



Australian Government

Department of Veterans' Affairs

Submission to the Productivity Commission Inquiry into Compensation and Rehabilitation for Veterans

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Crisis Counselling—1800 011 046

Veterans and Veterans Families Counselling Service (VVCS) can be reached 24 hours a day across Australia for crisis support and free confidential counselling. Phone 1800 011 046 (international: +61 8 8241 4546). VVCS is a service founded by Vietnam veterans.

Executive summary

Introductory comments

The Department of Veterans' Affairs (DVA) welcomes the Productivity Commission's Inquiry into Compensation and Rehabilitation for Veterans and its examination of how the military compensation and rehabilitation system currently operates and should operate into the future.

This submission presents information on Australia's current system of military compensation and rehabilitation, including detailed information on the veteran community, and on the governance, administration and delivery of compensation, benefits, payments and services to veterans and their families. In doing so, it recognises the past and present contributions of the Department and acknowledges the challenges, barriers and opportunities still to come.

In responding to the major issues as identified in the Productivity Commission's Issues Paper for this Inquiry ('Issues Paper'), DVA is taking the opportunity to frankly and clearly discuss issues in the system. By doing so, DVA hopes to inform the Commission and others of opportunities to reform the system, as well as the steps DVA is taking to address these issues and opportunities through its current and planned transformation initiatives.

The submission sets out important context for the Commission's consideration of the issues before it. It also outlines the system of military compensation, the reasons for the existing state, and some of the challenges and opportunities available. Some of the history of the system, as well as particular features of the existing system, are outlined to help in considering future reforms.

DVA remains willing to support the Commission with further data and information as required.

Environment

The rehabilitation and compensation system for veterans is steeped in history, stemming back to World War 1. Certain philosophical positions at its inception are still relevant today. Many legislative and policy reviews of the system have been undertaken over decades in response to changing circumstances, leading to the accumulation of legislation that exists today.

DVA is at the centre of a dynamic system of veterans' support involving:

- a complex legislative framework
- service delivery across multiple arms of government, including Commonwealth and state and territory agencies

- a large and broad-ranging ex-service organisation (ESO) sector¹
- a community of veterans and their families with changing circumstances and needs.

Military service is unique on a number of levels. There remains as strong a case today as there was 100 years ago to recognise this and the need for a bespoke, fit-for-purpose comprehensive system of support for veterans and their families beyond that provided through civilian systems. Military service is also markedly different to the employment of civilian emergency workers, particularly noting the nature of the contract that exists between Australian Defence Force (ADF) members and government, and that which exists between civilians and their employers.

Despite the shared connection of military service, the veteran community is a heterogeneous group with many defining characteristics. While the overall population is declining, as the World War 2/Korean War veteran group passes, there is a new generation of veterans and their families emerging with different needs and expectations.

Military compensation is inherently complex, with the need to cover a myriad of different circumstances, but this complexity has been exacerbated by a legislative framework involving three separate but overlapping Acts. This directly feeds into DVA's supporting systems and processes, and presents challenges for veterans, their families, advocates and DVA staff. DVA's processes are hard to understand, access and navigate, and at times this means that DVA appears insensitive and unresponsive to the dynamic needs of veterans and their families.

DVA has recognised that its services, approaches, processes and culture have not always kept pace with the changing needs and expectations of its veteran clients; nor has DVA kept up with community standards for service delivery, accessibility or engagement. DVA has listened to feedback from the veteran community indicating that improvements are required.

With additional Government funding support, DVA is in the early stages of its transformation program, which is focused on placing veterans and their families first. This has been a conscious decision of government in the 2017–18 and 2018–19 Budgets, and DVA is responding: significant progress has been made in the first year of DVA's transformation, but there is more to be developed and delivered. The transformation program needs to continue for DVA to be able to provide the support required by veterans and their families, and the service experience they deserve from a modern, veteran-centric organisation.

¹ These organisations exist to help veterans, as well as their dependants and descendants, in matters ranging from social activities through to advocacy services.

ESOs also provide support to the veteran community, ranging from camaraderie and welfare support, to advocacy when acting on veterans' behalf in making claims with DVA. These organisations vary in size and geographic spread, ranging from large organisations with a wide community presence across Australia (for example, the Returned and Services League (RSL) and Legacy), to numerous smaller groups and single-issue proponents.

An overwhelming characteristic of the ESO landscape is that these organisations operate almost entirely independently from each other, which can lead to duplicating support services and representation arrangements. Even if the emergence of an ESO peak body is not foreseeable in the short term, there needs to be greater collaboration across the ESO sector to better coordinate support and deliver more holistic services to veterans and their families.

Veteran Centric Reform

DVA's Veteran Centric Reform (VCR) measure is placing the veteran and their family at the centre of DVA's service delivery orientation and philosophy. There have already been a number of positive achievements in 2017–18 under VCR. With funding of \$111.9 million allocated in 2018–19, in addition to the 2017–18 funding of \$166.6 million, DVA will be able to make further transformative changes. A number of new initiatives, pilots, trials and scoping studies will also need to come to fruition.

VCR is a multi-year program that will remain a fundamental priority for DVA. Early wins from the transformation program include:

- **Straight-through processing** permits the use of Defence's training and service data to immediately satisfy the service-related requirement of certain claims. Where straight-through processing applies, claimants do not need to provide information about their specific service activities, reducing the time taken by DVA to assess liability.
- **Digitisation of records** is significantly reducing the costly and inefficient movement of paper files between locations during time-sensitive claims processing and other administrative activities.
- **MyService** is providing DVA veterans with a simple and convenient way to lodge an initial liability compensation claim online. This also provides free mental health treatment claims, needs assessments, and an electronic health card that specifies the conditions it covers.
- **Client segmentation** is providing DVA with data-driven analyses of veteran characteristics, needs and preferences, to help shape its future service delivery.

The case for legislative reform

There is a case for legislative reform. The current system has three Acts:

- the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- the *Safety, Rehabilitation and Compensation (Defence Related Claims) Act 1988* (DRCA)
- the *Veterans' Entitlements Act 1986* (VEA).

Together, these Acts comprise five schemes of entitlements (the DRCA preserves two additional pieces of previous legislation).

In previous decades, the avoidance of apparent or actual loss of benefits to any group of existing veterans has meant that reforms to legislation have built on existing entitlements, rather than revoking or altering them to align with new arrangements.

These three Acts collectively incorporate almost all of the benefits available to successive generations of veterans over the last 100 years. Most of these benefits are still available to veterans today, depending on the nature of their service and when they served.

The clearest manifestation of complexity from having three Acts is that veterans can have eligibility under more than one Act, requiring offsetting of compensation payments for the same incapacity or death. There can also be different outcomes for veterans who are in similar circumstances, depending on their eligibility under the different Acts, and the order in which claims are made. This submission highlights a number of current issues where this legislative complexity has given rise to specific 'friction' points in the system.

Complex legislation has driven complex processes and impacted on service delivery. Transformation is reshaping service delivery to be centred on veterans and their families' needs.

Legislation workshops with ESOs and other agencies have identified areas for possible legislative change and process enhancement. While these will be useful for informing Government, there is a need for broader reform and examination of some of the underlying settings that feed into the legislative framework.

Legislative reform options

With the Minister for Veterans' Affairs now having policy responsibility for all three Acts (since the passing of the DRCA legislation in 2017), legislative reform presents as a greater opportunity than when key legislation was separately administered.

DVA's preference is for a unified framework, with several options:

1. **Minimal rationalisation**, which would remove more obvious and straightforward areas of duplication but leave the three Acts in place.
2. **Broader rationalisation and harmonisation of the three Acts over time**, removing duplication and harmonising provisions of each Act to make them work in the same way. Harmonisation work would include four priority areas:
 - a. adopting the Statements of Principles (SoPs) regime of the VEA and MRCA into the DRCA
 - b. assessing veterans' levels of impairment across the three Acts against the most up-to-date assessment guide available
 - c. adopting the VEA and MRCA appeal pathway for merit reviews for the DRCA
 - d. addressing some of the differences between DRCA and MRCA in relation to incapacity payments under each Act.
3. **Rationalisation, harmonisation and simplification** of the Acts through a single major reform process. This would consider underlying settings for the current framework and seek to develop one Act going forward that would govern eligibility and entitlements for all veterans, encompass rehabilitation as a key outcome, and facilitate a veteran-centric approach. Elements of the existing MRCA may feed into the new Act.

DVA is of the view that while alignment of DRCA and MRCA would simplify many processes and streamline much of DVA's engagement with its veteran clients, legislative reform beyond harmonisation alone is needed to significantly modernise the military compensation system, remove multiple eligibility, and ensure better outcomes for all veterans and their families.

Broad reform would likely affect existing entitlements for some groups of veterans and would need to be addressed through transitional provisions to ensure no-one is any worse off under new legislative arrangements. Equally, it would not be the purpose of reform to increase the benefits or entitlements currently available to any individual or group of veterans. To be successful, these reforms would require considerable consultation with the veteran community and affected stakeholders.

It is also timely to consider the policy and decision-making roles of the Repatriation Commission and the Military Rehabilitation and Compensation Commission (MRCC). Apart from possible duplication of functions, their relationship with both the Minister and the Secretary of DVA need to be considered in a contemporary context. The concept of ministerial responsibility to parliament and the role of the Secretary under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) will be relevant.

DVA's continuing transformation

DVA's Veteran Centric Reform measure and future legislative reform could be considered as two parts of a single reform project, that together would address not only the client-facing elements of DVA's service delivery, but also the underlying processes that have been constructed to reflect the existing complex legislative framework.

To be successful, legislative reform should encompass the principles embodied in VCR and the work undertaken to date, and build on those principles to achieve a more modern legislative environment that provides simpler and more consistent processes for the delivery of veterans' support.

Improving veterans' transition from service

Transition, employment and rehabilitation are seen as critical areas for veterans and their families to achieve successful post-service life, especially as many veterans struggle with many aspects of daily life after leaving military service. A number of initiatives, particularly integrated approaches between the Department of Defence (Defence), the ADF, DVA and the Commonwealth Superannuation Corporation (CSC), have delivered good outcomes to date. Other pilots and trials now under way are showing promise.

More work is needed, however, to ensure all veterans and transitioning ADF members can access appropriate support when they need it, that support services are streamlined and seamless across agencies, and that there are multiple opportunities throughout the transition process for transitioning members to engage with support services.

The exchange of information between DVA, Defence and the CSC has improved markedly over the last few years, allowing DVA a greater awareness and knowledge of ADF enlistees and transitioning members. However, these manual exchanges need to be automated and expanded to other information. Automatically shared information will build greater knowledge and confidence in understanding the veteran population across all three agencies.

There is also scope for DVA to improve information provided to Defence on the nature of the claims received, which reflect the impacts of military service on veterans and their families. This in turn will assist Defence to better understand occupational risks and to identify opportunities to proactively manage those risks.

DVA's rehabilitation program provides broad support beyond the treatment services offered through health treatment cards, and beyond vocational assistance. It promotes veterans' wellbeing and quality of life through whole-of-person rehabilitation services to help them adapt to, and recover from, injury or illness related to their ADF service.

DVA's whole-of-person focus considers all aspects of a person's life in an effort to return a person to health and personal and vocational status similar to before they were injured or became ill.

DVA's focus on improving its rehabilitation services for veterans will continue; Government has also demonstrated its commitment to the employment of veterans through the Prime Minister's Veterans' Employment Program, which received funding in the 2017–18 and 2018–19 Budgets.

Veterans' families

It is well understood that veterans' families provide support for better transition and rehabilitation outcomes. Family members are usually best placed to identify early indications of poor mental health, and then to provide veterans with support to assist their recovery. The support of family members can also be critical for veterans to reach their rehabilitation goals, including returning to the workforce. From time to time, family members also provide an important conduit for information between the veteran and DVA (and with other sources of veterans' support).

However, family members themselves can be impacted by the veteran's service, including the time the veteran spent away from their family during their service, or they can be impacted by caring for a veteran who suffered an injury or disease related to their service.

DVA, in recognising the key role performed by family members, has identified that improving its support for veterans' families is a key priority area for further development, and is co-designing services and their delivery mechanisms with partners and families to better meet this need.

Statements of Principles

Under the MRCA and the VEA, Statements of Principles (SoPs) are used to establish causal connection between exposures or activities and specific medical conditions. The SoPs are based on sound medical-scientific evidence and are determined by the Repatriation Medical Authority (RMA), an independent statutory body. In order for a claim to succeed under the VEA or MRCA, at least one SoP factor must be met before a condition can be found to be related to service.

The use of SoPs has improved the consistency of claim assessment decisions. In general, SoPs provide a robust mechanism that supports veterans and their advocates to make claims, particularly as the SoPs provide a transparent 'check list' for the factors that will guide a claim decision.

However, perhaps because their use is non-discretionary, SoPs are perceived by some in the veteran community to be too rigid and inflexible. This largely reflects the intended operation of this system, in that the development or amendment of each SoP is based on an extensive review of world-wide expert medical literature.

There are opportunities to improve the use of SoPs, such as providing greater flexibility in their application by assisting some decisions on certain conditions to be linked to identified occupational-defined exposures.

Health care

There is scope to achieve greater efficiency and effectiveness in the provision of health care for veterans and their families. For example: better continuity of veterans' health care during transition from service; examining and improving the pathways from the Defence health system to DVA's health arrangements; delivering better mental and social health strategies; and achieving improved aged care access and delivery.

Immediate opportunities include the automatic transfer of the full Defence Health digital record into the new whole-of-population MyHealth record, and collaboration between DVA and Defence on shared purchasing arrangements to help align health care provision across both agencies, assisting veterans' continuity of care while also supporting contract and delivery efficiencies.

Further reforms in veteran health care could explore changes in the mainstream health and disability sectors, such as consumer-directed care. This work would need to consider the nature of the services included, the maturity and accessibility of the provider market, and the capacity of target groups to make informed decisions.

Measuring effectiveness

To date DVA has concentrated its evaluation efforts on individual programs, and specific sub-outcomes and initiatives. At the outcome level, DVA acknowledges that its performance measures have focused more on delivery inputs (e.g. time taken to process claims) than on measuring how well DVA achieved the intended purpose of each outcome. Such measurement is feasible and DVA intends to introduce better outcome effectiveness measurement.

Future shaping of the system

Further transformation will need to be based on a number of core principles derived from the following statement of intent:

Military compensation should be provided through a contemporary veteran-centric and beneficial system, informed by veteran and community expectations, which recognises and reflects the unique nature of military service, and is informed by best practice approaches.

A new military compensation system could:

- **recognise the unique nature of military service**, including: learning from and understanding the impact of military service on veterans and their families; and sharing information with other agencies

- **be veteran centric and beneficial**, including: providing medical, rehabilitation or income support to veterans, and their families who need it, in advance of claim determination, if necessary; giving veterans greater user choice; be based on wellness, not illness; having trust in its veteran clients; and working in a whole-of-government context while being fiscally sustainable
- **offer simplicity, fairness and consistency**, including: recognising veteran status automatically; determining liability for an injury or illness at or close to the time of occurrence; ensuring improvements to the system deliver fair outcomes; aligning ancillary benefits; and being flexible and enduring
- **deliver better transition and rehabilitation**, including: sharing information such as health records; supporting veterans in their transition before they are discharged; supporting veterans' and their families' employment initiatives and their employability; working with ESOs that support veterans and assist their integration into communities, rather than focus on advocacy.

The current transformation process is establishing new core capabilities of DVA, enabling the veteran community to engage with DVA in faster, more effective ways. The process is also creating assurances in its systems to enable each veteran and their family to receive the support they need.

The change has begun, moving from a model that focuses on a veteran's 'illness' to their 'wellbeing'. Legislative and related process reforms will enhance this change.

This should be seen, however, as only the start of a journey that would more completely transform experience for veterans and their families. This would include a seamless and successful transition from military service to post-service life, with greater collaboration between DVA, Defence and the CSC, and each of these organisations sharing accountability for improved veteran outcomes.

At the completion of this transformation program, DVA's role will be to focus on policy, stakeholder relationships, service commissioning, and an enhanced veteran experience. Many veterans and their families will be able to self-manage through online facilities, freeing DVA's staff to focus on those veterans with complex and multiple needs, based on an integrated whole-of-veteran view and more effective case management systems.

The use of data analytics and veteran insights will inform policy and develop services. Future transformation of DVA will change the experience of engaging with DVA for veterans and their families by enabling access to DVA-branded services across all channels, tailoring services to veterans' needs, streamlining assessments, strengthening private, community-based and public sector partnerships, and creating a veteran-centric, data-driven organisation and culture.

Workers' compensation price signal for military compensation

The Productivity Commission asks the question whether an annual premium paid by Defence to fund future emerging costs of the system would be appropriate as a claims/risk-based price signal to Defence of the impacts of military service, in the same manner that a workers' compensation insurance premium on an employer is intended to improve workplace safety and injury prevention.

One way to inform Defence of the impact of military service on veterans and their families would be for DVA to more systematically share its information on claim themes and patterns with Defence, as discussed above.

DVA believes that enhanced systematic information sharing between the two departments regarding the translation of service incidents into compensation claims provides a significant opportunity for Defence to proactively identify and manage occupational risk, in the absence of a price signal.

Conclusion

Compounding layers of military compensation legislation, the evolution of civilian workers' compensation schemes, and the need to respond to each wave of operational and non-operational service, have produced a complex compensation structure through which veterans, their families and DVA staff must navigate.

While older generations of DVA's veteran clients may remain satisfied with the services and benefits that they receive, newer generations of serving and former members of the Australian Defence Force have found DVA and its services to be difficult to access.

The current transformation process is addressing the most pressing areas of improvement within DVA: its processes, structures, culture and environment. However, there is no doubt that the system of military compensation in Australia needs improvement; systematic legislative reform will embed the Veteran Centric Reform principles in legislation and support simpler processes and better veteran outcomes. This will require input and support from all of the participants contributing to the system of military compensation.

Further reform and improved collaboration will offer the opportunity for DVA to focus in the future on critical areas of policy development, commissioning, stakeholder and veteran engagement, and governance, to the long-term benefit of the veteran community it serves.

Using this submission

Productivity Commission Issues Paper questions

This submission includes content that responds to or discusses the questions posed by the Productivity Commission in its Issues Paper. DVA has identified this content as follows:

- Section sub-headings identify those chapters in the Issues Paper that are relevant to section content. These sub-headings appear in the following format (any page numbers in these sub-headings refer to the Issues Paper):

Submission sections with information responding to Productivity Commission chapters are identified in these sub-headings.

- In addition, each area of text in the submission that addresses one or more specific questions from the Issues Paper is identified with the relevant question/s in the sidebar—see example on the left.

Specific questions posed by the Productivity Commission are identified against relevant material in the submission using sidebar text

Definition of veteran and military compensation system

In line with the Commission’s Issues Paper, this submission on occasion uses the term ‘veteran’² in a generic sense to mean both current and transitioned members of Australian Defence Force (ADF), as well as their widow/ers³, dependants and families; and unless otherwise stated, ‘the military compensation system’ means all compensation payments, services, allowances, payments and pensions available to the veteran community in recognition of military service.

A full list of abbreviations and acronyms used in this submission appears on page 156.

² A veteran is a person who performed one or more days of permanent service or duty, and includes current members of the Australian Defence Force rendering continuous full time service. General usage of the term ‘veteran’ in this submission also includes war widow/ers, partners and dependants.

³ Referred to as war widow/ers, and while the meaning is separately defined in each Act, it generally means a person who was the partner of, was legally married to, or was the wholly dependent partner, of a veteran. War widow/ers currently become war widow/ers if their partners have died as a result of their service, or the partners met certain eligibility criteria prior to death.

1 Purpose of the system

1.1 DVA's function

The function of a system of military compensation is to provide support to those who serve or have served in the defence of our nation (and to their families), when they have been injured, suffered illness, or have died in or as a result of their service.

Ensuring that veterans who leave service are, with their families, fully able to participate in civilian life, and can thereby enrich our communities, is one of the highest aims for any system of military compensation and rehabilitation.

DVA is the primary Australian Government policy and service delivery entity responsible for developing and implementing programs that assist veterans and their families.

DVA provides administrative support to the Repatriation Commission and the Military Rehabilitation and Compensation Commission, and is responsible for advising these Commissions on policies and programs for beneficiaries and administering these policies and programs.

These functions have remained unchanged as the repatriation system has evolved over the years, with DVA still providing services to support Australia's veterans and serving members and their families, through a system of care, compensation and commemoration.

DVA considers the Productivity Commission's Inquiry to be critical, and notes that it is being conducted as we are at the centenary of the introduction of the Repatriation Department and Commission.

DVA operates as part of a complex and changing system of veterans' support in which there are multiple veteran cohorts with different needs and circumstances, as well as many external organisations, a complex legislative framework, and services that are delivered across multiple agencies and government departments.

It is worth noting that the system of military compensation belongs not only to DVA. The delivery of the entire scheme of military compensation involves the \$11.6 billion⁴ of services, supports and payments delivered by DVA in 2016–17, a further \$0.8 billion⁵ of assistance provided to veterans and their families by the Commonwealth Superannuation Corporation (CSC), and also more than \$500 million on the health care of serving members by Defence.

⁴ DVA Annual Report 2016–17, p 169.

⁵ CSC Annual Report 2016–17, p 173.

At around \$13 billion a year in total, this is equivalent to around 42% of the entire annual Defence budget of \$30.7 billion⁶.

Although the military compensation and rehabilitation framework operates within a prism of broad government and community support, it operates alongside other workers' compensation schemes in place in the Commonwealth and each state and territory. The particular benefits and entitlements of the military schemes have been based on longstanding community and government acceptance of the unique nature of military service, and the particular risks and obligations entailed in the defence of Australia. However, such longstanding acceptance should not and does not confer immunity from examination as to relevance and appropriateness.

1.2 History and philosophy

The information in this section responds to the Productivity Commission's questions on assessing the veterans' compensation and rehabilitation system (p 8–9), how the nature of military service should be recognised (p 9–10), and the complexity of veterans' support (p 10–11).

We owe to those who have borne the brunt of battle more than the nation can ever adequately repay. They who stepped forth voluntarily in the hour of their country's need have carried themselves nobly and acquitted themselves well. These men, who went out with Australia's honour in their keeping, have covered her name with glory. They went forth willingly to do their duty to Australia; Australia must be equally ready to do its duty to them. It is the intention of the Government, so far as is humanly possible, to see that the debt is paid in full.

— Prime Minister Billy Hughes CH, KC, Bendigo, 27 March 1917⁷

The Australian Government first established a military compensation system in 1914 with the introduction of the *War Pensions Act 1914*, and then established the first repatriation legislation in 1917, when the *Australian Soldiers' Repatriation Act 1917* created the broad administrative arrangements for the business of repatriation. This Act (subsequently replaced by the *Repatriation Act 1920*) created the Repatriation Commission, which still exists today, and also established a Repatriation Board in each state.

With over 400,000 Australians enlisting during World War 1 (out of a population of 5 million at the time), significant numbers of veterans became part of Australian communities during and after the Great War. When the Repatriation Department came into being, it was responsible for returning and reintegrating Australian Imperial Force members (as they were then called) back home to Australia.

⁶ Defence Annual Report 2016–17, p 153.

⁷ Hughes, B, Election Speech (<https://electionspeeches.moadoph.gov.au/speeches/1917-billy-hughes>)

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?

These events established the work that is still performed in DVA. Throughout this 100-year history, the broad notion of ‘repatriation’—returning servicemen and women to civilian society and honouring their service and sacrifice—has informed all of DVA’s primary roles. At the same time, a fundamental role of DVA has been the provision of a substantial part of the ‘offer’ that is made by the nation to each service member prior to and on enlistment. This offer recognises the willingness of the enlistee to commit to service, be subjected to military discipline, and to be placed in harm’s way for Australia. In return, the Australian Government will look after them, including when they leave service.

Justice Toose, in his 1975 review of the Repatriation System⁸, identified a set of principles that governed the development of repatriation and military compensation in Australia at the time, which substantially reflected the Repatriation Act and other relevant Acts. These principles included:

- The nation ... has a duty to ensure that those who have ... served, together with their dependants, are properly cared for to the extent that they should never have to beg or rely on charity.
- Those who have served overseas or in a proclaimed theatre of war are likely to have encountered greater danger and/or more arduous service than those who had home service and, accordingly, they should have a more extensive cover.
- Compensation and other benefits should be available as a matter of right and not as a welfare handout, and in cases of doubt should be resolved in favour of those claiming to be entitled.
- Benefits should be provided whether or not similar arrangements are available to civilians in respect of accident or illness arising in civilian life.

What principles should underpin the legislation and administration of the system?

Those principles, reflected in early repatriation systems, are still evident in features of the current system.

The 2011 Review of Military Compensation Arrangements (RMCA), reviewing the operation of the *Military Rehabilitation and Compensation Act 2004* (MRCA) some seven years after it was enacted, described the compensatory benefits provided to veterans and their dependants as ‘an expression of gratitude by the government of the day, and through it the nation, for [veterans’] war service’⁹.

1.2.1 Previous reviews of military compensation

Over the last 40 years, in response to changing circumstances and emerging needs, a number of major inquiries and examinations of the services, benefits, entitlements and compensation available to veterans and serving members of the ADF, and their families, have been undertaken (see Annex 1).

⁸ Toose, *Independent Enquiry into the Repatriation System*, 1975.

⁹ *Review of Military Compensation Arrangements*, 2011, s 2.4.

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

These reviews included the Tanzer Review of 1999, which led to the creation of the MRCA, and the RMCA of 2011, which was substantially a review of military compensation arrangements post-MRCA.

These and other reviews have effectively been part of the Commonwealth's commitment to the support of veterans and their families, and have suggested changes to legislation or aspects of DVA's services to help to ensure that the compensation system is fair, and that it works effectively to achieve positive health, wellbeing and rehabilitation of veterans.

However, often the terms of reference for each inquiry or review have been relatively narrow, constraining impacts to specific elements or areas of support. And while most of the inquiries and reviews listed in this section resulted in direct or indirect changes to some part of the system of military compensation, the nature of some of those changes were generally piecemeal and ad hoc, and often took little account of flow-on effects to overall complexity.

Accordingly, it can be seen that the almost continual series of inquiries and reviews, with their compounding resulting changes on the system, have themselves contributed to what is now a complex military compensation system. The complexity of the system is discussed further in Section 4.2 of this submission.

1.3 DVA's governance

The information in this section responds to the Productivity Commission's questions on system governance (p 13–14).

The majority of DVA's ordinary activities are directed by the Repatriation Commission and the Military Rehabilitation and Compensation Commission (MRCC). These two bodies hold the majority of statutory powers under relevant legislation, including decision making on veteran client claims, which in turn is delegated to officers in DVA.

The separate roles of the Commissions and DVA have a long history, as the two arms—the Repatriation Commission and the Department—were established together in the 1917–18 period. The Secretary of DVA has a second role as President of the Repatriation Commission and a third role as Chair of the MRCC.

The two Commissions provide DVA and the Minister with views, advice and guidance on policy issues. They also make policy decisions of which the Minister is advised. They often consider the same issues and hold joint meetings. The Commissions' roles could be broadly considered as that of custodians of the broad system of military compensation and rehabilitation support.

The MRCC comprises the members of the Repatriation Commission plus two members from Defence and one nominated through the Jobs and Small Business portfolio. The additional members provide broader perspectives on veterans' policy issues, particularly Defence/ADF and Commonwealth employees' compensation perspectives.

Do the governance arrangements for the veterans' support system encourage good decision making—from initial policy development to its administration and review?

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

1.3.1 Interface between the Commissions and DVA

While DVA's governance arrangement involving the Secretary of DVA, the MRCC and the Repatriation Commission is possibly unique in the APS, this structure was intended to ensure there would not be conflict between the powers of the Commissions and the delegated delivery of those powers through DVA. That is, that delegates are delegates of the Commissions, not of the Minister or the Secretary. Further, the custodianship role of the Commissions would ensure that DVA's operations would be consistent with the purpose and principles of the system of military compensation and rehabilitation.

It is also timely to consider the policy and decision-making role of the Repatriation Commission and the MRCC in contemporary public administration. This should examine the role of the Minister for Veterans' Affairs within the legislation, bearing in mind the concept of ministerial responsibility, and the dual role of the Secretary of DVA under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and as a statutory officeholder as President of the Repatriation Commission and Chair of the MRCC.

Further information on DVA's governance arrangements is set out in Annex 2.

2 DVA's understanding of its clients

2.1 The unique nature of military service

The information in this section responds to the Productivity Commission's questions on how the nature of military service should be recognised (p 9–10).

DVA agrees with the description of the unique nature of military service as outlined in Section 2 of the Issues Paper. DVA's view is that the nature of military service is apart from and beyond ordinary civilian occupations and professions.

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?

Military service is unique on a number of levels. An ADF member is not, by legal definition, an employee. Military personnel are subject to military law and are not protected by the full range of industrial law. There is an argument that military personnel are required to forgo their basic human rights of 'life, liberty and security of person' as prescribed in Article 3 of the 1948 Universal Declaration of Human Rights. The Defence Force Welfare Association puts the following position:

No other calling, occupation or profession—including police and emergency services people who may at times voluntarily put their own safety and lives at risk—is required to surrender these rights.

Military law may, uniquely, require an ADF member to kill other human beings, to order another ADF member to kill, to order other ADF members to take an action with a high probability they may be severely wounded or killed, and may themselves be ordered to take an action with a high probability of being killed or wounded.¹⁰

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?

ADF members cannot refuse a lawful order, and cannot go on strike. An order that may result in an ADF member killing another person, or being killed, is effectively carrying out the directions of the government of the day through their chain of command.

These circumstances are different from civilian emergency services, where:

- emergency services employees or participants may withdraw from duty, or unilaterally choose to cease their employment relatively quickly and easily
- risk of injury to emergency services workers or the public often outweighs confrontation in dangerous circumstances.

¹⁰ Defence Force Welfare Association, *Fact sheet: Unique nature of military service*, available at www.dfwf.org.au/current-issues/military_accord

However, civilian work compensation schemes still present an appropriate benchmark for the policy design and application of military compensation. Most emergency workers are covered under Commonwealth or state/territory workers' compensation schemes.

There are some instances where special legislation is applied; for example, the *Safety, Rehabilitation and Compensation Amendment (Fair Protection for Firefighters) Act 2011* (Firefighters Act), which simplifies certain compensation arrangements for firefighters.¹¹ Further, particular powers of the Commissioner of the Australian Federal Police provide special compensation arrangements to AFP officers on particular international deployments.¹²

Military service encompasses the *profession of arms* concept, whereby the 'unique nature of military service requires that members of the ADF be liable for duty 24 hours a day, seven days a week'.¹³ This concept extends to members of the armed forces being held to a higher standard than other occupations or professions, summarised as:

- Members of the ADF are subjected to high stress for prolonged periods during the performance of military operations that involve complex and important tasks, often involving lethal force.
- The commanding power inherent in the military structure places higher standards on the quality of leadership where the risks of poor leadership are much greater than in civilian organisations.
- Members of the ADF are often the representative 'face' of Australia when overseas.
- There is a responsibility to uphold traditional high standards of the ADF and of previous generations of soldiers, particularly the ANZACs.
- The ADF relies on maintaining its reputation and trust in all of its engagements and interactions.¹⁴

Lastly, a significant element of military service is the time away from families that military personnel need to make in extended deployments, training exercises and posting cycles, which is disruptive for the serving members and their families.

¹¹ The Firefighters Act amends the disease provisions of the SRCA to provide timely access to compensation for firefighters who contract a prescribed cancer as a result of their employment. The Firefighters Act introduces a presumption of liability and qualifying periods for prescribed cancers diagnosed on or after 4 July 2011.

¹² Under an interim compensation scheme, AFP personnel deployed on certain high-risk international deployments would be eligible for a differential payment, equivalent to the difference between SRCA and MRCA compensation, through powers held by the AFP Commissioner.

¹³ Orme, C.W, *Beyond Compliance*, 2011, p 23.

¹⁴ Ibid, pp 52–53.

The broad and longstanding commitment to returned servicemen became the cornerstone for the establishment of the original Repatriation Commission, for the formation of the Department of Veterans' Affairs (and its predecessor, the Department of Repatriation) and for the provision of the compensation, benefits, allowances and services available to current and ex-members of Australian military forces and their dependants.

2.2 Veterans and their families in Australia

2.2.1 The wider veteran community

Except for veterans who have enlisted since early 2016, or were transitioned since mid-2016, the majority of living veterans are not known to DVA. There are approximately 165,000 current living veterans, plus a further 127,000 dependants known to DVA (around 290,000 DVA clients in total as at 30 June 2017).

Only one in three of all ADF veterans who have served since the Vietnam War are DVA clients, and only one in five of those who have served since 1999.

As the agency for all veterans and their families, DVA is taking steps to find out more about those veterans who have not yet engaged with DVA, and is looking for ways to engage with this broader community.

Measures that DVA is taking to reach out to the broader veteran community are set out in DVA's 'Key achievements' in Annex 3.

2.2.2 The veteran population—a diverse group

The stereotype of a veteran as an elderly white male does not represent the demographics of the current Australian veteran population. The veteran community is far from homogeneous; it has significant diversity, including:

- age: from younger veterans¹⁵ to older WW2 veterans
- gender: veterans are mostly male, but with an increasing number of female veterans
- different forms of military training and operational experience (including war, peacekeeping, border protection, and others)
- dependants: mainly females and children.

Other characteristics all vary widely across the veteran population, including: ethnicity and religion; education; post-military service employment and economic means; health and wellbeing status; and community participation.

¹⁵ 'Younger veterans' (or 'contemporary veterans') are those who have seen service with the ADF from 1999 onwards. These terms also generally refer to veterans aged 45 years or less.

2.2.3 The current and future DVA client population

Figure 1 Past and projected client numbers

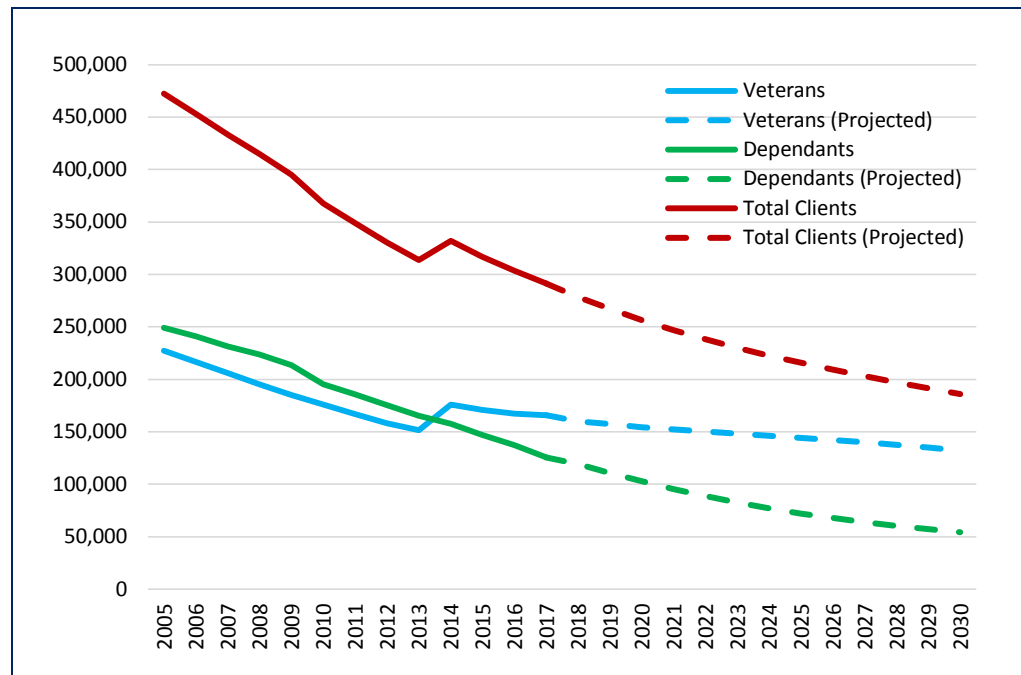


Figure 1 is based on DVA forecasting models, which estimate DVA's future client population. The fall in the total client numbers mainly reflects the decline in the cohort of WW2 veterans and their dependants. After 2030, this decline is expected to plateau.

Note that the small increase in population around 2013 and 2014 was due to a change in the model and how DVA counted its clients.

Figure 2 Snapshot of DVA clients by age as at December 2017

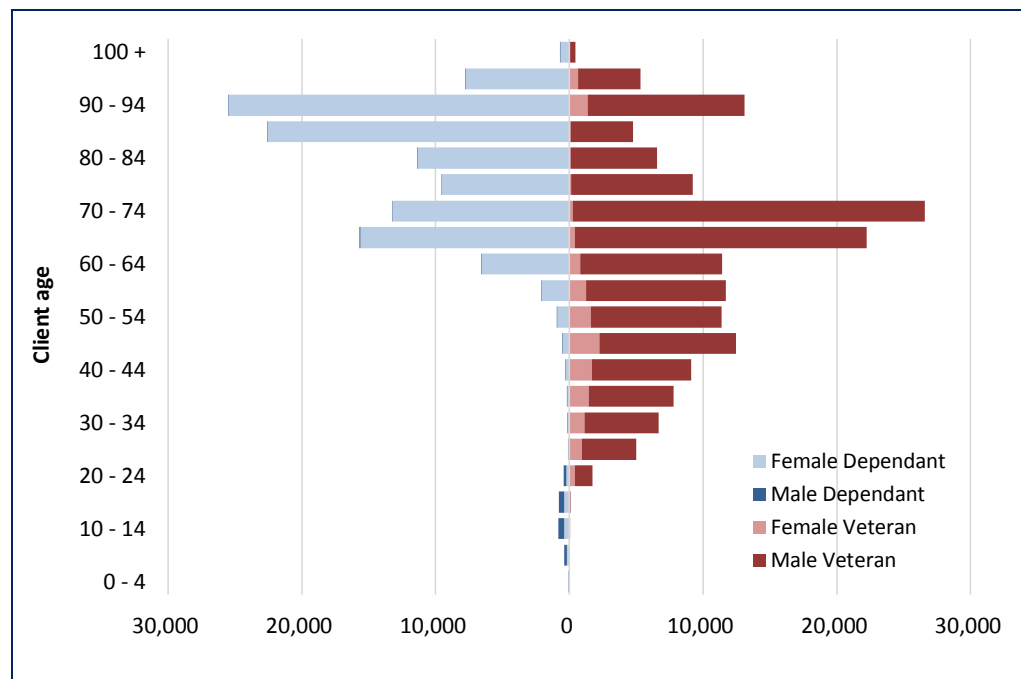


Figure 2 shows the unique nature of DVA's client make up, reflecting the predominantly male veteran population against the predominantly female dependant population.

It is worth noting that:

- the numbers of Korean/WW2 veterans (those aged 85 and older) are much smaller in size than the number of dependants from this cohort
- the Vietnam War veterans aged 65–74 are very prominent in the male population
- the only dependants in the DVA system aged under 65 are war widow/ers or service pension widows, service pension carers (younger partners) for veterans, or children of veterans either on payments/cards or in education (up to 16 years or 25 if still in education)
- while the group of female veterans is relatively small, there are specific new support needs for this group as they transition out of service, which are being articulated through the Female Veterans Policy Forum, for example.

2.3 DVA's unique role and value

The information in this section responds to the Productivity Commission's questions on a system to meet the needs of future veterans (p 9), and on system governance (p 13–14).

While DVA's structure, services and environment have all changed over the course of its history, the department needs to continue to know its veterans and their families, and it needs to understand and respond to the nature and impact of military service.

It has long been considered that DVA has a 'special responsibility' in fulfilling the obligations of the nation, and that the philosophy underpinning Australia's repatriation system should be reflected in DVA's quality of service delivery.

In its earliest days, repatriation support offered by the then new Department of Repatriation was relatively basic and experimental¹⁶; however, the services and support met, or attempted to meet, the basic repatriation needs of returned soldiers at the time.

The relationship between the nature of *effects of service* on military personnel, and the compensation, benefits and rehabilitation offered by Government in response, has been frequently revisited over DVA's history.

As each wave of military engagement has introduced a new cohort of service personnel to armed conflict, or to periods of service during times of relative peace, each has introduced its own unique impacts and effects on its veterans and their families. The policies, programs, services and support provided by DVA have, in turn, attempted to respond comprehensively to each set of needs.

How have veterans' needs and preferences changed over time?

Where, after World War 1, the Department of Repatriation provided health care to returning soldiers suffering from tuberculosis, or it responded to their need for employment or housing assistance, for example, DVA now supports the needs of current veterans who might need help with mental health conditions, rehabilitation, and social isolation.

The 'beneficial' nature of military compensation recognises there can be anticipated impacts of military service, but also unanticipated and unknown potentially harmful exposures (whether they might occur in training, or in deployment, or elsewhere).

The holistic needs of DVA's client group need to be well understood by the Department tasked with providing services and support to them.

¹⁶ Payton, P., *Repat, a concise history of repatriation in Australia*, 2018, p 14.

A relatively small but enormously significant part of DVA's role is the delivery of its commemorations function. This program, which has recently included the significant Centenary of Anzac events, supports and delivers events and material that commemorate and recognise important previous military engagements.

The commemorations function is considered an integral part of the Government's commitment to the members of its serving forces. Through acknowledging and remembering past service and sacrifice, this function not only develops the community's acknowledgement of military service and veterans' role in it, but it also reinforces veterans' understanding of their own role and purpose, thereby contributing significantly to validation of their service and their mental health and wellbeing.

2.4 Veterans' needs are different

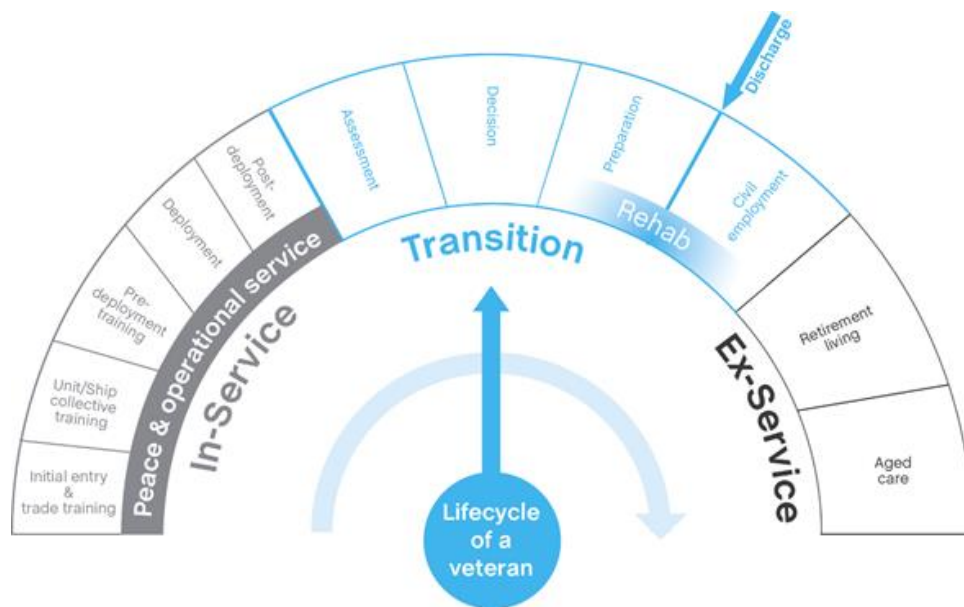
The information in this section responds to the Productivity Commission's questions on how the nature of military service should be recognised (p 9–10), and a system to meet the needs of future veterans (p 9).

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?

Veterans in Australia form a diverse and dispersed group of the population, with health and rehabilitation needs different to other parts of the population. They may have been transitioned from service with severe physical injuries from their war service or from their service under warlike conditions, or they may have suffered mental trauma from those situations, or both. Some veterans may unknowingly have ailments with no immediate symptoms; however, these conditions may be triggered at some point in the future with symptoms requiring treatment, or may never manifest. Veterans with peacetime or non-operational service may also have an immediate injury, or one that may manifest some years later.

Military culture can be expressed as a form of 'selfless service' in that the duty of military personnel is above and beyond an individual's needs: it reflects higher order needs of the military unit, of the entire military force, and of the country. Accordingly, serving and former military personnel might still tend to view personal issues and individual wellbeing as inappropriate or selfish. Accordingly, individual health issues and problems might go unreported. The avoidance of care does not mean there is an absence of need, and this is a critical element of support for veterans.

Figure 3 represents the 'lifecycle' of military personnel from enlistment to transition and life after service. From the perspective of a veteran, there is no point at which their needs abruptly change; rather, the transition from service to post-transition is a continuum, with common needs before and after they leave the ADF.

Figure 3 The 'lifecycle' of military personnel

Note: Figure 3 is most relevant to medical transitions from Defence.

2.4.1 Key considerations of veteran needs

A 2015 study by the Victorian Veterans' Council¹⁷ found that veterans have a complex and interwoven set of needs and issues affecting their quality of life, which broadly match DVA's own understanding of the veteran community. The Victorian study found that these issues, and their conditions, include¹⁸ physical and/or mental health, income security, social isolation, homelessness, domestic violence, substance abuse, justice system support, transport assistance, and others. Other impacts include effects on families, family breakdown, and family support needs.

How have veterans' needs and preferences changed over time?

Main areas of need

A number of key issues have emerged both in Australia and internationally for the newest cohort of veterans. While these issues are not new, for veterans they are having to be addressed in the context of modern-day society. The main issues here include veteran mental health and suicide/self-harm, transition and integration, employment, homelessness, and incarceration.

Financial counselling might also be an area of emerging need, where some former ADF members may struggle to manage their finances once outside of a military structure. There is strong evidence of an interrelationship between financial difficulties and poor mental health¹⁹; in addition, money issues are widely associated with spouse or partner disputes and family breakup.²⁰

¹⁷ Grosvenor Consulting/Victorian Government, *Veterans Sector Study Report*, 2015.

¹⁸ Ibid, p 12.

¹⁹ <https://mhfa.com.au/sites/default/files/MHFA-financial-difficulties-mental-health-professional.pdf>

²⁰ www.relationships.org.au/what-we-do/research/online-survey/august-2015-impact-of-financial-problems-on-relationships

It will be essential that DVA can anticipate these future needs, and to be able to respond as those new cohorts of veterans with emerging or complex conditions seek assistance.

Illustrations of veterans' wellbeing are provided in Annex 4.

Female veterans and veterans' families

Over recent years the proportion of female members of the ADF has increased from 13% in 2000 to nearly 17% in 2017, and much ADF recruitment advertising strongly features female ADF members, suggesting a likelihood that this proportion will continue to increase in the future.

The needs of female veterans are different again to those of male veterans; for example, female veterans are more likely to need support for issues such as domestic violence, female health, and physical or sexual abuse or harassment.

The perception by female veterans articulated at the Female Veterans Policy Forum is that DVA's health services are too oriented towards the needs of male veterans. New responses and services are needed to also meet the needs of female veterans and veterans' families.

2.5 Delivery challenges

The information in this section responds to the Productivity Commission's questions on assessing the veterans' compensation and rehabilitation system (p 8–9), a system to meet the needs of future veterans (p 9), and system governance (p 13–14).

DVA has substantially altered its services to meet the needs of new waves of veterans. One such transformation in services is occurring now, responding to a substantial change in DVA's client base. This is driven by the duration and nature of recent and current military engagements, and by the continuing decrease in the number of older veterans.

Of the more than 290,000 clients of DVA (including veterans, war widow/ers and dependants), around 170,000 are aged 65 or older, of which 150,000 (including widow/ers and other dependants) are aged over 79. By 2020, the total client population is expected to decline to around 243,000.

This change in the client base has created both more intensive health needs of an older, but declining, cohort, and more complex needs of younger cohorts.

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?

The contemporary challenges faced by DVA include:

- more complex claims processes, adding time and administrative cost to decisions (for information on claims, see Annex 5)
- changing community expectations for modern standards and channels for service delivery, accessibility and claim lodgement
- complex and difficult health and wellbeing issues across the whole veteran community, including their families
- a diverse veteran group, dispersed widely across Australia
- ongoing societal change in the nature of work, health care, and rehabilitation.

DVA's own surveys undertaken in the last few years have found that the younger veteran cohorts (with post-1999 service) are the least satisfied with DVA's services. While older cohorts have been the most satisfied with DVA's products and services, the oldest of those cohorts (aged 85 or over) is large (25% of DVA clients), but quickly declining.

Recent engagement with veterans and their families, especially as part of workshops and other fora, has provided substantial evidence that DVA's services, approaches, processes and culture have not been meeting their needs.

This feedback has been consistent and powerful, indicating that:

- DVA's processes and attitude are too adversarial, with interrogative investigation of claims
- veterans are not trusted to provide accurate information and there is too much reliance on medical evidence and supporting evidence from Defence
- DVA is process driven and the processes are too slow; when DVA does eventually accept liability for a condition, there is a further slow process to assess the claim
- DVA also tends not to proactively engage with its veterans and their families, and offers no single point of contact.

These concerns are most marked for the younger cohorts of veterans:

How about improving the DVA claims process—to stop being confrontational and having delegates act like insurance assessors picking through every claim for any reason to deny liability! Then we wouldn't need more and better advocates!
(DVA client)

Over the last few decades, as complexity has increased, 'stovepiping' has occurred where particular staff focus only on a single benefit or service transaction, rather than on the holistic needs of each veteran.

Where are the key deficiencies in the system?

Overly prescriptive processes provide little room for staff to offer creative solutions or to consider the unique elements of every veteran's circumstances:

Do the governance arrangements for the veterans' support system encourage good decision making—from initial policy development to its administration and review?

I'm medically discharging in three weeks. I put in a claim with DVA over a year ago and DVA has done nothing. There's no light at the end of the tunnel. It's been over a year and I have no sense of when there will be light. (DVA client)

In addition, DVA's assortment of legacy programs and services require the application of some 200 different IT systems, some dating back more than thirty years, to deliver them. As a result, DVA often operates under processes and systems that are at risk of critical failure, are resource and time intensive, and that are difficult and costly to maintain and change. Thus staff can have limited ability to know all the circumstances of the veterans and their family, or be aware of their past or ongoing interactions with DVA, preventing the provision of holistic support in anticipation of need. Veterans can also feel frustrated by the need to repeat information:

It's hard enough to tell someone once, let alone two, three or four times. (Currently serving Navy member)

3 DVA's response to the needs of the veteran community

3.1 DVA's transformation

The information in this section responds to the Productivity Commission's questions on system governance (p 13–14), claims and appeals (p 12), and on helping people transition from the ADF (p 17–18).

3.1.1 DVA's transformation program

In recognition of the system's shortcomings and the need for comprehensive reform, over the last few years DVA has made a business case to Government for a transformation program.

In the 2017–18 Budget, the Government provided \$166.6 million over four years to DVA and the Department of Human Services (DHS) for the first stage of DVA's Veteran Centric Reform (VCR) program.

The program is about putting veterans and their families first and delivering the services they need, when and where they need them. It is an opportunity to rebuild trust in the help and services available to veterans, and restore confidence that the wellbeing of veterans and their families is DVA's priority.

More information on DVA's transformation, including design principles and achievements to date, are outlined in Annex 3.

3.1.2 Engaging with veterans, their families and other stakeholders

Engaging with a broad range of veterans is, and will continue to be, a key priority in the transformation process in co-designing and implementing new services and programs.

Over the past year, DVA has consulted with over 1,700 veterans about the changes needed. New engagement fora, such as the Female Veterans and Veterans' Families Policy Forum (the Forum), have been created so that issues can be raised and the Government and DVA can gain a deeper appreciation of them.

The inaugural meeting of the Forum was held in December 2016 with a second meeting occurring in October 2017. Ideas and themes flowing from both meetings are available on the DVA website.²¹

²¹ www.dva.gov.au/consultation-and-grants/consultation-female-veterans-and-veterans-families

Are transition and rehabilitation services meeting the needs of veterans and their families?

A further workshop was held in June 2018 with a focus on:

- exploring options for a group program to strengthen veteran family resilience
- exploring the idea of a ‘female veterans champion’
- developing resources to assist access to aged care services
- exploring veteran families’ information needs and preferences
- co-creating the 2018 Forum, which is scheduled for 11 and 12 September 2018. These dates coincide with an event honouring the contribution and sacrifice of women as veterans and veterans’ family members.

In addition to helping to inform DVA’s transformation journey, Forum feedback:

- contributed to the decision to provide \$8.5 million in the 2016–17 Budget to expand eligibility for the Veterans and Veterans Families Counselling Service to the partners and children of veterans with at least one day continuous full-time service
- provided DVA with ongoing opportunities for engagement with female veterans and veteran family representatives. Forum representatives have attended co-design events convened by DVA on legislation reform and ADF transition
- contributed to raising awareness of the important contribution female ADF personnel make to the defence of Australia.

3.1.3 Beyond the veteran-centric model

A core issue for DVA to consider as it progressively implements the veteran-centric model will be the extent to which it focuses on the *whole-of-life wellbeing* of veterans. If this were to be DVA’s central tenet for its operations, it would reflect a philosophical move away from focusing on payments, benefits and compensation, to a stronger focus on veterans’ health, wellbeing, rehabilitation and productivity.

It is notable that the older VEA, under which nearly 16,000 primary claims were made in 2017–18, has a focus on illness and lifetime compensation payments, which is not conducive to a ‘wellness’ model.

Key considerations include:

- Veteran Centric Reform already places the veteran and their family’s perspective at the centre, to ensure that the system works from their perspective
- healthy living, healthy ageing and similar domains are the focus of other Australian Government agencies

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

- accepting a wellbeing policy as a core function of DVA would then inform all other aspects of its services, and how it collaborates with other agencies, shares information, and provides support to the veteran community
- continued support of the Prime Minister's Employment Program to ensure veterans transitioning from the ADF can find suitable employment if that is their wish
- a new model of delivery of transition services that has DVA and CSC involved at the start, not only on post-transition handover.

3.2 Funding

The information in this section responds to the Productivity Commission's questions on system governance (p 13–14).

In 2016–17, DVA supported 165,000 veterans and 127,000 dependants through \$6.4 billion in income support and compensation, and a further \$5.3 billion in health and wellbeing, including Gold Health Cards, White Health Cards, Veterans and Veterans Families Counselling Service (VVCS) counselling sessions, and travel to treatment.

DVA received \$306.5 million in departmental funding in 2016–17 to support the delivery of these services to the clients, making up 3% of DVA's total budget.

Over the last two Budgets, DVA has received around \$270 million in additional funding to support Veteran Centric Reform and DVA's transformation.

DVA's administered budget funding is primarily made up of Special Appropriations funding of \$10.12 billion in 2018–19 (which is demand driven to support benefits and payments to veterans and their families and are uncapped). These Special Appropriations comprise more than 98% of the Department's total administered budget funding allocation.

3.3 Understanding military compensation across jurisdictions and countries

The information in this section responds to the Productivity Commission's questions on helping people transition from the ADF (p 17–18).

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?

DVA has recently commissioned a desktop review comparing compensation arrangements and support services across Australian jurisdictions and internationally. The international comparison, which is specifically looking at military compensation, transition and rehabilitation arrangements, is seeking to compare services and benefits between Australia and each of the 'Five Eyes' countries (New Zealand, the United States, the United Kingdom and Canada), plus France.

This comparison will help DVA to determine its policy and service settings and offerings against equivalent arrangements that operate elsewhere.

Information from this study is expected to be available to the Productivity Commission soon.

4 DVA's perspective on specific issues, barriers, challenges and opportunities

The discussion in this section focuses on the 'friction' points in DVA's military compensation arrangements, which tend to cause most concern, or result in delays or other difficulties that most affect veterans and their families, as well as the opportunities to improve them.

4.1 Legislative history and the current Acts

While the *War Pensions Act 1914* was the first Australian legislation to address military compensation, the subsequent *Repatriation Act 1920* (originally titled the Australian Soldiers' Repatriation Act) was the first comprehensive Commonwealth legislation to specifically cover returned service personnel; this was succeeded by the *Veterans' Entitlements Act 1986* (VEA), which consolidated several Acts that had been made since 1920.

The VEA provides for rehabilitation, compensation and health care for:

- wartime and other particular operational deployments before 1 July 2004
- defence service (peacetime service), providing that at least three years' continuous full-time service²² were completed by 7 April 1994, of which all or part were on or after 7 December 1972²³
- ADF members who were present in a test area when atomic weapons trials were taking place, or who were later involved in activities relating to the testing, such as decontamination of equipment or vehicles (British Nuclear Test Defence service)
- members of certain peacekeeping forces (or as a member of an Australian contingent of a peacekeeping force) on deployments outside Australia, generally up to 1 July 2004.²⁴

²² Two exceptions to the three-year service requirement are completion of national service after 7 December 1972, and early discharge on medical grounds.

²³ In most cases, eligible defence service ended on 7 April 1994 unless the veteran commenced full-time ADF service on or before 22 May 1986, in which case all unbroken service was covered by the VEA until 1 July 2004.

²⁴ Certain peacekeeping service continues to be covered under the VEA after 1 July 2004.

Compensation under the VEA is typically provided through a lifetime, fortnightly disability or war widow/er pension, and health care under the Gold and White Card arrangements.²⁵

The *Safety, Rehabilitation and Compensation Act 1988* (SRCA) provided rehabilitation and compensation coverage for death, injuries and illness resulting from peacetime and peacekeeping (non-operational) service up to 1 July 2004, and for operational service between 7 April 1994 and 30 June 2004. The SRCA also preserved provisions from two previous Acts: the *Commonwealth Employees Compensation Act 1930* and the *Compensation (Commonwealth Government Employees) Act 1971*.

In 2017, the *Safety, Rehabilitation and Compensation Act (Defence-Related Claims) Act 1988* (DRCA) replaced the SRCA for ADF members. There was no change to eligibility or the coverage of entitlements or benefits available to current and former members of the ADF; the purpose of this change was to move all military compensation legislation under the Minister for Veterans' Affairs, which now presents a significant opportunity for harmonisation.

The *Military Rehabilitation and Compensation Act 2004* (MRCA) was introduced to provide a single, self-contained Act governing compensation for military personnel in response to recommendations of the Tanzer review (see Annex 1). MRCA provides rehabilitation and compensation coverage for death, injuries and illness resulting from all service (warlike, non-warlike and peacetime service) after 30 June 2004.

At the heart of all three Acts are the concepts of compensation for:

- impairment (loss of lifestyle and loss of function)
- inability to generate income (income loss)
- service-related death of a veteran where there are dependants.

These can be provided as fortnightly payments or a lump sum amount.²⁶

There are also benefits that recognise service—such as a service pension that cuts in earlier than the age pension. Medical treatment, rehabilitation services and other allowances and benefits are also provided.

More information on the chronology of military compensation legislation is in given in Annex 6.

²⁵ See Annex 16 for information on White and Gold Cards.

²⁶ Note there are differences between the Acts and the forms of compensations available to veterans.

4.2 Working with legislation and its complexity

The information in this section responds to the Productivity Commission's questions on a system to meet the needs of future veterans (p 9), the complexity of veteran's support (p 10–11), and on the claims and appeals process (p 12).

DVA's role

The legislation broadly works as a system of statutory entitlements. Under this legislation, DVA primarily operates as a service organisation to support current defence service and transitioned personnel. In assessing a claim, DVA staff, as delegates of either the Repatriation Commission or the MRCC, determine if the veteran is eligible for payment under one or more of the Acts; they then identify the payments and their amount under separate elements of the claim process.

Through these processes, DVA's intent is to identify what the claimant is eligible to receive, and that the amounts, benefits or services are correct and within legislative limits.

Complexities created by having multiple Acts

With changes to entitlements over previous decades, transitional provisions have usually been enacted to preserve perceived accrued rights, or to ensure existing entitlements or benefits being provided would not be affected, resulting in compounding legislative complexity.

The current basis for the legislative framework is that the time the relevant service took place determines which Act applies. So a veteran with service relevant to the VEA who makes a claim now, will have that claim considered under the VEA.

However, for much of the period since the early 1970s, veterans have experienced injuries or illnesses related to their service that fell within the remit of two or more Acts. This has created complexity in the provision of compensation and rehabilitation services and benefits and made it difficult for veterans and their families to understand the system of services and benefits and how best to access the support they need. It has also resulted in complex offsetting provisions to avoid double compensation payments. Significantly, there can be concurrent eligibility under the VEA and DRCA.

The VEA works significantly differently to the DRCA and MRCA, most significantly in that the VEA is based on *lifetime pensions and health care*, whereas the DRCA and MRCA are more akin to workers' compensation schemes. It is worth noting, however, that the MRCA includes some important features of the VEA that make it a unique Act.

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

Cases of multiple eligibility typically allow for the VEA to provide a disability and war widow/er pension and medical entitlement, while the DRCA provides compensation for the injury (most frequently taken as a lump sum payment, but also available as fortnightly incapacity payments). Both VEA and DRCA are subject to offsetting provisions.

While the introduction of the MRCA was an attempt at simplifying the legislation, members with eligible prior service are still permitted to claim against the DRCA and VEA.

Confusion has also arisen with veterans receiving different benefits for the same injury, or the same veteran receiving different entitlements for a second injury processed under a different Act. Some scenarios illustrating these different outcomes are provided in Annex 7.

Are there aspects of the claims and appeals process that result in inequitable outcomes for veterans?

Claim sequence effects under multiple Act entitlements

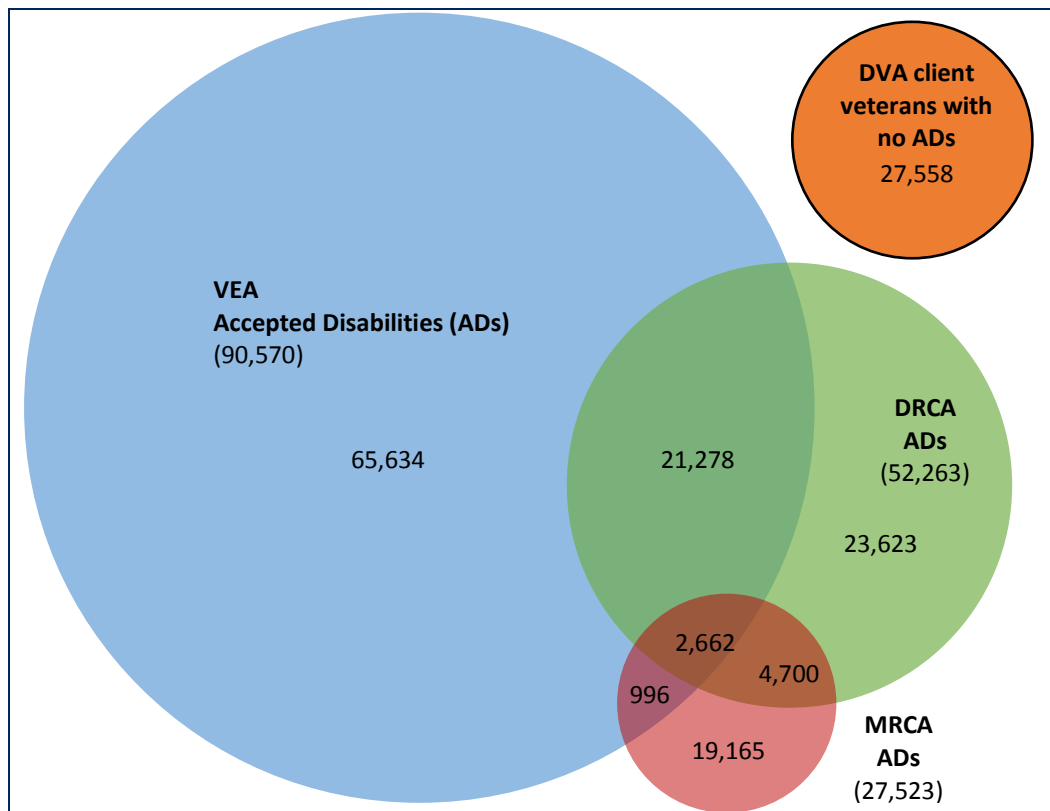
The introduction of the MRCA while retaining the entitlement to claim under the VEA and DRCA led to one unintended effect: veterans can receive different compensation amounts depending on the order in which they claim their conditions under each Act.

This is neither well understood within the veteran community, nor a desirable outcome.

Dual/multiple eligibility

Figure 4 shows these complexities have contributed to a situation where a significant number of veterans with an accepted disability have dual or multiple eligibility: there are 21,278 veterans with claims accepted under both VEA and DRCA; 996 veterans with dual VEA/MRCA acceptance; and 2,662 veterans who have claims accepted under all three of VEA, DRCA and MRCA.

Figure 4 Overlaps in Act eligibility, by the number of veterans with accepted disabilities



Legislation Workshops

The Senate Foreign Affairs, Defence and Trade Committee in its report on the Safety, Rehabilitation and Compensation Amendment (Defence Force) Bill 2016 made a number of recommendations. The key finding at 4.14, Recommendation 1, included:

The Committee recommends that the Department of Veterans' Affairs conduct a review of its consultation and engagement practices in order to:

- receive informed critical feedback on proposed legislative amendments;
- rapidly respond to concerns raised in the veteran community; and
- increase the understanding of proposed legislation changes in the veteran community.

In response, two Legislation Workshops have been held to address the three measures outlined in the recommendation.

The first workshop in November 2017 had representatives from the ESO Round Table (ESORT), Younger Veterans' Forum and Female Veterans Policy Forum to assist in shaping the legislative reform priorities for DVA. Many issues were discussed at the workshop, including simplifying and aligning the existing legislation, Statements of Principles (SoPs), offsetting, and permanent impairment issues.

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

The second workshop, held in March 2018 with the same representative groups, discussed transition, wellbeing and healthy living, and simplifying and aligning the existing legislation²⁷.

More information on legislation

Annex 6 provides a chronology of military compensation legislation, Annex 7 provides more information on dual/multiple Act eligibility, Annex 8 provides information on recent legislative changes, and Annex 9 provides information on offsetting.

4.3 Legislative reform

The information in this section responds to the Productivity Commission's questions on assessing the veterans' compensation and rehabilitation system (p 8–9), a system to meet the needs of future veterans (p 9), the complexity of veterans' support (p 10–11), and on the claims and appeals process (p 12–13).

Transformation is reshaping service delivery to be around veterans' and their families' needs; however, legislative reform—reflecting the principles of Veteran Centric Reform—will be needed to support this transformation.

It is critical that DVA is prepared to continually modify and adapt its services to meet the changing needs of veterans and their families. This should be within a legislative framework that operates on the basis of achieving broad veteran wellbeing outcomes without being overly prescriptive in the delivery of specific processes and programs.

With the Minister for Veterans' Affairs having policy responsibility for all three Acts since DRCA legislation was passed in 2017, there is now significant scope for legislative reform. When enacted, the MRCA was seen as the single Act for the future, and there may be elements of this Act that could feed into future legislation.

DVA's focus on reducing the complexity of administrative requirements will continue into the future. The enactment of the DRCA to replace the SRCA for ADF members and former members is an example of this commitment.

²⁷ Additional information on the Legislation Workshops is at www.dva.gov.au/about-dva/legislation/legislation-workshop.

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

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?

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

4.3.1 Towards unification: options for legislative reform

There is a case for a unified legislative framework. The MRCA could be the vehicle or basis for unified legislation, but this would need to be considered more fully. The options to achieve a more unified framework are as follows:

1. **Minimal rationalisation**, which would remove more obvious and straightforward areas of duplication across the three Acts, but leave them in place.
2. **Rationalise and harmonise over time**, removing duplication and harmonising provisions of each Act to make them work in the same way. Harmonisation work could include four priority areas (each of these options is discussed in more detail in Annex 10) as follows:
 - a. adopting the Statements of Principles (SoPs) regime of the VEA and MRCA into the DRCA (see Annex 11 for information on SoPs)
 - b. assessing veterans' levels of impairment across the three Acts against the most up-to-date assessment guide available (see Annex 12)
 - c. adopting the VEA and MRCA appeal pathway for merit reviews for the DRCA (see Annex 13)
 - d. addressing some of the differences between DRCA and MRCA in relation to incapacity payments under each Act (see Annexes 12 and 14).

It should be noted that once the DRCA and MRCA are harmonised, it then becomes feasible to absorb the DRCA provisions into the MRCA.

3. **Rationalisation, harmonisation and simplification** of the Acts through a single major reform process. This would consider underlying settings for the current framework and seek to develop one Act going forward that would govern eligibility and entitlements for all veterans, encompass rehabilitation as a key outcome and facilitate a veteran-centric approach. Elements of the existing MRCA may feed into the new Act.

While harmonisation of DRCA and MRCA provisions would simplify many processes and streamline much of DVA's engagement with its veteran clients, more immediate legislative reform that goes beyond harmonisation alone is needed to significantly modernise the military compensation system, remove multiple eligibility problems and ensure better outcomes for all veterans and their families.

Is it possible to consolidate the entitlements into one Act?

If so, how would it be done?

Broad reform would likely affect existing entitlements for some groups of veterans and would need to be addressed through transitional provisions to ensure no-one is any worse off under new legislative arrangements. Equally, the process of reform should not be seen as a means to escalate or increase the benefits or entitlements currently available to any individual or group of veterans. To be successful, these reforms will require considerable consultation with the veteran community and affected stakeholders.

Closing VEA and/or DRCA to new claims

The terms of reference for the Review of Military Compensation Arrangements (RMCA) of 2011 included consideration of the legislative and policy issues identified by stakeholders relating to the transitional arrangements between the VEA or the SRCA (now the DRCA) and the MRCA.

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

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

What transitional arrangements would be required?

The RMCA examined the option to reduce legislative complexity by ceasing future claims under the DRCA (or VEA) and treating them as claims under MRCA. Under such arrangements, previous claims would continue to be paid under the relevant Act, but new claims would only be eligible under the MRCA.

The RMCA found that most DRCA claims made under the MRCA would be eligible for a higher benefit, increasing the cost to Government. However, some claimants would be less well off.

For the VEA, the RMCA considered that the different nature and benefit structure of VEA (particularly its orientation to a flat-rate, lifetime pension) made it less appropriate for claims to be transferred to the MRCA.

However, considering the anticipated reduction in VEA claims over the next several decades as older veterans decline in number (see the age profile of DVA clients in Section 2.2.3), there may be a point in time where the size of the VEA-eligible cohort is so small that limiting new claims to only the MRCA would be feasible.

Separation of administration and entitlements in legislation

A further option for simplifying legislation may be to separate out the administrative provisions from each of the three Acts, bringing them together as a single Administration Act. The VEA, DRCA and MRCA would then comprise three sets of entitlements, which may then be themselves simplified and unified.

This arrangement—broadly modelled on the structure in place for Commonwealth Social Security legislation—would have the benefit of immediately unifying the administrative aspects of entitlements under existing legislation, without affecting veterans' entitlements. The issue of harmonising and simplifying entitlements could then be considered separately, potentially at a later date.

A variation of this arrangement may be to operate administrative provisions through regulations, rather than as a separate Act.

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

4.3.2 Future policy changes

To date, veterans' military compensation policy has often been developed in reaction to requests advocated by individual veterans or by ESOs; accordingly, those changes have often reflected only the specific circumstances of a limited group of veterans and/or their families.

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

Implementing policy responses to specific ad-hoc requests in this way adds to complexity and can ignore the needs of the whole veteran community, or can overlook the circumstances faced by other cohorts of veterans and their families in otherwise similar situations. Such responses are also likely to be based on particular historical or current circumstances, without considering all veterans' future needs and without prioritising improvements.

Finally, such changes can also introduce relatively minor but nevertheless compounding amendments to legislation, adding to an already complex system, and possibly introducing new differences that may then lead to calls for further extensions.

What principles should underpin the legislation and administration of the system?

There is scope for DVA to base the development of policy on principles, such as:

- The design and application of beneficial legislation is the starting point.
- Policies and programs are future facing—anticipating the future needs of veterans and their families and projected claims.
- Policy responses would be articulated ahead of need, and be based on the needs of the veteran community as a whole, or major cohorts of that community, rather than smaller groupings.
- New policies and programs must work and be understandable from the perspective of veterans and their families (i.e. be veteran centric).
- Policies should work to achieve simplification, rather than complication.
- Policy needs to be developed with a systematic approach, understanding how changing the policy 'levers' both impacts outcomes and affects other policy settings.

More on the design of future military compensation can be found in Section 5.

4.4 Financial compensation

The information in this section responds to the Productivity Commission's questions on assessing the veterans' compensation and rehabilitation system (p 8–9), the complexity of veterans' support (p 10–11), the claims and appeals process (p 12), providing financial compensation for an impairment (p 15–17), helping people to transition from the ADF, and on income support and health care (p 18–19).

4.4.1 Determining liability

Processes relating to claims received after the member has transitioned (often many years after leaving the ADF) rely on medical evidence and diagnosis, and usually also need information from Defence on the nature and cause of the injury to enable the DVA decision-maker to determine if the condition was related to service.

This information can take some time to be provided (slowing the claim process), and may not meet the DVA decision maker's needs.

An alternative system could be to determine liability at the time of the injury or incident, or close to that time. An early determination of liability could then be relied on should a claim be made at the time, or be made at any point in the future.

In considering such a model, issues around which agency would be in control of the decision, and any risks associated with an early determination, would need to be considered.

Collecting this information at or close to the time of the event, and having it available in advance of a claim being made would considerably reduce the time taken to process claims, establishing a smoother transition between Defence and DVA entitlements.

Beyond injury information, also of interest to DVA is the *exposure* of service personnel to situations, conditions or substances that may result in subsequent compensation claims. While information on incidents or durations of exposures may be difficult to collect, it is nevertheless an area worthy of further investigation.

4.4.2 Compensation payments

Issues concerning the adequacy, fairness, and timeliness/efficiency of compensation payments have been raised. Some of these issues have been known for some time, and DVA has in the past introduced reforms to mitigate their worst effects, although there is need for further improvement.

Where are the key deficiencies in the system?

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

The system of military compensation does not sit in isolation from other government and community support systems. The Clarke Review noted²⁸ other avenues for support to veterans and their families through the social services and other systems.

Veterans' entitlement to 'special' support alongside the support or services provided to most other citizens often raises a question of why the 'special' support for veterans exists. While a comparison of individual elements of support mechanisms, services or benefits may suggest that particular veterans' benefits are comparatively generous, there are many factors to consider, such as intent, needs and community expectations.

Financial compensation is augmented by the support a veteran receives under the DVA Health Card system. Rehabilitation services (medical, psychosocial and vocational) are also available under all three Acts.

The VEA does not distinguish between economic and non-economic loss compensation, whereas DRCA and MRCA do. Widow/ers' payments under all three Acts also do not separate economic and non-economic loss elements.

4.4.3 Compensation payments—some key issues

Some key issues affecting compensation arrangements have been raised:

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

- **The adequacy of Totally and Permanently Incapacitated (TPI) compensation under the VEA.** There have been calls for part of the VEA Special Rate Disability Pension (commonly known as the TPI pension) to be classified as 'economic loss compensation' and increased to the level of the after-tax national minimum wage 'as compensation for the economic loss they suffer due to their physical and psychological conditions'.
- **The service differential in military compensation.** Under the MRCA, different permanent impairment compensation amounts result from the same impairment rating and lifestyle effects, depending on whether the service injury is suffered or the service disease is contracted on warlike or non-warlike service (operational service) or peacetime service. A higher permanent impairment compensation payment is made for operational service.
- **The 'permanent and stable' requirement for permanent impairment compensation under MRCA and DRCA.** Both the MRCA and the DRCA require that a person's accepted condition/s be 'permanent and stable' before any final payment of Permanent Impairment compensation can be made. Many conditions will have periods where symptoms may be more or less severe, including fluctuations of symptoms, or 'spikes', as part of their normal manifestation.

²⁸ Clarke, *Report of the Review of Veterans' Entitlements*, 2003, 6.1.

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?

Are all of the payments available necessary and beneficial?

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

Are there complications caused by the interaction of compensation with military superannuation?

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

- **VEA Special Rate/incapacity payments or Special Rate Disability Payment.** An issue that reflects the complexity of dual or tri-Act eligibility and different legislative requirements in the different Acts relates to cases where inability to work has to be assessed under multiple Acts and the inability to work is due to several conditions individually accepted under different Acts.
- **Economic loss compensation under the MRCA and DRCA.** The Special Rate of disability pension under the VEA compensates veterans for their inability to work and is the same rate for all eligible veterans. In comparison, under the DRCA and MRCA, economic loss payments in the form of incapacity payments are aligned with the veteran's actual earnings before their incapacity.
- **The relevance of the Special Rate Disability Pension (SRDP) in MRCA.** The SRDP was built into the MRCA as a safety net to ensure that former members, unable to work because of accepted disabilities, would have access to benefits that are equivalent to the Special Rate of disability pension under the VEA. This payment is complex to administer and can act as a barrier to employment.
- **Incapacity payments—incentives for rehabilitation.** The MRCA considered the issue of whether the relatively high level of incapacity payments under the MRCA—ranging from 75% to 100% of pre-injury earnings, often including allowances—could act as a disincentive for some former ADF members to undertake rehabilitation and return to the workforce. The MRCA considered that this issue required further investigation and consideration.
- **Interaction between liability and non-liability insurance.** The compensation available to Defence personnel is a system that comprises both DVA-administered liability compensation legislation (MRCA and DRCA) and non-liability insurance administered by the CSC. In effect, there is a combination of liability compensation and non-liability compensation available to the same personnel, administered separately, but which operate concurrently and may be offset against each other. Some veterans find it difficult to understand why their entitlements under the superannuation system are being offset against their entitlements under compensation systems.
- **Offsetting complexities.** The inherent complexity of offsetting rules under military compensation can make it difficult for a veteran to understand what they are entitled to. In general, offsetting rules, actuarial principles and rationales are poorly understood; for example, many in the veteran community believe that offsetting deprives them of their rightful entitlements.
- **Permanent Impairment lump sum payments under MRCA and DRCA.** There is concern that some veterans who take the lump sum do not always use the payment in beneficial ways, and this may particularly be the case for veterans with complex mental health conditions. The financial burdens that receipt of such payments generate can exacerbate these conditions.

These are each discussed in detail in Annex 14. Offsetting is also discussed in Annex 9.

4.4.4 Family benefits

Financial compensation to the families of veterans is limited under the current legislative framework, apart from the assistance available to war/defence widow/ers, with access to a Gold Card, and VVCS counselling available to ADF personnel and their families where the individual has at least one day full-time service or has been involved in a high-risk activity.

However, from 1 May 2018 the Family Support Package became available to eligible veterans and their families, and to spouses or partners of veterans killed in recent conflicts or who have taken their life after returning from warlike service. This change was in response to recommendation 19 of the Senate Report—*The Constant Battle: Suicide by Veterans*.²⁹

The additional assistance provides for:

- expanded childcare arrangements in specific circumstances
- counselling support for the immediate family members of veterans experiencing crisis
- home help and counselling support for the spouses or partners of veterans who died in recent conflict or from suicide after returning from conflict.

In addition, a range of other measures, including counselling and carer support are provided (such as VVCS, discussed in Annex 15).

Are transition and rehabilitation services meeting the needs of veterans and their families?

A finding of the Clarke Review was that new compensation arrangements may be needed, including for veterans' spouses and partners and dependants.³⁰ The RMCA subsequently considered the arrangements for widow/ers and formed the view that the compensation arrangements of MRCA and increases in VEA pension rates since the Clarke Review indicated that no further review of benefits for widow/ers or dependants was needed.³¹

Nevertheless, DVA is now focused on supporting families and is working with veterans' families to identify needs and new services.

²⁹ The Committee recommends that the Department of Veterans' Affairs review the support for partners of veterans to identify further avenues for assistance. This review should include services such as information and advice, counselling, peer support and options for family respite care to support partners of veterans.

³⁰ Clarke, 6.69.

³¹ RMCA, rec. 29.1.

4.5 The question of a Defence premium

The information in this section responds to the Productivity Commission's questions on the role of the ADF in minimising risk (p 15).

The RMCA recognised that the absence of an effective price signal (in the form of premiums) is a barrier to understanding the dollar cost of service-related deaths, injuries and illnesses in the ADF. However, the RMCA did not believe a premium-based model would be appropriate for the ADF.³² Previously, the 1999 Tanzer Review suggested the need for the introduction of a premium for the MRCA, but this was not pursued.

Many ADF activities, even in peacetime, and not just when training for operations, are inherently dangerous. There are also practical issues with calculating a premium for injuries, illness or death related to non-operational service.

Under the SRCA, in addition to its scheme management functions, Comcare is the claims and liability manager for premium paying employers (Commonwealth departments and agencies, and the ACT Government, amongst others) in the workers' compensation scheme. This role includes the setting and collecting of premiums specific to each agency. Comcare's role is comparable to that of an insurer and fund manager as it has the power under the Act to apply premiums to meet Comcare's liability and claims administration cost.

Administration and governance of the MRCA is shared between the ADF (the employer) and DVA (the scheme administrator).

DVA notes that Comcare, as the workplace health and safety regulator for Defence, already conducts inspections and reviews with Defence in relation to incidents and injuries. Comcare has previously taken action under workplace health and safety (WHS) legislation where it is clear that Defence has breached the Act in its non-operational activities, and Comcare could be expected to take similar action in the future (either through court action or enforceable undertakings). Defence itself also undertakes injury prevention and rehabilitation activities.

DVA could provide more claims information to Defence on the impact of military service. This could cover:

- the nature of claims
- the duration between the original service-related injury or event and the subsequent claim
- statistics on prevalent conditions or impairments that may be related to particular kinds of service, training, operations or hazards.

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?

³² RMCA, p 247.

Such information may be used by Defence to adapt and change its training or other operational conditions to reduce the incidence or likelihood of similar future claims.

DVA believes that enhanced systematic information sharing between the two departments regarding the translation of service incidents into compensation claims provides a significant opportunity for Defence to proactively identify and manage occupational risk.

4.6 Transition, employment and rehabilitation

The information in this section responds to the Productivity Commission's questions on helping people to transition from the ADF (p 17–18).

4.6.1 Improving transition from the ADF

Between 5,500 and 6,000 ADF members leave the military each year. The transition experience for these ADF members varies. Many members make this transition successfully and quickly re-establish civilian lives. For some though, transitioning from the ADF is not as easy or positive as it could be, and they may face complex social, financial, employment and wellbeing challenges. This is particularly the case if they enlisted at a young age with little experience of adult civilian life or employment, and some may find themselves having to re-learn how to function in a civilian world that is very different to the protective and supportive environment of the ADF.

This highlights the importance of ensuring transitioning ADF personnel are fully supported through their transition. While Defence has primary responsibility for transition, DVA provides a broad range of services and supports that assist members and their families to manage their transition and their post-ADF financial and health needs.

However, while the work to date has made improvements to the transition process for many ADF members and veterans, some veterans do not seek to engage with existing support services at any point in their transition. While many of these veterans will go on to thrive in their civilian lives, others may need support but are unsure how to re-engage with Defence or engage with DVA.

Further work is needed to ensure that veterans do not 'fall through the cracks' during or after their transition from the ADF, and that there are multiple opportunities for veterans to engage or re-engage with sources of support throughout the process.

The ability for veterans to experience a seamless and successful transition to civilian life depends on DVA, the CSC and Defence collaborating in processes that support serving members before and after they leave service.

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

Potentially, DVA could commence rehabilitation pre-transition for those who have made the decision to leave. Under existing legislation, however, responsibility for rehabilitation remains with Defence as the rehabilitation authority until the point of transition.

Defence and DVA are working collaboratively to improve transition by piloting new initiatives to deliver integrated approaches to transition services, implementing the Early Engagement Model, and working to better understand the transitioned population through research.

Information on the DVA services and forms of support available to transitioning ADF members are provided at Annex 16.

What could be done to improve the timeliness of transition and rehabilitation services, and the coordination of services?

Collaboration between DVA and Defence

Transition Taskforce

The Transition Taskforce, established in response to the Coalition's 2016 'Creating a Better Veterans' Transition Process' election commitment, is examining the barriers to effective transition from military service and identifying opportunities for improvement. The Taskforce is made up of current and former serving ADF members and representatives from key areas within Defence, DVA and the CSC.

More information on the taskforce is provided at Annex 16.

Piloting new initiatives to deliver integrated approaches to transition services

In mid-2017, DVA was approached by the then Special Operations Commander, ADF, to develop a more holistic, veteran-centric way of providing DVA services to ADF members and their families as they transition to civilian life. The DVA-led Special Operations Forces (SOF) pilot model tests an improved approach to capturing member claims prior to a member's transition, and providing ADF members and their families information on DVA's support services. This approach looks at wellbeing and whole-of-person outcomes.

The pilot includes:

- a dedicated DVA Liaison Officer for SOF members and their families
- a dedicated case manager, where required
- a streamlined claims process focused on the transitioning member and their family
- early engagement and awareness to support understanding of DVA services and earlier lodgement of claims.

The learnings and feedback from this pilot will assist DVA to continue to improve how services are provided to Special Operations Forces veterans, and will assist to inform a repeatable, scalable model across the ADF. The ultimate goal is to

Are transition and rehabilitation services meeting the needs of veterans and their families?

empower and enable members so they are able to transition into a healthy, productive civilian life for themselves and their families.

DVA is also supporting the Defence-led Transition Health Assessment (THA) pilot at Holsworthy Barracks. This pilot is testing more integrated ways in which medical assessments can be consolidated and streamlined.

The THA pilot seeks to improve transition outcomes for ADF members who experience delays in accessing entitlements from DVA and CSC and undergo multiple medical assessments that require the member to provide the same or similar information to three government agencies. The single process reduces duplication across the three agencies and provides the member with certainty about the entitlements and support they will receive as they transition from the ADF.

A further area of collaboration between Defence and DVA is exploring an arrangement whereby a Defence general practitioner could trigger notification (a potential claim) to DVA of a service-related injury from the Defence eHealth System.

Early Engagement Model

Improved information sharing between Defence and DVA through the Early Engagement Model (EEM) has facilitated DVA establishing a relationship with ADF members early in their career and increases the number of current and former serving members known to DVA. Prior to the EEM the majority of veterans were not known to DVA once they transitioned from the ADF, as the relationship was predicated on the veteran submitting a claim.

Members who joined from 1 January 2016, and those who separated after 27 July 2016, are now being registered with DVA. Around 15,000 current and former ADF members who have not made a claim or approached DVA have been registered. More information on the EEM is at Annex 16.

Joint research

Almost \$6 million has been invested over five years by DVA and Defence to conduct research through the Transition and Wellbeing Research Programme to continue to develop a better understanding of individual veterans' needs, particularly around mental health. This is the largest and most comprehensive study undertaken in Australia on the impact of contemporary military service on the mental, physical and social health of serving and ex-serving military members and their families.

The first two reports, *Mental Health Prevalence* and *Pathways to Care*, were released in April 2018, with a further six reports to be released.

Are transition and rehabilitation services meeting the needs of veterans and their families?

DVA is also collaborating with Defence and the Australian Institute of Health and Welfare (AIHW) to improve the understanding of the incidence of suicide in the ADF and veteran community. Information on this and other issues related to veterans' mental health and suicide is at Annex 17.

This data, together with recommendations and outcomes of other key activities in this area, will be used in designing and tailoring policies and programs to assist at-risk veterans.

4.6.2 Measures to improve transition

On Base Advisory Service

DVA has recognised that direct and convenient advice to ADF members helps to achieve a successful transition from service.

The On Base Advisory Service (OBAS) provides a DVA presence on more than 40 ADF bases nationally to provide ADF members with information and advice about the support and entitlements that they might be able to receive through DVA before and after they transition from the ADF.

OBAS advisors also provide information about DVA services at Defence Transition Seminars. Current serving members are encouraged to meet with an OBAS advisor before they transition from the ADF.

Stepping Out

The Veterans and Veterans Families Counselling Service (VVCS) offers a free two-day program for all ADF members, and their partners, who are transitioning from the ADF or have transitioned in the last 12 months. The program focuses on skills that will assist members and their partners in their transition, including: planning; motivation and adaption techniques; expectation and attitude management; maintaining relationships; and knowing where to go to seek professional help.

This program is offered in addition to the full range of VVCS services provided to transitioning members and their families.

4.6.3 DVA programs to support members in their post-ADF life

Improving employment opportunities

Gaining employment, where appropriate, after leaving military service is a crucial element for the long-term health and wellbeing of veterans and their families, and particularly to achieve positive mental health outcomes.

In recognition of the importance of civilian employment to veterans, the Prime Minister launched the Prime Minister's Veterans' Employment Program in late 2016, with funding of \$2.7 million provided in the 2017–18 Budget.

This program aims to raise awareness of the unique skills and experience that veterans can bring to civilian workplaces, and to increase employment opportunities for veterans in the private sector.

Are transition and rehabilitation services meeting the needs of veterans and their families?

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?

There are six components of the program:

- Industry Advisory Committee on Veterans' Employment (IAC)
- Prime Minister's Veterans' Employment Annual Awards
- Ex-service Organisation Industry Partnership Register
- Department of Defence and Department of Veterans' Affairs initiatives
- Australian Public Service initiatives
- Department of Jobs and Small Business initiatives.

The IAC is providing advice on practical measures to embed veterans' employment strategies into the recruitment practices of Australian business. In its first year, it has focused on four priority areas, including:

- data, research and targets
- human resources policies, accreditation, retention and translation of skills
- communication (branding, awareness, transition seminars, website, job fairs)
- spouse employment.

The inaugural Prime Minister's Veterans' Employment Awards were held in March 2018, and will be conducted annually to recognise the achievements of Australian businesses and other organisations in supporting and employing veterans and spouses of serving ADF members, and veterans who are making significant contributions to their workplace.

The APS Jobs website now includes specific information for veterans seeking employment in the Australian Public Service (APS), a tool that aligns ADF ranks to APS classifications, and a toolkit that outlines information for veterans about working in the APS.

The Australian Government's jobactive website now includes an information page for veterans and an optional 'defence force experience desirable' flag to connect job seekers with employers.

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

Incentives to return to and stay in employment

There are no current incentives available to veterans to return to or stay in work. An example of such a scheme was the \$4,000 Job Commitment Bonus previously offered by the then Department of Employment to eligible individuals who remained in work for more than 12 months.

This is a potential area for policy reform to be explored in line with its impact on reducing incapacity payments compensation.

Sharing information between Defence and DVA

The Memorandum of Understanding between DVA and the Department of Defence formally recognises that responsibility for the delivery of care and support is shared across both agencies. To deliver this, DVA and Defence work closely together and share information regarding military compensation. DVA uses this information to ensure liability can be determined, and that correct incapacity payments are payable.

There has been substantial work to improve the collection and sharing of information sought by DVA from Defence, and much information can now be shared readily with DVA. DVA and Defence continue to work collaboratively to improve the process for providing information. These improvements will enhance DVA's ability to determine liability and claim assessments, through the provision of a comprehensive diagnosis of a condition or impairment allowing DVA to make an informed decision on the merits of the claim against legislative requirements.

As part of the ADF Transition Transformation program, Defence has implemented processes to ensure existing ADF members transition with their service and medical documentation. This documentation includes member service records, record of training and employment and copies of medical records. In addition, every ADF member and their family has access to *The ADF Member and Family Transition Guide*³³, either electronically or in hard copy. This guide provides practical information on transitioning.

There are further opportunities for cooperative information processing to reduce delays and to ensure records contain details that meet DVA's legislative requirements. One such area could be an expansion of the 'feedback loop' for claims where Defence is advised of claim themes and patterns. This is discussed further at Annex 18.

Other opportunities and barriers for greater information sharing

DVA works in partnership with other agencies—including Defence, the Department of Human Services (DHS), the Department of Health, the CSC, and others—to leverage skills, experience, systems and business processes.

However, the nature of this consultation and information sharing differs across departments and, in some cases, within departments. Many processes are still performed manually.

There is complexity in DVA's interaction with other government agencies as well, such as DHS when veterans are transitioning to DHS payments. A dedicated pathway into DHS is being established for DVA staff to better collaborate.

³³ www.defence.gov.au/DCO/_Master/documents/Transition/ADF-Transition-Guide.pdf

4.6.4 Community support for veterans and their families

There are examples arising of communities which are supporting veterans and their families in their post-service life. Through activities to engage veterans, link them to appropriate services, and support their employment, these communities demonstrate the respect they have for veterans and their families, and recognise the value which the veterans and families bring to their community.

Such active engagement by the community can achieve significant benefits for veterans and their families in providing opportunities to connect and engage in local activities, to find work and to improve their self-worth.

These examples demonstrate that communities, beyond the ESO sector and government, can play a valuable role in veterans' transition and in connecting them and their families to their new environment.

4.6.5 Rehabilitation issues

Rehabilitation services provided by DVA

DVA's rehabilitation program provides broad support beyond treatment services and vocational assistance. It promotes veterans' wellbeing and quality of life through whole-of-person rehabilitation services to help them adapt to, and recover from, injury or illness related to their ADF service.

Where appropriate, DVA can support vocational training and tertiary education as part of a rehabilitation plan, but this is only available at this time to those who are injured or ill.

Veterans' rehabilitation

DVA's whole-of-person focus considers all aspects of a person's life in an effort to return a person to health and personal and vocational status similar to before they were injured or became ill.

The whole-of-person approach has three elements:

- **medical management:** assisting a veteran with an understanding of and possible strategies to manage their overall physical and psychological health
- **psychosocial support:** assisting a veteran with their quality of life and independent functioning
- **vocational support:** assisting a veteran to return to sustainable and meaningful employment when ready.

Life satisfaction indicators

Rehabilitation providers work with veterans to develop a rehabilitation plan that includes the use of goal attainment scaling to develop personal goals, based on a

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

whole-of-person approach. In addition to goal setting, veterans rate their own life satisfaction before, during and after rehabilitation using life satisfaction indicators.

Are transition and rehabilitation services meeting the needs of veterans and their families?

Rehabilitation veteran survey

A pilot survey of veteran satisfaction with the rehabilitation program has been undertaken. Rehabilitation veterans will be surveyed within a month of their plans closing and evaluation of the anonymous results will be undertaken to inform program and policy development.

More information on DVA's rehabilitation services and forms of support are provided in Annex 15.

4.7 The provision of health care

The information in this section responds to the Productivity Commission's questions on helping people to transition from the ADF, and on income support and health care (p 18–19).

Since the devolution of the former repatriation hospitals from the early to mid-1990s, DVA has moved to being a national purchaser of health care.

The \$5 billion spent each year on health and community care services ensures that all veterans, including the wounded or injured, are able to access appropriate care services in each state and territory from both the public and private sectors, and across the range of services from hospital inpatient, community care, through to primary care in general practices.

Services include:

- general medical consultations and services
- allied health services, such as physiotherapy and psychology services
- rehabilitation services
- hospital services, including inpatient and outpatient services
- pharmaceutical benefits
- home care services to help veterans and war widow/ers who need assistance to remain living in their own home (including services such as domestic assistance, personal care, garden maintenance, and so on)
- community nursing services
- counselling services
- other services such as transport.

4.7.1 Continuity of care for veterans

A number of past reviews, including the Dunt Review (2009) and ANAO performance audits³⁴ considered the issue of continuity of care, and have stressed its importance. Through active continuity of care, the prospect of positive health and wellbeing outcomes for veterans is maximised, while the likelihood of relapse or re-presentation reduces.

Continuity of care involves undisrupted, active management of service personnel who are receiving medical attention prior to and post-transition.

Recent initiatives have been introduced that are reducing the likelihood of health care discontinuity, including the DVA On Base Advisory Service, the Defence eHealth System, and trials of earlier rehabilitation handovers and several transition trials.

Beyond these initiatives, there may be a case for consideration of a single joint Defence-DVA comprehensive health support contract to enhance continuity of care outcomes for veterans.

The veteran's pathway through the health systems

Before birth, Australians are supported by the national health system, which includes the public health system and private providers. At recruitment into the ADF they transition into the Defence health system. On transition from the ADF, they transition into the DVA compensation and rehabilitation system, and/or back into the national health system. At any stage during or after service they also may interact with the non-government veteran support system.

The highest risk of failure is at the point of transition from one system to another.

Post-transition, most veterans are only supported by the national health system, and most are unknown to DVA. Thus, there needs to be an appropriate focus on the national health system's supporting architecture for veterans.

Current supporting architecture does not achieve:

- awareness within the national health system (or automatic awareness by a treating general practitioner or emergency facility) they are supporting a veteran
- availability of a veteran's medical records within the national health system, specifically for GPs and emergency facilities.

Attempts have been made to address the above with the provision of a post-transition GP health assessment initiative, and inclusion in the MyHealth record of an 'ex-ADF' identifier. Unfortunately, the MyHealth ex-ADF identifier does not

Is health care for veterans provided in an effective and efficient manner?

³⁴ ANAO *Administration of Rehabilitation Services under the Military Rehabilitation and Compensation Act 2004*, 2016, available at: www.anao.gov.au/work/performance-audit/admin-rehab-services-under-military-rehabilitation-compensation-act

currently populate into the GP clinic patient-management software, and ADF health records are currently not able to be added to an individual's MyHealth record.

4.7.2 Non-liability health care

Has the non-liability coverage of mental health through the White Card been beneficial?

Historically, medical treatment has mainly been provided under military compensation schemes for conditions related to service and for which compensation is payable. However, the non-liability health care (NLHC) arrangements allow treatment to be provided under DVA arrangements for prescribed medical conditions, irrespective of whether or not they are service-related.

NLHC has existed in some form in the repatriation system since the period following World War 1. The range of eligible conditions has expanded significantly in recent years, however, particularly in relation to mental health treatment.

Non-Liability Health Care, including its potential extension, is discussed in Annex 19.

4.7.3 Review of DVA's mental and social health strategies

Mental and social health has been a strong area of focus in recent inquiries. DVA has commenced a review of its mental and social health strategic framework, and is exploring opportunities to align with similar strategies in Defence. A feedback mechanism may be valuable to provide information on DVA's experiences with its veterans and their families back to Defence.

Veterans who are medically discharged are generally in higher needs categories than people who access other rehabilitation and compensation schemes, and have exhausted options to return to work in the ADF. How should this be reflected in the design of rehabilitation services for veterans?

Veteran suicide, access and availability of mental health services, and the management of individual veterans by DVA were addressed in the four inquiries listed in Annex 1. Recognising the critical nature of the support that needed to be available for veterans suffering poor mental health, Government responded with a funding package as part of the 2017–18 Mid-Year Economic and Fiscal Outlook.

This work involves a number of reviews, studies and trials that are being progressively undertaken by DVA through a number of out-sourced and contracted organisations over the course of 2018 and 2019. These are listed in Annex 3.

4.7.4 Early access to medical treatment

DVA has started a two-year trial to provide veterans with early access to medical treatment, while their claim for acceptance of liability for a service injury or disease fitting 20 specified conditions is being processed under the MRCA or DRCA.

Provisional access to medical treatment is intended to contribute to improved physical and mental health of eligible veterans, as well as reduce deterioration of veterans' medical conditions, leading to a reduction in the need for future services.

4.7.5 Consumer-directed care—an NDIS model for veteran health care

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

The Issues Paper suggests that the veterans' support system needs to be considered in the context of reforms in other areas of service delivery that are aimed at improving outcomes for users and achieving better value for taxpayers' money.

The Issues Paper notes that the human services sector is moving towards providing funding directly to users and allowing them to exercise choice and control over the services they receive. Examples include the National Disability Insurance Scheme (NDIS) and consumer-directed aged care. This approach can give users greater control over their own lives, can encourage innovation and efficiencies in service delivery, and can focus the attention of providers on the needs of users.

Objectives of consumer-directed care models

The objectives of consumer-directed care (CDC) are to enable consumers to:

- have more say in the care and services they access, how they are delivered and who delivers them
- have conversations with assessors and service providers about their needs and goals
- work with service providers to develop an individual care plan
- agree how much involvement they will have in managing their support services
- know how a support package is funded and how their individual budget is spent through monthly income and expense statements
- understand how the service provider will ensure that the package of care continues to meet their needs with ongoing monitoring and formal reviews.

DVA agrees that a consumer-directed care model as part of the military compensation system should be further considered. The CDC model is discussed in detail at Annex 20.

4.7.6 Aged Care Reforms and potential for improved efficiency and effectiveness

The Department of Health is continuing to undertake a significant program of reform under the Government's Aged Care Reforms agenda. DVA Health Card holders—accounting for nearly 14% of the Australian population aged over 85 as at June 2017—are significant users of aged care services. Accordingly, DVA works closely with the Department of Health on the implementation of measures that affect the veteran community.

Notwithstanding the differences between DVA and external agency legislation in respect of aged and community programs, there is scope for DVA to continue to pursue efficiencies and business improvements to foster alignment with whole-of-government approaches.

These improvements include:

- enhancing the way assessments for aged care services are undertaken through the My Aged Care entry point
- implementing more contemporary approaches to the delivery of care and support services, such as consumer-directed care and wellbeing/'re-ablement', which underpin Department of Health programs
- reducing fragmentation of the existing aged care landscape
- simplifying navigation of the aged care system for veterans and war widow/ers with eligibility across multiple government programs.

4.7.7 Health services delivered through contractual arrangements

DVA's policy intent is to provide a universal service offer across Australia, to ensure that all eligible persons have access to the full range of services with minimal travel required. For example, DVA has arrangements for access to all public hospitals in Australia and to nearly all private hospitals, including day hospitals. This policy is loosely described as 'universal access'.

In response to the challenge of engaging large volumes of providers in the most efficient manner, DVA uses a range of contracting models. The choice of model involves a balance between administrative simplicity for providers, maximising geographic coverage for veterans and their families, and achieving value for money.

General complexities experienced by DVA as a major purchaser of health care

The VEA and MRCA Treatment Principles require treatment to be delivered by contracted providers/suppliers.

DVA is a national purchaser of health care and it shares many of the challenges, barriers and opportunities that face the health system as a whole. In addition, with a small client base, DVA card holders may only be a small percentage of a provider's business. This can raise a challenge for communication and liaison, particularly to raise the profile of DVA's specific issues.

Complexities and challenges are encountered by DVA as a major purchaser of health care across Australia. These types of challenges include:

- **How to respond to new treatment types and methods.** DVA generally relies on Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) updates, which flow through to DVA arrangements. DVA also has the capacity to approve health care treatment that is not listed on the MBS or PBS where a clinical case can be made that the new form of treatment is beneficial.
- **Health workforce shortages in different professions and in different areas.** Like the general health system, DVA also experiences difficulties due to workforce shortages, including in some rural areas. This is somewhat mitigated by DVA's transport arrangements, under which DVA funds veterans' travel to health care providers.
- **Rural and remote service delivery.** This includes issues around costs of service delivery and access to certain professions.
- **Navigating complex care.** This includes managing the complexities of the aged care system as DVA veterans transition from low-level care arrangements delivered by DVA, to higher level care arrangements administered by the Department of Health.
- **Measuring performance in health care in terms of achieving outcomes.** As a purchaser of services, DVA maintains robust performance requirements and standards for the services it buys. However, it can be difficult to determine the outcomes of all health care interventions.

Is health care for veterans provided in an effective and efficient manner?

DVA also has reciprocal health arrangements for the provision of treatment in many countries; however, outside these countries the provision of treatment can be complex for both the veteran and for DVA.

In light of these challenges, DVA has an opportunity to apply flexibility and agility in its dealings with service providers, and to be open to considering new avenues for the provision of health care to its veteran clients and their families.

DVA's Gold and White Cards—alignment through service provision

Under Health Care Card arrangements, DVA's health care purchasing is operationally 'agnostic' in respect to which Act is at play. To this end, provisions across different acts are applied consistently through DVA card arrangements, creating an equitable approach to treatment across DVA's different legislative and administrative frameworks. See Annex 16 for information on White and Gold Cards.

4.8 Advocacy by ex-service organisations

The information in this section responds to the Productivity Commission's questions on claims and appeals (p 12), and on system governance (p 13–14).

4.8.1 Veterans' support: the veteran organisation landscape

Following World War 1, returning veterans formed groups, clubs, associations and a range of informal and formal (legal) entities. Over time most faded away, but two key organisations emerged and became national enduring movements—the Returned and Services League (the RSL) and Legacy.³⁵ This pattern of new and fading organisations has continued after each major period of war, and is occurring again with the most recent wars in Iraq and Afghanistan.

While there are a significant number of ex-service organisations and veteran support organisations (all described as ESOs for the purpose of this submission), those expending more than \$1 million per annum in support of veterans and/or their families are primarily only the RSL, Legacy, Mates4Mates, Soldier On, and RSL DefenceCare. Generally only RSL and Legacy expend over \$6 million per annum. Only the RSL and Legacy offer a presence in most suburban and regional communities.

Organisations have different focuses; for instance, advocacy for legislative reform and reform of government veteran support policies and programs, or functions of camaraderie (informal peer support) and commemoration.

There is also an increasing number of small organisations that focus on a single issue or form of support that they believe to be a critical gap in the range of supports available to veterans. These organisations are usually restricted in their reach, operating out of only one or two locations.

The various ESOs and other veterans' support organisations are largely independent from each other, and there is no peak body or other broadly representative group for veterans and their families. The fragmented nature of the sector means that consultation with the sector can be difficult, with no common view or collaboration representing all veterans' needs. Without a consensus position, the sector is arguably also less well-equipped to engage in proactive approaches to support the veteran community.

Further, ESOs have not established a self-regulatory function to establish standards and to ensure quality assurance of their services.

³⁵ A number of organisations supporting veterans, war widows, and/or serving military officers formed after the end of World War 1 and around the time of, or just after World War 2. Some of those still operating today include the Air Force Association, the Naval Association of Australia, the War Widows' Guild of Australia, and the TPI Federation.

Role of ESOs

Current and former ADF members rely on the advocates and welfare officers within ESOs when submitting claims to DVA.

DVA funds the training of ESO advocates in compensation and welfare through the Advocacy Training and Development Program (ATDP), which involves:

- **welfare training** focusing on providing the skills to assist veterans and their dependants (including war widow/ers), to access the wide array of community services that are available, as well as DVA's health and housing services and other services that are not pensions related
- **training for compensation** focusing on developing the skills required to assist veterans and their dependants (including war widow/ers), to lodge claims under the VEA, DRCA and MRCA.

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

The nexus between veterans and their families, DVA, and ESOs is an inherently difficult one for government. DVA considers that ESOs play an important role in articulating veterans' needs, and in providing welfare support to veterans and their families. However, ESOs' advocacy role as enablers, or intermediaries, in supporting the making of compensation or benefit claims on behalf of individual veterans, reflects the complexity of the system and the difficulties veterans face dealing with it.

It is unclear whether veteran advocacy without formal systems of training and quality assurance produces optimal results. A number of ESOs have limited rather than comprehensive expertise, and many advocates are volunteers, making sector-wide professionalism difficult to achieve.

The number of volunteer advocates is declining, and they are often focused on their own issues, including their own service or transition experience. Anecdotal evidence also suggests there is a reluctance among younger veterans to seek assistance from traditional ESOs, preferring instead to seek professional assistance if required.

The Veterans' Advocacy and Support Services Scoping Study commenced in April 2018, under the leadership of Mr Robert Cornall AO. DVA expects it will inform the Government's view on the need for, and models for delivery of, veterans' advocacy.

Are advocates effective?

How could their use be improved?

The study is investigating how current and former Australian Defence Force members and their families are assisted to access entitlements and services. It aims to determine the most suitable advocacy model for Australian veterans and their families that:

- is efficient, effective and, at a minimum, is comparable in quality and value with those available to Australian civilians in accessing government entitlements
- is based on veterans' individual needs, and protects their interests
- is sustainable, consistent and scalable to meet fluctuations in demand

- provides personalised advice when claims are unsuccessful, and options for appeals.

However, DVA's intention to move towards a simpler military compensation system should, over time, ultimately significantly reduce the need for this kind of advocacy service.

Regardless of the future direction of veteran advocacy, DVA believes there to be a substantial and valuable contribution that can continue to be made by ESOs to the health, wellbeing and rehabilitation outcomes of veterans through mateship and support to veterans and their families, especially given a key strength of ESOs is their coverage across local communities.

An ESO peak body

Although the creation of a peak body for ESOs would be a worthwhile aim, as it would streamline points of contact between government and the ESO sector and could remove much of the fragmentation that exists in the sector (discussed previously), its establishment is not essential from a veteran's perspective.

Greater collaboration between ESOs, even without a peak body, would enable the ESO sector to deliver better-coordinated veteran support with fewer areas of duplication or service overlaps, to develop shared resources, and to enable fewer points of contact.

It may be appropriate for collaboration to be addressed through a social impact collaboration framework such as Collective Impact.³⁶ Other avenues to encourage or incentivise the ESO sector to collaborate to achieve greater impact for veterans and their families should also be considered.

More information on the ESO sector is provided with the discussion of governance of military compensation in Annex 2.

What role should ESOs play?

Are there systemic areas for improvement in the ESO sector that would enhance veterans' wellbeing?

³⁶ <https://collectiveimpactaustralia.com/about/>

5 DVA's vision for the future

5.1 Looking beyond DVA's current transformation

The information in this section responds to the Productivity Commission's questions on a system to meet the needs of future veterans (p 9).

As outlined previously in this submission, the Department of Veterans' Affairs is a unique organisation with a long history and culture of supporting veterans and their families. However, it is working with complex legislation, veterans with complex needs, and within a constrained departmental funding envelope.

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?

The current transformation process is establishing new core capabilities in DVA, enabling the veteran community to engage with DVA in faster, more effective ways. The process is also creating assurances in its systems to ensure each veteran and their family receive the support they need. There is a further opportunity to examine the complex legislative framework that forms the backdrop to military compensation, with a view to simplification for all those who deal with the system.

The change has begun, including exploration of moving from a model that focuses on a veteran's 'illness' to their 'wellbeing'.

However, this should be seen as only the start of a process that would completely transform the way veterans and their families interact with DVA, Defence and the CSC.

At the completion of this transformation agenda, DVA's role will be to focus on policy, stakeholder/service partner relationships and service commissioning. Most of its veterans and their families will be able to self-manage through online facilities, freeing DVA's staff to focus on those veterans with complex and multiple needs. That focus will be based on an integrated whole-of-veteran view and effective case management systems.

The use of data analytics and veteran insights will inform policy and develop services. Future transformation of DVA will change the experience of engaging with DVA for veterans and their families by enabling access to DVA-branded services across all channels, tailoring services to veterans' needs, streamlining assessments, strengthening private, community-based and public sector partnerships, and creating a veteran-centric, data-driven organisation and culture.

Ideas and areas for consideration in the shaping of a new military compensation system are provided in Annex 18.

5.2 A new set of guiding principles

The information in this section responds to the Productivity Commission's questions on assessing the veterans' compensation and rehabilitation system (p 8–9) and on a system to meet the needs of future veterans (p 9).

The work to achieve the more complete transformation will need to be based on a number of core principles. Broadly, these could be based on the following overarching statement:

Military compensation should be provided through a contemporary veteran-centric and beneficial system, informed by community and veteran expectations, which recognises and reflects the unique nature of military service, and is informed by best-practice approaches.

A new military compensation system could:

- recognise the **unique nature of military service**
- be **veteran centric and beneficial**
- offer **simplicity, fairness and consistency**
- deliver **better transition and rehabilitation**.

Each of these principles are each outlined in detail below.

Unique nature of military service

- Learning from and understanding the impact of military service on veterans and their families.
- Sharing information on impacts and veteran outcomes with other agencies, including Defence.

Veteran centric and beneficial

- A veteran who needs immediate medical, rehabilitation or income support can receive it—in advance of claim determination if necessary.
- Veterans and their families can choose their own services and support, where appropriate.
- The system will have regard to broader whole-of-government policies and their relationship to the needs of the veteran community.
- The system is oriented to the wellbeing of veterans and their families, not illness.
- The system must be comprehensible and have trust in the veterans and their families who interact with it.

What should the priority objectives for veterans' support be?

What principles should underpin the legislation and administration of the system?

- The system should be robust and fiscally sustainable (*noting there can be an inherent conflict within a system that is both beneficial and fiscally sustainable*).

Simplicity, fairness and consistency

- Recognition of veteran status is automatic, as it occurs at enlistment, and liability for most service-related injuries and impairments is determined at the time of occurrence.
- Complexity is reduced and the system delivers consistent and fair outcomes.
- Ancillary benefits across compensation Acts will be aligned or potentially unified into one Act.
- The should system be flexible and enduring, capable of responding to areas of individual need (*noting there are conflicts between being both simple and flexible, and also supporting the complex needs of veterans*).

Better transition and rehabilitation

- Information is shared simply and easily between DVA and Defence, Health, CSC, and other agencies.
- Health information is shared between Defence and the national health system.
- Veterans are supported in their transition to their life after service while they still serve.
- Veterans are not considered unemployable because of their impairments; they are employable even as and if they need and receive health care.
- Employment of veterans is a responsibility shared by government and industry.
- ESOs exist to provide veterans and their families with welfare support and guidance, and to galvanise community support for veterans to enable them to integrate into their local community; veterans no longer require assistance from ESOs to claim compensation or benefits because the system is simple to navigate.

5.3 Veteran Centric Reform

The information in this section responds to the Productivity Commission's questions on a system to meet the needs of future veterans (p 9).

In 2018–19, the Australian Government is investing a further \$111.9 million to continue transformation to deliver proactive, faster, easier and digitally enabled services. This enables DVA to continue its good progress achieved through the funding commitment of \$166.6 million over four years in the 2017–18 Budget, and to build on the improvements made in DVA's assistance to veterans and their families. In 2018–19, specific Veteran Centric Reform (VCR) priorities include:

How can the system better cater for the changing veteran population and the changing needs of veterans?

- expanding DVA's 'digital front door' *MyService* to include permanent impairment and incapacity claims
- building on the Students Pilot to expand into income support payments affecting 170,000 veterans and their families, delivered in partnership with Department of Human Services
- making it easier to access services by improving our website, letters and factsheets—giving these a veteran focus
- continuing to embed cultural reform and business process redesign to make sure our transformation benefits veterans
- streamlining more conditions so that veterans can get faster decisions
- using our data to anticipate veterans' needs and provide help
- providing one phone number—1800VETERAN—for veterans to call to access DVA services and experience quicker response times and improved call quality
- reaching out to veterans and their families who are not currently in contact with DVA to let them know about our services and support—for example through Australia Post and mobile service centres; veterans who would have missed out on help are now getting opportunities to connect
- continuing to work with veterans and families to design the changes.

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?

5.3.1 Looking forward: key elements for DVA

The following elements could comprise DVA's main areas of focus for the current and next stages of its transformation.

Put veterans and veterans' families first

Ensure processes, practices and methods of engagement are based on the needs of veterans and their families, and reflect the way that they want to access services and seek help from DVA.

Co-design policies and services with veterans

Through forums, surveys and other mechanisms, DVA will ensure that veterans and their families and key stakeholders are part of the design of new policies, programs and access arrangements.

Position DVA's focus on wellbeing, not illness

By positioning DVA's focus on wellbeing, the focus for transition and rehabilitation builds on veterans' capabilities to engage productively in new employment and quality of life. A whole-of-life model provides engagement and reinforcement from the point of enlistment.

Continue to develop the understanding of the impact of military service, including the impact on families

DVA will find better ways of capturing and understanding veterans' experiences, and the experiences of their families. By understanding these experiences, DVA will be in a better position to improve its services, and by sharing this information with Defence, strategies may be put in place to reduce risk and the impact of service, where appropriate.

Leverage services and capabilities from other agencies

Looking into the future, DVA is unlikely to be either able or best positioned to deliver the full range of services that veterans and their families need. Whole-of-government approaches can be leveraged, and agencies and organisations better equipped to provide some services can be tasked to undertake this work, leaving DVA better able to provide governance, policy support and engagement with veterans and their families.

Tailor and personalise services for individuals

Rather than relying on one-size-fits-all models and processes, DVA can learn from its interactions with veterans and their families to adapt case management processes to customise and tailor its delivery to meet the unique needs of each veteran and their family.

Learn from others, including veterans and the veteran community

DVA needs to become a 'learning agency', where its initial position is to learn from others, including veterans and their families and from the broader veteran community. New ways of engaging and delivering services will emerge as DVA learns more about veterans' experiences.

Evolve and modernise services and streamline processes

Substantial changes are needed to move from DVA's 20th century service-delivery model to reflect contemporary practices and veterans' needs and expectations. While this work is already under way through Veteran Centric Reform, more work needs to happen in coming years to embed new processes and a culture that truly supports veterans' and their families' needs.

Empower staff to achieve the best possible veteran outcomes

It will be essential that DVA moves from a process-driven, risk-averse delivery framework to one that allows staff greater flexibility in achieving positive veteran outcomes. Processes that presently restrict effective outcomes need to be overhauled, to improve both DVA's culture and the outcomes for veterans and their families.

New ways to engage with veterans, their families and ESOs

A key challenge and opportunity for DVA is to refresh its engagement with its veterans and their families (and prospective clients) and the wider veteran community, including ESOs and those veterans who do not seek DVA's help.

Central to this will be finding ways that DVA can share its challenges, including those in the policy and legislative environment, and achieve broad agreement on key reforms. Two key challenges here are:

- new ways to better communicate will need to be adopted
- mutual trust will only be reached if DVA first trusts its veterans.

Discussions on policy, for example, aim to establish a shared understanding that:

- the Government cannot deliver everything for everyone; changes must be sustainable
- DVA may also not be the enabler or delivery agent for some aspects. The effects of such changes need to be understood, but also they must reach a point of acceptability with the veteran population.

Community engagement and support of veterans and their families

Beyond DVA's engagement with veterans and ESOs directly, the role of communities in actively engaging with their veterans and their families offers the potential to improve the outcomes of veterans and their families, and to better connect them to their new environment.

Such approaches should continue to be pursued and supported by DVA and others where possible.

Transformation and future military compensation

More information on DVA's current transformation is at Annex 3, and issues and opportunities for a new military compensation and rehabilitation system are discussed at Annex 18.

5.3.2 DVA priorities for 2018–19

DVA's broad priorities for 2018–19, which incorporate VCR work, include:

- considering the legislative framework and measures that could be undertaken to reduce complexity
- looking for more and better ways to continue to engage with all veterans and their families, not just those making a claim
- using data, research and analytics to know veterans' life events and future needs
- working on improvements in program, service and support design, delivery and monitoring
- focusing on veterans' wellbeing, empowerment, and measuring success.

6 Conclusion

The Issues Paper referenced the Senate Foreign Affairs, Defence and Trade References Committee recommendation for a review of the veterans' compensation and rehabilitation system, stating that 'it is time for a comprehensive rethink of how the current system operates and will operate into the future'.

As has been articulated in this submission, the compounding nature of military compensation legislation, the evolution of civilian workers' compensation schemes, and the need to respond to each wave of operational and non-operational service, have produced a complex and interacting compensation structure through which veterans, their families, and DVA staff must navigate.

The current transformation is addressing the most pressing areas of improvement within DVA: its processes, structures, culture and environment. However, there is no doubt that the system of military compensation in Australia needs improvement beyond the current scope of Veteran Centric Reform.

The legislative framework is too complex and, while harmonisation of elements of the current Acts would be helpful, the possibility of having a modernised unified Act needs to be considered. In addition, many elements of service member transition, rehabilitation and employment can be improved, particularly to minimise interruptions along the transition path and to ensure veterans and their families receive the support they need, when they need it.

Continuing the process of reforms that DVA has commenced is needed, placing the veteran and their family first. At the same time, the principles within VCR and the work undertaken to date could be applied through systematic reform of the legislative framework.

The military compensation system delivers services through many agencies and stakeholders, both in and outside government. Complete reform will require their input, support and ongoing collaboration.

Collaborative service delivery will likely need to be extended further, providing the opportunity for DVA to focus in the future on critical areas of policy development, commissioning, stakeholder and veteran engagement, and governance.

Annex 1 Reviews of military compensation

Recent major reviews

Tanzer Review (1999)

The Tanzer Review was established following the collision between two Black Hawk helicopters near Townsville in 1996, which highlighted disparate compensation coverage between the victims due to differences between the VEA and the SRCA.

An internal Defence inquiry conducted immediately after the accident recommended increases in compensation to severely injured ADF personnel and to dependants of deceased personnel. While changes were made to legislation on the basis of those recommendations, no changes were made to harmonise the different Acts.

Mr Noel Tanzer AC was appointed in May 1998, and was specifically tasked with considering options for a single, self-contained compensation scheme to cover most aspects of military service.

The recommendations of the Tanzer Review led to the introduction of the MRCA in 2004, following substantial consultation with ESOs.

Review of Veterans' Entitlements—the Clarke Review (2003)

This Review was established in 2002, headed by Justice John Clarke QC and conducted by an independent committee. The Review, which ran concurrently with the development of MRCA, had the task of examining perceived anomalies in access to veterans' entitlements and levels of benefit and support provided to veteran disability pensioners.

Some 109 recommendations were made relating to the extension of VEA coverage, changes to the disability compensation pension structure, and the establishment of an integrated and comprehensive rehabilitation program. Of those recommendations, all but 38 (which were rejected or deferred) were either accepted at the time or after the recommendations were revisited in 2008.

It is worth noting that a key outcome of the Clarke Review was a renewed focus on rehabilitation.

The Review of Military Compensation Arrangements (2011)

The RMCA was initiated in 2009, and was conducted by a Steering Committee chaired by the then Secretary of DVA, Mr Ian Campbell PSM.

The RMCA featured broad terms of reference, including the examination of DVA's performance, review of the size of benefits payable under the MRCA, and analysis of anomalies between the MRCA, the VEA and the SRCA. This was an extremely comprehensive review, including examining options to simplify legislation.

While the RMCA found that the MRCA was generally sound, it made 108 recommendations in its 2011 Report. In early 2012 the Government accepted or modified 96 recommendations, and rejected only nine. The Government responded in the 2012–13 Budget with measures to implement almost all of the agreed recommendations. DVA's and Defence's consideration of agreed recommendations continued to 2016–17.

Military compensation reviews between 1975 and 2000

Between 1975 and 2000 there were 12 reviews of military compensation arrangements. While this submission does not attempt to address the findings of all of these reviews, the inclusion of this list (together with at least eight reviews since 2000) demonstrates that, on average, there has been a significant review or inquiry addressing military compensation (or some aspects of it) around every two years since 1975.

The reviews undertaken between 1975 and 2000 included³⁷:

- *Independent Enquiry into the Repatriation System*, 1975 (Toose Review)
- *Report of the Advisory Committee on Repatriation Legislation Review*, 1983
- *Study of Returned Service Women of the Second World War*, 1985
- *The Veterans' Entitlements Act Monitoring Committee Reports*, 1988
- *Report on Inquiry into the Needs of Australian Mariners, Commonwealth and Allied Veterans and Allied Mariners*, 1989
- *Audit Report: Compensation Pensions to Veterans and War Widows* (Auditor-General), 1992
- *A Fair Go: Report on Compensation for Veterans and War Widows*, 1994 (Baume Report)
- *Report of the Committee of Inquiry into Defence and Defence Related Awards*, 1994

³⁷ Source: DVA submission to the 2017 Senate Inquiry.

- *Inquiry into Military Compensation Arrangements for the Australian Defence Force*, 1997
- *Review of the Repatriation Medical Authority and the Specialist Medical Review Council*, 1997
- the *Review of the Military Compensation Scheme*, 1999 (Tanzer Report, discussed above)
- *Review of Service Entitlement Anomalies in Respect of South-East Asian Service 1955–1975*, 2000 (Mohr Report).

Inquiries and reviews concerning the mental health of veterans

The mental health of veterans has presented as a significant issue for the veteran community in recent years, particularly as younger veterans with recent engagements have faced circumstances—both as part of service, and in returning to Australia—unlike other previous engagements. These circumstances have contributed to many veterans suffering poor mental health.

In the past, DVA had been poorly equipped to respond to the then-emerging mental health needs of its veterans. Following the tragic circumstances of a number of veterans taking their own lives, several significant reviews into veterans' mental health and suicidality have been undertaken since 2009. These are discussed below.

Independent Study into Suicide in the Ex-Service Community

The Independent Study into Suicide in the Ex-Service Community conducted by Professor David Dunt (the Dunt Review, 2009) was established to examine the broad issue of suicide in the veteran community. The Dunt Review helped identify:

- veterans who are at increased risk of self-harm
- common contributing factors among veterans who died by, or attempted suicide
- the extent of suicide in the veteran community
- lifestyle or other factors that may be contributing to suicide by veterans
- administrative reforms or initiatives to help reduce suicide by veterans.

The Dunt Review provided a key platform to assist in the improvement of mental health support and services for the veteran community, including strengthening mental health programs, suicide prevention, and simplifying administrative processes.

DVA continues to build on the work arising from the Dunt Review as part of a multi-faceted strategy to prevent suicide and support those affected by it.

Other reviews and inquiries

Veteran suicide, access and availability of mental health services, and the management of individual veterans by DVA have also been addressed by the following more recent inquiries:

- the Senate Reference Committee on Foreign Affairs, Defence and Trade Inquiry into the Mental Health of Australian Defence Force Members and Veterans (2016) (Government response tabled on 15 September 2016)
- the National Mental Health Commission Review of Suicide and Self-harm (2017) (Government response released 30 June 2017)
- *The Constant Battle: Suicide by Veterans*, The Senate Reference Committee on Foreign Affairs, Defence and Trade Inquiry into Suicide by Veterans and Ex-service Personnel (2017) (Government's response tabled 24 October 2017)
- the Jesse Bird Joint DVA, Defence, VVCS Inquiry (2017) (Government's response to the Senate inquiry above incorporated its response to the Jesse Bird inquiry).

Of the 24 recommendations in the 2017 Senate Committee Report into Suicide above, the Government agreed to 22 recommendations, and agreed in-principle to the other two recommendations.

Thirteen of the recommendations call for reviews, studies or trials, including the inquiry by the Productivity Commission into compensation and rehabilitation for veterans. The reviews cover such issues as:

- the Australian National Audit Office (ANAO) performance audit on efficiency of veterans' service delivery by DVA, released in June 2018³⁸
- a study of how current and former ADF members and their families are assisted to access entitlements and services (the Veterans' Advocacy and Support Services Scoping Study³⁹—see Section 4.8)
- the mental health impacts on veterans and their families for compensation claim assessment processes
- veteran-specific online training programs for health professionals
- DVA's training programs for its staff
- DVA's use of medico-legal firms for compensation claims assessment.

³⁸ www.anao.gov.au/work/performance-audit/efficiency-veterans-service-delivery-department-veterans-affairs

³⁹ www.dva.gov.au/consultation-and-grants/reviews/veterans-advocacy-and-support-services-scoping-study

Annex 2 Governance

Governance structure and commissions

The Repatriation Commission and Military Rehabilitation and Compensation Commission

The majority of DVA's ordinary activities are directed by the Repatriation Commission (RC) and the Military Rehabilitation and Compensation Commission (MRCC). These two bodies hold the majority of statutory powers under relevant legislation, which in turn is delegated to officers in DVA.

The separate roles of the Commissions and DVA have a long history, as the two arms, the Repatriation Commission and the Department, were established together in the 1917–18 period.

The Repatriation Commission

Under the VEA, the Repatriation Commission:

- grants pensions and other benefits and provides treatment for veterans, their dependants and other eligible persons
- advises the Minister for Veterans' Affairs on the operation of the VEA and determines policy on its own account
- administers the VEA, subject to the control of the Minister, noting that under the Administrative Arrangements Orders, the Minister is responsible for administering the VEA (and the DRCA and the MRCA).

The RC has no staff of its own; it delegates its powers under subsection 213(1) of the VEA to DVA staff. The responsibilities of the two bodies are therefore inextricably linked and the RC has a vital interest in DVA activities and in the assessment of the appropriateness, effectiveness and efficiency of departmental programs. DVA reports to the RC on the administration of major programs and the progress and outcome of all major reviews, including the Australian National Audit Office performance audits.

The RC has three full-time members, appointed by the Governor-General: the President, Deputy President, and Services member. The President is also Secretary of DVA. The Deputy President is recommended by the DVA Secretary to the Minister of Veterans' Affairs, following a recruitment process. The Services member is known as the Repatriation Commissioner and is selected from nominations submitted to the Minister by ESOs.

The Military Rehabilitation and Compensation Commission

Under the MRCA, the Military and Rehabilitation and Compensation Commission (MRCC):

- makes determinations relating to the acceptance of liability for service-related conditions, the payment of compensation and the provision of treatment and rehabilitation
- seeks to minimise the duration and severity of service-related conditions and promotes the return to suitable civilian work
- promotes research into the health of members and former members, the prevention of injury and disease, and rehabilitation
- provides advice and information to the ministers and departmental secretaries of Veterans' Affairs and Defence and the Chief of the Defence Force, either on request or on its own initiative, and determines policy on its own account
- undertakes other functions that may be conferred on it.

As with the Repatriation Commission, the MRCC has no staff of its own, and its functions are delegated to DVA staff under paragraph 384(d) of the MRCA.

The MRCC Subcommittee is a sub-group of the MRCC; members of the Repatriation Commission constitute the MRCC subcommittee. It provides direction to the full Commission on operational or administrative elements of MRCC's business.

The MRCC has six part-time members. The President of the RC serves as Chair of the MRCC, ensuring consistency between the two Commissions and DVA. The other two RC members are also part-time members of the MRCC. Other current members of the MRCC include Ms Jennifer Taylor, CEO of Comcare (nominated by the Minister responsible for the SRCA, currently the Minister for Jobs and Small Business); Air Vice-Marshal Tracy Smart AM, Head of Joint Health Command; and Rear Admiral Brett Wolski, Head of People Capability (both nominated by the Minister for Defence).

The commissions often hold joint meetings as the issues covered are relevant to both.

Repatriation Medical Authority and the Specialist Medical Review Council

The role of the Repatriation Medical Authority (RMA) is to determine Statements of Principles (SoPs), which set out causal factors, based on sound medical-scientific evidence that can link particular kinds of injury, disease or death with eligible service. These SoPs are legally binding and form the basis for the determination of claims lodged by veterans, serving members and their dependants under the VEA and MRCA. (See Annex 11 for information on SoPs.)

The Specialist Medical Review Council (SMRC) is a statutory body that, on request⁴⁰, reviews decisions made by the Repatriation Medical Authority on SoPs.

The RMA and SMRC are independent of DVA due to the need for medico-scientific expertise on these bodies, and to separate the determination of SoP factors from the decisions on individual claims.

Veterans' Review Board

The Veterans' Review Board (VRB) was established by the *Repatriation Legislation Amendment Act 1984* and began operations on 1 January 1985.

The functions of the Veterans' Review Board are as follows.

- The VRB is a specialist, high-volume tribunal, providing independent merits review of decisions made by either the RC or the MRCC under the VEA and the MRCA.
- The Board receives approximately 3,000 applications by veterans each year.
- The Board conducts hearings in all capital cities around Australia, as well as some regional areas.
- Decisions made by the Board can be appealed to the Administrative Appeals Tribunal or, in some limited circumstances, directly to the Federal Court of Australia.

National Consultative Framework

The National Consultation Framework (NCF) is a comprehensive consultative structure designed to facilitate communication between the veteran and ESO community, the RC and MRCC, and DVA. The NCF was launched in 2009 and comprises five national forums, as well as forums in each of the states and territories (listed below). In addition, DVA consults on legislative issues through its Legislation Workshops (see Section 4.2).

- **The Ex-Service Organisation Round Table (ESORT)** aims to address issues of strategic importance to veterans and defence communities, and to assist in setting directions for the medium to long term. It is chaired by the Secretary of DVA.
 - The ESORT can refer any matter to another national forum and/or state/territory forum for consideration. State and territory forums can equally refer issues to the ESORT for consideration. Matters may also be referred from the ESORT to other consultative bodies to which DVA contributes and that exist outside the NCF, as deemed appropriate by the Chair on a case-by-case basis.

⁴⁰ Requests can be made by any of a claimant, ESO, or Commission.

- **The Operational Working Party** is chaired by the Deputy President of the Repatriation Commission and aims to:
 - enhance veterans’ understanding of DVA’s service delivery performance through information sharing and improved communication between DVA and the veteran community
 - be a forum for ESOs to discuss concerns arising from the delivery of DVA services
 - identify and provide recommendations for improvements in operational policy to promote quality and accountability in service delivery
 - deliver innovative solutions to systemic issues and drive changes to policy needed to assist veterans.
- **The Younger Veterans – Contemporary Needs Forum** is chaired by the Repatriation Commissioner and aims to:
 - assist in identifying priority emerging issues for veterans and their families across the age and conflict spectrum, particularly in the areas of mental health and social engagement
 - assist in identifying emerging issues for veterans’ families and support networks
 - identify and analyse trends across veteran cohorts and geography and raise awareness of these increasing and common issues with subject-matter experts from DVA, and with other state or Commonwealth government departments and agencies as appropriate
 - assist in identifying opportunities for increased engagement with younger veterans and their families who are geographically dispersed, or not affiliated with ESOs, through appropriate media and internet technology
 - enhance the veteran community’s understanding of DVA’s service delivery performance through information sharing and improved communication
 - identify and provide recommendations for improvements in DVA’s operational policy to promote quality and accountability in service delivery.
- **The National Aged and Community Care Forum** is chaired by the Deputy President of the Repatriation Commission and aims to:
 - be a link between ESOs, providers and DVA in the dissemination of information on health, aged and community care issues and mental and social health policy
 - provide information on the current and future aged care needs of veterans and war widow/ers and other members of the veteran and Defence community, including carers
 - be a conduit for developing and proposing better practice residential and community care arrangements for the veteran community

- influence future policy directions regarding ageing of the veteran community
 - monitor developments in the aged care industry and the aged care needs of the veteran community, including access to residential care
 - consider how DVA can better support people at home with community support.
- **The Female Veterans and Families Forum** is designed to engage with female veterans, and female partners, widows and family members of veterans to understand their specific needs. This Forum will help identify gaps in policies and services, and establish a more coordinated approach to dealing with the complex issues that women and families face across a range of topics and life events.
 - **State and Territory Forums** provide a mechanism for regular consultation and discussion between the Deputy Commissioner and ESOs concerning systemic issues that the veteran and defence communities see arising from the range of DVA operations, including:
 - operational issues
 - health care, including hospital and community-based care
 - aged care, both residential and community based
 - health and wellbeing
 - income support
 - compensation
 - rehabilitation
 - emerging issues for currently serving and recently separated ADF members.

The National Consultation Framework is reviewed every three years. DVA formally consults with the veteran community through the completion of a formalised survey. Through these reviews, DVA examines the effectiveness and relevance of the NCF in the context of the contemporary veteran community landscape, as well as the departmental environment, and considers any possible future structures for improved consultation. The last review was undertaken in 2016, with changes implemented in 2017.

Veterans' Agencies Forum

The Veterans' Agencies Forum was established in 2016. This is an informal forum that is comprised of members from DVA, most members of the MRCC, Veterans Review Board (VRB), and the Repatriation Medical Authority (RMA).

The forum was established to provide an informal mechanism for the agencies responsible for key elements of the repatriation system to discuss matters impacting the functioning of the system and to share information across various agencies.

VMRT and other cross government/jurisdiction fora

In late 2015, the then Minister for Veterans' Affairs, the Hon Stuart Robert MP, formed the inaugural Veterans Ministers' Round Table (VMRT) between respective Federal, state and territory ministers. The Federal Minister for Veterans' Affairs chairs this forum. The inaugural meeting was held in November 2016 and the most recent meeting was held in November 2017.

The following topics have been discussed in recent meetings:

- the lack of reliable data concerning homelessness, suicide and incarceration
- the transition of ADF personnel to civilian life
- the harmonisation of state-based benefits
- vocational rehabilitation
- issues facing veterans in each state and territory.

The Commonwealth, State and Territory Committee (CSTC) is a subordinate committee of the VMRT. The CSTC aims to address issues of strategic and operational importance to the veteran and Defence communities across federal, state and territory jurisdictions, including:

- acting as the main forum for dialogue between DVA and the state and territory government agencies responsible for veteran matters
- providing advice on how differing levels of government can better facilitate a common approach to veteran issues
- providing a mechanism to disseminate information about DVA and state and territory initiatives
- providing regular consultation and discussion about emerging issues affecting veterans and their families, such as veteran homelessness, transition from the ADF to civilian life, suicide prevention, incarceration and healthy ageing
- enhancing state and territory governments' understanding of DVA's service delivery programs and, where appropriate, identifying opportunities for involvement of state and territory governments
- identifying recommended topics of discussion for VMRT
- being a forum for continuing discussions on matters arising from VMRT.

Veterans' support organisations

The Australian veteran community

There are 1,339 charities currently registered⁴¹ that have nominated veterans and/or their families as at least one of their beneficiaries. In addition to this group of registered charities, there are a range of member-based ESOs, structured either as companies limited by guarantee, or as incorporated associations. Some smaller organisations operate without any legal entity status.

There are also numerous groups that have emerged in recent years that primarily exist only in the online domain through internet-based web sites and on social media platforms such as Facebook.

Veteran support organisation regulator

Currently there is no specific veteran charity regulator other than general charity regulation by the Australian Charities and Not-for-profits Commission and state fundraising regulators.

Self-regulation of ex-service organisations

There have been calls for self-regulation for organisations in the veteran support sector, including by then Minister Teahan in 2017⁴², and supported by the National Mental Health Commission in their 2017 *Review of Veteran Suicide*⁴³, which made observations of the sector, including rivalry between organisations, some duplication in effort, misalignment in strategic priorities, and some evidence of poor management and service delivery.

Veteran support services accreditation association

A National Collaboration Project chaired by Sir Angus Houston has been working with key ESOs and stakeholders to achieve a collaborative outcome, with a key focus on raising standards of veteran support services in order to achieve a reduction in the incidence of veteran suicide.

Leading proponents for best-practice collaboration in the social sector in Australia include the Centre of Social Impact, and a not-for-profit organisation called Collaboration For Impact. The National Collaboration Project has engaged with both these organisations and has developed a blueprint for a veteran support services accreditation organisation to establish standards for the delivery of veteran support

⁴¹ Data derived from www.acnc.gov.au/

⁴² www.dva.gov.au/consultation-and-grants/consultation-ex-service-community/eso-round-table-esort/eso-round-table-20

⁴³ *Review into the Suicide and Self-Harm Prevention Services Available to Current and Former Serving ADF Members and their Families*
www.dva.gov.au/sites/default/files/files/publications/health/Final_Report.pdf

standards and provide accreditation for veteran support service providers. Support for this proposal was provided at the VMRT in November 2017.

The DVA Scoping Study into Advocacy Services (described in Section 4.8) will provide an opportunity to examine this matter further.

Veteran support sector collaboration/standards/accreditation and its impact on veterans and advocacy

Collaboration⁴⁴ among the many stakeholders in the veteran support sector is minimal and there are no nationally accepted standards⁴⁵ for delivery of support services to veterans and their families and no system of accrediting services and service providers. The lack of collaboration, standards and accreditation is resulting in poor levels of effectiveness in the application of significant government and non-government resources in support of veterans and advocacy.

While in recent years there has been a growing interest and increasing academic research into achieving best-practice collaboration, there is limited awareness and understanding of what collaboration is and how it is achieved. As depicted in Figure 5, there is a collaboration continuum.

Figure 5 Collaboration continuum

Compete	Co-exist	Communicate	Cooperate	Coordinate	Collaborate	Integrate
Competition for clients, resources, partners, public attention.	No systemic connection between agencies.	Inter-agency information sharing (e.g. networking)	As needed, often informal, interaction, on discrete activities or projects.	Organisations systematically adjust and align work with each other for greater outcomes.	Longer term interaction based on shared mission, goals; shared decision-makers and resources.	Fully integrated programs, planning, funding.

Many stakeholders who claim to be collaborating in the veteran support space are often doing little more than co-existing and communicating, often only in Commonwealth and state government sponsored forums. There are few ESO sponsored forums. There are some examples of cooperation for discrete activities, but often without formal agreements. A number of ESOs are at the compete end of the collaboration continuum.

⁴⁴ Collaboration is potentially defined as longer term interaction between stakeholders based on shared mission and goals, shared decision making and resources, characterised by interdependent relationships, with complete shared responsibility, frequent and formal communications, with primary benefits to targeted beneficiaries and only possible benefits to collaborating stakeholders.

⁴⁵ ATDP are providing standards for training of pension claim advocacy but ATDP does not currently provide standards for the delivery of pension claim advocacy services or an operational model for providing those services.

DVA's relationship with ex-service organisations

The 2016 Aspen Foundation report, *Ex-Service Organisation Mapping Project—Final Report*, mapped the services provided by ESOs and ESO-like organisations.⁴⁶ This report highlights the complexity of the ESO landscape, identifying approximately 2,780 ESO locations around Australia.

As noted, DVA formally engages with ESOs under the NCF.

DVA also assists ESOs through a range of grants that can be used to fund programs and activities to better support current and former serving members. These include the following:

- The **Building Excellence in Support and Training** grants program supports ESOs to provide compensation and welfare assistance to the veteran and Defence community. It also links closely to the ATDP, which provides the essential skills for claims, advocacy and welfare work.
- The **Supporting Younger Veterans** grants program provides funding to ESOs to encourage partnerships that will deliver innovative and sustainable services for younger veterans and their families and build community capacity to meet the needs of younger veterans.
- The **Grants-In-Aid** program aims to encourage cooperation and communication between the former ADF community, ESOs and the Australian Government and also aims to encourage the advancement of the objectives of ESOs.
- **Veteran and Community Grants** provides funding for projects that support a healthy, quality lifestyle for members of the veteran community, assist them to remain living independently in their own homes, reduce social isolation, support carers and improve access to community services.
- **Saluting Their Service** Commemorations Grants support projects and activities that directly commemorate Australia's servicemen and women who served in wars, conflicts and peace operations. STS grants also promote appreciation and understanding of the role those who have served have played in shaping the nation.

Advocacy training and support

Recognising that under the current system there is a role for veteran advocacy, the Government has introduced measures to support more professional advocacy arrangements, providing greater reassurance to veterans and their families that their needs will be addressed.

⁴⁶ www.aspenfoundation.org.au/esomp

Advocacy Training and Development Program

The Advocacy Training and Development Program (ATDP) is a partnership between the ESO community, DVA, and Defence.

The ATDP provides nationally accredited training to advocates to ensure they meet national competency standards before they offer advice to veterans on entitlements and services.

As at early 2018 there were 436 advocates accredited under the ATDP Program, and 527 people had undergone training to seek accreditation. This figure includes those who were already accredited but were undergoing training at a higher level.

Building Excellence in Support and Training

The Building Excellence in Support and Training (BEST) grants program is a discretionary grants program that forms part of the Government's commitment to support the advocacy role of ESOs to the veteran community. BEST grants provide ESOs with a financial contribution towards this work.

BEST grants are calculated using a formula based on each eligible organisation's advocacy workload, calculated as a percentage of the national workload. This percentage is then used to determine that organisations share of the available funding. This formula is regularly reviewed in concert with the ESO Round Table to ensure it appropriately reflects the advocacy work undertaken by the ESO community.

Responsibility for the management of these grants has recently transferred to the Commonwealth Grants Hub operated by the Department of Social Services. However, DVA still retains budget allocation, policy development and ministerial responsibility for this program.

Veterans' Indemnity and Training Association

Veterans' Indemnity and Training Association provides professional indemnity insurance to ESOs and their advocates. (DVA supports this arrangement through subsidising the costs for insurance to ensure it remains affordable for all ESOs.)

Annex 3 Transformation

Vision and design principles

The transformation vision and design principles ensure that DVA is creating experiences that are consistent and that are aligned to the needs of veterans and their families. These are set out below.

Vision

Each veteran's service is recognised and respected, and both they and their families have a clear understanding of their entitlements and can access the right services and support, how and when they need them.

Service design principles

- **Veteran centric:** All services put the veteran first and incorporate veteran co-design and feedback.
- **Simple and seamless access:** Veterans and their families receive a relevant and intuitive experience with DVA that is consistent across all channels.
- **Make it easy to get it right:** Interactions with DVA are so simple and efficient that a resolution and/or way forward is reached at the first point of contact, and veterans and their families only need to provide information to DVA once.
- **Support veterans and their families to self-manage:** Veterans and their families are empowered with clear and relevant information and tools to enable them to effectively self-manage their interactions with DVA as they see fit.
- **Whole-of-veteran services:** DVA is able to provide veterans and their families with appropriate services and entitlements across all stages of their lives.

Veterans' and their families' needs

- **Awareness and transparency:** 'Keep me informed and set realistic expectations around predicted timelines and available support services.'
- **Streamlined service and continuity:** 'Provide me with certainty that I am going to be supported when I leave the ADF and only have to give you my information once.'
- **Simplicity and personalisation:** 'Support me to self-help and interact with DVA through the method of my choice, and be proactive in meeting my needs.'

- **Two-way trust and respect:** ‘Show me that DVA values the contribution I have made to my country and recognises my requests for support are genuine, so I can trust DVA will come through for me.’

Key achievements in 2017–18

DVA’s transformation has already made significant inroads in implementing a series of broad and substantial changes, reforms and new service models. The following summarises the key elements of DVA’s transformation so far, under three high-level principles to *know* veterans and their families and their needs, to better *connect* with them, and to provide better mechanisms and services to *support* them.

Know

Early Engagement Model	Accessing Defence information about new, current and transitioning ADF members so DVA can inform them about the support available to them—14,000 so far and growing.
Data analysis	Using DVA’s data to understand veterans and their families, as well as new, current and transitioning ADF members, so DVA can inform them about the support available to them.
Transition Taskforce	Improving support to transitioning ADF members so that veterans and families move successfully to civilian life.
Digitisation	Making veteran information accessible to multiple staff at one time by moving from paper files to digital records so DVA can provide faster support, claims and inquiry processes to veterans and their families—33 million pages so far.
Streamlining Processing	Understanding the unique impact of military service, DVA has analysed 40 conditions, linked these with length of service and allowed for automatic acceptance of claims, with more conditions to come.
Engaging with Veterans and their families	Consulting with over 1,700 veterans about the changes needed, implementing new engagement forums and working collaboratively with veterans and their families to build the programs and services they need.

Connect

<i>MyService</i>	Providing online, faster, simpler and streamlined access to claims for over 5,000 veterans who have registered so far, and working to register more.
Mobile Service Centres Pilot	Working with the Department of Human Services to connect with more veterans and their families, particularly those in rural and remote areas.
Australia Post Pilot	Trialling provision of DVA information services in three Australia Post retail outlets, and providing information at the War Memorial, with the explicit purpose of reaching out to more veterans and their families, particularly those who may not have an existing relationship with us.
Telephony Consolidation	Removing hundreds of call routes and numbers, working towards activating DVA's single 1800VETERAN number this year.
Website	Helping veterans and families find services more easily by making DVA's website more user friendly, with a modern design and intuitive navigation.
Veteran Employment Program	Raising awareness of the unique skills and experience that veterans can bring to the civilian workforce and connecting them to employers.
MyGov	Working with DHS to bring DVA's online services to the whole-of-government platform so that veterans and their families can access all of their government services in one place.

Support

Student Payment System Pilot	Developing new ICT capability in partnership with DHS—children of veterans will be able to submit their student claims online.
Income Support Payment System	Building on the student payment pilot, DVA will develop new ICT capability to deliver income payments to 170,000 veterans.
White Card and non-liability health care	Providing veterans with immediate access to mental health services and easier access to medical treatment and rehabilitation services.
Improved Processing Systems	Building new ICT capability so that staff only have to access one system instead of 18 to process claims, delivering faster results for veterans—e.g. free access to mental health care in about a day.
Veteran Payment and Family Support Package	Providing interim income support for eligible veterans and additional family support to help with child care, counselling and household assistance.
New service delivery approaches	Trialling tailored DVA support and services for transitioning Special Operations Forces members and a simplified medical assessment process for transitioning ADF members.
Veterans and Veterans Families Counselling Service expansion	Extending access to the counselling services to partners, dependants, immediate family members and former partners of veterans.

Building foundational capability

In addition, DVA is building foundational capability in key areas including:

- **Operational Performance Improvement Centre of Excellence:** supporting business areas to improve performance by driving consistent and comprehensive change across DVA.
- **Data and analytics:** supporting transformation through improved data-centric business capabilities.
- **Channel Transformation and Client Strategy:** building DVA's understanding of the way veterans and their families want to access services and aligns the engagement channels, including the delivery of the service delivery scoping and pilots with DHS.
- **Wellbeing services:** scoping, testing and piloting with the best service providers to better meet the needs of veterans and their families.
- **Proactive interventions:** implementing the Priority Investment Approach (including behavioural economics approaches) for veterans and their families to be anticipative of needs and provide early interventions for at-risk veterans groups, including expedited access to treatment.
- **Students and Income Support:** enhancing the Students and Income Support veteran experience and building foundational ICT with DHS for the delivery of income support services.

DVA's transformation is aligned with broader government reform agendas, such as leveraging whole-of-government ICT capabilities wherever possible. Rather than construct additional systems at considerable cost, DVA is adapting and re-purposing existing systems in partnership with DHS.

New forms of service delivery and user choice in public health, disability and aged care and other sectors, along with changes in digital service delivery and accessibility and grant systems, are all informing DVA's transformation and are influencing the delivery of services and improving DVA's capabilities to reach more veterans and their families.

Veteran Centric Reform and new ways of working

DVA's transformation (including the Veteran Centric Reform (VCR) measure) has adopted a scope-and-pilot approach to designing and implementing reforms. Iterative design allows DVA to bring some changes forward through early transformation, while delaying others to ensure veterans, their families and DVA staff are not exposed to adverse effects.

Scoping studies, pilots and trials encourage innovation, manage change, and minimise implementation risk.

Channel strategy and transformation trials

DVA is developing a new strategy and approach for service delivery, driven by data analytics and insights on the ways veterans and their families wish to connect with DVA and receive the services they need.

The strategy includes piloting and testing new opportunities to look at ways DVA can enhance service delivery to the veteran community. These pilots are designed to complement DVA's existing face-to-face services, including Veterans' Access Network offices.

Innovative pilots are being undertaken in partnership with DHS to expand DVA's reach using the DHS Mobile Service Centres—the *Golden Wattle* and *Desert Rose*—which service rural and remote Australia. The DHS Agent Network is also trialling the delivery of an information access point for services to veterans and their families, with 17 agents participating in the pilot.

DVA is also trialling information services with Australia Post. Three trial sites—in Woden, ACT; North Lakes, Queensland; and Mt Gambier in South Australia—are currently operational, testing new approaches to service delivery. This pilot combines hard-copy material (posters and pamphlets) with the use of Australia Post self-service computers loaded with DVA information.

DVA is also working with the Australian War Memorial to make information available to veteran visitors and their families.

Other pilots, tests and trials

A number of pilots, tests and trials of new systems, processes and delivery mechanisms are being undertaken as part of DVA's Veteran Centric Reform measure. These include the following:

- Implementation of the student pilot component of the Students and Income Support stream. The student pilot is the development of modern ICT to support payment of two DVA student payments.
- The Provisional Access to Medical Treatment Trial, Behavioural Economics Provider Randomised Control Trial, and the Behavioural Economics Transition Randomised Control Trial as part of Proactive Interventions.
- DVA is also streamlining how veterans and their families contact DVA and access information for telephony and website changes. Phase 1 of the telephony consolidation project has been completed, with 109 phone lines removed, and 250 out of 397 call routes removed.

As part of Channel Transformation and Client Strategy, there are five pilots under way, including:

- Support for Veterans Services via Mobile Service Centres (described above)
- Building DVA's Staff Capability to Undertake Trust and Company Assessments
- Enhancing Agent and Access Points with a DVA Service Offer
- Digitising Training Material for the DVA Face-to-Face Services
- The Australia Post Easy Access Pilot (described above).

A number of scoping study and pilot work packages have been planned for Year 2 (2018–19), including the development of an evidence base to drive longer term transformation initiatives from Year 3 onwards, and to support benefits assessment and minimise any implementation risks.

Year 2 scoping, pilots and external engagement will also be used to provide government with clear evidence and realistic implementation plans. These will support requests for longer term funding arrangements, aligned to service transformation plans and outcomes.

Funding to implement the second tranche of its transformation has been secured. The continuation of DVA's transformation beyond 2018–19 will be subject to future government decisions.

Data and analytics

DVA is moving to align more strongly with government direction on data and the digital economy and to implement a data-driven approach to policy and service delivery. DVA is in the process of implementing an approach to information, data and analytics that develops a robust evidence base, creates an intuitive self-service environment, and embeds a data-driven culture across the organisation. This will include:

- connecting data sources to create a consolidated veteran view
- embedding data analytics in the service delivery environment
- enhancing the availability and use of management information to report on service delivery performance, service performance, and to support a culture of continuous improvement
- enabling greater policy agility by enhancing the information that is available to evaluate policy delivery, and accelerating the time taken to conduct assessments.

DVA is exploring the use of data analytics to better engage with veterans, particularly to target at-risk veterans so support can be offered proactively rather than waiting for them to approach DVA.

DVA is also developing a Priority Investment Approach framework to understand which veteran cohorts would most benefit from targeted policy interventions. Under this approach, an actuarial model will be developed that will enable DVA to understand and monitor the expected outcomes of their veterans over their entire lifetime. In doing so, groups of veterans who may significantly benefit through more informed decision making will be identified, and DVA will look for ways to engage them, informed through appropriate behavioural economics analyses, which may achieve better and earlier self-management.

By identifying and implementing policy interventions that have the largest health and productivity benefits for specific veteran cohorts, the cost of veteran services will reduce.

Improving processing systems

The 2016–17 Budget provided \$23.9 million over two years to undertake urgent technical work to ensure critical compensation and rehabilitation processing systems operate effectively. Under the Improving Processing Systems Program, DVA is building a single compensation and rehabilitation processing system. The new system will enable non-liability health care, liability, needs assessments, incapacity payments, permanent impairment claims and rehabilitation assistance to be processed through the one compensation and rehabilitation system.

MyService

The *MyService* online portal was launched in early 2017 and is the first element of a contemporary digital interface for DVA. The *MyService* portal is available to current and former members of the ADF who have an electronic service record (those who have served at any time from 2002).

From late 2017 *MyService* was expanded to allow those veterans to register and submit initial liability claims. As at June 2018 over 5,000 registered users have lodged claims through *MyService* and, based on statistics from December 2017, around 50% of initial liability claims are now coming through *MyService*, facilitating a faster and easier claim experience for veterans and their families.

MyService is laying the foundation for the introduction of a contemporary digital interface for DVA, which is consistent with veteran expectations and meets the Government's Digital Service Standards. From 30 July 2018, DVA is linking *MyService* to the whole-of-government online platform MyGov, moving closer to a streamlined way for veterans and their families to interact online.

MyService provides DVA veterans with a simple and convenient way to lodge an initial liability compensation claim online, and it also provides mental health treatment claims, free needs assessments, and an electronic health card that specifies the conditions it covers.

MyService helps veterans identify how they meet DVA's eligibility conditions (SoPs) by leveraging an authoritative digital source of legal rules—the Federal Register of Legislation, maintained by the Office of Parliamentary Counsel. The service shows veterans, in digital form, an automatically updated list of eligibility conditions.

MyService is automatically updated with current legislation, and it filters the appropriate eligibility requirements and conditions based on each veteran's circumstances. This overall approach is the first of this kind in the Australian Government.

MyService is the outcome of the Lighthouse Project, a joint initiative between DVA and the Department of Human Services. The Lighthouse Project was a key part of DVA's transformation agenda, and has helped to align DVA's veteran-facing services with human-centred design concepts.

Digitisation of records

DVA commenced the digitisation of records in November 2016. Current digitisation activities within DVA include the digitisation of incoming mail, the digitisation of veteran files and the digitisation of historically significant library holdings.

This program has already delivered an efficient and effective mail digitisation service in which all incoming veteran-related mail is digitised and delivered electronically into DVA systems each day, allowing frontline claims and processing staff to leverage instant, national access to mail.

DVA has in excess of 1.5 million client paper files or an estimated 300 million pages of client records. In October 2017, the digitisation program commenced a large-scale digitisation of client paper records. By late March 2018, this digitisation service was routinely delivering more than one million pages of digitised client records per week; as of July 2018 approximately 33 million digitised pages had been delivered.

This approach provides real benefits to DVA and its veterans by significantly reducing the costly and inefficient movement of paper files between locations during time-sensitive claims processing and other administrative activities. Digitisation of records supports VCR through the availability of electronic images, allowing concurrent and immediate access to records necessary for claims assessment and processing.

To date the program has scanned:

- client files—over 100,000 files, or 33 million pages
- mail—over 300,000 envelopes, or 2.3 million pages

- library documents—annual reports (all) and Repatriation Commission minutes up to 1969, totalling 75,000 pages.

Straight-through processing

Under straight-through processing (STP) arrangements, training and service data provided by Defence are used to immediately satisfy specified SOP factors for certain medical conditions. Where straight-through processing applies, claimants do not need to provide information about their specific service activities, reducing the time taken by DVA to assess liability.

There are currently 40 conditions that are automatically assessed using STP and streamlining rules, and additional conditions are being investigated through a research project, which is currently under way. The current 40 conditions cover approximately one-half of all claims received, but not all claims meet the qualifications for STP.

The STP provides a semi-automated decision arrangement that helps determine the connection between medical condition and military service by automatically applying SoPs according to DVA-defined rules. For veterans whose service history satisfies the SoPs relating to their diagnosed medical condition, information and a recommendation is provided to the claims processing officer.

The next step in STP is to allow computer systems to accept claims that meet relevant criteria. Building on the STP rules that reduce the evidentiary burden on veterans and their families, *MyService* will be configured to provide acceptance of claims once an appropriate diagnosis is provided.

Information on streamlined claims is in Annex 5.

Students and Income Support claims processing

Students and their families are expected to be able to register and claim for the education allowance under DVA's education assistance schemes using a fully digital channel to be piloted by DVA in July 2018.

The student pilot is the first DVA application of the standardised, digital approach to business established by the DHS Welfare Payment Infrastructure Transformation Programme.

The introduction of digital claiming will improve the veteran experience by providing upfront confirmation of eligibility, reducing the amount of information required, and streamlining the provision of supporting documents.

Client segmentation

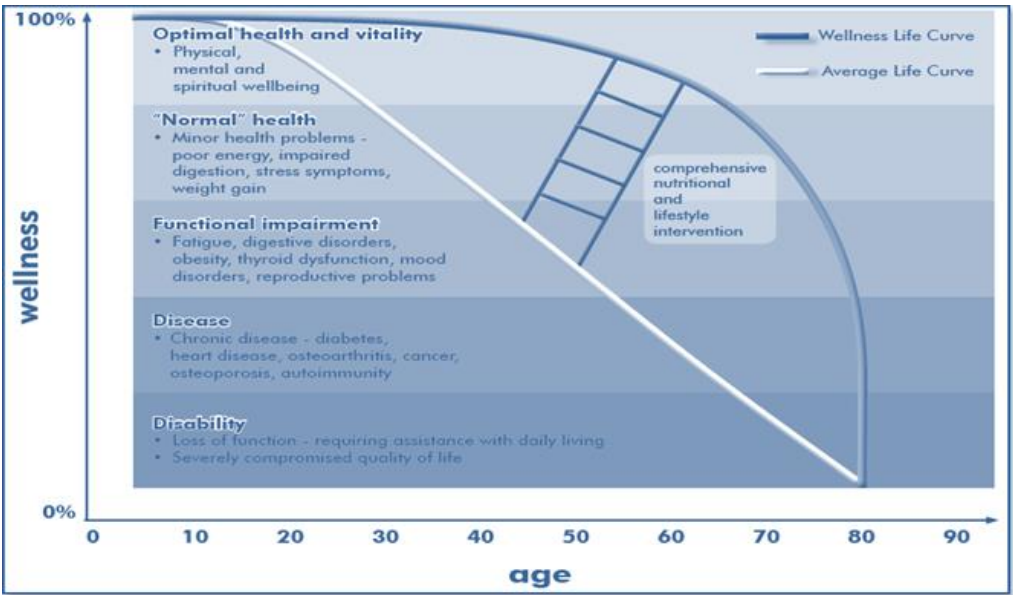
Client segmentation is a critical component of the DVA Client Strategy, which is being developed as part of the Channel Transformation and Client Strategy stream. Client segmentation enables DVA to better understand its veterans and their families, and to understand their needs and the services they require.

The segmentation framework provides data-driven analyses of veteran characteristics, needs and preferences. The framework will be continually updated, and each client segment will be supported by a detailed profile that gives an overview of the segment, demographics, service preference, and support needs and services.

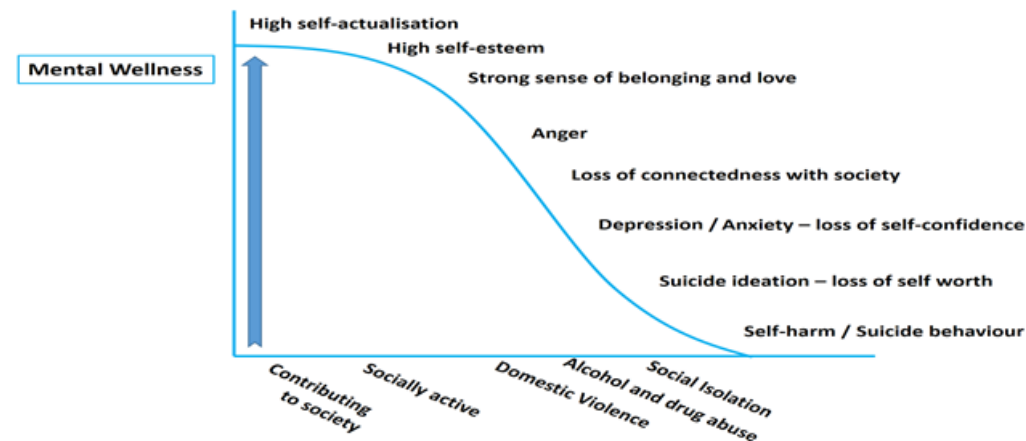
Through better understanding its clients, DVA will be in a better position to develop policy in anticipation of needs, and to proactively respond to emerging policy and service needs.

Annex 4 Veterans’ wellbeing

Veterans’ needs also change with levels of wellbeing. Two wellbeing curves are shown in the diagrams below: the first is an indicative ‘Wellness Life Curve’ that highlights some factors for extending time in the higher zones of the wellness curve.



However, other factors may also affect wellbeing, especially mental health wellbeing as depicted in the ‘Mental Wellbeing Curve’ below.



Annex 5 Claims

As can be seen from the table below, most kinds of claims have increased between 2014–15 and 2016–17, with further increases anticipated between now and 2019–20.

							Avg % chg during period 2014–15 to 2017–18
Intake	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	

Table 1

VEA claims	13,805	15,278	15,994	13,365	13,221	13,079	–1.1%
MRCA IL claims	6,448	8,473	9,316	10,845	12,897	15,338	+18.9%
DRCA IL claims	5,499	7,343	7,171	8,796	10,287	12,031	+17.0%
Total Initial Liability	25,752	31,094	32,481	33,006	36,406	40,448	

Table 2

MRCA PI claims	4,315	4,231	6,155	6,950	8,147	9,550	+17.2%
DRCA PI claims	3,837	4,385	5,934	6,400	7,590	9,001	+18.6%
Total Permanent Impairment	8,152	8,616	12,089	13,350	15,737	18,551	

Table 3

MRCA Incapacity claims	1,752	1,545	2,075	2,330	2,562	2,818	+10.0%
DRCA incapacity claims	408	454	651	602	685	780	+13.8%
Total incapacity	2,160	1,999	2,726	2,932	3,248	3,598	

Table 4

VVRS rehabilitation	113	74	65	54	45	37	–16.8%
MRCA rehabilitation	1,069	759	1,047	1,040	1,033	1,025	–1.0%
DRCA rehabilitation	377	386	723	898	1,116	1,387	+24.2%
Total rehabilitation referrals	1,559	1,219	1,835	1,992	2,194	2,449	

Table 5

VEA S31 reviews	1,205	1,129	1,030	1,004	945	889	–5.9%
DRCA/MRCA reconsiderations	1,398	1,399	1,729	2,050	2,329	2,646	+13.6%
Total reviews and reconsiderations	4,932	4,662	4,739	4,744	4,792	4,900	

Table 5 (a)

\$137/S37—VRB	2,329	2,134	1,980	1,690	1,519	1,365	–10.1%
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Table 6

VEA accounts paid	11,997	11,316	10,424	10,245	9,720	9,222	–5.1%
DRCA/MRCA accounts paid	76,861	85,611	95,383	103,580	114,410	126,373	+10.5%
Total accounts paid	88,858	96,927	105,807	113,825	124,130	135,595	

Note: For Tables 1, 2, 3, 5, 5(a) and 6 totals for 2017–18 have been extrapolated from year-to-date figures at 28 February 2018. Data obtained from the Rehabilitation and Compensation National Summary monthly reports.
a. Rehabilitation referrals received.

Figure 6 Numbers of claims, 2014–15 to 2019–20 (projected)



Streamlined claims

The MRCC and Repatriation Commission have approved a policy that allows delegates to simplify the investigation and decision-making process for claims that meet certain criteria under the MRCA and the VEA.

Under streamlining, once the medical diagnosis has been established, a suite of conditions can generally be accepted as service related without further investigation.

Straight-through processing is where ADF veteran profiles and/or details of service can be used as evidence that an eligible claimant has met the specified SoP factor for a particular condition without the need for further investigation.

DVA's systems do not record whether the streamlined or straight-through processing procedures were applied. However, in 2016–17:

- 24.7 per cent (3,884 out of 15,713) of compensation conditions were determined under the VEA where the streamlined procedures could have been applied
- 18.1 per cent (3,555 out of 19,683) of the liability conditions were determined under the MRCA where the streamlined procedures could have been applied. There was a further 17.8 per cent (3,510 out of 19,683) of the liability conditions determined under the MRCA where straight-through processing procedures could have been applied.

It should be noted that the number of conditions where streamlined or straight-through processing procedures can be applied has increased since December 2017. Collectively, these are now referred to as 'decision-ready conditions'. As at April 2018, there were 40 decision-ready conditions under the MRCA, of which 11 were also decision-ready under the VEA.

Annex 6 Legislation

Chronology and rationale for each of the Acts

Pensions, compensation, rehabilitation, treatment and other benefits for veterans, members and former members of the ADF and their dependants are currently provided (in most cases) under three separate Acts, the *Veterans' Entitlements Act 1986* (VEA), the *Military Rehabilitation and Compensation Act 2004* (MRCA), and the *Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988* (DRCA).

Veterans' Entitlements Act 1986

Veterans' entitlements under the VEA are in the form of certain pensions, benefits and allowances and the funding of medical treatment. Pensions are payable to veterans as both compensation in the form of a disability pension for service injury or disease and income support in the form of the service pension. Compensation is also payable to dependants where the death of the ADF member results from a service injury or disease. A range of additional benefits and allowances are also payable, including free medical treatment.

The enactment of the VEA in 1986 repealed and replaced the major veterans' entitlements Act, the *Repatriation Act 1920* and the Acts applicable to ADF service during the Malayan Emergency, the *Repatriation (Far East Strategic Reserve) Act 1956* and the Vietnam War, the *Repatriation (Special Overseas Service) Act 1962*.

The *Repatriation Act 1920* (made as the *Australian Soldiers' Repatriation Act 1920*) had repealed and replaced both the *War Pensions Act 1914* and the *Australian Soldiers' Repatriation Act 1917*.

At the time the *War Pensions Act 1914* was repealed, pensions and benefits were payable to dependants of an ADF member who had died and to incapacitated members of the ADF.

From its enactment in 1920, until its repeal and replacement in 1986, the major changes to the *Repatriation Act 1920* included:

- the introduction of service pensions for returned ADF members in 1935
- the provision of coverage to ADF members for service during World War 2, Malaya operations, the Korean War, and the Vietnam War
- the extension of coverage in 1973 to the peacetime service of ADF members
- the establishment of the Veterans' Review Board in 1984 to replace the Repatriation Review Tribunal, and the removal of the Repatriation Commission's appellant function
- the creation in 1985 of the distinction between 'qualifying war service'—which separated overseas war service and war service in Australia (which involved

direct combat and operational service in Korea, Malaya, Borneo or Vietnam, peacekeeping or ADF service designated as hazardous service)—from all other forms of ADF service covered by the *Repatriation Act 1920*.

From its enactment in 1986 until the present time, the major changes to the VEA included:

- the 1994 repeal and incorporation of the *Seamen's War Pensions and Allowances Act 1940*, which had been enacted to make provision for pensions and other benefits to Australian mariners who experienced hostile action during World War 2
- the introduction of SoPs in 1994
- the establishment in 1997 of the Veterans' Vocational Rehabilitation Scheme
- the extension in 2010 of eligibility to ADF members with 'British Nuclear Test Defence service'
- the 2016 extension of non-liability health care for certain mental health conditions to cover all current, former and future permanent ADF members.

Military Rehabilitation and Compensation Act 2004

The MRCA provides rehabilitation, compensation and treatment coverage for current and former members of the ADF for injuries, diseases or death related to service rendered on or after 1 July 2004. That date was also the date of commencement of the Military Rehabilitation and Compensation Commission (the MRCC), which administers the MRCA.

From its enactment in 2004 until now, the major changes to the MRCA include:

- amendments in 2013 to implement the recommendations of the RMCA, which included changes to permanent impairment compensation and changes to the MRCA/VEA/SRCA transitional arrangements
- the 2017 implementation of the single appeal pathway for the review of original determinations.

Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988

The DRCA provides compensation, rehabilitation and treatment for defence-related injuries, diseases or deaths attributable to service in the ADF rendered between 1 December 1988⁴⁷ and 30 June 2004.

The DRCA is unique in the sense that it commenced on 12 October 2017 as a duplicate of the version of the SRCA as it was on that day.

⁴⁷ Peacetime service is covered in the DRCA from 1949 to 2004 by virtue of the SRCA and its two predecessor Acts: the 1930 and 1971 Acts.

The *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Act 2017*, which provided for the enactment of the DRCA, also included amendments to the SRCA to ensure the transition of both Commonwealth civilian employees as well as ADF members to the DRCA.

The retrospective application of the DRCA will ensure that claims by ADF members relating to events during the period from 1988 to 2004 will have a version of the DRCA applied that will effectively be the version of the SRCA that was applicable at that time.

ADF members now covered by the DRCA will also be protected because all of the existing case law, and the decisions and interpretations that have been applicable in proceedings that were brought under the SRCA, will also be applicable in the interpretation and determination of the equivalent provisions of the SRCA that continue to be applicable for the DRCA.

The DRCA also contains transitional provisions preserving the rights and entitlements of ADF members with coverage under the predecessor Acts to the SRCA (the *Commonwealth Employees' Compensation Act 1930* and the *Compensation (Commonwealth Government Employees) Act 1971*).

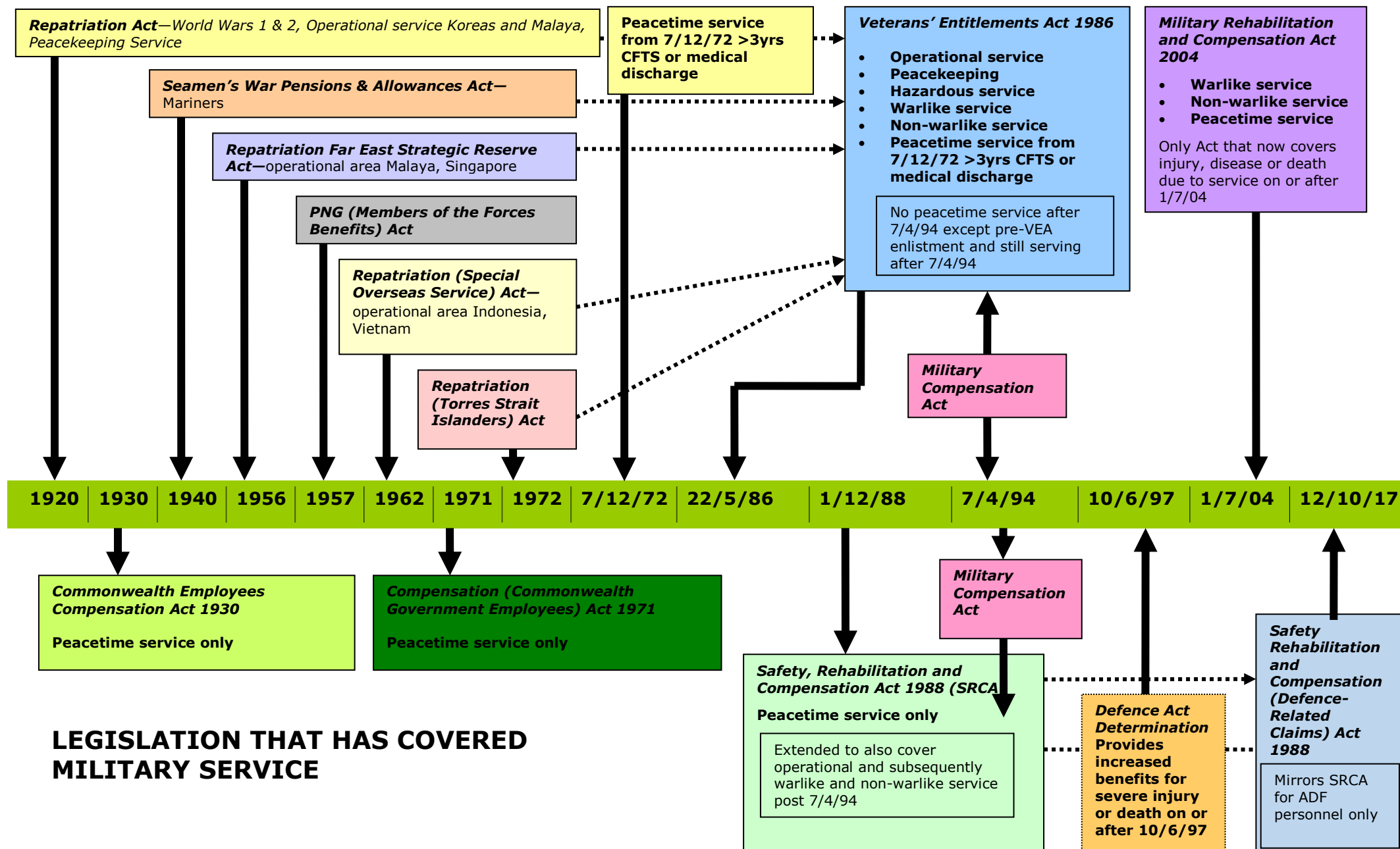
All injuries, illnesses and deaths related to service on or after 1 July 2004 (or related to service that occurred both before and after that date) are covered under the MRCA, with responsibility for determining and managing defence-related claims transferred to the MRCC.

Other legislation administered by DVA

DVA also administers a number of other Acts, including the *War Graves Act 1980*, through the Office of Australian War Graves, and the *Defence Service Homes Act 1918*.

Illustration of legislation chronology and coverage

The illustration on the next page sets out the various Acts that have been or are relevant to the system of military compensation, and the time of enactment and their relevant coverage.



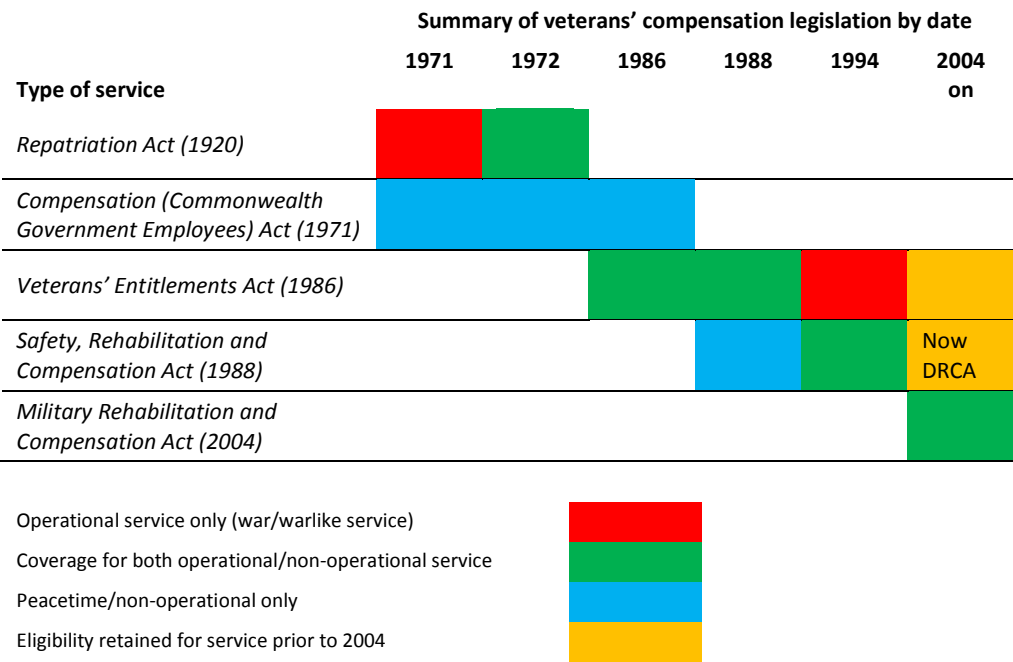
Annex 7 Dual/multiple eligibility

The Act that an individual is eligible under is determined by the period(s) and type(s) of service they rendered at the time they were injured, developed a disease or died. Dual eligibility under both the VEA and DRCA dates from 1972, when ADF members with three years’ continuous full-time service became eligible for peacetime service under the then *Repatriation Act 1920* (succeeded in 1986 by the VEA), as well as the relevant Commonwealth employees’ compensation scheme (now DRCA). Depending on the particulars of a member’s service, dual VEA/DRCA eligibility might cease from 1994 or 2004.

It is possible for service to be covered under multiple Acts, and as such claimants may be eligible to receive compensation under more than one Act, even for the same condition. If the ADF member claims and receives compensation under more than one Act for the same injury or illness, compensation offsetting applies.

The enactment of the MRCA from 1 July 2004 ceased dual eligibility for all forms of service from that date, but did not remove dual eligibility for prior service.

Simplified summary of claiming eligibility by date and Act since 1971



Legislation for dual/multiple eligibility

Prior to 1972 there was no dual eligibility for military compensation under separate Acts—the original Repatriation Act covered operational service, while the Commonwealth compensation arrangement covered peacetime service only. From 7 December 1972, dual eligibility has existed under various combinations of Acts, as can be seen in the table above.

Most legislative complexity being experienced by DVA and its clients relates to the period from 1972 through to 2004.

Transitional issues between Acts

When the MRCA commenced on 1 July 2004, it applied to the provision of rehabilitation and compensation for injuries, diseases and deaths related to all forms of ADF service rendered on or after that day. As an injury, disease or death may be related to service covered by the VEA or DRCA as well as defence service under the MRCA, the *Military, Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004* (CTPA) was enacted to include a set of rules for the interaction of the three Acts. This includes that the MRCA is applicable where the injury, disease or death relates to defence service rendered on or after 1 July 2004, or which spans that date.

The CTPA inserted a new section 9A into the VEA. The effect of section 9A and sections 7, 8, 9, and 13 of the CTPA, is to end liability under the VEA and to provide for liability under the MRCA for an injury, disease or death that is related to service in the ADF rendered on or after 1 July 2004 (or starting before and continuing to 1 July 2004 or after). Section 70A of the VEA (inserted by the *Veterans' Entitlements (Clarke Review) Act 2004*) is also applicable on or after 1 July 2004 (or spanning that date) to injury, disease or death from ADF service not covered by section 9A.

The CTPA inserted section 4AA into the SRCA (now the DRCA), which, together with sections 7, 8, 10 and 13 of the CTPA, ends liability under the DRCA and provides for liability under the MRCA for an injury, disease or death that is related to service rendered on or after 1 July 2004 (or spanning that date).

The introduction of the MRCA means there is no entitlement under the VEA or DRCA where clinical onset, or aggravation of an existing injury, is as a result of service on or after 1 July 2004, or which spans that date. The MRCA was legislated to take into account previous compensation received under another Act as part of the assessment methodology, such that a person's whole-of-person MRCA entitlement takes into account compensation already received.

All aggravations due to MRCA service of conditions already accepted under the VEA are determined as an Application For Increase in disability pension under the VEA. (Note that prior to 1 July 2013, veterans could elect to make a choice between the MRCA or the VEA for aggravation of an injury or disease. Section 12 of the CTPA was removed as of 1 July 2013.)

However, it is still possible for veterans to have dual eligibility under the VEA and the DRCA. Alongside the other benefits available to veterans and former members such as rehabilitation and treatment, the maximum amount of compensation available under each of the Acts DVA administers is designed to fully compensate a person for the effects of their service-related injuries or diseases, or death.

Where a person is also able to claim compensation for that condition from multiple Acts, or through the courts as well, legislation requires the Commissions to reduce that person's DVA entitlements so that the maximum amount of compensation available is not exceeded.

Where a claimant has had liability for a particular condition accepted under both the VEA and the DRCA, and has MRCA service, only an aggravation (due to MRCA service) of the VEA condition can be claimed but not an aggravation (due to MRCA service) of the DRCA condition.

Some service for which provision of pension is made under the VEA is specifically excluded from coverage under the DRCA. This principally affects service in the World Wars and post-World War 2 conflicts, in relation to which it was intended that coverage under repatriation legislation (now the VEA) should apply.

Case studies—effects of different Act eligibility and operational/non-operational service

In each of the fictional scenarios below, the ADF member receives the same injury and same level of incapacity; however, his entitlements to benefits and support vary as the support is based on the time of the event and the nature of the service involved.

Note that for each of these scenarios, superannuation benefits can also apply. A medically discharged member who has an incapacity of 30% or more (in relation to appropriate civilian employment) is also entitled to receive military superannuation invalidity benefits. These benefits include a pension based on the person's final average salary at discharge. This pension is indexed by the Consumer Price Index and paid for life. Commonwealth-funded superannuation benefits are reduced from incapacity payments dollar for dollar.

For the purposes of these comparisons, amounts are expressed in 2018 dollars.

Scenario 1: VEA/DRCA dual eligibility

Barry is a 24-year-old trooper in Second Cavalry Regiment serving in Afghanistan in December 2003. His vehicle is on a patrol and rolls over while trying to avoid an enemy position. His injuries cause him to be discharged from the Army and he is not able to undertake paid work.

Outcome: VEA/DRCA benefits (operational service)—dual eligibility

Barry may receive a VEA Disability Pension (DP) of up to \$1,372.70 a fortnight (if he qualifies for the Special Rate). If Barry chooses to receive a DRCA lump sum (of up to \$260,301.00), the DP will be offset by the lump sum/s. Barry may elect to not receive the DRCA lump sum, which would result in the full DP with no offset.

DRCA incapacity payments would also be available, up to \$2,635.90 per fortnight for the 45 weeks after the injury. His VEA DP would be offset by these payments.

Under the VEA, Barry is also eligible for a DVA Health Care Gold Card covering health care for all conditions, whether service related or not.

VEA Disability Pension

- Combined impairment of 60 points (warlike/non-warlike service)
- Lifestyle rating of 5
- 100% General Rate of DP = \$488.00 per fortnight
- Barry may be eligible for Special Rate (TPI) if he meets the 'alone' test
- Special Rate of DP = \$1,372.70 per fortnight

DRCA Permanent Impairment Compensation⁴⁸

Compensation rates (as at 1/7/2018):

Maximum lump sum permanent impairment s.24(9)	\$189,310.19
Maximum lump sum impairment component s.27(2)	\$35,495.68
Maximum lump sum non-economic loss component s.27(2)	\$35,495.68
Total	\$260,301.55

⁴⁸ There is no direct conversion between the DRCA Permanent Impairment (PI) Guide and GARP M. The equivalent impairment of the 60 impairment points cannot be converted to a whole-of-person impairment percentage under the PI Guide. For the purposes of the case study, its assumed GARP 60 impairment points equates to approximately 50% of the maximum rate of PI compensation under DRCA (as a MRCA client with peacetime service receives approximately half the maximum weekly rate, i.e. a compensation factor or 0.540).

Compensation payable for impairment of ~60 GARP points is \$130,150.78—approximately 50% of the total Permanent Impairment (PI) payable under sections 24 and 27 of DRCA.⁴⁹

Incapacity Payments

- DRCA—discharged before 1/7/2004
- Assumed last military salary rate (i.e. including Service Allowance) as at 6 May 2004
- Assumed PTE 3 @ 6/5/2004 = \$1,660.82 per fortnight
- Whole-of-person impairment increases up to and including 1/7/2017 = \$2,635.90 per fortnight
- Step-down to 75% after 45 weeks = \$1,976.93

Under DRCA, Barry would be unlikely to continue receiving incapacity payments after 45 weeks (if he is still not working).

Scenario 2: MRCA eligibility

Barry is a 24-year-old trooper in Second Cavalry Regiment serving in Afghanistan in December 2004. His vehicle is on a patrol and rolls over while trying to avoid an enemy position. His injuries cause him to be discharged from the Army and he is not able to undertake paid work.

Outcome: MRCA Benefits (operational service)

Barry would receive compensation for his permanent impairment of \$304,771.00 and incapacity payments of around \$2,910.00 each fortnight for the first 45 weeks, reducing to around \$200.00 a fortnight after 45 weeks. He would also be eligible for the Special Rate Disability Pension.

Under the MRCA, Barry is also eligible for a DVA Health Care Gold Card covering health care for all conditions, whether service related or not.

Permanent Impairment Compensation

- Combined impairment of 60 points (warlike/non-warlike service) with a lifestyle rating of 5
- Compensation Factor: 0.703
- PI payable = (Compensation Factor x maximum PI weekly rate) x Conversion factor
- Maximum rate of PI: \$464,364.05 = weekly rate of \$347.24
- Age next birthday for lump sum conversion: 38 Male

⁴⁹ The assessment of PI compensation under DRCA is an injury-based approach due to the case law of *Canute*. Therefore a client may receive multiple lump sum compensation amounts under sections 24 and 27 for each single injury. For example, client may have a knee, ankle and mental health injury, each of which will be awarded a separate whole-of-person impairment % and PI payment that exceeds the equivalent of a person's entitlement under MRCA with 60 impairment points, although the injuries are the same diagnosis and cause the same level of impairment. Therefore a client may in fact receive a lump sum for each injury up to an amount of \$260,301.55 (as of today's rates) even if their equivalent impairment is 60 impairment points.

- Conversion Factor for PI lump sum conversion (from 11/03/2015): 1248.5

PI payable = \$304,770.99

Incapacity Payments

- Discharged after December 2004
- Assumed last military salary rate (including SA) as at 2 Nov 2017
- Assumed PTE 3 @ 2/11/17 = \$2587.69 per fortnight
- Plus Remuneration Allowance as @ 1/7/2017 = \$322.64 per fortnight
- MRCA entitlement = \$2,910.33 per fortnight
- Step-down to 75% after 45 weeks = \$2,182.75
- Under MRCA, Barry would only be receiving about \$200.00 per fortnight in incapacity payments after 45 weeks (if he is still not working).
- The client would be assessed for SRDP eligibility—as greater than 50 impairment points.

Scenario 3: DRCA eligibility (non-operational service)

Barry is a 24-year-old trooper in Second Cavalry Regiment in 2003. Barry is on an exercise at Mt Bunday in NT preparing to go to Afghanistan. His vehicle is on a patrol and rolls over during the exercise. His injuries cause him to be discharged from the Army and he is not able to undertake paid work.

Outcome: DRCA Benefits (non-operational service)

Barry is not eligible for VEA benefits (see Scenario 1) as he incurred his injuries in non-operational service. He would be eligible for a DRCA lump sum of up to \$260,301.00. DRCA incapacity payments would also be available, up to \$2635.90 per fortnight for the 45 weeks after the injury.

Under the DRCA, Barry is also eligible for a DVA Health Care White Card covering health care for his DRCA-accepted conditions.

DRCA Permanent Impairment Compensation

Compensation rates (as at 1/7/2018):

Maximum lump sum permanent impairment s.24(9)	\$189,310.19
Maximum lump sum impairment component s.27(2)	\$35,495.68
Maximum lump sum non-economic loss component s.27(2)	\$35,495.68
Total	\$260,301.55

Compensation payable for impairment of ~60 GARP points is \$130,150.78—approximately 50% of the total Permanent Impairment (PI) payable under sections 24 and 27 of DRCA.

Incapacity Payments

- DRCA—discharged before 1/7/2004

- Assumed last military salary rate (i.e. including Service Allowance) as at 6 May, 2004
- Assumed PTE 3 @ 6/5/2004 = \$1,660.82 per fortnight
- Whole-of-person impairment increases up to and including 1/7/2017 = \$2,635.90 per fortnight
- Step-down to 75% after 45 weeks = \$1,976.93

Scenario 4: MRCA eligibility (non-operational service)

Barry is a 24-year-old trooper in Second Cavalry Regiment. Barry is on an exercise in December 2004 at Mt Bunday in NT preparing to go to Afghanistan. His vehicle is on a patrol and rolls over during the exercise. His injuries cause him to be discharged from the Army and he is not able to undertake paid work.

Outcome: MRCA Benefits (non-operational service)

Under MRCA, Barry would receive compensation for his permanent impairment of \$234,104.00 and incapacity payments of around \$2,910.00 per fortnight for the first 45 weeks, reducing to around \$200.00 a fortnight after 45 weeks. He would also be eligible for the Special Rate Disability Pension.

Under the MRCA, Barry is also eligible for a DVA Health Care Gold Card covering health care for all conditions, whether service related or not.

Permanent Impairment Compensation

- Maximum rate of PI: \$464,364.05 = weekly rate of \$347.24
- Age next birthday for lump sum conversion: 38 Male
- Conversion Factor for PI lump sum conversion (from 11/03/2015): 1248.5

$$\text{PI payable}^{50} = (0.540 \times \$347.24) \times 1248.5 = \$234,104.74$$

Incapacity Payments

- Discharged after December 2004
- Assumed last military salary rate (including SA) as at 2 Nov 2017
- Assumed PTE 3 @ 2/11/17 = \$2,587.69 per fortnight
- Plus Remuneration Allowance as @ 1/7/2017 = \$322.64 per fortnight
- MRCA entitlement = \$2,910.33 per fortnight
- Step-down to 75% after 45 weeks = \$2,182.75
- Under MRCA, Barry would only be receiving about \$200.00 per fortnight in incapacity payments after 45 weeks (if he is still not working).
- The client would be assessed for SRDP eligibility—as greater than 50 impairment points.

⁵⁰ A MRCA client with peacetime service receives approximately half the maximum weekly rate i.e. a compensation factor of 0.540

Summary of scenario outcomes

Location and date	Afghanistan Dec 2003	Afghanistan Dec 2004	Mt Bunday Dec 2003	Mt Bunday Dec 2004
Operational	✓	✓	x	x
Non-operational	x	x	✓	✓
VEA	✓	x	x	x
DRCA	✓	x	✓	x
MRCA	x	✓	x	✓
Health Care Card	Gold	Gold	White	Gold
Disability Pension	Up to \$1,327.70 f/n	Nil	Nil	Nil
Lump sum	\$260,301	\$304,771	\$260,301	\$234,104
Incapacity payments	\$2,635.90 f/n for first 45 weeks \$1,976.93 f/n post 45 weeks	\$2,910 f/n for first 45 weeks \$2,182.75 post 45 weeks	\$2,636 f/n for first 45 weeks \$1,976.93 f/n post 45 weeks	\$2,910 f/n for first 45 weeks \$2,182.75 post 45 weeks

Annex 8 Recent legislative changes

The amendments made by the *Veteran Affairs Legislation Amendment (Veteran-centric Reforms No. 1) Act 2018* provided for the implementation of some important measures including:

- Veteran Payment—an interim income support payment to eligible veterans and their partners while the liability for their mental health condition is being determined
- Family Support—additional childcare assistance for veterans receiving an incapacity payment and for spouses/partners of veterans of overseas conflicts who have died
- an extension of the period for brief intervention counselling, for up to five years post-transition from the ADF
- additional home care and counselling assistance to the spouse or partner of a recent conflict veteran who has died
- the Coordinated Veterans' Care mental health pilot, which will recruit up to 125 participants each year over a two-year period for the purpose of providing support to veterans in rural and regional areas, where mental health services may be more difficult to access
- automation of determinations of qualifying service, removing the requirement for a veteran to make an application for the determination.

Some other significant amendments to Veterans' Affairs portfolio legislation have been made by a number of Acts. These Acts and the relevant measures include:

- *Veterans' Affairs Legislation Amendment (Omnibus) Act 2017*
 - information sharing between the MRCC and the CSC
 - the ability to make legislative instruments to incorporate matters contained in another non-disallowable legislative instrument or other non-legislative writings as in force from time to time.
- *Veterans' Affairs Legislation Amendment (Budget Measures) Act 2017*
 - the Act includes amendments that establish an early access to rehabilitation pilot program.

- *Veterans' Affairs Legislation Amendment (Digital Readiness and Other Measures) Act 2017*
 - the Act includes amendments to the VEA, MRCA and DRCA to enable the use of computer programs to make positive decisions and determinations, and enable information sharing between the MRCC and the Secretary of the Department of Defence or the Chief of the Defence Force under the DRCA.

The *Veterans' Affairs Legislation Amendment (Veteran-centric Reforms No. 2) Act 2018* implemented several new initiatives to deliver benefits to veterans and their families. The Act contains two significant measures, including:

- provision of financial support to veterans who are studying, by enabling them to continue to receive 100% of their incapacity payments for the duration of their study commitment. Currently, incapacity payments are reduced after 45 weeks
- creating a veteran suicide prevention pilot to provide intensive management support services to help prevent the incidence of suicide. This measure follows a recommendation of the Senate inquiry report, *The Constant Battle*.

Other measures contained in the Act include:

- extending the time limit from six months to two years for wholly dependent partners to decide how to receive compensation for their partner's death, including the election of periodic payments, a lump sum, or a combination of both. This measure puts the veteran's family at the centre of the decision and gives them the time they need to make a decision
- allowing veterans under the MRCA to make an oral claim for compensation after they have made an application for compensation. This removes an existing requirement for a separate written claim. This amendment supports DVA's veteran-centric approach by making the claim process easier for veterans.

Annex 9 Offsetting

Compensation offsetting

Compensation offsetting describes various practices, each based on different principles, but commonly refers to the reduction of one compensation payment in recognition of another compensation payment being made for the same incapacity or death.

Compensation offsetting affects VEA, DRCA and MRCA compensation payments.

VEA pensions can be reduced where common law compensation or damages are received by a person in respect to the same incapacity or death for which the disability pension is paid. VEA offsetting mainly occurs where the underlying incapacity (not the injury or disease itself) is the same.

Compensation previously paid under the MRCA and DRCA is fully or partly repayable to the Commonwealth where damages are received by a person in respect of the same injury, disease or death for which MRCA or DRCA compensation was paid.

MRCA impairment in cross-Act eligibility cases

When the MRCA was introduced in 2004 some transitional arrangements were put in place to deal with circumstances in which a person already had a condition accepted under VEA or SRCA. These are described as 'offsetting' but are different to the offsetting described above.

The first purpose of these provisions is to ensure that impairment suffered as a result of previous VEA and/or SRCA conditions will be counted with the impairment from MRCA conditions towards eligibility for certain impairment thresholds, providing access to particular MRCA benefits (for example, provision of the Gold Card requires 60 impairment points). This arrangement maximises the veteran's impairment ratings so as to not disadvantage them from impairments under different Acts.

The second purpose is to assess permanent impairment compensation under the MRCA through a whole-of-person impairment under all three Acts, and then deducting the impairment from the VEA and/or SRCA. This ensures that the permanent impairment compensation payable under the MRCA cannot take the total amount payable under all three Acts to more than the maximum MRCA compensation amount.

The key principles here are that impairment should be based on a whole-of-person basis (not a simple sum of all impairments), and the total of a person's disability pension and permanent impairment entitlements under the different Acts should not exceed the maximum available if they were only eligible under one Act.

Following the Review of Military Compensation Arrangements in 2011, the formula for calculating permanent impairment compensation was amended to achieve a fairer outcome for MRCA conditions where VEA and/or DRCA compensation had been previously paid.

Superannuation offsetting

Both the MRCA and DRCA provide for the Commonwealth-funded portion of any Commonwealth superannuation paid to the veteran to be offset (on a dollar-for-dollar basis) against incapacity payments made for an inability to work as a result of a service-related injury or disease. Similar offsetting applies to the Special Rate Disability Pension under the MRCA, but at 60 cents in the dollar.

This offsetting reflects the principles that the Commonwealth should not pay twice for an inability to work, either through incapacity or retirement, in the form of both superannuation and compensation, and that a person should not receive a higher income maintenance amount from the Commonwealth in respect of their incapacity to work than their amount of pre-injury earnings.

The VEA disability pension is not offset by Commonwealth superannuation, reflecting the original 1920 establishment of the principles of this pension in the Repatriation Act.

Annex 10 Legislation harmonisation options

The following options for harmonising military compensation legislation were discussed in Section 4.3.1.

Universal adoption of the RMA's Statements of Principles regime

The application of a common set of assessment principles across DVA's three Acts could provide administrative benefits, but there are issues that would need to be addressed beforehand. The application of the 'reasonable hypothesis' (RH) SoPs is one of those issues.

Under the MRCA and the VEA, there are two SoPs that the RMA has developed for each condition. The RH SoPs apply if an injury, disease or death is related to 'operational' service, which includes warlike, non-warlike service, peacekeeping, hazardous and British Nuclear Test Defence service. Claims that are assessed under the RH standard of proof must be accepted unless the delegate can prove (beyond a reasonable doubt) that the condition is not linked to that period of service.

The 'balance of probabilities' (BoP) SoPs apply if an injury, disease or death is related to other periods of service (including peacetime service). The BoP standard of proof requires that a condition be connected, on the balance of probabilities, to a period of peacetime ADF service.

As the DRCA does not currently contain an equivalent RH standard of proof, consideration will need to be given to whether only the BoP SoPs would apply to DRCA claims.

The liability construct under the DRCA would also need to be altered as there are no equivalent 'heads of liability' as exist in sections 27–30 of the MRCA. The heads of liability work in combination with the SoPs to prescribe a separate set of circumstances or factors that are necessary to establish a connection between an injury or disease and a person's ADF employment.

Changes to the current arrangement could also produce situations where some veterans are advantaged while others are disadvantaged, with some claimants finding the application of the SoPs more definitive compared to the current use of specialist medical opinion under the DRCA.

Given that the SoP regime has been in place for around 25 years, whether SoPs are still 'fit for purpose', or if other arrangements may be a better fit, or better meet contemporary needs, are questions to be considered.

While SoPs are perceived to be inflexible in application, and are not able to be quickly amended, DVA considers that SoPs are robust and that their use supports more transparent and consistent decision making. Further, the design of the system of SoPs was carefully considered to require the development or amendment of each SoP to be based on an extensive review of international medical literature, rather than allowing consideration of a medical condition to rely on the views of particular medical practitioners, as had previously been the case (see Annex 11).

There are opportunities to improve the use of SoPs:

- greater flexibility in the application of SoPs by basing 'decision-ready' conditions on certain occupational-defined exposures would make claims simpler where there is an automatic link between certain military occupations and impairments (noting risks for flow on to civilian workers' compensation arrangements would need to be managed)
- improving the speed and responsiveness by which SoPs incorporate emerging science.

More information on the history and rationale for SoPs and the standard of proof is provided in Annex 11.

Assessment of impairment

Another area of potential alignment is the use of the Guides to Assessment of Rates of Veterans' Pensions (GARP for the VEA; GARP M for the MRCA) for the assessment of DRCA permanent impairment claims. At present, Part 2 of the Guide to the Assessment of the Degree of Impairment, Edition 2.1, as developed by Comcare, is used in the assessment of DRCA claims.

The guides used by DVA are not necessarily the latest assessment guides, and there can be significant differences in the assessment of benefits across each of DVA's Acts depending on which condition is being assessed and under which guide.

While the adoption of a single assessment guide for claims under both the DRCA and the MRCA would be a complex body of work, as there would be significant technical, transitional and implementation issues attached to the proposal, DVA is working on both GARP alignment and the use of SoPs in DRCA.

Currently, two veterans who have eligibility under different Acts with identically incapacitating injuries may obtain differing compensation outcomes. For example, the DRCA requires a higher incapacity threshold before compensation is payable, but assesses an individual injury without reference to previous injuries the person has been compensated for. The MRCA, on the other hand, has a lower bar for compensation, but requires that all of a person's injuries be looked at cumulatively to reach a whole-of-person impairment level.

The result of this is that the same injury may give rise to compensation under the MRCA, but not meet the threshold for compensation under the DRCA. On the other hand, in rare cases a person with many significant injuries may obtain a lower quantum of compensation under the MRCA (where the whole-of-person calculation tops out at 100 per cent incapacity), than they would under the DRCA (where each injury is assessed in isolation and no upper limit across all injuries applies).

Differences in incapacity payments between MRCA and DRCA

Incapacity payments under the DRCA and MRCA are compensation payments for economic loss due to an inability (or reduced ability) to work due to a service-related injury or illness. Current or former ADF members (Permanent or Reserve Force), Cadet Officer, or instructor of Cadets and declared members may be eligible.

Incapacity payments represent the difference between a person's pre-incapacity ADF earnings and their actual earnings. Incapacity payments are calculated based on 100 per cent of pre-injury earnings during the first 45 weeks of payment, after which an adjustment percentage (between 75 and 100 per cent) is applied to the calculation depending on the amount of hours the person is in employment. Payments are reduced dollar for dollar by the Commonwealth-funded portion of superannuation pension, and on the same basis for any earnings from employment.

There exist a number of differences between the DRCA and the MRCA with regard to incapacity payments. The MRCA includes in the calculation of incapacity payments for former permanent forces members an amount known as the remuneration loading. This is not the case for incapacity payments calculated under the DRCA.

In addition, the incapacity payments under the DRCA are subject to a further 5% of superannuation offset. This does not take place under the MRCA. Moreover, whereas the DRCA has a maximum value for its incapacity payments, this is not the case for incapacity payments under the MRCA. The DRCA also has a complex method for ensuring that incapacity payments do not fall below a minimum value, while the MRCA simply defines the minimum pre-injury earnings to be the national minimum wage.

It should also be noted that under the MRCA, severely impaired incapacity payees, with low prospects of returning to work, have the option of choosing the Special Rate Disability Pension (SRDP). This choice is not available under the DRCA.

Such differences can result in a significant difference between the value of the incapacity payments received by a MRCA veteran and those received by a DRCA veteran, despite the two having equivalent injuries and incapacity for work.

Some example scenarios illustrating some key difference in compensation outcomes in different circumstances are provided in Annex 7.

Other possible harmonisation

A number of other areas may benefit from harmonisation between the DRCA and MRCA. Such areas will vary in complexity and in their potential impacts on one or more veteran cohorts, and would require separate detailed consideration beyond the scope of this submission.

Further opportunities to align administration could include the following:

- Terminology can be defined differently in different Acts: for example, all three Acts have different rules regarding the date from which compensation is assessed.
- There can be different policy interpretations for the legislation under each Act.
- Needs assessments under each Act are inconsistent, resulting in certain forms of evidence and information collected under one Act that may not be transferable to another.
- Claims requirements, such as the form and nature of claims, can be made uniform across the three Acts.

Annex 11 Statements of Principles and standard of proof

Statements of Principles

Statements of Principles (SoPs) are legislative instruments that set out the factors that must, or must as a minimum, exist in order to establish that the causation of a given medical condition is related to service in the Australian Defence Force.

The amendments to the *Veterans' Entitlements Act 1986* (VEA), which formally established the SoP system under the VEA were made by the *Veterans' Affairs (1994–95 Budget Measures) Legislation Amendment Act 1994*. An earlier SoPs system had been in place since 1 February 1993.

The introduction of the SoP system, for claims lodged on or after 1 June 1994, was designed to provide a more equitable and consistent system of determining claims for disability pensions for veterans and their dependants.

SoPs must be applied in determining claims under the *Veterans' Entitlements Act 1986* (VEA) and the MRCA, but not the DRCA.

At least one factor in the relevant SoP must be met in order for a claim to be accepted. SoPs are determined on the basis of sound medical-scientific evidence (SMSE) by the Repatriation Medical Authority (RMA), an independent expert statutory body established under the VEA.

A key principle and rationale behind the SoP system is to ensure that all claims for a given condition are assessed fairly, consistently, and in keeping with the available SMSE.

Two SoPs relate to each medical condition: one for operational service, this being the 'reasonable hypothesis' SoP, which may offer a greater range of factors and which may have lower exposure or time thresholds to be met in order to relate the condition to service. The other is the 'balance of probabilities' SoP, used for claims attributable to peacetime service. This SoP applies a more stringent test to the consideration of the SMSE, and the factors in these SoPs often require higher thresholds be met.

While the SoP system incorporates different standards of proof for different types of service, decision-makers are required to make all findings of fact on the balance of probabilities.

The 'standard of proof' to be applied to claims and appeals had, prior to the 1994 amendments, been varied from time to time as a consequence of policy and judicial decisions (see section on Standard of Proof in this Annex).

Furthermore, while the RMA is solely responsible for the administration of the SoP system, it does not play a role in determining individual claims. Applying SoPs, and determining whether a claimed condition can be related to service, is the role of delegates of the Repatriation Commission and the Military Rehabilitation and Compensation Commission (MRCC).

Where the RMA has not created SoPs in respect of a given condition, and it has not previously determined that the condition does not constitute a specific kind of injury, disease or death, it is still possible to lodge a claim under the VEA or MRCA. Claims for such 'non-SoP conditions' are assessed on the basis of the totality of the evidence available to the decision-maker, including specialist medical opinion. The manner in which these claims are investigated and determined is similar to that followed for claims under the DRCA.

The RMA regularly reviews the SoPs to ensure they remain consistent with developments in the SMSE. In addition, persons with relevant service and their representative organisations are entitled to request at any time that SoPs be reviewed. Where the RMA subsequently declines to review a SoP, or where the RMA declines to make or amend a SoP, there is a right of appeal to a further independent authority, the Specialist Medical Review Council.

History of Statements of Principles

The Baume Review, *A Fair Go—Report on Compensation for Veterans and War Widows, March 1994* had noted the effect of the decisions of the High Court in interpreting the 'reasonable hypothesis' test as set out in the legislation at the time (prior to the 1994 amendments).

At paragraph 3.3.4 the report states:

The reasoning of the majority of the High Court (in the Bushell decision) leads to the consequence that a claim will succeed, so long as a medical practitioner 'eminent' in the relevant field of knowledge (whatever 'eminent' may mean in that context) is of the opinion that there is a reasonable theory which connects the condition and war service. It is of no consequence that other practitioners, or more eminent practitioners or even the majority of 'eminent' practitioners are of the contrary view. Accordingly, there is now an obvious temptation for applicants and their legal advisers to go 'doctor shopping', seeking a compliant medical opinion even when it is contrary to accepted and more respected medical views.

In introducing the legislation that introduced the RMA, SMRC and formalised SoPs—the Veterans' Affairs (1994–95 Budget Measures) Legislation Amendment Bill 1994—the Hon Kim Beazley AC, in his Second Reading Speech stated that:

The bill will, in effect, define by reference to such statements of principles the concept of 'reasonable hypothesis', as it appears in subsection 120(3) of the Veterans' Entitlements Act. The result will be that a medical hypothesis linking particular kinds of injury, disease or death with war service that does not have a sound medical-scientific base will no longer be sufficient to constitute a 'reasonable hypothesis'. This will be a matter solely for the expert medical authority to determine. I stress that the opinion of a single medical expert may still be sufficient

to constitute a 'reasonable hypothesis', provided that such opinion has a sound medical-scientific base, as determined by the authority.

These changes are consistent with the ruling of the High Court that the validity of the reasoning of all medical and scientific material must be examined. They are also consistent with the regret expressed by the Administrative Appeals Tribunal and others that such complex matters are left to be determined by laymen: In this regard it has become apparent that lay tribunals do not deal with medical-scientific issues consistently and, while nominally inquisitorial, appear to adopt an approach that is inappropriate for determining medical-scientific issues that call for detailed technical knowledge.

SoPs had been used to determine compensation claims prior to their formal introduction with the amendments to the VEA made by the *Veterans' Affairs (1994–95 Budget Measures) Legislation Amendment Act 1994*.

The Repatriation Commission had concerns regarding consistency in decision making and has decided to issue SoPs to delegates to use as a guide when determining claims.

The SoPs were intended to be consistent with current medical knowledge and case law. It was not intended that they were to be blindly applied or to subvert the statutory requirements of the VEA. The delegates of the Repatriation Commission were still required to consider the facts of individual cases and once the facts were found the SoP would promote a consistent outcome for similar medical fact cases, regardless of the officer deciding the case or in which state the claim is determined.

The Repatriation Commission provided approval for the first four SoPs on 20 May 1992. The SoPs concerned prisoners of war of the Japanese, non-Hodgkin's lymphoma and Vietnam service, hearing loss and acoustic trauma and skin damage and solar exposure. Additional SoPs were issued following a symposium held in July 1992, which considered another 100 conditions that were commonly claimed by veterans.

The major aims for the introduction of the early versions of the SoPs were to:

- promote national consistency in decision making
- provide useful guidelines for Repatriation Commission delegates
- reduce appeals to the VRB and the Administrative Appeals Tribunal (AAT)
- improve the timeliness and effectiveness of decision making
- reflect the best available medical knowledge
- reflect current views on legislative interpretation.

The SoPs took effect from 1 February 1993 and were applied to claims decided on or after that date, until being formally replaced with the current arrangements in 1994.

History of the standard of proof

The predecessor to the VEA, the *Repatriation Act 1920*, as introduced made no provision for a standard of proof, but the effect of its provisions was to leave the onus of proof with the claimant.

The 1929 amendments to the *Repatriation Act 1920* established an Appeals Tribunal, which was directed to ‘give to an appellant the benefit of the doubt’ and, if the appellant could make out a prima facie case, the onus of proof shifted to the Repatriation Commission.

Further amendments to the *Repatriation Act 1920* in 1935 directed the Repatriation Commission to ‘give to an appellant the benefit of any reasonable doubt’ and, following the 1943 amendments, all decision-makers were directed to ‘give to the claimant, applicant or appellant the benefit of any doubt’ and that ‘the onus of proof shall lie on the person or authority’ who opposed the grant of the claim, application or appeal.

The 1977 amendments to the *Repatriation Act 1920* implemented a recommendation of the Toose Report to clarify the ‘standard of proof’ provision on the basis that it had been the subject of conflicting opinions.

The amendments to section 47 of the *Repatriation Act 1920* directed all decision-makers to grant a claim or application or allow an appeal ‘unless it is satisfied, beyond reasonable doubt, that there are insufficient grounds for granting the claim or application or allowing the appeal’.

While the words used in section 47 suggested that the reverse criminal standard of proof may have been applicable, in practice it was intended to provide a claimant with the benefit of any reasonable doubt as stated in the earlier version of the provision.

That interpretation was valid for the period from 1977 until the decision in *Repatriation Commission v Law*.⁵¹ The High Court held that ‘the operation of that section [the equivalent of section 47] does not involve a two-stage process and that it requires that, in relation to any fact necessary to establish entitlement, the Review Tribunal must be satisfied beyond reasonable doubt that the fact does not or did not exist before it can refuse an application or dismiss an appeal by a claimant’. The effect of the decision was to apply the reverse criminal standard of proof to the Review Tribunal.

That interpretation was further modified by the decision of the High Court in *Repatriation Commission v O’Brien*⁵², which held that even where there was no evidence pointing to a war service relationship a pension will be payable unless it is shown positively that no such connection exists.

⁵¹ *Repatriation Commission v Law* (1981) 147 CLR 635.

⁵² *Repatriation Commission v O’Brien* (1985) 155 CLR 422.

The result of the *O'Brien* decision was that it was almost impossible for the Repatriation Commission to discharge the onus of proof conferred on it by the Act in rejecting a claim as interpreted by the High Court.

To set aside the effects of the *O'Brien* decision, the 1985 amendments to the *Repatriation Act 1920* introduced the concept of the 'reasonable hypothesis' as a means of modifying the 'beyond reasonable doubt' standard. The dissenting judgment of Brennan J in *O'Brien* provided the basis for the concept.

The 1985 amendments also created the distinction between 'qualifying war service' covering overseas war service, war service in Australia that involved direct combat and operational service in Korea, Malaya, Borneo or Vietnam, peacekeeping or ADF service designated as hazardous service from all other forms of ADF service covered by the *Repatriation Act 1920*. The more generous standard of proof applied to claims for ADF members with 'qualifying war service' and those with other ADF service requiring the Repatriation Commission to be reasonably satisfied that the claim presented material that raised a 'reasonable hypothesis' that the incapacity or death was related to war service.

The 1985 amendments also imposed a 40-year limit on the application of the more generous standard of proof for claims by dependants where the veteran or member has died. Where the death occurred 40 years after the eligible service the less generous standard of proof was applicable.

The VEA on its introduction in 1986 required the decision-maker to turn to section 120 of the VEA to identify the standard of proof applicable to the determination of the causation question; that is, whether injury, disease or death was caused by war. The 40-year limit that applied to claims by dependants was not imposed in the VEA. In delivering the Second Reading Speech for the Veterans' Entitlements Bill 1985, the Minister (for Aboriginal Affairs) stated that:

Having regard to the many strong representations about the alleged discrimination involved in maintaining a 40-year rule and applying the civil standard of proof to certain war widows' pension claims after that period, the Government has decided not to pursue this proposal.

The 'reasonable hypothesis' concept as applied under section 120 was considered by the High Court in *Bushell*, which considered how conflicting medical evidence is to be handled in applying the 'reasonable hypothesis' test. The High Court determined that:

[a] case must be rare where it can be said that a hypothesis, based on the raised facts, is unreasonable when it is put forward by a medical practitioner who is eminent in the relevant field of knowledge. Conflict with other medical opinions is not sufficient to reject a hypothesis as unreasonable.

In response to the decision in *Bushell* the then Minister for Veterans' Affairs, Senator the Hon John Faulkner established the Veterans' Compensation Review Committee on 13 August 1993. The report of the Committee, *A Fair Go—Report on Compensation and War Widows*, was released in March 1994.

In regard to the standard of proof the Committee stated that the standard of proof was 'confusing and complex to apply, is subject to wide interpretation in the Courts, is excessively generous and offers potential for exploitation through "doctor shopping".'

The Committee recommended that:

The current standard of proof in s 120(1) and (3) is replaced by a simple, easy to apply 'reasonable satisfaction' test with a beneficial addition that if a decision maker is in balance and undecided, the benefit must be given to the veteran and the claim granted ...

The intention of this amendment is to move away completely from the inappropriate and confusing reverse standard with the reasonable hypothesis test. The aim is to use a test which already is well tested but to make it more beneficial than usual ...

The Committee's recommendations were not adopted and the amendments that formally adopted the SoPs were made by the *Veterans' Affairs (1994–95 Budget Measures) Legislation Amendment Act 1994*.

The amendments included a new section 120A, which modified the operation of subsections 120(1) and (3). Section 120A of the VEA affects both subsection 120(1) and subsection 120(3) by prescribing the circumstances in which a decision-maker is permitted to form the opinion contemplated by subsection 120(3), namely, that the material before the decision-maker raises a reasonable hypothesis connecting an injury, disease or death with the circumstances of a veteran's particular service.

Subsection 120A(3) directs the decision-maker that, where there is a relevant SoP, it can conclude that there is a reasonable hypothesis only if the SoP 'upholds the hypothesis'.

Annex 12 Impairment assessment across Acts

Under DVA's legislative framework, impairment is compensated across three Acts. Depending on the nature and timing of a veteran's service, they may be entitled to compensation under one or more Acts.

Permanent impairments and the inability to work are compensated differently under the three Acts.

VEA	DRCA	MRCA
Fortnightly, tax-free disability pensions that can compensate for both the effects of the injury or disease and also the loss of ability to work	Permanent impairment payments that compensate for the effects of an injury, paid as a lump sum only AND Incapacity payments that compensate for an inability to work	Permanent impairment payments that compensate for the effects of an injury or disease, paid as a periodic entitlement with the option to convert whole or part to a lump sum AND Incapacity payments that compensate for an inability to work
Disability pension assessed using the Guide to the Assessment of Rates of Veterans' Pensions 5th Edition.	Permanent impairment assessed using Part 2, Edition 2.1 of the Comcare Guide to the Assessment of the Degree of Permanent Impairment.	Permanent impairment assessed using the Guide to the Assessment of Rates of Veterans' Pensions (modified) 5th Edition.

Under all Acts, veterans must meet a permanent impairment percentage threshold before compensation can be paid. Both the VEA and MRCA operate using a whole-of-person impairment methodology, meaning that a person's impairments are combined using a formula and a person can only be compensated up to 100% of whole-of-person impairment for their combined impairments.

On the other hand, under the DRCA, each injury is looked at in isolation, meaning that a person can notionally receive more than 100% whole-of-person compensation where they have multiple serious injuries. However, this also means that a person with DRCA entitlement cannot combine several small injuries to meet the threshold for compensation to be paid.

Annex 13 Reviews and appeals

Merit review framework

DVA has a robust merit review process across the three Acts. Wherever a veteran believes a decision is wrong, they have the right to request a review of that decision. The options available to a veteran to request an appeal will depend on which legislation the decision has been made under.

Under the DRCA, veterans can request an internal review by a reconsiderations officer who was not involved with the initial claim, who can re-examine the case. Where the veteran is still dissatisfied, they are able to appeal to the Administrative Appeals Tribunal (AAT).

Under the VEA, for compensation matters, a pathway of appeal to the Veterans' Review Board (VRB) exists; however, the Commission may, after compilation of the report of evidence in preparation of the VRB hearing, decide to review the case in the applicant's favour before a VRB hearing takes place.

Prior to 1 January 2017, MRCA claimants had a choice to pursue either a review by the VRB or a reconsideration by another DVA officer. Since 1 January 2017, the appeal arrangements for MRCA claimants have replicated the provisions under the VEA, offering a single appeal pathway to the VRB.

The VRB is an independent statutory body. Whenever it decides a case, the VRB must apply the law as set out in the VEA or the MRCA, as well as any other related legislation. Appeal from the VRB is to the AAT.

Claimants who are not satisfied with an AAT decision can appeal on questions of law to the Federal Court of Australia and then, by special leave, to the High Court of Australia. The Commission can appeal against decisions of the VRB to the AAT or against AAT decisions to the Federal Court or High Court.

The *Legal Services Directions 2017* provide that the model litigant obligation does not prevent the Commonwealth and Commonwealth agencies from acting firmly and properly to protect their interests. This gives the Repatriation Commission or the MRCC the ability to lodge appeals against decision of the VRB to the AAT or decisions of the AAT to the Federal Court in order to clarify a legal issue or to protect the integrity of the legislation.

Appeal pathways

Aligning the appeal pathway for DRCA

Alignment of the appeal pathway could also be considered; that is, an appeal pathway for DRCA veterans through the VRB and then the AAT.

Given that the MRCA and VEA appeal pathway processes are aligned, it may be appropriate to similarly align the DRCA appeal provisions.

The single appeal pathway under the VEA and MRCA would, if replicated in the DRCA, simplify and streamline the appeal process overall, making it easier for veterans to understand the system. Where multiple entitlements occur, there would be just one process for all claims.

For the DRCA, a refined appeal pathway would provide the claimant with the opportunity to appeal the reconsideration by the MRCC to the VRB with a right to appeal that decision to the AAT.

This type of change would align the DRCA with the MRCA. The amendments to the MRCA were recommended by the RMCA.

Alternative dispute resolution

Alternative dispute resolution (ADR) is an integral part of the appeal pathway, as it allows the VRB to resolve a large number of cases without the need for a full VRB hearing. ADR now operates in all states except Queensland.

As at the end of December 2017, more than 70% of matters that were referred to an ADR process were finalised without the need for a hearing. This figure is expected to increase as older, non-ADR applications are transitioned out and ADR is extended to Queensland.

There is scope for the use of ADR processes in DVA's primary claims and internal review processes, and so reduce the number of applications for merit reviews to the VRB or AAT. The use of ADR processes would ensure that issues can be better understood by DVA, and resolved from the claimant's perspective, at an early stage.

Given that one purpose of the VRB was to provide a more veteran-friendly process than that offered through the AAT, there may also be scope to enhance VRB processes to provide an even more veteran-friendly experience.

Appeal processes

Other review and appeal processes that presently have different provisions under the three Acts, and therefore could be considered for alignment, include:

- how to make an appeal
- time frame to lodge
- internal review rights
- time periods to lodge AAT appeals or for decisions to be in force before a new claim can be lodged.

Analysis of appeals

An annual statistical analysis is conducted on VEA, DRCA and MRCA compensation decisions that are set aside or varied by internal or external reviews. This ongoing statistical analysis shows that the overwhelming number of decisions made by Commission delegates are *not* appealed, set aside or varied.

Given the time it takes for veterans to consider and lodge an appeal and for the review to proceed, determinations reviewed in a year may not be those determined in the same financial year.

The percentage of primary determinations that went through an appeal (internal and/or external⁵³) has reduced from 13.4% in 2012–13 to 10.2% in 2016–17.

There has also been a decrease in the number of appeals set aside or varied from 39.9% in 2012–13 to 35.7% in 2016–17.

In addition, the percentage of set-aside or varied decisions as a proportion of all primary determinations remains low (5.3% in 2012–13 to 3.6% in 2016–17) and illustrates that most initial decisions are correct.

Administrative Appeals Tribunal appeals

Under the DRCA and MRCA, approximately 80% of appeals relate to claims for initial liability for an injury or illness and claims for permanent impairment compensation. Other appeals relate to benefits, including weekly incapacity benefits for inability to work, household and attendant care services, alterations to home or motor vehicle, and medical treatment expenses.

Under the VEA, a large proportion of appeals similarly relate to claims for recognition of injury or illness and assessment of disability benefit, including intermediate/special rate pension claims. Other appeals under the VEA include claims for service pensions.

There has been a gradual decline⁵⁴ over a number of years in the number of AAT applications made under the VEA; in 2014–15, for example, there were 270 AAT applications made under the VEA compared with 138 in 2017–18. The reduction in AAT appeals under the VEA is related to a number of factors, including the gradual declining number of VEA veterans (mainly veterans of the second World War), and the introduction of the MRCA.

In the case of the MRCA, appeal numbers have remained low⁵⁵, with only 55 appeals made in 2017–18, compared with 66, 89, and 112 respectively in each of the previous three years. This could reflect the introduction of the Single Appeal

⁵³ VRB or AAT

⁵⁴ Source: DVA

⁵⁵ Source: DVA

Pathway on 1 July 2017, as well as the introduction of Alternative Dispute Resolution (ADR) processes in the VRB across most of its VRB state registries.

During AAT appeal proceedings, applicants are afforded considerable opportunity to provide factual and medical evidence in support of their appeals. There is also opportunity to 'refine' and revise contentions made in support of claims and to seek up-to-date medical assessments of impairment levels. Accordingly, the reasons why decisions are overturned may include the emergence of new medical evidence, new assessments of the level of impairment ratings, changes to the approach taken in support of a claim liability, and changes in the criteria for assessing liability in a new SoP.

Applications to the AAT and the outcomes are set out in Table 3 (including cases that were remitted by the Federal Court to be considered again by the AAT).

Although the number of AAT decisions that were affirmed at the hearing are lower than compared to the number decided, not all were decided following an AAT hearing. Some appeals were withdrawn and others were resolved without the need for a hearing.

Table 3 VEA, SRCA and MRCA matters considered by the Administrative Appeals Tribunal in 2016–17⁵⁶

Category	Applications decided by AAT	Decisions affirmed, withdrawn, or dismissed by the AAT	Decisions settled by consent of the AAT	Decisions set aside at hearing
VEA	191	141	a	a
SRCA	84	61	20	3
MRCA	44	27	16	1

a. VEA decisions set aside and settled by consent: 50.

Some of the reasons identified for cases being set aside or varied include:

- the approach taken by applicants and representatives to the matters on which review will be sought
- the extent to which intervention occurs by the relevant Commission under s 31 of the VEA or s 347 of the MRCA
- the adequacy of information presented to primary decision-makers
- the nature and extent of new material presented on review
- changes to SoPs between the primary decision and that made by the Board, or a shift in focus by the applicant to a different factor in the SoPs

⁵⁶ Source: DVA

- changes in an applicant's degree of incapacity or impairment between the date of the decision under review and the date of the final hearing at the VRB in an assessment or compensation matter.

For 2016–17, seven cases were determined by the Federal Court, of which five had been lodged by the veteran or widow with the other two being appeals by the MRCC to rectify errors in VRB decisions. The Full Federal Court made only one decision during the period, the matter of *Repatriation Commission v McDermid*.⁵⁷ The decision was favourable to the Repatriation Commission. The Federal Court at first instance had made a decision that had the potential to impact the way offsetting was administered under the VEA. The Full Court's decision restored certainty in this area.

The High Court did not deliver any decisions, but did refuse an application for special leave to appeal from the Full Court decision of *Repatriation Commission v McDermid*.

Use of alternative dispute resolution pathways in appeal mechanisms

The AAT has well established ADR mechanisms aimed at resolving appeals without the need for a formal hearing. DVA engages fully with the AAT's ADR processes and has established 'bulk' listings arrangements of conciliation conferences with the AAT where multiple AAT cases are listed on consecutive days with a senior DVA officer attending each conciliation conference.

⁵⁷ *Repatriation Commission v McDermid* [2016] FCAFC 179.

Annex 14 Compensation issues

Adequacy of TPI compensation under the VEA

There have been calls for part of the VEA Special Rate Disability Pension (commonly known as the Totally and Permanently Incapacitated or TPI pension) to be classified as ‘economic loss compensation’ and increased to the level of the after-tax national minimum wage ‘as compensation for the economic loss they suffer due to their physical and psychological conditions’.⁵⁸

One such proposal would result in an increase in the ‘above general rate’ component of the TPI pension by around \$350.00 per fortnight, an increase from \$884.70 to \$1,233.80 per fortnight, the after-tax national minimum wage.

However, the TPI pension is currently not taxable, nor is it included in the income test for income support payments, nor offset by Commonwealth-funded superannuation, and it is payable past age pension eligibility age. All of these aspects would change under this proposal.

For example, treating a component of the TPI pension as economic loss compensation would make it comparable to other forms of economic loss compensation, such as incapacity payments under the MRCA and DRCA. The different treatment of these MRCA and DRCA payments, if similarly applied to this part of the TPI pension, would result in a reduction in payments for some TPI pension recipients.

Further, more than 80% of TPI pension recipients are above the age pension age. Aligning the TPI pension with the rules applying to other economic loss compensation payments (specifically, that they apply during working age) would mean its cessation at age pension age, currently 65.5 years.

Other similar alignment aspects, such as taxation treatment and indexation would also need to be applied to the TPI pension, which may also result in unfavourable outcomes for some recipients.

It is worth noting that the TPI pension was developed in 1920, before modern worker’s compensation arrangements had been established. As such, changes that attempt to apply some elements of modern workers’ compensation arrangements to the TPI pension would impact on the whole VEA Disability Pension scale.

A similar restructure of the Disability Pension was proposed in the Clarke Review⁵⁹, but was subsequently rejected by the Government.

⁵⁸ www.tpivic.com/about-us/tpi-federation

⁵⁹ Clarke, Rec. 80

The service differential in military compensation

A service differential, or a different benefit in military compensation according to whether a claimant had experienced operational (war or warlike service) or non-operational service (often called peacetime service) has been a feature of military compensation in Australia since the original Repatriation Act in 1920.

The service differential is reflected in the system in several ways:

- Access to the VEA has primarily been for operational service (noting that the VEA was extended to peacetime service between 1972 and 1994).
- Access to the DRCA is primarily for peacetime service (noting the DRCA was made available for operational service from 1994 to 2004).
- There are two standards of proof in the VEA and MRCA for deciding the link between service and injury or death: the 'reasonable hypothesis' standard for operational service and the 'balance of probabilities' standard for non-operational service. For DRCA claims, only the 'balance of probabilities' standard applies.
- There are two SoPs for each medical condition: one for the 'reasonable hypothesis' standard of proof and one for the 'balance of probabilities' standard of proof.
- There are different levels of permanent impairment compensation under the MRCA—see below.

The service differential in permanent impairment payments in MRCA

Under the MRCA, different permanent impairment compensation amounts result from the same impairment rating and lifestyle effects, depending on whether the service injury is suffered or the service disease is contracted on warlike or non-warlike service (operational service) or peacetime service. A higher permanent impairment compensation payment is made for operational service.

The difference at the low end of the scale is consistent at about 80 per cent (i.e. the rate for operational service is 180 percent of the rate for peacetime service). For more severely impaired claimants (50 or more impairment points), the difference in percentage terms between the compensation amounts diminishes. For claimants with severe impairment (80 or more impairment points), compensation amounts are the same for both operational and peacetime service.

In 2011, the RMCA considered the issue of a differential based on the nature of service. The RMCA presented a split recommendation to the Government—one to keep the differential in its current form, the other to modify it so that the difference

between the types of service is not as pronounced. The Government accepted the recommendation to keep the status quo.

Why should a service differential exist?

Veterans who participated in operational (war or warlike service) have strongly suggested that the nature of their service, compared to non-operational service, warrants special recognition in the way compensation is provided. At the same time, other veterans suggest that it is unfair to not provide the same level of compensation for the same kind of impairment.

In addition to the service differential in DVA's compensation arrangements, Defence recognises a service differential through rates of pay, service conditions, and housing.

As it stands, retaining the service differential for compensation has the benefit of the status quo; changing the arrangement would notionally result in a fairer and more equal outcome to veterans regardless of their service status (and would also reduce some MRCA permanent impairment system complexity). However, such a change would almost certainly attract opposition from many individual veterans and from ESOs, given that the nature of operational service would no longer be recognised through this form of compensation.

The 'permanent and stable' requirement for permanent impairment compensation under MRCA and DRCA

Both the MRCA and the DRCA require that a person's accepted condition/s be 'permanent and stable' before any final payment of Permanent Impairment (PI) compensation can be made. Many conditions will have periods where symptoms may be more or less severe, including fluctuations of symptoms or 'spikes' as part of their normal manifestation.

The permanence and stability of conditions needs to be considered in terms of whether there is likely to be a significant improvement or deterioration. 'Permanent' means that the condition is not likely to resolve. 'Stability' simply means it is unlikely to change (improve or worsen) to any major degree.

Where a condition is found to be permanent but not stable, the MRCA and DRCA offer interim permanent impairment compensation payments, a baseline payment that may be increased through finalised permanent impairment payments on the condition of being stable. The recent introduction of streamlined PI payments applies to the MRCA only (see Annex 15).

The RMCA considered concerns raised around the requirement for MRCA conditions to be stable before PI compensation was payable. It was considered that this requirement was causing delays in veterans receiving PI compensation.

At the time, the RMCA confirmed that the stability requirement was sound policy under the MRCA.

The RMCA believed that greater use of interim PI compensation payments would alleviate concerns around delays created by the requirement for impairment to be stable, and recommended their use accordingly. As a result, DVA encourages delegates to consider opportunities to pay interim PI compensation.

A recent policy change allows for DVA to pay interim PI compensation of at least 10 impairment points, where certain mental health conditions have been assessed as permanent but not yet stable.

VEA special rate/incapacity payments or SRDP

An issue that reflects the complexity of dual or tri-Act eligibility and different legislative requirements in the different Acts relates to cases where inability to work has to be assessed under multiple Acts and the inability to work is due to several conditions individually accepted under different Acts.

The VEA Special (Totally and Permanently Incapacitated) Rate has a criteria that a veteran's inability to work must be due to their VEA service-related conditions alone. Incapacity payments under DRCA and incapacity payments/Special Rate Disability Pension (SRDP) under MRCA are paid for inability to work as a result of a contribution to that incapacity from DRCA/MRCA conditions. In some cases, where more than one condition affects ability to work, and the conditions are accepted under different Acts, the provisions can be perceived to disadvantage a veteran.

Economic loss compensation under the MRCA and DRCA

The SRDP under the VEA compensates veterans for their inability to work and is the same rate for all eligible veterans. In comparison, under the DRCA and MRCA, economic loss payments in the form of incapacity payments are aligned with the veteran's actual earnings before their injury.

It is worth noting that DRCA and MRCA incapacity payments cease if and when a veteran is no longer incapacitated, usually following a course of rehabilitation. This reflects these modern Acts' focus on rehabilitation. The Special Rate under the VEA, conversely, is paid for life (that is, it does not cease at age pension age), with the understanding that the veteran's war-caused conditions are totally and permanently incapacitating (eligibility for TPI ceases should DVA become aware that the veteran can work more than eight hours per week).

However, while eligibility for incapacity payments requires service-related conditions to be a contributory factor to a veteran's incapacity, eligibility for the Special Rate under the VEA requires war-caused conditions to be exclusively responsible for an inability to work.

Also available under the MRCA and DRCA is a form of income support known as the Veteran Payment, which can be accessed prior to the acceptance of liability.

The difference in compensation structures between the Acts (VEA vs DRCA and MRCA) can be confusing and presents challenges in multiple-Act eligibility cases.

The relevance of the Special Rate Disability Pension in MRCA

The SRDP was built into the MRCA as a safety net to ensure that former members, unable to work because of accepted disabilities, would have access to benefits that are equivalent to the Special Rate of Disability Pension under the VEA.

SRDP is an ongoing, tax-free amount payable for life, and is designed to provide a similar safety net to the VEA Special Rate, but with offsets for Commonwealth superannuation, VEA disability pension and MRCA and DRCA permanent impairment compensation payments. Incapacity payments, in comparison, are based on a person's pre-injury earnings, are taxable, and are generally only paid to age 65.

There has been a steady increase in the number of SRDP eligibility decisions over each year of the scheme—with approximately 300 veterans eligible to date. However, only a small proportion of veterans make the choice to receive SRDP, and of those, only a few receive a greater than nil amount after offsetting (see Annex 9 for more information on offsetting). As such, it is questionable whether the financial safety net objective is being achieved with the SRDP in its current form.

Also, it could be argued that the SRDP, as a disability payment that acknowledges the veteran is not returning to work, is a poor and awkward fit in MRCA with its rehabilitation focus.

In 2011, the RMCA recommended that the SRDP be reviewed and this was accepted by the Government. This review was undertaken between 2015 and 2017, but no outcome has yet been reached.

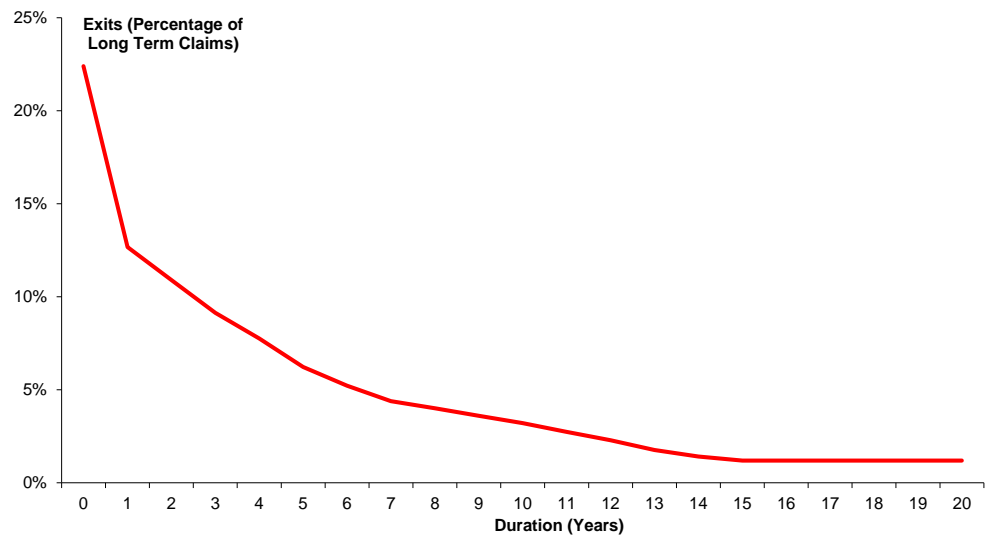
A research project is under way that is attempting to better identify the needs of SRDP-eligible veterans, noting that the SRDP is a complex arrangement where eligible veterans need to make a difficult one-off decision to choose SRDP for life, or choose incapacity payments to age 65.

Incapacity payments—incentives for rehabilitation

The RMCA considered the issue of the relatively high level of incapacity payments under the MRCA. For the first 45 weeks of incapacity, former ADF members receive 100% of their normal (pre-injury) earnings. After this period, the percentage varies from 75% to 100% of pre-injury earnings. This high level of payment, which often includes allowances, was considered by the RMCA as a potential disincentive for some former ADF members to undertake rehabilitation and return to the workforce.

The RMCA considered that this issue would require further investigation and consideration.

Figure 7 Long-term incapacity exit rates (selected exits, 2015)



As can be seen in the graph above, there is a relatively fast exit rate from incapacity payments in the first 12 months, with a much more gradual decline from that point on. The rate declines further at around seven years at 5%, and is virtually stagnant at 1–2% by 15 years.

This suggests that early rehabilitation measures in the first year presents the best opportunity to return a veteran to employment. Once much beyond that window, there is a stronger likelihood that the veteran will stay on incapacity payments.

Annex 15 DVA's rehabilitation services for veterans

Rehabilitation services provided by DVA

DVA's whole-of-person focus considers all aspects of a person's life in an effort to return a person to health, personal and vocational status similar to that before they were injured or became ill.

The whole-of-person approach has three elements:

- **medical management:** assisting a veteran with an understanding of and possible strategies to deal with, their overall physical and psychological health
- **psychosocial support:** assisting a veteran with their quality of life and independent functioning
- **vocational support:** assisting a veteran to return to sustainable and meaningful employment when ready.

DVA's focus is not about arranging an employee's return to 'the same job, same employer' after a service-related injury or disease, as a return to service is not necessarily possible or desirable.

The approach taken to rehabilitation has similarities with some international jurisdictions:

- The United States recently introduced legislation with a focus on education benefits for service members, veterans and their families.
- Veterans in New Zealand have access to rehabilitation through a universal compensation system, in addition to further benefits and services offered by New Zealand Veterans' Affairs. When developing a rehabilitation plan for a client, New Zealand Veterans' Affairs will consider the social, physical, emotional and spiritual aspects of rehabilitation, which has some similarities with DVA's whole-of-person approach.
- Veterans' Affairs Canada also approaches rehabilitation from a whole-of-person perspective and offers all three of medical, psycho-social and vocational rehabilitation to eligible people.

DVA case management pilot

A new DVA case management pilot aims to provide whole-of-person case management service via personalised, tailored assistance to two groups of veterans and their families:

- recently transitioned veterans who leave medically or administratively and who have complex medical and non-clinical needs
- veterans who have transitioned some time ago who may have fallen into crisis.

The pilot will involve 100 veterans in the first year and 200 in the second year. DVA's intention is to use a mixture of internal and external case managers who with the support of a multidisciplinary clinical team, to help the veterans participating to achieve personal goals for the immediate period.

Veterans and Veterans Families Counselling Service

The Veterans and Veterans Families Counselling Service (VVCS) has been the cornerstone of the Government's veteran mental health support response for 35 years. Its structure and function has evolved, in line with both the expectations of the expanding client base and increased sophisticated understanding of best-practice treatment of military mental health issues. To ensure it is well placed to respond to the increasing demand, VVCS continues to evolve and adapt its services with agility and a veteran-centric focus.

VVCS provides free and confidential counselling and mental health support. Access to the service has expanded significantly since 2014, beyond just individuals with operational service: all current and former ADF personnel with at least one day's continuous full-time service, as well as their families, can access VVCS for life. Reservists and their families, where they are eligible for a non-liability White Card, can also access these services. In addition, VVCS provides mental health first aid, as a duty of care, to any individual from the veteran community.

VVCS provides direct counselling and support through an integrated 24/7 national network, including 25 centres located across Australia, and a network of more than 1,200 outreach counsellors nationally. The VVCS service offers:

- counselling for individuals, couples and families
- case coordination for clients with complex needs
- group programs to develop skills and enhance support
- an after-hours telephone counselling line
- information, education and self-help resources, including social media and a website
- referrals to other services or specialist treatment programs.

VVCS expansion

Veteran eligibility for VVCS has expanded, most recently in 2016 and 2017. The most recent expansion, part of the 2017 Budget, extended access to:

- the partners and children of current and former ADF personnel who hold a Repatriation Health Card—Gold or White—for an accepted mental health condition. This will assist with early engagement and intervention both for ADF personnel and their families
- the former partners of current and former ADF personnel for a period of five years following separation, or for the duration of co-parenting responsibilities for a minor. This will minimise the ongoing adverse effects of family breakdown on all parties.

As part of its duty-of-care responsibility, VVCS does not turn away members of the current and former serving community in crisis or distress. VVCS will provide compassionate and/or duty-of-care support until a referral to a more appropriate service can be made.

The 2016 Budget expansion came into effect on 1 April 2017, which extended VVCS access to:

- family members of current and former ADF members who die by suicide or reported suicide
- siblings of ADF members killed in service-related incidents
- Defence Abuse Response Taskforce complainants and their families
- adult children (over the age of 26) of post-Vietnam War veterans.

Services for dependants, families and carers

DVA assists veterans and their partners through the transition process from the ADF to civilian life and beyond. Veterans who suffer service-related mental and physical injuries often have complex needs, and can require assistance to navigate and adjust to ordinary life. There is growing recognition that families play a crucial role in supporting veterans to achieve their rehabilitation goals, and to help them return to an active, fulfilling life following their ADF service.

The report of the 2017 Senate Inquiry made a number of observations reinforcing the crucial role that veterans' partners play in supporting them in their transition to civilian life.

As a result, Recommendation 19 of the Senate Inquiry confirmed the need for DVA to review support for veterans' partners, and stated the review should include services such as 'information and advice, counselling, peer support and options for family respite'.

War or defence widow/ers and dependants who are Gold Card holders can access treatment and services in the same manner as any veteran who has a Gold Card. They can also access Veterans' Home Care services.

In addition, if a war or defence widow/er and dependant has eligibility under MRCA and their ADF partner/parent died while deployed on warlike or non-warlike service, they can also access bereavement support services. This is not available to war or defence widow/ers and dependants with eligibility under the VEA or DRCA.

Widow/ers and dependants not eligible for the Gold Card may be eligible for treatment and services through other government agencies, such as Medicare and the Department of Health's Commonwealth Home Support Program or the National Disability Insurance Agency.

Extended family support for veterans

The Family Support Package was introduced on 1 May 2018. This package is available to eligible veterans and their families, and to spouses or partners of veterans killed in recent conflicts or who have taken their life after returning from warlike service.

The program was introduced in response to recommendation 19 of the Senate Inquiry report *The Constant Battle: Suicide by Veterans*.

The additional assistance provides for:

- expanded childcare arrangements in specific circumstances
- counselling support for the immediate family members of veterans experiencing crisis
- home help and counselling support for the spouses or partners of veterans who died in recent conflict or from suicide after returning from conflict.

Other support for families

Other support for families includes:

- education schemes for the children of veterans, which include financial assistance, student support services, guidance and counselling
- Long Tan Bursary, which supports children of Vietnam veterans to meet the cost of post-secondary education (and from July 2019, is being extended to the grandchildren of Vietnam veterans). Eligibility is subject to criteria being met
- veteran and community grants, which support organisations to deliver activities and services that sustain or enhance the health and wellbeing of the veteran community.

In addition, a range of other measures, including counselling and carer support are provided (such as VVCS, discussed above).

Incapacity payment 'return to work' incentives

The streamlined access to incapacity payments initiative aims to:

- provide veterans with mental health conditions accepted under the MRCA with rehabilitation support for 12 months following their return to work
- provide these veterans with access to income replacement compensation as soon as possible should they be unable to continue to work due to their mental health conditions.

The initiative intends to provide increased support to veterans who are testing their ability to return to work, or concerned that they may experience financial stress if they need to leave their employment because of their accepted mental health conditions.

This initiative is guided by evidence about the health benefits of meaningful employment, which has demonstrated that employment is as much part of a person's recovery from injury as it is a positive outcome of rehabilitation. Many of DVA's rehabilitation success stories highlight how important employment has been in helping veterans get their life back on track after a service-related injury or disease.

DVA currently offers an Employer Incentive Scheme, which involves a series of payments over 12 months, in the form of subsidies to third-party employers who provide employment to eligible veterans.

Annex 16 DVA's support to transitioning veterans

Financial support

Compensation

Current and former service ADF members may be eligible for compensation payments if they have sustained physical or psychological impairment or incapacity related to their defence service.⁶⁰ DVA encourages the lodgement of claims for any health condition veterans believe is related to their military service. On-base advisors are on military bases to support current and transitioning members to understand their entitlements prior to separation.

There are a range of compensation payment types available from DVA, including disability pensions, permanent impairment payment, incapacity payments, compensation following death, or war widow/ers' pension.

Of particular note for transitioning members, current or former ADF members who are totally or partially incapacitated for service or work as a result of a service-related injury or illness, may be eligible for incapacity benefits. These benefits are payments for economic loss due to the inability (or reduced ability) to work because of an injury or disease that has been accepted as service related under the MRCA or the DRCA.

For military compensation, DVA relies on information from Defence in order to ensure liability can be determined, and that correct incapacity payments are payable.

Income support

Medically transitioning members may be eligible for the invalidity service pension. This pension provides income support to Australian, Commonwealth and allied veterans and mariners who are considered permanently incapacitated for work due to medical factors, and who are not yet entitled to an age pension.

The Veteran Payment is also available to provide interim income support for those who have lodged a claim for a mental health condition under either MRCA or DRCA, are under age pension age, and are incapable of working for more than eight hours per week.

⁶⁰ Medical treatment can also be included as compensation under MRCA and DRCA.

Home ownership programs

Transitioning from the ADF may change members' entitlements under the Defence Home Ownership Assistance Scheme and may mean moving out of Defence-provided rental properties or giving up Defence rental assistance. Transitioning members may be eligible for subsidised housing loans, home support loans and associated insurances provided through DVA.⁶¹

Support to manage health needs

DVA health cards

DVA issues health cards to eligible veterans, their widow/ers and dependents.

Gold Cards ('DVA Health Card—All Conditions within Australia' and 'DVA Health Card—Totally & Permanently Incapacitated') provide access to a wide range of public and private health care services for the treatment, at DVA's expense, of all health care conditions, whether they are war- or service-related or not.

White Cards ('DVA Health Card—Specific Conditions') provides access to a wide range of public and private health care services for the treatment, at DVA's expense, of disabilities and conditions that have been accepted as war- or service-related.

Veterans who are former members of the ADF can also access treatment via a White Card for any mental health condition, cancer (malignant neoplasm) and pulmonary tuberculous, irrespective of whether the conditions are service related or not (note there are eligibility requirements for cancer and tuberculosis).

It should be noted that many veterans and dependants do incur some out-of-pocket expenses for pharmaceuticals.

Transition Taskforce

Recognising the importance of establishing transitional arrangements from the ADF that achieve the best outcomes for veterans and their families, the Government established a joint Department of Defence and DVA Transition Taskforce to examine the barriers to effective transition from military service and to identify opportunities for improvement.

The Taskforce was made up of current and former serving ADF members and representatives from key areas within Defence, DVA and the CSC.

⁶¹ www.dva.gov.au/loans-and-insurance

The Senate Foreign Affairs, Defence and Trade References Committee, in its 2017 report, *The Constant Battle*, recommended that the Transition Taskforce examine and address:

- any gaps in medical services or income support for veterans in transition or immediately following transition
- barriers to employment for veterans who are transitioning, such as workers' insurance issues and civilian recognition of qualifications, skills and training
- disincentives for veterans to undertake work or study resulting from the legislative or policy frameworks of DVA.

The Taskforce engaged with approximately 600 transitioning and recently transitioned veterans and their families to better understand the transition experience. The Taskforce also sought the views of ESOs, government stakeholders, and other relevant professional organisations.

Through these engagements, the Taskforce identified five key streams of focus, including:

- **service provision:** enhancing services and support available, streamlining supporting processes and integrating service delivery wherever possible
- **preparation:** providing greater scope for a member's preparation prior to transition from military service and building on best-practice models
- **information:** ensuring that transition from military service information is more accessible, more engaging, and easy to find and understand
- **employment:** aiming to better connect veterans with employment, connect employers with veterans, and connect veterans with each other
- **families and caregivers:** viewing families and caregivers as individuals in their own right and supporting them through transition from military service.

Defence and DVA are now working together on a range of initiatives to improve transition and support the work of the Taskforce, including DVA's transformation agenda and Defence's Transition Transformation program.

Taskforce learnings are already informing activities, including:

- **The Transition Health Assessment.** A Defence-led pilot, but designed and agreed by DVA and the CSC. It is testing more integrated ways in which medical assessments can be consolidated and streamlined.
- **The Special Operations Forces Pilot.** A DVA-led pilot testing an improved approach to transition and the way DVA provides support services for ADF members and their families, looking at wellbeing and whole-of-person outcomes.

- **The Case Management Model.** A proposal to test two case management models that seek to provide additional support to vulnerable, at-risk veterans.

The MRCA Rehabilitation Long-Term Study

The MRCA Rehabilitation Long-Term Study is a joint DVA – Department of Defence project. The project will examine the effectiveness of rehabilitation arrangements under the MRCA within both the Australian Defence Force and DVA over the long term. The project is led by DVA, but with shared governance oversight and funding from both agencies.

Outcomes from the study will help inform critical success factors for rehabilitation, and will provide DVA and Defence with a clear understanding of the effectiveness of current rehabilitation programs and services.

Given the breadth of activity currently occurring as part of DVA's transformation program and response to the Foreign Affairs, Defence and Trade Committee's report on the inquiry into suicide by veterans and ex-service personnel, commencement of the work has been deferred until 2019–20. However, the study design framework has been completed, and data analysis and development of a research plan is being progressed in preparation.

Prime Minister's Veterans' Employment Program

In recognition of the importance of civilian employment to veterans, the Prime Minister launched the Prime Minister's Veterans' Employment Program in late 2016, with funding of \$2.7 million provided in the 2017–18 Budget.

This program aims to raise awareness of the unique skills and experience that veterans can bring to civilian workplaces, and to increase employment opportunities for veterans in the private sector.

There are six components of the program:

- Industry Advisory Committee on Veterans' Employment (IAC)
- Prime Minister's Veterans' Employment Annual Awards
- Ex-service Organisation Industry Partnership Register
- Department of Defence and DVA initiatives
- Australian Public Service initiatives
- Department of Jobs and Small Business initiatives.

The IAC is providing advice on practical measures to embed veterans' employment strategies into the recruitment practices of Australian business. In its first year, it has focused on four priority areas, including:

- data, research and targets
- human resources policies, accreditation, retention and translation of skills
- communication (branding, awareness, transition seminars, website, job fairs)
- spouse employment.

The inaugural Prime Minister's Veterans' Employment Awards were held in March 2018, and will be conducted annually to help promote the key messages of the Program.

A further \$8.3 million was recently provided for this program in the 2018–19 Budget.

Early Engagement Model

The aim of the Early Engagement Model (EEM) is to ensure current and former ADF members are known to DVA now and in the future, to facilitate earlier access to DVA services and support.

Under the EEM, members who joined the ADF from 1 January 2016, and those who separated from the ADF after 27 July 2016 are now being registered with DVA.

Welcome emails have been sent to 11,095 newly enlisted ADF members, informing them of DVA's services.

This includes approximately 15,000 current and former ADF members who have not made a claim or otherwise approached DVA.

The arrangement⁶² provides authorisation for Defence personnel to disclose personal information held by Defence about a Defence member to DVA, including:

- Information about the Defence member's enlistment in, or appointment to, the Royal Australian Navy, Australian Army or the Royal Australian Air Force, or
- if a Defence member:
 - (1) is involved in a serious incident
 - (2) is to have their service in the ADF terminated administratively on medical grounds, or for any other reason that involves the use of prohibited substances or the misuse of alcohol⁶³
 - (3) commences the process to transition from permanent or continuous full-time service (CFTS) in the ADF

⁶² Defence Military Personnel Manual

⁶³ Disclosure to DVA related to the use of prohibited substances or the misuse of alcohol is only to occur where the Defence member's service is to be terminated in accordance with Part VIIA of the Defence Act. Disclosure is not authorised where the Defence member's termination is associated with possession or supply of prohibited substances.

(4) completes transition from permanent or CFTS in the ADF, or

(5) renders service which attracts eligibility as qualifying service as defined in the VEA.

This registration process includes the contact details for members, dates for enlistment/appointment and separation, service arm and unit, as well as basic biographical information.

This information automatically satisfies DVA's proof of identity requirements, reducing the time it takes to process claims, and it provides the opportunity for DVA to proactively connect with serving ADF members to ensure they are aware of the care, support and services available to them, both now and into the future.

DVA is currently using this data to contact all new recruits, introducing them to the Department. This data is also being used to support the provision of White Cards for mental health treatment.⁶⁴ Later phases of the EEM will look at the recognition of operational service for the purpose of DVA entitlements and also examine streamlining liability determinations for serious service-related injuries or incidents.

Under the EEM, the information shared with DVA will be updated over the course of a member's ADF career.

Supporting transitioning members with a mental health condition

DVA funds mental health treatment services through the broader Australian health care system, and in 2015–16 spent about \$196 million on supporting the mental health needs of eligible veterans and dependants.

Funding available for mental health treatment is uncapped, meaning there is funding available to meet demand, and there are no restrictions on an individual veteran's access to services. Funding is provided for:

- psychiatrist, psychologist, general practitioner and social work services
- inpatient and outpatient hospital treatment
- pharmaceuticals
- services through the Veterans and Veterans Families Counselling Service
- online mental health information and self-management support.

DVA is continually expanding and improving existing services and support. The 2017–18 Budget delivered more than \$58 million in additional mental health support, including a further expansion of non-liability mental health care to anyone who has served at least one day of full-time service in the ADF.

⁶⁴ Cost of pharmaceuticals are not covered for mental health care.

From mid-2018, transitioning members are better supported through the automatic issuing of a White Card for mental health treatment. This will help them gain quicker and easier access to support for any mental health condition.

From 1 July 2019, transitioning ADF personnel with at least one day of continuous full-time service (including Reservists on continuous full-time service) will be able to receive a comprehensive health assessment in each of the first five years after leaving the ADF. This expands on the existing one-off comprehensive health assessment that has been available to transitioned members since 2013.

DVA's *At Ease* portal⁶⁵ provides a suite of websites, apps and YouTube videos that offer self-help tools and advice about mental health and wellbeing for veterans and their families. *At Ease* focuses on general mental health and wellbeing, posttraumatic stress disorder, alcohol management and suicide prevention. DVA is currently modernising these resources to enhance the user experience, and to ensure they align with the evolving needs of contemporary veterans.

DVA also provides resources to mental health professionals, and has commenced a review of its online training courses following a recommendation from the 2017 Senate Inquiry report, *The Constant Battle: Suicide by Veterans*.

The Government is also investing in initiatives that seek to broaden its understanding of best-practice veteran mental health services, treatments and interventions, including the establishment of the Centenary of Anzac Centre⁶⁶, an initiative of Phoenix Australia. The Centre will comprise a Practitioner Support Service, helping health care professionals to deliver best-practice care to veterans with mental health conditions. In addition, it will also include a Treatment Research Centre to undertake clinically driven research to develop improved treatment models for veterans.

While there is an extensive range of services and treatment available to veterans, it is open for DVA to find new and better ways to encourage veterans to seek help when they need it, and to support their ongoing self-management.

Veterans and Veterans Families Counselling Service

Veterans and Veterans Families Counselling Service (VVCS) provides free and confidential counselling and mental health services to current and former ADF members with at least one day of service, along with their partners and children. VVCS provides direct counselling and support through an integrated 24/7 national network, including 25 centres located across Australia, and a network of more than 1,200 outreach counsellors nationally.

⁶⁵ <https://at-ease.dva.gov.au>

⁶⁶ <http://anzaccentre.org.au/>

Pilots and trials

There are several pilots, trials and new initiatives under way to investigate innovative approaches to improving DVA's mental health services and support. Those of most relevance to transitioning members include:

- **Stepping Out: Attention Reset Trial.** VVCS will soon commence a trial of an innovative attention-control training program with transitioning ADF personnel. The computer-based attention-control training is designed to re-calibrate an individual's attention and threat detection system to reduce and prevent anxiety and traumatic stress symptoms in this high-risk cohort.

If proven effective, the training program will offer a simple, affordable intervention to assist ADF personnel to attend appropriately to threat levels in the civilian world and to potentially reduce the development of mental health issues post separation.

- **Townsville Suicide Prevention Trial.** As part of the Government's broader investment in suicide prevention, the Townsville Suicide Prevention Trial (officially called Operation Compass) is strengthening existing services to better target former members at risk of suicide. This project is being led by the Department of Health through the North Queensland Primary Health Network, with support from DVA and VVCS.

The trial, has identified a number of priority areas for Townsville, including:

- improving emergency and follow-up care for suicidal crisis
- improving the competency and confidence of frontline workers to deal with suicidal crisis
- promoting help-seeking, mental health and resilience
- training communities, families and carers to recognise and respond to the signs of suicide.

VVCS is supporting the Townsville Suicide Prevention Trial with a community engagement pilot in the region. This includes the pilot of a care coordination team, comprising a skilled VVCS clinician and two lived-experience peers (community and peer advisors). The aim of this pilot is to enhance the management of complex and/or high-risk clients in the region; in particular, this is applicable to clients considered to be at risk of suicide.

- **The RESTORE Trial.** This trial is investigating whether an intensive delivery of prolonged exposure therapy, involving 10 sessions over a two-week period, will deliver outcomes that are comparable to the gold-standard prolonged exposure treatment protocol. In its current form, prolonged exposure therapy (the gold-standard treatment for PTSD) can be a difficult time commitment (10 weeks) for current and former ADF. If proven successful, this will increase the accessibility of treatment options for VVCS veterans.

- **Assistance Dog Trial.** In response to a recommendation from the 2017 Senate Inquiry report, *The Constant Battle: Suicide by Veterans*, DVA is conducting a four-year trial of psychiatric assistance dogs for veterans with PTSD. Under this trial, assistance dogs will form part of the veteran's treatment plan, being specifically trained to perform tasks that contribute to the management of the veteran with PTSD. The trial will involve the participation of up to 20 veterans who have been clinically diagnosed with PTSD.

Annex 17 Other measures to support veterans and understand needs

Understanding the incidence of suicide

DVA is collaborating with Defence and the Australian Institute of Health and Welfare (AIHW) to improve the understanding of the incidence of suicide in the ADF and veteran community. The study, 'Incidence of suicide in serving and ex-serving Australian Defence Force personnel 2001–2015', provides strong evidence to help target former ADF personnel most at risk.

AIHW will maintain and hold this dataset and, out of respect for family members and the privacy of the veteran community, it will remain de-identified.

Under a three-year strategic agreement between DVA and AIHW, AIHW will annually update incidence rates as new cause of death data becomes available. The next update is scheduled for the second half of 2018.

The opportunity for DVA over coming years is to analyse these data, together with recommendations and outcomes of other key activities in this area, and to design and tailor policies and programs to assist at-risk veterans.

Reform of DVA's online mental health resources

DVA invests in a broad range of online resources to increase mental health literacy and encourage veterans to seek help when they need it. DVA is currently modernising these resources to enhance the user experience, and to ensure they align with the evolving needs of contemporary veterans and their families.

DVA also provides resources to mental health professionals, and has commenced a review of its online training courses following a recommendation from the 2017 Senate Inquiry report, *The Constant Battle: Suicide by Veterans*. DVA is a key partner in the new Australian Digital Mental Health gateway, *Head to Health*⁶⁷, which aims to maximise the reach and effectiveness of the online mental health assistance available to DVA's clients, including those who may not necessarily identify as veterans.

⁶⁷ <https://headtohealth.gov.au/>

Other related issues

Homelessness

Veteran homelessness in Australia remains an under-researched area. The number of veterans experiencing homelessness or receiving homelessness support is not known. However, the Specialist Homelessness Services Collection does capture some information on DVA payment recipients, while the Census does not yet include veteran status.

Homelessness can be a reciprocal factor in poor mental health and a contributor to suicide, and more research is required to give greater clarity and identify how DVA can explore and develop resources to assist and reduce incidence of homelessness.

DVA has recognised the need to update its understanding of veteran homelessness, and has contracted the Australian Housing and Urban Research Institute to undertake research into the size, location and nature of homelessness among former members of the ADF. This research is due to be completed by the end of 2018.

In addition, the AIHW will report on veterans' use of specialist homelessness services for the first time in the AIHW 2017–18 report, to be published in December 2018.

DVA has also asked the Australian Bureau of Statistics to incorporate a question about respondents' veteran status in future releases of the Census.

Incarceration and supporting veterans in the justice system

A major issue for some veterans is their engagement with the criminal justice system, including representation, incarceration and related issues. While there is some information captured at the state and territory level, to date DVA has not significantly engaged in this space, and further research may be needed on the level of veterans' engagement with courts and on their level of incarceration, together with how support may be offered and whether DVA and/or other organisations are best suited to provide such support.

Annex 18 Future military compensation

This section provides some possible future policy, system or process improvements the Productivity Commission might wish to consider, as well as canvassing, as appropriate, relevant issues and challenges and opportunities for each.

Simplifying and harmonising legislation

Resolving liability complexity and speed

Several options could be available for future consideration by the Government:

- The initial determination of liability could be streamlined. For example, on a claim being made, liability is accepted subject to post-decision verification. In the meantime, the assessment of the compensation and/or other benefits could proceed. (It may be necessary to restrict the forms of initial compensation to avoid potential onerous repayment arrangements, such as in the event of requiring a lump sum compensation benefit to be repaid.)
- Increased use of *MyService* to accept liability of conditions under streamlining development and the use of an automatic acceptance of conditions as resulting from service.
- Greater use of trade/occupation for 'decision-ready' conditions to simplify acceptance of conditions caused by event exposure (e.g. chemical exposure, physical trauma exposure). However, the adoption of occupation-defined 'decision-ready' conditions would need to be considered cautiously, particularly noting the potential for the conditions to flow on to civilian workers' compensation.
- Determination of liability at the time of injury or incident.

Better provision of benefits

Streamlining access to health cards or pensions

One potential option for simplifying military compensation and its administration may be to introduce new eligibility triggers for some benefits, rather than continue to scrutinise entitlements and claims over long periods of time for the same clients:

- introducing new age and/or impairment or other triggers for Gold Card eligibility under VEA and MRCA
- another option may be to consider the provision of access to White/Gold Cards and/or pensions as trade-offs for other benefits.

Such changes could have significant administrative benefits, particularly in an environment of increasing claim complexity.

Potential changes to lump sum provisions

An issue for some veterans being paid lump sum compensation payments under the MRCA and DRCA arises when the lump sums are not invested for long-term returns. While not an issue for some veterans, anecdotal evidence suggests that others may experience financial hardship when the funds are exhausted.

A possible option is to amend the MRCA to only allow periodic payments with no option for the veteran to receive lump sum payments. However, this is likely to disadvantage those clients who are not subject to financial risk, either because they receive a relatively small payment, or they are in a position to make sound financial judgments with regard to large payments. The loss of the lump sum option may also be seen as a restriction of choice, and it also disadvantages those with limited life prospects.

This proposal would also require amendments to the DRCA, which currently only has provisions for lump sum payments.

Another option is to amend the MRCA to require a recipient of a lump sum to obtain professional financial/legal advice before a lump sum payment is made, which is already a feature of the Special Rate Disability Pension (SRDP) provisions of the MRCA for those who make a choice for the SRDP over incapacity payments. The same provisions also provide the client with compensation for the cost of this advice.

It should be noted that problems with current lump sum arrangements are informed only through anecdotal evidence from a small number of clients who re-present at DVA following exhaustion of their lump sum compensation amounts. Policy changes to these arrangements should rely on the collection of a more robust evidence base from a wider pool of clients, including those who have and who have not received lump sum payments.

Financial benefits for family members

The Productivity Commission may wish to consider if and how, and in what circumstances, partners, dependants and/or other family members of veterans should receive financial support as part of the military compensation system, beyond the extent and nature of services and support already provided.

Improving transition and rehabilitation

Mandatory transition processing option

Recently joint Defence–DVA–CSC initiatives have been put in place to address many of the barriers to a successful transition out of Defence, including dealing with

compensation and rehabilitation matters. However, these best-practice initiatives will be of little value if individuals do not undertake the steps required for a successful transition, either because the individual decides not to adhere to the offered process, or because a local commander does not allow appropriate opportunities for the transition processes to be undertaken.

The Productivity Commission may wish to note that the United States Government has addressed this issue by legislating actions and timelines required for service members to transition from the US military. There may be elements of the US model that would be worth considering in an Australian context.

A seamless transition to life after service

While there has been work to date on establishing 'warm handover' processes between Defence and DVA for members to move from service to post-service life, these are difficult to make 'seamless' from the veteran's perspective.

A better approach may be to have the same support staff work across Defence, CSC and DVA to ensure all aspects of the ADF member's circumstances are considered before, during and after the transition process, and to consider legislative amendments to permit early engagement by DVA in rehabilitation.

Closing the loop on DVA/Defence claim information

There is an opportunity for DVA to provide information back to Defence on the impact of military service.

Through the information that DVA collects through its claims, there is an opportunity for these data to inform Defence of:

- the nature of claims
- the duration between the original service-related injury or event and the subsequent claim
- statistics on prevalent conditions or impairments that may be related to particular kinds of service, training, operations or hazards.

Such information may be used by Defence to adapt and change its training or other operational conditions to reduce the incidence or likelihood of similar future claims.

There could be an opportunity to expand this arrangement so that DVA can analyse the information contained in the Defence eHealth System and Sentinel, for themes and emerging issues, providing an opportunity for tailoring services.

In addition, there may be value in sharing similar information with Comcare, particularly to support its role as the occupational health and safety regulator for Defence.

Supporting veterans' health outcomes

Veteran-centric e-health record

In conjunction with the ongoing development and roll-out of the national e-health record within the MyGov framework/platform, there is an opportunity to put in place a whole-of-government veteran-centric approach to the management of each veteran's health record. This would involve establishing a government goal of enabling an individual's e-health record to be portable between the national e-health record system, the Defence eHealth System, and DVA's e-record system. By enabling an individual's MyGov e-health record to be ported into the ADF e-health system at the time of recruitment, some costs incurred by Defence in its current recruitment medical examinations may be saved.

On transition from the ADF, an individual's DES record would be ported back into the national e-health record system to be available to a treating GP and emergency facilities and, once the member has granted access, be similarly available to DVA should the individual make a claim at any time in the future.

Continuity of care—a joint Defence/DVA comprehensive health care contract

Continuity of care represents best-practice rehabilitation and health care. Currently there is a systemic risk to continuity of care for a wounded, injured or ill ex-service veteran, arising through the change of health care contract at the time of transition from the ADF. Prior to transition, their care is delivered under Defence's Comprehensive Health Care (non-operational health care), and after transition it is delivered under DVA's health care contract.

From a continuity of care perspective, the ideal model would be a single health care contract with the same service provider/s, shared across agencies. Such a model would also offer potential procurement savings through the increased buying power of a combined comprehensive health care contract.

How to better understand needs and quality of care

A potential gap in the current system is the disconnection between DVA as a purchaser of health care, the provision of that care by third parties, and the perception of each veteran that their needs are being met.

A feedback mechanism that would engage veterans as they receive care, to ensure that the care is appropriate and that it meets their needs, may help DVA to better direct its health care resources and assist the veteran to receive better or more appropriate care.

Health care purchasing

A consumer-directed care model

While some of the benefits, risks and areas of caution around a consumer-directed care (CDC) model are detailed in Annex 20, DVA considers that a CDC model may be worth exploring, particularly for its cohorts of younger veterans and for non-clinical health care.

One option may be to consider the adoption of some particular features of a CDC model and combining those with the services DVA already offers. CDC elements that may present more significant opportunities include:

- user choice and self-management, reinforcing DVA's existing veteran-centric model
- user choice can help markets to provide better and more appropriate services
- adopting the concept of the development of a health plan with clear outcomes, rather than open-ended health care available through White and Gold Cards
- treatment cycles that require the client to return for a GP assessment periodically.

Potential absorption of DVA's purchasing into broader arrangements

One question to consider is whether DVA's purchasing can be absorbed into mainstream legislative arrangements. Currently, DVA's legislative framework offers a differentiated service that meets veterans' unique needs in respect of health, community and aged care services.

Conversely, mainstream aged and community programs available to the Australian community generally, under legislation administered by the Department of Health for instance, include a number of features not shared by DVA programs. These include waiting lists, age constraints, uncapped user co-payments and income testing.

In contrast, access to DVA-funded services under the VEA and MRCA is generally based on eligibility and assessed need, with no waiting lists, age requirements and minimal or no co-payments. Additionally, fundamental differences exist in the funding models in place, with mainstream programs using grant-based approaches, or subsidy-based arrangements, with DVA programs conversely operating on a 'fee-for-service' basis, using a network of contracted providers.

However, further clarity is needed as to where DVA could provide a 'top up' to mainstream services or where a different veteran-specific service would be more appropriate.

Policy, systems and collaboration

Coordinating support across the veteran support sector

In its 2018 report, *Ganging Up on the Problem*, the Centre for Social Impact suggested a number of areas that would be appropriate for coordinated and collaborative development, including a virtual ‘one-stop shop’ for service providers and ESOs to contribute to, providing one point of contact and information for veterans and their families.

In addition, the Centre suggested that, given the growth in the ESO sector and the corresponding issues that the sector is dealing with, the establishment of a single peak ESO body should be a priority for this sector.

A systems approach to collaborative development

A veteran-centric view of the veteran support system reveals not one, but multiple systems, which largely work independently from each other. These systems need to interact with each other effectively and efficiently if the best outcomes for the veteran and the taxpayer are to be achieved.

At the macro level these systems include:

- the public health system
- the National Disability Insurance Scheme
- the aged care system
- the Defence health system
- the military superannuation system
- the DVA compensation and rehabilitation system
- the system of non-government veteran support organisations.

In this situation a ‘systems thinking’ approach is worth consideration, given the significant and growing body of associated work in terms of academic literature⁶⁸ and applied research by organisations such as Stanford University in the United States and by the UNSW Centre for Social Impact (chaired by David Gonski) in Australia.

This approach aims to develop collaborations between systems and between stakeholders, including between government and non-government stakeholders, and may be an appropriate approach to address the need for the veteran support system to be a best-practice collaboration between systems.

⁶⁸ www.csi.edu.au/research/project/ganging-problem-collaborative-approach-improving-lives-veterans/

Data-driven use of artificial intelligence applications

Prevention and early intervention strategies are usually significantly cheaper than reactive treatment regimes. Investment in predictive capabilities, such as through the use of artificial intelligence applications for data analysis, may offer early intervention benefits for veterans. Such analyses may reveal opportunities for DVA to intervene or offer early assistance to veterans needing health or wellbeing support.

Artificial intelligence machine learning applications benefit from access to large-scale de-identified case data. However, post-transition veteran data is generally not available for non-DVA clients.

Previous attempts to determine the number of Australian veteran suicides have highlighted an inability to track non-DVA veterans. The United States has addressed this issue through the application of the general-purpose social security number as a military identification number, and then retaining it as their veterans' agency number.

The Productivity Commission may wish to consider the benefits of Defence and DVA using a common number such as an individual's MyGov number, tax file number, or other general-purpose identifying number that will remain with the individual during and after their period of military service. As identified in Annex 3, DVA is already linking *MyService* to the MyGov system to streamline services.

DVA's systems and administration

DVA's ability to receive the information it needs to determine liability and to assess a claim are critical to the speed and efficiency of DVA's claim processing. Although information from Defence and the CSC can be slow to arrive, and involves considerable manual processing, there has already been substantial work, especially in Defence, to improve its collection and sharing of information. Much information can now be shared readily with DVA, as some previous restrictions, such as privacy, have been addressed through consent processes.

The adoption of more automated processes to eliminate manual processing would achieve further major improvements in processing speed, accuracy and efficiency.

DVA is keen to strengthen its partnerships with other agencies and give this greater management attention.

Policy development

Historically, military compensation policy development and accompanying legislative amendments have often resulted from pressure within the veteran community for specific changes, improvements or adjustments to benefits. The resulting changes have often reflected the needs of one part of the veteran community, rather than of the whole cohort, or the potential needs of future cohorts.

In addition, changes made can be costly if they have been added to existing entitlements, rather than being offset by reductions or changes to existing entitlements (historically, entitlements have been cumulative, and have not been adjusted to offset improvements made to other parts of the system). Accordingly, considering specific changes in isolation is not sustainable for the Government.

There is therefore a need for DVA to more proactively drive the policy debate and to articulate the effect of individual policy changes on the system as a whole. To be able to do this, DVA needs to have a greater understanding of the entire veteran community, including the whole sector's:

- financial security
- need for health or wellbeing support
- need for rehabilitation or transition support
- emerging areas of need.

In addition, consideration of the system as a whole, as well as the broader veteran community, reduces the likelihood of individual changes being made without considering the total cost impact, or how offsets to other parts of the services or benefits for veterans could be considered.

Developing this broad understanding then becomes an opportunity for DVA to anticipate future needs and proactively promote policy changes ahead of urgency.

The work to achieve this level of understanding is based on greater use and analysis of data, deeper and broader research of the whole veteran community, and greater engagement of veterans in policy development forums and meetings.

There is also a need for more policy collaboration between the Department of Social Services and DVA, particularly concerning the introduction of reforms to social services benefits that affect DVA's veterans. Similarly, the arrangements between DVA and the Department of Health and with the Department of Jobs and Small Business could be strengthened by greater policy development sharing.

Better ways to measure effectiveness

Over many years DVA has established and developed various measures of its performance and of the effectiveness of its services. These have been and continue to be used to tailor DVA's services and to ensure that its systems and processes are working effectively.

While DVA's existing measures have been reasonably effective in determining how well DVA delivers its initiatives and sub-programs, they have largely been developed in ad-hoc and piecemeal ways, and have rarely attempted to more comprehensively assess the performance of DVA's outcomes as a whole. That is, most of DVA's performance assessments have tended to measure *delivery* (or *outputs*), rather than *effect* (or *outcomes*).

Areas of development that would be open to DVA to better establish outcome-level assessment could include, for example:

- surveys of veterans and their families to test a range of life domains, including financial security, physical and mental health and wellbeing, relationships, personal life satisfaction, employment, and satisfaction with DVA services and those provided by others
- personal interviews with a cross-section of veterans and their families
- further surveys or studies to canvass non-client veterans and their families to determine how or if DVA should engage with this larger pool of veterans or invite them to seek assistance
- supplementary case studies, particularly to more thoroughly investigate the outcomes experienced by veterans and their families with particular forms of interventions or in certain circumstances.

Annex 19 Non-liability health care

Non-liability health care (NLHC) is available for any mental health condition for any ADF member who has served for at least one day of continuous full-time service as a member of the permanent ADF. NLHC for malignant cancers and pulmonary tuberculosis is also available to members who served on certain types of deployments, or who rendered certain peacetime service.

This entitlement is entirely separate from the compensation process and does not require liability to have been claimed or established.

NLHC can also be provided where the member has previously lodged a claim for the condition, but that claim has been unsuccessful. A completed claim form and diagnosis is required to access NLHC for cancer or tuberculosis. For mental health conditions, no diagnosis is required in order to access NLHC, and the submission of a formal claim is not compulsory. The approval process for treatment has reduced in time from months to 18 days, and now can be granted in just one day.

As part of the 2016–17 Budget announcement, VVCS eligibility was extended to family members of those eligible for non-liability mental health care.

From mid-June 2018, all transitioning ADF members are issued with a White Card for mental health conditions for them to access treatment at any time in their life, should they need to.

Number of non-liability health care cases completed, 2012–13 to 2016–17

Non-liability health care	2012–13	2013–14	2014–15	2015–16 ⁽¹⁾	2016–17 ⁽²⁾
Intake—cases	2,746	3,121	4,819	7,157	7,784

(1) The 2016–17 Federal Budget, extended eligibility for NLHC to all current and former permanent members of the ADF.

(2) The 2017–18 Federal Budget, extended NLHC to cover all mental health conditions, including adjustment disorders, phobias, panic disorder, agoraphobia, and bipolar and related disorders.

Should non-liability health care be extended?

DVA considers the application of non-liability health care, through the use of the White Card for specific conditions, to have been of enormous benefit to the veteran community. This has enabled veterans to be able to gain faster care relatively easier than would otherwise have been the case. For critical conditions such as mental health and cancer, being able to seek advice and help without going through a claim process is essential.

Annex 20 Consumer-directed care

Lessons from applications of consumer-directed care: informed choice and advocate support

The model employed by the National Disability Insurance Scheme provides choice and control to people with disabilities (or their carer or family member), to allow them to determine and select their own health care arrangements to meet their particular needs.

Under the NDIS self-managed participant model, clients' needs are formally assessed and clients select the services/providers they want to use, and funds are provided to them to allow them to purchase those services.

Implementation of a consumer-directed care (CDC) model like the NDIS suggests that effective consumer choice requires informed and capable decision-making capacity. Such a model needs:

- a significant investment in consumer support through provision of information, education and help desk support (physical, call centre and online)
- case management
- a system of informed and capable advocates to support consumers in:
 - researching the options available
 - making their choices
 - accessing selected service providers
 - managing the provision of the services.

It should be noted that the more acute the health care needs are, the more likely an increasing degree of difficulty for a consumer to identify and select the appropriate services for their needs.

In terms of funding and budgets, for each individual consumer this model requires:

- an assessment of their support needs
- the allocation and management of a budget to provide supports and services to meet those assessed needs.

This requires significant resources to ensure an appropriate assessment capacity is available and able to support consumers across all geographic regions of Australia and in international locations where consumers are entitled to receive support.

A central control infrastructure is also required to manage invoices and payments, and to monitor and report on spending against the allocated budget.

Client needs can change, thereby requiring the model to be flexible and to be resourced for additional ad-hoc assessments and budget amendments. Such changes need to be able to occur in a timely manner to ensure continuity of care is sustained. (If continuity of care cannot be maintained, the model becomes less suitable for acute services, or where health conditions have not stabilised.)

Market development

New service providers may enter CDC-model markets where there are opportunities to expand their reach directly to consumers. Alternatively, some forms of service provision are poorly geared for direct interaction with consumers. In both instances, some regulation, control and support may be needed to ensure supply is able to meet demand and that forms of supply are appropriate for needs.

A CDC model for veterans' health care

There are opportunities for a CDC package to be developed for veterans. DVA already offers the majority of the services available under NDIS and Home Care packages. However, these are not currently coordinated as a 'one-stop-shop' package. The already-available Gold and White Card arrangements, including the health-related programs of Veterans' Home Care, Community Nursing, Rehabilitation Appliances Program, and Repatriation Transport, as well as rehabilitation programs and families support measures, could be redesigned to have one access point and one assessment to produce a DVA-specific CDC package.

Should such a model be further contemplated, seeking feedback from the National Disability Insurance Agency, the Department of Health, and the veteran community (especially those already on an NDIS package or Home Care package) will be essential.

The following issues are relevant to a discussion on this model for military compensation and rehabilitation:

- **Suitability for complex needs.** Does an NDIS service delivery model suit a veteran with complex needs, such as a veteran with multiple impairments, who may be living in a rural or remote location? Is the model affordable, and would it still offer quality of care?
- **NDIS market capability.** Is there an established and mature market of suppliers able to provide NDIS-like services to a veteran community? How much support would DVA or others need to provide to establish or build this market?

- **Critical mass.** Consideration would be required to assess if the veteran community and their support needs, in terms of size, would provide for the minimum critical mass to warrant the establishment and ongoing services infrastructure providing both consumer support (informed choice and advocates) and providing market stewardship.
- **Design principles.** Ensuring continuity of care, and retention of the existing principles that underpin military compensation, including avoiding out-of-pocket expenses.
- **NDIS client capability.** How well does an NDIS model work when the client is mentally incapacitated, or is otherwise not well placed to select the services that best meet their needs?
- **Scope of consumer-directed care.** The services being provided under the NDIS are essentially support services and not clinical services, which are funded through the existing channels such as hospitals, Medicare, etc. The scope and extent of services for DVA veterans would need consideration.

Risks of the model for veteran health care

There are both benefits and risks to a CDC model and these need to be carefully weighed up in relation to service offerings for veterans. CDC packages would need to be very carefully managed by experienced and qualified people. When this works well, veterans could be empowered to truly be at the centre of their care. Where it does not work well, there may be significant health issues left unattended. Risks to be mitigated include:

- risks of restricted or poor access to appropriate services, along with risks of high cost or poor quality of services
- veterans may not know appropriate pricing for their health care requirements (low health literacy)
- there is likely to be a significant power differential between the veterans and providers and health professionals
- there is a significant risk and a need for quality assurance measures for veterans under the Community Nursing Program, and this element would require separate consideration
- individual funding allocation exhaustion, and an accompanying risk of underlying liability should an individual with self-management responsibility inappropriately expend their funds
- there may also be a risk that some veterans who require medical attention forgo treatment in order to save their CDC budget against possible future need, resulting in escalation of their untreated medical condition.

Other considerations for a CDC model for veterans

In addition to the risks above, a number of issues would require detailed and thorough investigation and consideration before a CDC model could be developed. Such issues include:

- In relation to health treatment, DVA's treatment card system is already consumer directed. Once a person has been issued with a card, they are able to use it to purchase care across the health system, including their choice of treating practitioner and hospital. The person has considerable choice and flexibility; although as with the general health system that choice is largely guided by medical practitioners. That said, the system does not at present readily allow for packaging of health treatment under an NDIS-like planning arrangement and this may be worth further consideration.
- Understanding how an individual's competence to appropriately manage their needs would be assessed and managed. There are a number of examples within DVA's client group where self-management is not realistic, whether due to old age, mental health or other injuries such as traumatic brain injury. Their carers or family may be able to provide direction, but it does add another layer of consultation (the need to involve carers or family) in the process for many veterans.
- Consideration of the relevance of the model to the different segments of the DVA veteran base. Older veterans with Gold Cards and established relationships with health care providers are unlikely to be candidates for CDC; however, younger veterans in their early phase of engagement with DVA are much more likely to be candidates.
- In relation to aged care, once a DVA client's needs go beyond entry-level home care, they are cared for under programs available to the whole community in the mainstream system. The consumer-directed care initiatives in the mainstream aged care system apply to DVA veterans as they do to all citizens. They primarily relate to higher level home care packages rather than residential aged care.
- DVA could carefully consider and learn from the lessons in the rollout of consumer-directed care initiatives both in Australia—particularly the NDIS—and internationally.
- There is a view that the client is best placed to make decisions about the services required, which may be well justified in the context of non-clinical services. However, the veteran community can be viewed as no different to the general population in terms of overall health literacy or the ability to make decisions regarding appropriate treatment and realistic outcomes.

- CDC could have significant benefits for veterans; for example, it could address social isolation by including activities to address this in their package. The care plan could specifically address veterans' social, emotional and clinical needs, focusing more holistically on the veteran rather than only their clinical needs. It could also create a sense of empowerment, control and improve veterans' awareness of changes in conditions and related services.
- Some of the Rehabilitation Appliances Program suppliers have advised that there can be substantial bureaucratic 'red tape' to become an NDIS supplier. In contrast, many suppliers consider the current DVA system to be much more streamlined.
- Currently DVA funds whatever is clinically required (regardless of the total or annual cost), whereas the NDIS model has 'packages' with an annual limit for services. This could be seen by the veteran community as an attempt by DVA to reduce or limit their services, and the perception could be that they are losing an entitlement.

List of abbreviations and acronyms

AAT	Administrative Appeals Tribunal
ADF	Australian Defence Force
ADR	alternative dispute resolution
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ATDP	Advocacy Training and Development Program
BoP	balance of probabilities (standard of proof)
CDC	consumer-directed care
CFTS	continuous full-time service
CSTC	Commonwealth, State and Territories Committee (subordinate committee of the VMRT)
CSC	Commonwealth Superannuation Corporation
CTPA	<i>Military, Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004</i>
CSI	Centre for Social Impact
Defence	Department of Defence
DeHS	Defence eHealth System
DHS	Department of Human Services
DRCA	<i>Safety, Rehabilitation and Compensation (Defence-Related Claims) Act 1988</i>
DVA	Department of Veterans' Affairs
EEM	Early Engagement Model
ESO	ex-service organisation
ESORT	Ex-Service Organisation Round Table
GARP	Guide to Assessment of Rates of Veterans' Pensions
ICT	information and communication technology
Legacy	Legacy Australia Incorporated
MRCA	<i>Military Rehabilitation and Compensation Act 2004</i>
MRCC	Military Rehabilitation and Compensation Commission
NCF	National Consultation Framework
NLHC	non-Liability Health Care
NDIS	National Disability Insurance Scheme
OBAS	On Base Advisory Service

PGPA Act	<i>Public Governance, Performance and Accountability Act 2013</i>
PI	permanent impairment
POWs	prisoners of war
PTSD	post-traumatic stress disorder
RC	Repatriation Commission
RH	reasonable hypothesis (standard of proof)
RMA	Repatriation Medical Authority
RMCA	Review of Military Compensation Arrangements
RSL	Returned and Services League
SMSE	sound medical-scientific evidence
SMRC	Specialist Medical Review Council
SOF	Special Operations Forces
SoPs	Statements of Principles
SRCA	<i>Safety, Rehabilitation and Compensation Act 1988</i>
SRDP	Special Rate Disability Pension
STP	straight-through processing
TPI	totally and permanently incapacitated
VEA	<i>Veterans' Entitlements Act 1986</i>
VCR	Veteran Centric Reform measure
VMRT	Veterans' Ministers' Round Table
VRB	Veterans' Review Board
VSO	veteran support organisation—see ESO
VVCS	Veterans and Veterans Families Counselling Service
WPI	whole-of-person impairment
WW1	World War 1
WW2	World War 2