Submission by RSL Veterans' Centre East Sydney to the Productivity Commission's inquiry into the Department of Veterans' Affairs

RSL VETERANS' CENTRE EAST SYDNEY
18 Spring Street
Bondi Junction, NSW 2022
Telephone: (02) 9389 7245 • Fax: (02) 9386 5631
info@rslveteranscentre.org • www.rslveteranscentre.org
ABN 69 219 779 044

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What has the Commission been asked to do?

The Commission has been asked to undertake a comprehensive examination of how the current compensation and rehabilitation system for veterans operates, how it should operate into the future, and whether it is 'fit for purpose'. In undertaking this task, the Commission is to:

- review the efficiency and effectiveness of the legislative framework, and the effectiveness of governance and service delivery arrangements
- take into account the current environment and challenges faced by veterans, including considering:
  - whether the arrangements reflect best practice, drawing on workers' compensation arrangements and military compensation schemes in Australia and internationally
  - the use of Statements of Principles (SoPs) — which are legislative instruments used in the MRCA and VEA that set out the requirements for a veteran's impairment to be linked to their service
  - whether the arrangements deliver compensation and rehabilitation to veterans in a well-targeted, efficient and veteran-centric manner.

Assessing the veterans' compensation and rehabilitation system

QUESTIONS

What should the priority objectives for veterans' support be? Why? What principles should underpin the legislation and administration of the system?

The Centre believes that the underlying principle (as pointed out in the Issues Paper) ought to be that both veterans and current serving members of the Armed Forces enlist and serve and are likely to face more danger and unusual working conditions than any other group. As well, as members of the ADF they have unusual and often difficult working conditions. For instance, members need to follow orders without question, have little or no ability to invoke WH&S and similar legislation but that the vast majority of those who join do so because seen as "vocation", not just a job and that they are "serving their country".

Thus, it is the Centre's position that DVA must be more accepting of claimed disabilities and conditions, rather than seeking to reject them. Further and in support of that, DVA should live by its motto "Honour their service" and should work with whatever legislation it is considering for each claim (see more about legislation below) accepting that it is "beneficial legislation".

The Centre also posits that DVA need to accept that veterans struggle outside the framework of the ADF. There are many reasons for that. We address some of those later in this submission.

QUESTIONS

Is the current system upholding these priority objectives? Where are the key deficiencies in the system?

The Centre's position is that DVA definitely do NOT operate by those principles. There are numerous examples where it is obvious that claim handlers and delegates do not accept that the nature of service is likely to cause injury, e.g. back, shoulder, knees – if a soldier is doing lots of "ground pounding" then such injuries are likely, if not guaranteed, to occur.

Also it seems to the Centre that DVA do not understand or accept that most members of ADF don't report an injury/disability for many reasons; most significantly, if a person is found to be injured then it is most likely that he/she will be downgraded with consequent loss of pay and allowances or even medically discharged but also that there is a pervasive ethos to not be seen as a "whinger" and to not to let the team down (especially given that the Services work hard at building team efficiency and spirit).

Further, it is the Centre's position that there is a significant deficiency in the administrative structure of DVA, which leads to significant inefficiencies and often to disadvantage of the veteran. In particular, it is clear that many, if not most, sections of the organisation operate in "silos" and do not communicate, let alone co-operate, with other sections. This leads to delay, double handling, extra costs for both veteran and department and often to wrong decisions being made because the claim has been directed internally to the wrong section when it was first received.

Those inefficiencies seem to be known to DVA but not addressed. They are contrary to the explicit statement on page 11 of the claim form, departmental form D2051, that each claim will be looked at under all legislation; VEA, MRCA and SRCA/DRCA. That does not happen in practice. Each "silo" makes a decision om relation to whichever act it deals with and sends the matter back to the veteran. It is never sent to another "silo". The veteran then has to resubmit the claim again and hope it gets to another, different "silo". Further, the Centre has been explicitly informed that claim handlers do not read, let alone act. Upon covering letters from ESOs with claim forms which often set out what are the issues and how the accompanying claim form lies across two or more acts. Such practices fly in the face of the various acts being "beneficial legislation". The Centre has also experience a few quite opposite instances where claims have been passed back and forth between sections but without anyone seeming to take ownership of any of the issues. We suspect that this is evidence of staff just wanting to "get the file off the desk".

A system to meet the needs of future veteran

QUESTIONS

What should the system of veterans' support seek to achieve in the longer term? What factors should be considered when examining what is in the best interest of veterans?

DVA through veterans' support need to understand and accept the current nature of service; that there are many deployments, and even without deployment there is much

shifting around and postings and the effect those things have on veterans and their families. DVA and other support services need to recognise and address that there is less general support in the community than there was, say during WW2, i.e. often there is no definite or obvious reason for the turmoil requiring ADF involvement like there was with WW2, i.e. it is less clear cut and also much more open media opinion and too much criticism. Thus, there are additional stresses on members and families than previously.

So, support services, including DVA, need to consider and take account of the physical and mental effects on ADF members and their families. We have seen increased suicides and increased mental health issues (they were probably there before, e.g. WW1 "shellshock" but were just "swept under the carpet).

Support in the longer term needs to address the above issues and also to address the fast-changing nature of the society into which ADF personnel will be transitioning. People expect faster responses to their needs and use technology better while also expecting others, including DVA, to also respond in a timely and more "connected" manner. There has been a technology driven explosion in knowledge which has conditioned people to expect, as normal, that decision making will be faster and will also provide the "why", as well as the "what". Currently, many "Reasons for Decision" assert that the delegate has considered service records and medicals and then used that as a basis for denying a claim, when it is clear that the delegate has not reviewed all the records and/or has made serious errors when reaching a decision. In the future, veterans (who are generally better educated and informed than previously) will know that there is technology to assist the claims process and will want to see the evidence and the reasoning process used (as DVA are now required by law per *Wingfoot v Kociak,* to so do but rarely do in practice).

How have veterans' needs and preferences changed over time? How can the system better cater for the changing veteran population and the changing needs of veterans?

Veterans now have different choices from the previous rigid system, e.g. previously a person needed to reach certain rank by a defined age or be discharged. As well, there are now many different forms of service e.g. CFTS for Reservists. Also, now there are many different forms (often quite opaque or misleading) forms of post-service options, MSBS, as against DRFB. See: https://militarysuper.gov.au/education-and-advice/faqs/ for example.

Further, with the greater numbers of females in the ADF and thus becoming veterans, often where both parents are ADF members and where there are more "blended" families then the needs and preferences of veterans have become more complex and varied. There has also been a significant rise in the cost of many things, particularly housing, medical and education requirements that are provided to ADF personnel but which are often beyond the financial resources of those transitioning out of the ADF, either voluntarily or through medical discharge. That has forced many veterans to move to more remote and less expensive regions but which also take them away from supports and services, especially for veterans with ongoing physical or mental conditions.

QUESTIONS

However, the Centre's position is that the legislative distinctions made between types of service; VEA v MRCA v DRCA, leading to different outcomes are, to a great extent, artificial differences. Specific deployments followed by training for next deployment, plus CFT for reservists and Ready Reserve are all possibilities and each can lead to quite different outcomes for the injured service person and/or their families. All personnel are training to do the job in a system that is more focussed. It is the Centre's position that we don't need the artificial differences in legislation (and their attendant crossover, inconsistencies, anomalies and negative effects).

In particular, we see a very egregious anomaly for those personnel who served in the 1990's and 2000's before 2004. For example, a soldier could have been diagnosed with PTSD from warlike service in East Timor in 1999 and had that disability accepted under VEA. That person could have then been injured during training in 2001 and developed lumbar spondylosis which was accepted under MRCA. The person is precluded from either TPI or SRDP because the 2 conditions are accepted under different acts and thus preclude the granting a payment under the other act when the veteran is now unable to work.

How should the nature of military service be recognised?

QUESTIONS

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

Veterans on one hand have more services provided (as also discussed above), e.g. medical and dental while in service but also have no choice – they go to whoever they are directed/ordered. Often these lead to problems but DVA doesn't accept that they had no choice. It is quite apparent that DVA staff look at such issues with non-ADF eyes, particularly the front-line claim handlers and CMAs who have no Defence experience.

Defence personnel have to "learn" about simple things when they transition out, e.g. getting a Medicare card, that non-ADF grow up with and absorb from their own experience. These small things place extra stresses on ex-ADF people and their families when they leave. If ADF persons do adjust to service life (and we query if it happens much) they then have to accept a different set of circumstances when those members discharge in mid-life (30s-40s) and their children are by then teenagers. The issue which does not seem to be understood or accepted by DVA is that there is much disruption in Service personnel's lives, on top of them being more likely to suffer disabilities and diseases, etc.

As above, DVA need to think *for* veterans, i.e. to assist them, not trying to find ways to get the file closed as quickly as possible. They need to be more accepting and actually work **for** the veteran, including accepting that each volunteered to serve their country, thereby also taking on all its attendant problems. Veterans are not like people who did not serve but

those others have an "entitlement" approach and seem to get better treatment from those who provide benefits, than do veterans.

There are the other characteristics of service discussed above, e.g. WH&S issues, lack of autonomy, etc. The most significant differences are that the job involves the greatest amount of risk of injury or death (even more than emergency first responders) as the nature of the job is the likelihood that some other entity will be trying to kill or maim the member and that many of the things that are done in service have no comparable equivalent in civilian life. There is no civilian equivalent to firing a howitzer! As a corollary, firing a howitzer is not a directly transferable skill to civilian life. Thus, both while serving and after leaving, the service person faces challenges, risks and issues that are unique and should be seen as such.

That it is unique does not seem to be well understood or, if it is understood, is not appreciated. Maybe we all need to start with the politicians. They're the ones who send service people "in harm's way" and want them to be highly trained but don't want to pay the price afterwards, especially if they are injured or otherwise disabled as a result of that being sent "in harm's way".

What is the rationale for providing different levels of compensation to veterans to that offered for other occupations, including people in other high-risk occupations such as emergency services workers? Are there implications for better policy design?

The position of the Centre as stated above, is that the rationale for having different levels of compensation seems to be no longer valid (if it ever truly was). The nature of service has changed (as above) but the legislation has not similarly changed in any significant way. National Service ended 46 years ago. There are no more conscripts as against volunteers (if that was ever really a reason to differentiate – some conscripts went on active service and some didn't). All current ADF are volunteers and are focussed on being trained and being ready to go on active, operational service. That they may be injured while in training, rather than in a war-like situation is not a consequence of where or why they were in a certain place but is a consequence of the nature of their service, wherever it may occur, as set out above.

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

There are differences in some support and definite differences in the levels of compensation available and, in certain circumstances, as set out above, indefensible anomalies. Thus, the Centre's opinion is that there is no longer any more reason for differentiations (if there ever were). As also discussed above, the lines between different types of service are now indistinct, when a Reservist can go on CFTS. It is the Centre's experience that there are many service persons who change form one form of service to another, back and forth. To an extent that is a factor of interlocking factors such as the multiple but shorter operational deployments, the size and composition of the various

arms of service, the nature of many of the roles being performed, particularly in the more technical areas and the family and socioeconomic issues discussed above.

Have the Statements of Principles helped to create a more equitable, efficient and consistent system of support for veterans? Are there ways to improve their use?

The practical effect of Statements of Principles is variable. They provide some certainty and in a number of cases make it easier to relate the injury or disability to service.

But there are many anomalies. For example, changes to the SoP for PTSD added some factors but did away with others that were also relevant to service. Further, there are a number of anomalies in the SoP for PTSD in some of the defined stressors. These create possibly unintended consequences for some veterans. For example, the factor for having PTSD from seeing or retrieving bodies requires that the veteran sees more than one body. There could be many cases where seeing just one badly injured or worse mutilated or decomposed body brings about PTSD in the veteran but, as the SoP currently stands, the veteran who sees that single body does not qualify under the SoP.

It is also the Centre's position that there are anomalies within SoPs that the Repatriation Medial Authority could review but choose not to. The Centre has made submission to the RMA on issues based upon actual service but the Authority has declined to review the SoP. Given that the Centre and other ESOs are the most likely entities to see cases that involve actual instances where the injury, disease or condition is related to service, there should be a more collaborative approach taken.

What is the rationale for having two different standards of proof for veterans with different types of service? Are there alternatives to recognise different groups of veterans? What would be the costs and benefits of moving to one standard of proof for all veterans (for example, would it make the claims process easier)?

The Centre accepts that the Reasonable Hypothesis basis ought to apply to war-like and similar cases as against the Balance of Probabilities basis for non-war-like. WE accept that often in warlike situations things happen very quickly and where obtaining supporting evidence is difficult or, as we have experienced, the supporting documents are lost or destroyed. Thus, a more "relaxed" basis is appropriate. However, as discussed above, there now exists the changed nature of service with less obvious distinctions between the type of service. Significant training for the next deployment or for such things as anti-terrorism situations blur the distinction and, if one considers history, there were many deaths from training during WW2 which were covered as if warlike which would not now be so covered. We say again that they are artificial distinctions which can lead to injustices for serving members, veterans and their families.

As well, there are many "peacekeeping" type service incidents that have high risk e.g. Eritrea or Cyprus where the member is unarmed but in significant danger which does not qualify under the Reasonable Hypothesis basis or the deployments to Bougainville

where the nature of the deployment and thus the proof basis was only changed by ministerial direction.

The standard of proof part is not, in most cases, the issue that makes considering and managing a claim more or less difficult.

System governance

QUESTIONS

Do the governance arrangements for the veterans' support system encourage good decision making — from initial policy development to its administration and review? If not, what changes could be made?

There appears to be a disconnect between policy making and implementation by DVA claims handlers. For example, the NSW Commissioner for DVA said in May 2017 that claims by Infantry soldiers for injuries to shoulders, backs and knees would be "fast tracked" and accepted "at face value" (at least in most cases). The decision made sense given the nature of service for those in the Infantry. That is not happening in practice. We see claims by soldiers with shoulder and back injuries declined for many reasons, often because there is no clear radiological evidence (as required by the SoP) but who clearly have suffered wear and tear over many years of service. There may be no "report" or medical record (as the soldier hid the condition, for the reasons set out above).

Further, there are a number of areas where governance within DVA is poor and where there are instances of denial of procedural fairness (previously "natural justice"). The Centre has dealt with a number of matters where DVA has unilaterally terminated a veteran's incapacity or other payments based without notice to the veteran and (apparently) based upon information which DVA has obtained from banks and other sources, again without any recourse to the veteran. The veteran, then the Centre on his or her behalf, has to chase DVA for information and also to find the basis for the unilateral action. Often this is the aforementioned information from banks and similar. However, the "analysis" by DVA on which the unilateral decision is made is often flawed, out of date or would have been more and better understood if a slightly longer "snapshot" was taken. In all cases a revised decision was made but only after significant time, effort and cajoling made on the veteran's behalf.

In a similar way, the Centre has assisted veterans where DVA has made mistakes which, only after much time and effort and only by use of formal claims made under the Claims for Damages for Defective Administration format has DVA conceded that errors were made, again without any recourse to the veteran and, in each case, where the veteran has been significantly out of pocket and disadvantaged. That such CDDA matters take years literally to be concluded and with much "stonewalling" at even senior levels (of which we have evidence), is evidence of, in our opinion, poor governance within DVA.

As a corollary, the Centre points to the system of review of decisions by the Veterans' Review Board, on the one hand and that there is no avenue for such review for claims under DRCA. There is significant anecdotal evidence that requests for "reconsideration" by another officer within DVA for SRCA/DRCA claims are unlikely to be successful. Further, there is no transparency in the reconsideration process such that the veteran can have any strong belief that all issues were considered and objectively considered. The reconsideration process offends against the legal principle "*non iudex in sua causa".* It is the Centre's position that there be one system of review for all veterans' matters to the Veterans; Review Board.

Are incentives sufficiently aligned between agencies, or are there areas of conflict that could be better managed? If there are any incentive problems how can they be resolved?

The Centre is not certain as to which "agencies" the Inquiry is referring. If it is meant to mean within DVA then the Centre's position about "silos" is discussed above. If it is meant to refer to DVA vis-à-vis Defence then the Centre's experience is that there have been a number of problems where serving members are transitioning out of Defence and have made claims for injuries with DVA. In particular, where the member is being medically discharged, there have been difficulties and delays with Defence personnel completing necessary documents or failing to provide the member with complete sets of records, or both.

In a similar way, where the veteran has left service and has made a claim, there is a misalignment between Defence and DVA in relation to providing records. It is the Centre's opinion that there are problems in both departments. It is not known but surmised that transfer of this type of information is not seen as a high priority, especially by Defence which has compelling operational requirements but if there were better incentives, e.g. better systems and connectivity between the 2 departments, then this issue ought to improve.

Is the veterans' support system sufficiently transparent and accountable for both veterans and the community?

In broad terms, the Centre's position is that there is significantly insufficient transparency for both veterans and the community. Some of this has been discussed above. In particular, it is the Centre's position that there are too many cases where the Reasons for Decision state that the delegate "has reviewed service and/or medical records" but does not actually set out the actual document(s) referred to or the reasoning, even when it is pointed out to DVA that it is a legal requirement, per High Court in ***Wingfoot Australia Partners*** *Pty Ltd* ***v Kocak*** [2013] HCA 43. Further, there are many matters which are taken on review to the Veterans' Review Board where it becomes very clear that the delegate has not reviewed the service or medical records, both in the section 137 bundle of documents (which are often incomplete) and when a full set is finally obtained from Defence.

QUESTIONS

As a corollary to the above, there are also many instances where it becomes clear that the delegate has taken a very narrow view or chosen only one factor from the list in the SoP (or both) and when a broader and more "beneficial" approach is taken by the VRB, the decision of the delegate is set aside and the claim allowed.

Further, there are no statistics reported (and it appears none taken) of how many original decisions by delegates are set aside by the VRB. It is the Centre's position that such measures ought to be taken or, if they are taken, that they be made public. If there is a pattern of decisions being overturned, particularly in a particular area, they would serve as indicators of either the need for better training of DVA staff or of the need for legislative change (or both). They would also inform veterans and ESOs of how each piece of legislation should be approached and what are the requirements. That all leads to greater efficiency.

What role should ESOs play? Are there systemic areas for improvement in the ESO sector that would enhance veterans' wellbeing?

It is the Centre's position that ESOs play a very important part in the process. They are often the first point of contact for veterans seeking guidance and assistance. ESOs also support centres of excellence like the Veterans' Centre.

However, it is clear that the training system for persons assisting veterans and serving members and their families is not currently working. ATDP is not delivering sufficient trained person and, in particular, is not attracting or training many younger veterans and serving members. As well, the system is losing many ESO advocates and pension and welfare officers through age and/or the continuing complexity of the legislation and system. There are many ESOs but the level of knowledge and experience is extremely variable.

The centre proposes a two-tiered system with "ground level" pension officers to advise veterans and prepare original claims and then a smaller, more experienced and trained group of actual advocates to prepare and argue matters in the VRB and AAT.

The role of the Australian Defence Force — minimising risk

QUESTIONS

What obligations should be placed on the ADF and individual unit commanders to prevent service-related injuries and record incidents and injuries when they occur? To what extent do cultural or other issues create a barrier within the ADF to injury prevention or record-keeping?

Subject to what we say about serving persons being reluctant to report injuries that might lead to their downgrading or even medical discharge, The Centre accepts that WH&S legislation does apply to the ADF and to individual commanders, with necessary carve outs which reflect the unique nature of military service and operational requirements. We are also aware of instances where unit commanders and others such

QUESTIONS

as senior NCOs have taken actions and issued orders that, if taken to their proper conclusion would have resulted in those people being prosecuted under the WH&S legislation, as those orders and actions were not covered by the specific carve outs and took place in circumstances that amounted to bullying or harassment.

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

The Centre makes no submission to this question except as already set out.

Providing financial compensation for an impairment

QUESTIONS

Is the package of compensation received by veterans adequate, fair and efficient? If not, where are the key shortcomings, and how should these be addressed?

System is not adequate or fair. Many of those who receive compensation are not able to work or only for a small number of hours and the level of pension/incapacity payments is close to subsistence level. Vide where veterans tend to live after leaving services, in low cost/rent areas but also away from the support and medical and similar services they need.

As set out above about the nature of service persons' commitment and the fact that they are most often at or near middle age when they discharge (unless seriously injured during service) and that, in all those situations, they are at an extreme disadvantage compared to much younger members of the community, then what they do receive by way of compensation is not adequate or fair. Age discrimination exists and is known to exist. Also, unless the veteran was in a technical role, their transferable skills are seen as low by potential employers and even more so by young staff of recruitment agencies. Vide how many ex-infantry are only offered jobs as security guards, because recruiters don't take into account their training and experience; of working to plan and in teams (where their lives actually depended upon teamwork), also following orders but also that they are trained to use initiative, used to hard work and long hours. [There is a small shift to getting such soldiers jobs into construction as they fit in well with these skills but fall foul of militant unionists in the industry.]

Is access to compensation benefits fair and timely? In particular, are there challenges associated with the requirements in the MRCA and DRCA that impairments be permanent and stable to receive permanent impairment compensation? How could these provisions be improved?

It is very obvious that access to compensation is often neither timely or fair. The centre does acknowledge that in some cases and, with praise to some DVA staff, it has been done well in instances where the veteran has serious problems. We accept that there is a need for stability of conditions to allow finalisation of the level of incapacity but that

should not allow DVA to cease (i) assessing and managing the claim and (ii) not providing support and ongoing assessments in the many claims were "not stable" is given as the

excuse. There are instances where DVA does provide those but there are too many cases where DVA says "Not stable. Case closed or deferred".

Helping people transition from the ADF

QUESTIONS

Are transition and rehabilitation services meeting the needs of veterans and their families? Are veterans getting access to the services they need when they need them? What could be done to improve the timeliness of transition and rehabilitation services, and the coordination of services? What changes could be made to make it easier for ADF personnel to transition to civilian life and to find civilian employment that matches their skills and potential?

Transition and rehab are "patchy". In some instances, the DVA on base representative and the claim handlers have been very good and have really helped the member during complex and difficult times, especially where the discharge has been on medical grounds.

However, at other times as discussed above, there has been a "disconnect" between DVA and Defence, especially where final reports and discharge summaries are needed. There also appears to be a "disconnect" between Defence and DVA on the transfer of records, especially service medical records. That issue has been improved by the Defence eHealth records system.

There are many instances where only part of the records are provided. It should be obvious to DVA Records staff where, given the length of service, the number of records received is not matched the time served. For example, the soldier served 1985 to 2005 but the records are only for 1998-2005. DVA do not seem to look for the missing records but only act on what they have in front of them.

Hence, there are too many instances where "paper warfare" does not meet the member's needs and actually adds to their anxiety and/or frustration.

It is suggested that for both transition and for claims made, that there be a co-ordinating person who is identified to the veteran (or his/her representative) right at the start of the process and will be the point of contact, rather than the current, disjointed, piecemeal system. Currently, the veteran has to try to identify who is handling the transition at any one time via the DVA main switchboard. That is almost ALWAYS overloaded and when the call is finally answered, the operator can't identify who is currently handling the claim. That adds to the frustration of the veteran and exacerbates the belief that DVA are trying to deny all matters where, often, it is inefficiency rather than actual obstruction or denial.

Veterans who are medically discharged are generally in higher needs categories than people who access other rehabilitation and compensation schemes, and have exhausted options for

QUESTIONS

return to work in the ADF. How should this be reflected in the design of rehabilitation services for veterans?

How should the effectiveness of transition and rehabilitation services be measured? What evidence is currently available on the effectiveness of transition and rehabilitation services? How can the service system be improved?

There is little published measurement of any of DVA's processes. If they exist, they are not made public. Obviously, such measures of efficiency as time taken, number of recalls and revisions, number of enquiries made and time to respond and to actually address the issue of the call, would be measures of efficiency.

Measures of effectiveness would include number of claims made and the number that meet W.E. Deming's TQM "do it once and do it right". Measures of ineffectiveness would be number and type of claims that are referred to the VRB and, especially, where such claims that are resolved by the VRB without a hearing, i.e. that if DVA had looked more closely at the information or taken more time and /or interest (rather than just getting it off the desk), the matter would have been resolved at first instance.

There should be satisfaction feedback surveys of veterans who are discharging and analysis of good and bad points. Follow up would be then on how well and quickly the bad points, the things that frustrated veterans, were being addressed and fixed.

In some countries, rehabilitation services are provided to the families of severely injured and deceased veterans. Is there a rationale for providing such services in Australia? If so, what evidence is there on the effectiveness of these services?

It is not clear if this question means how effective are the overseas services. Generally, Australia ought to do cohort studies of the children of veterans during and after service. The dislocations and constant changes of home and school must have an effect. Indicators would be schooling achievement, rates of family mental health issues, rates of divorce and separation, number of families in financial trouble. These would probably be seen by organisations such as Legacy and RSL DefenceCare but not an overall picture.

Income support and health care

QUESTIONS

Is health care for veterans, including through the gold and white cards, provided in an effective and efficient manner? Has the non-liability coverage of mental health through the white card been beneficial?

The White Card for NLHC is done very well. Recent changes sped up service, which is extremely important especially for those with mental conditions.

The Gold card is not well done. The process to obtain the card is usually long and complex, except in the most obvious cases, for example a quad or paraplegic; a severe head injury or loss of limbs. Often such cases need to address usually multiple injuries and the interlocking effect of those, while also considering those injuries that are MRCA, not VEA and thus don't qualify and, in quite a few cases as outlined above, cause the veteran not to get the Gold Card because it is not covered or excluded by operation of legislation. The issue of serious injury in training, as against operational service, is again often an issue. Often, the veteran was injured on active service but the field medical records are not available. As well, for reasons set out above, the veteran does not report the injury at the time and, also, does not report it to DVA to have a contemporaneous record when returning from deployment, etc as DVA will contact Defence and then the injury is disclosed to Defence, leading to downgrading, medical discharge, etc.

As well, The Centre often sees examples where treating doctor(s), often specialists, report serious issues but DVA CMAs (who have not examined the veteran) reject that they are serious or are related to service (or both). Many times the "Minute" from the CMA and/or the delegate's Reasons, do not clearly explain why the claim was rejected (contrary to the requirement in the *Wingfoot* case). The Centre has seen too many examples to not conclude that focus is on finding ways to NOT award the Gold Card.

The Centre also makes the following suggestion: give a White Card to every ADF person who returns from deployment, when they return. The chance that they have a covered injury or disability is high and the benefit of them knowing cover is there and that they can take it wold obviate many of the issues which arise later as claims.

Is there scope to simplify the range of benefits available, and how they are administered? Are all of the payments available necessary and beneficial? Are they achieving value for money outcomes?

The Centre's position is that there is great scope to simplify the range of benefits and how they are administered. The first step should be to combined the 3 or 4 different and often contradictory pieces into one act and to remove the essentially irrelevant distinctions between the various types of service. That would simplify the range of benefits and, by implication how the benefits were administered. That must lead to savings in time, systems, staff and cost.

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

The obvious benefit of income support is many faceted. It provides an element of security, that is known to the veteran and thus helps to alleviate the issues, especially the mental issues

facing many veterans, especially younger veterans currently. In addition, such support would help those transitioning veterans who struggle to find civilian employment (for the reasons set out above).