

PRODUCTIVITY COMMISSION SUBMISSION

Title: Compensation and Rehabilitation for Veterans

Background

This submission is a summary response to the many issues raised in the Issue Paper of the Productivity Commission in May 2018. This submission only addresses some key principles and concerns and does not comprehensively address a number of the matters raised in the Issues Paper. There are many other matters that could be addressed if the Productivity Commission requests further detail or clarification. In particular, the Transition and Wellbeing Research Programme¹ data may be able to inform a number of the matters of interest as it holds information about access to compensation and clinical outcomes in recently transitioned ADF personnel.

This submission is made by Professor AC McFarlane AO, Director of the Centre for Traumatic Stress Studies at The University of Adelaide. The Centre for Traumatic Stress Studies has existed in its current form since 2010 and previously was related to the Centre for Military and Veterans Health, which was a conjoint initiative with The University of Queensland that is no longer funded.

The activity of the Centre has primarily addressed the mental health and wellbeing of the Australian Defence Force, as well as other populations exposed to traumatic stress. The Centre conducted the 2010 Mental Health Prevalence and Wellbeing Study of the ADF² and the Prospective Study of the Middle East Area of Operations Study. Currently the Centre is running the Transition and Wellbeing Research Programme¹ for Defence and DVA, which is examining the mental and physical health of Defence members transitioning from service and current military personnel.

The Centre also has extensive experience in studying disaster survivor³ and accident populations, including the long-term follow up of a population of children, exposed to the Ash Wednesday Bushfires, into adulthood. The Centre was also involved in a NH&MRC Partnership Grant that examined the mental health of the South Australian Metropolitan Fire Service⁴.

Professor Alexander McFarlane, has extensive experience with veterans, having had various roles with the Department of Veterans' Affairs since 1992. He was a member of the RAAF SR from 1995 until 2017, reaching the rank of Group Captain. In that position he had a variety of advisory and clinical roles and currently is the advisor in psychiatry to the Department of Veterans' Affairs. He previously was a member of the Rehabilitation Advisory Committee of DVA. He was involved in an inquiry examining the provision of health services and rehabilitation in Special Forces Command.

In his private clinical practice, he has extensive experience treating veterans and assisting in their compensation claims. He has also sat on the Medical Review Council Committee. He has been involved in extensive litigation involving Defence Force members, including the

Melbourne/Voyager disaster and the class action in the United Kingdom where the Falklands Gulf War and Northern Ireland veterans attempted to sue the Ministry of Defence over failure of 'duty of care'.

1. The Impact of Historical Responsibilities

It is critical that the historical origins of the current system of compensation and rehabilitation of veterans be considered so as to understand its design. This is also a critical issue in considering the effectiveness of the current administrative and service delivery arrangements for the provision of health care and rehabilitation.

In summary, the structure of the current system is significantly influenced by its historical obligations to the care of World War II veterans and Vietnam veterans and in turn how it has been required to progressively downsize with the death of the older veteran cohort. As a consequence, the current system is not optimally purpose designed to address the needs of the current generation of contemporary veterans and ADF personnel. The presence of historically derived structures means that there are considerable inefficiencies and less than optimal services in place. If the system was to be established *de novo*, a very different and far more efficient system would be created. As a consequence, the system is not 'veteran centric'.

3. Structure of Health Care Services in Australia

One of the major challenges in the Australian health care system is that there is a multiplicity of systems that care for veterans, namely the State health system, the private health system, the DVA funded Veterans and Veterans' Families Counselling Service and the ADF health system. As a consequence, there are many system interfaces at which a veteran's health needs and rehabilitation has the potential to be less than optimally managed or transferred.

The current system for providing care to veterans is very different from the coordinated and managed system of care previously provided by the Repatriation General Hospitals. DVA now assumes that in the absence of that system of care, services can be effectively purchased from multiple private and state health providers⁵. This creates considerable disjunctions in the system that vary from state to state and region to region. One consequence is that DVA has increasingly administered the health and rehabilitation services in a programmatic manner, that may or may not exist in a region, rather than having based it on the continuity of the clinical needs of the patients to ensure that they pass seamlessly through a health service independent of where they reside.

A critical disjunction in the health services and care for ADF personnel and veterans is at the point of transition. Particularly, in the circumstances of a medical discharge, this involves the transitioning of care from the acute rehabilitation of the ADF health system to another health service that may not be particularly attuned to the needs and challenges of veterans. Furthermore, this means that the ADF health service carries no long-term responsibility for the cost of inadequate early care or prevention. Equally, the ADF has little awareness of the long-term effectiveness of their interventions.

It may be more parsimonious to allocate more expenditure to acute effective care rather than bear the costs of long-term disability, which is the responsibility of DVA. Optimally, the health care systems of the ADF and DVA would be joined and have the same administration so as to create efficiencies and continuity of care. Families of Defence members could also come under this system so as to create efficiencies of size. Their care is already funded via Medicare so this would not mean a large impost. This would provide a critical mass of patients to allow the development of specialist services in the different regions, which would ensure better rehabilitation outcomes.

4. Governance and Oversight

The current system of care provided for ADF personnel has a large emphasis on the administrative processes and procedures in terms of reporting and oversight. There is insufficient clinical governance by appropriate medical specialities that oversight the structure and the system of provision of care. This would increase the necessary focus on optimal interventions and the monitoring of clinical outcomes. The ADF only has several medical specialists, generally depending upon Reservists or privately contracted specialists. An optimal service structure and staffing should be more designed around the definition of the clinical needs and the quality of services with accompanying quality assurance.

DVA is not staffed or structured to have the optimal clinical specialist advice to assist in the monitoring and oversight of treatment programmes. This situation has emerged since the divestment of the Repatriation General Hospitals and the associated loss of clinical resources. A bigger issue is in the compensation environment where the aim of the insurer is often to restrict the provision of services because of the related costs. Increasingly veterans are often referred to state or private services that deal with other workers' compensation jurisdictions. In those workers' compensation systems there are at times prejudicial attitudes⁶, to particularly psychiatric injuries and their rehabilitation, which does not bring optimal clinical outcomes. Veterans can be impacted by these attitudes.

Best practice requires a constant appraisal and consideration of emerging clinical literature about treatment and rehabilitation. At the present time, DVA does not have the necessary personnel to ensure the embracing of knowledge and information in optimal service design.

This utilisation of the published literature should be done in conjunction with research programmes studying the longitudinal health and rehabilitation of the Australian Defence Force and ex-serving personnel. The optimal use of the available information and data has been hampered by the progressive loss of trained staff within DVA, such as epidemiologists, and the increasing use of contract research, which potentially diminishes the independence of the advice being provided to the Department. The potential of the existing data sets that have been collected on Defence and ex-serving personnel is not fully appreciated or optimised.

5. Veteran Centric Care

For an ADF member who is discharged, it is important to realise that the Medicare and private health systems are in direct competition with the DVA funded services in the provision of

care. An individual is only a client of the Department of Veterans' Affairs if they have an entitlement. Given the administrative barriers, many veterans will choose not to receive care through the DVA funded system. At times, this is because the specialists they wish to consult do not accept the rebates offered by the Department because of their progressive diminution with the passage of time. This is similarly the case with ADF personnel where the inability to charge a gap means that many specialists will not treat ADF patients.

Previously, veterans were provided with a standard of health care significantly greater than the general community in the private system. This can no longer be guaranteed. A veteran centric system, if it is to live up to its name, should provide the highest standards of care available in a co-ordinated manner.

6. Statement of Principles

The aim of the Statement of Principles was to remove the problem of having competing expert opinions, often not optimally informed by the scientific literature, as to the nature of the relationship between a particular health condition and the military service. In general, there is much to recommend the SOP approach. However, at times these are interpreted in a restrictive manner with unreasonable demands of documented proof for the occurrence of events. This occurs largely at an administrative level within the Department and could possibly be minimised by a greater use of clinicians in reviewing doubtful cases.

The use and development of the Statement of Principles would be better served if there were regular interactions between professional bodies, clinicians and the Repatriation Medical Authority. This would serve to highlight some of the dilemmas and challenges of their application in clinical settings. Also, the Statement of Principles can only access Peer Reviewed documents. This highlights the importance of health surveillance studies conducted on veterans being published in the Peer Review literature. At the present time, there is no resources provided by Defence or DVA for the publication of these studies in the Peer Reviewed literature. Hence, research that should inform the SOP's is not being accessed.

7. The Clinician/Veteran/DVA and ADF Administration Interface

In civilian settings there is generally an interface between the clinician and the injured worker in many administrative processes. This is not always the case, such as in the provision of workers' compensation certificates. However, in the provision of reports, these are usually independently requested by the workers' compensation insurer's administrative arm or the injured worker's legal representative. In the veteran's system there is often a direct approach by the veteran to provide the necessary report or administrative documentation to support a claim. This creates a difficult challenge for clinicians if they are not entirely supportive of the injured veteran's position or understanding of their condition. In my experience, having an intermediary requesting reports and documentation allows a greater degree of independence and frank expression of opinion.

The interaction with the veteran is also at times clouded by the role of advocates who might coach the veteran in how to present to the clinician so as to optimise their claim. The advocate is not bound by the same professional conduct as lawyers. This situation places the

clinician in an unusually difficult position in assessing and representing the needs of the veteran in an impartial manner. This tension is one reason why clinicians are at times uncomfortable to treat veterans. This situation is not consistent with the 'codes of conduct' for independent medical opinions in other jurisdictions where this role is clearly separated from that of the treating practitioner.

The assessment of the veteran is also very dominated by the nature of the impairment assessment proformas that have been determined by DVA. These forms require significant review, including an examination of the assumptions and principles that lie behind them. Format and structure is a disincentive for clinicians to become involved in the care of veterans. Also, the levels of remuneration are not equivalent to what are provided by other workers' compensation schemes, which is a further disincentive for clinicians to assist veterans in this domain.

8. Comparison with Other Compensation Systems

The nature of military service, particularly war like service, places the welfare of personnel at significant injury or death. If service personnel are going to follow orders in combat they need to know that if they are injured in the course of their duties, they will be cared for or their dependents will be provided for. This is critical to morale and capability as well as recruitment for service. This sets military personnel aside from other workers in civil society and why they require different and generally more generous workers' compensation schemes. These schemes reflect that a civil society pays to those who volunteer to protect it.

Despite the identified problems with the system, in my experience the compensation schemes for military personnel and veterans are less stressful and more benevolent than comparable civilian compensation schemes. In general, it is more fairly administered and the recipients less stigmatised. As has been identified by the Victorian Ombudsman's inquiry⁶ these civilian schemes are often administered in ways that are distressing to the recipients of compensation through inappropriate selective use of medical reports and other detrimental practices for the injured worker. There are many myths about compensation that are used to stigmatise those who receive injury related compensation, such as the assertion that compensation is detrimental because it increases the rates of psychiatric disorder. This claim is then used to limit compensation, despite it not being supported by objective evidence^{7,8}. On the other hand, the excessive stress created by the schemes' administration has been demonstrated to worsen the psychological state of the recipients⁹.

In recent years, State Governments have increasingly aimed to limit their liability for long-term workers' compensation claims. These Governments have a fundamental conflict of interest in being the insurer and the employer of groups such as emergency service workers and the health provider. In a number of States, including South Australia, this desire to limit the costs of compensation schemes has meant cutting off workers' compensation payments after 2-years, except in cases of a permanent impairment of over 30%. It is important to recognise that individuals who join the emergency services are not dissimilar to those in military service in that they put themselves in harm's way to protect the community. They need to be able to do so in the knowledge that if they get injured in the course of their duties that they will be cared for by the State. These steps to limit liability fail to recognise the

importance of acknowledging the service of those who take on these high-risk roles. Emergency service workers have been fighting to have these changes reversed. This demonstrates the superiority of the current system of compensation for military personnel and veterans.

Hence, it is important that these restrictions, that are being placed more generally on the workers' compensation schemes, do not place military personnel and veterans at risk of being excluded from reasonable protection. In general, the schemes run by DVA, despite the identified difficulties, are more supportive and beneficial to the recipients and more equitably administered. This also highlights the risks of some of the attitudes in the state-based workers' compensation schemes infiltrating the administration of the DVA schemes.

References

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