

Submission to the Productivity Commission Review on the Veterans' compensation and rehabilitation system.

Disclaimer. This submission is a personal submission based on my own observations through my personal dealings with the Department of veterans' Affairs and for the last 16 years as a volunteer Pension Officer for a Legacy Club. I have attempted to answer some of the questions raised by the commission in the "Issues Paper". This submission is not to be misconstrued as anyone else's opinion other than my own.

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Preamble: I fully agree that military service is unlike other forms of normal employment and, as such, any comparison to a civilian workplace, health and safety, compensation, and rehabilitation legislation is totally inadequate. I do not support the concept that Military Service should be compensated at a different level to Emergency Service Workers. The only difference is that the Federal Government employs ADF members and the Emergency Service members are employed by State Governments. It would make sense to provide similar compensation and rehabilitation to all those employed in these high-risk occupations.

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About Myself.

I served for 38 years in the Army joining at age 17 and two days. During this service I incurred several injuries and, like others, fought like mad to maintain the required level of fitness until I retired at age 55.

After my service I worked for three years as a Public servant with Defence but became ill and was diagnosed with Cancer of the Thyroid, and underwent multiple surgeries and treatment at my own expense. I then began a long and arduous fight with the Department of Veterans' Affairs (DVA) and, after being totally misled by an RSL advocate, I became my own advocate. Eventually DVA accepted responsibility for my treatment, and reimbursed my out of pocket medical expenses, but flatly refused to accept liability, under the "balance of probabilities", and that the Cancer was, in the delegates opinion, "not Service Caused".

I was, at that time, receiving a disability pension from DVA for other non-life threatening injuries, namely spinal injuries, stomach ailments, and anxiety caused during service. My treating Doctor sent me to a Psychiatrist who diagnosed me with PTSD.

I am now TPI, and receiving a disability pension from DVA under the "Special Rate".

I still do not have Thyroid Cancer accepted by DVA.

As a result of my dealings with DVA at that time, where I found their staff to be extremely adversarial, condescending and even untruthful, I remain reluctant to pursue any other personal claims.

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Pension Officer.

My personal experiences with DVA led me to volunteer with Legacy and to undergo "TIP Training", and last year "ATDP Assessment", to become a Pension

Officer. In this capacity I prepare War Widow Pension claims for the Widows of deceased service personnel. I have held this position for 14 years.

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I dispute the comments made on page three of the Productivity Commissions Issues Paper, where it says:-

“The unique features of military service have led to a system separate from, and **more generous overall** than, the system of workers’ compensation and support generally available to civilian workers, including:

- easier access to support (through a **lower burden of proof** for accepting liability for a condition)
- a **higher level of compensation** than that available to other Australian Government employees.

(My emphasis as highlighted.)

In my opinion it is only through the provisions of the Veterans Entitlement Act “VEA” that any amount of “generosity” had been shown. The burden of proof is firmly placed upon the claimant, despite the SOP’s requiring a “reasonable hypothesis” or “balance of probabilities” to have been presented.

I believe that DVA staff in general, remain adversarial and use the wording of the various SOP’s to deny a claim at every opportunity.

There is no component within the VEA, MRCA or DRCA that caters for “Loss of future Earnings”, in particular with regard to “normal career progression and expectations of advancement through the ranks”.

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Assessing the veterans’ compensation and rehabilitation system.

The VEA Legislation pretty much provides for a “pension support for life approach” whereas the SRCA/MRCA Legislation sets the Veteran onto a “Rehabilitation Cycle”.

Under the MRCA, this results in the veteran reporting to a case manager who determines what rehabilitation is necessary, then the veteran is sent to a therapist who provides the therapy until such time as they determine the veteran is either rehabilitated to an accepted level, or the funding cap is reached. The veteran is then sent back to the case manager who re-assesses the Veteran. The cycle can be repeated indefinitely and particularly seems to be so in mental health cases.

All the while the veteran is in financial limbo, any small temporary disability pension he/she has been receiving, or carer payments to a spouse etc., is not counted as regular income by the financial institutions and they will not approve loans, or mortgages etc.

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Priority Objectives.

Priority objectives for supporting the veteran should be targeted at returning the veteran to full health, or at least the best possible health and fitness that is attainable, considering the damage sustained during service. Any **quantifiable shortfall**, (i.e. loss of capacity through injury/illness/accident etc.) if not readily

recoverable through rehabilitation or medical intervention, should be fully compensable either through lump sum or a fortnightly pension.

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How should the nature of Military Service be recognised?

As a DFRDB recipient I am disillusioned with the DFRDB pension that I receive and remember that during my service we were prohibited from investing in any other superannuation scheme. It is annoying that some Politicians consider my meagre pension as a "Welfare benefit".

I believe that the younger veterans leaving service today may be better off financially because of the superannuation scheme(s) that they were able to contribute into, and provided, that they can access this scheme upon separation from service, finance may not be their main concern. But continued health support is!

I would support the RSL submission that comprehensive lifetime health care post service should be seriously considered.

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The complexity of veterans' support.

It would be sensible to combine all entitlements under one Act but this may prove to be incredibly complicated.

It may be possible to achieve this by approaching the problem through investigation and comparison of the benefits available under the various acts for the most common sources of claims, (i.e. hearing loss, lumbar spondylosis, Malignancies, Mental Health, acquired brain injury etc.)

It is imperative that the veteran is supported in achieving the best outcome possible from the Act that provides the greater long term benefit.

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The claims and appeals process.

Advocates are vital to the effectiveness and the timely submission of claims. The introduction of the ATDP concept was rushed, it failed to adhere to the original model proposed by Bill Rolfe, and is particularly onerous upon the unpaid volunteer advocates. The previously TIP trained advocates will continue to drop out as the requirement for on-going mentoring, training and bureaucratic interference continues.

Throughout the many ex service organisations (ESO's) in Australia some advocates are paid practitioners and most are unpaid volunteers. This in itself has caused complications.

I believe that The Department of Veterans' Affairs subsidises some paid RSL advocates and that this subsidy is based upon the number of successful claims submitted by that advocate through the Department.

This has created the situation whereby the more "difficult or complex" claims are either, not undertaken or, put on the back burner, whilst the more straightforward simple claims are given priority. Some paid advocates have actually "turned away" clients with difficult complex claims, or told widows to seek assistance from their local Legacy club instead.

Volunteer advocates, like myself, are more disposed to submit a claim, when requested to do so by a grieving widow or family member regardless of the likelihood of a successful outcome. Provided sufficient grounds exist to submit a claim we will do so.

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Since the Department decided that all widows' claims would be processed in Melbourne, I have been constantly frustrated with the delays that have occurred in the claims processing, the quality and consistency of decisions, and the blatant adversarial approach to decision making.

There have been instances where (particularly during late 2017) I submitted several claims directly to the Melbourne DVA office only to find that four claims in a row had been "lost in the post". I resubmitted copies of the completed claims and the supporting documents but the subsequent successful claims were not backdated to date that the original claims were submitted. Thus penalising the widow concerned.

I was also annoyed when, in three separate claims; it became obvious that despite my having quoted, from the SOP, that more than one factor was relevant, the delegate had obviously only glossed over my statement, read the first factor, and then disregarded the other factors. As a result I initiated a section 31 review that on each occasion was subsequently successful. I remain convinced that the delegate, on each occasion, was either poorly trained or poorly supervised.

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The Statement of principles (SOP's) provide guidance, focus and consistency to both the advocates and the delegates alike. The advocates use them as a guide, a means of focussing upon the veteran's service and medical history and how the factors might be applicable in the claim.

The delegates seem to use them as a "proof to be met" regardless of whether it is a "reasonable hypothesis" or a "balance of probabilities".

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System Governance.

From my own observations it appears that there are way too many Ex Service Organisations (ESO's). Each has the welfare of veterans, or their families, or their dependants, as their "raison d'être". This has proved cumbersome, non productive and unnecessarily competitive in fighting over the meagre handouts from the Federal Government.

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The ADF must not be permitted to abrogate its responsibilities to the serving member and that member's family and dependants. Surely this falls under the legal umbrella of a "Duty of Care".

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The role of the Department of Veterans' Affairs must be maintained. Any suggestion that the Department of Human Services (DHS) could deliver more of DVA's services must be opposed. The confusion, alienation and lack of support already experienced by the veteran community through the closing down of the Veterans Affairs Network (VAN) offices and the relocation of some services through DHS has been shown to be detrimental to the veteran

community. Veterans and their families should not be aligned with “Welfare recipients”!

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Providing financial compensation for an impairment.

Overall the package of compensation received by veterans is adequate and fair. There will always be unique and complicated situations which require specialist attention. Surely the Minister, or a senior delegate could intervene in these cases?

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Access to compensation benefits should be available once a Medical professional has declared that a condition is either “Permanent or Stable” the delegate, or case manager should accept this and make a determination on what impairment compensation is appropriate. Seeking a second opinion from a medical professional employed within the department should not be permitted.

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As stated previously, it would be sensible to combine all entitlements to compensation received under the VEA, MRCA and DRCA, under one Act but this may prove to be incredibly complicated. Permanent impairment compensation and incapacity payments in the MRCA and DRCA should be made consistent wherever possible.

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There should be no complications caused by the interaction between “compensation” and “Military superannuation”. On the one hand compensation should be considered in regards to the veteran’s loss of health, earnings, quality of life, life expectancy etc. Whereas a Military Superannuation is a compulsory savings plan for retirement, similar to the various superannuation products available on the open market.

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I personally do not see any reason why there should be differing levels of compensation to veterans with different types of service in the MRCA. An incapacitated veteran regardless of service, is still “incapacitated”, no matter whether the injury was war-caused or accident caused. Provided that the injury/illness etc., was caused whilst in service the compensation should be the same.

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Compensation payments should be made to “compensate” the veteran for a loss, whether it is a loss in earning capacity, a loss in health or quality of life or a reduced life expectancy. If this loss is temporary then part of the “compensation package” should contain rehabilitation support plus incentives to encourage the veteran to return to work in a timely manner. If the loss is diagnosed as being “Permanent” then the onus is on DVA to compensate the veteran for any quantifiable shortfall, (i.e. loss of capacity through injury/illness/accident etc.,) that is not readily recoverable through rehabilitation or medical intervention, through lump sum payment or a fortnightly pension.

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Helping people transition from the ADF.

The ADF clearly has the responsibility for transition and rehabilitation services for its members, and for providing some transition services following discharge. However it is important that any medical condition that incurred whilst in service is recorded and accepted as “service caused” on the veteran’s medical history prior to discharge. DVA only accept liability for a condition “post discharge” but how hard would it be to have an injury or illness, which in most cases is investigated at unit level, accepted as “service related” before discharge? This would be in line with the DVA concept of “Veteran Centric Reform”.

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Income support and health care.

Health care for veterans, once eligibility has been established, is first class. The Gold, and White cards allow veterans access to all necessary medical treatments and a range of useful benefits. The introduction of the Non Liability Health Care provisions has alleviated some anxiety for veterans with specific urgent needs.

In the main I can see no immediate need to change the range of benefits available. I urge DVA not to palm off any administrative activities to the DHS. Veterans do not like to be seen as welfare recipients or “dole” bludgers.

Summary.

In summary I would hope that my input is of use to the inquiry.

I would like to concur and endorse the issues raised during Legacy Australia’s meeting with the Productivity Commission on the 20th April 2018, as reproduced below:

- Introduce an education allowance to DRCA similar to VCES and MRCAETS.
- Harmonise indexation and amounts of ongoing payments for eligible young dependents/orphans across all three Acts.
- Transition must be improved with particular focus on involuntary separations where any depressive disorder/PTSD/brain damage accompany the medical condition/injury (future implications for families-suicide etc).
- New repatriation approach very commendable but must be dovetailed with Defence for continuity through the transition process.
- Planning for the future essential-decreasing client base as WWII vets and widow(er)s followed by Korea pass on-reduction factor of approx. .91 will result in numbers reducing to about 35,000 by 2025.
- ATDP conceptually fine but demands on volunteer advocates are particularly onerous and will result in many very experienced, older TIP qualified advocates dropping out. (the current model is a far cry from the concept developed by Bill Rolfe when he was with the Department)
- Compensation rates, while vets and dependents would always prefer more, are generally adequate and realistic, but harmonisation where possible across the three Acts would be desirable to simplify processes.
- Oppose legal representation involvement in advocacy process, must avoid adversarial aspects during a very difficult time for dependent of deceased vets during bereavement as such would be unacceptable; who covers the legal costs which would invariably be involved.

- Medico/legal practitioners appear to have an adversarial viewpoint and are generally detrimental towards veteran's claims which has a flow on effect to dependents when the vet dies.
- Aging population, difficulty attracting younger volunteers to fulfil management/leadership/advocacy roles.
- VVCS privacy constraints work against alerting the rest of the Department of vets who are possibly at danger of suicide (depressive state, PTSD, constant severe pain from service injury, involuntary suicide).
- Affect of improper indexation of DFRDB on reversionary pensions for surviving dependents.
- Future absorption of DVA functions into DHS would be totally detrimental for vets and widow(er)s (aligning these people with the unemployed and Centrelink processes inappropriate for aging widow(er)s and other dependents).