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Productivity Commission

PRODUCTIVITY COMMISSION

COMPENSATION AND REHABILITATION FOR VETERANS

MR R FITZGERALD Commissioner
MR R SPENCER, Commissioner

TRANSCRIPT OF PROCEEDINGS

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COMMISSIONER FITZGERALD: Good morning, everybody. And thank you very much for attending. It's a joy to be up here in Rockhampton again. So today is the very last day of the public hearings for this particular inquiry, so we kept the good one until last up here. And we are pleased to be up here. This is, as you know, a public hearing to the Productivity Commission's inquiry into veteran's compensation and rehabilitation. So I'm Robert Fitzgerald. I'm the presiding commissioner and my colleague is Commissioner Richard Spencer.

So purposely, the round of hearings, the public hearings, is to facilitate public scrutiny of the Commission's work and to get comment and feedback into our draft report which we released in December. So the Commission's processes are very open. We make sure that you know what we're thinking and that's followed a very substantial period of consultation, both with older and younger veterans, on bases and off bases, right around Australia, prior to the draft and then following that, we do public hearings and some further consultations. So this is one inquiry which is very open and we welcome feedback, both positive and critical.

Following these hearings, we'll be working towards completing a final report and providing that to Government in June of this year, having considered all the evidence presented at these hearings and in submissions as well as other informal discussions. Participants and those who have registered their interest in the inquiry will automatically be advised of the final report's release by government and governments must release our report in full within 25 parliamentary sitting days after receiving that. And so that'll happen sometime in the middle of the year.

We like to conduct all hearings in a reasonably informal manner although some of you may say this is not, doesn't look very informal, does it. But we'll try to do our best with that. And I remind participants that a full transcript is being taken, hence a recorder on my right.

For these reasons, we don't take comments from the floor, but at the end of proceedings for the day, I'll provide an opportunity for any person wishing to make a brief presentation, a brief comment at the end of these proceedings and if you'd like to do so, please speak to Stewart who you would have met on the way in at the back of the room and we'll have a morning tea break just around 10.20.

Now, participants are not required to take an oath, but you are required under the Productivity Commission Act to be truthful in your remarks. Participants are welcome to comment on the issues raised by other people and in other submissions. The transcript of these hearings will be made

available on the Commission's website following the hearings and all of the written submissions except for those things that have to remain confidential are available on our website already, so you can go to the website and see what submissions have come in so far. There is a representative of Open Arms here present, if anybody would need their services; Karen Butler, and you can see Stewart if you need to contact Karen. And in case of a fire, there are two emergency exits located at each end of the hallway outside the conference room.

So I'd just like to, again, welcome you and thank you for your participation today. This is a very complex and detailed report. It's long and it has many recommendations. A couple of things I should say, during the day we'll clarify some misunderstandings. A lot of the submissions have misunderstood some of our recommendations and our reasoning. We'll help clarify some of those as we go through. But I just want to make a couple of points about it.

This is an inquiry that's looking for the future of the veteran's affairs system over the next 20 to 30 years. So we have no intentions of tinkering with the system for tomorrow. This is actually trying to say where do we want to be 10, 15, 20 years out and that's very important. So it's not about just trying to fix problems today, it's actually trying to say is this the best system for older and younger veterans going forward, and that's the difficult challenge. Easy to fix problems for tomorrow, very hard to come up with systems that again serve Veterans well into the future, given the changing nature of military service and military employment generally.

The second thing is again, there have been a number of misunderstandings in relation to some of our recommendations and as we go through this morning, we'll try and clarify some of those, but if, at the end of the hearings, you're still not sure about why we've said things, or you're not sure about some of our recommendations, you can contact the Commission. We're happy to have a chat over the phone about those things, or if you have further comments, you can get them in but submissions have formally closed. But if you do have comments you want to make, just send us an email and we'll consider that. But we do need to receive those very quickly.

As of after today, we do start a fairly heavy process of actually writing up the final report, so if you've got any comments, they have to come in very, very soon. But as I say, the formal submissions deadline has just about passed. So there's a slight change in the program today. Our first group wish to be put on a little bit later, so we'll do that to accommodate them. And we're going to start with Jack Parr.

MR PARR: Any seat? Yes.

COMMISSIONER FITZGERALD: Probably the second one along might be best.

MR PARR: This one?

COMMISSIONER FITZGERALD: Yes, that'd be better. If anyone is hard of hearing, sit up the front. You can bring your seat as close as you like to the witnesses. You won't intimidate them, but there's no – there's no amplification. These are simply microphones for the purposes of our friend on my right. So if you are hard of hearing, bring your seat as close forward, and I'd ask participants to speak as loudly as they can.

The procedure is that each participant will be given about 10 minutes to raise key issues they'd like us to hear and then Richard and I will spend about 10, 15 minutes or so just raising some questions and having a conversation. So we know that people could talk for a long time on this, but you are required to just make some brief opening comments and then we'll have a discussion. And as I say, if you have any further comments you want to make, just email them to us.

So you go by Jack, but I need you to give me your full name and any organisation that you represent.

MR PARR: Good morning, Richard. Good morning, Robert. My name is Alan Parr. Most call me Jack. Something to do with heavy lifting, I think. I'm a Vietnam veteran. I'm not representing any particular group here today.

COMMISSIONER FITZGERALD: That's fine.

MR PARR: Just Vietnam veterans.

COMMISSIONER FITZGERALD: So you're representing yourself?

MR PARR: Yes.

COMMISSIONER FITZGERALD: So if you could – Jack, if you could just give us 10 minutes of the key points that you'd like to make to us, that would be terrific.

MR PARR: I will – I'll have to condense what I had already prepared, so I might be jumping left and centre.

COMMISSIONER FITZGERALD: Sure.

MR PARR: Okay. I want to compliment the PC on your very comprehensive and thorough report. It's much too much for me to consume, so I started with the key points and I read the first couple of key points there and I picked out two words, fundamental reform. That's the one I want to focus on to start with. Then I looked further down the system, I saw the diagram of the current system - everybody's seen that. Okay. And then the proposed system. And I compared the two and I couldn't see much fundamental reform. I saw some changes, but not structural reform that there's a few things there. I'll talk to them. I'll address them as I go through.

Okay. Right. Now, the whole – from my understanding is, the whole force of this inquiry came out of the senate inquiry called the Constant Battle: Suicide by Veterans. Okay. So Recommendation 2 on paragraph 3.99 and paragraph 4.85, in that report, these were basically requests for the senate inquiry to the PC for a draft report.

The senate inquiry and this draft report came out of the issue of veteran suicide, as I mentioned before. Now, in that Senate report, there's the AIHW report in summary that says, on p. 16, 3.14, that "Between 2001 and 2015, there were 325 certified suicide deaths in the veteran cohort. Ninety were serving, 69 in the Reserve Forces, 166 in the ex-service, 303 men and 22 women. So my question to myself was, so how can changing the system significantly reduce these numbers? That's the thrust of what we're all about, I'm sure.

And from these numbers, you could probably derive that the greatest number of at risk veterans are for targeted attention, well, that's what – sorry, I'll rephrase that again. From these numbers, you could probably derive where the greatest number of at risk veterans for target attention would be. How then, are at risk veterans identified? I suggest they cannot be done by saying one group is more at risk than another group. That's because I believe that suicide is an individual phenomenon. It rests with a single person. Not with groups.

So the senate inquiry recommended the issue of the DVA White Card to all the veterans in transition. Those serving members who are going into transition to move out of the ADF, either into civilian life or into the Reserve Forces, and that is happening now. The Reserve Forces are currently receiving the White Card. Okay, now. I suspect that there might be an anomaly here. There's now two groups of White Card holders. The ones in transition and the ex-serving members or the old veterans who

carry the White Card. So there could be confusion there in the service community as to who's who.

But comparing a number of suicides from my numbers above, there are about the same number of suicides in the ex-service veterans, as in the ADF and Reserve Forces combined. Now, from what I can work out from those numbers, only a small percentage of those full time army personnel, service personnel, would be in transition at any one time. So there would still be a large number of serving members who did not get or do not get – that's all those who are not transitioning don't get a card. And I believe that there would still be a lot of veterans in that community who are at risk. Okay. So I am saying that we are missing this group of people, this cohort of people. So my proposal would be that every member of the Defence Force, serving member of the Defence Force should be issued with a card./ When they enlist they carry a card. Not necessarily a White Card, maybe a Blue Card, but it's a card with which they register with DVA. So immediately they join up and serve, they've got a – DVA's got a tag on them. And that has been one of the problems in the past; DVA couldn't find all the veterans around the place.
So that when these veterans – I'll call it a Blue Card to be distinctly talking about what I'm talking about – so at this stage, I would hope that every member in the Defence Force would have this Blue Card which has their DVA link. So at this stage, I would identify all veterans, all serving member veterans, all ex-members as being at risk.

The PC draft report has also not – I couldn't find it anywhere in the recommendations - adopted the senate recommendation 23 on p. 16 of their report and expanded on p. 25 and 26, re setting up the bureau of veterans advocates. I will now propose that such a unit in a broader form and using the notions I've developed above here, that those at risk notions – I believe this could be the key to a much improved model for veteran's welfare. Okay. All right. At this point in time, I'll just go for a little walkies and I'll get the Commissioner's copy of my model.

Excuse me for being proactive, sir.

COMMISSIONER FITZGERALD: That's fine. That's good.

MR PARR: Okay. I'd like to (indistinct words) if you look at my model, I have not thrown the baby out with the dish – bathwater. I have kept the Defence Forces on the left-hand side, the same as they were always were, except, I haven't put in a (indistinct) transition thing-o in there. I put the DVA over on the right-hand side with all the bodies that are in that and in the middle, I have put this veteran's advocates group of people which if you read the senate report, it expands on it and explains it in more detail.

It would contain professional advocates, ESO advocates, ESO welfare operators, Open Arms, Mates4Mates, all those organisations that support veteran's welfare. They could be in there. I believe that that unit should be independent of DVA, so they are not saddled with the bureaucracy of the DVA.

Sitting at the bottom of that group, veterans and veteran's families, medical and rehabilitation support and the – what they said there, the advocacy legal service. In that box I have put in there in red, two extra units: (1) is Outreach, (2) is Gateway. Okay. I'll just have to find where I've written them in my notes here. Okay. The Gateway Body, I believe should provide a primary gateway service for veteran's claims. Construct claims in a comprehensive and professional manner which in turn should ensure a high success rate with the DVA. Do all their work first hand, get – tick off all the tick boxes, and get a professionally done claim into DVA so that when DVA assessors get it, they've got all the information they need and they don't have to send it back and there'd be no argy-bargy.

Okay. I believe that that will ensure a greater success rate at the first round to start with. And this will then take some of the pressure off DVA and the VRB. And will lead to a less adversarial relationship between the veteran and DVA. To help achieve this, in future, there will be the veteran's eHealth service and the Defence Sentinel Records that will be very important in constructing those claims, because they will have the objective data, accurate and valid data. Okay. Secondly, the Outreach. And this is probably the most important function, especially in the prevention of self-harm. I'm talking about suicide. This section will be a trained group of counsellors whose task is to proactively contact veterans and veteran's families. Primarily by phone they will perform the task of what we now call caseworkers with their assigned veterans by regularly making contact to build up rapport, trust and confidentiality with the veteran. This will provide the veteran and veteran's family with a familiar contact person and a contact number in case of an issue that may arise, 24/7.

Thus, this will work in the reverse of crisis lines, like Lifeline and Beyond Blue that's required the client to phone them. This way it's around the other way. I realise that this will require a large and skilled workforce, but I believe it will have a positive effect on the welfare of veterans. The idea of this function, I derived from Operation Compass, prevention through connection. Now, I've got a website there, and it's a hashtag of check your mates. You might have come across it. Secondly, the model that I put with all the service organisations in that green box in the middle, perhaps I got my inspiration from the Oasis in Townsville for that, where all the service providers are linked together. Okay.

COMMISSIONER FITZGERALD: So you've got two minutes.

MR PARR: That's – two minutes?

COMMISSIONER FITZGERALD: Two minutes.

MR PARR: Okay. I have here, a list of points that this model satisfies and these points are all taken out of that and the senate inquiry. Okay. So, I've been given the windup signal so I will conclude my statement by saying something about myself.

I was a National Serviceman, conscripted in the seventh intake in 1967 and served in Vietnam in 1968. Most people know what a grunt is. A grunt is someone in the infantry core. All right. The role of the infantry core is to find the enemy, close with the enemy and destroy him. To do this in Vietnam, was we'd go on patrol in search of the VC on foot, through the jungle, bamboo, mountain, swamps and rice paddies, avoiding, likely ambush sites, being careful not to step on a mine or set off a booby trap. On our backs we carried our food, water, ammo and personal gear. I also had a radio and spare battery. Do you know what a shell scrape is? It's a hole in the ground, about 30 centimetres deep that you dig every night for personal protection. That I am here today to be able to talk to you is a testament that they are effective.

Do you know what a contact is? It's a firefight with the enemy. It could involve small, heavy arms, mortars and rockets. It's when the enemy is trying to kill you. And there are lots of incoming stuff. If it weren't – if you weren't there, you would never know what that stuff sounds like. When it's flying all around you. What it is like to have mortars and grenades exploding all around you and rockets shooting overhead, hoping they don't strike a tree. Many contacts in Vietnam started at a distance of 10 to 20 metres. At the same time, you're trying to stay alive and hopefully killing the enemy. Destroy the enemy, that's our mission. Maybe they are in a fortified bunker or in a tree. Sometimes it can last for hours or maybe over in seconds.

In a contact there's the smell of gunpowder, explosions of supporting artillery and mortars. Then, the gunships arrive and brass up the area and later attack aircraft to bust open the bunkers. If you're lucky you may get support by APCs and tanks. You know when some of your mates are wounded; you can hear their moans as life slips away or their screams of pain. You do what you can in the aftermath. You fix up the wounded, you cover the dead amongst the blood and the bodies and the body parts; the stench is overwhelming in the tropical heat. You wait for a dust off.

We who have laid bare in such actions share a special bond; an intangible that is sensed rather than seen. It is little understood by others. Many of our mates returned to Vietnam. In fact, I was there two nights ago. Van Morrison sings: "Hey, well, here it comes. Here comes the night." My wife has better nights in the spare bedroom. I know stand-down will come. That's when I'll be safe behind the wire, but until then, my duty is not done. I will continue to help support veterans and do whatever I can.

On special occasions we come together. We proudly assemble and march under our banner. With respect and reverence we read out the names of our fallen brothers. We still see their faces. We still hear their voices. We pledge that we will do everything possible until our dying day to ensure that their sacrifice and service to our great nation is remembered and honoured.

For me, personally – and I stress "personally" – this is being a veteran. Accordingly, I would assert that this is somewhat emphatically different to being in the ADF for one day. Lest we forget.

COMMISSIONER FITZGERALD: Thank you very much. Jack, we've got a series of your points that you've given to us, so we appreciate that. If I can just deal with a couple of issues briefly.

In relation to the White Card, my understanding is, and correct me if I'm wrong, that the White Card, now, will be given to anybody that served within the military if they ask for it. But I think it'll almost be automatic.

MR PARR: Okay.

COMMISSIONER FITZGERALD: Now, that's a measure, of course, that the government introduced and we are supportive of that measure for the reasons you've identified. But you've gone further to say that the White Card or a card – a "blue card" I think you describe – should be offered to people whilst they're serving. Is that correct?

MR PARR: That's correct, yes.

COMMISSIONER FITZGERALD: But why do you think it's necessary when serving given that, when you're in the ADF, you are provided with both physical and mental health services?

MR PARR: I believe that card will then access the Advocacy people directly, rather than going through the military and that is an issue that you guys have put into your draft report.

COMMISSIONER FITZGERALD: Sure.

MR PARR: - - - where there's a problem of the serving person going to the Defence people and saying, "I've got a problem".

COMMISSIONER FITZGERALD: Sure. The government, over time and recent times, and the DVA and Defence have been working to try to connect serving personnel with DVA earlier and, in part, the definition that the government developed, which is the one day in the military and you're a veteran, which is not our definition as you know; that's the government's definition. We work with that definition - was to try to do that.

Do you believe that from talking to people in the service and out of the service that there is a greater connectedness between DVA for serving personnel before they transition out? Are you aware of that?

MR PARR: I have no information to be able to answer that question.

COMMISSIONER FITZGERALD: Okay. Your model – and I'm sure Richard will have some questions about this – have a number of elements that we fully support; this veterans' advocate. It's not necessarily a standalone unit and we're very aware of Compass and Oasis and we were in Townsville last year and we looked at that model, and we were in Townsville two weeks ago, again, and had presentations at the public hearing.

Why do you think it's necessary, however, just fundamentally, to bring together all of these services in one body? What is it, do you think? That's missing at the present time that encourages you to this particular model.

MR PARR: Mainly coordination. So that when a veteran goes there, they go to a service point and, then, for what their needs are, they will be sent to the most appropriate component of that unit.

COMMISSIONER FITZGERALD: Yes. You've gone further, I think, than the model in Oasis and Compass in the sense that you actually see a number of the component parts, like, Open Arms, Mates4Mates or Soldier On; all those sorts of bodies been connected within that and some of those would be and some of those wouldn't be.

But just in terms of the well-being of veterans, what's your hopes that those sort of hubs or those sorts of coordinated services would deliver? What do you think would be the main outcome that they would achieve?

MR PARR: I think that the serving veterans in specific and this is the one that concerns me, see as an obvious contact point. Yes, and I think that they go to a one-stop-shop and they can be sorted at that stage, rather than trying to source left, right and centre what best suits them. They'll go to a consultant that will listen to their issue and, then, they will advise them the most appropriate path to take.

COMMISSIONER SPENCER: Jack, thanks very much for the diagram and also the other material. I just wanted to explore a little bit more the issue of the Bureau of Veterans' Advocates because quite rightly, you pointed out, we didn't have much to say about that in our draft report.

The reason for that and I think most people will be aware is Robert Cornall was doing a major study or review of Advocacy and that has just been released by the government, so we're actively looking at that and, hence, the interest in the model that you've put forward and also Robert's questions around that.

I just wanted to go to one issue though. You've mentioned underneath that area "Veterans and Veterans' families". Do you have any thoughts about this issue? We've heard quite a lot in the public hearings about, quite appropriately, the major focus is on veterans. But we've been reminded on a number of occasions that the family members need to be taken into account in all of these arrangements. Do you have any thoughts you want to share on that to help?

MR PARR: Yes, I believe that the partner and wife, or even children, are probably the people best suited or best positioned to see an issue arising. Whereas the veteran; he's probably saying, you know, "I'm bullet proof. There's nothing wrong with me." They're in denial, but others can see the problem and I've been through that.

COMMISSIONER SPENCER: Yes, okay.

MR PARR: And I think that if the families have that contact person that they can know that they can go and pick up a phone to say, "Hello, Fred, hello, Julie, look, I think we've got an issue here. Can you send someone out or can we have an appointment some time to talk through things?" it just would break down the barriers, if you like, to have a very quick entry and without prejudice.

COMMISSIONER SPENCER: Right, okay, no, thanks, Jack. And just on the issue of ESOs, we're going to have more to say about that in our final report because we have seen many great examples. You've referenced Oasis, Compass, up in Townsville which we think is a terrific model. But there are many other hubs that are starting to come to light from being explored around Australia. So we think that that's a very important part of the system as a whole. That there are roles that ESOs can play that government can't play. Some of the most vulnerable veterans don't reach out to government services. As you've rightly said, there needs to be outreach to them and we think many ESOs already do a great job around that but it could be supported to do even more. So we might have more to say about hubs in our final report.

Could I just go to the right-hand side of your diagram. I've noticed you've put the Australian War Memorial under the Department of Veterans' Affairs. My understanding is that's currently not the case; it sits independently. Is there a reason for including the War Memorial there or - - -

MR PARR: Yeah, I think I just copied it off your proposal. That's all.

COMMISSIONER SPENCER: Right, yes.

MR PARR: There's no great depth of thought in that one. Yes, I just put it in there to make sure it was there.

COMMISSIONER SPENCER: Okay, good, right, no, thanks (indistinct).

COMMISSIONER FITZGERALD: So can I just – a couple of questions. In your dot points you talk about there's a need for a less adversarial model of claims and reviews.

MR PARR: Yes.

COMMISSIONER FITZGERALD: Now, we've heard a lot about this. I know a lot of people today will tell us that we've got to keep the DVA and there's good reasons for that. But we also heard and see many inquiries that have been highly critical of the DVA over years. Do you have any particular view as to why the Department appears to be adversarial? Now, there are many good offices in that department and many experiences that are not. But why do you believe or do you have any reasons to answer why there is an adversarial model of claims at the present time?

MR PARR: It's only from what I hear from others. Me, personally, I have had no issues whatsoever and I have had total support and I give DVA 100 per cent every time.

COMMISSIONER FITZGERALD: Right.

MR PARR: And the - I'm in contact with a large group of veterans in my cohort and I would say by far the majority of those are very happy with DVA services. I think that it's – there are some horror stories, I know and I have no idea how those things happened.

COMMISSIONER FITZGERALD: Okay. That's fine. Just finally, in relation to the ESOs that Richard mentioned and where again you mentioned the (indistinct) model in part. What do you think the primary role of ESOs going forward will be? I mean we've got those that are dealing with older veterans. We know that young veterans won't join those groups but they'll join others. You've identified in your chart a number of new emerging groups. Do you have a particular view of what ESOs will look like or should look like going forward?

MR PARR: I support the current role of welfare officers in the ESOs. I think they do a tremendous job. They work as an outreach type of person being in contact with veterans and they know their local veterans. They know the ones that need assistance and help. They know the ones that are at risk. So I think they are very, very – they're boots on the ground in the community. They're the guys that are at the – at the front talking to veterans.

COMMISSIONER FITZGERALD: Okay. Do you have any final comment before we conclude? Just one. Otherwise you don't get any - - -

MR PARR: So – yes, well I think there's a number of my dot points there that will be covered by others and I think they have all the arguments and my arguments would not be dissimilar. So - - -

COMMISSIONER FITZGERALD: That's fine.

MR PARR: Yes, there is one. Joint Transition Command.

COMMISSIONER FITZGERALD: Yes.

MR PARR: Okay. I would put that in the bin. The core business of the military is to defend the country. They don't want to be distracted by these other things. They've got all the politically correct bloody cultural – you know, all the things I'm talking about. I don't have to list them.

Distractions. Distractions from their main aim and they don't want that. They want to get out there and defend the country and protect our borders.

COMMISSIONER FITZGERALD: Well we'll probably have comments about that during the day. Can I just make the comment – of course in New Zealand veterans' affairs is part of Defence in total, not just in relation to policy or transition and I'm not quite sure you could mount that argument in New Zealand. It's also not the case in a lot of the other countries. Australia has a very narrowly defined view of Defence and we hear that and we understand that and we know where they're coming from on that but it's not a universal model. Australia has a very narrow view of the defence force. Some of - others are explicit that part of their role is to in fact look after the wellbeing of their personnel for life.

That's not a concept here. We've put that into DVA. So I hear that comment. I would just simply say to you it's not a universal view amongst military forces around the world but it's very strong in the Australian culture and you'd know better than I, I don't have any understanding where that's come from but we hear it. So thanks for that. Okay. Thank you very much for that. That's good. Thanks for that. (Indistinct words).

MR PARR: Do you want a copy of my notes - - -

COMMISSIONER FITZGERALD: Yes, yes – no, that would be good.

MR PARR: I can – yes, or do you want me to – I'll sort that out.

COMMISSIONER FITZGERALD: That's good. So I understand, Brad - - -

UNIDENTIFIED SPEAKER: No, I'm moving on - - -

COMMISSIONER FITZGERALD: Who's coming next?

UNIDENTIFIED SPEAKER: David.

COMMISSIONER FITZGERALD: David Thomas is going to go next. Is that right? Sorry, about that. David, grab a seat. Probably the same one that Jack had.

MR THOMAS: Yes, my (indistinct) - - -

COMMISSIONER FITZGERALD: So, David, can you give your full name and if you represent an organisation.

MR THOMAS: Yes. My name is David Thomas, and like Jack I don't represent any organisation, but I have a strong connection with the veterans' community in Rockhampton. I'd like to thank the Commission for coming along here today and listening to the information that we can pass onto them. I'd also like to congratulate Jack on his detailed submission that he has presented.

COMMISSIONER FITZGERALD: Good.

MR THOMAS: It brings up a lot of issues.

COMMISSIONER FITZGERALD: So if you could give us 10 minutes of your key points and then we'll have a brief discussion.

MR THOMAS: Yes, well I've got – my first key point is what was the basis of the report initiated by the government and what was the terms of reference set. Now you've covered a lot of that in your address first up. You said – one of the major points that concerns me and it was raised by Jack that 50 year ago we come home from Vietnam and shortly after that the suicide rate within veterans was outrageous. We've come 50 years down the track and as Jack's figures show nothing has changed. So if nothing else if this Commission brings out is how to counteract that.

I'm not qualified to make a comment on how you stop people committing suicide because is it, as Jack indicated, a personal thing and I've been down that track many times but that is just something that it's an individual thing but if there were a system that could be put in place or people to be given the opportunity to talk to people that would be a step in the right direction. My second dot point, (indistinct) call it Defence personnel, veterans, regardless of the time and place served is not acceptable and not within the intent of that terminology. Now if you look at the terminology of a veteran regardless of if it's in the military on in the workplace, a veteran is somebody that spends a long time in a position.

I raised this with the Minister at our meeting in Yeppoon and he indicated that if you're in the military for one day you can be called a veteran. Now that's completely out of context with the word. I raised with him there when I went into recruit training in 1968 there was about 52 people in our platoon, and it was after a week there was four had been discharged, and they hadn't been discharged because of accidents in training, they were discharged because they never had the intellectual capacity to be able to handle the discipline and the army training and under that recommendation those people would be called veterans. They didn't have the capacity to be able to learn to train let alone serve overseas.

So they - in my estimate, those people would be called veterans and wrongly so. I consider that there should be a time, whether it be 10 or 20 years within the service that people then get the name of veteran. Sometimes it's not their fault if they don't serve overseas, that they put their hand up to serve overseas and they haven't done it but to give somebody the terminology of a veteran after one day is just outrageous, in my opinion.

The other – included responsibilities of work undertaken by DVA now to another agency would be backward step and veterans would suffer. The DVA core business is to look after veterans and that should be – that should - how it should remain. Now I say that – I worked in a government agency for a long period of time and in that time we've had numerous changes, restructures and everything that comes with that sort of thing. We've – we had engaged consultants. Other people outside the business to come up with these changes and it was always found that the best way to get improvement within an organisation is talk to people that do the work in the organisation.

I'm sure the Commission has spoken to people that work in DVA and have asked them what can be done to make the way they carry out their core business better and how can they better serve the veterans. Now you did indicate that in lots of other countries the veterans are looked after – the core business of veterans here under DVA are looked after by the military. Now that could be so but is it the same thing in that military as it is in Australia? For if – someone serving in the military goes to the military to get assistance, that could have adverse effects on their career within the military. So if that doesn't happen in those other areas well maybe fine, but as it stands now in the Department of Defence it could have adverse effects on their service.

The other thing that I have is comparing the work undertaken by the Defence Force with civilian occupations is beyond comprehension when considering workplace health and safety issues. I've worked in both areas and the difference is miles apart, because the Defence Force has a completely different working environment and needs demands to cater for these differences. Excuse me, I'll just have a drink of water. I'm not used to talking this much. People may argue with that.

The army - and I recognise we have with us today Lieutenant Colonel Byrnes, retired. That talks about the safety proportions in the army as it stands now and it's far different to what it was when I was in there in 1967/68, but to say that those - they are the same as the people in other occupations is totally different. I worked in a trade prior to the army and after I got out of the army in a fairly dangerous trade, carpentry, and even

in that you cannot compare what a soldier does to what a carpenter does for instance, and Jack highlighted that in his terminology of the carpentry. I think that - Defence is best served by their own standards rather than standards set by other people outside the Defence industry. That's what I have.

COMMISSIONER FITZGERALD: Thanks for your talking point that we have got. Can I just deal with a couple of issues, David. The definition of veteran is a government policy and one which we are not changing, but can I ask the question - I understand why you made the comments and many people have done that to us, and really that's a matter for government policy, but for us it comes - it hits the road in a different way. It's not about what you call people, it's about what you provide to people, what services. So are you opposed to the notion that a person that is injured in training in Rockhampton here for example should be compensated differently if they suffered the same injury when they arrived in Afghanistan, or is it that actually it's about the way in which we recognise the service as being different? We fully appreciate, absolutely appreciate that there is a difference from serving in war or non-war like environments and peacetime, but when you actually come to the injury young veterans are saying to us universally, across Australia on bases, "If I'm injured in training or I'm injured in war I should be compensated the same way." Older veterans are saying, "No, they're different", but is the difference only in the recognition, and we understand that, or is the difference is as you say we should actually pay them and compensate them differently?

MR THOMAS: No. No, they shouldn't be compensated differently. I think it's just in the recognition side of it, and I think that there needs to be some sort of a guideline or something set as at the time to get - if you're injured in training preparing for war treatment should be exactly the same as what it was if you're at war obviously.

COMMISSIONER FITZGERALD: Sure. So it's more about the recognition from you - - -

MR THOMAS: It's more about the recognition, yes.

COMMISSIONER FITZGERALD: Others have a slightly different view. Can I just take a couple - one other issue and then hand it over to Richard. This workers compensation issue, we absolutely appreciate it's different, but in 2011 the workers compensation - sorry, the workplace health & safety legislation that applies across Australia applies to the military in full force, with one exception, and that is in operational service. So since 2011 there has been a very substantial change in the

safety and injury profile within the military, and when we have spoken to people in Defence that's largely driven through that legislation, that regulation. So that already applies. So whilst it is different and there are elements that are different that sort of regulatory arrangement already sits in place, and some of our recommendations about how do we increase the incentives for the Defence Force to be even more safety conscious.

We recognise that there are injuries and injuries will occur in the Defence Force. There's no doubt about that, we understand that, and it's different from everywhere else, that's true, but do you think that there are learnings from workplace health & safety - there are learnings from workers compensation schemes - that could be built into the system without actually reducing the force capability, and that's really on behalf of military life, it's about force capability. Do you think it's - they're different, but they're not completely different in that sense.

MR THOMAS: I think you're trying to compare apples with oranges. I think that the core business of the military is very difficult to compare with outside - for instance if a battalion or engineer squadron was preparing for active service overseas and training and an injury occurred at that training the same process should be taken there at the training as it is when they're actually in combat. I think if you're going to train people for active service they need to be fully aware of what happens in that active service. You can't say in the exercise we're going to stop the exercise now because Jack Parr's been injured. When they come to active service if Jack Parr's injured they're not going to stop, and I think that's some of the issues that have to be addressed. I fully agree that if somebody's working in a base if you've got - well, I don't know if they have cooks in the army any more, but if you have the cooks in the army and workplace health & safety is not unlike what it is cooking in a restaurant for instance, but I think when you get into more combat areas there certainly is.

COMMISSIONER FITZGERALD: Sure, and there are some exemptions for operational service even to that regulation, but that's fine.

COMMISSIONER SPENCER: David, just a couple of questions. You mentioned in your dot points about our terms of reference, and Jack also mentioned that as well. Just to explain on that it did come out of *The Constant Battle* and the emphasis being on suicide and prevention of suicide, but the terms of reference I think as everybody understands goes far wider than that. In fact this is probably the most comprehensive review of the whole system that's happened for a long period of time.

As you know there have been multiple reviews looking at one aspect of the veteran support system, but this is a comprehensive review. But on that question of suicide prevention I just wanted to mention a couple of other items that people might like to be aware of. In addition to the work that we are doing on mental health, and we will have once again a lot more to say about that in the final report, the Productivity Commission is doing a whole of nation mental health review which will go over the next 12 to 18 months. So I think what's happening in a military context is also being reflected generally in the nation, a much greater awareness of the impact of mental health in the community, but we're very cognisant of the unique aspects of military service and how that plays up.

So Open Arms for example, we have heard a lot of good stories about how Open Arms is assisting, but also people saying what more can be focused on the needs of veterans and their families. I just wanted to - the issue, perhaps clarification around the Veteran Services Commission. This has been seen as us putting forward the DVA will no longer exist and there will be this body called Veteran Services Commission. We're looking at that issue again in terms of DVA's role, because our draft suggestion that policy go to Defence is not really supported by very few people. Most people don't see that at all for some of the reasons we have been discussing. But the idea behind the Veteran Services Commission, we see in other systems across Australia, it is a dedicated and unique system for the needs of veterans. That's why it's called a Veteran Services Commission, and to Robert's point we're looking to try - and I know DVA as well and people at the DVA looking at this - how do we find the best examples and the best practices from both here and around the world that can operate in the best interests of veterans.

Now here is something that's really stunned us. There was virtually no information that DVA could give us about the outcomes of their programs for the health and wellbeing of veterans. In any top performing civilian system that would be there immediately. You would know what's causing injuries, how to try and prevent them, how to rehabilitate quickly and how to actually provide the right kinds of services, and some very new ideas like consumer directed care giving voice to the veteran about what will meet their needs.

So in the Veteran Services Commission we say that as a vehicle to really try and bring a lot of that learning, discipline and outcomes focused to the work in the future, which has been missing. Now, we know the transformation program is under way in DVA, Veteran Centric Reform. That will achieve a lot of improvements and it should, it's a major investment. Early signs are very good, but even with that at this stage our feeling is we need to go further to have a fit-for-purpose system. As

Robert said it's going to be there for 20 or 30 years from now. So, David, just a quick final question. We talked with Jack about the ESO's role, and I would like to put the same question to you that Robert did. How do you see the role of ESO's in the future? We haven't said much about that in the draft and we want to say more about that in the final report.

MR THOMAS: I think one of the issues - well, not an issue, but one of the things that I think we should use as the guide you need to keep veterans together, to go to one place. Now, I can highlight that. I went - I did three months at the Toowoomba Mental Hospital and there was nine other people there with me, and they were all veterans. Now, we would never achieve the outcomes that we did if we were to have other people there, you know, with us that talked about things. We were happy to open up amongst our mates as opposed we wouldn't have been - we didn't know each other until we went to the hospital, but after two or three days we all understood what we were there for and we all understood how we all felt and we were very open with the doctors, with the health providers of what was the problems. I don't think you could achieve that if you had a mixture of other people.

If a veteran had a one point place of contact that would be good, because the one - in my situation the one point base of contact that I had was my GP, and I only had that because my wife went to them and complained about it, and he sent me off to other doctors. So I think that - yes, if somebody is there to be able - the family could go and talk with on different situations, because Jack's exactly right in what he said, everybody knows there's something wrong with you except yourself, and you won't accept that, but when you get professional advice from one person that's core business is to look after veterans it's different.

COMMISSIONER FITZGERALD: So one of the things we're trying to do in the final report is really look at the mental health system. So as Jack indicated earlier and you've supported, the white card is an important way of funding that. That's funding it, but actually what we're looking at in the final is the services that need to be provided. So various models like that and others are of particular interest to us. So right at the moment there does seem to be a gap in the type of mental health facilities or services available, for very soft entry - you know, soft community support, right through to much more acute needs. So we're just trying to understand that for the final report a little bit better, and it's a tricky area because we have got a mental health system that serves the whole community. The white card helps fund a veteran into that system, but we just don't think it quite works for veterans in the way that it probably should into the future. So it's a big issue.

MR THOMAS: When I got discharged, and I think it would probably be the same for veterans today, all our physical needs were checked - you know, you've got a bad back or you're deaf or whatever, but there was nothing with our mental checks, and I think if there's something there on discharge that the people get some counselling, and this is going to happen, or this could happen to you, are you aware of that, and this is your point of contact if that happens. The counselling - we see now that if police or firies go to an accident everybody comes back and get counselled. With discharged people out of the forces, and there's no — as far as I'm aware — there's no counselling provided. We're recognised at your death and we recognise all these other things, but that's minuscule compared to your mental health.

COMMISSIONER FITZGERALD: And we're trying to look at that. Can I just ask a question. The transitional arrangements are very important. There has been numerous inquiries into transition. Universally they have been critical of the transitioning so far undertaken, and a lot of our report is about transitioning, and most people are supportive of at least what it's attempting to do. Up here in Rockhampton do you have any involvement at all through the RSL or others with people transitioning out of the services here?

MR THOMAS: Yes. Not an official capacity, however if I can give you an example. I was at my psyche's about three or four months ago and this guy was from Afghanistan, come in with his wife who had been crying and a small child, and I went over to him and I said, "You're doing it tough. Has the doctor recommended that you do a PTSD course", and he said, "Yes", and his wife said, "No, he won't do it", and I said, "Mate, you do yourself a favour and do it." On Anzac Day for instance RSLs — where obviously young guys there — make it a point and go and talk with them, you know, and tell them that, you know, "Don't be afraid. If you're not feeling the best seek some help."

COMMISSIONER FITZGERALD: Good advice. Any final comments, David?

MR THOMAS: No. I just think the points that I've raised there I think most people feel fairly strongly about it, and I agree with Jack, the service I've had from DVA has been excellent. I've never had any problems. They look after us quite well. I know there are some horror stories out there, but there always will be.

COMMISSIONER FITZGERALD: All right, thank you very much.

MR THOMAS: Thank you.

COMMISSIONER FITZGERALD: Thanks very much, much appreciated. Now if I'm correct Mr Brad Bauer, is that right?

MR BAUER: This is my presentation.

COMMISSIONER FITZGERALD: Good. Thank you very much for this. So you've got - - -

MR BAUER: The first few pages is actually what I'm going to be presenting today.

COMMISSIONER FITZGERALD: That's fine.

MR BAUER: And the rest is - - -

COMMISSIONER FITZGERALD: No, that's terrific. Thank you.

MR BAUER: My name is Brad Bauer. Most of you guys know me. I'm a Vietnam veteran. I am not representing any group at this stage. However, I do belong to the TPI Association and also the RSL. I'm also a welfare officer and I also have been an area representative for the VVCS when it was operating at the time quite a few years ago.

I do apologise for a brief report, because I only just heard about it recently. For whatever reason I didn't get the message that this was actually happening, so I've had very little time to prepare. So please I do apologise for that, but I'm sure many other people will raise more issues than I can today.

Anyway I'll start with this; there's a document from the Federation of Australia, the Rehabilitation Appliance Service Review, and it was done in July 2018, and from that I recommend that the VEA home and garden maintenance to be reintroduced. It would appear from the document, the review, that the entitlement was removed sometime after 2012. Many of those issues are addressed in the fact sheet HCS01. In this document, the fact sheet, under the heading "Safety related home and garden maintenance where pruning grass, grass cutting or weeding can be done only where a hazard exists."

I suggest that it is a personal hazard for an aged veteran, particularly one with disabilities, to attempt to address some of these activities, particularly mine. It is government policy to try to keep aging population, veterans in this case, in their own home for as long as they are able with assistance.

This is one area that can assist in doing just that. As a welfare officer I come across this quite a lot of the time.

Going on, I refer to the key points in the Productivity Commission draft report 2018 and the following section, and I quote:

> *"This will require new governance and funding arrangements. A single ministry for Defence personnel and veterans should be established. A new independent statutory agency, the Veteran's Services Commission, should be created to administer and oversee the performance of the veterans' support system. DVA's policy responsibility should be transferred to the Department of Defence with a new veterans' policy group."*

I suggest that the Department of Veterans' Affairs be retained as the only agency dealing with veterans. It will need to be revamped to deal with the current issues facing veterans. However, that agency should be totally independent and not tied to the Department of Defence in any way. The reason for this is that the Department of Defence was their employer at the time when we incurred our injuries and subsequent problems arising from that employment. For that reason there should be no suggestion of the influence in any decision on the supply of the support, needs and entitlements of veterans. Consequently the Department of Veterans' Affairs will need the funding to implement those decisions.

The current system should be, and this is the next section, the current system should be simplified by continuing to make the system easier for clients to access. A complex system does not need to be complex for users. Rationalising benefits, harmonising across the acts, including a single pathway for reviews of decisions, a single test for the liability and common assessment processes, and moving to two, compensation and rehabilitation spends by July 2025.

Scheme 1 should largely cover an older cohort of veterans with operational service and injuries that occurred before 2004 based on a modified Veterans' Entitlement Act 1986, VEA. Scheme 2 should cover all other veterans based on a modified Military Rehabilitation and Compensation Act 2004, MRCA, and over time will become the dominant scheme. I agree that the system should be simplified. In my opinion, there should never have been additional and separate acts, MRCA and SRCA. All that needed to happen was to modify or add to the Veterans' Entitlement Act. There should never have been separate legislation for different conflicts because the injuries from war service are the same whatever the deployment. They are either physical or mental or combinations of both. Therefore treatment support entitlements should be

the same. The only difference today is that we have improved technology in every sphere of life. Consequently, there is no need for complex systems, just improved processes.

COMMISSIONER FITZGERALD: All right. Thank you very much, and thanks for your written submission and also your material behind that. Can I just deal with a couple of issues, just your very first one, the VEA home garden and maintenance system.

MR BAUER: Yes.

COMMISSIONER FITZGERALD: So thank you for that particular issue. We're trying to get uniformity across all there acts, DRCA, MRCA and VEA in the short term in relation to home services. As you may or may not be aware, they're different under different acts.

MR BAUER: Yes, some are the same and some aren't, yes.

COMMISSIONER FITZGERALD: Yes, and we can see no rationale for that at all. We think that these should apply well across all acts, but your point is a particular one that in relation to the current arrangements there's been a removal, as you've indicated, on particular home and garden maintenance, or a narrowing of who can be eligible for that.

MR BAUER: Yes.

COMMISSIONER FITZGERALD: So thank you for that. How has that played out for? Has that been directly affecting you or is it - - -

MR BAUER: Absolutely, at times, like probably most the guys here we have problems, physical and mental, so consequently you are unable to do it, so then you have to hire in people to do so, and it's also, it affects you because you feel that you cannot maintain your own residence. It is a mental thing as well. It's better for me personally, and maybe others, to be able to deal with your own situation, look after yourself, be as independent as possible, but it is no longer possible. As we age, as our problems get worse, and as our physical situation declines.

COMMISSIONER FITZGERALD: Right. In relation to the other aspects of the home services arrangements, do you access those as well?

MR BAUER: Yes, some of them.

COMMISSIONER FITZGERALD: Are you eligible for that?

MR BAUER: Yes.

COMMISSIONER FITZGERALD: And how does that work from your point of view?

MR BAUER: Very well.

COMMISSIONER FITZGERALD: And you're able to access the services by just contacting DVA?

MR BAUER: DVA and also we have an occupational services here today, Jo Couper, and I contact her, so the two combinations are working well for me.

COMMISSIONER FITZGERALD: That's good. Can I just deal with a couple of other very brief issues and then hand to Richard. You have raised the issue right at the end of your presentation about people being treated the same, irrespective of where the injuries occur. Is that correct?

MR BAUER: Yes.

COMMISSIONER FITZGERALD: And that's a view that's been particularly put by younger veterans, but it's not a view that's been put by some older veterans. Can I just understand why you think they should be treated the same and not differently as it has been in the past?

MR BAUER: Well, it's quite simple. You go to war, a few things happened to you, and you're either mentally affected by the trauma, you either get shot or hurt physically, and the combination, or you might step on an IED or whatever, so you've got physical injuries, mental injuries. It happens in every war, so why should anybody be treated differently whenever - whatever conflict you're in. So it's pretty simple to me.

COMMISSIONER FITZGERALD: And does your view extend to people being injured in non-warlike environments, or sorry, in peace time or, you know, yes, I'll just use the term peace time operations and war type operations.

MR BAUER: There's a difference there.

COMMISSIONER FITZGERALD: Yes.

MR BAUER: There is a difference in my opinion. If you're training in Australia to be a carpenter and you get injured, and if you're training to be in the military, you are training to kill. That's what you're trained to do.

It's an entirely different type of training. The recognition should be different. This is a - a civilian is, you do a job as a carpenter. A carpenter in the military is first the basic training is how to kill. Consequently, it has to be recognised as different.

COMMISSIONER FITZGERALD: Different from carpenters, but in relation to injury, if an injury happens on an Australian base or an injury happens on a base in Afghanistan or it happened in a peace-keeping mission in East Timor and whatever it might be, your view is that they should be treated differently or the same? I just want to be clear on your - the last paragraph.

MR BAUER: Well, it depends on the injury. It depends on the injury and what it is. The treatment of each injury has to be case by case.

COMMISSIONER FITZGERALD: Yes.

MR BAUER: Consequently, if you get a leg blown off or you got it cut off in an accident in Australia, I think it's probably a similar thing, except just remember, though, these people have put their lives on the line every day of the week when they're in a war zone.

COMMISSIONER FITZGERALD: Sure.

MR BAUER: And so that recognition has to be there, and compensation should be appropriate.

COMMISSIONER FITZGERALD: Brad, just to go back to this issue of the range of benefits you receive.

MR BAUER: Yes.

COMMISSIONER FITZGERALD: One of the things we've looked at is, what has been happening in other systems to support people with a disability, for example, or with particular needs, and there's been this notion of trying to get more choice to the individual about what they think is in their best interests, and that's at the heart of the National Disability Insurance Scheme because the words that get used are choice and control. So for that particular scheme, you have to have a permanent and significant disability, and then you are entitled to reasonable and necessary supports, but within the package, you get a lot of choice as to what kind of service would best meet your needs. So I'm just wondering about that because when I read about the home and garden maintenance program, it sounded very specific.

MR BAUER: Yes.

COMMISSIONER FITZGERALD: And you're saying as a veteran, "Well, you know, that's what would meet my needs. That's what I would like", so.

MR BAUER: That was one of the things, yes.

COMMISSIONER FITZGERALD: So do you think there is an opportunity here to try and enable the veteran to have some more flexibility or choice about, within a package that's approved by DVA or by ...

MR BAUER: I think that has some merit, yes.

COMMISSIONER FITZGERALD: And also it's been, community aged care, that happens as well.

MR BAUER: I know it well.

COMMISSIONER FITZGERALD: Yes, you get the package and then you can choose, you have much more control over - - -

MR BAUER: Yes, I know that package well.

COMMISSIONER FITZGERALD: Yes.

MR BAUER: Because I've dealt with aged veterans and also in my own family.

COMMISSIONER FITZGERALD: And does that - do you see that working well or what's your - - -

MR BAUER: I see it - look, the idea is well.

COMMISSIONER FITZGERALD: Yes.

MR BAUER: The implementation is something less to be desired. I'll tell you why. Because there's a bunch of providers out there are jumping on the band wagon and they're ripping this system off big time. And consequently 30 or 40 per cent has gone in administration costs straight away. It's a cost – the idea is terrific, but in the actual implementation is people are – it's a gravy train for them. And they're abusing the actual people they're providing for because they're using a lot of the money that should be actually used in providing the services.

COMMISSIONER SPENCER: So what do you think the answer is to that? More oversight? More regulation of those - - -

MR BAUER: Well, it has to be something, more oversight or regulation, because these charges are absolutely beyond - and in fact there should be an inquiry done on it.

COMMISSIONER SPENCER: So just coming back to the two scheme approach. I think you indicated back in 2004 when the MRCA was adopted, your preference would have been for the VEA to continue?

MR BAUER: Well, I can't see the problem. VEA was working quite well and there's a different conflict, as I understand it. And a different time and place. There's still a war. Why is something that's working no longer working? You have to add a different legislation. What ended up being with MRCA and SRCA was that it became complex and you (indistinct) recognised in your whole system. You didn't need to make it complex. It was simple. All you had to do was continue to do it. There's no need for complexity in these issues in my opinion. The law service, the injuries are such, you then deal with it, everybody the same.

COMMISSIONER SPENCER: So it's – I mean, to go back 15 years later and unravel that particular complex situation is, I don't think is going to be possible, so given we've ended up with these three pieces of legislation to try and at least both harmonise in the way that Robert said but also to what we say is to roll DRCA into MRCA to this two scheme approach, what are your views on that? It may be a second best solution from your point of view, but do you think it's a reasonable direction to go in?

MR BAUER: I would disagree that you can't unravel it. You're open to modification, and it's up to you guys to decide what those level and that modification will be and consequently, I think you should take out all of the complexity, all the rules that you – and these, it drives the advocates crazy as you know, take it all away, make it simple. And take 90 per cent of your legislation away and make very simple processes and I do believe you can unravel it. It can be changed.

COMMISSIONER SPENCER: Okay. And just one last question and the question we've explored earlier about the future roles of ESOs. Have you got any thoughts beyond what we've discussed already?

MR BAUER: Yes. Yes, I do. I'll give you – I'm glad you asked that question, because I do have a – and because I am a welfare officer and

(indistinct) represented the VVCS in the past. The difference between ESOs and any other organisation is the ESOs are manned by veterans; consequently there is a relationship between veterans that you won't get anywhere else with any other group. So we, as veterans, know what other veterans are going through. We can – we know how they're feeling, what's happening and what their needs are. That is certainly not, in my case, and I've had some horror stories with the Department of Veteran Affairs, some absolute idiots in there trying to tell me about my issues, when they know nothing about what's going on and abusing me at the same time. So the difference is somebody that has been there, done it, experienced it, consequently they're the people that need to assist other agencies, (indistinct) the Department of Veteran Affairs and Open Arms and any other organisation like that to deal with these issues.

COMMISSIONER FITZGERALD: Just going off from Richard, it's not possible – in 2004 the government of the day decided that there needed to be a new direction in relation to military compensation. And that's where, as you know, MRCA came from. But it wasn't just about the conflicts. It was actually a very different approach. One was a relatively passive system where you received life-long pensions. MRCA was designed to be a fairly proactive system, trying to encourage rehabilitation, people back doing work, if that was possible. So they're very different in their approach. Now, this is 2004, so clearly at that time, the governments of the day and the parliament of the day universally said that we needed a new approach, so I just wanted to test that with you. We understand VEA has elements we're told the veterans like. We've recommended VEA stay (indistinct) veterans. So we haven't said it should go as you well know, but MRCA was fundamentally different in character.

So can I just understand it, was it just that you thought this was unnecessarily complex, or did you actually fundamentally disagree with the new direction. Which is a much more proactive one. It's also about some lump sum payments. It's about giving more power to the veteran to make choices about their future, if they get a lump sum payment, that for example, so they're fundamentally different in character. So it's not - I understand it added complexity, that's absolutely true. But do you think that the approach that was adopted was a problem approach, or do you think that just could have been merged into the VEA?

MR BAUER: Well, I believe it should have been merged into the VEA, but the other part of what you're saying is there's nothing wrong with rehabilitation. If a veteran can be rehabilitated to whatever degree he can be. And I don't see why that's not incorporated in the VEA. I mean, what's wrong with that? What's wrong with rehabilitation except that one

of the problems with a career for a person in the military these days is if they identify that they've got a problem, it does affect their career and the rehabilitation part of it can be detrimental to them. However, there's nothing wrong with rehabilitation. Absolutely nothing wrong with it and it should be in every piece of legislation.

COMMISSIONER FITZGERALD: Okay. And the issue about lump sum payments, you may have no view (indistinct) about that. Under VEA, you can't have that, it's a life time pension. Under DRCA, you can and under MRCA – sorry, under MRCA you can have either a periodic payment or a lump sum and under DRCA it's only a lump sum payment. We're looking at all of that, sort of arrangements. But did you have any views about that or that wasn't of concern to you?

MR BAUER: It certainly wasn't – I haven't really looked at it, particularly, but from my opinion and being under the VEA system, I find the pension system very, very good.

COMMISSIONER FITZGERALD: Yes, we understand why people like that. All right. Any other final comment?

MR BAUER: No, not at this stage, I don't – unless you've got any other further questions.

COMMISSIONER FITZGERALD: No. That's terrific, Brad. Thank you very much.

MR BAUER: Okay.

COMMISSIONER FITZGERALD: Good thanks for that. Thanks for the material. And if you have any other thoughts the company (indistinct words).

MR BAUER: I will, I will.

COMMISSIONER FITZGERALD: Just quickly (indistinct words). We'll just have one more participant before morning tea. And I think that's Alan Sisley? Alan, if you can give us your full name and whether you're representing any organisation or just representing yourself?

MR SISLEY: My name's Alan Sisley. I'm not representing any other organisation except myself.

COMMISSIONER FITZGERALD: Good. So Alan, the same thing. If you can give us 10 minutes of your key points. You've given us a written

submission as I understand it, and I've just read that. So thank you very much for that, but if you can, as I said, like the others, 10 minutes to give us your key points.

MR SISLEY: Well, my background is like Jack. I'm a National Serviceman. I went to Vietnam, I was in the same battalion as Jack at the same time in Vietnam. When I read the Productivity Commission, well, I'll start off by saying, I fully endorse the TPI. I read the TPIs submission. I fully endorse what they've got in that. I'll go now to my points and as I – as they were saying, I'm going to reiterate what we've all heard so many blooming times unfortunately. I mean, who is a veteran? Most dictionaries describe a veteran as a person who has seen active service in the case of military or a person who has been in an occupation for a considerable time. I mean, we can take – extend that to, if you want to talk about vehicles, what a veteran vehicle is, what a classic vehicle is, but they all are undermined by that considerable amount of time. Referring to a military person with one or more days' service as a veteran, flaunts this definition and as such, if the term is to be used, should have a more realistic qualifying period.

A case in point, the old days you could go and get a driver's licence after one day, now you've got to do a minimum of 100 blooming hours. I mean, that doesn't – I mean, all I'm getting at here is they've extended a period before reason. And they've given a definition of how many hours you've got to do to get a licence.

This should also – a realistic definition is what I'm getting at. It applies to the licence – why shouldn't we apply it to what a veteran is? The commission's report in using this definition lowers the standard use since World War I and previous wars that distinguish those who served our country in peace time and those who have served our country during the conflict, giving rise to the question of whether this has been done to justify the amalgamation of all acts into one or to define the risk factor of the unique occupation as being the same in both circumstances and as such should be brought to the standard of civil health and compensation schemes. Either way, I don't agree with it.

Next point was "Abolition of DVA". The DVA needs some very seriously reforms is not disputed by those who have been associated in any way with it. It is a system that has been decaying since the government requirement for employment of people or, as I put it, migrants and inexperienced people with no military awareness within the public service system. That come in around 2005; the employment of the people who do not have any understanding of our culture nor our way of life, gave rise to the adoption of a matrix system of assessment which in no

way follows the reasonable hypothesis standard applicable to war-like operations as it would be impossible to cover the varying situations that pertain to any individual case with that type of system.

I mean my own personal dealings with DVA and, like, I wouldn't give you two bob for the people who work in DVA. I mean originally they told me I wasn't even in Vietnam; that I went for a 30-day visit. I've been through six VRBs and one AAT. The AAT didn't even bother telling me their results – the only way I found out was when DVA sent me a letter of demand to pay back money. That's the first time I heard about anything.

Through the whole process, the balance of probability principle in which I had to prove everything that I have, everything I had to ask for I had to get – if I didn't have a written paper there as to approve it, I was knocked back and denied. So, as I said, my opinion – I mean I consider DVA to be a good organisation, but unfortunately these matrix systems they seem to use on how they assess people, you cannot cover the complexities of veterans under a matrix system because there's too many variables.

Matters of repatriation, compensation and rehabilitation. The Commission accepted military service as being a unique occupation and identifies that almost every aspect of uniformed life comes with a risk. This in itself precludes the introduction of a health scheme similar to civilian counterparts, as this would detract from the ADF mission and aims.

You said yourselves before, we have views of the OH&S. I was still in the services when they brought it in; was the old weather station. If it got above say 36 degrees you weren't allowed to train. I mean if I'm sitting in a war and it's above 36 degrees, unfortunately enemy don't turn around and say, "Well, it's too hot, we're sitting down."

To adopt OH&S policies with the ADF would require the change of all requirements the Commission published as its reasons it considers it unique in the first place. I mean we can't just suspend the unit so we can go and investigate an OH&S incident like we do in civilian life. It wouldn't work in the military because that means you'd be in the middle of an exercise; it costs a fortune and if you're going to stop it to do an OH&S, it would be ridiculous.

If we consider each reason the Commission gave and apply OH&S to them, we would not be training our soldiers for the reality of an armed conflict and the deprivation of health and fitness associated with the conditions found on a battle field and how do we distinguish between the

repatriation compensation or rehabilitation matters associated with their return if we fail to train to meet their demands in the first place.

It would be a legal nightmare for – I should say, it would be a legal windfall for lawyers who practise in this type of legal matters and a nightmare for Defence to fight. I mean if you're not going to train the soldier in war conditions, you then send him to war and he gets a trauma out of it, you're leaving yourself open to legal action. Same as you are in OH&S; if they prove you've done something against OH&S the lawyers would jump on you.

We then must consider how we establish this health scheme and the commission propose to cover such matters. Is Defence to fund and/or run the scheme? If so, like any other insurance business, while in a peace-time situation it may not present too hard a proposition, as this use of OH&S principles would limit the number of claims and the only real problem would be if Defence was found to be at fault and sued by the respondent.

However, in a conflict period, depending on the method of payout that is instituted, it could prove to be a very financially damaging as, again, people will be put into situations that they are not necessarily trained for and, again, lawyers would have a field day.

The Commission, as proposed, the rehabilitation system as it (indistinct) to be a focus on well-being and rebuilding lives and its desire to get the serviceman back to a position where "as with all other government" – this is their quote – "as with all other" - - -

COMMISSIONER FITZGERALD: We're just going to run out of time. So, look, don't bother quoting us.

MR SISLEY: Okay, then.

COMMISSIONER FITZGERALD: If you want to come to your concluding points and, then, we'll have a conversation.

MR SISLEY: Well, you made the statement before, there, (indistinct) that what I was trying to get at, I had two sons still in the army. Now, the army brought in one of their – what do you call them – laws saying that if you go to a conflict situation, when you come back to Australia you had to be at the psych to get an analysis done.

Neither of my two sons who have been to Afghanistan, Middle East, neither of them and one who is still in the army – neither have ever had a

psych test. The other one got out of the army because, like me, PTSD hit him and he was going to – he had to get out because he couldn't stay there.

The system you have at the moment in DVA, as I say, is a reasonably good system. The people who are in it, and as I said to the Minister the other day when he brought up the point, when we came back from Vietnam, World War II soldiers didn't consider us worthy to be in the RSL. He also made the point that the World War II people who were in DVA didn't look kindly at any of our problems.

Unless you change that attitude in DVA, doesn't matter whether you call it DVA or whatever the new word is, unless you change that you are not going to succeed in anything you bring. You've got to change the attitude of the people in there.

You were talking, again, you brought up a couple of subjects with people here about how do we perceive things. When we went to the Minister the other day, I looked around the room. There was not post-1973 conflict bloke in the room.

COMMISSIONER FITZGERALD: Sure.

MR SISLEY: Because, like us, when we went into the RSLs, we were treated like poop – like shit. They feel the same, now, because they're talking to angry people. We're not angry, we're angry with what happened to us; we're angry with the fact that we never got, like the army even says to my son, "We will look after you by giving you a psych evaluation." They don't even bother doing it.

COMMISSIONER FITZGERALD: Okay, thank you.

MR SISLEY: That is, to me, what the problem is. Nothing wrong with DVA, it's the philosophy that's inside that organisation that is the problem.

COMMISSIONER FITZGERALD: So, look, thanks, again. Thanks for your written submission and there's a couple of points I'll raise. Can I just go back to this issue; just to clarify, again, the term "veteran" is the Commonwealth Government's term, not us.

MR SISLEY: I realise that, sir, yes.

COMMISSIONER FITZGERALD: So I just want to make that clear and we don't have a particular view about it. We have a particular view about how you treat veterans and that's our particular attention.

In the relation to the statement of principles, you've had all of your claims dealt with on the balance of probabilities. Is that what you were saying to us?

MR SISLEY: Well, there was – as I said, I had to prove that I was in Vietnam because they said I went for a 60-day visit.

COMMISSIONER FITZGERALD: Sure.

MR SISLEY: No national service soldier/private ever got a 60-day visit to Vietnam.

COMMISSIONER FITZGERALD: Sure, yes.

MR SISLEY: I mean when you get that from an organisation, I mean I have a letter from the assessor telling me that I've got PTSD, which I got in Vietnam. The probability that Vietnam was the cause of it is about all he said, but this one comes to me and says, "No, you didn't get it in Vietnam. You've got it, but you didn't get it in Vietnam.

MR FITZGERALD: Were you eventually – I don't want to go into the personal details unless you wish to, but were you eventually – was it eventually deemed that you were, in fact, - - - ?---

MR SISLEY: I eventually got my PTSD, they gave me - - -

MR FITZGERALD: As a service related injury?

MR SISLEY: Yeah, they gave me 90 per cent pension. They then turned around and I had a phone call from Brisbane who – one lady there said that they're fighting – that their two doctors that I didn't – have never seen, reckon I shouldn't get 80, they wanted to drop it back – well, it was 90, sorry – "they want to drop you back to 80". I then had a phone call from Adelaide telling me they want to drop it back to 70, another two doctors' assessment. I then had a phone call from Melbourne telling me they'd knocked me to what I originally had, 50 per cent. I went to the AAT and as I said, the only way I found out that I'd lost the case was when DVA sent me a letter of demand.

MR FITZGERALD: You've been through, I think you said in your statement, that you've been through six or more appeals with VRB and

one with the AAT. What are the learnings out of that for us? So we've made some recommendations about the VRB. We have said it should stay, but we think it should do a slightly different job, with the AAT in place. What do you think is the critical learning from your experience for us?

MR SISLEY: Well, the processes are there. I mean, when I went to my advocates they sat down, explained to me the process of the DVA and I thought "Yeah, that's a fair and meaningful process". The problem I found was from then on. When I went to the VRB they would come up with what they considered their opinion. You would then discuss that and put your points to that. You'd then go back and I'd go – you'd leave and then you come home. Well, the next time I got there was not anything about what we discussed at the VRB, it was their next set of things they found wrong.

Now, I don't know why, I mean, we prove what they say is wrong. The assessment I got back would be still saying no, because of these reasons. I mean, I don't know how you fix that system. To me, my only way is, as I suggested to the minister the other day, employ all these poor blokes that have got legs blown off, indeed who are aware of the situations, who understand what military service is. I mean, you discussed there before, a bloke breaks his leg and as I put in my submissions, if I break my leg out here, at Shoalwater Bay and I get it blown off in Afghanistan say, there is a difference about the compensation. Are you going to play the bloke from Vietnam or from Afghanistan a civil compensation and disregard the traumas that he went through because as you said, sir, it is not only a broken leg.

However, a broken leg in peace time is bloody different in getting it blown off or wounded in a battle. As Jack said, you're in a different situation. Whose payment method are you going to use, the health scheme like they do now, if I break it as a carpenter or whatever it is, the health scheme lays out how much money you pay for that leg. They don't take into consideration any trauma you might have got out of it. I mean, if you going to turn around and say that the leg is a leg, tell me how much you're paying first and you're going to forget the trauma over here.

MR FITZGERALD: I should just make the comment that under our proposals and under the current scheme, a person that is injured within the military irrespective of where the injury occurs, currently is paid higher than a normal workers' compensation and we agree with that. So we are not – we are not trying to drive down the payments and benefits to equate with ordinary workers' compensation. That is not our proposal. It never has been, never would be. We recognise that the scheme has a differential

which should be different.

The question is then, as you say, how do you apply it? But we are not recommending that may be paid the same rates as the ordinary person, at all. We are saying very clearly, there are elements of those workers' compensation schemes which actually are very good, and those elements should come in. But that's not about the benefit or the rates, and so thank you for raising that. I will just ask Richard.

COMMISSIONER SPENCER: Alan, I just want to explore with you a bit further, you know, your concerns and it has come up several times about occupational, health and safety, workplace health and safety and how does that impact on the primary role that the ADF has, and that is to prepare for war.

When we look at other schemes, I mean of the features of other schemes is to actually try and prevent unnecessary injury. Now, I visited New Zealand to look at their scheme and as Robert said earlier, their scheme has – their Veteran Affairs within Defence, so Defence does carry responsibility around the welfare of its serving members. So if you like, that's around the duty of care.

But also one way of looking at it is there's the duty to prepare and that's a big challenge for any military. What's the right balance between duty to prepare for warfare and duty of care in how you go about the New Zealand example was that their chief-medical officer said "When we have too many injuries and unnecessary injuries in training, I'm concerned about that". So that sounds very clear. But then he went on to say, "And when we have too few injuries, I'm really concerned about that as well". And that's this notion of to prepare, as several speakers this morning have said, there will be injuries. There's no doubt about it. But where do you strike the balance?

So it is really to come to back to this issue of the responsibility of Defence around that issue. But we've been surprised by a number of people who have spoken to us about having had injuries or having, as you recounted to us earlier, things that should have happened in Defence haven't happened. Who is responsible for that and who should be? Now, we tried to put in our draft, well, we put in our draft we think Defence carries some of that responsibility and people have said to us, "No, no, no, you can't do that". Two reasons that are usually given; one is because it comprises the duty to prepare. Well, other systems seem to be able to grapple with that.

The other one is, "We can't trust Defence, we don't trust Defence. I mean, we've had some veterans say to us "They broke us. I don't trust them to

have responsibility for this. It has to be with DVA. So I come back to this question now, Alan. It is a very difficult challenge that everybody has and the ADF certainly has it. But when you recount your own experience and that of your son, we grapple with this idea why Defence should not have more responsibility for the wellbeing of its serving members. Can you comment further on that for us,

MR SISLEY: I agree with you, it is the Defence responsibility. I mean, as the TPI Association said, take the old F-111. That was their responsibility, but accepting of it. If you leave it in their hands, I mean, somebody's got to get blame for that. Nobody wants the blame. Nobody wants to bloody put the finger at anybody. I agree with Jack's idea. If you have an organisation outside of Defence that you can go to, which we all assumed what DVA was, you're not talking to your bosses. You're talking to somebody who can give you advice on how you go about what you're trying to get. To say there is no stigma, if I went to my boss and said, "You're to blame because you didn't carry out enough – I was the safety officer at Shoalwater Bay. You didn't do enough safety". I mean, they had a – just off the thing – 155 artillery fired one night outside of the (indistinct) closure. Over the top of your shoulder of the base, jumbo jets flying 500 people in it. If that round had hit one of those planes there would have been a hell of a bloody thingo. The finger of blame then has to go somewhere. Defence doesn't like to be blamed for themselves.

So you've got to have an organisation that is outside the system that you can go to, put your complaint in. They then make a decision whether or not they're at fault and if they are, then that person who was at fault should be dealt with, but if you do it yourself and go to your boss and he knows that it's going to ruin his career, you're the one who's in more trouble than he is, because that's the nature of people.

COMMISSIONER SPENCER: So one of the ways we're trying to explore to close the loop on this, and really good systems, there's a lot of information captured about the consequences of injuries and why they happened, which helps inform how better to prevent them in the first place.

We know DVA is thinking about that already but certainly some of our recommendations go to really trying to capture that information and feed it back to Defence because nobody sets out to unnecessarily hurt anybody and we absolutely understand that, but it's often knowing what the consequences are of certain ways about going things that can be helpful to train appropriately and strike that right balance. And I just want to come back to something else because you have mentioned this and I think others have sort of said this and we've certainly had it in other hearings, and that

is the - this is about cost savings and concern about that, and I just want to say that the - if our draft recommendations go ahead in their current form, this will cost the government more, so it is not about cost savings.

The DRCA and MRCA, there are cost implications for that. There are a range of issues that have been looked at at the moment in terms of the financial consequences and we will have more to say about that in the final report. But we think the system for the future will need investment and investment will require the government to put more funds into the system as a whole, so I just wanted to give you that reassurance.

MR SISLEY: I used to be the union - I was - I used to work out at the airport out here. When they had closed things down we had brought in financial advisors. Now, the blokes who worked for civil aviation they were changing from the Commonwealth superannuation scheme to one of these internal government whatever the department schemes. Now our consultant - and that was instead of a pension you get a lump sum. Now the two, the three consultants who come and spoke to the people out here all said the same thing, "Don't go to the new scheme because if you get a lump sum then you live with it. This - you spend - this costs you this much a year. The lump sum will disappear within 15 to 20 years, so if you say that it's going to cost the department more money, it will only cost them on whether or not they make compulsory lump sums or a pension. That is the only way of - - -

COMMISSIONER FITZGERALD: So just to clarify. Our recommendations absolutely don't make lump sums compulsory. It's your choice.

MR SISLEY: Sure.

COMMISSIONER FITZGERALD: And our view is about that now. The question is whether or not you believe individual veterans should have the right to exercise a choice.

MR SISLEY: (Indistinct).

COMMISSIONER FITZGERALD: Exercise choice.

MR SISLEY: Choice, yeah.

COMMISSIONER FITZGERALD: So, in VEA you have no choice, it's a pension and we're recommending VEA stays. But - but, we are also saying that in relation to MRCA and DRCA it should be a choice that the veteran has; that is a lump sum or a periodic payment. Now the question

is for government is do you or do you not give individuals choice? And in every other scheme they have choice, or they have a lump sum payment. So we say there's an option, can I take either, not forced to, and that's different to what's there at the moment. So that's a very big question because some people will make poor choices, they will not do well with their money, others will do very well with their money. But if you just put yourself in the place of government, should governments be saying to veterans who are 30, 35 and 40, "We will make the decision for you", and throughout the Productivity Commission that's a hard thing because most of us have choice, so why should veterans have no choice? And so what we're trying to look at is what's the right balance? But to say, no, government will make up its mind that you can't have a lump sum, that's a big call. Equally, saying you have to a pension, that's a big call. So, we're just trying to work it out. That's where we're at.

But the point that Richard was making is this scheme will cost more. Not less. So all the submissions that have said this is about cost saving by the Productivity Commission could not be more incorrect. It will actually cost more because we're actually improving some of the benefits, particularly for those that have been injured in peace time so at the end of the day a whole range of veterans will be better off. So that's part of the scheme. For the very reason we said before, we don't - we're not trying to numb the start to a workers compensation scheme but we are very clear about the good things in workers compensation schemes and we should be able to bring those into the system. But we thank you for your point there about that.

Can I just ask the last question about your sons. We have heard this a lot. Before discharge, most military are entitled to and are required to undertake some sort of medical check and some psychological testing. You have indicated in relation - was it both sons or one son, that didn't happen?

MR SISLEY: When they come back from - from the - - -

COMMISSIONER FITZGERALD: They were supposed to have that as well.

MR SISLEY: They were supposed to get it then. They never had it. When my youngest son got out in Darwin, he was - nothing was done until he went and saw one of the - to do with the military come round and seen him a month later and said, "You're entitled to this, this, this and this". He then went and got them done. He was not told that before he got out.

COMMISSIONER FITZGERALD: We've heard that many, many times so thank you for that story. One of the transition things - the issues in relation to transition are meant to try and reduce the risk of that occurring and we have heard that it's absent.

MR SISLEY: I even - as I said, my older son was on a driving course because he was APC and they had to go and - a commander of this APC and it was one of the captains who - a female captain who picked him up on his anger, for his PTSD for want of another way of putting it, and she asked him had he been psyched and he said no. And she said, "Well I'll have to do something about it", but still nothing was done about it. I mean they were aware of it. The lady, the captain had - she talked - brought him and spoke to him about it but nothing - and that's where, I'd say all the time, the military system doesn't like the finger getting point back at them, so they don't follow up on these things, they push them aside and hopefully it'll go away, and most of the time it does because we get frustrated and we say, "Well bugger it, what's the use". I mean I wouldn't go back to DVA again.

COMMISSIONER FITZGERALD: We're aware of that.

MR SISLEY: Because I know it's not going to go anywhere.

COMMISSIONER FITZGERALD: Well thanks very much for that, Alan. Is there any final comment that you'd like to make before we - - -

MR SISLEY: No, sir, no. As I said, I agree with what the blokes have said to you so far. I mean as I said to the new secretary the other day down there, if you don't fix your internal problem as far as your own staffing problems - I mean civil - if you want to go and go look at civil aviation. You don't, even as a military person in there, I couldn't - every three months somebody come in and check that I was doing what the department said the way you were doing it. There's no set reason in DVA. That lady who wrote to me and told me that I had PTSD and didn't get it from Vietnam, how that assessment was ever written, allowed to be written and passed and nothing done about it later, when she had no qualifications at all to make that statement, there's a problem you've got in the system. And if you don't fix that problem, these people aren't going to stop being angry and you blokes aren't going to come to, as you said, external organisation, they're not going to come to the RSL - they're talking to us angry people, and that's not - and that's not going to help your system doesn't matter how you change it, if nobody is going to come to it.

COMMISSIONER FITZGERALD: All right, thanks very much Alan. We will now break for 15 minutes. Morning tea is straight across in the

room on the other side of the hallway, so if you just make your way there, there's morning tea, but we will resume at 11 o'clock precisely. Thank you very much.

SHORT ADJOURNMENT **[10.48 am]**

RESUMED **[11.03 am]**

COMMISSIONER FITZGERALD: Okay, we will resume. I thank you for that short break. If you need to get any water or that just get up and wander. We are moving now to the Central Queensland TPI Association. If you could three gentlemen give your full name and the organisation that you represent. Thank you.

MR JOYCE: My name's Keith Joyce, I'm involved with the TPI Association. I'm a Level 4 advocate under the old advocacy scheme, and together with these two gentlemen and a number of others who couldn't be here today we operated in an organisation called the Central Queensland Veterans Support Centre.

COMMISSIONER FITZGERALD: Terrific. So just stop there for a moment, I will come back to you. If you can give your name.

MR BREWER: Neil Brewer, I'm the secretary of the CQ TPI Association.

COMMISSIONER FITZGERALD: That's terrific, and the last one?

MR HEALEY: Daniel Healey, and I'm a member of CQ TPI Association.

COMMISSIONER FITZGERALD: Okay, thanks very much. Back to you, Keith.

MR JOYCE: Okay. I'd just like to make the point that when we got together on this it was some time ago, but I haven't been able to make all the meetings. We did advocacy alone, we're not involved - we're not an ESO as such, or we were not, and we just looked after the advocacy and pension claims. Welfare - well, I'm not a welfare officer, that's not my calling, and then in the period of 2002 to 2007 we processed around about 300 applications for pension, and I mention this because of the advocacy

people, or the advocates that we represent, have a fair cross section of ideas that they gleaned from veterans in the process of preparing the cases.

I was very lucky to have these fellows prepare most of the cases that I presented to the VRB and to the AAT. I thought I'd make that point because these fellows may be speaking from personal experience, but more particularly the experiences that they gleaned from other individuals who have made claims to the Department.

Having done that one of the main contentions we have is the use of the term "veteran". We seem to have heard it fairly often this morning. Our main thrust is we believe that the very last Australian war veteran deserves nothing less than the very best of treatment and compensation provided to any and all of his or her predecessors. To neglect or fail to do so is a betrayal of the principles and standards of care for war veterans in Australian history.

We feel that it's being weakened by the use of the term, and we're not in any way being derogatory to those who have volunteered and only served one day, but we believe there is a very definite difference between peacetime service and operational war time service, and in that regard we come to the balance of proof and the reasonable hypothesis statements of principles.

I have noticed a comment by someone that the SOPs have been continually changed. Well, I didn't see anything wrong with that. What it indicates is that they are able to absorb what comes out or what's presented to the likes of the VRB and the AAT, and make changes accordingly. We fully support that old system, because earlier on we discussed treating everyone the same as veterans, and immediately came to mind the balance of probabilities and the reasonable hypothesis. Now, if you apply those you can't treat everyone the same objectively because of the way the balance of probabilities work and the statements of the reasonable hypothesis work. In the reasonable hypothesis of course he has to be given the benefit of the doubt as well as the conditions under which they operate.

I never served with any battalions, Australian battalions. The only battalion I served with was the 3rd Battalion of the Fifth (indistinct) Regiment, and then worked by myself with a reconnaissance company. So I can't do any comparisons with that. These fellows are much more adept at that side than I am. But we would just like to make the point that if the new veterans, the later veterans I should say perhaps, feel that they are advantaged by the system that is in place at the moment we don't wish to say they're wrong. We fully support what they accept or they're

prepared to accept, but there is one very important point that needs to be pointed out to them, and that is, as a personal example, I'm 73. When I got out of the army I didn't claim anything. I didn't claim anything for 30 years.

Now, if I got a lump sum payment at that particular time, in the last 10 years I've had numerous operations and treatments in hospitals, the best of treatment, I'm not complaining about any of that, but if with those lump sum payments and they'd go 30, 40 years down the track, as I did, and a lot of people here have, they come to getting that treatment. If they've taken a lump sum of money, that might not be available to them. So taking your point earlier, sir, about the choice, I think in exercising the choice of a lump sum payment they need to be very carefully advised as to what the implications of that are. If they want to accept it after that, well, that's up to them, their choice.

I don't have anything further, sir.

COMMISSIONER FITZGERALD: Good.

MR BREWER: I'm basically going to address the statement of principles.

COMMISSIONER FITZGERALD: Sure.

MR BREWER: Mainly because to me it's the ideal way of differentiating between a war veteran and a non-war veteran. Specifically what he's talking about, this veteran thing, I think it's a generic term and I can live with that, but a war veteran works under the risk hypotheses and a non-veteran, a non-war veteran goes under probabilities.

Now, there's a significant difference, and you can isolate the difference, because a non-veteran, a non-war veteran will in 99 per cent of the cases have a paper trail. I'll give you an example. If a digger is playing football, damages his knee, that - he'll immediately get checked. He'll get an RAP. There'll be an instant report. Paper trail will be there.

Same, another soldier on operations, we'll use Vietnam because that's my experience, is out on patrol, trips over, twists his knee, he's given an Aspirin by the platoon medic and said, "Get on with it, son. Stop being a wuss". That's never recorded anywhere. Therefore, the big difference is the paper trail and the non-paper trail which is why the benefit of the doubt must be kept in and must be emphasised for war veterans. That's why I think there's an absolute requirement that there are two different

standards of proof, and what we've currently got, or what the VEA have got is, it does have the two standards of proof.

That's really what I was emphasising on SOPs. I think SOPs, they set the basis. They give - everybody works off the same sheet of paper, the same level. Non-war veterans have their set of SOPs, and the war veterans have their set of SOPs, and it gives a baseline for everybody to work to. By that, I mean, is that you can identify exactly where - when a person's crook enough that they can be given some sort of compensation. So I believe it's a good system and it works, and I don't think we should combine them. They should be kept, because of the paper trail. That's the crucial think, I believe, and nobody seems to have mentioned that.

Now, I believe DVA does a great job. I wouldn't like to see DVA change and go underneath the fence. I just reiterate what I've said about it. My experience with DVA, as I was a level 3 advocate under the old system, was always positive and were always helpful. Sure, there's problems. Al Sisley is the classic example. Things get screwed, but he would be in the 5 per cent that doesn't do too well, so I think DVA does a great job and is in a good position.

Next one was, oh, yes, that's the abolition of DVA, okay. Transition's been covered. The abolition of the Gold Card, we definitely don't support that at all. I think the Gold Card is, it's earned. People who get the Gold Card, earn the Gold Card, and that should continue. We shouldn't change that.

Workplace health and safety, I - you've got it in our submission, but I'd like to just read it out. We don't agree with it. That contemporaneous workplace health and safety legislation should be applied to peace time military forces, especially whilst in training for war or operational service which often applies to many the majority of the time. Therefore, you've actually said it, and it's been said here before, workplace health and safety, from my experience, because I was one of the people that helped introduce the legislation into the army in 1992, and we had the choice not to go along with it.

The CDF at the time, General Graveson, decided that we will go with the civilian thing which I think was a big mistake because we are unique in the way we do our training. We train for war. We don't train for peace and therefore we must be as realistic as possible. Our officers and NCOs are trained to take the least amount of - to do risk assessments because they don't want to lose their people. So it's not as if it has to be legislated. You don't want your people to be killed or injured while you're training, and the same as in war. That's what we're trained to do. To actually try to

legislate something like that is beyond me. I don't think it's necessary. Okay, that's - yes, that's what I've got. Over to you now, mate.

MR HEALEY: You guys are probably going to be sick of hearing this this morning, but I'd just like to support some of the previous speakers on their comments around who is a veteran, and I know that you guys probably can't do anything about it per se, except voice our concerns about the use of the terminology as to who is a veteran.

I thought Jack articulated the thing very well. I mean, I served in Vietnam with the 3rd Cavalry Regiment, and we did lots of things. One of them was ready reaction in Nui Dat and I think I was posted to 1 Troop, 3 Cav. In the first two weeks I was in 1 Troop, eight out of 14 nights I got reacted to a contact and I can remember sitting at the gates waiting to pick up mini team and listening to the conversation on the radio going on between, I was the troop leader's driver so he was communicating with the infantry unit where we were going out to assist.

Every time the infantry unit spoke, all you could hear was continuous non-stop gun fire, and I can remember sitting there thinking, "Why on god's green earth am I going out there to join in this bloody contact", and thinking to myself, "Will I see the sun come up in the morning?", and I sat in lots of ambushes as well, and I used to think the same thing, "Will I see the sun in the morning?".

So somebody who hasn't been on operational service doesn't really know what it's like to be in a contact. I think it's disrespectful to veterans. I think somebody pointed out, you know, veterans have been identified since World War I as somebody that's seen operational war service. I think it's disrespectful that, using the terminology in your report here, that a round table of Australians, veterans and ministers, "Ministers agreed that a veteran would be defined as anyone who served at least one day in the ADF". Well, by doing that, what they're saying, as far as I'm concerned, is that a war veteran is the equivalent of somebody who's been in the service for one day, and in the overall review that's going on here, by bringing everyone down to that same common denominator, is everyone going to be treated at that lower level denominator? I could go on about it all day, but I think I've said the piece there.

A few other things to do with DVA. I agree with Neil. I've always had good interaction with DVA when I was an advocate, and I personally think that putting the responsibility for rehabilitation and compensation under Defence is a bit akin to putting the fox in charge of the hen house, and again, from my own personal experience, I can tell you from right early in recruit training. Anyone who continually went to the RAP and

got a chit for going off sick for the day or whatever was soon identified as a malingerer and generally given a hard time by NCOs and others. And I think if you put Defence in charge of rehab, it would make people in the service reluctant to put in a claim for any injuries, I think. I think by having DVA administer compensation rehabilitation, you've got an organisation that's seen as being separate to Defence, at arm's length, I suppose from Defence, and people feel they will have their claims treated with some degree of confidentiality. I heard there were some speakers spoke previously. It might have been yourself, Robert, who was asking about did they think that injury caused in peace time should be the same as injury in war time. And my memory as an advocate was that if you made a claim, and you went and had medical examination and claim filled out by the medical doctor or specialist or whoever, ultimately you're rewarded impairment points and, predicated on the impairment points, determine what compensation you would be paid.

I, personally, think that you know, there's also been conversation around the difficulty with claims and people having difficulty getting quick response to claims. I think it became more difficult when SRCA and MRCA came in. I mean, I've made claims under the VEA as well as SRCA and MRCA and the VEA is far more easier to navigate and probably get a quick response to. I mean SRCA, MRCA relies on a paper trail predominantly. And sometimes that's hard to come by. But I think the impairment point system, I think that worked quite well. I can't see why you should walk away from that. SoPs were always, I mean, we relied on SoPs when somebody was making the claim to determine what their condition, how they lined up with the SOP. And the RMA, I thought, did a great job, so.

MR BREWER: Can I just add one little bit (indistinct)?

COMMISSIONER FITZGERALD: Yes, briefly.

MR BREWER: The previous speaker mentioned rehabilitation and you asked him about it and I fully agree with it, rehabilitation, which is what MRCA does, but I'd also add the caveat that rehabilitation must be with compensation if the rehab doesn't – is not possible, because that's one of the real problems. Like, PTSD is still currently incurable. Therefore, you can't rehabilitate some people completely at this stage. (Indistinct) say, I don't know what's going to happen in the medical thing, so people need to be compensated for that and that's (indistinct words) we always do. I just wanted to make that point.

COMMISSIONER FITZGERALD: Okay. Thank you very much. Thanks Keith, Neil and Daniel.

MR HEALEY: Can I just make one more point?

COMMISSIONER FITZGERALD: Sure.

MR HEALEY: I'm just aware of the time. But in relation to the Gold Card. The Gold Card is a recognition to the holder of the card of his or her sacrifice to Australia and recognises significant impact of the conditions as a result of service and it's not a prize as I think somebody was trying to point out, some comment in your report from somebody in the RSL. From memory, you've got to be, I think, have 70 per cent impairment to be eligible for a Gold Card or turn – have turned 70, you know, be a returned serviceman and have turned 70. And I don't see why that should change.

COMMISSIONER FITZGERALD: Well, look, just a couple of things that I can – thanks for that, Daniel. So obviously we've heard our comment about the term veteran, that's not ours, that's governments. We work within that. Just a couple of things. The peace time and operational aspects, we understand the difference, I mean, we've heard from so many people over the whole 12 months in relation to that, but the point that I was trying to raise with one of the participants earlier - is it about recognition or is it about compensation and should they be different? That's the question for us. Going forward – going forward. So I think everyone in this room recognises that the contribution and the circumstances of people going to war is different from peace time. Absolutely. The question is, how does that get recognised and that is the challenge I think we're facing.

So can I come to the SoPs? We think the SoPs should apply to all three acts so we absolutely agree with you. We think it should stay absolutely. The question for us is whether or not there should be one test. That's the question. You've indicated very clearly, you think the two tests should stay and that may well be the case, but one of the things we're looking at is whether the test should in fact be the reasonable hypothesis test across the board. So we haven't come to a conclusion that it's the balance of probabilities, we've simply raised the issue. So at the moment, there's modelling being done by government if we're looking at that. So would you have a different view if we recommended that the reasonable hypothesis test, the very lowest was the one that would apply across all, that's operational and non-operational, injuries? Would that worry you?

MR HEALEY: It wouldn't worry me at all, because it's a positive step that's going the right way. And what is – you know, the benefit of the

doubt is obviously going to be applied to every case. Or should be applied to every case.

COMMISSIONER FITZGERALD: That's right.

MR HEALEY: I had no problem (indistinct) I would definitely argue I think if it was the other way around.

COMMISSIONER FITZGERALD: Sure.

MR BREWER: The way that (indistinct).

COMMISSIONER FITZGERALD: So can I just understand this, Neil and it's trying to understand where people are coming from. If we were to recommend one test in the SoPs and it was the reasonable hypothesis one, you logically say that's fine. But what I want to get to is that would effectively remove the distinction between peace time or operational or non-operation and so this is where we're struggling.

Is it that you really want to keep that distinction or do you only want to keep that distinction if we were to adopt the higher test? The harder test?

MR BREWER: Exactly, that's my personal opinion.

COMMISSIONER FITZGERALD: No, no, that's – well - - -

MR BREWER: It's that I can't see there'd be a problem if everybody gets – of the same level. I'd still have problems with the term veteran being used as a one day person.

COMMISSIONER FITZGERALD: No, no, that's fine.

MR BREWER: But I understand where you're coming from, yes.

COMMISSIONER FITZGERALD: Can I just deal with a couple of other things, then? The Gold Card, if I can, the hard edge stuff. We're not recommending the abolition of the Gold Card, as you know. We are recommending that those that are currently entitled continue to be entitled. There's no question about that, where we have no intentions of removing Gold Cards from anybody and we didn't propose that in the report. We did say it shouldn't be extended to new categories. New cohorts of people. So as you know, from time to time, the government gets requests to extend the coverage of the Gold Card to a new group. And we're not very keen on that. But can I just ask this question. We understand why people want the Gold Card, but one of the things we find is the Gold Card is a

payment system. It's a way by which you can access services. And that's all it does. Now, I know why you want it and I understand it, and we're not recommending that it disappear for those that currently have it. Absolutely not.

But we are concerned that that's not enough, that we actually have to look at the health and medical system to actually look at the services that are being delivered. And I was wondering whether you've had any experience up here in the Rockhampton environment as to people being able to and not able to access services in a physical, you know, medical services or mental health services. So just from the local perspective, are you able to access services given the Gold Card or the White Card or are there gaps in services up here in Rockhampton that you're aware of?

MR JOYCE: Sir, from my experience, the – I've had to go to Brisbane for certain treatments that were not available in Rockhampton. Kidney transplant for instance and some other matters of various scans that I had to have. They're not available here in Rockhampton.

COMMISSIONER FITZGERALD: That's just because they're not available. It's not because of the (indistinct). Sorry, I'll just put that into context. We've been looking at the prices that deviate pay, health practitioners, medicos and mental health workers and there are variations and some people have said to us that the fact that the DVA pays a lower price means that some health practitioners won't provide services to veterans while reluctant to do so. So it's in that sort of context. I can understand in some rural areas and regional areas the services are just there, but have you found any problems at all (indistinct) about accessing.

MR BREWER: We do have GPs that won't – don't recognise the Gold Card in Rocky and surrounding areas. So you do have to shop around to find one that's accepted, same with the dentist. And even some specialist ones that we do have won't – just won't – don't want to do it – know about of course exactly if you said about the lower cost, that's – they want to make more money. They're greedy. That's the way I look at it, so, yes, there is a problem. It's not insurmountable, but there is a problem there.

COMMISSIONER FITZGERALD: All right, and we're with you with that. In relation to mental health service - you may not have any experience with that – but are you able to access services that are in the town or in the region?

MR BREWER: It's fairly limited here. We do have it and there are some good practitioners. The best one died just recently which is not real good for a lot of us. But I think he went mad because of all our

complaints to him. But there are some very good psychiatrists and psychologists here, but there aren't enough of them.

But that seems to be the biggest problem and I think most of the guys here would probably agree that it is difficult to get sometimes – unless you can get on to somebody because they all want to seem to retire after they've earnt a bit of money, they sort of shoot through.

COMMISSIONER FITZGERALD: It's not a terrible aspiration I have to say. Can I ask one question and, then, Richard, no doubt, will have just a couple? Just in relation to the Defence Force; we hear you loud and clear that you don't want Veterans' Affairs under Defence, although we never recommended that. We only recommended that the policy go under Defence.

MR BREWER: Yes.

COMMISSIONER FITZGERALD: We didn't recommend the administrational scheme go under Defence. But putting that aside - - -

MR BREWER: Right, I misunderstood that.

COMMISSIONER FITZGERALD: No, that's fine and everybody else has. So you're perfectly fine.

MR BREWER: Yes.

COMMISSIONER FITZGERALD: It's our problem. But anyway we've heard very clear the ESO community by and large opposes the recommendation of putting policy within the Defence. But I do want to just deal with this issue about workplace safety. As you said, you were instrumental in the early 1990s of implementing that. It's been very formalised since 2011.

MR BREWER: Yes.

COMMISSIONER FITZGERALD: It is the way of the world and Defence have been saying to us that it's had a positive impact on the production of unnecessary injuries.

Now, it is true that as we've gone around a lot of bases, individuals might say to us, "It's softened up the training; it's dumbed down those aspects." But by in large when we talk to those a little higher up the ranks, they say that they work within it.

So it wasn't our recommendation to introduce it. It's been there and it is the law of the land. So I'm just wondering whether or not experience might indicate that some of the concerns you and others have had are able to be dealt with within the military system. I know at the time there were lots of concerns; we know that. But do you think it's possible that the Defence actually is working around the sorts of complications that are brought in?

MR BREWER: They are trying to, but as I said earlier on, we are trained for war. That's what our whole role is.

COMMISSIONER FITZGERALD: Yes.

MR BREWER: And you can't make compromises and that's what's happening now. That's what the Defence has to do to meet the legislation. And when you make compromises when you're training that has a great potential for people to die when we go out into operations – and that's my concern and it was my concern while putting in – you know, to helping introduce the bloody legislation. And we were ignored and we didn't have to go the way we went.

COMMISSIONER FITZGERALD: And you would've gone a different way?

MR BREWER: Yes, and we could've gone – and that's always been a concern.

COMMISSIONER FITZGERALD: That's all right, thank you.

COMMISSIONER SPENCER: Can I just ask a couple of questions around the transition issue? Because we've heard a lot from serving members and also, recently, discharged members about their experience through transition.

So as you know, we've got a particular recommendation around a Joint Transition Command which would be sitting in Defence and it would be for a period of time before the member discharges and for a period of time afterwards.

The current situation is that it's unclear where responsibility rests for that period. There are some very good pilots underway for cooperation between Defence and DVA to overcome that. But it's been put to us it is such a critical period. Many members transition well – get on with the rest of their lives – and that's terrific. But for those that are really vulnerable and really struggling, that's a key time.

So our structural change/recommendation is around this Joint Transition Command. So I'm just interested in your thoughts about that and how you think that could assist because, as advocates, you've often no doubt dealt with people who are in that transition process. So you're observation and transition periods would be very helpful how that's best done.

MR BREWER: Well, yes, I think the transition command is probably what we need in the future. It's going to help. It can't detract from anything so it's got to be positive – it has to be a positive and I think it would actually help, particularly some of the more vulnerable veterans and, you know, I guess the makeup of it and that sort of stuff is going into the nitty gritty because obviously you'll have to have psychologists and psychiatrists and bloody physical people and all that sort of stuff that would have to be involved. And how it's done, whether it's done by people still in the military or are they out of the military, then, that's the sort of question. But I think it's got to be a positive. I mean I just can't see it not being.

MR JOYCE: I have a nephew who is a major in the army and he contacted me late last year in regard to a claim he wants to put in and he was quite specific about saying he didn't want it to go through the military system. Now, you might say if you heard that from a digger, that's understandable. But this fella's a major and he's been in quite a number of years. He's to get out shortly, so I guess he's looking at his future planning.

But there is a conflict of interest in the military's job and the job of those who, by whatever name, are responsible for looking after veterans after they get out of the service and I don't know how they're going to get around that.

COMMISSIONER SPENCER: We hear quite often people are saying that as much as possible claims information about employment prospects, a whole range of things should be done before the person actually discharges to assist them. Generally speaking, from your experience, would that be helpful that there's more of that before the member discharges?

MR JOYCE: If it's obvious at the time that they are going to discharge, yes, that'd be appropriate. But some of them are only thinking about it and they don't want the hierarchy to know and that's understandable.

COMMISSIONER SPENCER: Right. We've heard quite a few stories about frustrations around superannuation and benefits under superannuation and dealing with Commonwealth Superannuation Corporation. Have you heard similar stories or is that a great difficulty?

MR BREWER: Absolutely. Well, one of the problems is the old system which was a DFRDB system which quite a few here are involved in and MSBS. MSBS won't allow you to draw until you're 55. Now, under DFRDB you could get it up to 20 years which was a real asset to people getting out of the military. So you could join at 17; at 37 you could go out with a pension. Whilst it wasn't a large pension, it was still a pension that you could get and you could get another job. And that got stopped when MSBS came in. You've got to be 55 or if you're fortunate like me - they made me redundant - I could get it that way. But that's a big worry with a lot of people.

Most of the guys who were under DFRDB are all out, now - or all the people would be out, so they're all on MSBS. But nobody can get out at 20 years and get another employment with a little bit of extra pension to keep them going. To me, it's always met with a problem and a lot of people pointed it out to me.

COMMISSIONER SPENCER: Look, just one last general question given, you know, your long experience in different organisations; the future roles of ESOs. Your thoughts about that as to what that should look like and I just want to preface that with a couple of comments.

It's very much up to ESOs as to what they choose to do and how they do it. I mean it's part of a civil society and it's a terrific part of civil society. But from government's point of view it's how you leverage that capacity and those resources and that can happen in many different ways.

So, well, we actually understand the vital role that ESOs play, the potential they play and even greater role in the future around particularly supporting veterans being sometimes a soft entry point to the connections they need, the networks they need, the services they need and that work will continue whatever government does. But is there an opportunity here for government to really be supportive or to leverage the work of ESOs in that future?

MR JOYCE: My experience with the ESOs, sir, is that most of the leaders of the ESOs haven't got a clue about repatriation matters. They are, if you like, the ESO's politicians; the popular fellas that get elected but they don't really know the sort of work that us fellows do, and as a result when proposals are put by government they look around the table to

see how many is voting "Yes" and how many is voting "No", and that's about the extent of their experience.

COMMISSIONER SPENCER: So if governments were more focused on what services would benefit veterans and who can best provide those services and make available funding to organisations to provide those services, is that a better model, because that's about services and what's in the best interests of the veteran?

MR JOYCE: Our experience is that that would be a better model, and had the funding continued I have no doubt our organisation would have continued too.

COMMISSIONER SPENCER: Good. Thank you.

COMMISSIONER FITZGERALD: Is there final comment before we conclude? We are very grateful for your detailed submission, as we have been from your other associations, the TPI Associations throughout Australia, and you have raised a number of issues which are all worthy of further discussion, but time is against us, and I thank you for that. Is there any final comment?

MR JOYCE: Sir, you mentioned the payment made by government for medical services. Just something I picked up in the blood - not donation - you give blood for examination - pathology, that's it - and one of the nurses said to me she hadn't been in that particular section at all, and she asked, "Is this paid by DVA or charged to DVA or is it charged to the Health Department?" She said, "DVA" - this is one of the more senior nurses - she said, "We charge it to DVA because they pay more." I didn't make any comment, I just (indistinct), and that was only a matter of three or four weeks ago. So I just wondered, you know, we received the undertaking that when the repatriation general hospitals were transferred to the State health systems it would not be to the detriment of veterans. Well, I think veterans who are getting these services should have a think about whether they are getting the service we used to get. I don't believe we are.

COMMISSIONER FITZGERALD: We will be looking at some of those issues specifically in the final report. Thanks very much Keith, Neil and Daniel, we appreciate that. Josephine Couper, please. Do you want to just move to the second seat. So that's great. Josephine, I think you know the drill, so if you could give your full name and any organisation that you represent.

MS COUPER: Sure. Good morning, everyone, I'm Josephine Couper, I'm representing myself.

COMMISSIONER FITZGERALD: If you could just turn one of the microphones towards you.

MS COUPER: That one?

COMMISSIONER FITZGERALD: That's fine. That's for our friend over there. Good. So again just ten minutes to give us your key points.

MS COUPER: Josephine Couper, occupational therapist, representing myself. Just to give you a bit of background information I'm a private provider, so I'm in private practice, but I purely work for Department of Veterans Affairs. I've been doing this for 15 years now. I only became aware of this thanks to Brian last week I think, he sent me an email, so apologies for the brevity of my information, but I have come to it late.

So essentially I have been doing this for 15 years as I said. I provide assessment and interventions basically through what's called RAP or the Rehabilitation Appliances Program. I also refer clients to other veteran services like Veterans Home Care and Veterans Nursing Care. So before I - I suppose I've got three issues that I wanted to raise, and they're areas of need that I have identified just from my clinical practice, but before I get to that I just did want to say that I feel very privileged to work with the veteran community, and I do believe that Allied health professionals are very well equipped under the current scheme to provide effective services for veterans for the benefit of veterans. So I do think particularly the RAP program is excellent. It's a comprehensive program, and I've worked in other areas in health and I can certainly see the benefits of this program to the client group.

So just to - there's three points which I have submitted the email about. The first is transport. So under DVA for my client group they're covered for medical travel, which is great, and that's very beneficial to the veterans. However I do see that there is a need for some transport assistance for those who have retired from driving, so probably the older veterans that I see, and this is where there's a bit of a disparity between services through veterans and just the aged services that are available.

So for example if I have got a client that's getting services through Blue Care if they're getting it through Veterans Home Care they can't access transport for shopping, whereas if they're a non-DVA client they can access through My Aged Care assistance for shopping. That's not precluding the veteran then going through My Aged Care, but it doubles

up on a lot of processes where it would be much simpler if Veterans Home Care could say, yes, we can take you shopping. Not a big area, but for those people who need it, it would make a big difference.

The second is, which Brad touched on earlier, is mowing and garden maintenance. So as veterans age many experience difficulty in managing their garden and mowing, and this would have to be the biggest thing, the biggest complaint I have from the clients that I see, is that there's not a lot of help with them in managing this area.

Out of interest though, and I think there is some discrepancy here, because I do have a 66 year old veteran who has a gold card, but has approval through what was SRCA, DRCA. So he actually is fully funded for his mowing and garden maintenance at 66 years old. I've got a 98 year old veteran under VEA who I can't get any help with that. So I think there's some areas there that need addressing.

So that was the second point, and the third is the Coordinated Veterans Care program. So this is an excellent program. I'm not sure if many of the vets here are aware of it. There's a practice that I work with in Mapoon and they have a designated practice nurse who runs the program for the GP clinic, and essentially she sees the veterans or war widows on about every six weeks and she basically coordinates any Allied health needs that they have. She links them into Veterans Home Care, Veterans Nursing, refers them to the podiatrist, the exercise physiologist, and when I say "she" she organises through the GP because they need the referrals, but I think it's a really valuable system because she's almost like a case manager for the veteran and it works really well. Clients that I see that are under this program appear to me to be getting the better health care service than those who may not. It's not a criticism it's just saying I think we need to look at this program and perhaps see how we can encourage more practices to take it on board or let veterans know that that program is available. So, yes, they were the three main points that I have.

COMMISSIONER FITZGERALD: Thanks very much, Josephine, and we are very grateful for some of these points you make. Can I just understand the transport one. You say the DVA provides transport for medical travel, but the concern that you've got is the gap where a person loses the ability to drive and that means that they no longer have community access.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: So does anybody under the DVA multiple Acts access, what, community access type transport, or it's just not available across the board?

MS COUPER: They are able through Veterans Home Care to get non-assisted shopping. So they can get some shopping done, but they're not allowed to go with them. Whereas if they did that under what's called the Commonwealth Home Support Program they would be able to go with the lady from Blue Care. It's not to say they can't get access under My Aged Care, but it's just another system they then have to go through when they're already in the veteran system. Then they have to send out a new assessor to get them approved through My Aged Care just because Veterans Home Care can't take them shopping.

COMMISSIONER FITZGERALD: So can I just talk about this. Our view is that irrespective of what Act you're under, VEA, MRCA, DRCA or our two scheme approach, these sorts of things should be common across the whole lot.

MS COUPER: Sure.

COMMISSIONER FITZGERALD: It shouldn't make any difference.

MS COUPER: Sure.

COMMISSIONER FITZGERALD: In relation to home care and transport and garden maintenance and everything else. Now, there may be reasons why that's not practical, but at the moment, we'd see no logic in the system. And frankly, it wouldn't cost a huge amount to fix that. But is there a system that you look at, given that you operate in the (indistinct words) system and all that sort of stuff, that you'd say that's a system that should be replicated in the veteran's space? So you deal across different approaches and there's difference NDIS approaches, age care approaches, veteran's approaches. Australia's not short of approaches.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: But is there one that you say this would work best in the veteran's space?

MS COUPER: Look, you know, I think the My Aged Care is in theory a good practice, but it's also quite confusing for the community and for the elderly to negotiate. I think, generally, the veteran's services are good. There's a few gaps, but I do think they need to be more flexible. You know, so I think, like a home care package type system would work under

veterans very well, rather than just saying we can give you an hour and a half per fortnight, just specifically for this as she said before, what do you need? If we allocate two hours or whatever it is per fortnight, what do you need help with rather than their prescriptive - - -

COMMISSIONER FITZGERALD: What's the downside in that being implemented? So Richard raised the issue about consumer directed care, I'd have to say this is a very odd – this is a very odd inquiry because we've done lots of human service inquiring into disability, aging, child care, all sorts of it. In most of those, the whole notion of empowering consumers to make choice is powerful. Except for the veterans space where nobody talks about it.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: Give us benefits but don't empower us.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: Don't give us choice. Tell us what we need. Very odd. So we're trying to say well, maybe there's a better way of doing that. But is there any downside to introducing a more flexible home care arrangement, such that might exist in other services?

MS COUPER: Look, I suppose one downside, and it was touched on before, is I have seen under the home care packages, where a bulk amount of funding is given to a client if they choose to either run at themselves, or give it to an NGO to manage for them. Is there – those administrative costs tend to be quite large and I have had veterans who have been – who are getting assistance through veteran's nursing and veteran's home care through an agency who also provides packages. And they may be asked to go onto a package, receive the same amount of care but it will actually cost them more money. But the service provider is probably better off, so I think there are some risks there. Yes. That I have seen happen in terms of, yes, how that's operated – organised and operated, yes.

COMMISSIONER FITZGERALD: Josephine, just on that theme, are you involved in the NDIS at all?

MS COUPER: I haven't, no. I'm purely doing DVA. I have some awareness of – yes.

COMMISSIONER FITZGERALD: Right. Okay. Because, yes, this is a similar issue in NDIS of course, and so that's been grappled with at the

moment and there's a quality in safety commission that's been established last year to try and regulate providers to - - -

MS COUPER: Yes.

COMMISSIONER FITZGERALD: So do you hear, if you hear about how that is going? That effort to make sure that there is appropriate administration, but it doesn't become frankly a provider of (indistinct)?

MS COUPER: Look, I've certainly spoken to other therapists who've been working in the area and again, it's – I think it's been a difficult process and I think it's – yes, it's perhaps for them it's a difficult system to work in and very much paper driven in terms of reports, et cetera, but yes, I certainly haven't gone there yet. Because I've been just too busy at this stage, just with the DVA work. Yeah.

COMMISSIONER FITZGERALD: Okay.

COMMISSIONER SPENCER: And Josephine, your comments about coordinated veteran's care is really interesting because the – there's a theme here about the health care home model that the Federal Department of Health is exploring as well to try and get past this fee for activity and the (indistinct) 15 minutes to get the benefits that you described with an almost and as you say a case management person.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: So you reference that particular practice on the Capricorn Coast. Are you aware of others in this region or?

MS COUPER: Look, not to the same extent. And you know, there may be other surgeries that perhaps are doing it but on a smaller scale. As I said, this practice is employed a full time practice nurse who goes around and you know, just talking to other allied health professionals that are also providing veteran's services, they would be in agreement that it's a much better system there. Because unfortunately, I get calls from a lot of veterans and I need to say "Well, you need to go to your GP and get a referral, and it's – in this day and age, there are still GPs that don't know how to refer to Allied Health Professionals. Whereas in this system, the nurse, and it doesn't necessarily have to be a nurse, but the nurse is there and we'll say, well, this is what we need", and go back to the GP and say, "Let's do A, B, and C," and the person's connected then to who they need to see.

COMMISSIONER SPENCER: No, well, thanks Josephine. That's interesting to hear how well that's working at the – on the front lines of these sorts of programs. I'm not sure, it's my ignorance, but I think the – there – it's been rolled out to a certain extent, but I think it is quite limited at this stage, so we should look at whether, you know, the success today, it actually should be replicated in many more places.

MS COUPER: Places, yes.

COMMISSIONER SPENCER: That is the case at the moment, but that's very helpful to understand how that works.

COMMISSIONER FITZGERALD: I think we have made some comments in the draft report about the coordinated veteran care program. We were quite supportive of it because it has that coordination function, by its very name.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: Can I just ask this question, if a medical centre – does the medical centre have to apply to DVA in order to become part of the program? Is that how it operates? Or do you not know?

MS COUPER: I don't think they have to apply, but my understanding is they enrol the veteran in the program and then there's obviously so much funding per year to run that program within the practice. Yeah.

COMMISSIONER FITZGERALD: But you wouldn't be able to have a dedicated nurse practitioner unless you had multiple clients, would you?

MS COUPER: That's correct. Although, you could have part time.

COMMISSIONER FITZGERALD: Part time.

MS COUPER: Yes, certainly.

COMMISSIONER FITZGERALD: Just a final question for you. We've heard and we've raised it earlier today, about the pricing or the payment structures that have been paid to health practitioners including Allied Health workers and we've had lots of representation from various Allied Health workers in every single hearing we've had. Do you have any particular comment about the way in which therapists are remunerated and/or supervised in relation to DVA?

MS COUPER: Look, I am aware that, you know, in terms of your general payments, if I was doing an assessment for Suncorp or another non-Medicare provider, I would be certainly be renumerated at a greater level. But there are also advantages to the program. I find it great, because I don't have to charge the client. I charge Medicare, which is lovely. So I'm not having to chase up accounts, et cetera, from my point of view. Yeah, and look, I found the supervision that we have – OT advisers, based in Brisbane and I talked to them regularly. And that's really helpful, so I can talk through cases and I get advice and check on things with them.

COMMISSIONER FITZGERALD: So can I just ask this question. It was put to us by a group of Allied Health Workers the other day, who were quite supportive of the arrangements, except when we came to the outcomes area that DVA is one of the very few agencies that has no idea of its outcomes in terms of people's benefit, well-being. It's quite unusual. And largely, that's because it's benefit driven, rather than outcomes driven.

MS COUPER: Yes.

COMMISSIONER FITZGERALD: So we were a bit surprised by that. But they actually say we collect the data, but DVA doesn't want it. So they would say at a practitioner level, we know the outcomes for clients, but they said to us, and again, DVA may come back to us and say this is not true. They said that DVA just doesn't want that information. Is that largely true?

MS COUPER: Well, it is largely true. Yes. They do – we do take feedback for what we call major modifications. So the only time, like, if I prescribe an over-toilet aid for a client, pretty much, I can't tell straight away, does it help them get on and off the toilet, you know, it's fairly evident,. But I do keep that information because I talk about, in my clinical notes, transfers and mobility and all of that. Really, the only time we provide feedback to the department is for major modifications, so if we have a stair lift put in or a bathroom modification, we do sit down with the client then and say on a scale of one to five, how much has this increased your safety in this area? So there is for major modification, there is some feedback there.

COMMISSIONER FITZGERALD: But not generally?

MS COUPER: Not generally.

COMMISSIONER FITZGERALD: No, okay. That's fine. Is there any other final comment that you'd like to make, Josephine?

MS COUPER: No. Thank you for your time.

COMMISSIONER FITZGERALD: That's terrific. Thank you very much. Yes, we've had lots of input from (indistinct words).

MS COUPER: That's good.

COMMISSIONER FITZGERALD: It's been good.

MS COUPER: Thank you so much.

COMMISSIONER FITZGERALD: And on my list, I have Christopher Campbell, is that correct? Christopher. For those that are interested in what time we'll finish. We'll finish between one and 1.30. It's not – we won't be taking a lunch break. It just depends on how many people want to speak at the end of this, but that's around the time we're aiming for. But we want to be flexible. Christopher, if you can give your full name and any organisation that you represent?

MR CAMPBELL: Christopher Campbell. I am not with any organisation, just here on my own. It's a – mainly to talk on the subject of the sports – the exercise program that's run by DVA.

COMMISSIONER FITZGERALD: Yes, that's fine. So you just pause for a second there. So if you can give us 10 minutes of the key points that'd be terrific.

MR CAMPBELL: Yes. Basically the program that DVA runs is to help the mobility of all veterans and there's some contention that the program's going to be reduced and that we will have to have a doctor's recommendation every 12 visits which becomes very inconvenient for the veteran and also quite expensive for DVA.

We basically believe that the exercise program 1) keeps us very fit and able to run our lives. I know from my own perspective that I was at a point of nearly in a wheelchair. I was suffering with PTSD and also my wife was having trouble caring for me. I also had an alcohol problem.

Now, since I've been on the exercise program for two years, I'm able to do most things for myself and it's greatly beneficial to everyone that I know that does the program. So I guess the – I mean there's not a lot in

it. It's just basically an exercise program that they run and it's to keep us fit and healthy to have a decent quality of life.

So I've known a lot of veterans over the time that become recluses and stay at home. This program actually gets you out of the home, helps to socialise people. Probably doesn't matter whether they're World War II, Vietnam Vets or Afghanistan Vets, they all mix. So it's beneficial in that respect also that they can share views and things from their past and probably help them in their day-to-day lives.

Basically that's pretty much it.

COMMISSIONER FITZGERALD: Thanks very much. Chris, can I just go back a little bit just so that I understand this? You've had claims in through DVA?

MR CAMPBELL: I have, yes, and (indistinct) yes.

COMMISSIONER FITZGERALD: And you're a Gold Card recipient?

MR CAMPBELL: Yes.

COMMISSIONER FITZGERALD: So these particular exercises, physiology sessions that you're doing, are you paying them through the Gold Card or are they being paid for as a separate program?

MR CAMPBELL: It's a separate program and it's paid for by DVA.

COMMISSIONER FITZGERALD: Right.

MR CAMPBELL: You can also claim the transport to and from the exercise program. Pretty much it's got to be with an exercise physiologist though, it can't be just with a gym or someone at a gym. It's got to be a professional person.

COMMISSIONER FITZGERALD: And how long have you been accessing that service for?

MR CAMPBELL: Two years, now.

COMMISSIONER FITZGERALD: Is it open-ended or – you've mentioned before there's proposed some changes where you have to go back to a doctor after a number of services. Is that what you're referring to?

MR CAMPBELL: That's what I'm referring to, there. They're changing it. I think there's been a bit of manipulation of the system and people are trying to make a little bit more money out of it and I think that that's where it's surfaced that DVA's found out about it and they want to limit the service and they want more control over the service I think, yes.

COMMISSIONER FITZGERALD: Are the services provided by what sort of organisation?

MR CAMPBELL: Well, the lady that I go to she runs Activate Health in Yeppoon and a number of Vets go along there.

COMMISSIONER FITZGERALD: Right.

MR CAMPBELL: I know that four or five of us have lost an enormous amount of weight, so that's been beneficial for us. I myself, I mean it's got me out of heading into a wheelchair as well as probably being an alcoholic and living on the streets. I know my wife's a lot happier, now, I mean she – that's the other thing with this program is that some of the exercise physiologists allow the wife to go along as well.

Now, my wife was suffering, both her hips were nearly wrecked from caring for me and she got to the stage where she had to have both hips replaced. Well, by the fact that we were going to the exercise physiologist helped her greatly, she's now living a much better quality of life, as well as I am.

COMMISSIONER SPENCER: Chris, I guess one of the questions that DVA would be looking at is this for a defined period of time to get you back to good health more in a rehabilitation type role or is it ongoing? I mean I sense in what you're saying that you'd like this to be ongoing.

MR CAMPBELL: Yes.

COMMISSIONER SPENCER: But do you get a sense from DVA, their view is it's for a period of time, you know, so your personal story there are issues that need to be addressed. This program helps you that there's a finish point. Do you think that's reasonable that at a certain point - - -

MR CAMPBELL: Well, the Minister did say to us the other day at Yeppoon that it was ongoing and we could go for three days a week for as long as we wanted. But they wanted us to go and have this doctor's review after 12 visits. Well, it just seems to be a waste to me to be going for a doctor's visit. I mean the exercise physiologist – she gives feedback to the GP. All it is is it's costing them another visit to the doctor, as well

as the inconvenience for us. I mean we go enough to the doctors and it's an inconvenience to go along just to say to the doctor, "Well, I need a review," and I mean, well, I don't know what that costs, but it's whatever the Medicare fee is - every 12 visits. Well, every 12 visits is only one month of going to the exercise physiologist.

COMMISSIONER SPENCER: So what do you think the GP will be asked to do to say that there's further improvement to be made around your health and, therefore it should continue or - - -

MR CAMPBELL: Well, that's what we're asking him to do a report to go to DVA to say that we need to continue the exercise.

COMMISSIONER SPENCER: Yes.

MR CAMPBELL: I mean other than that, unless your health deteriorated or something like that they'd probably want to know. I don't know, but as from the other lady saying that they don't really worry about reports from anybody so I mean the exercise physiologist, as long as you're attending, it's doing you the world of good and it's maintaining your health and your quality of life.

COMMISSIONER SPENCER: And, Chris, you mentioned that there's very much a collegial sense amongst the group that goes; that you are together. So do you think there are benefits that come from the program that you're there together, you can talk about other issues?

MR CAMPBELL: Most definitely.

COMMISSIONER SPENCER: And that does happen?

MR CAMPBELL: Yes, and the information I've gathered just by going along to the sessions, just talking to the other guys that I didn't know we were entitled to, I've now just the other day found out about the TPI organisation; I've joined that. So now I'm networking broader, finding out more details about what we're entitled to, things that guys might be doing in the community and getting involved. So to me, I think that's gathering knowledge and any knowledge you gather's got to be a good thing.

COMMISSIONER SPENCER: Right.

MR CAMPBELL: Yes.

COMMISSIONER SPENCER: Chris, are there any other programs from DVA that you've been involved in, you've had experience of in terms of assisting your health?

MR CAMPBELL: No, this is the first actual – an exercise program that I've been involved with.

COMMISSIONER SPENCER: Sorry, you may have said this already, but how long have you been involved in this program?

MR CAMPBELL: Well, it's probably over two years, but I'd say two years, yes. But I was; I was at the point of diabetes.

COMMISSIONER SPENCER: And how did you hear about it?

MR CAMPBELL: When I did my first visit to the psychologist she said that I had two weeks to give up the grog or she'd make sure I did, and she said, "I want you to go along to this program." I spoke to my GP about it and he put me on a plan which included this exercise physiologist and she told me about the program.

COMMISSIONER SPENCER: Right, well, look, thanks very much, Chris. And I think it's an interesting example of how the system can best respond to particular needs. But also I think it illustrates, as you said, the social connections are an important in a sense an additional benefit.

MR CAMPBELL: Most definitely, yes.

COMMISSIONER SPENCER: And it comes back to something else we've been talking about today and that is the notion of veterans' hubs and where there can be points where veterans can get together. It may be around a specific need like this, but it gives you an opportunity to explore what else is available and where else might I be able to get sort of further assistance or social contact. So that's part of why – you know to go back to something you talked about much earlier, Oasis and Compass and those models are very interesting because it is often a connecting point to assist veterans to get the services they need. So thanks very much Chris.

MR CAMPBELL: No worries.

COMMISSIONER SPENCER: Any final comments you'd like to make?

MR CAMPBELL: Sorry?

COMMISSIONER SPENCER: Any final comments you'd like to make?

MR CAMPBELL: Just one other thing I'd like to say is that I – my father-in-law, he was an ex-vet as well, fought in Korea and was in the occupational forces of Japan. They gave him a gold card but never gave him ever a pension. Now, I find it very difficult to accept that you would tell someone you're entitled to a gold card but not to the pension, and he struggled all his life, not getting the services that he should have been getting. It wasn't until I married his daughter that he even found out about his gold card. And they never bothered to further that.

Now, they had been VAN officers at the time and those VAN officers were supposed to deliver services to these people and failed to do so. Never informed people of what they were supposed to be doing. So when you say the DVA doesn't follow up on things, I find that very difficult to swallow too, because the – in this day and age we have a quality assurance, and in quality assurance you have indicators that indictors whether your service is working or not. Now, I know the DVA services aren't working because my father-in-law No.1, didn't get a pension and my son, when he got out of the army, he went to Afghanistan, he never got any services as well.

Now, he was suffering greatly with PTSD and attempted to commit suicide, and even after the suicide nobody wanted to know. Nobody came near him. I took him to Dr Steele in Rockhampton who was a psychiatrist and luckily I did because she was the one that got him back on track.

So what's going on – you know, you say put DVA into Defence, and I find the same thing that the fox is in charge of the henhouse, and we really need for our children that are coming that are going into the services, we need them to be looked after when they come out of the services, because I know from my experience when I got out, it was just walk out the gate.

My father-in-law just walked out the gate and my son. There was no follow-up. I mean, these guys, especially my son, he was trained to kill and he'd just come out of an operational service and three weeks – within three weeks he was committing suicide. So there's got to be something wrong. His mate committed suicide, so I mean, the indicators are there. It's not working and there's something – I mean I found DVA very good to deal with, and they are in a great deal of areas, but when it comes to discharge, if Defence was looking after – well, if it is Defence that's looking after it, then that's where it falls down.

And the other thing on that subject also is that when you join up, you go along to the recruiting centre. They sign you up. You go and have your haircuts and the next thing, you walk into a room, you put up your right hand and you swear an allegiance to the Australian people. Well, that's where it's wrong. If those people were go and do their recruit training first, if they fail that recruit training, they should not have to swear in, but if you complete that training then you swear that allegiance.

When these gentlemen said that a person that's done one day's training is entitled to a gold card, I have to agree with them. Why should I person like that get a gold card? But that wouldn't happen if that allegiance was sworn after they finished their recruit training.

COMMISSIONER SPENCER: I don't think they're entitled to a gold card but there may be circumstances where that happens.

MR FITZGERALD: Yes.

MR FITZGERALD: But just you're more general point is, without question, without doubt the very biggest area of concern in relation to this whole exercise has been around transition and we have to do much, much better. There's been lots of inquiries. There's lots of good initiatives, but it doesn't come together. And so we try to look at a structural approach but at the end of the day, what happened to your son shouldn't happen, and frankly there's no need for it to happen. So we've all got a common cause in this room, and that is to make transition much better. How you do it, a bit tricky? But you are absolutely right, and your son and others shouldn't be in that circumstances.

And as somebody said this morning, this whole inquiry started off as suicide prevention. So we see it as a whole range of things that comes together to make it, you know, less likely that a person's going to be suicidal and you've highlighted part of that problem. There's lots of others, but that's part of it. So thank you for that.

MR FITZGERALD: Thank you.

COMMISSIONER SPENCER: Thanks very much, Chris. Appreciate it.

MR CAMPBELL: Pleasure. Thanks.

COMMISSIONER FITZGERALD: Dr Ken O'Brien. So, Ken, if you could give us your full name and the name of any organisation that you represent.

DR O'BRIEN: Okay, thank you. My name is Ken O'Brien and I'm here representing myself and – well, the entire veteran community.

COMMISSIONER FITZGERALD: That's fine. We have the name of your service. Are you representing that service?

DR O'BRIEN: No, well, that service does come on board with me; more than normal post-traumatic stress disorder support services.

COMMISSIONER FITZGERALD: But you're representing yourself?

DR O'BRIEN: Correct.

COMMISSIONER FITZGERALD: Okay.

DR O'BRIEN: That's my service.

COMMISSIONER FITZGERALD: That's your organisation. That's fine. So you know the process.

DR O'BRIEN: Yes.

COMMISSIONER FITZGERALD: If you can give us 10 to 15 minutes and then we'll have a short discussion.

DR O'BRIEN: All right, well, one of the troubles with being the last person speak is that my head isn't - - -

COMMISSIONER FITZGERALD: Almost last.

DR O'BRIEN: Almost last, thank you – is that my head is now swimming with all this information that's come on and I'm wanting to provide additional evidence or even rebut some of the comments, but in 10 minutes can't do that.

I will very quickly touch on this because it's not actually part of the scope of this particular reason we are here. But that whole term of "veteran" comes back again and I do have a solution that I can propose during discussion time for that that remains fateful to the experience of military communities.

Now, one of the things that's become aware is that a culture is developed and identified by the language it uses to describe itself so that it can relate to other cultures, and one of those fundamental core language is

terminology that we use. Now, I've heard this afternoon that there is a lot of debate around the terminology of veteran. My concern is, whether the outcome of this Productivity Commission is going to be faithful to the people with the lived experience within the military culture, when they themselves don't rest with the definition of that term.

Today, I'm sitting here and I'm surprised to hear that I can call myself a veteran and it doesn't sit well with me because the ethics within my culture don't agree with the definition of that terminology derived by people outside that culture. That's like marriage guidance counselling from someone who hasn't been married.

What I propose is that the Commission suggests to its superiors that we go back to the coal face and say, "How do you define a veteran?" I believe there are three tiers; a veteran, a returned serviceman and an ex-servicemen, but I can go into that in more detail. So, again, my concern is how faithful will the outcomes be if we can't even be faithful to the definition of the term which underlies and underpins this entire study.

Onto suicide. Now, I've worked extensively within the military community over 35 years. I was born into a military family. My father's a Vietnam veteran. He was exposed to Agent Orange. I have a son with Spina Bifida and a daughter with emotional dysregulation issues and my father has post-traumatic stress disorder and so do I.

As there are people in this room that can commend to, I have served the veteran community for all of my life, not just that which I could claim 35 years of academic study and work and practice and volunteer work. Suicide in military communities should not be treated the same as suicide in non-military communities. Currently, suicide is treated as a mental health issue and medicalised. You go to a hospital and you'll find this.

Now, a lot of civilian suicide attempts are not due to mental ill health. They might be financial, they could be cultural, they could be economic, they could be age-related because they're a burden on their family in the way they are. We are seeing a large number of this happening.

Now, I do believe that we need to step back from the medicalisation of suicide and look at this in a broader picture. In presenting that broader picture - and please understand that four days ago I was only coming along today as a participant to listen to you, and in the evening of four days ago I get a phone call from Kevin that says "Could you write something down and submit it. So it's been a bit of a rushed job. I had about 18 hours to do that, so I'm going to give you the best I can.

Very quickly, based on a lot of the experience I've had over the last 35 years working with the veteran community on a professional level, a lot of the anecdotal evidence I've accumulated supports a lot of what's been said here today. But I want to step back from individual aspects of their struggles with DVA, which has saved a lot of lives, it's a system that has worked for many people in the past, probably worked for the majority. I did hear something about 5 per cent of people it didn't work for. So all in all it's better to have it and not need it than to need it and not have it. But I do believe that DVA and whoever succeeds in receiving the next instalment of what we call DVA should focus more on measuring the outcomes of treatments, not on their participation rates about whether you turned up to the OT or the doctor or that, but actually what has it done for you. Now, this is similar to the NDIS system, where if it works, you'll – sorry, you'll go along to a practitioner who works for you. Now, we all saw that with the late patron – not patrons, sorry, but the benefactor for the Vietnam Veterans' Association of Australia. And we all know who he is locally, and he passed away recently, who gave his time selflessly, and his physical property selflessly, to military families. Very highly respected. And it wasn't about money to him.

Now, that's the culture I'm talking about. And if we can install that or promote that by walking to those practitioners that support us, voting with our feet, then like the NDIS system, and hopefully the Productivity Commission could take that as a recommendation, that these practitioners who wish to serve us will be nominated by us. Does that make sense? No? One thing I've learnt growing up here is that reputation is a lot, goodwill is a lot. In a practice, if you're a practitioner, word of mouth spreads very quickly amongst the veteran community, and if someone says "Go see Bruce, he's good," then Bruce will get business. If someone says "Don't see Bruce, he's a waste of time," Bruce will lose business. That make sense? That's what I'm hoping that we can have here so that practitioners and the veteran community can be better served with more meaningful and culturally-relevant services that actually have outputs that can be then measured and presented to DVA.

Now, we've already talked about a veteran-directed approach rather than a personal-centred approach, which is currently used by civilian community-based organisations, where the veteran is not put in the seat in the middle of the group and the group discusses what they feel is best for him or her, but where the veteran themselves is able to determine what they feel they need. However, moving on a little bit – I'm going to jump around a bit here, is a whole-of-family assessment and review. Rather than just looking at the veteran and taking data from the veteran's experience, I do believe that the assessment needs to incorporate the whole of family. Not only their current partner, but even a previous

partner, because they may have children to that previous partner, and those children can carry a genetic predisposition or anomaly to certain behaviours, whether it be due to Vietnam exposure to Agent Orange, or whether it be to Post-Traumatic Stress Disorder or other situations that they experienced, be it in Vietnam or Afghanistan or Timor, or anywhere else Australian servicemen and women have been deployed.

A whole of family assessment will have very, very far reaching beneficial outcomes. Now, I hold in my hand here – some of you may be family with this. It's the Vietnam Veteran's Family Study. I was the central member on the concatenative form of that. I went down to Canberra and they asked me questions, and they hammered me. I tried to get off that because I had my own suicidal ideation. They talked me out of it and put me back on it. Page 11 paragraph 2 quite clearly states that children – sons and daughters in Vietnam veterans – and let's extend that out to all military families - are almost twice as likely as the sons and daughters of other families of being diagnosed with depression or being diagnosed or treated with anxiety and making plans for attempting suicide. It's there in black and white. So if the DVA are claiming they don't have the data and don't have the statistics, they're not reading their own paper.

I was – when I was contacted four days ago, I was asked to step back from a personal approach to this and say "What can DVA do better? How can we develop a better system?" As I said, it's the system that works for most people, but is it going to continue to work, and we have to have that best practice and continual improvement approach here. So with that whole of family approach, I do believe that we need to look at employment incentives for employers, which includes some form of a widespread education about the value of the qualities of military service it has to the employment place. How we can assist with bottom line operational efficiency, minimising costs and risks, absenteeism – and there's one thing a veteran is used to, or ex-servicemen, is turning up on time, if not before time.

Now, I have a 17-year-old daughter who started her first job yesterday and didn't want to go back today because she didn't like it, okay? Employers who understand the value of military service will then also invest more time in retaining their employees who come from a military background, not just the military servicemen themselves but their immediate families, because there is value to growing up in a military family. Children are raised differently to non-military family children. There are rules and regulations to follow, everything from washing the dishes in a particular order and making your bed before you leave your bedroom – which we try to do, right down to your ethics in the workplace and how you interact in general society. These have implications at school, they have implications

in the classroom and in the playground. A child who is raised in a dysfunctional family situation will have a dysfunctional education, will then become a dysfunctional adolescent, and likely become a dysfunctional adult. So we talked about duty of care and we talked about duty of preparedness to care.

MR SPENCER: Duty of care and duty to prepare.

DR O'BRIEN: Duty to prepare, I believe that extends out to the veteran and their families as well. Now, I know that there's good supports while that person is wearing the uniform in service of Australia, but again it's been reiterated, it doesn't happen once they walk out the gate. That's a failure of the duty to care, but it's also a failure of the duty to prepare.

MR SPENCER: It's usually in a slightly different context. The duty to prepare being the duty to prepare for warfare.

DR O'BRIEN: Okay.

MR SPENCER: You're using a slightly different context, but I think a very interesting one, that is, what's going to come next in your experience or your life as a result of your service.

DR O'BRIEN: Yes, now, I'm not saying that the Department of Defence needs to be responsible for children and grandchildren's inability to socially interact, but I do believe that there needs to be an education of health practitioners to be more aware of that, particularly those that may not come from Australia, to understand that the military culture within this country is unique, the military culture is unique, and that military service is unique. That often the comorbid and secondly emotional and psychological difficulties and challenges associated with a physical impairment occurred, whether it be within peacetime or peacekeeping service is different to those of a wartime service, the psychological impacts are different as well.

And these need to be considered when mental health programs are being developed and implemented within our society, and the people to educate that to are the practitioners. A simple tick and flick where it's – when a person presents to the practitioner for the first time and says "Yes, I am from a military family history," as I said, a culture is based on the history of the lived experience and languages they derive to promote or express – like, everyone in the military speaks English, but ours is a different format. It's not understood by people who haven't served. Same as an ex-serviceman, me, who has never been deployed overseas into a war situation may not understand your experiences, and you're trying to

explain that to me using the same language base that I'm understanding, English.

Sometimes it's difficult to get your point across. Same with general practitioners, same with schools and the same with employers. And I do believe a very simple, rapid and cost-effective way in the long-term to invest – and we're talking about – you've mentioned the term invest a few times here today, to invest in this community and long-term minimise the detrimental costs and multigenerational impacts is by an educational program.

MR SPENCER: Ken, just another couple of minutes, and then we'll have a conversation about a number of these issues that you're raising.

DR O'BRIEN: Yes, so I've touched on genetics. Now, epigenetics is another aspect of the genetic and medical paradigm which has been covered in the intergenerational study, and a lot of my research I've devoted over 30 years into the epigenetics of Post-Traumatic Stress Disorder and how it manifests in multiple generations, piggybacks on testosterone and we call it things like autism, Asperger's, bipolar, ADHD, conduct disorders, depression, anxiety and schizophrenia, just to list a few.

Now this, because it's new scientific evidence to come out of the community, and mostly internationally or sourced from an international research centre, a lot of our practitioners, particularly those in rural towns and back woods centres like Rockhampton, where silos are predominantly evident within our practice frameworks, are slow to pick up on. And there's a lot of rejection, where children and grandchildren of Vietnam veterans, or even nieces with poly-ovarian cysts and other cancers that are not explainable. People with lung cancer who have never smoked, people with these reproductive disorders and being considered – what is it when you can't reproduce, the term escapes me – when you're impotent, based purely on something that doesn't have an explanation. Where did this come from? Oh by the way my father was a Vietnam veteran exposed to Agent Orange, or my father is an Afghanistan veteran, or an Iraq veteran who saw some dust and breathed something yellow in once before I was born. So these need to be considered with our health framework for long term investment into the health and wellbeing of Australia's military families.

Finally – I'm going on and on and on, but the issue of suicide. If you incorporate this whole of culture approach, based on how the people with the lived experiences define the culture, then you'll have a far more appropriate and meaningful outcomes for long term benefits, and it will

benefit the governments because it won't be as costly in the long term, and the outcomes will be positive because they were derived by the people for the people, which is the underlying philosophy of a government.

MR SPENCER: All right, thanks Ken. Look, thanks for your – and put together at short notice, so it's a terrific paper raising a whole series of issues. Look, a couple of overarching things that I take from your comments and reading your paper is that it's often the interface between universal system that we have in this country to treat and respond to certain conditions and injuries versus the military-specific nature or origin of those injuries or illnesses, and what is the appropriate response. And that's one of the challenges which you rightly say, is how do you combine both those – and you've given some very good examples how that can come about through GPs having better knowledge, through lived experience – people with lived experience being actually at the front end of some of the services and responses that are needed, so absolutely. So look, I think the – a couple of things I come back to. You've referenced the NDIS – and this has come up a bit earlier today about the notion of empowerment, and how that is not without its challenges, but being introduced into a range of human services. So from your paper and what you said this morning, that's an important aspect for you, is it, to have the veteran more in the centre, as you said, not being talked about, but actually included in the conversation and the family being part of that?

DR O'BRIEN: Absolutely, but even – you specifically used the term "consumer-directed" earlier today.

MR SPENCER: Yes.

DR O'BRIEN: I agree with that, veteran-directed. And I've been advocating this for a couple of years, which has just fallen on deaf ears in the local community, because they're funded to give a consumer-focused – or a consumer-centred – again, you could have a deaf and dumb person sitting in the centre of the room without the capacity to contribute to their own health plan and still called consumer centred. That's not consumer-centred, that disempowers a person. So a veteran who is trained, who is hardened, who is selected to be above average from the civilian mainstream, to disempower them under the same approach is to re-disable them, or to deeper the level of disability by disempowerment. To put them in the director's chair, piloting their own claim to good health, where they are making decisions based – now again, the family must be at the epicentre, not just the veteran. Because as was also raised, quite often the veterans are ignorant to health issues that they may be contributing to that their partner and children are aware of.

MR SPENCER: Yes.

DR O'BRIEN: Dementia is one of the classic examples.

MR SPENCER: So Ken, just a question on that, because broadly-speaking we're very supportive of that approach, and hopefully – I doubt you've had a chance to read the 800 pages of our draft report.

DR O'BRIEN: A few of them, but no, not the whole thing.

MR SPENCER: Hopefully the overview, so – but look, you'll get a sense of where we're going. So from what you have been hearing and looking at in our draft report, in your view do we need to go further on some of these issues, or are we going in the right direction? Do you have any thoughts to assist us on that?

DR O'BRIEN: A bit of both.

MR SPENCER: Yes.

DR O'BRIEN: There are some good directions – and I give a lot of credit to the intentions that we've learned on previous mistakes. So I mean, before the DVA – I wasn't around then, so I don't know – I'm not qualified to pass judgment on what the services were before the DVA and whether they were appropriate and faithful to the experience of military service, and returning to an indifferent civilian culture. But I do know that yes, we are on the right track. Any advance in – any track that saves lives and improves health has got to be a good track to be on. I feel that we can still learn from failings of both individuals from ESO organisations and from the community as a whole. And thank you for this opportunity for us to voice our concerns.

And again – and sorry, just to eddy in a little bit – area there, we're talking about who's responsible for this. You're saying it's the Defence response – no, we are. The people in this room are responsible for bringing you the information so you can inform policy change. That's why we call it an informed decision. Where do you get your information from? It's us. So it's our responsibility to turn up to these things to give you that information. Now, that's why I've taken the time out of my day today. You know, I could be earning $200 an hour, or even more, but I don't, because my passion as the son of a Vietnam veteran, having served and having a child with a recognised condition that may or may not have been from my father's exposure to Agent Orange, I have a duty of care to my family, and I have a duty of care to my culture and community to be here.

So thank you for the opportunity to present. I kind of – bugger it, it was at the last. Because like I said, my head's full of so much stuff right now.

MR SPENCER: Yes.

DR O'BRIEN: There is neurological evidence, there is measurable evidence, that the impact of military service-related trauma is different to civilian trauma, where it might be a one-off event. So moving on from that, what – we're in the right path, but there are some areas that need to be improved on, and I would strongly urge you to focus more on looking into the expressions, the language and the lived experience, because that is where the evidence is collected from for evidence-based research and evidence-based practice. The evidence is here in the room. The evidence is in this study, and the Australian Institute of Health and Welfare's statistics, while slightly old, the information is there. That's why I'm shocked to hear the DVA don't know what's going on. It's right here, and there are six volumes of this. If we listen to the people and ask what they want, we do our best to give it to them. I know not everybody's problems will be answered by this, and it may create additional problems that didn't emerge before, but it's best practice and it's continual evolution, and it's working to improve the mistakes we've made before. So yes and no.

MR SPENCER: So Ken, we're working towards a model – and it's in draft at this stage, so it may be moderated in the final report, but I think it does pick up on some of the elements you're talking about, and that is very clear research about what works and what doesn't and why. You're adding into that a cultural context and lived experience, which we know increasingly is an important perspective in mental health. So the veteran's lived experience and the input of that is really important.

DR O'BRIEN: Absolutely.

MR SPENCER: So in terms of a structure – so we're looking at structures and systems, and what structures and systems best respond to that input. Because we can have input through one inquiry, but this has to be a continuous evolution of research, thinking, experience, lived experience. Future warfare will be different from what is being experienced in this room today. So that's one of the reasons why we have looked for a structure that can be open to and influenced by and respond to expertise and learning and thinking. What struck us is that the system at the moment is a fairly closed system. So some of the things you're referencing that are happening in other parts of society in other systems don't seem to enter into this system. So we have a sense, as Robert referred to a number of inquiries before – things are happening elsewhere which are improving and helping to get better outcomes, but we don't tend

to see it here. So when you look at the structural response that we're talking about, a veterans' services commission that's set up to have the expertise, more commissioning around research, more data and information about outcomes that feedback to both prevention, rehabilitation and ongoing health and well-being needs, is that going, once again, in the right direction? I mean I understand you're saying there needs to be more of that and you're making a very strong argument about the cultural input, but is that starting to go in the direction for the future that we need?

DR O'BRIEN: Yes – summarised, yes. It's in the right direction.

COMMISSIONER SPENCER: Yes.

DR O'BRIEN: The failure to incorporate the cultural and lived experience aspects undermines the foundations of the validity of the data being produced. As I've just clearly stated, the definition of veteran is not one that's agreed to by veterans.

COMMISSIONER FITZGERALD: Yes, look, we agree with the general thrust about what you're talking about. I must say that the lived experience of veterans, this is a system where veterans inform it a lot. They certainly influence policy more than any other inquiry I've ever been. It's the only place where people say the department's owned by a cohort – veterans and when we look at it, however, much of it doesn't work in favour of veterans' outcomes despite people saying DVA's wonderful, it doesn't focus on outcomes; it doesn't focus on about achieving long-term improvements in well-being and health. It funds health services; it provides benefits.

So why do you think that is? Why do we have a system that is very influenced by veterans? The ESORTs and the ESOs are dominant, they have great influence over ministers, they have been able to stop changes happening or encourage changes to happen. But like Richard said, it hasn't been about getting better outcomes. It's about getting better benefits, and NDIS and age care is not just about funding, it's actually about services. So where is this disconnect?

See veterans themselves, and I appreciate, the need for that sort of approach. I'm really just trying to – and I mean I know veterans here do because they're sitting here – but why do we have this disconnect in the veterans' space?

DR O'BRIEN: Because there's a breakdown in the filtering or the interpretation by people without leading experience who make the

decisions. There is a breakdown in the way that we are forced to articulate on a common language to people who don't have lived experience, who may not have worn the boots, who may not have worn the battle scars so to speak, and it's not a fault of the system per se but it's a fault, perhaps, of all systems where those without lived experience misinterpret the meanings of the messages we're trying to give you or give the people who make those decisions.

The way I propose – and this is just off the fly – is that we have more people with those blown up legs – that gentleman's not here now – but with those battle-worn scars that are part of a, shall I say right now, a consultative advisory forum - - -

COMMISSIONER FITZGERALD: Sure.

DR O'BRIEN: - - - that before any policy is enacted that it goes through them first to see will it be relevant; will it be meaningful on the coal face when they hit the ground. Are they going to be detrimental to veterans and their families or and the community whole or is it going to assist them?

Now, that may be where – well, instead of having captains and pen pushers and other people that haven't been shot at and seen their mates blown up or seen the violence of warfare, where those people are not left solely to being the decision makers. There is actually a filtering process that goes through that enables us the opportunity to make sure our messages are understood at the goal post.

COMMISSIONER FITZGERALD: Well, we agree with the outcome; that is to get the right information to the table. But that's also got to be good research and evidence-based when it's prepared – expertise.

DR O'BRIEN: And that's empowering health professionals as well.

COMMISSIONER FITZGERALD: And we came to look at certain models (indistinct) can I just deal with one last issue and only very briefly? You've warned us against medicalising or a medicalised model in relation to suicide prevention.

DR O'BRIEN: Can I reframe that? You choose the word "warned"; I choose the word "advised".

COMMISSIONER FITZGERALD: That's fine. But we've heard this in this space. So what is the fundamental difference? We understand social determinacies of mental health and health generally. We

understand what you said that suicide and suicide ideation and what have you can arise from a multitude of different factors; many interconnected, some less so. So what do you think is the fundamental approach that we should be taking in relation to mental health but, in particular, suicide prevention which you say, you know, should not be a medicalised model. What's the fundamental shift you would recommend to us?

DR O'BRIEN: My recommendation is based on a lot of anecdotal evidence I've heard from the veteran community, from a lot of suicide interventions I've given and my own attempts to take my own life. It is about all that I've said before, about being understood because a military person that's been trained to think in a particular way to optimise available resources to achieve their mission or the outcome that they intend to, before they call Lifeline, which is almost a dishonourable thing to do, will have exhausted all available resources to achieve it.

So if they do make that call or if they do call Open Arms or if they do call DVA, it's because they have expended their final reservoir of resources that they have. This is not a call for help. This is not, "Please, we'll put you on hold." This is urgent, now, need help before I take myself out and maybe others around me," because that's what I'm trained to do.

When the brain is in a crisis situation like that it goes into survival mode and if it means that it will blow itself up to take out more enemies around it, it will do so and it cannot function, particularly in the male brain – but that's a topic for a different discussion – that when it's under significant threat it will do that. The brain will optimise for that default; to survive.

We're not seeing this in the decision making process. This information's not being filtered down because it's not being regarded as military-specific. I'm presenting that to you, today.

Suicide is needed to be taken seriously in the military context. Not in a civilian context by civilian-trained or civilian qualified practitioners who may not have that cultural understanding. Bruce did; which is why we would all applaud him for what he did in this local community. He has saved more veterans, their spouses and their children; he was my mentor for 16 and a half years. He saved my life and so I'd like it well known that we need a legacy here for Bruce.

COMMISSIONER FITZGERALD: Any final comments, Ken? I know you've got lots and we've got your paper and you're at liberty to send us more.

DR O'BRIEN: I'm extremely passionate about this.

COMMISSIONER FITZGERALD: But any very final brief - - -

DR O'BRIEN: Okay, look, I think I've reiterated on that. I don't need to summarise it. But a more structured approach within the system that validates, gives voice to and acknowledges the voices of the people who have experienced it. To allow them the capacity to be part of that decision-making process is going to give far more long-term beneficial outcomes and minimise the risk on our nation for those that defend its sovereignty and its borders and their families for generations to come.

How many veterans here in the room have got sons or nieces and nephews that serve in our defence?

VOICE: Lots.

DR O'BRIEN: Yes? I heard one person say earlier. Right? There is quite often multi-generational service as families, as there are multi-generational issues with that service. Again, we need to listen to the people.

COMMISSIONER FITZGERALD: Good, thank you very much. And, again, thank you for your paper. Look, thanks very much, we'll be in touch.

DR O'BRIEN: Yes.

COMMISSIONER FITZGERALD: I said that we would invite people to make brief statements at the end of this and one person so far has put their name forward. But as this person presents, if you want to make a final comment, if you haven't already presented, then, this is your opportunity. So is it Terry?

MR KERLIN: Yes.

COMMISSIONER FITZGERALD: Please, so introduce yourself.

MR KERLIN: Terry Kerlin. I'm representing myself. I just want to submit a few views of my own.

COMMISSIONER FITZGERALD: Please.

MR KERLIN: I'm a Vietnam veteran. I was in the armed services for 15 years. I volunteered for national service when it first came out in 1965, and when the battalion got their warning order to go overseas, I extended

that two years to three years to do service with the battalion because I was a corporal section commander at the time and to pull out then, would be like a rat deserting the sinking ship.

So I did my tour of duty with the battalion, came back and then I served for a further 12 years in the reserves. But my main point that I'd like to bring up is the education of our health professionals. I don't have the answer to this, maybe it could be through the university training, but they need to know something about how a veteran thinks, or what he's been through.

I can give you a couple of examples, personal examples. When I did go for a hearing test, the audiologist said to me "What can you put your hearing loss down to?" which was about 50 per cent loss. And I said "The associated combat noises, artillery, machine gun fire, explosions," and he said "Didn't you wear earmuffs?" I sort of – I was like a stunned mullet, I didn't know what to say to him, but I said "You need to have your ears open to give orders and to hear orders," I said "Earmuffs weren't a choice at all," and that was my experience with him. And the other experience was when I was referred to a psychiatrist – I have PTSD. The chap's name – I'll mention his name, [redacted]. I saw him and instead of sort of addressing the things like the out of character behaviour, which is a symptom of Post-Traumatic Stress Disorder, or the drinking problems – I didn't think it was a problem, it was only when I couldn't get it was a problem. But he was more interested in asking me do I love my mother and father. I mean, that had nothing to do with the whole reason I was there for, and this is where – I walked out of that particular appointment, I then contacted the Vietnam Veteran's Counselling Service after that, and they are a marvellous group, and I think there should be more groups like that around, that an ex-serviceman can go to. We had mates from (indistinct), and others that slip my mind at the moment, but I think the Vietnam Veteran's Counselling Service – it's not only available to Vietnam veterans, it's available to all veterans. And I just think that we need to educate our health professionals a bit more. That's all.

MR FITZGERALD: Can I just – we've heard – we're looking at the mental health space, and Open Arms is a very important part of that, and we are supportive of that, and you've had a good experience through that. But the other part of it of course is the general mental health space, you know, psychologists, psychiatrists and counsellors more generally. So this issue about education, education in military aspects of their clients they're seeing like yourself, that's what you're talking about. In the township like Rockhampton, do you know whether or not that happens? Do you know that there's any sort of – do any ESOs in this township

actually put on any sort of educative program for allied health workers, medicos, others at all?

MR KERLIN: It was mentioned by doctor – over here. Bruce Hackett, he used to look after veterans real well. And he sort of put me on to the – probably the right people.

MR FITZGERALD: The right people. Because in South Australia I think it is, Richard, in South Australia they have a very strong research approach to some of these issues associated with one of the hospitals down there, and part of their program is to educate health professionals in the general community around those sorts of veterans' issues. So taking up your point, we've seen a little bit of that. Not a lot, but we've seen a little bit of that.

MR KERLIN: Yes, but I think it should come, you know, through their early training.

MR SPENCER: Terry, I'll just mention on other issues, in that you mentioned you were in the reserves for 12 years. And the comment has been made – we've heard it in several hearings that our report doesn't have a lot to say about reservists or their particular situation or what happens to them on discharge. So we will have more to say about that in our final report. I just wanted to acknowledge that since you were in the reserves for 12 years. But you may just want to – having done three years, as I understand it, in the service and then 12 years in the reserve, what was your experience of moving between the two and when you finally left the reserves?

MR KERLIN: Yes, I found that – going from full time service to part time service wasn't a problem. It's when I got out. Things sort of didn't start to fall in a heap until after I sort of left the military scene.

MR SPENCER: Yes, and it's been suggested – not suggested, we've been advised to have more – to focus more on that for people leaving the reserves, and we do that as well.

MR KERLIN: Yes.

MR SPENCER: Okay, any other comments?

MR KERLIN: No, that's it.

MR SPENCER: That's all right, thank you very much. Thanks Terry.

MR FITZGERALD: Thanks Terry. So are there any other persons who have been in here this morning who would like to make a final comment if you haven't already presented? Going, going, sure? Gone. All that I have to do is to firstly thank you for participating today, and thank you generally for all those that have participated in other hearings right across Australia. There's been very large numbers and lots of people having participated as members of the audience, and that's been terrifically helpful. Again, if you need to put in a final comment to us, please do so as soon as you possibly can. It can just be by way of an email. So people after these sorts of sessions sometimes think of a particular issue they want us to think about, so that's it. And finally again – and the final report will go to the government in the last week of June. It's up to the government as to when it releases it, but it must be released by the government within 25 parliamentary sitting days, but you will see the products of our final report. Otherwise, this concludes our public hearings. Yes?

UNIDENTIFIED SPEAKER: I just have one question. You're proposing a veteran's commission. Can you explain the different between the Department and the Commission?

MR FITZGERALD: Yes, well I can do that just on the record for the moment. One of things that's happened is that government departments are under the control of a minister directly, and the Secretary is appointed by the minister, and they operate within departmental approaches. All governments around Australia, the nine governments of Australia, in relation to issues like compensation, workers' compensation, accident compensation, have all moved away from a departmental model.

They've all moved to a commission, or what's called a statutory authority, whereby it is somewhat independent, but it still reports to a minister, but it has its own board of directors, the CEO may or may not be appointed by that particular organisation, but it operates in a very different structure, and all governments have moved to that model, because the departmental model is not a good model for administering these sorts of schemes.

What Richard's been saying however is there are real advances in having a statutory authority. You get a different culture, you get a very outcomes-focused organisation, the organisation is absolutely required to meet very strong KPIs. But the whole approach, the way in which you engage staff is quite different. So there's not a single compensation scheme left in a Department, except for Veteran's Affairs. So when we looked at this we tried to say – it wasn't coming from saying DVA is doing a bad job, what we have said is what is the best way forward? And

the best way forward for the administration of a scheme is, we think, in a statutory authority.

The next question then becomes, well what do you do with policy and other bits and pieces? And so we looked at that separately, and we heard your comments about that. There is – there was a view, we thought, policy would be better integrated into Defence for the reasons we've set out, but that hasn't been a view that's been accepted by here or anywhere else with a few exceptions. So the notion of a statutory authority is a very normal way to administer compensation schemes, Comcare is an example of that. The Victorian Traffic Accident Authority is another one. They're all over the place.

But departments are subject to particular pressures and particular ways of operating that are not present when you look at a statutory authority. Statutory authorities have particular benefits, and I can assure you our Productivity Commission is a statutory authority, I was commissioner of another commission in New South Wales, I've lived and breathed them, I know their advantages over departments. So that's a very short way of saying we've been trained to grapple with what's the best to deal with these elements. And our view up until now has been a statutory authority in relation to administration might be the way forward.

But then you've got to deal with all the other issues. I should say however, statutory authorities are responsible to the minister. Veterans don't lose access to the ministry, in fact we're increasing that. We're talking about a ministerial advisory council. You don't lose the capacity to influence policy, because policy sits in the department. So policy sits there, not in the statutory authority.

So if you're worried about payments, benefits, entitlements, that's absolutely within the department, and absolutely the responsibility of the minister. That doesn't go to the statutory authority, ever. Just the same as Comcare, policy is set by government, it administers the scheme. So if the concern is that if we had a statutory authority you would lose influence over policy, that was never our intention, never. But we did put forward an alternative model about where that should be, and we've listened to you very carefully about that. Any other final comments, Richard?

All right, we will now permanently, we'll just bring the hearing to a conclusion, thank you very much.

ADJOURNED