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Productivity Commission

**PRODUCTIVITY COMMISSION**

**VETERANS' COMPENSATION AND REHABILITATION**

**MR R FITZGERALD Commissioner**
**MR R SPENCER, Commissioner**

**TRANSCRIPT OF PROCEEDINGS**

**AT HOTEL GRAND CHANCELLOR, ADELAIDE**
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**COMMISSIONER FITZGERALD**: We might commence. We're just a couple of minutes early. Firstly, thank you very much for coming and I've just got an opening statement which I'll read very briefly and then we'll get under way. I must say it's a joy to be back in Adelaide.

Good morning, everyone. Welcome to the public hearings for the Productivity Commission's inquiry into veterans' compensation and rehabilitation following the release of our draft report in December last year. I'm Robert Fitzgerald. I'm the presiding commissioner on this inquiry and I'm with a fellow Commissioner, Richard Spencer.

The purpose of these hearings is to facilitate public scrutiny of the Commission's work and to get comment and feedback on the draft report and it's very much part of the process by which the Commission operates in relation to public inquiries. Following this hearing, which is the first, in Adelaide, hearings are also planned for Perth, Darwin, Wagga Wagga, Canberra, Melbourne, Hobart, Sydney Brisbane and Townsville. We will then be working towards completing a final draft report which will go to the government at the end of June this year, having considered all of the evidence presented at the hearing, and in submissions as well as other informal discussions.

Participants and those who have registered their interest in this inquiry will be advised when the final report is released by the government and the government has to release it within 25 parliamentary sitting days after the completion. The draft report is produced by the Commission. The final report is produced by the Commission but released by the government which is a slightly different process at the end of the task.

I would like to conduct all hearings in a reasonably informal manner, although I wonder about all of that, but I remind participants that a full transcript is being recorded. For this reason, comments from the floor cannot be taken during the discussion but towards the end of the proceedings of the day I will provide an opportunity for any persons wishing to make a short statement subject to time, and there may be a couple of people who want to make a very short statement later in the day. Participants are not required to take an oath but should be truthful in their remarks. Participants are welcome to comment on the issues raised in other people's submissions.

The transcript will be made available to participants and will be available from the Commission's website following the hearings. Submissions are also available on the website and just to remind you, we're seeking submissions from the community generally, and interested parties during this month.

For any media representatives attending today, some general rules apply, and you're asked to see one of our staff for a handout which explains those rules.

Just some housekeeping matters. In relation to our occupational health and safety requirements, I'm required to remind you that there are exits both at the rear and the front of the room behind us. In the event of an emergency an alert tone will be sounded. If an evacuation is required a staff member from Hotel Grand Chancellor will escort all guests to the designated assembly area at the secure park entrance at Clubhouse Lane.

Today I'd like to thank you again for attending these particular proceedings. The report is a very complex report. It's the largest single inquiry into this area ever. It looks at all aspects, and so as a consequence of that, we've chanced our arm, got a lot of issues, and that's what we were tasked to do. So we understand that there are many and varied comments from various people about all aspects of this particular report and we certainly welcome this.

So I'd just like to now call our first participants, and if you could give me your, each of you your full name and the organisations you represent for the record, please.

**MR DENNEY:** My name is Bill Denney and in a sense the three of us represent the nine bodies that are here today.

**MR HIGNETT:** I'm Bill Hignett and I'm here representing the nine bodies that are here.

**DR BLACK**: Robert Black, Air Force Association, but a representative of that nine, group of nine.

**COMMISSIONER FITZGERALD:** So just for the record, can I just identify the nine agencies or organisations. Returned and Services League of Australia, Vietnam Veterans' Association of Australia, Vietnam Veterans' Federation of Australia, RAAF Association, National Servicemen Association, National Malaya Borneo Veterans' Association, Korean Veterans' Association and the Military Brotherhood Motorcycle Club. Is that correct?

**MR DENNEY**: And the War Widows' Guild.

**COMMISSIONER FITZGERALD:** Thank you for that.

**MR DENNEY:** However, the South Australian branches of those organisations, not - - -

**COMMISSIONER FITZGERALD:** I was just going to clarify. So in respect of all of those nine it's the South Australian branches.

**MR DENNEY:** Yes.

**COMMISSIONER FITZGERALD:** Okay. Thank you very much. And I understand one of you has been delegated to present.

**MR DENNEY:** Yes, Commissioner, and I in fact go over a little bit of that. Ready to go?

**COMMISSIONER FITZGERALD:** Yes, thanks.

**MR DENNEY:** Yes. Good morning, Presiding Commissioner Fitzgerald and good morning Commissioner Spencer. Thank you for inviting us to present to you this morning. We welcome you to Adelaide and respect your role. We understand it to provide quality, independent research and advice to government.

I'd like to introduce my colleagues in perhaps a little bit more detail. Dr Robert Black AM. Dr Robert Black is a former group captain in the RAAF and he's a medical specialist. He had seen active service in Rwanda, Bougainville and East Timor and was a member of the Veterans' Review Board for nine years. He has rendered extensive community service, and still does so, and this includes his current appointment as the President of the RAAF Association South Australia.

Mr Bill Hignett OAM is a Vietnam veteran. He is a senior member of a number of ex-service organisations. Mr Hignett has made a significant contribution to the ex-service community over many years, particularly through his roles with the RSL and the Aboriginal Veterans, South Australia. He currently volunteers with the Veterans' Advocacy Centre based at Plympton which has been very pro-active in all of this work.

I'm Bill Denney AM BM. I'm a former lieutenant colonel who served in the army for 21 years. I saw active service in Vietnam. I'm a former Vice-President of the RSL South Australia and the Vietnam Veterans' Association. I've had a few positions since I left the military, most notably adviser to the Attorney-General of South Australia and Director of Veterans SA.

As you said, Chair, we appear today representing the South Australian branches of nine ex-service organisations and I'd just like to mention again because there's many people here from those organisations, the Returned and Services League, and we have the State Vice-President, Cheryl Cates, and the regional coordinator, Rod Murray who's here; Vietnam Veterans' Association, and we have President Rob Schahinger, and two past presidents, Philip St John and Paul Coppock; the Vietnam Veterans' Federation, Robin Carbins the treasurer, and the RAAF Association of course is Robert. The Malaya Borneo Veterans' Association and Brian Selby's here, there, right in front of us; National Servicemen's Association, their State President, Barry Presgrave OAM; the Korea Veterans' Association, Mr John Jarrett. The Military Brotherhood are not represented today, and the War Widows' Guild with Helen Meyer and Jill Davidson. Jill is the treasurer. So they are the nine organisations that we are representing here this morning, and I'd like to acknowledge, Commissioner, the members of the SO's who got up early this morning to be here, and to show their solidarity with our submission and all it contains.

Commissioner, never before have so many ESOs joined together under one banner to show their support and interest in such a cause, such is the importance of your draft report and our response to it. The ESOs that support our response represent the majority of veterans from South Australia. They've read your draft report. They've spent much time considering their response to it and we hope our response today, what we say, does justice to their concerns.

South Australia is unlike other states. We are smaller and more homogenous. Many of our veterans are impacted by geographic isolation and the paucity of significant regional centres. All of this seriously impacts service delivery in our state. As such, we believe we are very well placed to comment on the efficiency or otherwise of the Department of Veterans' Affairs, DVA, and how it currently fulfils its obligations to serving and past veteran community.

Our submission is comprehensive but can be summarised in six key points. The first relates to the Commission's draft recommendation to abolish DVA and replace its functions with a Veteran Services Commission. We agree with the Commission that the DVA is somewhat out of date and would benefit from reform. We agree with, indeed we applaud, some of your suggested changes. The revised focus on lifetime wellness is admirable.

We support investigation into the Joint Transition Command structure. Many of us who separated from the ADF after several decades of service

are acutely aware of the problems we faced and the lack of available support at the time. That said, we do not agree that all things considered, the current DVA model is not fit for purpose and is not working in the best interests of veterans and their families, nor the Australian community.

Is significant change required? Yes, indeed, but we are firmly of the belief that the current DVA model is salvageable. In some form it has provided exceptional support to hundreds of thousands of veterans and other clients for over a century. It is a structure that has been specifically created for veterans and is much loved by them, particularly older veterans over 65 years of age, which interestingly, and I know we're looking to the future, but interestingly the veterans over 65 comprise at the moment 68 per cent of the DVA client base.

We feel restructuring to assess and rectify many of the problems you have noted is a fundamentally better way to address those issues. We feel that many of these problems could be rectified relatively quickly and relatively simply, thus ensuring the outcomes the Commission, veterans, their families and the Australian community desire and deserve. We note that much good work has been initiated by DVA in pursuit of the outcomes sought by the Productivity Commission through its veterans-centric reform and feel that DVA should be allowed to complete implementation and have it tested before such a - any radical structural reform is initiated.

We feel that the proposed structure of the Veterans Services Commission suggested as part of the restructure, particularly the loss of a dedicated Minister of Veterans' Affairs, could result in a crucial loss of focus away from your stated core aim. Likewise, we worry that the transfer of veteran policy development into the Department of Defence will create a fundamental and irreconcilable conflict of interest. As we see it, Defence cannot be expected to train for and fight the nation's wars while concurrently having to manage issues like rehabilitation and workers' compensation.

To expect military leaders to be focussed on anything other than their war fighting role will compromise their primary objective and put the lives of their soldiers at risk. We do not believe that by applying a real budget constraint you will improve the long-term performance and sustainability of the veterans' support system.

A second point relates to the unique nature of military service. We are particularly concerned about the Commission's understanding of the nature of military service because, in a very real sense, this underpins any system designed to support veterans and their families. We acknowledge the Commission's perspective, but with respect, we don't think it captures

the true spirit of sacrifice that is accepted and lived by those in our Defence Forces.

The profession of arms is truly unique. While we can talk about and from your report the requirement to follow orders, frequent relocations, long and irregular hours and high risk situations, that really does not capture the totality and mindset of the men and women who have, as we often say, signed a cheque to the nation. The amount payable written on that cheque is up to and including my life.

The depth of commitment and that follows afterwards is absolutely unique and fundamentally different to almost every other career in our nation. The system of support that underpins it we believe should be likewise. Members of our Defence Forces willingly and knowingly put themselves in harm's way in the execution of government policy, making their circumstances substantially different to a civilian worker's compensation arrangements or similar. Moreover, ADF service is the only employment in the nation where the employee is willingly prepared to accept and live by a separate disciplinary code, able to punish by imprisonment, such is the depth of commitment expected of and offered by those who enlist.

We do not agree that the current system, the description of the current system of compensation as being unduly generous and feel the word fair would be more appropriate. There might be issues of application and eligibility to be addressed in some areas, but this is more a process of refinement rather than anything else. We remain loyal to the Gold Card system. The Federal Government created the Gold Card system. They did so because they closed repatriation general hospitals and this was seen as the most efficient way to ensure that those who needed medical treatment received it. We believe that a Gold Card system, or something very similar to it, remains the best way to ensure that those who have suffered in the service of their nation are adequately cared for.

Likewise, we strongly support the retention of the Veterans' Review Board in its current guise. We can understand the temptation to adopt the recommended model, but from decades of close personal experience, both as a member as in the case of Dr Black, or as someone who has appeared before it, myself, we know just how important it is and how it truly helps get to and understand the totality and the truth of a veteran's claim. It follows that we see the VRB as a great enabler and that it value-adds whenever its services are required.

Finally, we offer our support for the retention of two standards of proof. We accept that the nature of some injuries will be no different whether they are suffered at peace or at war, but this does not apply in all cases.

We believe that the circumstances under which a wound or injury is incurred is important. Things happen in war that don't happen in peace time and accepting two standards of proof is a moral and equitable way of accommodating this.

Commissioners, that concludes our opening address. Thank you for your patience. I hope I kept to the 10 minutes and we now stand ready to answer any questions you may have. Now, a large number of veterans contributed to our submission, so we may not have detailed answers to all your questions, but we'll definitely try. Thank you.

**COMMISSIONER FITZGERALD**: Thank you very much, and we've read the submission and it's very detailed, and thank you for going through and commenting on all the recommendations.

Can I just raise a couple of issues. In your oral submission just then you referred to the removal of a dedicated Minister. In fact, our recommendation is that there be a Minister for Defence Personnel and Veterans, in fact a strengthened position. At the moment they come together. We think it actually should have one Minister, but can I ask this question. We've looked at the veteran throughout their life, both in service and out service, and the remuneration and the benefits and services they receive in service, and the benefits and remuneration and support they receive post service, are not unrelated.

There's a continuum, and yet at the moment we have policy here and policy there, and there's no connection, and so one of the things we've been trying to say is, how do you actually have policy that actually deals with the whole person throughout their life? What do you pay people in service, recognising their commitment, their deployment overseas is important. The way in which you compensate where there's injury or illness is important. The way you compensate people through services is important like rehabilitation, both in service and out service.

So one of the challenges we've been facing is, how do you actually get a continuity rather than this disconnect between the two, and I'm just wondering whether you have a view about that, and you may not.

**MR DENNEY**: Well, you make a valid point, Commissioner. I guess what we've been talking about Veterans' Affairs which does sort of focus on the latter rather than the serving personnel. What do we think about that?

**DR BLACK:** If I might comment, I'm not sure that many of those who have served and leave the services regard it as a continuum, and it may be

that the Commissioner was a bit constrained by trying to make it a continuum. Certainly was a continuous life, but it's not a continuous career or set of circumstances, and I think that that, you might be making it a bit difficult for yourselves in trying to do so.

**COMMISSIONER FITZGERALD:** You'd acknowledge, and I think in your submission, for example, in relation to transition, there's great improvements that can and need to be made. We've made some suggestions and you've indicated that they have some merit in relation to the transition command and so on. Do you think that the planning, the policies that relate to veterans generally, are being well-served in the current structure? I mean, you've indicated that DVA has many problems, and there have been many improvements in recent times, and we've acknowledged both of those, both the problems and the improvements, but are you satisfied at the moment with the quality of policy-making that's occurred in relation to veterans generally?

**MR DENNEY:** I think generally we are, and I think that's reflected by - statistically by all those that are part of the DVA catchment. This doesn't say, as I said before, there's not room for improvement, but I think generally speaking what I think is the satisfaction rate is somewhere around 82, 80 - in the 80 per cent mark.

**COMMISSIONER FITZGERALD:** So in relation to that, that varies according to age.

**MR DENNEY:** Yes, it does.

**COMMISSIONER FITZGERALD:** Those sorts of figures?

**MR DENNEY:** Yes, it does go down for the younger ones.

**COMMISSIONER FITZGERALD:** For those under 50 there's a high level of dissatisfaction.

**MR DENNEY:** Yes.

**COMMISSIONER FITZGERALD:** For those over 50 there's a high level of satisfaction. So we're conscious that the veterans' community is very diverse. We don't appreciate it as well as you do, but we understand it better than we did at the beginning, and it does seem to be different expectations for younger veterans and older veterans. Would you agree with that?

**MR DENNEY:** I would, and I think that reinforces Robert's point that it might be very hard to bring them together like that, the difference between 68 per cent of your veterans who are over 65 years of age now and to have one structure for them, and to have the 46 per cent of veterans who - younger veterans who aren't happy with DVA, have another structure for them. I think it's very hard to try and pull them together as Robert said earlier on.

**COMMISSIONER FITZGERALD:** So if I could just - Richard will raise some questions, but if you ask this question, I - - -

**DR BLACK:** Could I just go back, sorry, Commissioner, you brought up the question of transition and a very important issue because, as you've identified some of those being discharged, and I would use that word rather than transition, I see transition as a euphemism for sometimes the processes of leaving the Defence Force and going out into the wild world. You had to deal with the question of a very significantly high incidence of suicide in a group of individuals and that group I think can be identified as those leaving the service, being discharged, let's use that word, that active verb, rather than the non-specific noun of 'transition'. That that group of people are leaving a career path which they had intended involuntarily, often because they've been broken during their service. That seems to me an extremely important group for, if there is going to be any Joint Transition Command or some structure, that seems to be a very important group to handle and look after, and I would hope that that structure might, rather than enable discharge, prevent discharge until the claims and problems of that group are dealt with and I suspect that a lot of those people would feel more comfortable, would feel contented or feel proud if they were retained in the Defence Force.

I think I did point out in my earlier submission that one of the problems that the Defence Force has is that there are not many positions that aren't close to the sharp end these days, and things like security and drivers and transport and so on, and people in the mess, stewards and so on, they're all civilianised now and that's a problem that I don't think that is going to be part of your remit but those people are in trouble if they are discharged against their will.

**COMMISSIONER FITZGERALD:** And we've concentrated on that particular group, particularly the 20 per cent that are discharged on medical backgrounds. Can I ask this question, just in relation to that. The proposal we put forward is a Joint Transition Command which would be able to provide support services for people post-discharge for a period of time. We've indicated an indicative period of six months. I think your submission goes for a longer period, is that correct?

**DR BLACK:** Indeed.

**MR DENNEY:** I think two years I think is what we were talking about.

**DR BLACK:** Yes.

**COMMISSIONER FITZGERALD:** Could you just talk me through why you think two years is an appropriate figure? I know there's no science in this but what do you think is reasonable?

**MR DENNEY:** I think, personal experience, is one of the issues, and it will depend a lot upon whether other aspects of your recommendations are adopted, they're talking about getting people to start thinking about their discharge, in some cases almost the day they enlist. I think with that to be brought to fruition people are better placed when they transit out of the services and you might be able to reduce the time, but I think from experience and discussion the general feeling is particularly longer term members will take a lot longer to adjust than six months. Yeah.

**COMMISSIONER SPENCER:** Thanks very much, Robert. And look I just wanted to add my word of thanks to everybody for coming today, and clearly the amount of thoughtfulness and preparation that's gone into assisting us with this inquiry, so thank you very much for that. The second point is, as you know we're trying to look maybe 20 to 30 years out, to see what is a scheme - aspects of the scheme that will work well in the future. And as Robert suggested earlier, we've put forward some bold changes, some of which you disagree with and others do and - but it's created a conversation which is really important about how we best go about this.

One of the issues we're grappling with, and many others before us have, is the current complexity of the three acts and multiple different arrangements which everybody agrees is not in the best interests of veterans and of people trying to administer the scheme. So our proposed solution is to move to what we describe as that two scheme model over time, where VEA would be largely preserved as it is at the moment. DRCA would be rolled in MRCA and that would become ultimately the scheme of the future. So I just want to - if you have any comments on both what we're proposing around that approach and the timing of that approach.

**DR BLACK:** Yes, I can - we can agree with a lot of those suggestions. Harmonising the Acts, not just easier for veterans and advocates but easier for delegates making decisions. We can certainly applaud that and we can

applaud the common use of statements of principle, those wonderful legislative instruments that have been around for over 20 years, since the Bone report I think, and which enabled two standards of proof, which we would hope to be preserved, leaving a fairly open transparent prospect of success.

What I'm worried about, what we are worried about is the downgrading of the common review pathway, which is applauded - the common review pathway is applauded, but to downgrade the VRB's position is not something that we can applaud, particularly because there is a suggestion in the draft report that more decisions would go to the AAT, the Administrative Appeals Tribunal. Now that is a scary place. That is a place where the stress is going to increase, and the expense for veterans. In the VRB it's cheap, there is no adversarial approach. The people on the other side of the table are - members of the Veterans' Review Board are there to find out, to search for additional information and its aim, its mission if you like is to find the correct and preferable decision, and if there is a claim that can be granted, then that claim should be granted and that award given if there is a framework that can be seen. So the VRB in its present situation is something that we hope will be preserved.

You did report on the success of single person decisions, the alternative dispute resolution processes that I would suspect have been a success, certainly shortening some of the processes, but to have single persons making these decisions they have to be very clever or very experienced and they will only get their experience with three person tribunals and hearings within the Veterans' Review Board. So three person tribunals and the sort of interrogation and information gathering that the VRB does is something that I hope that will be preserved.

Now the AAT as I mentioned, expensive, adversarial. The veteran who claims there will for the first time see a lawyer representing the department or the commission really. That lawyer is defending the delegates' decision. It's the first time the person will see that "it's me against them". That is going to be - increase the stress. One of the principal aims I suppose of the Commission's task was to find out about the stress of the claims process and the fact that suicide is around the corner, and it may be exacerbated by the claims process and the stresses of it. There's a good body of literature and an expert in South Australia in the form of Alexander McFarlane - Sandy McFarlane, showing that those who have stresses in this claims process will have worse lives, worse health outcomes subsequently. But in terms of reducing stress, pushing more to the AAT will certainly not do that and in my opinion will increase the stress immeasurably.

**COMMISSIONER SPENCER:** Thank you for that observation. As you're probably aware, there's the actually the Senate inquiry back in 2016/17 which led to our inquiry, so part of what we're trying to explore here through a number of different changes is how to reduce the stress of that process. So part of what we're trying to explore with the VRB is how could more of the ADR type process, the earlier determination and certainty for everybody be brought back more to the initial claims system. Rather than it having to be something which subsequently veterans have to engage with after perhaps frustration and difficulty through the early stage of that process. So your thoughts about how to do that in any submission you put in would be very helpful.

Could I just go to a different issue now and this relates to ESOs. We said in our draft report that - we did not say a lot about that because Robert Cornall, as you know, was running an inquiry around that particular issue and his report I think it's - it has been released yet, or it's about to be released, I believe. But what struck us is that the ESOs represent an extraordinary valuable hidden asset within the system and how can that be made better use of in the future? Now, our view would be that's largely up to ESOs. We in government have no place to inform ESOs as to what their role should be. However, on the other hand, government can assist, can help to fund certain efforts, certain possibilities and opportunities, and so we're interested in, once again, any submission that you would – in your comments today, but any submission you put in subsequently about how can the role of ESOs be more utilised to enhance the system as a whole, and that's beyond the advocacy role. That's about, I'd suggest, around about services and other ways to support veterans that's not possible through a more formal system.

**MR HIGNETT:** Yes, we're grappling with that at the moment, and of course, with South Australia, we're much smaller than the other states, and so there's got to be much higher levels of cooperation between the ESOs.

That (indistinct) we're exploring the content of a community of practice for advocates, and there are – unfortunately, there are a number of restrictions that DVA have got. For example, on an earlier report that DVA had, I think in 2010, showed that I think only 24 per cent of veterans making a claim in South Australia in the country regions were actually supported by an advocate, whereas mostly around the country, it's in the order of over 90 per cent.

But DVAs got a restriction on the travel, for example, so that you can only – your advocates can only get reimbursed for their local travel. So, when we're actually travelling around the country, we're lucky in South Australia, we got a grant from the South Australian government.

We actually raised this issue with the Minister for Veterans' Affairs when he was here for last week. But I think we realise there needs to be much, much greater levels of cooperation. They're an advocacy. Certainly, in terms of supporting the veterans, it is really our key focus at the moment to make sure that they actually are able to put their (indistinct) forward with any claims or any appeals or representation. Thank you.

**MR DENNEY:** Advocacy is that one requirements that seems to cross the generations entirely. You know, welfare may not, and other support services provided by ESOs, but advocacy is the one that you'll get the young soldier, sailor (indistinct) and a woman who's only been in a few years needs support right through to the older World War II veteran.

**COMMISSIONER FITZGERALD:** So we'll be looking at the Robert Cornall report. What we will be doing is distinguishing between advocacy in relation to claims, and then the very important work that you do, which is generally the advocacy and support, the wellbeing side of it.

The question that Richard's raised is, putting aside the advocacy in relation to claims, because that's – we'll specifically look at that issue, and that's really what Robert Cornall's been looking at.

But we are interested from the ESOs what is their role going forward in the general wellbeing area. But the most important issue what is the role of government in supporting you in that? And that's the part of the work that we'll be looking at in the final report, which we didn't look at in the draft. Now, it might be minimal, it might be almost nothing, other than a few grants. But if you have considerations, that would be good.

Can I just go back to Richard's first question? I just want to understand, as Richard's indicated, we decided to keep the VEA and we – I'll go back. We couldn't work out how to bring it all together in one Act, in one scheme, and we looked at all that very hard.

So the VEA continues on with some modifications, and then, as Richard said, the DRCA and MRCA come together and they effectively deal with different people from different eras, as you know.

From what I understand from what you've said in your submission, and just then, you're relatively supportive in principle that that's okay. A two-stream approach is an appropriate way to go. Is that correct?

**MR HIGNETT:** Yes.

**COMMISSIONER FITZGERALD:** Okay. Can I just go back a little bit? If I can just test out a couple of issues. In relation to the VSC, the Veterans Services Commission, this is a work in progress.

A couple of the people have indicated that we put in all of this into the Department of Defence, and as you know, that's not the case. DVA is part of the Defence portfolio already. So the Defence portfolio is not the department.

So the VSC, if you had it, would have its own Board of Commissioners made up of veterans and expertise. It would take the very best principles in relation to the way in which you run compensation schemes. It wouldn't be involved in policy and all those other areas. But it would be a best practice, efficiently run administer of compensation, rehabilitation and health services.

As we now do in every other part of government, we never have compensation schemes run through departments, and there's very good reasons why that doesn't happen anymore. It used to, doesn't now.

So, is the great concern that the Commission would still be veterans only? It would have a veterans centric. It would have the best practices available to you. Taking the Veteran Centric Reforms, and as you know, our timetable says 'don't do anything until they're completed.' So we completely agree with you.

Is there a fundamental problem with that, or is the real issue about what we've said in relation to planning, policy, those sorts of issues? So could I just clarify. Because at first instance, the Commission actually delivers heaps to veterans, and it's all about veterans. Nobody else. It's not about workers' compensation, or about anything else. It's about veterans. So you get the best of both worlds.

So could I just understand clearly, is it that concept, or is it actually around the policy and those sorts of issues?

**DR BLACK:** I think, Commissioner, it's about the splitting of the policy under Defence. The splitting of the two, and I think that's what's sort of enabled – disabled it to a large degree. That's, I think, the way we've viewed it. Putting the Defence policy group over under Defence to us is difficult to accept as being as good as we'd like it to be.

**COMMISSIONER FITZGERALD:** And if you didn't have it in Defence, let me just give a proposition. Let's say you did have a Commission which is only about the administering of compensation,

rehabilitation and health services. It's not about policy. Your fall back position is there would be still a DVA?

**DR BLACK:** Yes.

**COMMISSIONER FITZGERALD:** And that DVA would have a number of functions, including policy, and I presume, liaison and coordination with ESOs. Those sorts of roles and functions. Is that correct?

**DR BLACK:** That's our view.

**MR HIGNETT:** And continuing with the commemorations and war graves functions as well.

**DR BLACK:** We see problems with the AWM dealing with that, because there's no AWM in various parts of the country. There's just one.

**COMMISSIONER FITZGERALD:** The second one, can I just test out? You've indicated in your opening statement, and in your submission, that you prefer to keep the two standards of proof that apply. So let's go back. We agreed with the statement of principles. Very good. Excellent. We think they should be retained, and as you know, New Zealand is going to adopt them, so that's good.

So the standards of proof. We've got these two standards. We've got this reasonable hypothesis, and then we've got this very generous, you know, it's called beneficial balance of probabilities.

Logically, you would only have one, so and in simplifying the system, you'd only have one. So what are you worry – sorry, not what are you worried about, but why do you think we should not go down that path? Why do you think we should keep two standards of proof, which are quite close. They look very different, but in practice, they're quite close. So what's the argument that you think we should be most mindful of in that area?

**DR BLACK:** Well, I think that part of the reason is, and perhaps the difficulty that the Commission has had is adoption of this definition of veteran. Because that definition is not something that people would accept. That the veteran goes from one extreme to the other, and although it's a continuum, there is a line that is drawn, usually by the Minister of Defence, as to what is operational, hazardous, peacekeeping, warlike, qualifying service, and what is peacetime service.

And on one side of the line, we can see no reason why it should have a standard of proof other than the civil standard of proof of the balance of probabilities.

The other standard of proof, however, originally, and the earlier legislation preceding the Veterans' Entitlements Act, and including it, and (indistinct), what it used to be, that the benefit of doubt was given to the claimant, the veteran. He wasn't a veteran then, he was a returned serviceman.

**COMMISSIONER FITZGERALD:** Yes.

**DR BLACK:** Didn't regard himself as a veteran. What did that mean, the benefit of the doubt? Well, the definition came following the High Court determination in the O'Brien case in the 80s. One of the learned judges used the expression, "reasonable hypothesis", and he referred to it, described it. That was further defined, in fact, by a three-person panel of the Veterans' Review Board, you'd be interested to know, and that has been quoted repeatedly in judicial decisions, as to what a reasonable hypothesis is.

And as you say, it is a very generous – it's perhaps as low as a one in 20 probability. But nevertheless, it isn't the benefit of all reasonable doubt. So it's a defined benefit and perhaps the so-called beneficial legislation refers not just to that, but some of the words in the various acts in saying that a claim related to service can be because of an occurrence because of the conditions of service relating to service would not have occurred but for service, those words I think are what is referred to as "beneficial legislation" as opposed to just the standard of proof that we're talking about.

**COMMISSIONER FITZGERALD:** Could I ask this question. Do you think that that double standard, the two standards, is this - do you think only needs to stay in place for a period of time, or do you think it's a permanent fixture that has to stay forever? So you were what Richard indicated, that we try to think 20 years out. Do you think that it is actually an essential feature that needs to stay in perpetuity?

**DR BLACK:** I do, and I think that for 100 years now that is what the nation has expected, the way it should treat its war veterans. So I think that that should stay. There may be some future definition which is more easily clarified, but until then I think that should stay.

**COMMISSIONER FITZGERALD:** One of the previous inquiries actually talked about a single standard but a midpoint; that you actually

put a stab at somewhere between the two. We'll look at that and explore that a bit further but that has certain added complications, I have to say.

**DR BLACK:** Well I believe that - I'd certainly be against that and we understand that that's been looked at by Bruce Topperwein and looked at if the standard was the balance of probabilities that perhaps 30 per cent of veterans would not have got anyway. So, that we don't think is a good thing.

**COMMISSIONER FITZGERALD:** Okay. We will look at that. Is there any further - a final comment that you'd like to make before we conclude?

**DR BLACK:** Could I just refer to one aspect of the Gold Card.

**COMMISSIONER FITZGERALD:** Yes.

**DR BLACK:** Because one of the recommendations is that no future group should be considered for the Gold Card.

**COMMISSIONER FITZGERALD:** Correct.

**DR BLACK:** I'm not sure whether that is at age 70 or other circumstances. This recommendation has already been pre-empted by a decision by the Federal Government to grant the Gold Card to members of the civilian surgical teams in Vietnam.

**COMMISSIONER FITZGERALD:** Yes. Indeed, we're aware of that.

**DR BLACK:** And I think it would be unwise to say that we've got a clear vision of the future. There are other groups of people that perhaps the government might feel were worthy. We can think of a few examples; for example, a terrorist attack in Australia and servicemen were involved in this. They didn't overseas service, they didn't have war service, but maybe a government might feel that that is a group that could be similarly thought of.

For many years Legacy and I'm sure the War Widows' Guild would agree with this, that Legacy has been looking to ensure that World War II widows all receive the widows' pension and with it the Gold Card. There are not many now and probably 70 per cent - 60 per cent certainly of war widows from World War II do have the widows' pension and Gold Card. But Legacy has got two groups of Legacy widows; those with and those without the Gold Card, and they talk to each other, not necessarily happily. And some resent it because their husbands may have had more

meritorious service than the one who's got the Gold Card. And I can perhaps envisage a day where the government in its beneficence might decide that there are sufficiently few of these widows that they will in fact give them all the Gold Card. And there are some who, I should say that looking at the criteria that [indistinct] used, that is those who'd suffered most and those who deserved most, there are some widows who when they lose their husband they lose a service pension and a disability pension, and is now left with just one service pension, that is an old age pension. That is a means tested pension. That widow is in trouble financially and I would hope that one day the government will decide that that is a group that might be worthy of the Gold Card.

**COMMISSIONER FITZGERALD:** Okay, look thank you very much for that. That's much appreciated. I know it's only a short presentation but your submission is very detailed and we're very grateful for it.

**MR DENNEY:** Commissioner, could I just acknowledge a person, Mr Paul Tyson from the Veterans Centre at Plympton. He was very instrumental in getting this off the ground and helping us with the submission.

**COMMISSIONER FITZGERALD:** Thanks. Could I just make the comment. Given that you've come together in a way that's not normal, that you said at the beginning, this is an integrative process, we want the submissions. We will be further considering all of the issues and if further issues, concepts, thoughts come to you during this process certainly for the next couple of months we would be grateful for those. And as you know, and I've made this offer previously, we're happy to engage with organisations, independent of this public hearing, to clarify parts of our report if that would be beneficial to you. Because understanding it is half the battle and then us understanding your responses. So again, thank you very much.

**DR BLACK:** Thank you.

**MR HIGNETT:** Commissioner, I've got one question to ask and that relates to in the report you indicate you're going to be waiting for the scoping study for advocacy to come down before you make some final recommendations relating to that area. Given that you've got to report by June, I think the end of June, I'm just wondering, once that report's down will there be an opportunity for us to make comments on that?

**COMMISSIONER FITZGERALD:** Well that's a very good point. The answer to that should be yes. I should say to you, the report has been delivered to government. The question is only when it's going to be made

public, which is the government's responsibility. But we would hope that happens soon and, yes, absolutely. If that comes forward with particular recommendations that you're either in favour of or against, we'd be very keen to hear from you about that, so that will inform our thinking. So, yes, thank you very much for that, we would be grateful.

Could I have the next participant, Mr Robert Manton please.

Thanks very much. If you could give me your full name and the organisation that you represent.

**MR MANTON:** Robert Manton, Director of Veterans SA, representing the Veterans' Advisory Council.

**COMMISSIONER FITZGERALD:** Could you just move the microphone closer. Good, thanks Robert, we've met before.

**MR MANTON:** We have.

**COMMISSIONER FITZGERALD:** Good. So over to you.

**MR MANTON:** Thank you for convening this public hearing today and for the opportunity to appear before you on behalf of South Australia's Veterans' Advisory Council. By way of introduction, I'm Rob Manton, Director of Veterans SA, a South Australian government agency responsible for matters affecting the veteran community in South Australia. I transitioned from the Australian Army in April 2011 after 30 years of service, including operational service in Iraq and the Middle East.

The Veterans' Advisory Council South Australia considered the Productivity Commission's draft report, "A better way to support veterans", at an extraordinary meeting on 24 January 2019 and unanimously determined to provide a submission relating to the draft report that is currently under development and you have been provided with a synopsis of the submission. The synopsis does provide the key areas that the VAC submission will address and I will, with your indulgence, provide an overview of those areas in my statement, and accordingly some of the words I use this morning you may already have read in the synopsis provided.

There is an overarching comment, the broad demographic of veterans or those considered part of a veteran community in South Australia are ranging in age between 18 and 102, although I'm told there's a war widow who is 109, and comprising and serving and ex-serving Defence Force members across multiple conflicts from World War II to Iraq and

Afghanistan. Spouses, partners, children, parents, extended families, carers and service providers offer significant challenges to anyone involved in either developing a veteran support system or executing its functions. However, the efforts underway by the Commonwealth Department of Veterans' Affairs in its Veteran Centric Reform program are encouraging our support and should continue to be supported.

The VAC considers the uniqueness of military service cannot be overstated. No other calling requires the surrendering of liberties to the extent that military service requires in both peace time and in war. In addition and often overlooked, servicemen and women are subject to the Defence Force Discipline Act 1982, 24 hours a day, seven days a week, when serving. No other form of employment that I'm aware of subjects its employees to separate jurisdictional processes to the same extent as the military.

Further, the war fighting culture of defence requires the mindset to legitimately apply lethal force in pursuit of state based, and often against other equally trained and supported forces. The scale and scope of service of defence members' work is not replicated in any other state based services. No of part of the state can plausibly lay claim to a role that exists to purposefully kill, wound, and/or destroy life and property.

Accordingly, the Council is firmly of the view that the existing veterans' compensation and rehabilitation system ought not be compared to other workers' compensation schemes. The task of defending the country against aggressors, foreign or domestic, is unique, under any interpretation of the word.

The VAC is united in its view that any changes adopted following the Commission's work must not be detrimental to veterans or the veteran community, and the Council unanimously endorses the Commission's view that a wellbeing focus should underpin the veteran support system.

The Council agrees that the veteran support system requires, in some areas, fundamental reform. However, the Council counsels against radical reform. This observation stems from its deep understanding of the culture and norms of military service, and the Veteran community.

By its very nature, the veteran community is traditional and conservative, and while trained to be flexible and able to react and deal with change, radical reform proposals are unlikely to attract broad support.

The VAC agrees the legislative changes required, ideally, ultimately result in a single piece of legislation, and the VAC has advocated for this

approach for some time. Accordingly, the Commission's recommendation of a two-scheme approach is supported in principle, but more detail would be welcome.

The recommendation to disestablish the Department of Veterans' Affairs was unanimously opposed by the Council. The Council considers the loss of a department of state would seriously diminish the standing of veterans and the recognition of their service.

The commensurate loss of a department secretary was considered disadvantageous to the veteran community, removing an advocate at department secretary level with a seat at the Commonwealth secretary's table.

The establishment of a Veterans Services Commission is considered worthy of consideration, within the context of a departmental structure, not at its expense.

The recommendation to transfer DVA's policy responsibility to the Department of Defence was unanimously opposed by the VAC. Indeed, from a personal perspective, this was the recommendation that caused me the most concern, due to the potential for subordination of veteran policy to other high priority Defence department tasks, and a real potential for conflict of interest.

The Council believes that the role of Defence is, in its most strategic sense, to fight and win the nation's wars. Accordingly, its focus is, and must remain, on its national security responsibility that is arguably the highest priority of any government.

The men and women who executive this fundamental and vital role should be afforded a dedicated focus policy development organisation within a department of state.

While the VAC is divided regarding the recommendation to levy defence to the cover the costs of future claims by veterans, it endorses the recommendation of a single Minister for Defence Personnel and Veterans.

The VAC considers the single minister concept nests the responsibility for the health and wellbeing of those who serve with that minister, both during and after their service. It would ensure a single minister would seek to engage with Defence on best practice management of serving men and women, and remain responsible for them when they transition from the military.

The VAC agrees that transition is a key issue that must be addressed. Accordingly, transition awareness and planning should be incorporated into the annual reporting, and/or induction regime of military commands.

The VAC considers the establishment of the Joint Transition Command within the Department of Defence is one potential model that should be examined further, and while the majority of Council members supported the model, there was consensus that further detail is required.

A variation on this model for consideration is the creation of a single coordinative function for all transition services into one branch under the Vice Chief of the Defence Force, a step down from the establishment of a joint transition command.

The Council is of the view that the Commissioner's highlighting of a hub model is also worthy of close examination as an aid to successful transition. The partnership hub of the Jamie Larkin Centre in Adelaide is an excellent example of a single location offering a variety of services, including advocacy, employment assistance, welfare, health and wellbeing, financial counselling, et cetera.

A hub model is likely to address some of the ex-service organisation challenges currently being experienced, and under review in the Cornall Review.

The VAC opposes any changes to the DVA Health Card – All Conditions Australia, or the Gold Card, and unreservedly rejects the notion offered in one submission that DVA's health card system encourages a view of the system of a contest to be won with the Gold Card as the prize.

In these days of technological advancement, consideration could be given to a single chipped health card, that as conditions are accepted, can be updated. Serving personnel should be issued a card at enlistment that supports DVAs relatively recent approval of non-liability mental health care, and that can be amended through an individual's career to acknowledge any further accepted injuries or illnesses. This would avoid the need for a coloured multi card system.

The establishment of a Veterans' Advisory Council was unanimously supported. However, the VOC believed that state and territory membership should strongly be considered to provide a federal minister ground truth at the local level.

The VOC unanimously opposed the recommendation to transfer commemorations and war graves to the Australian War Memorial.

Council considers that, internationally, the soft diplomacy opportunities offered by commemorating our war dead in overseas locations is not something that the Australian War Memorial could support.

I am happy to discuss any of the aspects raised in this statement, or the synopsis provided, and where I'm able to provide an answer, I will, and where I can't, I will take a question on notice and respond at a later time.

**COMMISSIONER FITZGERALD:** Thank you very much for that, and we appreciate your participation in the consultational processes on behalf of the Veterans' Advisory Council.

Just a couple of quick ones, and then Richard may have some, and I'll come back. Can I just go to this issue about not wanting policy in Defence, and we understand that this is a fairly consistent theme in many of the submissions.

Are you satisfied, and I asked this of the first group, that policy in relation to veterans is currently being handled in the best appropriate way, and if it isn't, what do you think needs to be done about that?

And I go back to the point that I made early in the conversation, is there is a disconnect between policy that takes place for serving personnel, and personnel that then leave, and so the question is, if our recommendation around policy isn't appropriate, how do we improve policy generally in this space?

**MR MANTON:** I think that if you're talking a process, there is certainly room for improvement with regard to the development of veterans' policy within the existing department.

My view is, in the same way that government encourages ex-service organisations to come together and speak with one voice as much as possible, and that's what the last group that you saw here, and that's what the Veterans' Advisory Council attempts to do.

In the same way, I think government should be encouraging the two departments responsible for those who wear a uniform to come together and respond in the same way. I don't view, however, that that – and I don't believe that the Council views, however, that that policy element should sit in a department that potentially will subordinate the importance of the development of policy for people once they have left, to other, here and now, this is my primary task if I can win the nation's wars. That is the greatest concern.

Equally, there is the potential, and this is where the conflict of interest, I think, comes in for commanders at all levels to be encouraged to go careful with your people. Because there is a potential here that they could be impacted post service.

**COMMISSIONER FITZGERALD:** Yes. If I can just explore that a little bit further. The government itself determined that a veteran was any person that served more than one day in military service. Now that's not our determination, that's government, and so the whole notion over recent years has been that Veterans are seen as once continuous group of people from the earliest times in defence right through until end of life.

And yet, you and others have indicated that the policy, nevertheless, needs to be split in order that it doesn't get sublimated to the other issues. Do you think in any way that the government approach is inconsistent, therefore, or sorry, or do you think your approach, that of your advisory council, is inconsistent with where the government is trying to go with the way in which it deals with Veterans? Or do you think it can be accommodated through the way (indistinct).

**MR MANTON:** I think it can be accommodated. I don't believe it's inconsistent, and the reason I say that is simply that whilst in uniform, the individual member, whilst they may be classified, and I don't believe it's in legislation, I believe the determination of the revised definition of veteran was determined at the Veterans' Minister's Round Table and was promulgated, for want of a better word, in a media release. I don't believe it's enshrined in legislation. It may be, I don't – I can't confirm that.

**COMMISSIONER FITZGERALD:** I don't either.

**MR MANTON:** The reality, though, is that despite the fact that those people in uniform serving now may well be classed as veterans under that definition, they are the responsibility of the Chief of the Defence Force and the Secretary of the Department of Defence whilst they are serving in that uniform.

And when they transition from the service, they become – they lose that department of state advocacy element that exists when they are in uniform, and it is that bit where people leave Defence and say, "I've had enough, I'm leaving", they really don't want to be relying on Defence to go back to them and say "Your policy is rubbish", as far as ex-serving people is concerned because they don't want anything to do with Defence anymore, and so I think you do need that separate entity.

**COMMISSIONER FITZGERALD:** I'll come back with a couple of questions later, Richard.

**MR MANTON:** Sure.

**COMMISSIONER SPENCER:** Thanks Robert. I just want to go to p.7 of the summary that you gave us because the - and this is to do with the Statements of Principles. Generally speaking we've heard widespread support for that and, as Robert said earlier, we believe that the Statements of Principle works well, could always be improved but is a good feature and a number of submissions were received in support of that. You seem to be suggesting here that there are major issues from your point of view. I am just wondering if you can clarify; is it the Statements of Principles, is it the way in which it's applied, what are your concerns around the SOPs?

**MR MANTON:** I am by no means an expert and hence in my - in the submission that was provided to you we indicated that we would come back to you in the full submission - sorry, in the synopsis, we'd come back to you in a full submission with a detailed analysis of the concerns. So I don't want to go too far down that path. What I will say is that talking to - the Commission - the Council, rather, is divided in whether probability or likelihood are the best conditions to be applied. There is not a consensus yet amongst the council as to which of the two criteria ought to be adopted, if one needs to be adopted.

But I think, secondly, and this came from a discussion I had, not with a veteran but with someone who advocates - or who is a lawyer and has been engaged by veterans previously, who said that - and he went into some detail at the time which not being a lawyer went a wee bit over my head, notwithstanding, his point was that if you don't satisfy precise - exactly what happens in some of those Statements of Principles you get nothing. And that is the challenge I think. And I was interested in the Commissioner's comment earlier and indeed to the group earlier where it may well be that there is a middle road that can be found here and whilst that is challenging I guess that's the job of those in your position, to come up with some options for government to consider. I really don't want to go beyond that, only because I have yet to get a consensus opinion from the Council.

**COMMISSIONER SPENCER:** We would welcome those further thoughts on the SOPs. Can I just add one other comment that you made about cards. I mean clearly there's a very strong defence of the current Gold Card system. What we've been wrestling with here is how to ensure that those who need specific healthcare conditions which are related to service do get what they need, and particularly those in greatest need. Do

I understand correctly, so I just want to clarify this, that I think you were describing something like a smart card, and remember we're talking about what is going to be best over the next, you know, ten, 20, 30 years, technology and better data and systems are moving us in this direction. Did I hear you suggesting there can be a smart card which during the lifetime of a person's service can capture those incidents and those injuries or illnesses that relate to service, which can be reflected in some sort of smart card. Is that what you were suggesting?

**MR MANTON:** I certainly think it's an option that could be explored. If there is a concern about gold, silver, bronze or whatever the case may be, then perhaps - and I think one of the requests for information, further information that your report had was is there a need for a coloured card system and, if not, what is an option. So it's an option that could be explored. At the end of the day the eligibility criteria is the eligibility criteria and ought not change. However, my biggest concern is, just as a personal example, when I transitioned from Defence, and I am a client of DVA but I've not claimed anything, notwithstanding that, if serving members, particularly current serving members tend to be ten foot tall and bullet proof, and say "I'm all right. Leave me alone, I'll soldier on, I'll carry on with an injury or an illness and what have you," and then when they get out they've got other priorities. So coming back and making a claim that then gives them a White Card for specific conditions or something else is another bit of administration that they'll get to eventually but not necessarily now.

Where if, and it comes back to this point about the two departments working more closely together, if the individual is issued with a card at enlistment and that card already reflects, as DVA does, that nil liability health care for mental health is available, and that as the knee is done or repaired, or the shoulder or the back or whatever, that condition is then chipped onto that card, then that is theirs, that is their white card for that particular accepted condition, once accepted. It also goes to the point about transition. The view of transition - and the Veterans' Advisory Council has been looking at transition for two or three years now and indeed promoted it as the theme for the last couple of veterans' ministers roundtables and indeed at the Invictus Games it was taken on as an international forum - if you - part of the successful transition is - the idea of a successful transition to me ought to be, on the day you depart you are farewelled by a member in uniform who says, "Thank you for your service. Can I have your ID card please, and let me introduce you to your post-service family" and that's the DVA representative with the White Card or whatever card it is that has your accepted conditions on it. Because Defence have looked after you up to the point that they pass you over to a different department that will now take up the treatment of those

accepted conditions. If there is a card that follows you through and is chipped as you go, then that's an automatic transfer and a much more seamless way of doing it.

**COMMISSIONER FITZGERALD:** Just following on from the health area, we are looking at the whole health area. The Gold Card is an important part of that and we understand that, but it's only a part of a much broader consideration around health. Are there concerns by the council, it's not in your submission, about other aspects of the health supports or services? We are looking at that smart card idea by the way, but the health issue is much larger. Do you have any other comments that you think we should take into account when looking at this health area, beyond the Gold Card itself?

**MR MANTON:** I think it's, as I said in my statement, and the synopsis also says and I think there'll be more to say in the submission, is the focus on wellbeing is critically important. I say that from the point of view that - I'll go back to the initial point I made about the demographic the veteran community spans, 18 to 102 and older in some places. There is a significant number of contemporary younger veterans who have now seen service since - really since Timor-Leste in 1999 right through to ongoing operations in Iraq and Afghanistan - who have deployed on multiple occasions and who are now transitioning off to do other things. But they still have an entire lifetime of value-add to a community in terms of work, in terms of their own wellbeing. And so, therefore, I think the submission will have more to say about the point that you've raised, about the focus on wellbeing and about the overall health matter that needs to be addressed, particularly as we look forward through the next 50 years. You're looking 20 years, we sort of advocate for a period of what's the next 50 years look like.

**COMMISSIONER FITZGERALD:** Can I just get a clarification from you. Your advisory council has indicated some support for the VSC, the Veteran Services Commission, but as you say in your submission the terms - in the context of a departmental structure not at its expense, can I just understand that. Does that mean, provided a department, the Department of Veterans' Affairs was to remain in some form, there may be some merit in looking at a specific commission to deal with the administration of compensation, rehabilitation and related matters?

**MR MANTON:** As an ex-military person I can tell you that the - every slide that ever goes up when we give a presentation is a Y diagram. So if I were to equate it to a Y diagram it would be a dotted line.

**COMMISSIONER FITZGERALD:** Sure.

**MR MANTON:** As opposed to a solid line.

**COMMISSIONER FITZGERALD:** Yes, sure.

**MR MANTON:** Where does authority sit I guess is something that needs to be grappled with.

**COMMISSIONER FITZGERALD:** Sure.

**MR MANTON:** And I wouldn't want to go any further at this point.

**COMMISSIONER FITZGERALD:** No, that's fine. Well just so that there's an absolute clarity at the moment, the VSC would report to the minister, and that would be the Minister for Defence Personnel and Veterans, so that remains. It is a government statutory agency.

Can I just ask one other question and just to clarify your comments. We have recommended a ministerial advisory council. Your point, however, is that's okay, except it needs state representation on it. Can you just explain to me why that is a necessary model in this space?

**MR MANTON:** Sure. The experience that we have here in South Australia is that the Veterans' Advisory Council, and this is the first state that established one of those back in about 2009, the membership of that council, and it's appointed council by – currently by the Premier, or if not the Premier then whichever minister is responsible, and whilst it is advisory it also has a representational component to it too. So it represents various constituents. It's not unreasonable that the VAC will always have an RSL representative, a Legacy representative. It may not be the president or the board member but it will be a representative of someone who can take the information back to those bodies and bring their concerns forward.

The challenge for a ministerial advisory council, and I'll give you the example of the Prime Minister's employment initiative, and I can't remember the group that sits over that. That is a group of people that out here in the provinces there is no visibility of that – of the outcomes of that employment initiative at all, other than an award ceremony in Canberra and we're convinced that that is because at the coalface out here in the provinces the information is not getting back to either Canberra or the eastern states or whatever the case may be.

I would strongly, and it's a personal view as well as the Council's view, advocate that if you want – the Minister was – sorry I'll just go back a

step. The Minister was in regional South Australia last week and did an interview on ABC regional radio in which he made the point that this is where you find out what is going on when you actually get out and get boots on the ground and we understand the ministers can't do that on a constant basis.

And that is why state and territory representation is absolutely critical to provide the Minister with what is happening in South Australia with regard to advocacy services. What is happening the Northern Territory with regard to what DVA is doing, whatever the case may be, and it will be different depending on where the veteran community resides.

**COMMISSIONER FITZGERALD:** My last question then, Richard may have a final one. Our report is very light in relation to the responsibilities of state and territory governments, and that's largely because many have very little involvement and some have more. It wasn't clear to us what the role of state and territory governments should be. Maybe it should be what they're doing, maybe it should be more. Do you have a particular view as to whether our final report needs to be more explicit about the role of state and territory governments in this space?

**MR MANTON:** South Australia I believe was the first state to establish a state level Minister for Veterans' Affairs, and that's now been adopted nationally. In every state and territory there is now a minister who is responsible for veterans' affairs by name. It may well be a lower level minister reporting to another minister. In a number of states and territories, Queensland and South Australia particularly, the Premier is that person, with someone working to them to provide that day to day, week to week interface.

My view is that – and it was – you say it was light on, and I looked at the book and went not very light.

**COMMISSIONER FITZGERALD:** The book is not but the part about state governments is.

**MR MANTON:** Yes it is, and it – you're right it is light on it and I think there is room in there for consideration and for what state and territory governments ought to do. Essentially in South Australia the role of the Minister for Veterans' Affairs and the agency is to be that interface between the veteran community and the cabinet table, and then to encourage, through the Veterans' Advisory Council, that minister at state and territory level to advocate, raise matters, respond to issues that are raised at a federal level that do have an impact.

Because at the end of the day the Commonwealth pays and the state delivers. So the Commonwealth, from a Veterans' Affairs perspective, can develop a wonderful health care system but if it can't be executed at state level then it's not a particularly good system and so it's really that – getting that dynamic between those two. In the same way we want ex-service organisations to work together, departments to work together, we'd like too state and territory governments to work together as well. However, understanding that it's the Commonwealth government that deploys these people and ultimately has responsibility to pay for them, but the states are the ones who actually have to execute and deliver that.

**COMMISSIONER FITZGERALD:** Okay. Richard, any final questions?

**COMMISSIONER SPENCER:** I just have a very quick comment. You mentioned Joint Transition Command and that you're in principle supportive of that idea. There may be alternatives which we're going to explore.

**MR MANTON:** Yes.

**COMMISSIONER SPENCER:** And we'd welcome you putting forward any alternatives to that model.

**MR MANTON:** Sure.

**COMMISSIONER SPENCER:** Once again I think everybody is in agreement. The need for transition to be far better handled than perhaps it is at the moment, or that it is at the moment. So alternative models perhaps to what we're suggesting would be much welcome. Thank you.

**COMMISSIONER FITZGERALD:** Okay. Thank you very much for that.

**MR MANTON:** Thank you.

**COMMISSIONER FITZGERALD:** That's terrific. Good. Thanks Robert. (Indistinct words). Thanks very much (indistinct words). Thanks. I should just explain the opportunity for anybody else to stand up and make a comment a little later is after lunch. Does that work for you?

**MR SCHAHINGER:** Unfortunately, no.

**COMMISSIONER FITZGERALD:** All right. How long is your comment that you'd like to make?

**MR SCHAHINGER:** There's a comment in respect of (indistinct).

**COMMISSIONER FITZGERALD:** Okay. So if you do this now, but it's only for two minutes. Is that right?

**MR SCHAHINGER:** Yes, sir.

**COMMISSIONER FITZGERALD:** So you'll have to come and give your – you'll have to go on the record. So if you just come across, give me your name and then just give us the comment and then we'll move on to the next participant. Otherwise we're going to be in troubles. So if you could give me your name and any organisation you represent or in your own capacity.

**MR SCHAHINGER:** Commissioners, my name is Robert Schahinger. I'm the President of the Vietnam Veterans' Association of South Australia.

**COMMISSIONER FITZGERALD:** Good.

**MR SCHAHINGER:** My comment is to do with the expectations, technology and attitudes of the presentation today. I understand there is need to harmonise aged veterans as to current veterans, and I see a big void in that respect. We've very little representation for younger veterans, as I noticed here. I could be wrong but that's the way we see it, and we have difficulty in the harmonising of the two groups and that's represented – because we're dealing with the future, we're not dealing with the past.

And so, therefore, there are converting views but our views are a little bit different to the current views because if you're talking about the chip, you know the card to carry on the information that we're going to carry on through our whole life. It is a concern with me that we don't have that connection. We experienced that. We've got 85 per cent of older veterans happy with DVA, a lower number of veterans – the contemporary veterans – are not happy. I want to know why.

I think it's because of our changing society, our technology, expectations. There's no lack of communication for younger people to talk to older veterans, which we have the experience. They're the situations that concern the Vietnam Veterans' Association and myself. Thank you, Commissioner.

**COMMISSIONER FITZGERALD:** Good. Thank you very much.

**MR SCHAHINGER:** Thank you, Commissioner.

**COMMISSIONER FITZGERALD:** Thank you very much. Could I now call Returned and Services League SA/NT. I think we're still in order. Hi Steven.

**MR CEISSMANN:** Good morning.

**COMMISSIONER FITZGERALD:** And Kim, isn't it?

**MR HENSHAW:** Yes.

**COMMISSIONER FITZGERALD:** Thank you very much.

**MR CEISSMANN:** You're welcome.

**COMMISSIONER FITZGERALD:** Good. Could you both give your full names and the organisation you represent.

**MR CEISSMANN:** Yes, Steve Ceissmann. I'm the Senior Advocate at the Torrens Parade Ground, RSL state branch.

**COMMISSIONER FITZGERALD:** Thank you.

**MR HENSHAW:** Kim Henshaw, CEO of RSL SA/NT.

**COMMISSIONER FITZGERALD:** Good, thank you very much, and just your opening statement.

**MR HENSHAW:** Yes, Commissioner, as I – I think the best way for us to introduce what – how we feel about the potential for change is to say that we 100 per cent agree with the submission that the eight ESOs have put in. We don't see rehabilitation and compensation schemes for veterans and ex-service people to be very similar to workers' compensation, mainly on the grounds that the object of a workers' compensation scheme is to get people back to work. The object of a rehabilitation scheme for ex-service people is to get them back to a reasonable lifestyle, and I think those two things are very, very different and the object is, therefore – sorry, the means to get to that has to be very different. Steve.

**MR CEISSMANN:** Yes, and the areas we need to look at we believe is with the transitioning of our veterans. The other area we need to look at is the advocacy side of the house for veterans, both older veterans and new veterans. In that area we need to look at, and the other area is also combining the welfare side and the advocacy side for veterans, which needs to be looked as well.

**MR HENSHAW:** I think we're in a fortunate position of seeing the whole range, age range of veterans from very young veterans who are transitioning out for whatever reason, through to the older vets who may have transitioned out some many years ago, and the one thing I will say is our experience is that, particularly where veterans are medically discharged, they are usually angry. They chose a profession and a career of being in the services, and that's been taken away from them.

So the ability for them to transition into a useful member of society, and even useful for themselves, is limited by that factor.

**COMMISSIONER FITZGERALD:** Thank you very much for that. Can I just raise a couple of questions, and I appreciate that you're supportive of the submission that we heard at the opening of today.

You made the point that workers' compensation arrangements and the compensation arrangements for veterans is different because of that return to work and, in fact, return to a (indistinct) meaning for life.

Nevertheless, there are elements in relation to the way in which you run a scheme. A compensation scheme is made up of – they're all different. They're all over the place, whether they're workers' compensation, dust injury, all sorts of compensation schemes operate in Australia, and they're all different legislation, different purposes.

So when we looked around Australia, we tried to say how do you run a modern compensation scheme? Not the benefits, not the legislation, but how do you actually administer it?

And so, at the end of the day, we looked at the best models. So would there be a view that, if you can come up with a better model of administering this unique scheme, but taking the best practice from some of those other schemes, then that's an appropriate way forward if you're trying to design it.

So we acknowledge absolutely that it's not a workers' compensation scheme in the normal nature, but it has a lot of characteristics that are similar to the way in which you administer that scheme, and so that's what we were trying to get at.

**MR HENSHAW:** I think efficiency is something, particularly in government services, that we should all aim for, absolutely, and best practice in the administration side of any scheme and any project that the government runs is very important.

I think what we would stress though is that these are unique people who have come from unique circumstances. This is the only job in the world where your manager asks you to go and put yourself in a position where you could be killed, and that is absolutely unique to these folks.

And so while we are very supportive of any administrative efficiencies, we must never forget that these people are absolutely unique in our working environment.

**COMMISSIONER FITZGERALD:** Sir, as I asked the earlier participants this morning, is your major concern with our recommendation that moving or shifting policy out of DVA and removing that department, is that the major concern as distinct from creating a mechanism by which you better administer the scheme?

**MR HENSHAW:** Indeed. I think, as has been mentioned, DVA is very well thought of by the vast majority of veterans, particularly the older veterans, and I think the comment was just made that part of that is perhaps because of their years of experience with DVA, and knowing a little bit better how to navigate that department.

I think the department itself has done a great job of becoming more veteran centric, and so anything that would detract from that concept of having a single department that is very veteran centric and intent on doing nothing other than providing for the betterment of veterans, we would not support.

If there was a way to keep that and, as you say, improve the administrative back office processes, for example, then we would agree with that.

**COMMISSIONER FITZGERALD:** So, at the moment, DVA and Defence have entered into large outsourcing arrangements, and previous reviews have indicated that most of the DVA functions could go into the Department of Human Services. We don't believe that, as you know. We believe some back office should – we actually believe there should be a veteran centric commission. Now, some in government don't think that's right, that most of the functions should go to DHS.

So you could keep DVA but have nearly all of it done in DHS. That's where we're heading. Ours is actually doing something quite substantially different, but absolutely maintaining that veteran focus on it.

So has there been much thought given to the current direction of outsourcing within the department?

**MR HENSHAW:** Yes, there has. As late as last Friday, I was talking to DVA about the concept of DHS officers becoming the point of contact in many circumstances for veterans, and that's something we do not agree with. We think that there is a different dynamic amongst the other clients of DHS that is not helpful to veterans, and it's not helpful to their mental health.

So we certainly would not support DHS becoming the point of personal contact between Veterans and the government. If DHS was able to take over back office functions in a more efficient fashion, I think we would be happy with that.

**COMMISSIONER FITZGERALD:** Can I just go to a couple of other comments you made, and then Richard, and then I'll come back to a couple of issues.

The difference between older veterans and newer veterans I think is clear, and you acknowledge that, and certainly that's what we've seen. We've tried to accommodate that by keeping the VEA, by having a different scheme for younger or newer veterans. We've tried to maintain that difference for a couple of areas, but – and including in the health area, there are different views about those particular arrangements.

So given that there are different expectations of the older community and younger veterans, what do you think, fundamentally, is that difference? What do you think, from what you're seeing, is the fundamental difference between the expectations of older veterans, many of whom have had their benefits well and truly settled, and younger veterans who – a lot of it is about returning to work, to family life, to community life, in a very proactive way, which is not encouraged in the VEA, but is encouraged in MRCA, for example.

So I'm just wondering, can you tell me what you see in the difference between those two groups are?

**MR HENSHAW:** I'll let Steve answer that.

**MR CEISSMAN:** The contemporary veteran nowadays are currently doing three and four rotations overseas on operations, coming back. Within that time, that generally lose at least 70 people who want to get out and discharge from the Army because they've had enough.

The ones that want to soldier on are the ones that want a career. However, they've come back injured and they start their processes through the chains

of command which you have, your welfare boards, which are done quarterly. They get downgraded to J31. They're given six months at the welfare board to do the best they can to get them back to a J2 or a J1.

If they're going along processing, and remember, in this welfare board you have psychiatrists, doctors, rehabs, everybody's there, and they discuss the veteran right through, and if they consider that he's going well and they believe he can get back to where he needs to soldier on, they'll give him another six months, and that's really good.

Where it comes to the punch is when the turn around after that and say, well, you're not going to get back, mate. We're going to have to downgrade you to J51. Straight away, there goes his career in his Army. He loses faith in everything. He's not listening properly, and then starts to (indistinct) the transition from there, and that's where it all starts to fall apart.

Army's doing a very good job at this point of time, because they're transitioning, they now have a member that's coordinated who represents Canberra, from the APAC, and he assists all – attends all welfare boards, and assists a lot of the veterans to process through.

The transition itself now has a warrant officer and a major in there for the Army side, and once they've been downgraded they then have to pertain to the transition itself, where they are actually talked through their procedures for discharge.

Well and good, but again, because they're angry, they're cranky, and they're not listening, half their stuff doesn't get done properly, and this is where we're falling down a little bit in that area.

The rehabilitation side within Defence is very good. They have their resource team within the med centre. They outsource to the rehab people outside. Those rehab people do a plan for the Veteran to get him back to where he can go. Now, if he's J51, they'll sit him down and they'll discuss what they can do for him and what types of job he can get, and they'll process him through and get him qualified to do a job when he gets out, which is a really good thing for him.

They've also got the new section now, where they head upstairs to the civilian side of transitions, and they solely operate on what jobs are available for that veteran, and what he can look at to transfer out to get a job.

Now if he decides that I used to be a truck driver. Due to my knees, right and left knee, I can no longer do that job. I need to do something where I can have a desk job and I can get up and walk around", so he might decide to be a, say, a clerk in an office. So he'll go up there and he'll say, "Look, this is a job I believe I can get". They'll look at what he can do and they'll say, "Well, you've served this long and we can allow you to do these courses to get you qualified". So Army and their side of it are doing a pretty good job. The areas that are letting people down are RAAF and Navy.

The RAF have an MSC, but that MSC can only intervene when given permission by the hierarchy of the RAAF base and that's stupid because there's people in the RAF that need assistance and they're not getting it, where that person, you could direct them to the people they need to see, like advocates, and which they do when they're allowed to. Navy hardly do anything. When they come to us I'll say, "Did you do this?". "No. No, I just got up here and signed this and I'm out, that's the end of it", so it's not just the Defence side that's not talking. It's the actual (indistinct) of Navy, and they need to get together and start talking and come up with a system that can be in place to assist these veterans to get out in a proper manner.

The other side of it they look at and they're not told enough about is compensation, Comsuper. They got to the Comsuper things once they're downgraded, and they'll sit there and they'll hear all these days' worth of bloody interviews, and they only take in what they want. The rest of it they're not - they don't hear, and when they walk out there it goes in there and out this side. They have a data dump. They're good, however we still need to process them from there. They need to go back to their units and the units need to say, "Right, this is what you were told, this is what you were told. This is where you need to go now", start directing them to those things. There's not enough places and positions for that.

**MR HENSHAW:** So I think, Commissioners, one of the questions of us is what's the difference between older veterans and younger veterans and Steve's given a pretty good example of how a younger veteran may be transitioned. I think there's a different expectation from younger folks about how they should be treated and that's - I'm not trying to be disparaging, but I think it's just different from the era of, say, the Vietnam veterans who were brought up in a different - with a different ethos, and however did a service that was at least equal to anything that anybody's ever done.

So it's a societal shift, I think, in attitudes as much as anything. Young people tend to feel, or should I say they tend to be less patient than the

older folks, and because of that they are less - seem to be less resilient through the process.

**COMMISSIONER SPENCER:** Yes, I just wanted to go back to some of the discussion we were having earlier about this idea of workers' compensation schemes, and I think a concern that's been expressed by many people that they feel that what we're talking about is just picking up a workers' compensation scheme from civilian circumstances and applying it in the military context, and look, as Robert was mentioning earlier, that's certainly not what we're suggesting. What we have done is to look at what are the best practices, what gets the best outcomes from other workers' compensation schemes as we were required to do by terms of reference but we were happy to do that.

I think what we've observed is, some of the things that you've actually been alluding to or discussing that you see very prominently in the best schemes elsewhere, that is very pro-active engagement with the individual, what is described often as case management. That is very quickly, "What's the issue for this particular individual?", rather than treating people pretty much the same or cohorts the same, and sometimes civilian schemes are characterised as a return to work, but what we saw was that the best schemes are, yes, return to work if that's possible, but return to meaningful life. That's the other possibility.

So I think there are parallels where we can learn, but as Robert also said, we think that that scheme absolutely has to be military and in a sense veteran-centric so wherever it sits it should be in an organisation that does represent that. Look, the other thing that we observed in really excellent schemes is that they really track outcomes, they really track the data and we've commented a lot on that in our report and we think that should be a feature in the future.

One of the things we hear quite often, and I just wanted to pose the question to you about the South Australian context is, it's all very well having various health services, access to various services, but when you go to get them, they're not there, and that is challenging generally in Australia. I mean, generally speaking, in a city context, you're probably going to have more success than if you're rural and remote, but a comment was made in one of the submissions we received today that there are particularly unique aspects in South Australia to actually getting access to the services that people need and I'm just wondering if you can comment on that from your experience.

**MR HENSHAW:** I think the certainly low population and very large land mass, remote communities right throughout that land mass makes it

difficult from a geographic point of view to access some of the services, but there's also some other issues. If you read the positions vacant in South Australia a vast majority of - well, not a vast majority, but a large majority of them are for skilled medical people, so there's clearly a very severe shortage of skilled medical people in the state which makes it difficult.

Anecdotally we know of, for example, some practices that, whilst they advertise they will accept a veteran's Gold Card, for example, put caps on the numbers, and so if you happen to be one or two over the cap for the day then you'll be sent somewhere else and we don't think that's acceptable, and so I think the whole issue of health care, as you say, rightly say in Australia is a very difficult one. I think in South Australia it's made more difficult for two reasons. One is small population, very large land mass, and the second is a lack of skilled personnel within the system at the moment.

**COMMISSIONER FITZGERALD:** Thank you. Just in relation to health, just following on from that, I presume from the earlier submission that you're endorsing, can I just clarify your view in relation to this issue. We've heard from some veterans that they would like to be able to use health practitioners, but those health practitioners all require a gap payment and Veterans' Affairs, as you know, won't allow that. Do you believe that veterans should have the right to be able to go to a medical practitioner who does, in fact, charge a gap if they're willing to pay the gap? And is it right that that choice is denied to veterans currently?

**MR HENSHAW:** I think in a general sense choice should never be denied to anybody, particular in health care. I've got to be honest and say I have not heard at all the argument that some veterans would like to go to a different medical practitioner and pay a gap. I've certainly heard the opposite, and that is that they don't want to pay a gap because most of these people are on fixed incomes and certainly are not wealthy people, and therefore health - and have health care concerns.

So if they were to go to a health practitioner where they had to pay a gap, my fear would be that that would reduce the amount of times that they may be able to see a practitioner, and anecdotally, I don't have any data to back it up, but anecdotally I have not heard that there are veterans in South Australia who would prefer to go somewhere where they pay a gap.

**COMMISSIONER FITZGERALD:** And just to follow up from Richard's point, accessibility of the health care system, we've heard that, and again we're going to look at this in more detail, but some of the payment arrangements by DVA fall well below market rates that's

impacting on access. That may or may not be the case in South Australia. Is that a problem here or are you able to access services relatively reasonably, at least in the Adelaide context?

**MR CEISSMAN:** Yes, it does, especially with psychiatrists. If you need a report from a psychiatrist, standard report from a psychiatrist that a veteran's got to pay is around $2,000-odd. If DVA pay it's around $1,500, and a psychiatrist won't write a report unless DVA have requested it for the fact that the veteran cannot afford to pay it, so yes, it does have an effect.

**COMMISSIONER FITZGERALD:** In relation to the health area, just in relation to mental health, you've mentioned psychiatrists. The White Cards are now being universally available effectively for all ex-service personnel. Is that working out well in the state of South Australia?

**MR CEISSMAN:** Yes, it does. The White Card for mental health, we fill out forms and send it off. Generally within two weeks they've got a White Card and the White Card's presented and, yes, it works wonderful. Got no qualms about that.

**COMMISSIONER FITZGERALD:** Are there any final comments you'd like to make, or Richard?

**MR HENSHAW:** No, we have nothing more.

**COMMISSIONER FITZGERALD:** Any other final comments?

**MR CEISSMAN:** No.

**COMMISSIONER FITZGERALD:** All right. Thank you very much. That's good.

**MR HENSHAW:** Thank you.

**MR CEISSMAN:** Thank you, Commissioners.

**COMMISSIONER FITZGERALD:** Thank you for that. So could I have Michael Longford. Good, welcome, Michael.

**MR LONGFORD:** Thank you. It'll take me a while to sit down.

**COMMISSIONER FITZGERALD:** M'mm?

**MR LONGFORD:** It'll take me a little while to sit down.

**COMMISSIONER FITZGERALD:** That's all right. Not a problem. Well, it may be for you. Michael, if you can give us your full name, and if you are representing an organisation, that organisation.

**MR LONGFORD:** My name's Michael Longford. I'm just representing myself and other veterans.

**COMMISSIONER FITZGERALD:** Terrific. Thank you. Michael, would you just like to make an opening statement?

**MR LONGFORD:** Me?

**COMMISSIONER FITZGERALD:** Yes.

**MR LONGFORD:** Yes, okay. I served for 22 years in the military. I served 10 years in infantry and 13 years in catering corps. I've had my knee replaced twice. I've got ankylosing spondylitis in my neck, I've got lower lumbar spondylitis and I'm on 80 per cent pension with Department of Veterans' Affairs. So I get a wage of $200 a week and I haven't worked for three years, so. I've got some dot points if I want to go through them.

**COMMISSIONER FITZGERALD:** Please.

**MR LONGFORD:** The first one is doctors, how many doctors have I seen over the years. How long is a bit of string? I've seen quite a few. My experience with the Department of Veterans' Affairs have been going for eight years and I've got no satisfaction whatsoever. I've had 25 doctors' appointments, specialists, filled out forms, claim forms. I've filled out 25 claim forms and it takes so long for the process to go through that I feel like giving up sometimes but I can't. The claim forms, why are there so many? Why are there so many claim forms we have to fill out? I come under three different acts I think it is, MRCA, SRCA and VEA, I assume.

To be honest, Veterans' Affairs and the VRB is not working in my case. In other cases it probably is, but in my case it's not. There's an outreach system now that they've brought in to help veterans. The outreach system isn't working either. I went to the Review Board November last year and they overturned my decision through the outreach and it took them 13 weeks to get back to me saying that, "Yes, we've overturned the decision into my favour", and I went to see my advocate last week and I said, "How long will this take?", and he said, "Well, how long's a bit of string?". So he couldn't tell me.

So eight years I've had claims in with DVA. Every time I've put in a claim, I've put in 12 claims, I've had 12 different people come back with a letterhead and it's just not good enough the way that I'm being treated, and I know other veterans, some of them are in the same boat, and my wife works five days a week from 9 until 6 at night, and I can't do much at all now because of my back and and my neck, and all I want is what I'm entitled to.

I've been struggling for a long time now, for three years with no work. I get $200 a week and if I can say that last year I had my prostate scraped and it cost me $900, and I get $200 a week off the Department of Veterans' Affairs. That's a little story that, it's just I can't afford to do anything, and luckily my wife is working, so she supports me, and my other friends support me as veterans, so, but that's, you can ask me some questions if you like.

**COMMISSIONER FITZGERALD:** Michael, could I ask you a couple of questions?

**MR LONGFORD:** Sure.

**COMMISSIONER FITZGERALD:** When was the first time you put in a claim to DVA?

**MR LONGFORD:** Roughly eight years ago.

**COMMISSIONER FITZGERALD:** And were you still in service or had you left the service?

**MR LONGFORD:** No, I've been out for 20 years.

**COMMISSIONER FITZGERALD:** You've been out for 20 years?

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** You've said that one of the great frustrations is these multiple claims.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** What's driving the number of multiple claims? Is it that your injuries are becoming apparent over time?

**MR LONGFORD:** Worse, yes.

**COMMISSIONER FITZGERALD:** Or is there something else at play that's causing you to have to put in so many claims?

**MR LONGFORD:** Well, now I'm getting older, the injuries are getting worse as - and they're turning into arthritis sort of thing.

**COMMISSIONER FITZGERALD:** Sure, and so do those eight claims covered different conditions.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** And can I ask this question, and again, you don't have to answer any of this, how many of those claims have been successfully found in your favour?

**MR LONGFORD:** I've got eight recognised conditions.

**COMMISSIONER FITZGERALD:** Right. You've indicated that you're frustrated by the Department and we've heard that many, many times.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** And you fall into that terrible category of being under three acts.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** Which we hope to change.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** But what do you think would have been the things or the steps that would have made that claims journey better for you? So what, if you look back on that eight years, and I know it's a complex period of time and you're still going through it, but do you think were the two or three things that would have made that process much better for you?

**MR LONGFORD:** I think number 1 would be advocates, better advocate service, because they have poor advocates. Mine only work once a week. They're volunteers, so every time I want to ring somebody the advocates are not there or he's unavailable.

**COMMISSIONER FITZGERALD:** Right.

**MR LONGFORD:** Number 2 is paperwork. I brought in some paperwork here that says that I've injured my back 10 times in the military and that's only 1 per cent of what, the paperwork I've got at home. It's sits high, the paperwork. And number 3 is time, and really, the Department of Veterans' Affairs is wasting money on other veterans and to go to see doctors, paperwork, so they need to fix up their system to speed the claims up.

**COMMISSIONER FITZGERALD:** In relation to the advocates, did you use advocates from a particular organisation or did you use - have you used several different advocates during the process?

**MR LONGFORD:** They're from the RSL.

**COMMISSIONER FITZGERALD:** M'mm?

**MR LONGFORD:** RSL.

**COMMISSIONER FITZGERALD:** And as you know, there's been a review of advocates being done by Robert Cornall.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** And the government will release that report at some stage, hopefully soon. What do you think could have improved in the advocacy space for you?

**MR LONGFORD:** I think we need paid advocates to - full-time, are there five days a week, because at the moment they're just there once a week which is - they're all volunteers. They don't - they do a good job, but you don't really want to be somewhere if you're not getting paid, do you? I don't.

**COMMISSIONER FITZGERALD:** Did you find the advocates, and I want to be careful here, but were they well-trained and knowledgeable and it was just simply they weren't available, or were you concerned about the quality of advocacy generally?

**MR LONGFORD:** Can I be honest with what I'm saying or - - -

**COMMISSIONER FITZGERALD:** Well, that's generally the purpose of these hearings.

**MR LONGFORD:** Okay. I just don't want to bag too many people.

**COMMISSIONER FITZGERALD:** No, well, you have to make that judgment call.

**MR LONGFORD:** Okay. At the start, no, they weren't very good at all, but now I think the system's working a bit better with the veterans, but it's time to see them that - when I first started this eight years ago, the advocacy wasn't very good at all. I'd ring them and they'd say, "Oh, I'm busy today", or, "Come into town and sign this bit of paper", and - but it's improving. It is getting, but first off it wasn't very good.

**COMMISSIONER FITZGERALD:** So can I ask this question, the DVA as you know has this Veteran Centric Reform program on, and we have supported that in the report, and most of the changes we've recommended should take place after that has been completed, by 2021. There are some changes that should happen immediately, of course. Have you noticed significant or any improvements, and if so what, in the last two to three years?

**MR LONGFORD:** None. No improvements. It's gotten worse.

**COMMISSIONER FITZGERALD:** Okay.

**MR LONGFORD:** Can I say that my dispute is still going. Last year I put in for my lower lumbar spondylitis and in January last year of my lower back which I injured in 1983 in the army, so the Department of Veterans' Affairs turned around and said, "No, well, you're outside the 25 years, the onset". I said, "No, I got diagnosed again in 1993, so that's 10 years", and they said, "No, we don't think you did", so they knocked it back in June. It took them that long to do that case. So from June, I put in a - I reviewed it straight away, and November they came back and said, "Yes, we've overturned it in your favour", and now they've overturned - I've had my knee recognised as service-related, but the Veterans' Review Board has overturned that now into their favour for no reason.

**COMMISSIONER FITZGERALD:** Well, could I just take that last point if I can.

**MR LONGFORD:** Sure.

**COMMISSIONER FITZGERALD:** You've been critical of the VRB in your short statement. Can I just deal with that last one. When you say "for no reason", did they give you a reason?

**MR LONGFORD:** No, they just said it wasn't service-related.

**COMMISSIONER FITZGERALD:** You've had matters previously which have gone to the VRB and proven in - - -

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** And had decisions reversed in your favour?

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** So can I just ask this question, is your view of VRB determined on what the decision is, or is it the process itself and the way in which they make decisions that you think is flawed?

**MR LONGFORD:** I think the decision-making, I don't think it's correct. It's - they give you with one hand and take from the other. When my knee first got - I put in for it for five years straight. It wasn't service-related, and then last year it was, so that's good, I didn't work for two years, but my knee has stopped me from working, but I'm on $200 a week. So then my back gets found not service-related and then it is service-related. So that's fine, my back's fine. And then now, my knee's not service-related. So I don't know what's going on.

**COMMISSIONER FITZGERALD:** All right. And would you take that decision to the AAT or what will you do?

**MR LONGFORD:** No, I'll keep going. I can't give up.

**COMMISSIONER FITZGERALD:** Do you take that through to the AAT?

**MR LONGFORD:** Yes. It all depends on the outcome of this next - I've already been to the VRB and they've - if it comes back positive with the Gold Card TPI or whatever, I'll accept that, but if it doesn't I'll go - - -

**COMMISSIONER FITZGERALD:** Go for another claim?

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** Okay. I'll come back to a couple of things.

**MR LONGFORD:** Okay.

**COMMISSIONER FITZGERALD:** Richard.

**COMMISSIONER SPENCER:** Yes, just going back, I mean, it's 20 years since you discharged, and presumably when you had to go back and get information or your records to actually establish when some of the injuries occurred, can you tell us a bit about that? Was that easy, was it difficult?

**MR LONGFORD:** No, it was quite easy.

**COMMISSIONER SPENCER:** It was quite easy to get those records?

**MR LONGFORD:** Yes.

**COMMISSIONER SPENCER:** So were the injuries recorded at the time?

**MR LONGFORD:** They are, yes, I've got them here actually.

**COMMISSIONER SPENCER:** Okay, so they were in the records.

**MR LONGFORD:** Okay, that's good. The - - -

**MR LONGFORD:** The point is with that, sorry.

**COMMISSIONER SPENCER:** Yes, yes, sure.

**MR LONGFORD:** I've got here eight times, nine times when I injured my knee in service, but DVA just wrote back and said, "Well, they were minor injuries", and I said, "Well, not at the time. They were pretty serious to me. In infantry, it's not a normal job. It's heavy, it's hard", and they said, "Well, we don't think it is". See, the problem is that nobody in DVA has ever been in the army and never been in infantry. It's a hard job, so, but after that it was quite good. The documents came back quite quickly. They sent me a disk, so, but when you've got all this information here and they criticise you as a person, sort of thing.

**COMMISSIONER SPENCER:** So, and can I just, with your VRB experience, is your advocate - are you self-represented, or has your advocate been there with you through that process when you've appeared before them?

**MR LONGFORD:** Yes, the first, I've been to the VRB twice. Five years ago, didn't get anything at all.

**COMMISSIONER SPENCER:** Did you just go alone or did you have an advocate?

**MR LONGFORD:** No, I took my advocate.

**COMMISSIONER SPENCER:** You had an advocate with you, yes.

**MR LONGFORD:** And the second time we went November last year. I didn't go to the VRB, they had the outreach and the outreach overturned the decision in my favour, but that took 13 weeks to come back as in my favour. The system just takes too long.

**COMMISSIONER SPENCER:** And you mentioned in answering a question to Robert that you hadn't observed any changes as a result of the transformation project underway within DVA. When you say changes, is that about the outcomes you're seeking or the way in which you're going treated? Do you see yourself being treated differently in terms of the communication, in terms of explanations about what's happening and why? Do you detect any difference?

**MR LONGFORD:** Yes, it's - I don't know if I'm being targeted or it's - other veterans are being targeted as in, my conditions are service-related, but you're only on 80 per cent pension, and I can't work for three years, and I said before, earlier on that I get $200 a week. If I could go back to work I would, and I did try to go back to work, but my back and my knee have just, I couldn't - I couldn't do it.

**COMMISSIONER FITZGERALD:** What support do you think that the ESO community needs to provide to veterans in your circumstances? They've obviously provided the advocates, the volunteer advocates currently.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** And that system is under review. Do you believe that the ESO community generally should, in fact, be more supportive of injured veterans or in your case would that not have made any difference to the way in which you were dealing with life?

**MR LONGFORD:** I don't think it would have made a difference in my case. I feel like we're - I'm in a boat where there's a war and there's non-war. If I'd have gone to war I'd be on a Gold Card TPI, because I've been told lots of times, "Michael, did you go to war?". I said, "No, I haven't been to war. Why?", and the said, "Well, your claim would be so much

easier", so we're under two umbrellas. We have to get away from that, and I'm under too many acts.

**COMMISSIONER FITZGERALD:** Sure.

**MR LONGFORD:** One of the acts, sorry, one of the acts that I was under was in 1971. They need to change the acts.

**COMMISSIONER FITZGERALD:** So you may or may not be familiar, Michael, that we're recommending two schemes where there'll be the VEA and the one single act which will be a combination of DRCA and MRCA, and you can elect from the VEA into that, so eventually veterans will be able to be under one act entirely for all their claims if they so choose. Would that sort of system, without going to the technicalities of that, have made a significant difference to the way in which your claims have been dealt with?

**MR LONGFORD:** I don't think so, no. It's - I don't know if it, I don't think it's that complicated. I was injured in the military and - - -

**COMMISSIONER FITZGERALD:** They should just deal with it.

**MR LONGFORD:** Yes, and they should deal with it.

**COMMISSIONER FITZGERALD:** But the being under three acts has its own complications.

**MR LONGFORD:** It does, yes, definitely.

**COMMISSIONER FITZGERALD:** Sure. Michael, just a couple of other questions. You've got a claim in at the moment which I presume is assessing whether or not you need a permanent incapacity or impairment which would give you access to lifetime benefits and pensions.

**MR LONGFORD:** Yes

**COMMISSIONER FITZGERALD:** And that claim is the last one that you've put in.

**MR LONGFORD:** Is that lower lumbar spondylitis?

**COMMISSIONER FITZGERALD:** M'mm?

**MR LONGFORD:** Is that about my back, lower lumbar?

**COMMISSIONER FITZGERALD:** I'm not quite sure.

**MR LONGFORD:** Yes, I've put in a claim.

**COMMISSIONER FITZGERALD:** Right, and that particular claim, can I just ask this question, is that being dealt with under VEA or under MRCA or DRCA or you don't know?

**MR LONGFORD:** I thought it was under something or other, I don't know. No, it's under VEA.

**COMMISSIONER FITZGERALD:** Right, okay.

**MR LONGFORD:** When I first - this is a claim I put in in January last year and it's still not finalised, so it's - - -

**COMMISSIONER FITZGERALD:** And just if I can just take that, why do you think it's not finalised? Whether the decision's in your favour or not is an issue.

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** But why do you think it's taking so long? Is there a problem with information or is there - - -

**MR LONGFORD:** Yes, it's - well, they've got computers and they keep sending me paperwork.

**COMMISSIONER FITZGERALD:** Giving you stuff or asking for stuff?

**MR LONGFORD:** Just giving me information and when - they took from January last year to June to overturn, or to say no about my back, it's not service-related, yet I had either medical certificates here saying that I've injured my back. See, it's outside the onset of the 25 years of the, when I injured my back. You've got 25 years to put in a claim, and get diagnosed, so I did that in 1993, and Veterans' Affairs said, "Well, no, you didn't". I said, "Yes, here it is, I've got it here, the report".

**COMMISSIONER FITZGERALD:** Right.

**MR LONGFORD:** So then in June I appealed it straight away and then it took to November.

**COMMISSIONER FITZGERALD:** And its state at the moment? Where is it now?

**MR LONGFORD:** I don't know.

**COMMISSIONER FITZGERALD:** Is it with VRB or is it with DVA?

**MR LONGFORD:** It's gone back to DVA.

**COMMISSIONER FITZGERALD:** Gone back to DVA?

**MR LONGFORD:** Yes.

**COMMISSIONER FITZGERALD:** Okay.

**MR LONGFORD:** And they could make a decision again and overturn it again and in their favour, so.

**COMMISSIONER FITZGERALD:** Sure. Richard? Anything you want to - - -

**COMMISSIONER SPENCER:** No.

**COMMISSIONER FITZGERALD:** Is there any other final comment you'd like to make, Michael?

**MR LONGFORD:** No, not really. I think I've got my point across**.**

**COMMISSIONER FITZGERALD:** I've got your point, and we've heard that many times. I know that people are supportive of DVA at the moment, but we are aware - we've heard from dozens and dozens of people they've had difficult circumstances in the process.

**MR LONGFORD:** Can I say that it's very frustrating, you know, it's - I'm the sort of person that, I did 22 years in the military and I've worked just about all my life, and I'm sitting at home in a lounge chair trying to get up and I'm not, sort of, old as such, you know, but I feel like I'm about 80, but I'm just frustrated to find out what's going to go on with me in the future, sort of thing.

**COMMISSIONER FITZGERALD:** Sure.

**MR LONGFORD:** Am I going to get any help from anybody?

**COMMISSIONER FITZGERALD:** Good. All right. Thank you very much, Michael.

**MR LONGFORD:** Thanks very much.

**COMMISSIONER FITZGERALD:** We'll take a five minute break and then Mr Kerry Lampard will be the next up, so just a five minute break. We'll start precisely in five minutes.

**SHORT ADJOURNMENT** **[10.30 am]**

**RESUMED** **[10.40 am]**

**COMMISSIONER FITZGERALD:** So Kerry Lampard, please. The technician's just going to add some loudspeakers so it's easier to hear. We'll just ignore him. Good, thank you very much. Welcome.

**MR LAMPARD:** First, can I thank you gentlemen for hearing us. I appreciate it.

**COMMISSIONER FITZGERALD:** Just a second. They're all talking. Can we just, no talk at the back please. Thanks. So that's right. Welcome. If you'd like to make a statement. Just firstly you have to give your full name and if you represent an organisation, the name of that organisation.

**MR LAMPARD:** My name's Kerry Lampard. I don't represent any organisation but I'm an ex-veteran and member of the SAS Association and the RAR Association, so.

**COMMISSIONER FITZGERALD:** That's fine, but you're here in your own capacity? Good. Please, just an opening statement.

**MR LAMPARD:** Okay. I put in a brief submission to the Commission. No doubt you guys have got a copy of it.

**COMMISSIONER FITZGERALD:** Yes.

**MR LAMPARD:** I'd just like to mention a couple of things, and I heard you mention in order to before about the Veterans' Entitlement Act perhaps going back to one act. In my first comment or suggestion, there are three acts at the moment covering veterans. What I think the Veterans'

Affairs Department should do is go back to one act so that it's no worse off for veterans, and not subject of political interference at any stage. How you do that, I don't know, but that's for smarter people than me. This should also make it a lot easier for training of advocates, future advocates, future pension officers.

The three acts at the moment are an absolute bloody nightmare for blokes who are volunteers. The second point that I made to the Commission is, it's difficult for a claimant to access his records once they leave the ADF. Now, it might be a bit better now. I left the ADF back in the 70's, and members may not present to DVA for quite a number of years before their injury becomes apparent, i.e., the gentleman before us with the bad back.

One of those things, and I think the Commission's already looking at it, is digital history of the soldier and that can be done by a little card and that could be borne by the cost by the member so that when he turns up to DVA office some 10, 15 years after he's out of the army, in goes the card, computer brings up his medical history and his service history. This would eliminate lots of disputes. So I think that you guys are already looking at digital history records.

The third one, third submission I put in, in box 9 and 10 of the draft report mentions transition and mental health. If we go down to amalgamating DVA with the ADF, then the ADF needs to be properly resourced, properly funded and seriously about it. So I don't know how that's going to play out so I leave that up to you. On page 52 of the review, if accurate records are kept by the Department of Defence, it would eliminate a lot of issues, in my book, that pensions officers have to deal with. Veterans' Review Board would be less, so it needs to be addressed so that life is made simple.

Just a comment, that's my submissions. Just a comment, I don't know if you know of John Burrowes from Victoria who's a pensions officer and advocate. Been doing it for a long time. He's also mentioned about the erosion of TPI and pension rates. In 1974 they were 75 per cent of average male weekly earnings, and that's been eroded. Now it's 40 per cent. So the Commission needs to have a look at that if they can. The Department of Veterans' Affairs are dealing with less and less veterans as the older guys fall off the perch, so that needs to be addressed, in my opinion, and I probably think you guys are going to get a fair bit of that when you go to Victoria.

But otherwise I appreciate that this has got to be the first time the DVA's had a Commission for a long time looking at ways that they operate, but they're not operating very efficiently at the moment. It's 30 or 40 years

old. We've got computers and digital stuff now which is terrific, so that's all I'd like to say.

**COMMISSIONER FITZGERALD:** So thank you very much, Kerry. Can we go back a little bit. In relation to the digitalisation of medical records and what have you, that's under way to some degree. Your own personal experience, you're a client of DVA?

**MR LAMPARD:** Sorry?

**COMMISSIONER FITZGERALD:** You were a client or are a client of DVA?

**MR LAMPARD:** Yes, I am a client. My first dealings with DVA as an infantryman, two tours of Vietnam, I got knocked back and had to go to the Veterans' Review Board, and I notice with the review board, and I don't know if it's changed, I was not allowed to have legal representation. The Veterans' Review Board had a lawyer, a doctor and a psych guy, plus another ex-officer which to me was a bit one-sided. So maybe that's changed now, I don't know, but I had to deal with DVA on a couple of occasions and it was difficult, but now I've got to say, you know, I'm satisfied 90 per cent of the time with DVA, but if you're a new guy coming through the system under the three acts, I think it'd be a bloody nightmare.

**COMMISSIONER FITZGERALD:** Can I just deal with the three acts. We've looked at the three acts in detail.

**MR LAMPARD:** Yes.

**COMMISSIONER FITZGERALD:** And tried to work out what is desirable and then tried to work out what is feasible. They're different. You'd probably be aware, we've come down to the view that the only feasible way forward is to keep VEA but to create a new single act for those that are not within the VEA, and then the option for people to move from VEA to those new acts if they so choose. Your own claims, were they under the three acts, if I could ask?

**MR LAMPARD:** No, I was only under the Veterans' Entitlement Act.

**COMMISSIONER FITZGERALD:** Veterans' Entitlement Act.

**MR LAMPARD:** Yes.

**COMMISSIONER FITZGERALD:** And have you been an advocate or a supporter of people that have been putting claims in recently?

**MR LAMPARD:** No, initially I looked at being an advocate but when they brought in the three acts I just couldn't hack it, so, but I know other pensions officers and advocates do find it difficult.

**COMMISSIONER FITZGERALD:** Yes, it is difficult. The three acts themselves, they have different purposes. One is very much about lifetime income support. The other one is much more about a pro-active return to either work or referred to a meaningful life. Do you think in your experience that those sorts of approaches for older veterans, which is really about certainty of income support, whereas for younger ones it's about some different things in terms of, you know, getting back into work and activities. Do you think that is a fair description of how veterans operate?

**MR LAMPARD:** Yes, more or less, but I - I keep coming back to the three acts just make life difficult for everybody involved.

**COMMISSIONER FITZGERALD:** They do. Your comments about VRB, have you had recent experience with the VRB?

**MR LAMPARD:** No, no.

**COMMISSIONER FITZGERALD:** All right. So when was the last time you would have had involvement with the VRB?

**MR LAMPARD:** A long time ago. Probably 20 years ago. I had to front the VRB Board and I thought the way it was loaded, if I can use that word, I was not allowed to be represented by - I could have an advocate there but not a lawyer, whereas the VRB Board were loaded up with lawyers, so it's a bit intimidating.

**COMMISSIONER FITZGERALD:** Robert Cornall's report, I think, will deal with those issues so we'll look at it in time. Do you believe you were disadvantaged by not being able to have a lawyer at the VRB?

**MR LAMPARD:** At the time I think so. Ultimately I was, you know, I was approved for TPI, but initially I was knocked back which took a lot of time. I was still working, and to front the VRB Board takes time and effort, time off work, et cetera, et cetera, so it needs to be simplified, and I think with the digital history, service history and medical history of a veteran, you put it in the bloody computer and up comes all the

information and it's there in two seconds so there can be no disputes and it would probably mean the VRB Board is used a lot less than it is now.

**COMMISSIONER FITZGERALD:** And you indicated that we're looking at that and we are looking at how to further enhance, how to further improve information collection. DVA and others tell us that that's been significant improvements and hopefully people will give us some practical feedback about that.

**MR LAMPARD:** Yes.

**COMMISSIONER FITZGERALD:** Richard?

**COMMISSIONER SPENCER:** Yes. No, thanks very much for raising these issues. Just a couple of observations which may be of some reassurance that things are happening. We think things should probably go a lot further, but in terms of the digital records, as Robert mentioned, the – currently, it's the Sentinel system within services captures injuries.

And also there's an electronic health system. We've made various recommendations about how they should be joined up to give a more comprehensive record about what's happened during service.

But maybe you could comment on this, because we've heard from a number of Veterans that there's a reluctance to report injuries because that can be – it can be perceived to work against you for deployment.

**MR LAMPARD:** Yes.

**COMMISSIONER SPENCER:** Or also against the culture, which is one of you should sort of toughen up and get on with it. Was that a feature during your period of service, and do you want to comment on that?

**MR LAMPARD:** My service, if I sent to the RAP, and I was sick or injured, or thought I had a twisted ankle or something, then it would be written in my records, medical records, you know, dislocated shoulder, or twisted ankle. But it wasn't always, what's the word I'm looking for? It wasn't always authenticated. So, you know, 20 years on when you come to get your medical records, it may not be there.

But with the digital history, electronic history, you go to the RAP now, and especially in the infantry, you put your card in and it's recorded digitally, so it's there forever.

So a lot of the times, the RAP would be your first port of call for an infantryman to go to if he was injured or sick, and sometimes it wouldn't be recorded. Because it was written by hand on your medical notes, so if you had a card with your digital medical issues, then there's – it's authenticated. It can be done at the local level.

But you're right about the infantry. If you're not 100 per cent fit, you're reluctant to go to – because you may not be ready for deployment. So it's a bit of a Catch 22, and I'm – back in my time in the Army, if we had someone injured, then the CO could put that guy on light duties for a while. But now, if you're injured, you may not even – you may be posted out of the unit, because you're not fit enough to be deployed

**COMMISSIONER FITZGERALD:** Could I ask a question about the proposal we're putting forward about transition, and the Joint Transition Command? And just to give a bit of background to this. DVA and Defence are doing some very interesting work.

There's a particular trial that's been underway for some time with the Holsworthy Army Base in Sydney about better preparing members during service for their transition. So I just want to acknowledge that there are some good initiatives underway, but we think some of those good initiatives need to go further.

So I'm not sure if you had a chance to look at our proposal around the focus on, and how that might be best done with the Joint Transition Command. Do you have any comments on that?

**MR LAMPARD:** No. I'm not familiar with all that.

**COMMISSIONER FITZGERALD:** Yes.

**MR LAMPARD:** But I think anything's better than what's happening at the moment. In mental health transition, it needs to be focused more so that the soldier who's taking a discharge knows exactly his – he can get this information or he can get this help.

In my time, it was pretty well off the cuff, you know. You'd done your nine years, see you later.

**COMMISSIONER FITZGERALD:** Just a question in relation to ESOs. Can you just go back? When you started, you indicated an organisation that you were associated with. Could you just repeat that organisation's name for me?

**MR LAMPARD:** Say again?

**COMMISSIONER FITZGERALD:** You mentioned an organisation that you were involved with.

**MR LAMPARD:** Yes.

**COMMISSIONER FITZGERALD:** Which one was that?

**MR LAMPARD:** Well, I was President of the SAS Association for 18 years in Adelaide.

**COMMISSIONER FITZGERALD:** Yes.

**MR LAMPARD:** But the ESOs, I see too many ESOs springing up, which means, you know, we don't have a collective voice, in my opinion. We need to go through like the alliance, which is Navy, Army, Air Force alliance, which is very good and that talks at the Prime Minister's Round Table, which I think's a good move. That way, we're all under the one umbrella.

**COMMISSIONER FITZGERALD:** So, could I just ask that question? You might want to explore that a little bit further. What do you think we should say about the ex-service organisation community, and they way in which governments should deal with that into the future?

Now, Richard indicated very early in the morning that, at the end of the day, ESOs could do whatever they like, and they will, they should. That's civil society.

But do you believe that there is a better way of coordinating the activities of the ESOs, and if so, what should we say about that? And you may not have a view about that.

**MR LAMPARD:** No. Well, I don't really, but the alliance that we formed - the RAR Association, the SAS Association, the Navy Association. Some years ago we called it the alliance, and that's been working well, because we have an office in Canberra represented, and we get to the actuaries when we need it.

So I think the ESOs, in my opinion, get too fragmented sometimes, and sometimes it's, you know, can't be helped. People go off and start their associations, like you said. But, you know, the more under one umbrella, I think the more politicians will listen to us.

**COMMISSIONER FITZGERALD:** This alliance, how long's that been in operation, to your knowledge?

**MR LAMPARD:** Quite a long time now. I think it was probably mid-90s it was formed. It's still going and it works pretty well, as far as I'm concerned.

**COMMISSIONER FITZGERALD:** Could I ask this question? Were you aware that there are many, many ESO organisations? Why do you think there are so many that are being formed? Is it just simply the nature of individuals coming out, forming groups, people of like circumstances? Or is there a fundamental problem with the way in which ESOs operate, especially for younger veterans?

**MR LAMPARD:** Well, there was a problem with the RSL history. You know, some of the Vietnam Vets were not treated well by the RSL, so the RAR Association formed, and so on and so forth.

So, these splinters groups, own interest groups, own unit groups, that decide to have – set up their own association. So I don't think there's any one reason for it, but it just seems, with a fragmented voice, the veterans' community doesn't always get it right.

**COMMISSIONER FITZGERALD:** And finally, can I just ask, and again, you may have no view on this. We are looking at the health services, and we've asked this question a couple of times, from your own personal experience, or that of information from colleagues and friends of yours, are veterans able to access health services in South Australia reasonably well, particularly in Adelaide?

**MR LAMPARD:** Well, from my personal experience, and I can only talk for myself and a couple of close mates, most of them are pretty happy with it. One of the doctors I go to whinges sometimes that the Veterans don't pay enough for their reimbursement, especially the dentists.

**COMMISSIONER FITZGERALD:** Right. Okay. Any other final comments or questions? Thank you very much, Kerry. That's terrific.

**MR LAMPARD:** All right. Thank you for the opportunity.

**COMMISSIONER FITZGERALD:** Yes. Thanks very much for that. And if we could have Daniel Foley, please. Thanks.

**MR FOLEY:** How are you?

**COMMISSIONER FITZGERALD:** We'll keep it painless.

**MR FOLEY:** I hope so. If I start stuttering, don't worry. I'll get over it.

**COMMISSIONER FITZGERALD:** Daniel, if you could give your full name, and if you represent an organisation, its name as well.

**MR FOLEY:** My name's Daniel Joseph Foley. I'm just representing myself, no organisation, and my background's Royal Australian Navy as a supply officer, in the end.

**COMMISSIONER FITZGERALD:** Yes. Can you pull the middle microphone just a little bit closer to you? Thanks. That's the one that's amplifying. Thank you.

**MR FOLEY:** Is that better?

**COMMISSIONER FITZGERALD:** Yes. Please.

**MR FOLEY:** Okay. Firstly, I'd like to thank yourselves and your support staff for doing this. It's been a long time, and it's given a few of us a bit of hope that something might actually change, which is a good thing.

The first part I'd like to talk about is compensation disparity between the two compensation systems. So not the VEA, but the DRCA and the MRCA.

At the moment, there are two distinct classes of veterans receiving compensation payments today. The second class veterans are paid under the SRCA, now the DRCA, and receive tens of thousands of dollars less each year, and this is factually – you can see this quite easily if you look at the rates, than their MRCA counterparts.

The monetary gap grows bigger with every year, as it's actually compounding each time. So when the rates do go up, SRCA gets a lot less than MRCA people.

This wasn't the case up until October 2001. MRCA – sorry, SRCA actually was paid via military pay scales, and it was only in 2001, an amendment came through and linked it to the WPI, Wage Price Index, and that – at the time, no one seems to have put their hand up and said, oh whoops, this could be costing people money, which was a very sad thing.

Since 2001, military pay rises have outstripped the WPA rises by, in some cases, up to two per cent a year, and that is a huge difference when you compound it since 2001. That initial rise of, say, two per cent over would compound it over 17 years. It's a huge difference.

The 2001 amendment gave no benefit to veterans at all. It didn't introduce anything good. We had no need for it. We had a fixed pay scale and we should have stuck with that. There was no reason to change it.

However, I believe it was brought in under the – because it affected other people under the actual Act who were on non-fixed wage benefits, and the like. But we should have either been grandfathered or it just not applied to us. However, that wasn't the case. So yes, it was totally unsatisfactory.

In contrast, MRCA payments have always been based on the military pay scales since 2004, when it came in, and this keeps the people level with the people they can no longer work with, and it's considered best practice, as far as I know. But they don't get a reduced rate just because they can no longer work due to a military exception injury.

Now, the other problem is, under the SRCA, you cannot reconcile what your pay - with your entitlements. To do so, you have to get every Wage Price Index for the last 17 years and apply it to the amount, either in 2001, or the amount when you left the Navy after 2001.

And most people cannot do that. It took me about three letters and I don't now how many emails to get that information, and I'm an ex-supply officer. I know how to do the figures. It's impossible for the average Joe Blow to work out whether he was being paid the right amount or not. He just has to go to DVA and ask nicely, to see if he's right.

Now, the other big one is that the MRCA recipients receive a Defence Force loading of $7,900 a year at the moment. Now, this is a Defence Force loading for the amenities they've lost from leaving the military, either injured, or later receiving money under MRCA.

Now, I can't see a guy who was injured on, you know, before the MRCA came in by one week, and a guy who was injured one week after the MRCA coming in, having any difference in amenities. So why is it only paid to one group of people?

Now, when you add that to the difference in the pay, you're literally looking at tens of thousands of dollars a year, and for someone on a – say a younger military veteran, that can be a huge difference in his life.

The next one is AAT costs for – the Arbitration Commission, sorry. Costs, bother financial and psychological. Challenging a DVA decision requires lawyers, doctors, and other expert witnesses, which can result in many tens of thousands of dollars expense to the veteran. Even if you do win, DVA will only reimburse expenses they consider appropriate. So they will cherry pick some of the expenses.

During the hearing, the veteran has their past dredged up, a past they may be trying to forget, in front of complete strangers, and this is not a nice feeling at all.

In my case, the defence costs, my defence, my lawyer's fees and that, came to over $46,000. Now, DVA decided they'd pay back $26,000 of that when I won, because they cherry picked and set rates, which I wasn't informed of before the event, and this was my first time, really, using a lawyer in my life.

I had no idea where to go or what to do, and there was no assistance for anybody. So I wore a $46,000 bill, with $26,000 back. If I'd lost, I would have worn the whole bill. That's totally unfair. I mean, they made the wrong decision, I get to pay. Thank you very much.

DART. I can't remember what the acronym stands for.

**COMMISSIONER FITZGERALD:** Yes, I'm familiar with it.

**MR FOLEY:** I believe DART was a fantastic idea, because it actually looked at people, junior recruits. I was one of them as well. And it actually brought into the open some of the mistreatment that went on with very young people.

The problem that I see is that a person who was horrifically abused in some cases in these situations, and he couldn't get away, because it was illegal. You would be arrested by police should you leave Leeuwin, if you ran off. These people were even returned to Leeuwin, and yet the maximum payout's $30,000 for some of these people. That's ridiculous.

You know, you had – if you can see my notes there, I put in that $60,000 was given to a MP who fell off a pushbike in Canberra after being told not to ride it. You know, and that was way back in the 90s. Yet now, we're giving $30,000 to a guy who legally couldn't leave where he was being abused, and he was being abused under the care of the government as a 15, 16, or 17 year old person.

So I think that needs to be looked at, the rate of compensation that is given out to veterans over many different areas. We always seem to get the bottom of the stick. Politicians seem to get the top of the stick.

SRCA health care changes. A change went through in about 2014, which basically means that if you had a Gold Card under the VEA, or you had accepted conditions under the SRCA, and say you needed antacid. You would go to the chemist, buy your antacid, the one that worked for you. There are many in the system. And then you send in the receipt and you'd be fully reversed – reimbursed.

At the moment, thanks to this amendment, you have to go to a doctor, you have to have a full doctor's run up, they have to ring up VEA or SRCA, get a script. You then take the script to the chemist, pay the difference, the fee, the six dollar fee, and then receive what they can get out of the VEA or SRCA, and they only list certain items. And that's it.

So you don't get exactly what you need, and you have a trip to the doctor for no reason, for antacid, and this could be for stump bandages. It could be for anything, you know, and it's ridiculous. But supposedly, it was to help us again.

The big one for me is compensation payments and being cut by 25 per cent after one year. This is across both the compensation schemes, MRCA and SRCA.

At the moment, DVA pays specialist doctors to assess veterans' work capability, and then give work rehabilitation release where appropriate. So you go see a doctor, they – the DVA state, and they're the ones that say, yes, you can work or no you can't. Or yes, you can go to rehabilitation, no you can't.

Now, if the doctor has said that and you don't go to rehabilitation, or you don't go to work, or attempt to find work, they will cut your compensation because you're not fulfilling your part of the contract. Fair enough.

However, if your doctors says you cannot work, and you cannot go to rehabilitation, and you're still that way after one year, they will cut 25 per cent of your money straight out. What, it's cheaper to – by 25 per cent. My electricity bill doesn't go down. My mortgage doesn't go down. My school fees for my kids don't go down, and it's just a mandatory 25 per cent after one year. Why?

It leaves you in the position that you have a choice. Do I go to work against my doctor's orders, which would not be advisable, and which

could actually exacerbate your condition. Or do I not pay the mortgage, and lose my house? Or do I not send, you know, take my kid out of the school I want to send her to and put her in somewhere a lot cheaper? Or maybe I sell the car.

But why should I have to make those decisions after one year, when I'm probably in a very sad way, either medically or physically or psychologically. And this just hits you real hard. It hits your family as well, because all of a sudden they're having to tighten their belts by a huge amount of money.

The next one is advancement. If Able Seaman Blogs gets hurt, he will remain on the Able Seaman pay rate for the rest of his life if he cannot work again. And that, you could be talking of an 18 year old kid here. Is that fair? It's not his fault he cannot get progression. So he could be on $30,000, plus Wage Price Index, for the rest of his life. It doesn't really give him much of a start.

Now, why can we not put in where a person gets the pay side of the promotion up to a certain length. So maybe the average person would get promoted to sergeant, say, in Army terms. Why can that not happen?

Because these kids, they're left with nothing, and it doesn't have to be all the way to the top, because not everybody gets there, and it would just give them a little bit more to live their life. And that's a hell of a lot of a difference, someone to look forward to something financially than to be left in the gutter.

Superannuation. That same 18 year old bloke will have no superannuation payments for the rest of his life, if he cannot work. Now, the rest of Australia, it's in your PAYE. If you're a Pay As You Earn customer, you get superannuation from your employer. Most people who sign up with contracts get some sort of superannuation.

Now what the DVA, (indistinct) has done has classed us as PAYE for tax purposes, for Medicare purposes, and for Centrelink purposes. But when it comes to superannuation, we're not classed that way, and so they get out of paying any superannuation at all.

So you've got young blokes coming out who, by the time they're 60, will have nothing. Well, just about nothing. And again, I think that's totally unfair. The government is cherry picking certain parts out of what is a person's – it's a conditions of service and their employment package covers that, and the DVA is just ignoring that.

Another one that really irks me is when the government spends 100 million dollars on a museum in France, 150 million dollars on Centenary celebrations, and yet we've still got people living in the streets who are veterans. Why can't we prioritise the living over the dead, and I say that with all due respect to those who went before us, but I would rather see people who come out of Afghanistan now put in a house than some people traipsing through some place in France that we paid for, and I understand some of you may disagree with that.

Impairment payment recovery. Under the SRCA and VEA, as far as I understand it, you pay it for life. You know, if you took that early, say that 18 year old bloke again, and he's under the VEA or the SRCA, he pays that for life, as far as I understand. I may be wrong there, but I don't think there's any cap on it when it's finished. So it's like a loan that you never give back, which is a bit unfair.

My last bit, and I'm sorry I've taken a bit longer than I thought I would.

**COMMISSIONER FITZGERALD:** It's all right.

**MR FOLEY:** I'll read this if I can. Last but not least, I believe depression and suicide rates are increased in veterans who are financially threatened or insecure, when they feel mismanaged or ill-treated by DVA, and when they are ignored by the politicians that place them in harm's way. Financial problems cause a loss of self-worth. They cause families to breakup, and in doing so, deny veterans much needed family support.

When DVA knocks back a claim or pays some veterans' at lower rates than others, and continually makes changes to legislation that erode the entitlements of Veterans, you can get an even greater lowering of self-worth, increasing depression, family breakup, and finally, suicide.

When the politicians ignore veterans' pleas for equitable compensation, pensions, and superannuation, yet still pose for war zone opportunities, and continue to improve their own benefits, veterans feel dirty and used.

When Ministers spend money on commemorations and museums in far lands whilst we still have homeless veterans here in Australia, we can only wonder at the Ministers' actual commitment to us.

Please take action to rectify the areas I have mentioned, but especially the financial discrimination shown to SRCA recipients.

Thanks for your time and consideration.

**COMMISSIONER FITZGERALD:** Thanks very much, Daniel, and thanks for your submissions, both the recent one and previously.

Just a couple of quick ones if I can to start with. The difference between SRCA and MRCA, for those in the know, are significant. You're aware that we are recommending that, for most SRCA and DRCA – sorry, SRCA – sorry, DRCA and MRCA be merged into one Act, at a particular point in time.

The question for us clearly is, at what rate does the impairment payments get paid? So at the moment, you've got the DRCA rates, which are low. You've got the higher rates, which is under MRCA, and then you've got a midpoint.

So I can guess what you're going to tell me, but I'd like to know from you what do you think the rate for impairment should be if there is a merge of that going forward?

**MR FOLEY:** By impairment, do you mean compensation?

**COMMISSIONER FITZGERALD:** Yes. For injury, not incapacity to work, but impairment payments. So they're the lump sum payments that are available.

**MR FOLEY:** The lump sum payments are very rarely taken, as far as I know, and I would – honestly, it's the compensation side that's the big question for - - -

**COMMISSIONER FITZGERALD:** Incapacity side?

**MR FOLEY:** Incapacity side. It's people who cannot work. In most cases, you'd be mad to take the impairment amount if it impacts on your compensation side, because you may be off work for 20 years, 15 years, or partial work, or whatever. So I'm not really - - -

**COMMISSIONER FITZGERALD:** No, that's okay. I think you can. In fact, you get the lump sum payments and then there's the separate issue in relation to incapacity.

**MR FOLEY:** You may be right, sir.

**COMMISSIONER FITZGERALD:** But that's okay. No, that's fine. You've raised the differential between the MRCA and SRCA, and we're looking at that, and so thank you for raising that with us. But that

(indistinct) the question that we have to now actually answer, if we are going to go forward and have these merged Acts.

Your comments about two things. One is DART. I'm very familiar with DART, and DART was scheme that was established for those that were abused within the military, and I've met with many of those in the previous – I was the Royal Commissioner on the Commission into Child Sexual Abuse in Institutions, including in relation to the Defence Force.

Your point there is that some receive maximum payments, and I think it's up to $50,000. Some got $30,000, some got $20,000. Your point is that that's inadequate.

Those that were in fact victims of sexual abuse within the military were able to claim under the normal DVA arrangements as well, if there was, you know, incapacity – if there was impairment.

But we have heard that many that were successful under DART have been denied claims under DVA. You weren't referring to that in your - - -

**MR FOLEY:** No.

**COMMISSIONER FITZGERALD:** You were simply referring to the payments that were made under DART itself. Is that right?

**MR FOLEY:** That's correct.

**COMMISSIONER FITZGERALD:** Okay, because there is another issue that's in relation to that.

I should make the comment that we will look a little bit more about those that were sexually abused within the Defence Force in the final report. Not a lot, because it's been done by other inquiries, but we have had a number of submissions indicating people think that we have not paid sufficient attention to that group of people that suffered injury and harm as a consequence of their time in service.

The health care, can I just understand, because I'm not completely understanding. In 2014, you've indicated that SRCA was changed to help Veterans get non-prescription health aids and medicines. Your point there is it's the process by which you access is the problem? Not the actual benefit that's entitled.

**MR FOLEY:** Three things really, sir. First one's the process. They've added in steps that were never there before. I mean, to get antacid, you have to go to a doctor.

**COMMISSIONER FITZGERALD:** So they've got to be under a prescription instead of under purchase. Yes.

**MR FOLEY:** Yes. But the second one is, there's only limited choices. So, in some cases, different medicines work for different people. So one brand of antacid may work on – I'm using that – it may be one type of amputee sock is different to another sock, and doesn't rub for that person, or it doesn't give them an allergy. They have to go with the one that the Vet – is on the Veterans' scheme, because it's coming through as a script.

And the third part is, they have to now pay for the script, and that may not be much for each script, but over a period of time it can add up, and it's an amount, that especially if you're not earning that much, can add up, and you never had to pay before.

So there's three areas there, and it was supposed to help us so we didn't have to send receipts in, which you can actually scan and email.

**COMMISSIONER SPENCER:** All right. Thanks very much. Look, just a couple of questions. First of all, the point that you've made about the significant expense that you incurred as a result of appealing various decisions, and as we've commented several times this morning, Robert Cornall's report may or may not have something to say about that impact.

To give it a bit of context though, I think one of the things we're really trying to address is that, and I think everybody will be in agreement with this, that ultimately the only decisions that go to an AAT are those that are really clarifying points of interpretation or judgment, rather than mistakes or errors that have been made in an earlier part of the process, and this can always be improved no doubt with other suggestions. But part of what we're trying to do is to shift better decision making earlier in the process. Clearly it's going to be more effective. Clearly reduces stress. So some of the comments we've made this morning about ADR, alternative dispute resolution, bringing that forward is part of that.

The other point I just wanted to probe a bit further was the advancement point, and this may or may not have been brought to our attention before, I'm not sure. We have a team of about 18 working in the Productivity Commission, so there may be more, but it's a very interesting proposal you've made, that when people, particularly on low ranks they get, in the sense, quarantined into that for the future, and your suggestion about how

that might rise over time. I just want to clarify, it's always hard to predict what would've happened but I think you've suggested maybe in your longer document that in certain areas of the service there would be a predictable, reasonably predictable promotion path at certain levels in service and your suggestion is that be reflected in adjusted benefits over time. Am I understanding that correctly?

**MR FOLEY:** Correct. In the military to become, say, from able seaman to leading seaman would take between two and - when I was there, between two and four years, and most people would have been promoted to that rank in that time, and if they weren't then they probably wouldn't get signed back on again. That's the way it worked. Now I'm not suggesting that that person who was damaged, in recruits we'll say, would have become a leading seaman. What I'm suggesting is he had the chance to and that has been stopped by his injury. It hasn't been stopped because he didn't want to do it. It was stopped because of an injury. And I find that he'd been left on the able seaman rate, because I believe that's what they put him on, or the minimum wage under SRCA, and being left there for the rest of your life is - it just doesn't make sense. If he'd got out of the military normally or stayed in the military he would've progressed, whether it be outside, inside or whatever. And just because your life is put on hold by an injury doesn't mean that it would've been put on hold had you not had an injury. And I find it, especially for the young blokes, it's really - it must be so hard for them to know that, "Geez, I've had a major accident and I'm going to be on this amount of money for the rest of my life, plus wage price index, and they're going to take 75 per cent off me, and I'm not going to get any superannuation".

**COMMISSIONER SPENCER:** Thanks Daniel.

**COMMISSIONER FITZGERALD:** Just in relation to your point about mental health, can you just tell me what you believe or what your experience, both personally and dealing with other people, in relation to the mental health supports in the DVA space. In fact from your comments, your very last comments that you made, you've raised a whole range of issues and we're very acutely aware that mental health in veterans, particularly in the first five years of leaving the services, is much higher than in the general community and we're aware that there's been a lot of action to try to deal with that, including the white card being extended into service. Just anybody leaving service can access mental health services for the rest of their life if they so need it. But do you have any specific views about what we should be looking at in this space?

**MR FOLEY:** I will just tell you my background on this.

**COMMISSIONER FITZGERALD:** Sure.

**MR FOLEY:** When I left the military I had no idea about DVA at all and I was a lieutenant at the time and I'd gone through the ranks. No idea about any of it. It wasn't until I became incapacitated pretty well a few years later that someone, an RSL person, pointed me in the right direction. Now, from that, it still took another three months to get me into see a psychologist but I believe that was more the local area than DVA. DVA were happy to pay and all that, and you know that side was very good, and since then they kept paying and all along those lines. However, it's very hard to organise things when you're not really there, if you have an understanding. So as much assistance that can be given to a person, not just "Yes, you can go find someone to go" but "Here's a few recommended people", or, "Here's someone to help guide you on the way", or "I'll make the phone call for you", because some people are in a very bad way by the time they work out they're sick. And it's very hard for them to actually get out and do things like that, and so they might procrastinate and not do it for a while and things just get worse.

**COMMISSIONER FITZGERALD:** So what do you think practically would've helped you and would help a veteran that's leaving now that is likely to suffer or may suffer some mental health conditions in those transition periods? What do you think is of practical support or assistance to you or those people?

**MR FOLEY:** I think every establishment, unit, what have you, should have someone who pulls them aside and gives them the full rundown of what is available and how to access that. That's the first thing before they leave the actual - the military, because they really need that. Because when I left I knew nothing. The next step is, when they do front up at DVA - actually, no, I'll even go one further back. I think they should get a phone call one month afterwards, two months afterwards, and maybe one month and then six months, just to have them check in. Now maybe not DVA, someone they don't know, maybe someone from their unit. Maybe that same officer who told them about DVA, just to see how they're going, because if they can relate to someone they might actually give a few clues, "Well I'm not handling it quite as well as I thought". And then from there, if they do front up to DVA and say, "I need help", they're walked through the process. Now some people won't require it but there will be some people who do. And it's not always the guy who looks like he can do it is the guy who can do it. Some people go home and procrastinate, look through the phone book and three months later nothing's happened.

**COMMISSIONER FITZGERALD:** Any other final comments or questions, Richard?

**COMMISSIONER SPENCER:** No.

**COMMISSIONER FITZGERALD:** You've given us a detailed submission both previously I think and now you're talking to us today.

**MR FOLEY:** So just about every review that's been done, yeah.

**COMMISSIONER FITZGERALD:** Yes, well, there's been a lot of them. I should just say one other thing. This is the most comprehensive review that's ever been carried out. We are conscious of the enormous number of reviews that have happened. What we have deliberately tried to do in this is actually look at strict structures and systems. Everybody has looked at benefits or services, but actually it's the structure and the systems that allow good programs, good benefits, good anything else to be delivered. So we've taken a very different approach than some of the previous inquiries, but your comments are wide-ranging and we welcome them. Most importantly, I just want to pick up, as you are aware we have made the determination that people that are injured, whether they are in war or warlike or non-warlike or peacetime should be treated the same in relation to that injury to the extent possible going forward. I think from your thinking you would be supportive of that approach.

**MR FOLEY:** Definitely. I mean the people in the Black Hawk disaster in 1990 deserve the same as somebody anywhere else. They were wearing night vision - just as an example. Or the people on Voyager.

**COMMISSIONER FITZGERALD:** So the challenge for us is how do you achieve that, and that's a great challenge. Thank you very much for that. Thanks Daniel.

**MR FOLEY:** Thank you for listening.

**COMMISSIONER FITZGERALD:** And if we could have Rod Murray please. Good. Rod, if you could please give me your full name and any organisation that you represent, its name as well.

**MR MURRAY:** Rodney John Murray and I represent myself.

**COMMISSIONER FITZGERALD:** Thank you very much. If you'd just give us an opening statement.

**MR MURRAY:** Yes, from my submission, as you can see from my submission I've had a reasonable lengthy time within the Defence Forces and perhaps unusually I've been on the medical side of things for over 40

years and also a period of seven or eight years at the end of my career in occupational health and safety, particularly as safety manager at the Royal Adelaide Hospital and also as a SafeWork inspector.

With regards to Defence being responsible for rehab compensation and the levy to fund it, obviously I've pointed out a couple of things in there which I think are relevant, but most importantly I think is the fact that there will always be casualties with regards to war service or active service, and also for that matter with people who are actually doing the role of containing with the peace processes. But realistically, as far as I'm concerned I recommend that a veterans' department must be maintained, whether it be DVA or whatever name you like to call it. Certainly from my point of view I've had a very reasonable and relatively straightforward dealings with DVA, but Defence cannot be responsible for the total rehabilitation of their personnel, I think that's going too far. Yes, contrary to the principle, defence must wage war if and when necessary and continue to do so without distraction. And on that basis I believe that there must be a Minister for Veterans' Affairs and not subsumed into defence overall.

On p.2 of the overview the PC - sorry, I'll refer to use the PC if - - -

**COMMISSIONER FITZGERALD:** That's all right.

**COMMISSIONER SPENCER:** We're used to it, that's fine.

**MR MURRAY:** Between 17 and 18 the Department of Veterans' Affairs spent 13.2 billion supporting about 166,000 veterans and 117,000 dependants, which works out to 47,000 per client. What I've come to look at is how this cost comes about and its comparison to the civilian entitlements regime. Therefore, I've suggested that perhaps this overall cost really should be adjusted downwards to reflect such items as aged pension versus service pension, which is exactly the same thing, and so on down the line and, therefore, that will then bring you to what is the true cost of a veteran. So, therefore, there would be obviously most probably some slight or meaningful disparity between the civilian cost and the veteran cost but that would give a true picture of the extra money most probably being spent between the civilian-type compensation schemes and obviously veteran schemes.

The Gold Card. With regard to the Gold Card, obviously it's considered to be generous. I don’t believe it is but one of the things that you pointed out is that the cost of the Gold Card per person reflects the aging cohort, in that this reflects the older profile of VEA clients that are more or less all Gold Card holders, about 98 per cent are under the VEA. And the most common eligibility pathways for the Gold Card are via qualifying service

and age and being a dependant of a deceased veteran under various circumstances. Each of these are concentrated older cohorts of DVA. Now, once again however, when you look at the cost of the Gold Card, the Gold Card figures on the advice that I received from DVA are not adjusted downwards by the amount which would've been met by Medicare or the pharmaceutical benefit scheme and other obvious entitlements.

So my recommendation that the Productivity Commission should look at the appropriate data from Medicare to ascertain comparison to a similar cohort, and I think that's very important, a similar cohort, so that an accurate figure of the real cost of the Gold Card be obtained. And once that data has been realised, one of the recommendations that I have been putting forward for a number of years is that every veteran with qualifying service, and obviously that means that they will have been on operational service or active service, be given a Gold Card on discharge. Now, I don't think that overall cost may be that much different but, however, I think my bottom line on that would be, and this is an indication of what has happened with White Card and the ability to get post-traumatic stress actioned immediately, is perhaps that the bottom line should be when you leave with qualifying service you should have a White Card immediately, with the ability to go to a psychologist. But more importantly, I think, to also cover your GP expenses. You will find that the difference between accessing a GP in some areas, a lot of GPs do bulk bill but a lot of GPs don't. Now, for somebody who's come out of the service and is on a minimum payment or whatever system, perhaps that fact that they are going to have to pay another $40 or $50 to go and see a GP may prevent them, because of their resilience, in saying, "No, no, I'll keep on soldiering on".

Now, realistically I don't believe that that cost would be that much overall with regards to that, but I believe it would have some major benefits in that every person with their own GP, their selected GP, actually builds up a trust and obviously that GP gets to know that client very well. Now, I believe that certainly in this day and age GPs are much more better informed with regards to mental health and, therefore, they could potentially pick up on the fact that the person they're dealing with obviously has - possibly post-traumatic stress and, therefore, recommend to them that they actually go and get some help.

Now, if that in itself, by introducing that cost of carrying the GP is introduced saves just one person's life, I think it would be well worthwhile. And more importantly, I think in many ways is that, as I've pointed out, we do not know how many Australian veterans there are, and this applies not only here in Australia but also around the world. There is, I believe, going to be a question on the 2021 Census, as I was advised that

by the Premier of South Australia, and I would suggest that the Productivity Commission and DVA certainly have input into what question - what subsets of that question be put to the Australian public. But more importantly, the census however will not be accurate as there are many veterans who live overseas. There are, of course, many British citizens who were residing in Australia at the time of the first and the second national service, who served and may have returned to the UK or live in other countries. I recommend the government, by use of the UK media and the internet, try to reach out to those persons who are entitled to benefits. And this is one thing that I believe DVA and Defence have not done very well in the past, is to actually ascertain their client base, and there must be ways and means of advertising et cetera and getting in contact with more people. On that basis also I would suggest that in other countries where a person contacts an Australian embassy or consulate they could be asked whether they are a veteran. It's a simple one question that can be asked when somebody approaches a consulate or an embassy and obviously from that we can obtain more data and find out exactly how - as close as possible, as to how many veterans there are out there.

I have noted that obviously the transition process now is getting much better with regards to Defence and DVA actually sharing information and obviously that needs to improve greatly.

With regards to the comments about VCO and ESO cooperation and coordination, I've made a statement there about a particular incident but in my role as RSL Regional Coordinator I look after two regions, 15 sub-branches over 1,500 service members and there's a lot of cooperation out there. You'll find, like myself, I'm not only a member of the RSL but I'm also a member of the Vietnam Veterans' Association and also the TPI Association. There is a lot of cooperation, as you've already noted, and I was one of the contributors to the submission that was done first thing this morning. There are ESOs out there as well who are purely, as was stated previously, just unit associations and also I belong to one of those unit associations. And I think that's particularly a problem that we face, in that I am unaware myself of any unit association that has advocates. I'm aware of unit associations that do do a little bit of welfare, but how the Commission and how DVA and the government get all of these ESO's to concentrate perhaps more on advocacy and welfare, of course, is always going to be difficult, but realistically there are some major ex-service organisations out there and I think government would be wise obviously, where possible, to direct a lot of their efforts through those major organisations. Thank you.

**COMMISSIONER FITZGERALD:** Good. Thanks very much for that. Just a couple before Richard. In relation to, you're absolutely right that

the spend of $13.2 billion is a gross figure. It's not netted off against others. We would love to have those figures by the way, and if we're able to find the net cost then we would be very pleased because that's actually- you're actually right, that's exactly the point.

The second point I just want to make because I'm sure it's unclear is, our schemes will actually cost more. I've said to many veterans' groups, this is not a cost-cutting exercise. It's an efficiency exercise absolutely, but actually our proposals will cost more to government, not less. So anyone who is out there saying, "Oh, this is about cutting costs", I wish it were, it isn't, and it will cost more because we're including additional benefits for a whole group of people in the schemes.

But can I just deal with this issue, if I might. The Gold Card, we now have a White Card. The White Card picks up those conditions that have been agreed by DVA as having been service-related and it covers universally mental health. Some might say that in fact that is exactly the right way to approach this, that if there is a connection between ill health that should be compensated not only in terms of compensation but services. We agree, absolutely. So that's a well-targeted scheme. It identifies the problem, it provides the funding for the services and the hopefully you could actually access those services and we have other comments.

Gold Card doesn't do any of those things. It's very different in concept. It came out of a totally different era. Now, we're not recommending that anyone who currently has a Gold Card should lose it, absolutely not, but actually it's a design of a system when we didn't have Medicare, we didn't have robust health care systems. It's of a different era. So our view is at the moment is, is there better way of delivering targeted health services for those in need throughout their whole life. Our view would be the Gold Card is not an effectively, you know, it's not a well-targeted way of delivering health services, particularly for new veterans going forward.

So I understand where Gold Card came from. I fully understand why people are very loyal to it and are passionate about its maintenance, but actually it doesn't meet any good principles going forward. So can I just ask your experience in this. I'm not trying to devalue the importance of the Gold Card, but honestly, when you look at it, it doesn't meet the normal principles of supporting people based on any form of need including ill health or injury going forward.

**MR MURRAY:** I agree to a certain extent. The differential, however, I think is that when you're in the Defence Forces your health and your dental is covered all the time, no matter what. When you leave, you're

suddenly confronted with the fact, well, hang on, I'm going to have to take out private health insurance, you know. Who is my local GP? So this is one of the reasons why I stated previously that give the Defence personnel a card, the epitome obviously would be the Gold Card but the White Card in itself, why not that give that to them as soon as they leave so that the day that they walk out, they walk out with a card in their hand.

They can immediately then find out who their GP is and say to them, "Do you accept DVA charges for GPCs?". Then they can make a proper choice as to which GP. They may choose to stay with that GP because of other recommendations, even though that GP may not take the White Card, shall we say, for GP services, but I firmly believe that by giving just that little bit extra we will prevent certainly hopefully some of these suicides, and certainly make their transition into civilian life that little bit easier, just by having the GP content on a White Card.

**COMMISSIONER FITZGERALD:** And just to be clear, from what you're saying is, you can access a GP who bulk bills.

**MR MURRAY:** Yes.

**COMMISSIONER FITZGERALD:** But it's where a GP charges a gap or an additional fee that is the problem.

**MR MURRAY:** Well, it could be. It can be.

**COMMISSIONER FITZGERALD:** But that's the issue that you think should be resolved?

**MR MURRAY:** Yes, well, if you take the GP component out of the Gold Card, so in other words whatever the differential is. I've got no idea what that differential is. That's what I think needs to be put into the White Card.

**COMMISSIONER FITZGERALD:** The White Card. Okay. Can I ask the second question but it's related to that. You have to be able to access services whether you get the Gold Card or the White Card or anything else, and we've asked several participants about accessibility to services. You've indicated the issue about the price differential in GPs.

**MR MURRAY:** M'mm.

**COMMISSIONER FITZGERALD:** More broadly than that in South Australia, for example, are there serious issues in relation to being able to access other services, mental health or other services, or do you think that

in the South Australian landscape accessibility is not a huge problem? Or you may not have a view.

**MR MURRAY:** From my own personal experience, but this of course could be due to the fact that I've worked within the South Australian health system for a considerable period of time, I have never had a problem with the acceptance of the Gold Card. However, I do know of others who have had problems and this is through my position as regional coordinator.

I have heard directly from people who have been asked for gap payments, et cetera, and of course, I haven't asked the obvious question which is, "Did you actually make that gap payment?", because that's something that obviously DVA should be looking at properly, but there will always be a need for more services, particularly out in the regional areas. A lot of specialists do travel out to the regional areas, et cetera, but of course this is sporadic. They're not there on a permanent basis. Obviously it might only be once a week or once a fortnight that they're travelling out to the country areas.

**COMMISSIONER FITZGERALD:** Richard.

**COMMISSIONER SPENCER:** Yes, thanks, Robert. Rod, I just want to go back to your opening comments about the role of Defence, and this has come up several times today so I just want you to comment a little bit more on that and our thinking, and then put a question to you about that.

We would all agree, I think, that preventing injuries in the first place is a significant and important part of any responsibility of an organisation or an entity, and that usually is referred to as the duty of care, so in the civilian workplace that's the duty of care an employer has.

In talking to the representatives of another country's military system, they talked about the tension and the balance of duty of care but duty to prepare, and for what you and others have really referred to as the role that we ask the members, the men and women of the military to do on our behalf. So that's an acute tension that they're conscious of, that duty to prepare and duty of care.

So we have been trying to think of ways in which we can both provide incentives, but also help Defence, if you like, achieve a better balance. Now, there are things in place that do that. First and foremost is the capability to actually go to war, so clearly defence has an interest in maintaining health and welfare for that reason. The other incentive - sorry, I just lost my train of thought on that, but let me just come back to

that issue of where we're going and saying that unless defence understands the long-term consequences of injuries and what caused that injury it's very difficult for it to take action. It's well-meaning in trying to minimise injuries, but it may not be aware of what happens in certain training incidents and other training circumstances which can create that long-term injury.

So what we are suggesting clearly this morning, people are very clear they think Defence should just be simply focussed on their preparation for war. Are there other ways, do you have any other thoughts on ways in which defence could be assisting to strike that balance between what I've described as duty of care and duty to prepare?

**MR MURRAY:** One of the significant problems we face, both within Defence, but also in the civil area, this is from my experience on the rehab side of Royal Adelaide Hospital, is that no matter which organisation you have, you will always get under-reported, and if we can achieve a near to 100 per cent reporting of incidents then we will have a much better database on which to be able to establish which regimes will work better and which won't.

So therefore I think it's inherent on Defence to encourage all personnel to report any incident no matter how trivial it may seem because that can be a trigger of something else at a later date. It might be months later, years later, but it also may be the next day or the day after that they exacerbate that entry purely and simply because of the fact that they've reported it in the first place.

**COMMISSIONER SPENCER:** So is that a cultural shift that's needed, do you think, in order to encourage reporting?

**MR MURRAY:** Definitely a cultural shift to be achieved because one of the things is, obviously, resilience is the biggest factor with regards to how a Defence Force operates. You gain that resilience by discipline and by preparation, physical preparation, et cetera, but then that is carried over once you leave the Defence Force and that resilience itself is a barrier to trying to access appropriate treatment they will research and all that sort of thing.

So how we achieve that, we've got to change our culture a little bit. The culture of the Defence Force has certainly changed since my time in it. I've now been out since 2001, although retired, so technically I'm still in, but its culture has changed and its constantly evolving, but if we can get people to report, well, then, we get the data and therefore we can make changes.

**COMMISSIONER SPENCER:** Thank you. Just another quick comment on that and then a quick question. I think most people are aware that workplace health & safety legislation came into effect back in about 2012 and what struck us is, there was a fair amount of concern at the time that this would compromise the issue that's been raised here this morning about will that inhibit Defence's primary responsibility of defending the nation, but I think what we hear these days is that, no, it hasn't, but it's had a significant impact on reducing injuries in service and in training, so that was a - that's an interesting example of how defence can be assisted to try and strike that right balance.

I just wanted to go to the last comment you made about ESOs, and thank you for that story about how a woman who was in need or a widow in need was assisted because I think that that highlights something we're conscious of. Both Robert and I have extensive experience in volunteer organisations and we're acutely aware of what ESOs can do that government can't do for all kinds of reasons. Trust is a big part of that, and also people who know the experience and can come from that point of view which is extremely difficult for government.

So I think, once again, for those of you who are here representing ESOs, we would really encourage you to think about what kinds of services, what kinds of assistance along the lines you describe here would be beneficial for the whole system, and what could government do to help to assist or leverage the value that ESO's bring to that kind of support, and I just wanted to thank you for that story because I think it's a great illustration of something that can happen, cannot happen through a government intervention but it can happen through volunteer efforts that really concern people. So, thank you.

**MR MURRAY:** May I just add to that in that, I do Meals on Wheels as well, and one of the things that I've noticed in doing Meals on Wheels is that, in actual fact, we come into contact with a lot of veterans, and it's not because of what they are, but it's the memorabilia they've got around in their house, and therefore I speak to them not just as a deliverer from Meals on Wheels. I speak to them also from a veteran point of view.

Now, Meals on Wheels is one of those classic organisations, I think, which could help to find out how many veterans we have out there. It's just one of those simple little things that really Meals on Wheels do have the possibility of supplying us with more contacts we'll pay for.

Mate, and may I just comment on some of the things that I've heard today now rather than later or - - -

**COMMISSIONER FITZGERALD:** We're running out of time, so just if it's two minutes, yes. Beyond that, no.

**MR MURRAY:** All right. My transition out of, like many national servicemen at the time, mine was delayed somewhat because I've stayed in for a while, but most nonetheless servicemen of the second national service, the Vietnam mob, they got off the plane and, "We'll see you later, mate". Transition is the most vital part that we can do for the future of our contemporary service personnel.

Secondly, as far as the two systems are concerned that you're recommending, I absolutely agree with what you're trying to do. My argument would obviously be that you take the best of the DRCA and MRCA and that's what you should hold. With regards to under-reporting, I've already covered that. Yes, so, community obviously there is overlap, and just one personal touch as the previous speaker said, I go to the podiatrist. I have occasional tinea pedis. It's a common complaint throughout all services. Would you believe that the podiatrist, and this I believe is a problem because of the Podiatrists' Association and DVA, a podiatrist cannot prescribe Lamisil which is one of the treatment ointments, all right? I had to then go to the GP. Now, there's money being wasted every time a Defence Force personnel goes to the podiatrist with tinea pedis. All right?

**COMMISSIONER FITZGERALD:** Yes. Thank you for that.

**MR MURRAY:** Thank you.

**COMMISSIONER FITZGERALD:** Okay, thank you very much for that. We appreciate those personal experiences as well, so thanks very much, Rob. That's good. And if we have Ms Chloe Field, please. Cleo, you coming? You right? Have a seat there.

**MS FIELD**: Thank you.

**COMMISSIONER FITZGERALD:** Good, Cleo, if you could just please give me your full name and if you represent an organisation, the name of that organisation.

**MS FIELD:** Yes. My name is Cleo Field. I'm with the Partners of Veterans' Association. I'm the secretary of the South Australian branch and I'm also the South Australia representative on the National Board.

**COMMISSIONER FITZGERALD:** Okay, thank you very much, if you'd like to just make an opening statement that would be terrific.

**MS FIELD:** Go ahead? Thank you. Firstly, I don't know if everybody does realise that PVA is an ESO, and it is very essential that as partners we have a voice. I'm representing partners and families. First I'd like to say that we stand beside them, the veterans, and we'll fight for the respect and dignity that the veteran deserves.

I have given you an outline of the PVA submission which lists three points. I would like to bring to your attention the final point which is the recognition of partners. Can you please define "and families". "The widow and dependent child of a deceased veteran" is well-defined. The partner, while caring for a veteran, while they are suffering from a stress-related illness, is left to the public health system if they cannot afford private health. We feel if you use "and families" that should include the families of the living veteran.

The recognition of partners is about not only the mental or emotional health which is given help through Open Arms, but also the physical or clinical health issues caused by looking after the veteran. It is documented the depression, anxiety and stress that partners are under so it is logical that this leads to numerous stress-related illnesses such as Parkinson's, shingles, auto-immune diseases and secondary PTS.

Besides older studies most recently The Road Home has financed studies relating to the health and wellbeing of carers of serving and ex-serving veterans of our younger or newer veterans' partners. The results show that nothing has changed in regards to living with a veteran suffering from mental health issues. Stress-related issues are also documented in the female and family forums. We are thankful for Open Arms which is available to us for counselling but assistance is needed to keep the partner well so that they can continue to look after the veteran, hence saving the government a great deal of money.

Having a card, and we don't care what colour it is, would be used for stress-related illnesses. The aim is to keep the partner will, and in doing so will also benefit the veteran, and of course DVA, but to do any of this you firstly need to recognise the partner. Thank you.

**COMMISSIONER FITZGERALD:** Thank you very much, and thank you for your submission. So if I can just come to a couple of the other issues that you have mentioned.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** Can you just talk to me a little bit about, you've mentioned here a veterans' children education scheme.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** So do you just want to make a comment in relation to that?

**MS FIELD:** Well, at the present time the veteran's child, their rate changes when they turn 16. First of all, schooling these days, we feel that this is very antiquated. Not many children leave school at 16 any more, whereas when this was originally started that was the norm. Now that that's happened, when they reach the age of 16, the child then is taxed on that income that they receive, and this is purely a discrimination to the veteran, so we're asking that that be changed and we've been trying, fighting that for about 20 years now. So we think that now with this Commission it's a good time for change to happen, and that whole scheme, which I do believe was part of your review, is being looked at.

**COMMISSIONER FITZGERALD:** It is part of the review, and so is the second set of issues that you've raised which is home care services. Do you just want to, for the record, just indicate what you'd like to happen there?

**MS FIELD:** Well, we feel that there is no need for the two separate services which is the Veterans' Home Care and Household Services, and the Veterans and Home Care Entitlements. So we just feel that combining those, every veteran or every person that is entitled to home care services should have an OT come in and assess their home, whereas at the present time, the one has an OT that comes and assesses what their needs are. The other one is purely done over the phone, and so we feel that there is a lot that can be helped to keep the people in their home purely by having an OT come and assess the house.

And I can speak from a personal point of view from that one. When my husband had first approached with Home Care Services and we did have an OT come out, we were only asking for one thing. When they went through the house he was entitled to about six or seven different devices that we had no idea were even available, and it certainly helped to improve his value of life at the time.

**COMMISSIONER FITZGERALD:** The two schemes, as you say, the Home Care operates under the three acts, and the Household Services operate under two, and we are looking at this, but just clarify for me,

what's the difference in the purposes between the Home Care and the Household Services?

**MS FIELD:** The difference is that with the Veterans' Home Care and Household which is the one where they get the OT, that is to keep them in the home with whatever is available to them. The other service is more a house cleaning and gardening, and speaking about that, we'd like to see that gardening increased because it's at the moment very vague and we think that there are health issues such as people, if they only get very, very limited gardening, then they will do the gardening themselves which will cause extra injury to themselves, or if they can't - or they might need something done and it's a slippery area, they, you know, they can slip up and injuries. So we feel that it's a health issue to increase that gardening.

**COMMISSIONER FITZGERALD:** All right. Thank you very much for that. Richard?

**COMMISSIONER SPENCER:** Yes, just on the third point that you raised there, you mentioned Open Arms and the VVCS.

**MS FIELD:** Yes.

**COMMISSIONER SPENCER:** That's obviously just had that recent change of name, and from your comment I think you were very complementary about that, but do you have suggestions or any further recommendations about how Open Arms can be more responsive to the needs of carers and families and partners?

**MS FIELD:** Well, we fought for the Open Arms, it was VVCS then, to have a lifetime for our children to get counselling, and that's been very beneficial. Even now some of them are only going there now after many in their 40's and 50's, and we think that the newer veterans, I think they're only getting limited counselling for their children and for their families. So if that could be increased, I think, or included as to a lifetime, I think that that would be very beneficial.

We've also just recently had where separated and divorced partners, especially if they have dual custody with their children, can now receive that counselling, and why I say we're thankful, because it's the emotional side, but what we are asking for here is to be taken care of through a card for physical, the stress-related, and that's all we're asking for is the stress-related illnesses.

I can give you an example of one - the veteran who was not well at all had to go into hospital. His wife as also suffering from Parkinson's and

numerous she rattled, she was taking so many pills, but she had to be hospitalised as well. When it came time, when he was released, they were setting up, because she was in hospital, they were trying to set up for him, for a carer for him. He absolutely refused. He said, "No, my wife is my carer". So, she had no other option but to sign herself out of hospital and go home and look after him. That's just totally unfair that that sort of situation can happen. She got worse, but she was still caring for him because he was being looked after, he was the DVA client, so he was being looked after, but nobody was looking after her. So, this is our point, is that we need that card that is going to give us the assistance so that we can better and longer look after the veteran, look after our husbands or partners.

**COMMISSIONER FITZGERALD:** All right, thanks Cleo. If you were to do that, you extend the compensation scheme in a way that was ultimately never intended.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** And so I just want to push it because you will see from our draft report that we're not enthusiastic about that.

**MS FIELD:** Yes, I got that.

**COMMISSIONER FITZGERALD:** And I know that I'm going to get savaged in a couple of the public hearings coming up.

**MS FIELD:** I think you might.

**COMMISSIONER FITZGERALD:** But for us it's an extremely important issue, as it is for you. But it's very important because if you extend the benefits under the veteran support scheme, as we're calling it, there has to be a really strong rationale and there is huge cost implications on everything we do, notwithstanding the comment before which was actually valid, but it's the net cost. So, the question for us is whether or not you increase the level of services available, as Richard's indicated, through Open Arms and other means, which we're very open to, or you open up this entitlement to a wide range of new participants, partners.

So, what is it in the veterans' space that differentiates partners from other people, and I'm not trying to diminish the position but I want to just make it clear. Many people who have partners that are suffering psychological illness as a result of their work, that has enormous impacts on the partners and children and others and we know that many people in workers

compensation and other schemes when they're not able to work, particularly, suffer very high levels of mental health and that impacts on the whole family. So I'm not trying to say they're the same but I'm saying they're similar.

As a society we don't provide universal access to payments for mental health services. We simply say you access the normal services that are available in the community. So the question is this, and you may think that I'm naïve in asking it, but what is it that actually distinguishes the partners' stress, the partner's ill-health that needs a special card to support that? I understand stress exists, absolutely. You know, I had a long history of dealing with people that are in very vulnerable circumstances, including ex-veterans and their families, so I understand that. But does it warrant an actual card, a new entitlement, or does it mean that we have to improve the services that are available and the support mechanisms and, frankly, improve our mental health systems more generally, and as you know, the Productivity Commission is reviewing the whole of Australia's mental health system.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** So that's taking place as we speak. So I just really want to sort of push it back to you a little bit, not to dismiss your arguments but to get a very clear reason as to why we would extend it this far.

**MS FIELD:** Well, your last point, I think if partners were included in that I think that that would be suitable. We could cope with that. But I think at the moment, at the moment a very big issue is "and families" because for the living veteran we don't feel that "and families" is - should be included because we're not benefitting, we're not giving any benefit, so don't say "and families" if you don't mean it, or make it clear, because at the - you know, once the veteran is deceased - and I'm a war widow - so I understand, the widow is looked after. You know, there's areas, let's - yeah - but, you know, when my husband passed away it was they were there for me and I received benefits and it was very good. But for the living veteran, the partner doesn't have any support so we just feel like, except for Open Arms and we fought for that.

**COMMISSIONER FITZGERALD:** Sure.

**MS FIELD:** So, you know, we're thankful for it and for our children. But we just are feeling that "and families" needs to be defined and if you can define that somewhere then at least you have some structure to go by.

**COMMISSIONER FITZGERALD:** So let me be very clear. We include living partners in our definition of families. There's no question about that. But having said that, then you have to define the sorts of benefits or supports that you provide to members of that family.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** And that's where the rubber hits the road.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** And what you're asking for I understand. The question for us is, does it meet a threshold which warrants a significant increase in the level of benefits to an additional group of people within the veteran community? And that's the question. You understand that fully.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** So that's where we're struggling and we have struggled in the draft, and that's why it's so important that this next part we look at that more fully.

**MS FIELD:** Yes. And what we're looking for is that you just recognise what we're saying and we would like to be included in that new structure. If there's going to be a new structure, I think that we need to be included in that, and well defined where we are in that structure.

**COMMISSIONER FITZGERALD:** Could I just ask one other question. When you are the partner of an active service person and when you then - when the partner leaves service, discharges from service, do you and your members experience a really significant change in the level of support? Do you feel partners are well supported whilst their partner is serving and unsupported when they're not, or do you think, as some people have said, you're pretty unsupported the whole way through? I was just wondering whether you see that defining moment when the partner is discharged changes radically, the supports for the partner.

**MS FIELD:** Yes, it does.

**COMMISSIONER FITZGERALD:** And if so, how?

**MS FIELD:** Yes, it does, and it depends on how they are transitioned out. You know, if it's a voluntary transition that's a bit different because

they go through that. If they've been transitioned out through a mental or physical disability that is a whole different kettle of fish. And we speak to the spouses of the people who are doing the PTS program and they feel like they have just had their total rug pulled out from underneath them. They can't find support, they don't know where to look for support. These are the partners I'm talking about.

**COMMISSIONER FITZGERALD:** Sure.

**MS FIELD:** The veteran is being guided to a certain extent. I feel very much that Defence is getting it right. You know, they're taking these things into consideration now, whereas they weren't before. But it still means that the partner has to know where to go. She's left with her children who are struggling. She's not getting any support in any way. Most of them don't even realise that they can go to Open Arms; they've never even heard of that. So what was said before about the transitioning is very important and we strongly advise that during that transition process to make sure that the partner is there and hears what's going on because it doesn't always get - - -

**COMMISSIONER FITZGERALD:** In relation to that, we're at one, absolutely. We have made a number of comments about a radical change to transitioning but one of those has to be the inclusion of partners and family members much more actively and much earlier. So we fully support that.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** In relation to services generally, we've talked about Open Arms and Richard has indicated that, you know, that we've looked at that and as you say they're increasing a lot of the services. Is there anything in that space that you think they should be doing that they're currently not doing?

**MS FIELD:** Yes, but I couldn't give you any examples off the top of my head. This is something that we do speak about at our national conferences and recommend, and we have a representative on their board. So they're well aware of how we feel.

**COMMISSIONER FITZGERALD:** In relation to the ESOs, the Veterans' Affairs has this ESORT.

**MS FIELD:** Yes.

**COMMISSIONER FITZGERALD:** Do you feel that partners and

families generally are well represented in the policy forums of government?

**MS FIELD:** We make certain that we are.

**COMMISSIONER FITZGERALD:** Sorry?

**MS FIELD:** We make certain that we are. We're part of ESORT.

**COMMISSIONER FITZGERALD:** Right.

**MS FIELD:** And ADSO as well. And that's what we're there for. We're there to represent the partners. And we also think differently, which is a - - -

**COMMISSIONER FITZGERALD:** Sure.

**MS FIELD:** And sometimes we're swept under the carpet. Other times it depends on the issue; the issue and we feel strongly enough about it we'll hammer away at it with our velvet gloves and make certain that we get our voice heard. But we are very strong within ESORT and we find that they do listen to us and we're part of them.

**COMMISSIONER FITZGERALD:** Any final questions Richard?

**COMMISSIONER SPENCER:** No, that's good, thanks.

**COMMISSIONER FITZGERALD:** Any final comments, Cleo?

**MS FIELD:** I'm fine with everything.

**COMMISSIONER FITZGERALD:** All right, thank you very much for that.

**MS FIELD:** Thank you for - - -

**COMMISSIONER FITZGERALD:** We will now just adjourn for 30 minutes for a lunch break, it's an early lunch break I know, and then we'll go through the rest of the proceedings. Thank you. I should just say, we will be finishing at four, no matter what.

**LUNCHEON ADJOURNMENT**

**RESUMED** **[12.52 pm]**

**COMMISSIONER FITZGERALD:** Okay, we might start. Thanks very much for coming back, and Raymond Kemp. Yes, thanks, very much, Raymond. If you can give your full name and any organisations that you represent.

**MR KEMP:** Raymond John Kemp. I'm representing myself.

**COMMISSIONER FITZGERALD:** Terrific. Thank you very much. And if you could just give us an opening statement that would be great.

**MR KEMP:** Good afternoon, thank you for letting me talk here. On the key points, I honestly don't think the system is totally broken. Yes, it does need some fixing and that's in the liability side of the system. Once a veteran has completed that journey through the claims process, I believe the system works well.

I also believe the department itself is understaffed with full-time staff. There's just too many contractors there and they move in and move out of the department at their leisure which has caused us problems with doing claims, and the computer systems are totally updated. I've been on the phone with delegates and they might have eight or nine systems open just to answer a basic question.

I don't believe that the department should be moved to Defence. I believe it should stay with its own minister and own secretary. If we love the Secretary of Veteran Affairs and they become the Deputy Secretary in some department, we'll lose the impetus we have now and we won't get as much done for our veterans.

Also I don't agree with Defence being limited to premium. I totally agree with a Joint Transition Command. Transition is a problem, especially, I believe, with the Navy. I had an occurrence where a friend was just phoned up and asked to go to the front gate and hand his ID card in and that was his transitioning.

The Veteran Centric Reform should continue to be rolled out. I just think that there's a loss of interest in the online claims portal which advocates use to lodge their claims online. An applicant can't lodge for online service. He needs the client to be able to log on, so you can't do anything remotely if the client's not there. I personally believe if we're going to

move to two acts, which I like the idea of, we should be doing it sooner rather than later.

On draft recommendation 8.1, which is about the two SOPs. Initially I was for getting rid of one of them. However, I now believe, after hearing that, to move to the RH SOP, reasonable hypothesis, it's going to cost around about a billion dollars I was told by someone in the department. Therefore in all likelihood we'd move to the balance of probability because that's obviously going to save money. By going to one - if we go to the balance of probability it's going to knock a lot of veterans out of, especially serving, that had served overseas, out of getting compensation. For example, 25 year rules, 15 year rules for osteoarthritis, cancers, blood-related cancers where benzene's involved. So I'm now in favour of keeping both SOPs, and I changed my mind in the last couple of days after having a good think about it.

I don't believe we should get rid of the VRB. The VRB works well. There is a couple of problems with the VRB. One is they don't - the information isn't fed back to the department when a decision's overturned, and for instance, I've had five or six decisions overturned in the last 12 months in relation to submariners' and sinus barotrauma. Barotrauma is where you have sudden increases and decreases in pressure. Submarines have that happen all the time, and the SOP was changed in December '17 to include submarine service. Since I've been putting the claims in they all get rejected at a primary level and they're overturned at the VRB because once you explain to the VRB how a submarine operates they fully understand, but the delegates, they just overturn it.

I've got one at section 31 at the moment and they're seeking doctors' reports and that was an incident on the HMAS Onslow where a sailor was killed and the engine run on and sucked most of the air out of the submarine, so a massive barotrauma. I can't understand why, and I've sent the incident report through as well, so it shouldn't be just overturned.

I personally believe that a delegate, when he's about to reject a claim, he should ring the advocate and discuss with the advocate why he's rejecting the claim. Maybe there might be some more information we can get. Another medical report or something like that saves all the angst of going through the VRB and that.

The outreach program is excellent. Very few of my appeals now go through to a full VRB hearing. They're settled at outreach by just discussing it, and I've had a couple where I've withdrawn claims because I know it's not winnable once we start discussing it, but in general they're overturned and it's a good system.

That's basically my submission.

**COMMISSIONER FITZGERALD:** Thanks, very much, Ray for that. We very much appreciate it. Can I just, a couple of things, just the VRB experience, as you know, we're not getting rid of the VRB, but we are suggesting that it be changed in relation to its decision-making abilities, but can I just go back. In your more recent claims with VRB, you experienced some of their alternative dispute resolution procedures.

**MR KEMP:** Yes, that's correct

**COMMISSIONER FITZGERALD:** Can you just tell me about that experience and how good, bad or indifferent that was?

**MR KEMP:** Well, one of them took a phone call at half past 9. But within one minute we'd agreed and his comment was, "What do you want?". I said, "I want him to have 70 per cent, not 60 per cent disability". He said, "I've already worked to that he should be on 70 per cent disability by looking at the GARP", so we didn't even have to go through the whole procedure.

**COMMISSIONER FITZGERALD:** So look, one of the issues we've been looking at with the VRB is not whether or not it does a good job, that's not the issue, but the issue was for us to try and improve the original decision-making process. That's what this is all designed to do, and then to have a review process both through the VRB and the AAT, the more complex and difficult matters. But can I just use your example as a submariner. You talk about the incidents that happened. When it gets to the VRB it's accepted pretty readily.

**MR KEMP:** Yes.

**COMMISSIONER FITZGERALD:** Yet at the delegate level that's not happening.

**MR KEMP:** It's not happening.

**COMMISSIONER FITZGERALD:** So what do you think is wrong, what's going wrong in that?

**MR KEMP:** Well, they're reading the SOP and they're looking for the - and the factors in there, submarine, service in submarines which, before I got - I put the submission to get that changed, that had ascending or descending from a submerged casing, and when I spoke to the RMA said,

"Well, it's in there - the factor for a submarine's in there". I said, "No, we don't actually ascend or descend from the submerged casing. We're in a tube that has changes in pressures imposed on us by how we operate.

So they then say, "Oh, yeah, we understand that", so I put in a submission and it now says service in Australian submarines, but when it gets to the delegates, I don't understand why they reject it. You don't get a reason. They just say, "There's no medical evidence that you've had a barotrauma". Well, one of the problems is, on a submarine there's no, hardly any time would there have been medical documents kept. There was no doctor on board, no medic. There's a coxswain who had done a two-day course in how to apply a Band-Aid and generally a Band-Aid with a Panadol stuck underneath it, and that's - the paperwork wasn't kept, and everyone, especially if you've got a head cold, you would experience a pretty severe barotrauma (indistinct). You only have to have a minor head cold, but they want to see the paperwork.

**COMMISSIONER FITZGERALD:** So if the VRB makes a determination in your favour, you mention that one of the problems at the moment is the slowness by which that information gets put back to DVA?

**MR KEMP:** Well, all the materials go back to the delegate, so you may have - say you've got six overturned decisions for the same disability, it could go back to six different delegates, so there's no central repository that says, "All these disabilities are being overturned at the VRB. We need to look at why and what we're doing wrong", but because this person's not talking to this person, - - -

**COMMISSIONER FITZGERALD:** So one of the issues that we've identified is there's not a learning from the decisions of the VRB, and what you've just said basically indicates that's the case.

**MR KEMP:** That's correct.

**COMMISSIONER FITZGERALD:** But how do you think you can better educate delegates so that the initiating decision, the first decisions are likely to be more accurate because we've been looking at the rates of reviews and those sorts of things, so what do you think is the one or two things that you think at the delegate level needs to be attended to?

**MR KEMP:** Well, most of MRCA and VEA initial liabilities are in Melbourne. If a ship or submarine goes into Melbourne, then the department should be taking people down to have a look and see what these people are operating in. By the same token, take them up to Puckapunyal or whatever tanks are or aircraft and - Janice is not here, but

I've arranged for people here before they moved all the initial liability out of Adelaide to go down to ASC when a submarine's going out on refit and to get an idea what happens on it.

**COMMISSIONER FITZGERALD:** So it's really about that better understanding of the environment?

**MR KEMP:** A better understanding of the environment would be - and all delegates should go through maybe some little training course on that.

**COMMISSIONER FITZGERALD:** So you've mentioned the issue of Outreach which is really to seek additional information and talking to you about it.

**MR KEMP:** Yes.

**COMMISSIONER FITZGERALD:** I have to say, we think that's pretty stock-standard stuff that should happen much earlier than the VRB and we've recommended that. Why do you think that doesn't occur at a much lower level?

**MR KEMP:** Probably their workload. They've got a huge workload, some of these delegates.

**COMMISSIONER FITZGERALD:** Right, because we've heard that the outreach actually does resolve quite a lot of issues very quickly.

**MR KEMP:** It does.

**COMMISSIONER FITZGERALD:** Our view is that that should be internalised into DVA, as well as being done by the VRB. In your cases, that may have facilitated much earlier and different decisions.

**MR KEMP:** Probably would have saved six to 12 months in messing around with an - and also it's not that, it's the stress on the client.

**COMMISSIONER FITZGERALD:** That's right. Did you use an advocate during these processes?

**MR KEMP:** Yes, I did.

**COMMISSIONER FITZGERALD:** And how did you find that?

**MR KEMP:** I wouldn't have got where I was without an advocate.

**COMMISSIONER FITZGERALD:** And do you have a current claim at the moment?

**MR KEMP:** No.

**COMMISSIONER FITZGERALD:** You've had them all settled at this stage.

**MS KEMP:** Yes.

**COMMISSIONER FITZGERALD:** Okay, that's good.

**MR KEMP:** Mine have been settled since 2014.

**COMMISSIONER FITZGERALD:** 2000 and?

**MR KEMP:** Fourteen.

**COMMISSIONER FITZGERALD:** Fourteen, all right. Thank you very much.

**COMMISSIONER SPENCER:** Yes, just a couple of questions, Ray. What you're describing with DVA is in a sense, I'm not saying he's responsible for it, but it doesn't sound like it's fit for purpose in the sense that the delegates, there aren't enough delegates, lack of training, lack of awareness about issues, and you also raise this issue about contractors coming in and out. So is that a - so am I understanding that correctly, all of those factors are combining in a very complex system to be a bit of a recipe for confusion.

**MR KEMP:** Yes.

**COMMISSIONER FITZGERALD:** Stress, tension.

**MR KEMP:** I've found the permanent delegates do a far better job than the contractors. The incidence of rejected claims are less with the permanent delegates than - - -

**COMMISSIONER FITZGERALD:** You may not be able to answer this one, but do you have any - do you understand the reason why there are so many contractors or why there seem to be so many - - -

**MR KEMP:** I assume it's the government policy of staffing levels.

**COMMISSIONER FITZGERALD:** Right, okay.

**MR KEMP**: I've got no idea why the - that's just my assumption.

**COMMISSIONER FITZGERALD:** Right. Perhaps I can just go to something else and that is the - you've made the comment about the Veteran Centric Reform, it should continue to be rolled out. Your experience, because you've been dealing with DVA for how long now?

**MR KEMP:** As a client or as an advocate?

**COMMISSIONER FITZGERALD:** In both. Could you - - -

**MR KEMP:** Right, as a client since 2003 and as an advocate since 2011.

**COMMISSIONER FITZGERALD:** Right, okay, so are you seeing changes? Are you experiencing changes or significant improvements?

**MR KEMP:** I've seen one change and that happened last April where they changed the medical impairment forms and I put a submission in but it was too late for the review where doctors have actually refused it for that, that medical impairments because they're triple app forms, they're complicated. Instead of having four or five pages, they're now 30-page forms. That is a real problem that even the delegates are complaining about it saying that it's slowing the process down.

**COMMISSIONER FITZGERALD:** Right.

**MR KEMP:** And they repeat themselves. They'll ask the same question on each page because you're doing a different injury, instead of lumping the things together and that.

**COMMISSIONER SPENCER:** Right, and Ray, do you intend to continue to be an advocate or what's your - - -

**MR KEMP:** I'm planning to go until I'm 70.

**COMMISSIONER SPENCER:** Right. I won't ask when that is.

**MR KEMP:** Six years.

**COMMISSIONER SPENCER:** Okay. There we go. Thanks.

**MR KEMP:** Five and a half.

**COMMISSIONER SPENCER:** Right. So can I turn your mind to the question of the future of advocacy? It was mentioned several times today. Robert Cornall's report will be hopefully due out shortly so we'll see what his inquiry is going to recommend, but from your point of view what needs to improve, change, be different around the advocacy system in the future, and I just think, initially just thinking about advocacy for claims.

**MR KEMP:** Well, on a region-free implementation group, so that's a group of advocates, so ATDP, and I know there's a lot of people that don't like it, but personally I think it's training a better advocate. It's just some of the workload it's putting on the advocates so for mentoring and that's a bit of a problem, but the outcome, we could better train volunteers. I see a need for volunteers. You know, if you have all paid advocates then I don't know if you're going to get the passion that volunteers have. You know, if you have all paid advocates then I don't know if you're going to get the passion that volunteers have towards advocacy.

**COMMISSIONER SPENCER:** How do you think that should be addressed though? Because we've heard from a number of ESOs that are involved in advocacy that the number of advocates who are volunteers are diminishing and we're not seeing the younger ones come through, so - - -

**MR KEMP:** Well, that's a problem. I don't know how we're going to do that, but I'm a volunteer and I'm very passionate about it. The only reason I'm saying I'll go on to seventy is I think by then I'll be starting to lose the edge, you know, and there's people out there I think are too old to be doing it, and, yes, I don't know how we're going to get the younger people in. I honestly don't.

**COMMISSIONER SPENCER:** No.

**MR KEMP:** The only time you see the young people is when they've done a claim and they've stuffed it up and they want your help with it, VRB. They'll go off and do their claim and I see them come to me with 20 or 30 injuries where, you know, you're claiming for a broken fingernail sort of thing where you don't need to claim all that stuff. You know, you go for, I believe, the big stuff that's going to hurt you later on in life, but a broken finger is maybe give you a bit of arthritis or something but it's not big, and they then come to me ask me to help them get them out of trouble because they mess up the whole claim.

**COMMISSIONER SPENCER:** So do you think they've been well advised before leaving, before discharging?

**MR KEMP:** I don't think they've been well advised at all.

**COMMISSIONER SPENCER:** Okay. So sometimes we hear it's a little bit of in a generational issue. Veterans want to do their own thing, but your experience is they don't seem to be fully aware of what their rights are, how advocacy can assist, and so they tend to come to you when there are problems.

**MR KEMP:** Yes.

**COMMISSIONER SPENCER:** Okay.

**MR KEMP:** Now, I've been told this by some people, when they deploy they have a – meant to have a one-on-one psychological, you know, talk and then when they come back they then have a one-on-one, but I believe it's all in a room, and whose got psychological problems. Well, none of them are going to say they've got psychological problems, so when it gets to a claim the department has got this form saying that, "You went to Afghanistan but you come back with no problems". Well, it could take years to come on but they're not going to own up because they could end up getting discharged as well.

**COMMISSIONER SPENCER:** Yes. Yes.

**MR KEMP:** I think the Army, from what I understand, has got a better transition system than definitely the navy. The Navy system, from what - - -

**COMMISSIONER SPENCER:** Right. Right.

**MR KEMP:** And from my experience 20 years it's just not very good.

**COMMISSIONER SPENCER:** And you know of the Joint Transition Command and you've indicated in your submission that you're in favour of that.

**MR KEMP:** Yes.

**COMMISSIONER SPENCER:** And that it should be the responsibility of Defence?

**MR KEMP:** Yes.

**COMMISSIONER SPENCER:** And just a quick one, we suggested that that period of responsibility go for six months. We've heard earlier today that the suggestion should be longer than that. Do you have a view on it?

**MR KEMP**: I think it should be at least 12 months.

**COMMISSIONER SPENCER:** At least 12 months, all right. Thanks very much.

**COMMISSIONER FITZGERALD:** Certainly through that joint transition thing we hope that Navy, Air Force and Army do a universally good job as distinct from only one of those three at the moment.

Can I just, in relation to your statement of principles, the SOPS, I understand your position. We're looking at obviously various different permutations of that and looking at the costs of those. If the costs were of a lower order – I don't know where that figure came from, but if it was a lower order your view is that if you went to the reasonable hypothesis test you'd only need the one standard, I presume? If you went to the lowest test then you'd only have one obviously. And your concern is you have the two, either it goes to the balance of probabilities and some people would miss out, or it's going to be too costly. That's basically your position.

**MR KEMP:** And I can use an example of that. On the Friday before Christmas I had a phone call from a veteran down south, that's TPI, he's just had an operation on his leg and he needed an electric wheelchair or a gopher because he was on a pretty big slope, and his wife couldn't get him down the slope for six to eight weeks. If he damaged his leg he would've lost it. Now, to get an electric wheelchair or a gopher you have to have an accepted condition. He didn't have it. Osteoarthritis is an accepted condition at that stage. Under the system at the moment, because he's a Vietnam veteran, without the 25 year rule, I would've been able to put in the claim, got his osteoarthritis of the ankle, accept it, and he could have got his gopher, electric wheelchair. If we go to the balance of probabilities he's outside the 25 year rule, nothing.

**COMMISSIONER FITZGERALD:** Okay.

**MR KEMP:** And so I have no musculoskeletal accepted conditions myself, but if in years come I lose a leg and I need something, as a returned veteran with qualifying service, I could put in under the RH SOP and get it, but if we go to balance of probabilities I'm stuffed too.

**COMMISSIONER FITZGERALD:** Okay. Thank you very much for that.

**MR KEMP:** Yes.

**COMMISSIONER FITZGERALD:** Any other final comment or you've said - - -

**MR KEMP:** No, I was a bit lost when all the stuff about Gold Card. There's something in one of them about co-payments. Now, that would mean everyone would have to go and get every disability known to mankind accepted to – and that would cause a lot of work as well.

**COMMISSIONER FITZGERALD:** Yes.

**MR KEMP**: You know, if you wanted to cover osteoarthritis, knees and knee replacements and that. So that was one of my concerns, the co-payment thing. I don't know what you were thinking, how you were going to work that.

**COMMISSIONER FITZGERALD:** Well, we're looking at the whole health thing now in detail, and it's very complex.

**MR KEMP:** Yes.

**COMMISSIONER FITZGERALD:** So thank you very much for that. And, again, thanks for your written submission as well. We'll now move to John Simmons.

**MR KEMP:** Thank you for having me.

**COMMISSIONER FITZGERALD:** Good. Thank you. Good. John, if you could just pull the middle microphone just a bit closer to you, that'd be great. Thanks. John, if you can give us your full name and any organisation that you represent.

**MR SIMMONS:** My name is John Bradley Simmons. I did, up until last week, represent Ex Military Rehab Centre at Edinburgh.

**COMMISSIONER FITZGERALD:** And today?

**MR SIMMONS:** Just myself today.

**COMMISSIONER FITZGERALD:** Just yourself, okay. No, that's fine.

**MR SIMMONS:** Still intend to make a brief submission about XMRC, but it's - - -

**COMMISSIONER FITZGERALD:** That's fine. No, that's good. If you want to make an opening statement that'd be perfect.

**MR SIMMONS:** I guess largely I agree with a lot of the comments that Ray and many others have made regarding DVA. I'm probably unfortunately known for being one of the people that dislike DVA the most. I notice that Janice Filby vacated the room when I walked so that's probably a fair indication.

The system itself would probably work fairly well if there was a significant cultural change within the staff at DVA. I think that's probably what most people would argue is that the culture within is so old and crusty, for want of a better word, that it just continues to fester and doesn't really change. We have a vast issue with DVA that when somebody gets significantly upset they're sin-binned. They're put to what is known as the client liaison unit or the managed access department where your restrictions are significantly, or your contact with DVA is significantly restricted. This ultimately, I guess, gives DVA an upper hand in how they deal with what they believe are difficult or significantly difficult clients. This also gives them fairly good ability to call the police whenever they wish upon the person that they've put in the sin-bin as such, which ultimately means that you have no right to question the delegate or their decision.

I don't believe that changing DVA to a system managed by Department of Human Services or another entity is going to work. DVA needs to remain an independent. It needs to have its own authority the way it sort of stands at the moment, but, again, we've just appointed a new secretary who, in essence, has been a part of this same festering system for some time, and I don't think we're going to see the change that we need to see while we're just promoting within the same crusty people.

Transition systems, especially in this State, I guess considering where XMRC was located out at Edinburgh the system is drastically flawed. We have a couple of part-time officers, who deal with the transitions of members that are in service with the Army or Air Force. There's a part-time warrant officer out there that assists with claims advocacy, and the manner in which that claims advocacy is done, as Ray said, there's a lot of young guys trying to do their own claims, and those claims are basically coming out as handfuls of rejected documents, and it's simply because there's a drastic lack of understanding of what they're filing for.

And I guess the last thing about it all is the CDDA, which is the claim detriment caused by defective administration, I think, largely if a lot of people knew what this process was we would be raising a lot of these

issues through an alternate means, I guess, rather than senate inquiries and ultimately these sort of Productivity Commissions.

The claim for defective admin, if they weren't administered via DVA themselves, we would probably find that a lot of these issues would be corrected, but it's basically the perpetrator investigating the perpetrator and they're almost always going to find that they've done no wrong.

**COMMISSIONER FITZGERALD:** Thank you. Any other comments?

**MR SIMMONS:** No.

**COMMISSIONER FITZGERALD:** Can I just deal with the last one first. Have you had any personal experience, either for yourself or people known to you, that have put in claims for defective decision making?

**MR SIMMONS:** Yes, I've done two.

**COMMISSIONER FITZGERALD:** And tell me a little bit about the good and bad of that.

**MR SIMMONS:** So the first one I did was in relation to a permanent impairment claim that I had. The claim was initially rejected and then it took 329 days for that claim to be reviewed internally by DVA. The DVA staff, when I filed it to the AAT, Janice said to me to withdraw it, and they would internally review my claim rather than it go through the AAT. This was a blatant lie, because there was no process that allowed for that type of internal review according to their own then senior staff.

So I filed a claim, the claim exceeding the amount that can be determined by DVA staff. It had to be determined by the Minister. It was then determined by a Ms Caroline Spears, who used to be the principal legal officer for DVA, and she declined it on the grounds that I had other avenues of compensation which there were none.

Second time around it was the same claim. It had been – the claims themselves take over a year. They take about 16 or 18 month on average to be dealt with. Again, this one shouldn't have been dealt with by DVA and it was dealt with by Liz Cosson herself, and she declined it saying that they don't pay compensation for excessive delays, despite the fact that we've got CDDAs to other people where they have paid for delays.

**COMMISSIONER FITZGERALD:** If you had proceeded down the path of going to the AAT obviously you don't know what the outcome of that would've been but would that have been a better process?

**MR SIMMONS:** Well, it did go to the AAT as an alternate resolution process. The AAT doesn't compensate you though for delays. It will only overturn a decision made, so that's why the CDDA was filed. Ultimately the decision by the AAT was found in my favour fairly briefly. It didn't even go to any formal hearings. It was decided at an early directions hearing that I was correct and ultimately that a failure had occurred within DVA. They hadn't considered all material.

**COMMISSIONER FITZGERALD:** Did you at any stage receive an explanation from the department as to why the claims were taking this excessive period of time?

**MR SIMMONS:** No. It was – sorry, I shouldn't say no. Initially I wasn't. It was only in November last year when I complained fairly heavily to the Prime Minister's office, which eventually made its way back to Liz Cosson. I was spoken to by a Bobby Campbell, who is now Liz Cosson's right-hand man, and she gave me an excuse that my file, because I'd been dealing with DVA since 2000, was a paper file. The paper file had been transferred on numerous occasions between Ministers, DVA in Perth, Brisbane, Melbourne, Adelaide and New South Wales. Then they went on to say that there was also delays because of my file being on the computer that different people were trying to access and couldn't which contradicted the earlier statement that my file had been, as a paper file, had been passed around on numerous occasions. I FOI'd the cover of my DVA file, which doesn't indicate that it had been passed around the amount of times that they had claimed.

**COMMISSIONER FITZGERALD:** You mentioned that those that are causing difficulty as claimants end up in the client liaison unit or somewhere else in DVA. Can I ask whether you were one of those?

**MR SIMMONS:** I am.

**COMMISSIONER FITZGERALD:** You are. And you said the consequences of that means that you're not able to deal directly with delegates and others. Who do you deal with if you end up in that particular spot in DVA?

**MR SIMMONS:** We're given a handler or a single point of contact. In the past year I've had eight different single points of contact.

**COMMISSIONER FITZGERALD:** All right. Are they called case managers?

**MR SIMMONS:** No, now they have a title of managed client coordinator. But they used to be client liaison officers.

**COMMISSIONER FITZGERALD:** You indicated that you believed that the core of the problem with DVA is culture, and you indicated that's largely because of the nature of the personnel. When we were looking how you might re-structure the governance of this area, we looked at alternative schemes that exist in commissions and statutory authorities and they operate quite differently to DVA. They have very different cultures and they operate in very different ways, drawing on best practice from other areas. You don't seem to think that would be an adequate response in relation to the administration of claims, putting aside the police and all those. Is there a particular reason why you don't view that as a possible improvement?

**MR SIMMONS:** I guess the personal experience with XMRC, I was doing advocacy but from a law base. I'm studying law. I guess the big issue is that in trying to move this somewhere else, and to Department of Human Services or something like that, it would significantly concern me to try and take ex-service personnel and put them in a Centrelink office to wait and deal with a person. I think the biggest issue that most of the people have identified is the lack of knowledge by delegates. So regardless of where we move the policies to, unless we have a cultural change we're not going to gain a front foot.

**COMMISSIONER FITZGERALD:** Okay. And I should just make this point clearly, we're not recommending that the administration of the scheme go entirely to the Department of Human Services, although the Government is contracting many of the back office functions to that agency.

Can I ask one other question, and then Richard might have – the Ex-Military Rehabilitation Centre, you were there until last week. Can I understand the nature of that organisation?

**MR SIMMONS:** So it's basically an organisation run by volunteers. As part of it, it has a men's shed and workshop. It also has a large mess hall where ultimately people can come to participate, have a feed, meal, catch up. We now have a full-time qualified advocate out there. A lot of what, I guess, myself and a couple of others deal with is ex-service people that are imprisoned or going through significant legal issues, homeless – yes, I guess it's a fairly broad centre that offers a lot of assistance rather than just a refined either advocacy or welfare as such.

**COMMISSIONER FITZGERALD:** So I do want to ask one other

question, and that is during your processes you didn't mention the VRB. Did you have matters dealt with through the VRB?

**MR SIMMONS:** Mine were all AAT matters, so they're all under what was SRCA and now DRCA.

**COMMISSIONER FITZGERALD:** Thank you very much.

**COMMISSIONER SPENCER:** John, I just want to go back to, as you know, what we're proposing is a Veterans Services Commission, which would be veteran centric. We have looked at best practice in a whole range of other schemes, and in our view at this stage we believe that that structure would bring the capability together that you feel is missing from DVA at the moment, very much with a board that's accountable, CEO reporting direct to the Minister, so has authority as well.

I guess I come back to a fundamental question, and that is that DVA's performance over a long period of time, in fact it could be argued for decades has been subject to numerous reviews and often quite a lot of criticism. So you can say, well that's about their performance and the performance needs to get better, and there are ways it can happen. Or there is something that is fundamentally wrong with the structure.

So part of our thinking in all of this is that a departmental structure does not lend itself well, because a lot of constraints, some of which you mentioned yourself, to really (indistinct) a best practice scheme in the best interests of veterans. So behind our thinking is that setting up a Veterans Services Commission is a way to get through the issues that you've been describing, which are longstanding.

So when you say, "Well DVA has got to change, the culture's got to change," I mean part of our thinking, and so I'd just like to get your response to this is well, this has been talked about for decades. What gives you optimism or hope that change at this point would happen? I mean the VCR, everybody who's looking at the VCR says that's good, there's been good progress. Too early to say whether that's going to be, you know, ultimately transform the department in a way that many people would like to see. But we think there are inherent limitations in the departmental structure. It's not done in any other scheme involved with compensation around Australia. They're all in bodies like a Veterans Services Commission, dedicated to that group.

So my question I guess is you know, from your experience with DVA, which is not – obviously, you know, you're describing not a very happy

experience. What would give you hope or optimism that that could change? Or is it, are we going to be here in five or ten years' time again?

**MR SIMMONS:** We're probably going to be here in five years' time at least. I'd say that this is probably something that's going to be a seven to ten year process to try and get anywhere. I think it's a very outdated system as it is, and I think it would be unrealistic to expect anything in under five years to change so significant to stop us coming back and revisiting this sort of exercise again.

I guess I'll read just a brief piece from this, and this is my personal experience with DVA, is I got my entire DVA file FOIed. And one particular page says, "I want to write to him and tell him he won't get incap and will wait for final med board before we consider PI assessment."

The next line goes on to say, "I have spoken to Q and he doesn't want to do anything, not even the vocational assessment, unless he has to." The following page to this said, "Don't give him anything. He's not entitled to anything."

That's why I say there's a cultural change. What we now see with DVA, and this has been in the short term, and I guess one of the big things which is a significant, hopefully saving grace for a lot of cases is the Veterans' Payment system. This was written when I discharged. Back in 2000, I discharged with nothing. I was homeless, my parents ended up taking me back in after Defence. The thing we see now is that DVA, with Veterans' Payment, they are getting something which is stopping I guess a lot of guys becoming immediately homeless after Defence when they have nothing.

So I guess that gives some very little optimism that reforms are happening, but I think we still need to be fairly broad-minded to see the larger reforms happening, and I guess ultimately that's why I say if we can start to make these small improvements, that will amount to a larger, hopeful reform somewhere along the line, but I don't see it being too immediate.

**COMMISSIONER SPENCER:** Okay, thanks, John. The Veterans' Payment to which you refer is the new interim arrangements, is that right?

**MR SIMMONS:** Correct.

**COMMISSIONER SPENCER:** Yes. Yes, that's fine. Have you, through the Ex Military Rehabilitation Centre, seen any significant

improvements in DVA as a consequence of the Veteran Centric Reform process that's now been in place for around two years, and it's got a while to go. So at the grass roots level, your level, have you seen any noticeable changes?

**MR SIMMONS:** Without being offensive, not really. I think a lot of it is still just a lot of people are blowing hot air, and we're not really seeing too much.

**COMMISSIONER SPENCER:** You mentioned, and somebody else mentioned earlier, that young veterans are putting their own claims in and having difficulties with those. Why would young veterans not be using either the current advocacy services, or systems that are available?

**MR SIMMONS:** At the risk of offending some people in the room - - -

**COMMISSIONER SPENCER:** It's all right. We do that all the time, it's okay.

**MR SIMMONS:** I do it all the time as well. So I've just got to apologise in advance. I guess a lot of the people that I deal with at the moment are all contemporary veterans. I don't really have any that are under the age of 35. I think I'm still older than most of the ones I deal with. They don't like the stigma that's attached with RSLs. They don't like going to, I guess, an older veteran who they feel may judge them based upon the clash of experiences between the pair. So I guess there's been that cultural issue as well within the public's mindset, which has probably filtered through to a lot of veterans, that Vietnam veterans fought one fight and won the war, and these guys have fought another one and a lot of them won't go and approach them on that basis, so they will try and nut out their own claims. And then once they're in so dire, they give up or they'll end up going to an older veteran, and we have that issue that yes, I guess some of those claims are pretty untidy and do take a little bit of work.

**COMMISSIONER SPENCER:** Sure. The MyService initially is meant to reduce the need for applicants. It doesn't eliminate advocates obviously, and we're very supportive of many of the advocates. But have you noticed, or are you getting feedback that those sorts of processes are helping younger veterans, or not really?

**MR SIMMONS:** I guess a lot of the younger veterans again that I deal with are finding MyService and the old MyGov version still relatively easy to upload claims. I think it still just comes down to the fact that they don't really know what they should be providing with the claim. If they were to take the pages from them, their Defence med records, which is the

recorded history of the event, that would ultimately tie down a lot of the links, or the casual link to service that DVA want to see in things like that. So it is helping a lot, but there's also a lot of education that's still needed for some of these guys.

**COMMISSIONER SPENCER:** Sure. And the issue in relation to transition, if I can just come back to that. We've made significant recommendations in relation to transition, including a new way by which that's dealt with in defence. Do you believe that – have you seen any significant improvements in the way in which young veterans are being discharged and transitioned in the last year or two?

**MR SIMMONS:** I guess most of the experiences I've got with people transitioning are nearly all the negatives. I mean I can give brief – without specifics. One digger that I've got at the moment was being administratively discharged.

**COMMISSIONER SPENCER:** Right.

**MR SIMMONS:** He's medically not fit on the grounds of mental health. There should be – well under the transition, there's supposed to be a three month discharge period. The unit wanted him out so they could refill his position, so they changed it to two months, which obviously short-changed him the ability to then have all his arrangements met in time to discharge, which ultimately has led to a significant failure and suicide attempt.

**COMMISSIONER SPENCER:** Right. And my last question is, it's not one that you've mentioned, there's – we've asked throughout the day about access to health services. Your experience in relation to being able to access rehabilitation and mental health services generally within the South Australia context?

**MR SIMMONS:** I guess mine is probably – and I don't know what others have said. I've had ten operations on one knee. I finally had a replacement done in 2017. I've been on opioids for four years straight because of it. The lack of understanding that comes from I guess a lot of these organisations. I tried to consult with VVCS. They don't understand the difference between mental health and pain aspects. So that particular night in September, I had 86 opioid tablets between Tramadol and Endone. I tried to consume them all, so that's probably answering what it is.

It got to the point where yes, I wasn't getting the help that I thought I needed. It was falling on deaf ears, so yes.

**COMMISSIONER SPENCER:** And if I could just follow on from your personal experience there, what would have made a difference for you, or for people in similar circumstances to that which you - - -

**MR SIMMONS:** Sorry?

**COMMISSIONER SPENCER:** What do you think in the system would need to change to have made a difference for you, or for people in similar circumstances?

**MR SIMMONS:** I think the biggest issue is there's just what appears to be a lack of understanding of pain and mental health. Pain, and this is one issue, one reason why I'm in CLU, is pain causes you to become aggressive.

**COMMISSIONER SPENCER:** Sure.

**MR SIMMONS:** Pain causes you to become tired. There's - the flow-on effects from pain to mental health are massive, so – and a lot of people don't seem to understand that one sort of goes hand in hand with the other, and you'd end up with I guess ultimately, in my position, is flying off the handle at DVA delegates, being labelled as a "significant risk" and then in the back of a police divvy van, so.

**COMMISSIONER SPENCER:** Good. Is there any other comments or any other questions (indistinct) ask after that?

**COMMISSIONER FITZGERALD:** No, that's fine, thanks.

**COMMISSIONER SPENCER:** Any other comments, (indistinct)?

**MR SIMMONS:** No.

**COMMISSIONER SPENCER:** No, that's fine – sorry, John, I should have said. So sorry, thank you very much for that, John.

**MR SIMMONS:** Thank you very much.

**COMMISSIONER SPENCER:** That was terrific. Thank you very much indeed, thank you. And we'll have Les Smith, please.

Good, thanks Les. If you could give your name and any organisation's name that you represent.

**MR SMITH:** Yes, no worries. I'm Les (indistinct) Smith, and I'm representing myself.

**COMMISSIONER SPENCER:** Terrific, thank you very much. Les, if you just want to make an opening statement, that would be terrific.

**MR SMITH:** Yes, my opening statement is to do with compensation, and when does compensation become a loan that you can never pay off.

In 1991, I was a very fit infantry sergeant at Keswick. I'd done over 20 years' service as an infantry soldier. In 1991, I had the misfortune of doing my back in and I had to have two back operations. After six months, I was back in uniform and I was approached by compensation if I wanted to take a lump sum compensation payment, which I did. They offered me – I was assessed at 9.6 in how the system works, and I was offered $54,136.

At the time, I was on a White Card 60 per cent pension, which was $120. Two weeks later they said, "Okay, here's your money, nothing's going to happen." Two months later, I got a letter from compensation saying, "We have notified Veteran Affairs. You cannot have two bites of the cherry. We need to find out if you've been overpaid or have to pay any of this back."

**COMMISSIONER SPENCER:** Just drop the microphone just a touch and push it back a little bit. Thanks.

**MR SMITH:** The reply came back, "No, you haven't been overpaid, you haven't paid too much money, however, you have to start paying back $90.01 a fortnight, and that will be taken out of your White Card 60 per cent." So they reduced my fortnightly payment by $90. I was getting $30 or whatever it was a fortnight.

They said that would go on for a few years. After a couple of months they told me that. I subsequently discharged from the army in 1993 and started working, and after that, I ended up becoming a TPI Gold Card because I couldn't work anymore. I then received another letter saying, "You cannot have two bites of the cherry. You have to pay back this $54,136.09, and we are now going to take $110 a fortnight out of your Gold Card payment.

Twenty-six years later, I am paying back $155 a fortnight still today. I contact them regularly. I speak to a lady by the name – the last three years has been Reni, who was the boss of the compensation department, that tells me, "You will never pay off that loan. You've got to pay it until

the day you die, and then if your wife becomes a war widow veteran pension, it will then be reduced from her payments until the day that she dies."

If I had have known this in 1991 or July 1992 when they offered me the money, no one in their right mind would accept $54,000. At this stage, I calculate I've paid back over $80,000. They will not tell me how much I have paid. I have emailed and spoken to them and asked for a detailed account. I have asked them for a payout figure so I can pay it out. You can't. I have got to keep paying this until the day I die and beyond.

She tells me that I am not the only person in this situation. There is thousands of ex-military personnel that have got compensation and done this. $150-odd a fortnight out of a man's pay or pension is a week's groceries. If I had have went to the bank and asked for a $50,000 loan – or 54 – I would have paid it off. In that 26 years, I have paid off five houses that I have lived in, from Perth to Sydney to Adelaide. Yet I can't pay off a $54,000 compensation payment which I got for pain and suffering, and now they class it as a loan. It's got to end.

**COMMISSIONER SPENCER:** Thank you very much. Can I just go back a little bit so that I can fully understand. When you say the compensation people, who are they?

**MR SMITH:** Rehabilitation and compensation. They used to be at Keswick Barracks here.

**COMMISSIONER SPENCER:** Right. And they're not DVA?

**MR SMITH:** No, but they work in conjunction – they were working in conjunction with DVA over payments, so you couldn't be double paid. That's what was explained to me.

**COMMISSIONER SPENCER:** So the debt that you're paying off is payable to whom?

**MR SMITH:** It comes out at – well, it was never explained to me it was a debt. It was a lump sum I was offered. I was assessed by a DVA medical doctor in Adelaide here, and he assessed me under the old system: two points for this, two points for that, 9.6. And they assessed me at 9.6, which was entitled to $36,700 for pain and suffering, and $17,000-odd for economic loss. Because I couldn't be promoted, I was a sergeant at the time and I couldn't be promoted. I was (indistinct) at the time, you know, fairly operational, but after that I was made HO, which is home only.

I couldn't be posted outside of Australia. They wanted to discharge me. I fought to stay in, and done over my 20 years to get my pension.

**COMMISSIONER SPENCER:** So just to clarify, this was a payment that was made by a different body but DVA for an injury that had occurred.

**MR SMITH:** Rehabilitation and compensation.

**COMMISSIONER SPENCER:** Yes. And now you receive a benefit through the DVA?

**MR SMITH:** TPI Gold Card.

**COMMISSIONER SPENCER:** Yes, and a benefit, obviously a pension.

**MR SMITH:** I get my - - -

**COMMISSIONER SPENCER:** You get the Gold Card and a pension?

**MR SMITH:** No, I get my DFRDB pension, which is standard.

**COMMISSIONER SPENCER:** Yes.

**MR SMITH:** And I get my TPI pension.

**COMMISSIONER SPENCER:** Yes, that's what I meant.

**MR SMITH:** Yes.

**COMMISSIONER SPENCER:** And it's from those payments that this amount has been deducted?

**MR SMITH:** Every fortnight, yes, $155 goes out of my veterans' affair pension, my TPI pension, and has done for 26 years.

**COMMISSIONER SPENCER:** So when you say to – sorry, in relation to the totality of this issue, do you deal with DVA only now?

**MR SMITH:** Both.

**COMMISSIONER SPENCER:** Who's the both?

**MR SMITH:** I ring DVA here in Adelaide, and they say, "It's too hard for us. We've got to put you through to compensation." I used to speak to Remi in Queensland. I spoke to her last year in - - -

**COMMISSIONER SPENCER:** Sorry, can I just get a clarification of, who is compensation now? Who is that, is that – which organisation is that?

**MR SMITH:** I couldn't tell - - -

**UNIDENTIFIED SPEAKER:** Yes, it's the military – it's the military rehabilitation and compensation act. And they actually now work out of – they used to work in Keswick.

**MR SMITH:** Yes.

**UNIDENTIFIED SPEAKER:** And now they work out of (indistinct) house. There are (indistinct words) house, which is where DVA are working out of (indistinct).

**MR SMITH:** Yes, well I - - -

**UNIDENTIFIED SPEAKER:** And I've actually heard that, exactly your situation as to (indistinct), but the exact same thing (indistinct words).

**COMMISSIONER SPENCER:** Okay. Thanks, we'll follow that up. But when you actually have said to somebody that you want to be able to pay out the debt or loan, they say you can't pay it out.

**MR SMITH:** You can never pay it out. If I had have been told that to start off with, I mean, my wife doesn't understand the military, and nor do I to a great extent, but as she says to me, if you go to the bank and get a loan, like I say, we've paid off houses after houses, there's always a payout figure, always, but with the military or DVA or compensation or whatever you want to call, it there is no payout figure. It's got - they explained it to me like this. You can't pay it out because how does the system know that you never got that $54,000, put it in the bank and are drawing interest on that, and I gave it - it doesn't make sense. It just doesn't make sense. Why would you do that? And that's their logic behind not being able to pay it off, because they think you're drawing interest on it.

And I cannot get an answer. I, as two weeks ago when they come back from Christmas leave, I emailed Remi. I rung her last week and she said my case has been given to another person to look at because they've got a big backlog. I said, "I need a detailed account of everything that I've paid

back because I'm coming down here and I want something, some evidence to show them". Can't have it, and I'm not the only one There's thousands obviously in the same situation. Not only do I have to pay it back for the rest of my life, when I die and my wife, she's got to.

**COMMISSIONER FITZGERALD:** So without understanding completely the technicalities behind all this, and I don't presume to understand it, when you received your original compensation for pain and suffering, and then you received I presume payments through DVA, through the TPI processes, did you have any objection to them being adjusted? Did you agree that double-dipping was a problem and - - -

**MR SMITH:** I had no option.

**COMMISSIONER FITZGERALD:** They said it wasn't and you accepted that?

**MR SMITH:** I couldn't - I went to the Veterans' Review Board. I sat before the panel, spoke to them, but see, when it first started, when I was on 60 per cent White Card and they just reduced by 120 or whatever it was by 90, I had to accept it. I was still a military member. But when I got out and became a TPI they said to me, "Now" - they just sent me a letter saying, "You're now being reduced from whatever by $110", and that's when I fought it and I said, "No, this is not right", and they said, "It's the law. It's in black and white and you can't fight it".

**COMMISSIONER FITZGERALD:** And that was the VRB?

**MR SMITH:** Yes, and that was in 1994.

**COMMISSIONER FITZGERALD:** And do you accept that decision?

**MR SMITH:** I fought and fought and fought and there was nothing I could do about it.

**COMMISSIONER FITZGERALD:** Did you, or was it available to you, to go to the AAT to have that tested?

**MR SMITH:** No.

**COMMISSIONER FITZGERALD:** No, okay, but your problem right at the moment is really the inability to extract yourself from this ongoing debt loan.

**MR SMITH:** Absolutely. Twenty-six years.

**COMMISSIONER FITZGERALD:** Well, I don't understand it either, so there you are. Okay.

**MR SMITH:** No one understands it.

**COMMISSIONER FITZGERALD:** Well, we'll follow it up just to try to understand, from a system's point of view, not from - did you, during this process have you sought either legal or advocacy advice?

**MR SMITH:** Yes, I have, and no one will take it on because it's fighting City Hall. They said it's enshrined in the evidence in the book in black and white and you just can't fight it because it is the law.

**COMMISSIONER FITZGERALD:** And so right at the moment where does it all stand? You're still having this amount deducted?

**MR SMITH:** Yes, it just - it comes out and every time I get a payslip or a tax document and everything and it says this minus $152 or minus, every fortnight. It just automatically - I never see it, never seen it, and the wife is real happy.

**COMMISSIONER FITZGERALD:** Richard?

**COMMISSIONER SPENCER:** Yes, I'm just interested as to with your engagement with DVA over all of this, is the response you get, "The rules are the rules", or do you get some sympathy to say, "Yes, this is not a good situation but we can't fix it"? What's the explanation or response you get.

**MR SMITH:** I get sympathy. I get sympathy from the people I talk to in compensation. I have them crying on the phone saying, "You know, sometimes you can't afford to buy groceries", and they cry with me, and they say, "But there's nothing you can do". It is the law.

**COMMISSIONER SPENCER:** Are you aware whether this has gone to a higher level in DVA? Is it understood at a senior or significant level?

**MR SMITH:** I have asked to speak to the top person in compensation who used to be in Brisbane, but as far as I know the top person now is Remy, that's all I know her as, in Victoria which I spoke to her last week, and she just says, "Sorry, there's just nothing we can do. You can't take it anywhere because it's enshrined in law and there's thousands of youse".

**COMMISSIONER SPENCER:** And the thousands is the number she's mentioned. Is that right?

**MR SMITH:** Yes, absolutely. Absolutely. I'm not the only one. There's heaps of people in the same situation.

**COMMISSIONER SPENCER:** Right. Well, as Robert said, we, you know, we obviously don't understand all the details of it, but we'll certainly look into it. I had a more general question if you're happy to move on.

**COMMISSIONER FITZGERALD:** I should just make the comment, where this arises is a little bit, not in the same way, but we've had a number of submissions in relation to superannuation insurance payouts which are effectively compensation and how that is offset against payments from DVA or vice versa, and people have argued with us about the fairness of that approach. So we're looking at that, but I must say, you've raised a separate issue going back a long way, and the issue of not being able to pay out the debt is an interesting one, so I hadn't heard that before, so thank you for raising that.

**MR SMITH:** I've actually spoken to people that have put in for compensation claims for lump sum payments in the last two or three years and I've advised them not to do it because they'll just pay for it for the rest of their life.

**COMMISSIONER FITZGERALD:** Again, I won't go much further, but if you received a lump sum payment for a pain and suffering that is for impairment under any of the - well, under the acts that you're allowed to. That should not be a problem, should it.

**MR SMITH:** No. It shouldn't be, but it is because you've got to pay it off. Like I've been paying it for 26 years.

**COMMISSIONER FITZGERALD:** No, no, I understand your circumstances. I was just talking about more generally. Okay.

**COMMISSIONER SPENCER:** Les, mine was just a more general question and that is, I notice you've been with us for some time this morning, but it's whether there was anything you wanted to comment on in terms more generally of our draft report. Is there any particular aspect other than this particular issue you've brought up for us today?

**MR SMITH:** Well, only that the whole system is broken. It's - I've got a friend in the audience here who you've listened to this morning who's been

fighting his case for Gold Card and stuff for 10, 12 years. I know another guy in Adelaide who's got a hernia problem. Military accepted and his stomach's out like this and he can't get into a hospital because DVA won't pay for it. He's got to pay for it himself. The system is just so broken, you know? People ring up and ring up and ring up and just can't get through, you know. They can't tell them, "You just go from there to there. There to there". All the time it's just so broken, and I don't believe it'll be fixed as the last gentleman said in the next five or 10 years. They'll resist it.

**COMMISSIONER FITZGERALD:** Are the processes that you've heard of in recent years in relation to, say, to the VRB and all of those things, you don't believe that those sorts of processes have made or are making a difference, a significant difference?

**MR SMITH:** No. No, I - we're fighting another issue which is nothing to do with this, but it's to do with the second Malaysian emergency from '68 to '89 which you've no doubt heard of. We've got a board of inquiry going through in that that's been fighting that for nearly 20 years to get recognition and it's the same as the DVA system. It's just, you know, you're just fighting, fighting, fighting, fighting.

The laws are there in black and white like our RCB campaign. They're there in black and white that need people to just go, "Look, that's what happened", but they don't. They duck shove it over there and change the rules and do everything, and we've just got to keep fighting, same as with DVA. You've just got to keep fighting. If that department - like, one case, a bloke's had seven or eight different people send him a letter for the same thing. A letter goes in, he gets seven or eight different responses from different people. There's not one person to look after the one case, the one person's case. It just goes from desk to desk. It should be one person look after the case, and I believe the people that are on the review panels and stuff like that shouldn't be colonels, brigadiers, field marshals or whatever. They should be soldiers that know the system.

**COMMISSIONER FITZGERALD:** Can I just take that point. One of the things that's emerged in our consultations was the issue of equity but there's a number of different takes on that, but one of the issues that arose was there was - a number of people spoke to us that felt there was a lack of equity between the different ranks.

**MR SMITH:** Yes.

**COMMISSIONER FITZGERALD:** And we've tested that a little bit and there's no doubt that in some areas your ranks do matter, but in the

system for compensation and your dealings with DVA, and again you can only speak from your own experience, do you believe that people of different ranks are treated differently in the way in which matters are dealt with? Not the actual benefits, but the way people are dealt with, or do you think that's something of a past era?

**MR SMITH:** No, it's relevant today. I was fortunate when I first put in for my Gold Card many years ago, 1995 I think it was, I had to go before the review panel and the review panel, I think from memory it was six people. There was five what I would class as civilians, not ex-military, and there was one gentleman there that I was pretty sure I knew. One gentleman said to me, "Your back, it's not military-related", and I said, "Well, it is, we used to have carry 50 cal machine guns around in the bush, you know, in 1973/74". He said, "But you don't carry machine guns, 50 cal machine guns. They go on top of 113 APC's", and this gentleman down the end turned around and said, "No, he did". It turned out he was my OC in Delta Company 6RAR in Enoggera that was on the review panel, and that's the only reason I got my Gold Card, because he could back up what I was saying, because the others had no idea.

**COMMISSIONER FITZGERALD:** Sure.

**MR SMITH:** The review panel just don't know, and that's why they should be military personnel, ex-military but not generals and brigadiers. Stuff like people that have been in the trenches. I'm not saying that they haven't, but they're normally in their tents. People, RSM's, warrant officers, sergeants.

**COMMISSIONER FITZGERALD:** Just related to that, the Statements of Principles that are now used for determining the claims in a sense are meant to deal with part of that, aren't they, so that you are now very specific about, you know, if you've carried X amounts of weights or been in these involvements and so on and so forth. So do you get a sense that sort of ad hoc nature of decision-making has changed, so whilst there is still discretion, these systems, like the Statements of Principles, reduce that risk of, you know, inexpert people making these sorts of judgments?

**MR SMITH:** They do. They do, yes, 100 per cent because they just don't know what people do within the system, but if you had - look, there's RSM's, warrant officers, you know, class 2's and staff sergeants, so they know. They know the workings of an inventory unit or on a tank or a ship or whatever. They know. The hierarchy, once they come out of Duntroon, Portsea or wherever, and it's nothing against them, they do their job. They do a great job, but they're not in the trenches with the soldiers.

**COMMISSIONER FITZGERALD:** All right. Thank you. Is there any other comments you'd like to make? Richard?

**COMMISSIONER SPENCER:** No, that's good. Yes.

**COMMISSIONER FITZGERALD:** Thank you very much, Les.

**MR SMITH:** Thank you.

**COMMISSIONER FITZGERALD:** We appreciate that. And if we could have Mr George Mikajlo.

**UNIDENTIFIED SPEAKER**: We're running a little early.

**COMMISSIONER FITZGERALD:** Right, that's okay. Who else is here.

**UNIDENTIFIED SPEAKER:** So we might move to Claudia.

**COMMISSIONER FITZGERALD:** Yes, that's fine. Thanks. I understand we're going to have a couple of short presentations of people that have presented that have asked for an opportunity to do so, so we'll use this time at the moment to do that. Claudia Cream. Thanks, Claudia.

**MS CREAM:** My name is Claudia Cream OAM. I have been in the veteran community for about 14 years and I was a past president of the War Widow Guild of Australia (South Australia Inc.). Also I have been an ambassador for the Partners of Veterans' Association since 2010 and also a member since 2005, and now I'm a committee member of the War Widow Guild, and I'm giving this submission as a member of the veteran community, a war widow and a member of the War Widow Guild and of Legacy.

Now, please pardon my ignorance - - -

**COMMISSIONER FITZGERALD:** Just pause for one moment. Could you move the microphone forward just a little bit. That's right.

**MS CREAM:** Thank you.

**COMMISSIONER FITZGERALD:** And just drop it down a bit. Down. That's it. Good. Now you can speak.

**MS CREAM:** Thank you, yes. Please pardon my ignorance but I have read the draft report of the Productivity Commission in relation to

reforming system in the veteran community. I do think it is a very good idea to combine the three acts, the Veteran Entitlement Act, the safety, rehabilitation, company, defence-related. This is law with a clean act and Military, Rehabilitation and Compensation Act into one single act to simplify the system and to make it less complicated, and also to have a single standard of proving. It's easier for the ordinary veteran, member of the veteran community to understand just one act instead of three acts.

Now, in case the DVA is absorbed into the Defence Department, and I hope not, and if this Veteran Services Commission is to be set up, will there be offices in different states to deal with veterans' matters of all kinds rather than just going to Canberra? Would that be offices in different state?

**COMMISSIONER FITZGERALD:** I'll come back to that.

**MS CREAM:** You'll come back. Okay, good. If so, now, will there be staff on the phone to answer veteran queries rather than, you just go online to get the information? That's another query. Veteran information, I know a lot of them online, but older veterans, the older war widows, they have not - they haven't got the computer skills to get the information online. People talk about MyService; 'they will know how to get to MyService.'

Now, I do think computer training within the veteran community is necessary to provide to older veterans, war widows, to learn about computer, to get information online because a lot of them, the older war widow, they have no idea about what online means. They don't know how to get information from the computer. They don't even operate a mobile phone. So I don't know how they can get the information online.

Now, another point is, the procedures to become an advocate and social officer in the veteran community is so complicated. Please simplify. Simplify the procedures so that the ordinary member of the veteran can volunteer to become advocate as well as social officer. At the present moment is too complicated for them, and also a feedback system would be good if it's on a confidential basis, be set up within the reform system in the veteran community for improvement of provision of services so people can inform this particular department, you know, what's going on. There's something not right about provision of some services. You know, they can tell that department.

Also, as you can see, I am an Australian from multicultural community. There must be multi-cultural Australia in the Defence Forces. A policy of inclusiveness, inclusiveness to be adopted to change the negative attitude

towards Australians, Australians of multi-cultural backgrounds to join the Defence Forces, to be treated equally and with a fair go attitude because Australia is a multi-cultural society and is going to be more multi-cultural.

I just would like to give just my example. When I joined the veteran community, joined one organisation, they didn't talk to me for four years. All right? But anyway, I will leave that behind. Leave that behind. And I would like to do thing for the veteran community and so I just would like to promote this inclusive attitude, not exclusive attitude towards the Australians of multi-cultural - from multicultural backgrounds. Thank you so much for listening.

**COMMISSIONER FITZGERALD:** Good. Thank you very much, Claudia. Just a couple of questions which may have some - do you believe that people from multicultural backgrounds are significantly disadvantaged within the veteran community currently? So I know that you had those experiences previously, but can you enlighten us as to what you think the significant disadvantages your community faces currently.

**MS CREAM:** You're talking about the - within the veteran community?

**COMMISSIONER FITZGERALD:** Within the veterans community.

**MS CREAM:** You see the thing is that Australian - I know there's some Australian from the multicultural background, they are in the Defence Forces here, but I think attitude has to be changed to be more positive towards them, to welcome them, rather than say - well, you know, saying something "You don't belong here", you know they will say something in a very indirect way to say, like, "Why you here, huh?" and "I don't expect you to be here", that means that person does not belong. I mean what's the whole point of belong, to want to belong if somebody tells you, "Well, no, you don't belong here". So I think that belong is important and to be treated equally. Fair go, Australian fair go. Not just to the mainstream Australians but also to the Australian of multicultural background. Equal basis. Because we also Australian; we so proud to be Australian, even we come from a multicultural background.

**COMMISSIONER FITZGERALD:** Claudia, do you believe or do you have any evidence of the way in which people from multicultural backgrounds are being dealt with by, say, the Department of Veterans' Affairs or other parts of the Defence Force at the present time? Do you believe they are treated the same way, or do you believe they're treated differently?

**MS CREAM:** Is it they wouldn't want to say anything because they really worry, even if they're bullied, they would not to sort of blow it all up, and they will just keep it quiet, go on - go on with everybody else. Because they know if they speak up openly they may be treated differently, in an unfair manner, because there's not too many of them and they maybe gang up, you see. So they usually go along with - with everybody. So if anything is unfair we just tolerate it.

**COMMISSIONER FITZGERALD:** You mentioned a couple of things, if I just pick one or two of those and Richard might have some questions. One of those was about the ability to feedback commentary around services. So can you just explain to me what you're talking about there in a little bit more detail and what you think needs to be put in place.

**MS CREAM:** Yes. For example, the Department of Veterans' Affair, I don't know whether there's such a feedback system. You know, if somebody is not happy with the - some services provided by the Department of Veterans' Affairs then they can actually go to a particular team, or one person, to say "Look, I'm not very happy with, you know, what I'm receiving because of this and this", and it would be really good to be done on a confidential basis so that this team can feed that feedback to the Department of Veteran Affairs and say, "Hey, this got to be improved because something is not working efficiently", you know, and I do hope that the Department of Veteran Affairs not going to be absorbed into the Defence department because going to be a huge department, I don't know how they can manage all of that. But anyway, is up to the government.

**COMMISSIONER FITZGERALD:** No, that's fine.

**COMMISSIONER SPENCER:** Thanks Robert. Claudia, you make a very powerful statement.

**MS CREAM:** Thank you.

**COMMISSIONER SPENCER:** One Australia, and I think everybody would agree our military should reflect our society and everyone in our society and if injury or illnesses are incurred that it should be absolutely the same for everybody. So that's a very powerful statement and thank you for that. You also raised a couple of detailed questions about - with the Veteran Services Commission, whether there will be offices here or what would be online. That level of detail we haven't gone into but the guiding principle of a Veteran Services Commission is to be veteran centric. So if the need is for that, to have physical presence, and we've heard that from a number of other people as well, to be physically present

around Australia, to have services and access to services in ways that work for people, that absolutely should be the case.

**MS CREAM:** Yes.

**COMMISSIONER SPENCER:** And in our experience bodies, like the VSC, that are set up specifically around the individual respond very well to that. We think that's very difficult sometimes for a department structure to do, but a commission of the kind we're talking about would be aiming to do that.

**MS CREAM:** Yeah, because I know that, you know, in the (indistinct) to say "Course effective, course effective" but I'm just thinking it's not easy for the ordinary veteran, member of the veteran community have to go to Canberra, or to ring up Canberra, you know. So I say is good idea, please do have a local office here so that they can actually go to the office and also have the telephone, have somebody man the telephone rather than, you know, online. And computer training, please, you know free computer training, give funding to that.

**COMMISSIONER SPENCER:** One of the issues that we have raised with DVA is the need for direct person to person contact for those that are not able to access computerised systems, and we hope that that's part of the current system. It certainly needs to be. And that would also obviously be important going forward. So we recognise that whilst most people are able to access through the computer and internet, many people can't, so we've already made that observation.

**MS CREAM:** Thank you.

**COMMISSIONER SPENCER:** Can I just ask one question. You are currently with the War Widows Guild?

**MS CREAM:** Yes, that's right, I'm - I was a past president and also now I'm the committee member.

**COMMISSIONER SPENCER:** In that particular guild are there many people from NESB backgrounds or multicultural backgrounds?

**MS CREAM:** No, no. I'm speaking as a member of the association, not on - not through - authorised by the committee, yeah.

**COMMISSIONER SPENCER:** No, no, I fully understand that.

**MS CREAM:** No, no, I'm the only person but I think - I think there are few multicultural members but they don't - they don't join the guild because, you know, of the isolation or they feel that - they don't feel comfortable there, yes.

**COMMISSIONER SPENCER:** Right. And do you believe that for people from multicultural backgrounds that they require their own ex-service organisations, or do you think the way ahead is better inclusion or integration within existing organisations?

**MS CREAM:** Inclusion is much better, rather than set up separate services for them, and I think inclusion's better. It's good for the Australian society as a harmonious society so everybody who is active of their background, you know, they have a say, you know part of the - part of the society.

**COMMISSIONER FITZGERALD:** Good. All right, thank you very much.

**MS CREAM:** Thank you. Thank you, bye.

**COMMISSIONER FITZGERALD:** Thanks very much Claudia, we appreciate that. That's good. And if we could have Robert Black back, thanks. Robert, if you can give your full name again and the organisation you're now representing.

**DR BLACK:** Thank you, Commissioner. Robert Black, I'm the president at the moment of the South Australian Division of the RAAF Association. I've had experience with the Veterans' Review Board for nine years. I have worked at the repat. hospital for over 20 and I'm a veteran, and I've had some experience in the medical politics area beforehand.

Thank you for giving me the opportunity of having a second bite, as it were, but you did suggest that any comments about other matters raised one could comment, and I have now unfortunately several comments to make.

**COMMISSIONER FITZGERALD:** Good.

**DR BLACK:** And the first is the last that we heard of that poor gentleman who got into such a bind over a lump sum payment. It was pleasing to me to see that you are recommending some - abolition of some lump sums and it has always seemed to me that accepting lump sums creates difficulties.

MRCA now provides financial advice before accepting a lump sum and that's a very good thing, but many appear to have been accepted without added explanation and clearly you heard a very good example of that.

You asked a question why young veterans doing their own thing - didn't put it quite that way - but making their own claims and it certainly puzzles me. But one of the reasons why they are doing it, I don't think it's a good reason, is that the material from the department implies that it's an easy thing, "Just do it online", and it isn't an easy thing. When something is difficult, complicated and liable to end in trouble why imply that it's easy. And I think there should be some sort of brake on young people making their own claims; even a message to say, "Have you thought of getting further advice?" There are all sorts of things in the later Acts, the medical reports and so on, that may delay the acceptance of a claim.

You did ask a question of Rod Murray about the Gold Card and you made a comment that it was a feature of a past era, and I wondered what you were talking about, because the Gold Card had a - has a history only of just over 20 years. It was introduced in the mid-1990s, and it was introduced for one very good, simple reason. You have suggested that it's not well focused, in a way, it isn't. But it is in fact specifically addressed to provide health services - all health services - for various groups of veterans and dependants, who over the last 100 years have been deemed, by the department of veterans affairs or it's repatriation department, has been eligible for those benefits.

And this came to a halt early in the 1990s, when the repatriation and general hospital system was completed. The federal government let go those hospitals, and they went to private institutions, or to - or to state - to government departments. What a shame it was, in retrospect, and the reasons behind it, were false because they believed that the DVA was running out of claimants and they wouldn't need to last very much longer. And the same with the repat hospitals.

You raised a question earlier about the apparent inequity in having different levels of benefit for the same injury, illness disease or death from the different Acts, and that certainly is a problem, and we would think that it is a little bit curious. But, there is a legislative history that gives precedent to this idea, because the first 50 years of the Australian veteran or returned servicemen compensation system, those who did not return from active service, operational service, qualifying service with various names, and who served simply at home, defence service, had absolutely no access to the Acts that preceded the Veterans' Entitlements Act. Especially, of course, the Australian Soldiers' Repatriation Act, and it's got various names until it became the VEA.

So, the servicemen and women, who did not have active service had simply no access to these compensations and things. The only access they had were to, and equivalent to, a normal Workers' Compensation Act, and indeed it was various Acts that preceded SRCA, now DRCA, perhaps (indistinct). But that was a Worker's Compensation Act, and that was all that servicemen and women had access to. Clearly, those Acts had benefits that were much less than the VEA and its antecedent legislation.

And I think that is the basis why it appears that those with similar injuries or illnesses or impairment or incapacity receive different compensation from different Acts. It certainly puzzled me MRCA came around that this was happening, but I think that's the reason for it.

Gaps, gaps we've heard from various people, and they are very important. They are a threat to the utility of the repatriation of cards. If doctors will not accept the repatriation cards, because they are not permitted, it is illegal for them to charge a gap, they will use the Medicare charge and charge a bigger gap. One can say about greedy doctors and doctors who don't bulk bill, they have their own problems, doctors do. But, it simply is a threat that the department needs to understand that unless what it pays for medical services, and that includes hospital services, as well as medical services, the cards, White or Gold, will not have the utility that they are meant to have, that indeed the DVA promises, (indistinct), when a Gold Card is issued.

And the final comment, if I may, is about Statements of Principles, because you did query, I think, Mr Spencer, Rob Manton when he was here, because he pointed out that the Veterans' Advisory Council in South Australia had shown some doubt about Statements of Principles. I think we all understand that there are two standards, two sets of Statements of Principles for every disease or condition, and these are at the two different standards of proof which we hope to retain. But, I think, Mr Manton suggested that there was a lawyer among the Veterans' Advisory Council who said that this is a problem, because one cannot argue that what is nearly in the Statements of Principles as a factor could be argued that that factor is nearly met but not quite, why can't we get compensation from this?

People have suggested elsewhere, and I think you've received, comments about this in the submissions. Now, the Statements of Principles are not wide enough. They should be regarded as guidelines, they don't have sufficient latitude. They have sufficient latitude. They have very wide latitude. And the latitude is determined by the standards of proof. Whether it is reasonable hypothesis, 1 in 20, or balance of probabilities,

perhaps 50-50. These factors, in the statements of principles show that huge latitude, that this is allowed. Can I take one example: in the Statement of Principles from (indistinct) there's a very common condition affecting many men, there is a factor which says "28 days or more on land in Vietnam, or in the case of the sailors, ingestion of potable water produced by distillation from estuarine waters in Vietnam."

**COMISSIONER SPENCER:** What on earth does that mean?

**DR BLACK:** It means, that those soldiers, sailors and airmen have ingested the dioxins, the by-product, of Agent Orange. There is no other factor for (indistinct) from any other group of veterans. So, 28 days. There is a lawyer who has represented a person who had service in Vietnam for 14 days. He said, "Well, 28 days, why not 14." The reason why not 14 is that 28 days gets down to 0.05, or 1 in 20. Five per cent. It's not a reasonable hypothesis, is not, 1 in 50, it's 1 in 20.

So, it surprises me that the Veterans Advisory Council in South Australia didn't have sufficient experience to explain that problem. So, those are a few comments I'd just like to clarify.

**COMISSIONER FITZGERALD:** Thank you for that. We'll only raise one question. Can I just ask, before we do that, is George Mikajlo here? Yes, okay, thank you. So just one or two, and then we'll go to our next participant. In relation to the Gold Card, and I understand what you're saying, that when we moved away from having repatriation hospitals, the Gold Card came into its own, you yourself acknowledge that it's not a, necessarily, well-targeted card, but it has benefits, significant benefits. The issue we've got is not removing the Gold Card for those that have received it. It's whether or not that's the best way of going forward in terms of health service funding, delivery, those sorts of things.

So, I wonder, are the ESOs prepared to look at alternatives? Not to replacing the Gold Card for those that received it, but in terms of future claimants in relation to that. Or is it really the case that no matter what we put forward, the Gold Card is going to be, you know, what the ESO community really wants. So, is it only going to be the Gold Card, or is the ESO community prepared to look at alternatives for new claimants going forward?

**DR BLACK**: Well, your position is that the Gold Card is not well targeted. My position is that it is extremely well targeted, towards those people who the Government have deemed eligible to receive benefits, in the form of all health services. Now, the precedent for that came in the 1970s, a precedent, it's not quite the same. But up until the 1970s, and

you've referred in your report that scurrilous publication by John (indistinct) - you know that little book? John - I've forgotten the name now, DFC, a decorated airman, who worked in the repat system as a doctor; he's an Adelaide graduate. And he pointed out the way in which people abused the system in the 50s, 40s and 60s of the repatriation system. At that stage, you were only treated in the repat hospitals for your entitlements; nowadays called your accepted conditions. If you didn't have an accepted condition, you had to be sent elsewhere.

So there was in fact a lot of illness focus, if you like, concerned with those illnesses that were accepted by the department because otherwise you wouldn't get free treatment. So this was in the 1970s and then in the 1970s, the Whitlam Government decided that veterans of the Boer War and World War I were all very old and were probably needing lots of health benefits, health services, and so it said that whatever health problem you had, not just your entitlements, you could be treated at the repat hospitals for free.

Twenty years later, we're coming down to the 90s and that's when World War II veterans were given the same thing, but there were no longer repat hospitals, so that's why it got the Gold Card. Now, I can't think of anything that is going to provide health services for a group of people deemed then, now and perhaps in the future as deserving the benefit of all health services other than something like the Gold Card.

**COMMISSIONER FITZGERALD:** Can I just – my final point is just going back to the lump sums. Lump sums are available both on the MRCA and DRCA and we're going to combine the two. You're correct that financial advice is an important component under one of the Acts at least, and that should be provided. Many people do take lump sums rather than pensions; whether that's a good thing or not is irrespective. Is there anything over and above providing financial advice that can help people who do choose to take the lump sums, you know, exercise good judgment? It's a problem – it's a – when I say it's a problem, this is an issue that besets all compensation schemes. It affects the, you know, common law compensation schemes and what have you, people by and large in Australia are entitled to lump sum payments if they are receiving compensation. Some people make wise choices, some people make poor choices. But is there anything else that needs to be done if people are entitled to a lump sum other than financial advice?

**DR BLACK:** Well, just don't take it, but my advice is this: if you've got a lump sum and you take a lump sum as a commutation it's occurring also in the community over commutation of benefits from the DFRDB scheme. My advice is live a long time because then you will continue to get the

benefits, the payment and if you live a short time, well, you won't be very happy that you haven't paid off your debt, but you won't be getting a bill from the DVA. So that's my advice. Live a long time and get as much money out of the system as you can.

**COMMISSIONER FITZGERALD:** Richard, have you got any - - -

**COMMISSIONER SPENCER:** No, no, that's fine.

**COMMISSIONER FITZGERALD:** All right. Thank you very much for that, Robert, we appreciate it.

**DR BLACK:** Oh, and make sure when your doctor signs the death certificate he includes on it one of the benefits that you've got from DVA.

**COMMISSIONER FITZGERALD:** That's right. George? If we can have that, thanks. Thank you very much.

**MR MIKAJLO:** Thank you, Mr Chairman.

**COMMISSIONER FITZGERALD:** That's good. So you just want to grab a seat? You might want to push the microphone just this way a little bit. Just a touch. Just up this way a bit. A bit this way. It just picks – it just balances off. If you can give us your full name and your – whether you're representing an organisation or yourself?

**MR MIKAJLO:** No. My name is George James John Mikajlo. And congratulations in saying my name. The first time I - - -

**COMMISSIONER FITZGERALD:** (Indistinct words).

**MR MIKAJLO:** - - - when I'm (indistinct) the poor old RSL called me Michelangelo. So you're doing a lot better. I'm not representing anybody, although, I have got a mother-in-law who's in Warburton and I want to mention her case as well today.

**COMMISSIONER FITZGERALD:** That's okay.

**MR MIKAJLO:** Because I think there's a gross deficiency in the system. The other issue I would like to raise is that I used to be a former deputy hospital secretary at a repat hospital in Adelaide. And in fact I was employed by DVA until 1980 when I resigned to go into private – private work.

**COMMISSIONER FITZGERALD:** Sorry. Can you just push the microphone down?

**MR MIKAJLO:** Down?

**COMMISSIONER FITZGERALD:** Down. That's it.
**MR MIKAJLO:** Thank you.

**COMMISSIONER FITZGERALD:** Good. So if you just want to, like, make an opening statement. That would be terrific.

**MR MIKAJLO:** The issues – I (indistinct) minor issues as well. The one about the War Widows; I've got a mother-in-law who's developed a knee issue where she can't even get up to go to the toilet and I'm acting as carer for her at the moment. And the ridiculous part is that I'm supposed to attend Flinders Medical Centre for rehabilitation, hydro and physio, three mornings a week, but I can only get a carer coming in for 32 minutes a day. Now, I can get him to come in for longer, but it averages out if you have it every day for 32 minutes a day. That is totally inadequate to look after a level 4 person who's virtually needs rehabilitation. Our intention is to rehabilitate her and eventually get her to go back to her home. My wife is a registered nurse, I've got qualifications in psychology and health administration and we're doing our utmost to minimise the expense for repat/DVA.

The other issue I wanted to raise, listening to the earlier discussions about doctors and the fees they charge, that reminded me of my experience at Repat Hospital DVA where most of the medical staff that were actually employed within the medical staff actually came to work at the department or in the hospital there. And I'm talking about a GP's work as departmental medical officers, doctors who have health issues, had great difficulty coping with our practice and they were looking for lighter work. And some of them, I'm afraid were not very sympathetic to the veteran community. I remember one doctor that used to scream at patients, DVA patients, because they were smokers.

Now, I don't smoke. I disapprove of smoking, but the reality is that some people do and he should be treating people properly all the time. And what worries me is that those DMOs that are working now in the department, may very well be the same, that they're people who are either past it, haven't kept up with things, they wanted the easier job, and got a job with DVA. Now, in my own particular case, I've had a battle with DVA for many, many years. Partially, I may be wrong, but initially, I was the first non-Anglo-Saxon overseas born person employed by DVA in

South Australia. I was often reminded that my father fought on the wrong side.

I did not really enjoy my time working in the branch, the (indistinct) street office of the department. However, I managed to score a promotion to go to the Repatriation General Hospital and there I progressed very rapidly, and in fact, I ended up winning a scholarship to go to do my Masters in Sydney for health planning. The issue was, as I was quite well paid, I never intended to put in claims for DVA either. There were a number of injuries I – injured with – at the Army. On my first day in the army, I was asked to volunteer for picket duty and being a very naïve young 18 year old private, I did so. That morning, during the night – or about 1 o'clock in the morning, I woke up and I thought somebody had stuck a bayonet in my head. That's what it felt like. What had happened was an inch ant had crawled in my ear and started hacking its way through the ear drum.

So they said to me, "Well, George, you've got to have your ears looked at every day in Victor Harbour, you may as well go into permanent picket duty for us at camp." The next day it was even more exciting. A drunken kangaroo shooter came along and – this is in the hay day of national service - there were 650 people in low bushes around the place and he was going to go around driving his Ute and shooting kangaroos. Now, when my mother and I came to Australia, I came out as a – just over 10 years old from Hungary, and we went through Budapest after Russian tanks had been through there. So I had a fair exposure to seeing what gun wounds could do and everything else. And I did develop PTSD as a consequence of that. I mean, the guy, when I didn't want to let him in, cocked his rifle, shoved it in my stomach and said, "Open the [expletive] gate, sonny."

Now, I didn't realise what had happened at the time and as a consequence - I was at uni at the time doing chemical engineering - I dropped out of uni, I drank like a fish, the army was very conducive to that anyway and, in fact, I was very lucky that after about three years I got picked up by the police for exceeding .08, and I gave alcohol away after that, fortunately.

The other thing that happened, I was getting so rundown, was that I was admitted to Royal Adelaide Hospital for 10 days with pneumonia as a 22 year old. But I still did not realise what was – what had happened to me.

I then got married in 73, commissioned in 71 as an officer. Married in 73, and because I couldn't sleep because of PTSD, I decided to enrol myself at Flinders University to a degree in Politics, Economics, and first year Psychology.

I thought Psychology may give me the answers, and I finished up doing the three year, full time degree, three years part time, whilst I was also doing Army. So I was doing the equivalent of about three jobs, and coping with it. So I could cope with it because I wasn't sleeping.

However, I realised in the end that it wasn't doing anything for me, the Psychology, and I went on to do an MBA, and I was partway through that when the departments came to me and offered me a paid scholarship to go to Sydney to do my masters degree in health planning.

One of the other consequences I had is that I couldn't stand conflict. I ran away from conflict all my life, and I think that was a side effect of the PTSD.

In 1981, when I came back from Sydney, the department, or the Minister for Repatriation, Newman, appointed a friend of his, Colonel Bruce Rogers, as the Deputy Commissioner Repatriation in Adelaide.

Bruce Rogers may have been a very nice person, but with the doctors in the hospital, and especially came in with very minimal knowledge about DVA or repat at the time, there was a lot of conflict, and I ended up resigning from the department. I just could not cope with that conflict.

I finished up working in the private sector, establishing nursing homes, running hospitals, and I was CEO of the Blackwood Group, running Blackwood Hospital, Warragita Lodge, Cherrington Retirement Village, Gawler Hospital, the whole lot. Gawler Private Hospital, sorry.

In 2003, my young daughter – I've got three children. My eldest daughter's a rocket scientist at DSDO. My son's a corporate accountant for Woolworths, and my youngest one is a agriculture scientist.

But at the time, she was still at school and she joined the Army Cadets. The Army asked me to put on a uniform again, and that was the biggest regret of my life.

In 2003, December 2003, we were asked – I was in a camp, and a young lady, 18 year old, claimed that she'd been bitten by something and she couldn't walk, she couldn't do anything, and two of us had to carry her about a kilometre through the scrub, at night, in the rain, and admittedly, I was a little bit sore afterwards.

I then, at the same time, also developed ringworm like sores all over my body, including my feet. Found it very difficult to walk, and there were also a couple of other incidents where young cadets booby-trapped the

seat, and I sat on it, rolled out backwards, hit my head, went through a low axis doorway, and just as I was going through, one of the young cadets called out, "Sir", and hit my head.

And also, an incident where a young kid – to sit in the front of a minibus, next to the driver, was considered a status symbol by some of these kids, and this kid saw that there was nobody in the seat, in the front passenger seat, so he hopped in there and slammed the door as hard as he could into my spine.

Anyway, I then put a claim in on my own personal insurance, because I had income maintenance insurance for about $120,000 a year, which is a lot better than what DVA pays anyway, and I was given a MRI, and the MRI showed nothing. So obviously there was – the insurance company had adequate reasons to refute my claim.

But with the sores I had, and the backache, and everything else, I was finally diagnosed as having tinea. I had two different strains of tinea infection, tinea trichophyton rubrum, and mentagrophyte.

The specialist who treated me finally, in October 2004, kept me on the oral antifungals for six months, or 28 weeks actually, rather than 12 weeks, which is the manufacturer's recommended maximum.

I developed arthralgia, myalgia, and also chronic diarrhoea. The doctors didn't really know what was going on, and I tried to explain that I believed it was medication issues. However, that was not accepted and, in fact, when I did put a claim in on repat, the department flew a assistant secretary claims and appeals, Paul Ontong, from Canberra, to fight me in the AAT.

Now the department, as it's quite entitled to do what it likes to protect its own assets and things like that, but what gets me with Paul Ontong was that he made the statement, and he made the statement in front of a lawyer, a lawyer by the name of Tony Kerin, who's still employed in Adelaide, that as a cadet officer, I was not entitled to any compensation for loss of income, or anything like that. So stop wasting your time. I'll give you some money that will pay your legal fees, see you later.

So what Mr Ontong did, is he made up a number of diagnoses. He made up a diagnosis for temporary aggravation of cervical cancer – cervical spondylosis, temporary aggravation of thoracic and temporary aggravation of lumbar spondylosis, and he paid enough money to cover my legal costs.

However, if you refer to MRC31, MRC31 instruction fact sheet, it clearly states that cadets, or cadet officers, are entitled to loss of income, or income maintenance protection. So Mr Ontong lied through his teeth.

Secondly, the diagnoses he made up had no factual basis on them, because it was – I recently had a MRI done in 2018 and, in fact, I had developed stenosis of the lumbar and cervical area. However, my thoracic spine is fine. Absolutely nothing wrong with it.

Now, the SOP clearly state that, you know, some of this stuff did develop in a certain period of timeframe. My form accident, which Mr Ontong claimed was the result of the back pain I had, was a 1981 accident, well outside the timeframe as stipulated by the SOPs.

However, I was not familiar with the many facets of the SOPs or the DVA claims process, having been out of the game for about 20 years, so I – and the lawyer accepted what he said. So he was a liar.

**COMMISSIONER FITZGERALD:** Sorry, I'm just going to have to caution that we are going to run out of time. So we're trying to restrict the opening statements to a short period, so you'll need to get to the point quickly.

**MR MIKAJLO:** All right. Well, the thing is, following on from that incident, I then put a – I appealed again. I reapplied for the irritable bowel, which at the time was diagnosed as pancreatic – pancreatitis and pancreatic insufficiency, and it was accepted.

DVA sent me along to a doctor at MLCOA who then said, "Oh no, I don't think you've got that. I think you've got irritable bowel syndrome." So they said to me, "Oh well, in that case, you're not suffering from pancreatitis. See you later. Goodbye." No conversation.

So I then reapplied for the irritable bowel syndrome, and that was accepted. Sorry, that was rejected. I then had to go to the VRB and it was accepted. Now, to come here today I have not eaten since last night. I cannot eat during the day because I've still got foetal incontinence if I eat. Now, I just got my letter from DVA and they're very generous, they've given me 10 points for my foetal incontinence.

You know, it seems to me that, you know, every time you put a claim in the doctors don't – what should happen, I believe, is the DMO should call you in, have a chat to you, and discuss with you why you're claiming it, how you're claiming it, rather than look for the first available opportunity to reject a claim.

There's no ownership, I believe of, you know, the way the process works for the DVA, and, I mean, it shocked me when I discovered that in fact a senior member and assistant secretary of the department could tell a lie in front of a lawyer. So, anyway, to sum it up, my irritable bowel syndrome isn't accepted by the VRB, and I'm just waiting on assessments at the moment.

**COMMISSIONER FITZGERALD:** Thanks for that.

**MR MIKAJLO:** Can I mention one other thing?

**COMMISSIONER FITZGERALD:** Sure.

**MR MIKAJLO:** It really pissed me off, I've also got tinnitus, because one of the things that happened to me in the army also was I was deafened by gun fire and I've got a bit of hearing loss associated with the ant bite as well. Now, I've been using a masking device for about 30 years and I had a real collection of used ear phones which I plug in at night. I went into DVA in Adelaide and I said, "Look, you know, this is getting ridiculous, paying for all these ear phones. All of these are cactus. They've had it now. Can I get some sort of reimbursement or anything for it?" and the guy said, "No, because the audit requirements don't allow us. We need receipts for everything".

Now, that's [expletive] to be honest, and he just threw them away. You know, like, I feel that, you know, dealing with DVA is like extracting teeth. Thoroughly pissed off with them, to be honest. That's about all.

**COMMISSIONER FITZGERALD:** So, look, can I just ask a question, you've now been dealing with the DVA for how long? When was your first claim put in?

**MR MIKAJLO:** I put my first claim in about – I put in a claim for tinnitus and right ear injury about 19 something, 1990 something. I can't remember exactly. I didn't want to claim. It was only because I needed a hearing aid.

**COMMISSIONER FITZGERALD:** So this has been a long period of time that you've been associated with putting claims into the DVA?

**MR MIKAJLO:** Yes.

**COMMISSIONER FITZGERALD:** Long time. During that time right up till the current claim, what elements of the system have improved if at

all, or you believe the system remains fundamentally flawed. So have we seen any improvement at all or any changes?

**MR MIKAJLO:** I honestly believe it's worse than what it used to be. Back in the days when I was working for DVA the department only used to employ ex-servicemen, and I believed there was greater empathy for the fellow ex-serviceman and if somebody was putting it on they would say so.

One thing I did leave out, is that in fact in 2007 I was in so much pain at the time that I was referred to the pain clinic at Flinders and I was put permanently on morphine which I hadn't taken but that pain at the time was mainly due to the arthralgia and myalgia which Terbinafine induced in me, but nobody would listen.

**COMMISSIONER FITZGERALD:** If I'm correct, your recent claim which has ultimately been successfully determined, that was after the VRB intervened?

**MR MIKAJLO:** Yes.

**COMMISSIONER FITZGERALD:** So one of the questions we've been trying to understand is what is going wrong at that initial determination by the delegate, and we've made a number of recommendations around that, but from your point of view what do you think is happening at that point?

**MR MIKAJLO:** The system doesn't work. I mean, I can supply you with a document here that shows what the symptoms of the Terbinafine, the medication I was on. And one of the side effects of that, apart from the diarrhoea is the fact that you will get heart, burn, indigestion, everything else. Now, I also developed grade 3 esophagitis, I was all ulcerated everything else. It happened in the three months I was taking Terbinafine, and that's not been accepted, because it doesn't comply with SOPs. SOPs do not mention the medication, even though it states so clearly in the manufacture's documentation that the drug causes that issue DVA are not interested.

**COMMISSIONER FITZGERALD:** So when you say the DVA is not interested, just explain that to me. Do they reject the evidence or do they just simply – when you say they're not interested, what does that actually mean?

**MR MIKAJLO:** You get a letter back saying the delegate has declined your thing. You don't get - - -

**COMMISSIONER FITZGERALD:** Do you they normally give you a reason or no reason?

**MR MIKAJLO:** No, it doesn't comply with the SOPs.

**COMMISSIONER FITZGERALD:** And that's all they say?

**MR MIKAJLO:** Yes.

**COMMISSIONER FITZGERALD**: But do they tell you in which way it doesn't comply with the SOPs?

**MR MIKAJLO:** Sorry?

**COMMISSIONER FITZGERALD:** Do they tell you in which way it doesn't comply?

**MR MIKAJLO:** No.

**COMMISSIONER FITZGERALD**: They just simply say it doesn't.

**MR MIKAJLO:** No, it just doesn't meet the - - -

**COMMISSIONER FITZGERALD:** So when you get to the VRB we understand that one of the positive elements of the VRB dispute resolution procedures is outreach where they actually seek further information. They have a dialogue with the claimant or the person asking for the review.

**MR MIKAJLO:** There is a - - -

**COMMISSIONER FITZGERALD:** And a lot resolves at that point.

**MR MIKAJLO:** There is a problem with that as well, because you see what happens is, the VRB is briefed by the department, and the claimant does not exactly know what the department puts up before the VRB. Now, last time I went to the VRB when they accepted the irritable bowel syndrome I also appealed against the fact that my initial claim when they accepted the pancreatitis they rejected income maintenance on the grounds that I was already incapacitated. And the incapacity was only because I claimed on my private insurance after I was injured at army.

Now, the VRB, and with due respects, asked me several – or repeated several times the fact that insurance companies have got different standards for acceptance of claims. Yes, they do, but that's not why my

claim was rejected. The claim was rejected because: (a) there was no clinical proof, so they didn't have to accept it anyway; and, secondly, the injuries I had were army injuries that happened just before I put a claim in.

**COMMISSIONER FITZGERALD:** Just if I can ask, given the recent determination by the VRB and now DVA, what's your expectation in terms of benefits and entitlements? What do you think will now occur?

**MR MIKAJLO:** Well, when I developed the arthralgia and myalgia I had two children still at Scotch College Private School. I desperately needed to work, and I didn't want to give up work, but I had to give up work because of my condition. My wife is suffering from Sarcoidosis which is an auto-immune disease and she's had to go back and work as a nurse because of the bloody mindedness of the DVA delegates.

**COMMISSIONER FITZGERALD:** But your expectation, sorry, if I could just ask this, George, your expectation is that within a short period of time you'll receive compensation for the accepted condition?

**MR MIKAJLO:** I've been offered $10,000 or $11,000, it's under that sum, as a lump sum or 21,000 or 22,000 if I wish to not get a pension for not being able to work since 2003. It's ridiculous.

**COMMISSIONER SPENCER:** You've mentioned about the SOPs, but have you been given any indication in which that would be looked at, or are you just simply given an answer it doesn't fit therefore - - -

**MR MIKAJLO:** Doesn't fit, that's it. I mean, look, in some ways, I don't blame Paul Ontong because the side effect I had was caused by the medication I was on, and at that stage it was still relatively new. However, there was a comedy or errors. The dermatologist kept me on it: (a) didn't diagnose it for almost a year what it was. In the meantime I was pumped full of antibiotics. Then when it was recognised she kept me on it for seven months and ignored the fact that I was getting diarrhoea and everything else, and it was not clearly documented. So Mr Ontong probably assumed that I had arthritis or old age or something like that, and he went for the most simple convenient way of refusing the claim.

**COMMISSIONER SPENCER:** George, I don't know whether you've had a chance to look extensively at our report. We - - -

**MR MIKAJLO:** I've had a look at it but - - -

**COMMISSIONER SPENCER:** We write a lot and there's an overview up front which gives a more condensed version. But do you have any

thoughts or comments on some of the key directions we're going in as to whether you think those would be useful for the future.

**MR MIKAJLO:** I believe the most important factor is the people that work in the department. I'm an ethnic, I came here as a refugee, however, I would strongly say that I would prefer dealing with an Anglo-Saxon than a Vietnamese or somebody else. Now, I'm not being racist or anything else, but the reality is that unless you've had experience working in the army, and I would, in fact, dearly love to see ex-servicemen working in DVA. They haven't got the empathy. I mean, I was told, when I put in for PTSD, my claim was rejected. And the rejection was they didn't even read past the ant bite on the eardrum. They said, "Oh, well, you don't get PTSD from an insect bite". Big deal, rejected out of hand.

You know, what really bugs me is that the system at that stage, and I feel empathy for a lot of ex-service people who go back 20 or 30 years because at that stage the occupational health and safety requirements and the debrief that happens today were not there. My older daughter is a major in the army reserve, she is the scientist, and the system is completely changed from what it used to be in the army, defence system. That system there works. But the understanding of the department as to what happened in the past is just not there. So the further your claim goes back the worst the pensioner is off.

**COMMISSIONER FITZGERALD:** Is there any other final comment you'd like to make before we conclude?

**MR MIKAJLO:** Thank you for the opportunity.

**COMMISSIONER FITZGERALD:** No, that's terrific. Thanks very much, George. We appreciate that.

**MR MIKAJLO:** Would you like a copy of my ramblings?

**COMMISSIONER FITZGERALD:** No. Sorry, your ramblings?

**COMMISSIONER SPENCER:** Yes, sure.

**COMMISSIONER FITZGERALD:** Yes, that'd be fine. If you can give them to our staff that would be good. And can we have Professor Alexander McFarlane. Good, thanks very much for doing this. If you can give us your full name, and the institution that you represent.

**PROFESSOR McFARLANE:** Yes, my name is Professor Alexander Carl McFarlane, and I'm the director of the Centre for Traumatic Stress Studies at the University of Adelaide.

**COMMISSIONER FITZGERALD:** Terrific. And I understand you have an open statement?

**PROFESSOR McFARLANE:** Yes, if I could just make a couple of opening comments. Look, I'd firstly like to thank the Productivity Commission for the thoroughness and the depth of the preliminary report that it's received, and I think it's got many elements that I think are to be strongly recommended.

But, you know, inevitably I guess there are issues that I would sort of disagree with. But, look, I think one of the things that I particularly would like to appreciate is your understanding of the critical need to better the governance and the use of information, and if I can just give you one small example, at the centre that I direct has been conducting transitions and wellbeing research program, which is essentially looking at everybody who has left Defence from 2010 to 2015, and as I set out in my statement, I think there's been no proper discussion with the department about the reports that we've proceeded with. And just to give you one reason why that's important, we were able to calculate that there were in the order of probably about 2,500 members who have been discharged with post-traumatic stress disorder. Now, only about 60 per cent of them have had any contact and are registered as DVA clients.

Now, the reason why that's important is because what it shows is the visibility that DVA has of people who have potential claims is actually missing a very significant population. Now, I would've thought that it would've been of fundament interest to them to find out who were that other 40 per cent, and what health services and compensation systems might they have been accessing.

So, you know, I think whilst the department talks about Veteran Centric Reform, and, look, I think there are lots of good people that are trying to do the right thing, I think that's an example of how basically it's a department that no longer has health professionals in it at any senior levels except one or two individuals, but they really are in advisory roles. It's the absence of people in policy, and basically it's a department that doesn't know what it doesn't know, and I think your preliminary report really highlighted that.

The second issue is a matter that I don't think your report covered sufficiently is the context of the general health system in which veterans'

health care is provided. Particularly in mental health there is a national system in crisis. It does not provide any long-term care. It is very bad at dealing with people who have got relaxing conditions.

In the private sector there is no coordination of services, so the idea that you could give veterans private health insurance I think really would negate the need to have a system of care. And what DVA in a sense has given up having sold the repat hospitals is that it no longer has a system of care. It essentially buys services believing those services to be available in the community, and I can promise you they are not.

Now, and, look, I think another really important issue that we've just heard a series of statements about how terrible DVA is, look, I have had very extensive involvement with the workers' compensation systems nationally particularly dealing with emergency personnel and I would always choose to be a veteran. If one of my children wanted to become an emergency service worker or a member of the Defence Force, I would always tell them to join the Defence Force because of how badly they would be treated by the workers' compensation systems. So that I think the idea that you could get a group of people who come from the workers' compensation systems who might represent the interests of military personnel in a humane way is, I think, misplaced. You know, I think, well, ironic that the financial systems Royal Commission is being released today, because I think you'll find much of the ethics, the modus operandi of the compensation industry is one to be shied away from.

My final point is that there's obviously the recommendation that Defence would be capable of managing transition. Interestingly the Canadian Defence Force, and I'm not sure if you're aware of this, is actually in the process of setting up a transition command at this present time, and I think the way that they're going about that would be well worth your consideration. But the important issue is that in a veteran's life span 90 per cent of their health care is provided by the veteran system. Defence is a system that is attuned to garrison health care, not to specialist rehabilitation and I've indicated that I'd like to make a private statement to you in-camera after about some issues in relation to that, so that I think Defence doesn't have the expertise and is not equipped to oversight and manage a system of rehabilitation and lifetime care of people who have had military service.

**COMMISSIONER FITZGERALD:** Thank you very much for that. So we have a submission from you and it's more detailed than that. Can I just take up a couple of issues? In relation to not having a system of care, so we've got a very large expenditure in relation to the health system by both military and by DVA, so we spend a very large amount of money in

this space. So one of the things that's exercised our minds is that, yes, DVA can fund health, which it does through the cards and other means, but you're saying what we're concerned about is you don't end up with a system of care, we just seem to be ending up with a funding mechanism.

But there is a caution, and the caution is to what extent should you in fact or need veteran specific health care or mental health care services. So I was wondering if you could explore that with me. In relation to physical health there is an overwhelming sense that in fact that you don't need to go much beyond the current general health care system. In the space of mental health care there is a greater argument to say there might need to be specific services for veterans. They're very simple views but we need to put those. What's your view about the extent to which DVA or whoever it is should actually be designing and funding specialised services?

**PROFESSOR McFARLANE:** Look, I think that's an extremely important question that gets to the nub of the problem. I was at a conference in the Netherlands in April last year which brought together all of the main European nations that have been fighting in the recent wars in the Middle East and as well as the US, Canada, and the UK, and what's fascinating about that is that France is the only continental European country that has a veterans system after World War II for obvious reasons. But what they've all recognised that even in the context of really very good health systems veterans pose very specific and challenging health issues, and what they've had to do is to really develop a system particularly for mental health care for those veterans because one of the important issues is that post-traumatic stress disorder that is not treated well within the general mental health system. It's a highly fragmented system. You know, there are services for victims of crime, victims of violence, for sexual assaults, but there is no centralised area of expertise, and I think what used to happen is that the repatriation hospitals provided at least some capacity to have an organised service.

So, you know, I think that's one of the main reasons why you actually do need to have some system of care that's put in place because there is no development of capacity. You know, the training in most undergraduate and postgraduate degrees, including psychiatrists and Masters in Clinical Psychology are completely inadequate for managing post-traumatic stress disorder. And I think the other problem you've got is you've got this divide between the public and the private system. For example, when the repat was closed here obviously the Jamie Larkin Centre was established but I actually met with Senator David Fawcett, who obviously has an interest in military matters, and the Minister, Leesa Vlahos, who was the Minister for Mental Health and they agreed that the ideal situation would

be to actually pool all the money that DVA put into South Australia to mental health care and try and design a health care system that shared the assets and so you actually had a tiered set of services.

Now, it was impossible for DVA to talk to the state Department of Health and the private system and progress that despite the interests of the politicians in that idea, and I think that's an example of the complete inability of the system at the moment to recognise that, you know, you do have this pool of money but the optimal solution would be to put it into a tiered structure, because the other issue is that you've got the, well, Open Arms, which used to be the Vietnam Veterans Counselling Service, because that used to be a counselling service that wasn't a mental health service. I mean it's still not a properly equipped mental health service, so you've got this sort of hybrid organisation also sitting off to one side. Now, I think a lot has been done to improve the quality of the care that they provide, but that's another example where you've got this sort of arm that really isn't attached to the body, and basically I think the system really falls down in dealing with people who don't respond to treatment, and that's about 60 per cent of veterans. Nothing is being done to improve the quality of the interventions and the care for that group, and that is of enormous importance to having better outcomes in rehabilitation.

**COMMISSIONER FITZGERALD:** So in South Australia, as I understand it, you have a Veterans' Health Advisory Board; is that correct?

**PROFESSOR McFARLANE:** Yes. I sit on that, so - - -

**COMMISSIONER FITZGERALD:** You sit on that?

**PROFESSOR McFARLANE:** Yes.

**COMMISSIONER FITZGERALD:** And you have a dedicated little unit, who we heard from this morning, which is attached to or supports the Veterans' Advisory Council.

**PROFESSOR McFARLANE:** Yes.

**COMMISSIONER FITZGERALD:** And you've just mentioned the, is it Jamie - - -

**PROFESSOR McFARLANE:** Jamie Larkin Centre, yes.

**COMMISSIONER FITZGERALD:** - - - Larkin Centre and Richard and I both went there on a previous visit. So if you just take this State,

just this State, what would you like to see, and the second part of that is, who drives that? Is it DVA, is it the Commonwealth Government that has to drive, or do you believe that it lends itself to a State initiative with the support of perhaps the Commonwealth? So where do we go, and as I've indicated previously, the Productivity Commission is now reviewing the whole of the mental health system in Australia, neither Richard or I are on it, thank goodness, so it's a very timely, you know, insight at least into one part of the Australian community.

**PROFESSOR McFARLANE:** Well, look, just to give you an idea, firstly the State Department of Health is remarkably naïve about the veterans' matters. Now, it would be about six years ago now I was at a meeting where they were going to close some of the beds in the psychiatric unit at the old repat hospital as a cost saving initiative. Now, they didn't even understand that those beds were being paid for by the Commonwealth through the veterans' budget and they would actually lose that funding. That was the level of knowledge that they had.

Now, the other part of the story that you haven't mentioned, and I'm not sure if you're aware of this, there's actually a group of about 10 psychiatrists which is probably more psychiatrists than the Jamie Larkin Centre, who work out of the Adelaide Clinic, which is a Ramsay Hospital, who actually run an emergency service for veterans because the Jamie Larkin Centre basically cannot cope. It is not responsive to the needs of many veterans.

Now, I've been to meetings on the same day both related to the Jamie Larkin Centre. I was on the advisory group that looked at how to relocate that service, at a meeting at the Adelaide clinic and you could've lived in two parallel universes. There was absolutely no connection between those services, and the trouble is that the Department of Health does not see itself as having any responsibility for what goes on in the public sector for primary care, and you've got to realise that primary care, and the private sectors are integral to any effective health service.

Now, what does DVA say about it? Again, I've got an advisory role as the mental health advisor in psychiatry to DVA. I had a meeting with one of the senior personnel there where I discussed this issue, and they said it's not their business to interfere at a State level. So it's almost like you've got this Mexican standoff, where nobody takes responsibility. And I actually think you need to have clinicians in policy roles in Canberra in DVA who understand the State health systems. You know, I think often people who work in the Government departments in Canberra have this command and control view as to how things happen, with a

complete lack of awareness of the complexities of the networks and systems that exist at a State level.

**COMMISSIONER FITZGERALD:** Yes. The Commonwealth Government might say that its primary responsibility is funding, which it does through a whole range of mechanisms; the White Card, Gold Cards, some direct funding, everything else. And really it's not its role any more to actually design the actual service system. Now, that's a very simplistic view. From what you're saying and from what we've heard in relation to the mental health space that isn't going to be good enough. It's just not going to work.

**PROFESSOR McFARLANE:** Well, look, I think that's the way that they speak. The trouble is it does not work, and there's nobody at a State level who has sufficient breadth of responsibility or I imagine legislative responsibility to be able to take on the brief. And I think the issue about veterans is that it is a Commonwealth responsibility. You know, they haven't outsourced Defence to the states. They took it in at the time of the formation of the Commonwealth, and I think they are also therefore left with the responsibility for veterans who have served.

**COMMISSIONER FITZGERALD:** Richard, just on that, anything?

**COMMISSIONER SPENCER:** Yes. I think one of the issues, because we look at this in a number of different ways, and that disconnect between State and Federal levels. I'm just wondering, we started this conversation with the general system is woefully inadequate. So in the longer term, and our study is about the longer term, so we're trying to work out whether a veteran specific system is needed, and what you're saying right now the answer is yes, because there isn't the level of expertise within the general health system. Both through the other inquiry the PC is running, but also through some of the initiatives through primary health networks trying to connect up with local health networks, trying to do a regional mental planning, there's a project underway in Townsville that you're probably familiar with, with VHN around veterans.

**PROFESSOR McFARLANE:** Yes.

**COMMISSIONER SPENCER:** So where do you see this eventually? I mean, if we were to look about 20 or 30 years ahead will the architecture of this still look the same? An improved perhaps but still inadequate system for veterans, or would the general health system ultimately get to the point where more of that could be accessible and appropriate for veterans? I mean, do you have a view on that longer term generally?

**PROFESSOR McFARLANE:** Yes, look, having, you know, really been involved in this system now since 1980 I think if some radical initiative is not taken it will remain as dysfunctional as it is. And, in fact, in some regards I think it's got worse.

You've got to remember that DVA used to have 20,000 employees in 1990, and a very substantial body of medical expertise in a whole series of domains, and that's just been diluted.

And the idea that somehow the purchaser provider models and primary care networks can establish expertise, it's not going to occur. I mean, look, one of the views – look, and obviously you are interested in the proper spending of public money and the creation of efficient systems.

One of the things that I think perhaps it would be worth contemplating is that the Australian community – post-traumatic stress disorder is probably, with depression, the most costly psychiatric disorder, yet it's fundamentally missing from most mental health systems.

Because of the effects of violence, motor vehicle accidents, et cetera, in our community, quite apart from military service, and one benefit of actually creating and sustaining and better organising the military system is that it would have spinoffs for the provision of care for those other groups.

That is the core of expertise that is just fundamentally missing within our system at the present time, and you've got to remember that post-traumatic stress disorder was late in the day in terms of its acceptance, and as a consequence, there have been very few proper funding initiatives.

For example, with depression, you've got the Black Dog Institute in New South Wales, which is an example of a centre of excellence. You've got the Youth Mental Health Network, which is an example of trying to do early intervention in psychosis.

You have none of those sort of systems in place for post-traumatic stress disorder, despite the morbidity and the cost to the community. And see, I think the other issue is the funding for mental health services for PTSD is spread between motor accident commissions, workers' compensations systems, the public system and the veterans system, and I think if they were forced at some level to come together, I think you could get some real efficiencies.

The other issue is, even at state, the state levels, with the department – police, ambulance and fire services all have different health services that

come under different ministers. There's no coordination of the quality of care between those systems.

So I think there's just a disparate sort of chaos, really, in this space, and it's why I think the Veterans initiative is so important in setting a national example.

**COMMISSIONER SPENCER:** Could I take you back to an earlier stage of this, because I think in any system where there's injury and illness, you'd start with prevention.

So we've been really trying to address that issue, which is a difficult challenge within the military, because – and we've heard it here today - that it is to train members to go off and do on behalf of the nation, to be ready to do things that are, by definition, nobody else is asked to do in our society, and that it has consequences. We often hear Defence's responsibility is solely about that.

We struggle with the notion of duty of care. What is the Defence's duty of care, and it's been put to us that the tension that exists for the military is the duty to prepare for what people are going to be asked to do, and the duty of care, and there's a balance to the struck there.

And some of our recommendations are going to this idea of what can be done initially to both prevent and minimise an issue which manifests itself later with the consequences we've been talking about.

And what struck me, and I'll just give another kind of sort of take on this. I attended a seminar at the University of Sydney a few months ago with specialists looking at mental health issues for Veterans, both in the US and in Australia, and what struck me, they said if you don't go back to some of the root cause of this, the culture within military, you will be missing an important part of how to start with the preventative end, and then ultimately, as you're saying, the specific responses that are needed when these conditions manifest themselves later, and they always will.

But frankly, is there too much of that that's occurring unnecessarily, and they had quite a strong view on the culture of military, and I wonder if you have any thoughts or thoughts on that from your experience, and any thoughts about ways in which the military can be better, or Defence can be better informed about what can be done within a difficult environment, of duty of care and duty to prepare, that may be helpful and as part of a continuum on this sort of issue.

**PROFESSOR McFARLANE:** Look, again I think that's a very interesting and complex question. The Institute of Medicine did a review of all of the preventative programs for military personnel, and there are lots of programs that talk about resilience training, et cetera, et cetera, et cetera, and this is, I think, published in 2017 and it concluded there was no evidence that anything worked, other than screening.

And I would have to say that the Australian Defence Force has been a real leader in introducing screening of people post-deployment, and I think one of the other issues is that individuals in the Defence Force are very reluctant to speak of their emerging difficulties, and I think that creates all sorts of challenges for detection and care, and for the duty of care.

But the other thing, and again, this is an issue that I think is poorly understood, and we've been able to show - this is not in the public domain quite yet, so I'm going to be limited in what I say.

But we've got a cohort that we've looked at prior to and following deployment who have now followed up for five years. This is part of the Transition Wellbeing Research Programme, and what people really haven't quite grasped is that most people who become unwell don't become unwell acutely. That is by far the exception.

Most people adapt and then, with the passage of time, and it's because of the effects of ageing and inflammation and the accumulations of other life stresses, that's what leads to the consequence, long-term consequence of the combat, and we can show the neurobiology of that.

So I think if you were really going to talk about duty of care and prevention, it's about actually understanding that early dis-regulation which occurs. But I think the trouble is that most of the people who are in positions of administrative seniority have very little understanding about what we're now understanding about the underpinnings of these disorders, and look, the science has come a very long way.

But the problem, there isn't a receptive ear to what that science is, and I think there really needs to be a lot of thought put into this, and that's just not happening at the moment.

**COMMISSIONER SPENCER:** Thank you.

**COMMISSIONER FITZGERALD:** You made the comment over in your paper, and just orally, in relation to defence not being a great place for long-term rehabilitation and care of Veterans. We see a role for a veteran specific body, but we do see an increased role for Defence, at least

in the transition period. About 80 per cent of all transitional activities take place by defence, and frankly, it needs to improve dramatically.

So I just wonder if you could just explore that a little bit further? I mean, both defence and the DVA exercise and spend a fair bit of money in the rehabilitation space. We have been highly critical of those areas, particularly in relation to DVA, but also in Defence.

One of the issues at the moment in government is there seems to be the answer is just outsource it. So we just give a particular company the national contract, and it's all gone. We have a very different view about that. We think that there are problems with that, and I was wondering about your view of this?

**PROFESSOR McFARLANE:** Well look, I would like to give some of my evidence in relation to that question in camera.

**COMMISSIONER FITZGERALD:** Sure.

**PROFESSOR McFARLANE:** For what I can say on the public record. Look, when I first was recruited into the Reserves, one of the things that you did as a Reserve officer was to provide treatment for currently serving personnel, and so that the Reserve network of specialists was very important to the medical manpower within defence.

Now because you've got to remember that our Defence Force, I think now, has two full-time medical specialists. The psychiatrist has only been there for two years, and he's not in uniform, and there's a surgeon.

In the Canadian Defence Force, they have 12 full-time psychiatrists. They've got about 10,000 more defence members. So there's a woeful inadequacy about specialist knowledge and expertise within Defence, and progressively - when the Medibank Solutions contract was let, most of those Reservists who previously had provided care knew about the military (indistinct) and refused to become part of that network.

Because I'm not sure if you're aware about the fee structure. Medibank Solutions took a third of the fee, and the specialists had to just take the standard bulkbilling fee for Medicare.

Now many of these people are senior clinicians, who willingly gave up their time for Defence, only to just sort of be really treated terribly, I think, by them with that contract. So it had no concern about quality.

Now I'll never forget a meeting I had. Actually, it was in Parliament House here with the local commander for Defence Force, and he said, well aren't all the psychiatrists who we're now using registered, fully registered specialists by the Australian and New Zealand College of Psychiatrists? I said, yes, but they're not – they people who really have a choice about quality are not going to be functioning under that fee structure, and you're not getting the people that have had a lot of experience.

And there was another pilot. This fellow was a – he commented, he said to the Chief of Defence here, he said, well sir, do you fly Tigerair? And he said, of course I don't. He said, now I understand the problem.

And I've certainly had Defence members who previously were treated under the old system, had very, very good treatment, and then subsequently – this is including with orthopaedic injuries – have gone off to second quality specialists and getting very poor quality care, so that - you know I think the Defence contract that's been put in place has very few quality provisions in it, that often people have got no links to military service. The communication back into the military is very poor because there's actually an intermediary of the health administrator between the commission and the specialist. One of the things about the way primary care referrals work is you have got a group of specialists who you refer patients to and you ring them up and you say, "Look, I've got this problem. What do I do about it?" Well as soon as you put an organisation between the specialist and the primary practitioner you break down that whole transfer of information and that trust. So I think the system that's been put in place really is, you know, the worst of managed care, in a way.

**COMMISSIONER FITZGERALD:** Okay, good. I understand you want to make some comments in camera at some stage.

**PROFESSOR McFARLANE:** Yes.

**COMMISSIONER FITZGERALD:** So we'll facilitate that in a few moments. So I'll just conclude your testimony for the moment if I can. Is there anybody else in the audience that would like to make a statement before we conclude? Yes. So if you could just leave for a moment Alexander.

**PROFESSOR McFARLANE:** Yes, sure.

**COMMISSIONER FITZGERALD:** And just come through. We'll have to keep these quite short, so that's fine. And I think you'll need to sign a form at the end of this - not Alexander but the others.

**MS NORREY:** I will be brief.

**COMMISSIONER FITZGERALD:** That's fine. If you can just give me your name and any organisation you represent.

**MS NORREY**: Lee-Anne Norrey, and I am here with the TPI Federation, which is the Totally & Permanently Incapacitated Ex-Servicemen and Women, and I just really wanted to talk about a few things that were mentioned today. One of them is you have asked a number of times about seeing medical specialists here in South Australia. And one thing that I've had a personal issue with and have discovered that it is a broader issue across South Australia is getting psychological help or psychiatric help that is very specific to your needs. I have needed to meet with a chronic pain specialist and that is something that DVA has simply not approved. And I've gone through VVCS, who have been fantastic, but they simply don't have those kinds of specialists on their books. So after meeting with one of their specialists a few times, she said to me, "I'm sorry I simply can't help you at all", so I'm essentially stuck now with either not seeing a pain specialist or paying for it myself. And from that instance I have spoken with a number of other people who have had that exact same problem and I don't understand why that is a problem at all. But it would seem that it comes back to DVA not paying these specialists as much money as they would like to be paid, which is quite tragic.

And one of the other things that I think is really important is how many ESOs we have. And I understand that nobody really wants to have much to do with the RSL, and I'm certainly one of those people, but they really in the olden days did a very good job of being this one group who lobbied for all defence personnel. And now when we have many hundreds of ESOs I think it's just diluted the core of any kind of impact we can have, getting the things that we need across to government. So I think it's really important for people like the AMSO group to be the umbrella that perhaps we are all under. Not necessarily that it's that group but something like what those people are trying to do. And that's really all I wanted to say, thank you.

**COMMISSIONER FITZGERALD:** Could I just ask the last question. What role do you think government has in trying to aid the ESO community? I mean, just to put it clear, most people would say that ESOs, like all other community organisations, can come and go as they wish and organise themselves as they wish. But do you think government has a specific role in trying to, as I think Richard indicated before, leverage better outcomes from that vast network?

**MS NORREY:** Yes. I don't exactly know how it would be done, but one thing that we've talked about in our organisation is the possibility of having tiers of ESOs, that you have - which I don't see necessarily how this would work, but that you would perhaps have ESOs with maybe 1,000 members, or that they have advocacy work, they do welfare work, that they are more supported by government, and that the lesser ESOs with smaller numbers perhaps have less support by government, so natural attrition will make them want to join a bigger ESO group. I don't know that that's really the answer but it's one suggestion.

**COMMISSIONER FITZGERALD:** Fine. Richard, anything?

**COMMISSIONER SPENCER:** No.

**COMMISSIONER FITZGERALD:** Thank you very much.

**MS NORREY:** Thank you.

**COMMISSIONER FITZGERALD:** Does anyone else want to make a final comment? So, if that's the case, I'll just need to need formally - firstly, thank you, thank you for your participation and for your attendance. Secondly, I just want to say that we would like your submissions in this month. The deadline for them is very tight but we are a little bit flexible with that but not much. And if there's anything that's arisen today that you want further clarification on from us, please contact our office.

So I just need to formally adjourn these proceedings until tomorrow, where we reconvene in Perth. So thank you very much.

**MATTER ADJOURNED UNTIL**
**TUESDAY 5 FEBRUARY 2019**