the "brand" of DVA is somewhat "tarnished" and mistrusted, and this has extended to a mistrust of DVA being associated with the body that provides training to advocates via the ATDP accredited training. The essence of this concern relates to DVA, as the body that determines the outcomes of veteran claims having a perceived conflict of interest in its association with the ATDP accredited training for the advocates who prepare the claims that DVA then determines outcomes for.

6.3.4. Whether this conflict is an actual conflict or merely a perceived conflict, this has been raised with the RSL as a potential area of conflict for the Department and thus should be addressed, especially if younger advocates are to be attracted into training.

6.4. *If there are any incentive problems, how can they be resolved?*

6.4.1. The RSL notes that, in the past, the BEST funding model has undergone several iterations, all of which seem to have been focused on rewarding claims volume rather than claims quality. The funding models also seem to have taken a very limited and restrictive view as to how much time a claim takes and assign funding using very simplistic assumptions which do not necessarily reflect the reality of increasingly complex claims, multi-Act claims, claims with large numbers of conditions associated with them, or the individualised nature of support provided by advocates.

6.4.2. It is the experience of the RSL that some clients require only a few, relatively short appointments, even for relatively complex claims, whilst others may require a large number of long appointments to provide support in addition to frequent phone and email contact, even for relatively simple claims, due to their differing physical and emotional support needs during the claims process based upon their individual circumstances and that advocates adjust their service provision to reflect these differing time requirements – the simplistic formulae used for BEST funding do not adequately capture this.

6.4.3. It is noted that the BEST Funding model for 2018-19 is being reviewed by DVA.

6.5. *Is the veterans' support system sufficiently transparent and accountable to both the veterans and the community?*

6.5.1. While ESOs are generally committed to being open and transparent with their members, the RSL acknowledges that there are some barriers to this transparency:

6.5.1.1. The difficulty of sharing information between ESOs and between layers of nationally federated ESOs due to internal communication issues, particularly for larger bodies;

6.5.1.1.1. The conservative nature of information sharing by DVA and the nature of DVA ICT systems, which are not fit-for-purpose and require updating and integration.

6.6. *What role should ESOs play?*

6.6.1. The RSL supports the ADSO position that ESOs should be fully active and effective partners in the veterans' support system through the delivery of high quality advocacy services in partnership with each other and with Defence and DVA.

6.6.2. Interactions with DVA via the National Consultative Forum and at the State level via each regional Deputy Commissioners' Forum have improved ESO-DVA communications, and ESORT has assisted with some high-level interactions between ESOs, however, there is considerably more work to do to increase partnerships.

6.6.3. Despite the increase in use of technology for communication across the veteran and ESO community, there are still barriers to communication within and between ESOs which need to be addressed to improve effectiveness of service delivery and information sharing with the veteran community.

6.7. *Are there systemic areas for improvement in the ESO sector that would enhance veteran wellbeing?*

6.7.1. Aside from better communications and increased partnerships between ESOs, the RSL endorses the ADSO position of a social enterprise model for advocacy services.

6.7.2. Referring back to the points made at 6.3.2-6.3.4, an independent incorporated body to train and accredit advocates, provide indemnity insurance for advocates and to offer and monitor ongoing professional development could be formed which could be independent of DVA, addressing the potential conflict issue raised earlier.

6.7.3. This body could also set quality standards and provide quality monitoring of advocacy service delivery, much like professional standards associations in professional fields, maintaining a register of accredited advocates and managing mentoring of newly trained advocates.

7. The Role of the ADF in Minimising Risk

7.1. *What obligations should be placed on the ADF and individual unit commanders to prevent service-related injuries and record injuries when they occur?*

7.1.1. It is the understanding of the RSL that ADF policy makes injury prevention and recording the responsibility of each level in the chain of command. Thus, failures in these areas are disciplinary matters and it is understood that training at various levels in the ADF reinforces these concepts. Further, there are numerous OH&S policies and guidelines which are documented covering a range of topics, including the weights of packs to be carried by members based on body weight and protective equipment to be worn in exposure situations, etc.

7.1.2. From a broader perspective, there are also statutory requirements under the *Workplace Health and Safety Act 2011* that apply to ADF personnel which all personnel should be aware of and which are covered in numerous training courses throughout an ADF career.

7.1.3. However, there are numerous examples of failures to recognise risk leading to injury – from members being expected to wear packs far in excess of accepted weights, exposures incurred in the F-111 DSRS program, etc. This suggests that, while training may provide information about safe practice expectations, there may be a lack of understanding about risk, risk assessment and risk management, which is not always understood from training about workplace safety and that safety training may need to be reassessed or reinforced.

7.1.4. ADSO notes in its submission that the military is a profession and makes observations about professional development and adherence to ethical, professional and accountability standards, which are fully endorsed by the RSL.

7.2. *To what extent do cultural or other issues create a barrier within the ADF to injury prevention or record-keeping?*

7.2.1. The ADF is, ultimately, a combat force and is culturally directed toward maintaining combat-readiness. This may place personnel and commanders in situations where they face a clash between ensuring that combat readiness and risk of injury.

7.2.2. When weighing the consequences of risk of injury, some commanders will err on the side of risk avoidance and be deemed too cautious, while others will emphasise combat readiness and be deemed a "good leader", in spite of the increased risk of injury placed upon their personnel. Which is the right approach would depend on the fine balance between the risk of injury or death and combat readiness and could vary greatly with circumstance and would ultimately not be tested until a combat situation arose.

7.2.3. While there must be a focus on attempting to avoid risk of injury where possible, this must be balanced against the security of the nation for which the ADF train, and there is no simple answer to how this balance is achieved. The most that can be said is that current training in injury prevention and recording may not focus enough on risk identification and assessment to provide commanders with the tools they need to assess the situation adequately.

7.3. *The ADF is not financially accountable for the cost of compensation or for the cost of treating service-related injuries and illnesses after a veteran leaves the ADF. Is this a barrier to the ADF having an adequate focus on preventing injury and illnesses and providing early intervention and rehabilitation support?*

7.3.1. The opening statement of this question poses a number of problems, as it presupposes that the ADF is somehow a wholly separate and private entity from DVA as though the two were not two agencies of the same government. Whilst the ADF does not bear the cost of compensation and treatment of ADF personnel after discharge, these costs are transferred to another branch of government. This suggests a somewhat punitive approach to the ADF's management of its personnel in an effort to force them to be more responsible for the risk to personnel by increasing the cost to the ADF of injury to their personnel. This seems somewhat self-defeating as, no matter how punitive the approach becomes, at some point the cost of supporting the discharged member will transfer to DVA unless that department is subsumed under the ADF.

7.3.2. It was noted in the RSL (Tasmania Branch) Inc. submission to the Senate Inquiry that one area of concern relating to the ADF medical treatment of its personnel experienced by its advocates was that, with many musculoskeletal injuries, there was a significant delay between the initial injury and any form of imaging being carried out by the ADF, with only physiotherapy being undertaken in the interim. This practice did not match how similar injuries would be managed in a civilian patient, in whom an X-Ray or MRI would normally be routinely ordered in order to rule out fracture or tendon/ligament damage. It was noted in that submission that in a number of cases where advocates had encountered clients with these types of injuries who had imaging delayed by as much as 6 months, the injuries had proven to be quite severe (e.g. detached ankles, fractured ankles, etc.) and should have been imaged immediately. The results in each of these cases was inappropriate management of the injury for an extended period, ultimately leading to delayed surgery requiring considerably more reconstructive work than would have initially been the case with a much worse final outcome ultimately resulting in medical discharge, which could have been avoided by earlier imaging and proper intervention.

7.3.3. Whilst the RSL would support the ADSO position that the ADF should not be financially responsible for the compensation and medical treatment of discharged members, it does note with concern the issues raised above by the submission to the Senate Inquiry by the Tasmanian advocates of the RSL and would suggest that there may be

an aversion to the use of imaging within the ADF for certain types of imaging, perhaps due to cost. If this is the case, this needs to be addressed, as this could avoid the unnecessary cost of much more aggressive treatment at a later stage and could avoid the need to discharge a member that might otherwise be able to remain and actively serve for considerably longer.

7.4. *If so, how might this be remedied?*

7.4.1. The RSL is concerned that, if the ADF is deemed to be responsible for the compensation, rehabilitation and medical costs of veterans, the appropriation for DVA would be significantly reduced from levels that are already inadequate. Further, this money would only be transferred to Defence – the cost would not be eliminated, simply transferred to another agency, failing to achieve any kind of efficiency.

7.4.2. The RSL notes that the ADSO position on this line of questioning matches the RSL position.

8. Financial Compensation for Impairment

8.1. *Is the package of compensation received by veterans adequate, fair and efficient?*

8.1.1. The RSL takes the position that when assessing veterans' compensation, the totality of the compensation and rehabilitation system across all legislation must be considered holistically, as the legislations has been developed over time to reflect cultural and historical developments reflective of attitudes and experiences that have developed over time. Individual examination of specific entitlements or aspects of the system will undoubtedly lead to focus on the differences and fail to appreciate the manner in which the system has evolved over time to address the changing needs of veterans and perceptions of society.

8.1.2. Further, any approach to assessing the fairness, adequacy and efficiency of the package of compensation must also consider the entire socio-economic spectrum and avoid narrow focus on purely economic factors.

8.1.3. While efficient delivery of entitlements and services is desirable, it is often the experience of the RSL that "efficiency" conflicts with adequacy and fairness and usually arises out of reviews of economic aspects alone and is achieved through cost-cutting and "efficiency dividends", which usually result over time in poor or reduced services and outcomes across the entire socio-economic spectrum.

8.1.4. As pointed out in the ADSO submission, the fairness and equitability of each of the pieces of legislation relates to the context in which it was developed – each was developed in the context of particular circumstances and suited the environment in which it was formulated and was fair and equitable for the circumstances it was created for. As each has evolved, it has largely remained consistent with its original intent and goals – the VEA with the provision of an income support pension to assist veterans with injuries or diseases arising out of service, and the DRCA and MRCA with rehabilitation services and non-economic loss compensation and income support while rehabilitating back to work.

8.1.5. The adequacy of the economic component of the compensation can only be assessed in the context of the expectations of how that component is intended to be used by the veteran – incapacity payments are a replacement for income, and should be able to provide sufficiently for cost of living expenses. Similarly income support pensions under the VEA should be able to reasonably compensate for the level of impairment and any associated expectations around capacity for work (i.e. total incapacity for work

attracts an income that can support the veteran, lower incapacities provide support that can cover non-economic loss and out-of-pocket expenses). Whether the indexation or quantum of these payments is adequate is a separate issue.

8.2. *If not, where are the key shortcomings, and how should these be addressed?*

8.2.1. There are two aspects to whether there are shortcomings to the fairness and adequacy of veterans' compensation under current arrangements:

8.2.1.1.1. Firstly, each Act is a product of the time and circumstances for which it was developed and the way in which it has matured over time and seeking to identify shortcomings today of legislation designed under different social and economic imperatives provides a less than useful perspective.

8.2.1.1.2. Secondly, the primary perceived shortcomings that would be of relevance that arise do so under circumstances of eligibility under multiple Acts.

8.2.2. When veterans have eligibility under the VEA and DRCA, and conditions are recognised under both Acts, offsetting between the disability pension under the VEA and payments received under the DRCA are applied, reducing part or all of the payment under the VEA, which the veteran may view as a shortcoming.

8.2.3. Under VEA-MRCA dual eligibility situations, where operational service exists immediately prior to 30 June 2004, the VEA pension may apply for another 50 years or more for the eligible veteran, however, many of these veterans will also have warlike or non-warlike service under MRCA and will thus be unable to take VEA pensions and be limited to taking entitlements for such service and operational service under the MRCA provisions, forgoing a disability pension until death under the VEA.

8.2.4. Whether each of these situations represents a shortcoming or is considered fair or adequate is impossible to determine without a case-by-case analysis as each situation will vary based on a wide range of variables. The danger is that this inquiry will be faced with a number of personal submissions outlining a range of individual cases, which will not necessarily be representative of the majority of circumstances, potentially creating an unrealistic view of potential shortfalls of the totality of the veterans' compensation package.

8.3. *Is access to compensation benefits fair and timely?*

8.3.1. There are multiple aspects to this question with respect to what is meant by "compensation" and what is meant by "access".

8.3.2. "Compensation" in the narrow sense may refer to the purely economic payment of entitlements in the form of disability pension under the VEA, or permanent impairment payment or incapacity payments under the DRCA or MRCA (or any of the ancillary payments under any of the Acts).

8.3.3. "Compensation" in the broader sense may also refer to medical treatment, rehabilitative services, household services, attendant care services, transport services and any other ancillary services that may be accessed.

8.3.4. In the simplest sense, "access" to these elements may simply refer to the ease with which the veteran can engage with DVA to activate some form of compensation payment or service, either by initiating a claim or, once a claim is accepted, by using a White or Gold Card, arranging a rehabilitation service, or other service available through DVA.

8.3.5. In a more specific sense, "access" may refer to the time it takes for a veteran to be able to establish a condition as service caused from lodgement of a claim through to

successfully receiving acceptance of liability and payment of an economic compensation payment.

8.3.6. With regard to compensation in the broader sense, the range of entitlements and benefits offered to Australian veterans compares favourably to those offered to Canadian veterans[10] and New Zealand veterans[11] and superior to those of the US and UK. Given the difficulties in the UK over provision of veterans' health services within the NHS, the RSL supports ADSO's position resisting any suggestion that medical administration of veterans' health be transferred to the Department of Health or that support or incapacitated veterans be transferred to the NDIS, especially in light of current difficulties with the NDIS.

8.3.7. With regard to the broader definition of "access", veterans generally have easy access to entitlements in that claims may be lodged by veterans directly by post, online through self-service, via advocates through ESOs (either by post or through the ESO Portal) and may lodge directly through DVA offices and have access to information via on-base advisors if still serving and have access to considerable information online.

8.3.8. Whether "access" to "compensation" (in the narrower sense for both terms) is "timely" depends on exactly at which point the data is viewed. Current trends within DVA and the VRB indicate that average time to process claims and appeals is falling.

8.3.9. However, there are examples of particularly egregious circumstances in which totally inadequate performance cannot be ignored, such as the case of Jesse Bird[12]. In spite of broad systemic improvements within DVA, individual circumstances still arise where manifest failures of process still occur leading to tragic outcomes. These failures unfortunately only provide fuel for further criticism of the Department which is able to be used on modern media platforms in such a manner as to make them seem the norm rather than the exception, which favours nobody.

8.4. *In particular, are there challenges associated with the requirements in the MRCA and DRCA that impairments be permanent and stable to receive permanent impairment compensation?*

8.4.1. The RSL is satisfied that these questions have arisen out of issues raised in the Senate inquiry and have since been addressed by legislative amendments that have addressed the primary concerns with the permanent and stable definitions in both the MRCA and DRCA and have also introduced interim permanent impairment payments to both Acts. These amendments that have been passed are consistent with the first option advanced in the ADSO submission.

8.5. *How could these provisions be improved?*

8.5.1. The RSL is satisfied that these provisions are now satisfactorily addressed by the most recent legislative amendments that were passed as part of the VCR.

[10] *Veterans' Wellbeing Act 2005* (CA).
[11] *Veterans' Support Act 2014* (NZ).
[12] https://www.dva.gov.au/consultation-and-grants/reviews/government-reports/bird-review-recommendations

8.6. *Is there scope to better align the compensation received under the VEA, MRCA and DRCA?*

8.6.1. The RSL submits that this matter is being addressed by the Legislative Forum and should be resolved collaboratively between DVA and the ESO community with due consideration to the well-established legal doctrine of accrued rights.

8.7. *In particular, could the provisions for permanent impairment compensation and incapacity payments in the MRCA and DRCA be made consistent?*

8.7.1. The RSL submits that this has been largely achieved via the most recent amendments passed by government as part of the VCR.

8.8. *Are there complications caused by the interaction of compensation with military superannuation? How could these be addressed?*

8.8.1. There are a number of well-known difficulties related to the administrative failures that occur upon discharge around the provision of superannuation payments via CSC and their interaction with DVA payments and the difficulties with correct and timely communication of information between Defence, CSC and DVA to facilitate quick and accurate calculation and payment of superannuation and affected DVA payments.

8.8.2. There interaction between superannuation payments and incapacity payments is well known and understood, and work is ongoing between Defence, CSC and DVA to correct these issues. These same difficulties affect payments of Special Rate Disability Pension (SRDP) under MRCA for veterans who qualify for this payment.

8.8.3. The RSL understands the ongoing work to rectify these issues, however, it must be understood that failures in this area are unacceptable as they place considerable additional strain upon veterans by:

8.8.3.1. Placing the veteran and their family in financial jeopardy;

8.8.3.2. Creates the potential for a debt to DVA in the event that failures of communication between these three areas result in DVA overpaying the veteran, adding additional financial strain;

8.8.3.3. Create another significant stressor at a time when stress is high due to transition from service life and potentially uncertainty over outcomes of DVA claims;

8.8.3.4. Adds to potential mental health concerns if they are present; and

8.8.3.5. In the age of social media, creates opportunities for instant criticism which gains considerable traction and widespread distribution.

8.9. *What is the rationale for different levels of compensation to veterans with different types of service in the MRCA?*

8.9.1. The issue of different standards of proof for different types of service was discussed under header 5.10, as was the rationale for this distinction. The same principles apply to the different levels of compensation. It should be noted that, although there are two tables for compensation under the MRCA, at the highest levels of impairment, both tables reach 100% level of compensation, however, the approach this level at different rate, to reflect the assumed differing levels of risk associated with the hazard resulting in impairment.

8.10. *Should these continue?*

8.10.1. The RSL supports the ADSO position that the elimination of these differences in compensation progression would be contrary to the well-established legal doctrine of accrued rights. However, consideration might be given to adopting the expansion of

definition proposed in the discussion to standards of proof at 5.10 and applying it equally to the levels of compensation under MRCA.

8.11. *For those veterans who receive compensation, are there adequate incentives to rehabilitate or return to work?*

8.11.1. With regard to the VEA, this question is largely meaningless, as return to work is not the purpose of the VEA, which is focused on economic compensation via a pension and medical support.

8.11.2. However, it is the RSL's experience that younger veterans do not wish to remain off work and on a lifelong pension if there is any possibility of a return to work and their expectation is entitlements that provide medical support, rehabilitation and employment support and an opportunity to move on to the next stage of their life and continue to support their family.

8.11.3. For the majority of younger veterans, unless they are in receipt of a Class A or B invalidity pension under MSBS or in receipt of incapacity payments and/or permanent impairment payments under the MRCA, they have no option but to return to work to support their family and are usually far too young to consider retirement from the workforce.

8.11.4. MRCA prioritises rehabilitation ahead of compensation. For this reason, unless the veteran is engaged in a rehabilitation program involving study designed to return them to work either by updating or completing qualifications or by transferring to a new skill, after 46 weeks on incapacity payments, the payments drop to 75% of the previously paid rate.

8.11.5. In the past, permanent impairment claims could only be determined once the conditions were deemed permanent and stable, causing considerable problems and hardship in some cases. Under amendments to both the MRCA and DRCA, this has been altered to allow less restrictive definitions for permanent and stable, and to allow for interim permanent impairment payments to be made once claimed conditions have passed a minimum threshold of impairment and are deemed unlikely to improve further, but have not yet stabilised.

8.12. *Are there other examples of compensation schemes that provide support for injured workers and successfully create incentives to rehabilitate or return to work?*

8.12.1. It is the RSL's view that there are unlikely to be better examples to be found given that both the MRCA and DRCA were grounded in workers' compensation philosophy.

8.12.2. It is worth noting that some insurance-based workers' compensation schemes only provide incapacity payments for a limited period and use the cessation of payments as a forced incentive for return to work.

8.12.3. The RSL does not deem this to be appropriate in the veteran context, as there are some contexts in which a return to work is simply not possible and cessation of payments is an unnecessarily punitive action in these situations and there is no provision in the DRCA for an alternative payment for a veteran who has no prospect of returning to work.

8.12.4. Similarly, the SRDP payment in the MRCA, whilst designed as a "safety net" for such circumstances, does not always work appropriately for cases where a return to work is not possible due to the way that it interacts with all other sources of payment, including lump sum permanent impairment payments which may have been received many years prior to qualifying for SRDP. Because of the way that SRDP interacts with

these permanent impairment lump sums and MSBS pensions, it is possible for a veteran to be receiving an MSBS pension inadequate to support themselves or their family and have their SRDP reduced to $0 by past lump sum payments that were likely used to pay off a debt such as a mortgage while having incurred other debts in the interim. Thus, the SRDP payment may need reassessment to see if it meets the need it was created to fill.

9. Transition from the ADF

9.1. The RSL recognises that the transition from the ADF to civilian life presents a significant challenge to ADF personnel, particularly when the transition is involuntary due to medical discharge. These difficulties can affect all aspects of the veteran's life and the added stressors to the veteran can also significantly impact upon their families. Having said that, the RSL fully supports the positions advanced by ADSO in their submission and has no further points to add to their presentation on this issue.

10. Income Support & Health Care

10.1. *Is health care for veterans, including through the gold and white cards, provided in an effective and efficient manner?*

10.1.1. Veteran health care is a complex issue handled by a number of actors within the system controlled by a number of variables.

10.1.2. Within this system are:

10.1.2.1. The type of card the veteran holds: White or Gold;

10.1.2.1.1. A range of medical professionals and allied health care practitioners to whom the veteran might be referred for aspects of their health care, all of whom must decide whether the treatment card is accepted, either due to eligibility requirements (in the case of White Card), or economic reasons (the determination of whether the Medicare Schedule Fee plus Veterans Access Fee is sufficient compensation for their services);

10.1.2.2. The quality of service of the provider (based on effectiveness and efficiency); and

10.1.2.3. The degree of satisfaction the veteran has with the level of service or care received (based on either immediate outcomes or long term health or both).

10.1.3. Of these variables, DVA (and, by extension, government) has control of only one – the type of card issued to the veteran, and has no control (in particular) over whether a provider accepts patients on DVA treatment cards as patients for treatment, which may limit treatment options for the veteran.

10.1.4. Any assessment of the effectiveness and efficiency of the White/Gold Card system must recognise this inherent limitation and the factors influencing provider decisions as to whether to accept DVA clients as patients (primarily economic).

10.2. *Has the non-liability coverage of mental health through the white card been beneficial?*

10.2.1. The experience of RSL advocates has been that this initiative has been well received and it provides an avenue for quick access to treatment, assessment and diagnosis, which may then pave the way for a full liability claim in the future.

10.2.2. The speed with which access to this service is granted gives heart to those who access it and experience has been that it has restored a level of faith in DVA and has assisted in engaging veterans into the claims process that might otherwise have avoided interaction with DVA and remained untreated and without access to their entitlements

and access to rehabilitative support for their injuries as well as economic support while returning to work.

10.2.3. One negative piece of feedback received by RSL advocates relates to the exclusion of Reservists who have not had continuous full time service. Whilst the rationale behind the inclusion of Reservists with CFTS is understood, advocates have encountered many long-term Reservists who have in identical training scenarios to full-time serving members, including recruit training, engaged in protracted exercises and experienced many years of the maximum number of permitted Reserve days engaged in essentially the same duties as full-time serving members and yet are denied NLHC coverage, whilst full-time serving members are provided with this coverage after just a single day of full-time service (which includes the first day of recruit training, which is identical for many Reservists). Many such Reservists justifiably feel aggrieved that they are noticeably excluded from the NLHC provisions.

10.3. *Is there scope to simplify the range of benefits available, and how they are administered?*

10.3.1. When looked at in their totality, the range of entitlements and support available to veterans is overwhelming and confusing, however, it is the rare veteran who is exposed to more than a limited range of options at any given time, unless they are seeking to manage their own claim and are overzealous and unfocused in their research.

10.3.2. The legislation is supported by a defined process and Factsheets prepared by DVA, though from the experience of RSL advocates, these Factsheets could be improved as some veterans find them overwhelming and confusing, especially in the way they are presented on the DVA website.

10.3.3. Further, at each stage of the claim, a determination letter is provided to the veteran outlining the decision reached, the reasons, the entitlements flowing from that decision, and the next steps, which can be read at leisure. Again, however, whilst determination letters have fluctuated in quality and clarity over the years, they still may be improved somewhat for readability and clarity.

10.3.4. In order to minimise confusion on the part of the veteran, there are two principle suggestions tendered by the RSL:

10.3.4.1. First, veterans are encouraged to use an advocate to make their claims, as an advocate will manage the claims process and explain each step along the way, addressing entitlements as and when they become relevant and explaining determinations and reasons for determination outcomes.

10.3.4.2. Secondly, factsheets may be improved for clarity, however, the principle difficulty the veterans encounter is locating the correct factsheet, and none of the three options for locating these on the site seem to assist.

10.3.4.3. A suggested alternative is a more graphical and intuitive interface to the factsheets based upon a decision tree, which begins with the legislation being searched on (with clarifying dates of eligibility), branches to types of service, and then branches further into different topics (such as liability, treatment, permanent impairment, incapacity payments, etc.) to reflect each stage of claim, or each type of entitlement as it becomes relevant to the step being reached in the tree.

10.3.4.4. This would present the information in a logical flow that would make more sense to the veteran and make the information easier to access. The more arcane searchable interfaces by Factsheet name, topic or number should remain for advocates and

delegates who have detailed familiarity and need to access a known sheet quickly, however, the visual interface should reduce confusion and "information overload" for many veterans seeking information.

10.3.5. Other than veterans making use of advocates to simplify and streamline the claims process and making information in factsheets and determination letters easier and more logical to access and understand, there is no inherent need to "simplify" the entitlements in the sense of reducing the number or nature of entitlements – they are generally fit for the purpose they were designed for at the times they were introduced and as they evolved over time, however, ease of access and understanding is the key barrier to their use – easily overcome by trained advocates and more intuitive interfaces to information.

10.4. *Are all of the payments available necessary and beneficial?*

10.4.1. This question is fraught with the potential for unintended consequences.

10.4.2. It must be remembered that there are a range of payments (beyond those already discussed) which have evolved over time to meet needs that have arisen at various times and that, even now, new payments are added as needs arise (the most recent VCR amendments added a new type of payment to the VEA for veterans covered by any of the three Acts (the veteran payment). These payments serve a purpose and address specific needs, removal of them in an effort to "simplify" or "improve efficiency" may have unintended consequences.

10.4.3. This is best illustrated by example with the introduction of the White Card for DRCA. Under the DRCA, health care was provided in those circumstances when the cost of treatment was "appropriate" relative to the "charges customarily made" for the treatment.

10.4.4. The introduction of the White Card was seen as a beneficial simplification of this process, however, it resulted in a loss of benefits when DRCA covered veterans sought to repair or replace hearing aids that they had been previously issued under the old arrangements which were now not available under the White Card scheme.

10.4.5. Prior to this change, veterans could access whatever hearing aid best suited their needs and circumstances. Under the White Card arrangements, they were entitled to only base-level hearing aids and bore the differential cost if they wished to retain the hearing aid to which they were accustomed.

10.4.6. Based on this experience, the RSL believes that any proposal to "simplify" the scheme of payments available under the veterans' support arrangements must be very carefully considered to avoid any similarly unfortunate unintended consequences.

10.5. Are they achieving value for money outcomes?

10.5.1. This is difficult to assess without knowing what variables underlie the costs and benefits being assessed to determine "value for money".

10.5.2. With regard to veterans' support payments and other entitlements, there is a strong social element to these benefits, which is difficult to equate to an economic value, making such a cost-benefit analysis difficult.

10.5.3. Further, opportunity costs of reduced benefits or poorly explored alternatives are not yet defined or understood, nor are the costs associated with impacts on other areas within DVA if the number and types of payments are reduced and these have flow-on effects to other areas.

10.5.4. The RSL is of the opinion that this question cannot be adequately answered without a full socio-economic analysis of the costs and benefits of the entire veterans' support system, which may be more time-consuming and costly than the effort justifies.

10.6. *What are the benefits of having generally available income support payments also available to veterans through DVA?*

10.6.1. Within the classification of "Income Support" payments[13], it appears that the maximum rates of the Service and Partner Service Pensions and the Centrelink Age and Disability Support Pensions are identical ($907.60 for singles and $684.10 each for couples per fortnight on 30 Jun 2018)[14].

10.6.2. Given that these rates are identical, there would appear to be no benefit to making the Centrelink payments available to veterans via DVA.

10.6.3. However, there is no relationship between the VEA General Rate Disability Pension, Intermediate Rate Disability Pension, Special Rate Disability Pension or Extreme Disablement Allowance and the Centrelink Disability Support Pension, so there may be some value in making these payments available to eligible veterans via DVA if appropriate.

10.6.4. Similarly, there may be benefit in providing access to the Centrelink Carer Payment and Carer Allowance payments to veteran's partners (or adult children if appropriate) via DVA where they act as the primary carer for the veteran and meet the requirements of these payments, providing a "one-stop-shop" for all payment matters relating to the veteran, including for the carer if they are a family member of the veteran.

10.7. *What are the costs?*

10.7.1. Should the Centrelink payments discussed above be made available to veterans or their relevant family members via DVA, then the costs associated would relate to ensuring that DVA staff are suitably trained in administering these payments and assessing claims for them. Otherwise, the cost of the payments themselves would simply involve a transfer of appropriations from Human Services to DVA.

10.7.2. However, should the aim of this line of questioning relate to a transfer of DVA functionality to Human Services, the RSL must state is strenuous objections to such a move and fully support and endorse ADSO's opposition to such a move.

10.7.3. The RSL submits that the separation of payment of veterans' payments to another entity separate from the body that determine the entitlement to payment and quantum of payment would introduce inefficiencies as this imposes a barrier between the determination of a payment and its quantum and the preparation and processing of that payment.

10.7.4. Should inter-departmental communications technologies be interrupted for some reason, this could introduce unnecessarily delays in payments, or introduce errors in the event that the quantum of a payment is changed within DVA, but not implemented correctly on the Human Services side, potentially resulting in underpayment for an unspecified period, resulting in financial hardship.

[13] https://myaccount.dva.gov.au/new-pension-rates.html
[14] https://www.humanservices.gov.au/individuals/enablers/payment-rates-age-pension/39901
https://www.humanservices.gov.au/individuals/enablers/payment-rates-disability-support-pension/39881

10.7.5. This could also result in potential overpayment for a similarly unspecified period, resulting in a debt with its associated added stress and financial hardship.

10.7.6. With the reputation of Centrelink relating to debt collection, particularly relating to automation of this process with the now infamous "Robodebt" process, having the payments reside with Human Services risks the collection of overpayment also reside with them, introducing risk of improper handling of this process by staff not accustomed to dealing with veterans.

10.7.7. Again, the RSL would strongly resist efforts to transfer responsibility for payments of DVA payments to Human Services.

11. Summary

11.1. The RSL has concerns that the nature of the issues paper suggests a purely economic focus to the inquiry, raising the spectre of "efficiency dividends" in a department that is already under-resourced and struggling to improve services with what appears to be an inadequate appropriation to deal with ICT and resourcing issues.

11.2. Veterans' support legislation has evolved over the last century based on Australia's proud military tradition and its historically voluntary Defence force and the tradition of sacrifice of its service men and women and the support of the community for the veteran community. As such, it recognises the unique nature of service and, while complex, has evolved to meet particular needs that have arisen over time.

11.3. Whilst there has been much difficulty over recent years, there have been substantial steps toward change, which have resulted in significant signs of improvements within DVA and the ADF, which are encouraging to the RSL and the ESO community.

11.4. There remain a number of challenges for all of the veteran community, including ESOs, and for DVA and Defence to address to progress the collaborative relationship and deliver better outcomes for our veterans.

11.5. There is some scope for harmonisation of the legislation, and increased scope for training of professional and accredited advocates who can ease the claims and appeals process for veterans to achieve the best outcomes that each veteran is entitled to in the easiest and most pain-free manner possible.

11.6. With continued collaboration and increased communication between all areas, the RSL believes that it is possible to improve the delivery of advocacy services to our veterans and for Defence and DVA to work with the ESOs to achieve a smoother, simpler and more balanced process into the future.

12. Recommendations

12.1. The RSL recommends that the Productivity Commission Inquiry into Compensation and Rehabilitation for Veterans find that:

12.1.1. A purely economic approach to veterans' support and compensation is an unacceptably narrow view of the issue and that a broader, socio-economic view is more appropriate.

12.1.2. An effort to harmonise some aspects of veterans' support legislation be made, with the following being a priority:

- Implementation of an two-step version of the Statements of Principle liability process across the VEA, DRCA and MRCA:
  - Step One: Does the claim satisfy an existing factor within the SoP? If yes, accept liability, otherwise proceed to Step 2,

- Step Two: Does the medical evidence available, in the expert medical opinion of the evaluator indicate that, on the balance of probabilities, in the circumstances of the injury or disease, the veteran's service significantly contributed to the injury or disease? If yes, accept liability, if no, the claim fails.
  - Align DRCA with MRCA for method of assessment of level of impairment (impairment points);
  - Align DRCA with MRCA for method of assessment of amount of permanent impairment quantum and provide for weekly payments.
  - Expand the application of the "reasonable hypothesis" standard of proof to cover peacetime activities where the level of risk of injury, disease or death is of a level similar to that experienced on an operational, hazardous or warlike/non-warlike deployment (e.g. high level chemical exposure, severe incident, live-fire exercise, wargames, etc.).

12.1.3. The ATDP be separated from DVA and set up as a separate entity with responsibility for training advocates, maintaining register of advocates, maintaining continuous professional development of advocates, overseeing quality control of advocates and service delivery and setting of professional standards for advocates.

12.1.4. Expand non-liability health care for mental health conditions to all Reservists.

12.1.5. Improvements to the interface for Factsheets on the DVA website be made to adopt a workflow or knowledge tree interface whereby factsheets are accessed by stage of claim and relevant entitlement or process at each stage through a more intuitive and graphical flow diagram interface.