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Submission to The Productivity Commission's review into Compensation and Rehabilitation for Veterans

by Hilton Lenard and Keith Russell of the Defence Force Welfare Association – ACT Branch on 3rd May 2018

Thank you for the opportunity to provide some information to this inquiry.

Background of the authors of this submission.

Hilton Lenard served 39 years in the Australian Defence Force (ADF), 20 years as a regular Artillery officer and 19 years the ADF reserve forces. He had a tour of duty in Vietnam as a combat artillery officer. As a client of Department of Veterans Affairs (DVA) for over thirty years, before Statements of Principle (SoPs), he fought a number of personal claims through the Veterans Review Board (VRB) and one claim where DVA appealed his successful VRB determination to the (Administrative Appeals Tribunal) (AAT). Hilton has been in receipt of DVA compensation payment since 1985. Since then he has assist others with their dealings with DVA. As a qualified and experienced Training Improvement Program (TIP) since 2013 and now Advocacy Training Development Program (ATDP) Recognition of Prior Learning (RPL) advocate for compensation, working as an advocate with the DFWA ACT Branch and the Veterans Support Centre Woden, sponsored by the Woden RSL Sub-branch. He has active membership of a number of other active Ex-Service Organisations (ESO's).

Keith Russell a TIP qualified advocate for compensation and welfare, works as a welfare officer for the ACT Branch of the Defence Force Welfare Association. He is retired Royal Australian Air Force Engineering Officer with almost twenty-four years of service.

Submission

This submission is from the ACT Branch of the DFWA and all comments related to the demography in Canberra, where almost all of our pension cases are younger veteran aged 30-45 years and welfare clients are elderly veterans, or their widows, in their late 80's to early 90's. We would most likely have a completely different set of issues had we been located near a large military base with a much younger demography.

We believe that the DVA system is fundamentally sound, robust and works reasonably well. It is improving, particularly in recent years with DVA emphasis on Veterans Centric services.

In particular, we:

1. work comfortably with the three Acts of Safety, Rehabilitation and Compensation (Defence-Related Cases) DRCA, Veterans Entitlements Act (VEA) & Military Rehabilitation and Compensation Act (MRCA), including their many amendments;
2. work comfortable with the SoPs as they provide the necessary certainty in the determination of claims, compared with the pre-SoP experiences;
3. consider the Repatriation Medical Authority (RMA) is responsive whenever we regularly seek their assistance and advice, which is always freely provided. The RMA

review their SoPs regularly, so they remain current. It is possible and easy for an ESO or a veteran to request the review of any particular SoP or request the investigation into a non-SoP condition; and

4. believe that the distinction between Qualifying Service and Peacetime Service in all Acts and the SoPs is fair and appropriate recognition of the levels of service provided by veterans within the ADF.

That said, we also believe there are areas in the administration of Veterans' compensation and welfare that could be improved. Three important potential legislative changes considered worthy of consideration are:

1. Australian Military Covenant is appropriate as an agreement of responsibility and trust between all service personnel, the government and the people of Australia. This would be a no cost to Budget action that will provide the moral and legal grounds to provide the government guarantee to all Veterans' services.
2. We believe that on discharge from ADF, members with war or war-like (qualifying) service be granted a GOLD treatment card (covering all conditions) and those on discharge without qualifying service (ie peacetime service only) be granted a WHITE treatment card for all medical conditions listed on the final discharge medical. This would be treatment only and any liability would need to be established for compensation services. Although this may at first appear a high cost to the budget, most of the cost would be offset by the reduction in the administrative process of assessing claims, subsequent VRB and AAT hearings, and a likely significant delay in veterans making their costlier liability compensation claims.
3. Statements of Principle be introduced into DRCA. This is now possible as DRCA comes under the authority of the Minister of Veterans' Affairs, as a purely Veterans' Act. This would bring all three acts under the same medical proof requirements.

There is talk of replacing the three Acts with a 'new single Act'. This has already occurred with the establishment of MRCA in July 2004. We believe that the further replacement of these three existing Acts with their complex trail of amendments dating back a century, with a single Act, would be an administrative nightmare and definitely a step too far. MRCA, in effect did this and has been in effect for just 14 years. There has been one amendment. We consider that it would be most beneficial to concentrate updating MRCA to improve the efficiency and operation of that Act. It is time to commence work on the second series of amendments to MRCA. In another fourteen years the number of veterans operating under the DRCA and VEA will be diminishing significantly.

Thus, following on from this point, there are some differences between the three Acts that could be resolved by legislative amendment; the different in the Funeral Benefit between VEA and Safety Rehabilitation and Compensation Act (SRCA) and the use of offsetting for some MRCA payments are two such areas that could be improved. We are sure that other Advocates in other regions will add to this list to make a worthwhile potential second amendment to DRCA.

Administrative aspects - claim assessments and the claim review/appeal process

It is the DVA administrative procedures of the three Acts that is directly affecting and hindering some veterans, in the processing of their claims.

One area where the DVA system has been letting down some veterans is use of contract doctors in the claim assessment and needs assessment processes of all Acts. The administration in some cases leaves something to be desired as demonstrated by the three cases from our veteran files. Personal identifying details have been removed. These members are prepared to give further personal evidence on their DVA experiences, should the Commission require.

Pension Case Studies

Case One –Veteran X has among his accepted disabilities, lumbar, thoracic and cervical spine injuries accepted from his war-like and peacetime service, totally consistent with his service. These claims were lodged in early 2014. A contract doctor for the MRCA Permanent Impairment (PI) process declared correctly that eighty (80) percent of his pain originates from a disc prolapse L5/S1 and incorrectly determined that his L5/S1 is not part of his accepted ‘lumbar spondylosis’ condition. Therefore, his current PI assessment was only for twenty (20) percent of his total back pain. On the advice of the PI Delegate, a further initial claim was lodged for his disc prolapse L5/S1. This claim was rejected on the basis that his L5/S1 disability was already covered under his Lumbar Spine condition. The classic ‘Catch 22’.

He had used up his DVA Review process (the initial MRCA claims were lodged pre-January 2017) so the only option was a complicated appeal to the AAT. As his advocate, his case was presented to the second highest level of DVA administration, an unusual step. The case was referred back to Initial Claims at DVA Victoria for reconsideration, where the solution was to wait a month until the twelve-month time had passed then advised the veteran to request a new Needs Assessment. This was done; the assessment subsequently undertaken by a different DVA Contract Medical Office. The new medical assessment correctly assessed the back conditions and the veteran was awarded the correct PI assessment for his accepted conditions including all his spine injuries. However, the DVA Assessing Officer ignored the members D2669 Lifestyle Questionnaire, and awarded a life style of rating two, whereas the D2669 clearly indicated a lifestyle rating of 4. The veteran could not, for example bend and lift his baby child from the floor.

The ensuring requested internal review by DVA resulted in the usual rubber-stamping of the original delegate’s decision so the matter progressed to the Alternative Dispute Resolution (ADR) stage of the Veterans Review Board (VRB). There is no doubt that the ADR would correct the lifestyle rating as four. The veteran had a subsequent claim now at Needs Assessment. A separate Delegate contacted and advised that he could not proceed with the new Needs Assessment until the ADR had been resolved. But if the veteran withdrew the ADR, he would assess all claims with a lifestyle of four. This occurred, and the final assessment was PI=47 and a Lifestyle=4, a totally satisfactory result.

After several years, this veteran received what he was entitled to from the beginning but initially denied and forced into the appeals system due to bad administration.

Case Two – Veteran Y In his claim for cervical spondylosis condition was rejected. This injury resulted from exactly the same ADF conditions that caused the other two back injuries. He subsequently resubmitted that claim with strong supporting medical opinion and witness statements. This was again rejected by DVA in May 2017. The veteran requested VEA S31 internal review which, as expected, upheld the original DVA decision so he elected for the VRB to reconsider the rejected claim.

His VRB review request of July 2017, stated:

“I formally request an internal reconsideration of the determination contained in the Reference, to reject my claim for Cervical Spondylosis.

Dr x’s diagnosis, in which he states, in part: “Mild cervical vertebral strain consistent with a zygapophysial arthropathies or other cause, and for which his long-term service in the NAVY is most likely a reasonable contributing factor to the onset and progression of this complaint. This is consistent also with the nature of his mid-thoracic and lumbar regions”.

I contend that Dr x’s diagnosis “for which his long-term service in the NAVY is most likely a reasonable contributing factor to the onset and progression of this complaint” provides the Balance of Probabilities proof required by the VEA.

Dr ’s diagnosis meets the requirements of Statement of Principle 67 of 2014, factor “6.

(f) having trauma to the cervical spine at least one year before the clinical onset of cervical spondylosis, and where the trauma to the cervical spine occurred within the 25 years before the clinical onset of cervical spondylosis.”

I further contend that the witness statements provided with my original claim demonstrate the activities I was required to undertake on various HMA Ships, and that the subsequent injury which developed over time, meets the requirements of Factor 6 (f) of the SoP.

I further request that if the above reconsideration is not in my favour, that my case be referred to the Veterans’ Review Board, for initial case appraisal at the ADR phase of the VRB.”

On 16 August 2018 the DVA Review Officer replied, in part:

“I have reviewed the available evidence including the information contained in your service medical records. I am, however, unable to find evidence of a trauma that occurred to your cervical spine as required by the Statement of Principles, and as a result of your service. I am therefore unable to intervene and vary the delegate’s decision under Section 31.”

On 2 February 2018 the Veterans’ Review Board Alternative Dispute Resolution Board member declared:

“24. For the reasons given above, the Board finds that the factor set out in the Statement of Principles is satisfied by the evidence in this case. The Board is therefore reasonably satisfied that the material before it raises a connection between Mr X’s cervical spondylosis and the relevant servicer as required by the Act.

25. The decision under review is set aside and the decision of the Board is substituted that the Commonwealth of Australia is liable to pay pension for incapacity arising from cervical spondylosis from and including 17 February 2017.”

In reviewing the initial paperwork, the ADR officer had just one question, which the veteran answered in a single page signed letter by return email. The question requested qualification of a one-line answer the veteran had made in his original claim lodged in 2015. If the DVA Initial Claims officer in the 2015 or 2017 applications, had asked that question as part of their initial investigation. The claim could have been resolved correctly, at that time. Instead, the initial claims delegate chose to use an unqualified five-word answer to a standard question in a previous claim as the grounds to reject both claims. The veteran and his advocate remained

unaware of the ‘real’ reason of rejection (the misinterpretation of a five-word answer to an earlier claim) until we were at the ADR phase of the VRB. The correct result for this claim could have been achieved several years earlier. The anguish caused to the veteran and the physical cost to DVA could have been averted.

Case Three – Veteran Z His GP, also an experienced ADF doctor, diagnosed the initial Thoracic back injury as *“Intervertebral disc fracture and endplate disruption”* With *“CT findings (Schmoris nodes, loss of vertebral height, **T10/T11 area**)”* with *“Pre-existing clinical history consistent with repetitive axial loading and overloading. Pre-existing history of acute back injury on operations. Statutory declaration describing acute back injury during sport.”*

The DVA contract Doctor at the time of the initial claim made the diagnosis of **“T11 Compression Fracture”**.

The Needs Assessment delegate advised of the contract doctor conducting the Permanent Impairment assessment reported: *“Please note: In the report from Dr x, dated 31 January 2018, he reports; Based on the recent MRI the compression fracture is T12 level not T11.”* *“In the report, Dr x has apportioned 50% of your lumbar spine impairment to the T12 compression fracture. As 50% of your lumbar spine impairment is relating to a condition that has not yet been accepted, please lodge a claim with liability for the newly identified condition.”*

For a single injury, there are now three doctors providing slightly differing diagnosis. The client’s doctor diagnosed the **“T10/T11 area”**, the contract DVA doctor at the time of the claim diagnosed **T11** and now the contract PI assessing doctor diagnosed **T12 not T11**. Therefore, the veteran is denied fifty percent of his entitled compensation and will need to go through the procedure of claiming the same condition again, and possibly the appeal process, because two DVA contract doctors can NOT agree.

The issue is not with DVA outsourcing their work to contract doctors, as this makes economic sense. But there must be procedures when such disagreement between such external doctors exists, that DVA client is not disadvantaged and forced to the appeal process, as has happened or will happen in the cases above.

There are clearly DVA issued guidelines issued from time to time to their delegates. This understanding to achieve some consistency in claims. However, in many years of exposure to DVA determinations, never have we been able to obtain these directives. We discover these changing circumstances (directives) through exposure to many determinations. One of the primary roles of the qualified advocate is to assist the veteran to lodge a complete claim that can be assessed by the delegate with the minimum need for additional information to assess that claim. Advocates ensure veterans submit with their claims with the evidence required to meet the requirements of the appropriate SoP(s). The procedure of keeping advocates in the dark regarding these internal changes in policy appears counterproductive and annoying to the experienced advocates.

Welfare – Delivering compensation and rehabilitation to veterans in a well targeted, efficient and veteran-centric manner

Compensation includes follow on support activities such as home support, access to counselling, respite care and the extensive range of support services offered by DVA to Veterans and their families, transport, on-going medical services etc. Delivery of these services is one area where we see DVA functioning at the coal face. While there are occasional problems, DVA sponsored services are generally well received by veterans. The Veterans Home Service is an approachable organisation that works well with the veteran or their widow/widower. We receive good comment about the transport services and the opportunity to have an occupational therapist visit a veteran to ensure that any rehabilitation aid or home safety issues are identified and then resolved is appreciated by the veteran. These are generally effective and efficient processes.

Welfare Areas for Improvement

An area of concern is where DVA outsourced a function such as home services. We have a number of elderly veterans and war widows who depend on home services such as cleaning and who have become comfortable once a relationship is established with a particular person. Veterans and especially elderly widows who have expressed a strong wish to retain a particular service provider can become stressed when a different and unknown person turns up without any previous advice that would be the case. In some instances, the service provider is willing but untrained to deliver that particular support.

We have on occasions attended a veteran's home at the time a particular service is to be delivered to ensure that the service is carried out in a professional manner and to a satisfactory standard. Generally, there is no concern but on occasions the work has been rushed and the service provider would have left well short of the contracted time had we not been there.

While we appreciate DVA cannot control service delivery at this level, DVA can require, as a condition of retaining a contract, that the service provider inform the client of any change well ahead of time. Regular monitoring of contractor performance and feedback questionnaires from veterans could help to identify those service providers who need to improve their quality of service. DVA has the commercial power to ensure that contracted service providers comply with agreed care arrangements. Failure to meet DVA standards should result in a loss of contract.

Failure of the service provider to turn up for a particular activity is also a great concern to veterans. There are a number of instances where service providers simply do not turn up. In some cases, failure to turn up has no real lasting impact. However, in one case a respite care provider did not turn up and provided no advice that they would not be there. In this particular case, an elderly WW11 veteran with dementia was receiving in-home respite care to allow his wife to leave the home for a short period. When the respite carer did not arrive the veteran's wife, who was not well, was left with a terrible decision to leave her husband and visit her doctor or to cancel her appointment. The wife was confident that the respite carer would arrive and left to keep her appointment. She arrived back home sometime later to find that respite carer had not turned up. Apart from the shock and guilt felt by the wife there was no lasting damage done, but that was just good fortune as the elderly veteran could have come to misfortune. This couple were in their 90's and should not be subjected to such events. As before, DVA cannot control service at this level but DVA can require, as a condition of retaining a contract, that the service provider inform the client of any change well ahead of time.

There is overlap between the support services provided by DVA and by Department of Human Services (DHS) and there is often the need to veterans/widows/widowers to move from DVA provided services and in some cases Aged Care Assessment Team (ACAT) Level 1/2, to those provided by DHS (ACAT Level 3 or 4). To ensure that veterans and their families receive the most appropriate advice and support there would be advantage in advocates receiving additional training on the Aged Care Act and its implementation. An alternative, and very significant approach may be to consolidate all veterans care arrangements by making DVA responsible for high level care.

Case Coordination

Case coordination is provided by DVA to certain veterans. This facility provided a single point of contact for the veteran to all DVA activities. This is an excellent facility and has the effect of significantly lowering the stress associated with the claims and compensation determination process. The effectiveness of case coordination can be seen from the following example.

A veteran was awarded significant compensation (under MRCA) but he had difficulty in determining how he should take that compensation. His difficulty stemmed from an on-going legal action that where his decision on how to take the compensation could impact his overall situation significantly. Late on a Saturday he received a large legal bill and was stressed on how to pay that account. We met on the next day, Sunday, and completed the election for him to take a lump sum payment. The completed payment election paperwork was emailed to his case coordinator on Sunday afternoon. The case coordinator called on Monday morning and advised that he had processed the paperwork and that the veteran could expect to hear back later that day. The veteran received the decision by email on Monday afternoon advising him that payment had been determined and would be paid within a few days. Payment was made later that week. Clearly experienced case coordinators have the ability and authority to prioritise work within DVA to assist veterans.

We requested that a case coordinator be assigned to another veteran with both physical and mental health conditions but as of now a case coordinator has not been assigned.

Case Coordination is a great help to clients and facility should be extended to cover all veterans with more than a single claim.

Conclusion

In this submission we have concentrated on the 'coal-face' issues of our daily experience with compensation and welfare within the Canberra Region. Advocates in other regions and ESOs will have further recommendations reflecting their experiences that will add to and complement our experiences.

There are number of policy-based issues such as military pension indexation, operation of the Commonwealth Superannuation Corporation (CSC) and other issues that impact members of the Australian Defence Force, Veterans and their families that have not been addressed in this submission. While these issues impact the welfare of members of the Australian Defence Force, Veterans and their families those issues appear to be outside the Terms of Reference for this Inquiry. However, they should be considered in the near future.

We have outlined several instances where assessment of claims for compensation have been far from ideal and have resulted in unnecessary stress for the veteran and resulted in additional cost and resource implications for DVA. There is also a reputational cost associated with such cases. We have also outlined some instances where ongoing welfare support has fallen short of acceptable standards. We have made some recommendations that could address these issues.

Notwithstanding the issues outlined in this submission we consider the legislative backing of the various Veterans' Acts basically sound and provides a workable solution to most situations.

The work already taken by DVA and the contribution of recent years Budgets, particularly in the IT and Veteran Centric Program, are essential and should show considerable improvements in the delivery of services. We consider it important to build on the existing base of services and not attempt to make drastic changes to the existing framework of services.

The Productivity Commission has a unique opportunity to assist the Government give DVA the resources and direction to deliver the services to the Veteran community that is appropriate in a country such as Australia.

DVA will be judged by its service delivery. Working together, the advocates in the ESOs around Australia can assist and therefore contribute to the effectiveness of DVA's service delivery.