

Productivity Commission Submission

Dr Warren Harrex BMedSc(Hons), MSc(Occmed), MBBS, DAvMed, DObstRCOG
FAFOEM FAFPHM

Thank you for the opportunity to provide a submission. I note the scope of the Terms of Reference and I have provided responses to some of the issues under consideration. My comments are primarily from a health professional's perspective, as this aspect should not be overlooked.

Whether the arrangements reflect contemporary best practice, drawing on experiences of Australian workers' compensation arrangements and military compensation frameworks in other similar jurisdictions (local and international);

Mandating ADF reporting of workplace illnesses and injuries

The hazardous nature of military service is well established and military personnel are frequently placed in high-risk environments where a safe working environment cannot be assured. This is now required under current occupational health and safety legislation for most other forms of employment. Military service also involves a requirement for individuals to follow orders despite the potential risks to their own lives or health.

Such risks are accepted by military personnel as inherent in the nature of military service. To offset some of these risks is the assurance of the provision of a high level of health care during military service. There has been, and continues to be, considerable emphasis by military health services on mitigating the hazards likely to be encountered by military personnel during their peacetime or warlike service.

Prevention of illnesses and injuries has been a major imperative for military health services as this both conserves personnel and is a force multiplier in the military context. There has been a far greater emphasis by the military in prevention in areas such as health education and promotion, public health, immunisations, medical and dental fitness assessment and surveillance than in other working populations. Prevention activities continue during operational deployments with uniformed health personnel usually deploying with the military personnel they support.

The emphasis on prevention and control of potential hazards in the planning and delivery of health support for military activities is evident when considering the main roles and functions of a military health service which are listed as follows:

- Operational health support
- Casualty evacuation

- Military medical specialties (such as aviation medicine, underwater medicine, tropical medicine, chemical and biological warfare)
- Medical and dental fitness surveillance, monitoring and assessment of fitness for duty
- Occupational and environmental health, including food, water and waste management
- Health promotion
- Treatment services

The maintenance of morale in the face of hazards and dangers associated with military service is facilitated, not only by good leadership, but by the expectation (if not a guarantee) that military personnel will be well-cared for if they become ill or injured as a result of their military service. Military personnel thus have a high expectation for, and reliance on, quality health services.

This high expectation continues following completion of their service, with military personnel expecting a responsive, efficient and effective compensation system. It is little wonder then many of them become disenchanted when faced by a maze of complex processes and legislative nuances which appear to hinder and delay rather than enhance the determination of compensation claims and entitlements.

The ADF has placed considerable emphasis on prevention, as well as treatment and rehabilitation of military personnel well before current occupational health and safety legislation became widely legislated. Ready access to health services have been provided regardless of whether any clinical need was caused by or related to military service. As well as the health planning in support of military operations, a priority of the ADF health services has always been the treatment of ill or injured military personnel, and their early return to duties. Experienced military medical officers have unique knowledge of the potential working environment and hazards which may be encountered. They are able to advise personnel authorities on the employment restrictions necessary for the appropriate utilisation of military personnel. Accordingly, many ADF medical officers received training in the identification of and control of workplace hazards, the provision of appropriate advice on fitness for duty and rehabilitation of ill and injured workers. Many have become specialists in occupational and environmental medicine which was established as a faculty of the Royal Australasian College of Physicians about 20 years ago,

The high number of incidents, many of which were considered as dangerous, is noted at page 2 of the issues paper (over 14000 incidents among 58 000 permanent members and about 22 000 reservists). This indicates military service must rate as one of the most hazardous types of employment in Australia today.

But when it comes to treatment of its personnel, the ADF does not differentiate whether the illness or injury is work related or not. The priority is on clinical management and return to duty.

This approach of not establishing whether an illness or injury is work related can no longer be regarded as best practice.

From a compensation liability perspective, it is important to identify work related illnesses and injuries as soon as possible after they are incurred. This allows the best prospects of obtaining contemporaneous information as to causation, cost of treatment and loss of time from work. The rates of work-related injuries or illnesses, the costs of treatment and the loss of time from work can then be reported in accordance with usual reporting requirements such as the lost time frequency injury rate (LTFIR). Safework Australia recommends this Workplace Injury and Disease Recording Standard to give individual workplaces a guide to create an inexpensive and easy-to-use method of recording information on work injury and disease.¹

From an organisational as well as insurer perspective, monitoring of work related illnesses and injuries as they are identified allows appropriate workplace investigations and preventative measures to be implemented, as well as holding to account the supervisors responsible for the safe conduct of work. Currently there is around a seven years delay in military personnel submitting claims for compensation with many not doing this until separation from the ADF.

The consequences of delays in submitting claims creates difficulty in obtaining contemporaneous and reliable evidence to ascertain legal liability. Much of the angst among veterans claiming compensation from DVA may be arising from the delays in obtaining such information retrospectively.

The other important consideration is that the absence of the submission of compensation claims as soon as possible following the occurrence of a work related illness or injury is the inability to implement corrective measures to prevent future injuries and reduce claims. Failure to submit claims in a timely manner may also result in inappropriate assessment of the cost of provision of health services in the ADF. For instance, in the ANAO report into the ADF health services in 1996, health care was costed per member at about \$6540, almost three times the Australian average². However, this comparison with Medicare data from AIHW did not factor in the cost of treatment of compensable illness and injury. Workers compensation costs for other Australians is not costed to Medicare, but is picked by insurers.

This comparison with Medicare data has led to an unfortunate conclusion that the ADF health services were inefficient rather than raising awareness of the cost of treatment of work related illness and injury. This failure has resulted in a significant reduction in the structure and function of the ADF health services. The resultant focus on health care costs, including increasing civilianisation of the health services, has been at the expense of training and retention of uniformed medical practitioners with military medicine expertise. For example, the Air Force does not currently have any military medical officers with sufficient experience to fill the position of Director General Air Force Health Services. Specialist training in the ADF is now focused on medical administration more befitting civilian treatment services rather than a military organisation with exposure to many biological, physical, chemical and environmental hazards. In the past, specialist training in the ADF has been encouraged in occupational medicine as this is more appropriate for a military organisation. Currently, ADF medical officers only require a two week introductory training in occupational health, which is surprising given the high rate of reported incidents.

¹ [http¹s://www.safeworkaustralia.gov.au/statistics-and-research/lost-time-injury-frequency-rates-ltfr](http://www.safeworkaustralia.gov.au/statistics-and-research/lost-time-injury-frequency-rates-ltfr)

² https://www.anao.gov.au/sites/g/files/net616/f/ANAO_Report_1996-97_34.pdf

Recommendation 15 of the 1996 ANAO report advised Defence to:

- a) give greater attention to epidemiological research into injuries and illnesses in the ADF;*
- b) develop both short and long term strategies aimed at reducing the level of injuries and illnesses; and to*
- c) identify all costs associated with compensable injuries and illnesses in the ADF, and put in place arrangements for these to be the budget responsibility of the relevant sub program managers.*

So one of the most important measures to improve the compensation claim process would be to mandate that compensation claims be lodged as soon as practicable by military personnel following workplace illness or injury. Most insurers requires reporting to be made within seven days. The ADF health services are in an ideal situation to identify such potentially compensable conditions. This would be to the advantage of the ADF health services in that the health care costs associated with such conditions could be attributed to the appropriate program managers rather than costed against the health services as does the ANAO. The ADF health services should not be held accountable for the omissions of supervisors responsible for the safe conduct of work.

The processing of compensation claims while military personnel are still serving has the advantages of obtaining contemporaneous information as to the circumstances of the events including possible exposures and causation as well as obtaining clinical advice from those with knowledge and expertise about the military environment,. It would facilitate legal liability being determined without unnecessary delays. In addition, military personnel would not be disadvantaged from obtaining treatment by needing to wait for claim determination as many currently do after leaving the military.

The other major advantage is the timely submission of contemporaneous compensation claims would allow collection of the appropriate statistics on work related illness and injury. This is very likely to lead to a refinement of training methods and safer working conditions and a subsequent reduction in both claims and costs. This would be consistent with the ANAO recommendation.

Appropriate medical assessment of compensation claims

The DVA compensation process given its three differing legislation Acts is complex. There has been an increasing recognition in workers compensation areas that this is an area of medical specialist expertise.

The RMA Statements of Principles have been a welcome addition to the compensation determination, providing an independent authoritative body of scientific evidence of the factors leading to illness and injury. The major difficulty is applying these factors to ADF military service. In many cases, the appropriate assessment of a claim requires a detailed knowledge of military service. During serving, ADF medical officers become skilled and experienced in providing advice to personnel authorities on fitness for duty because of their knowledge of the

military roles and potential hazards. In complex cases, they consult specialist clinicians who are familiar with military service to assist in clarification of risks and clinical outcomes. Similarly, in recruiting, the ADF has recruiting centres with access to a panel of clinical specialists, many of whom are Reservists with military service, to assist in determining fitness for entry to military service.

It would be best practice for DVA when issuing Requests for Tender for clinical advisors to add military experience at least as a desirable criteria. In addition, the formation of a panel of clinical specialists with military experience to advise on claims would be advantageous in resolving compensation claims rather than relying on referral to often unknown civilian clinical specialists who may have little or no military experience. In particular, occupational physicians with past military experience are likely to be a valuable resource in resolving many of the complex issues involving liability in relation to military service. The appropriate specialist advice may significantly reduce the processing time of claims and also reduce the number of reviews by the VRB and AAT.

Non liability for mental health conditions

This has been an important and significant improvement for the benefit of many veterans. However, it has increased the demand on scarce mental health services in the community. Many privately available mental health services, including alcohol and drug residential rehabilitation programs, are expensive and there are no standards for accreditation of such service. There is a need for DVA to evaluate and contract appropriate mental health services to ensure quality and cost-effectiveness. Outcome data from long term follow up is also important in this area.

Although introduced as a measure to address veteran suicide rates after leaving the military, the emphasis should not just be on the provision of mental health services. Unemployment is a major factor contributing to suicide, so there needs to be a commensurate effort for veterans to participate in meaningful employment. The recent emphasis on transition management and coordination between the ADF and DVA is welcome, but veterans need ongoing access to such services following separation from the ADF. This may be necessary for up to three years following separation to allow full reintegration back into civilian life and resolution of issues identified during transition.