

Productivity Commission Submission

Dr Stephan Rudzki AM. MBBS, Grad Dip Sport Sc, MPH, PhD, FACSEP.

Thank you for the opportunity to provide a submission. I note the specific questions raised in your discussion paper and I have provided responses to some of the questions raised.

What should the priority objectives for veterans' support be? Why? What principles should underpin the legislation and administration of the system?

There should be a separation of rehabilitation and compensation. The present system requires a successful compensation claim in order to access rehabilitation services. Defence provides medical care and rehabilitation to all its members without any requirement for compensation. If the system were truly "seamless" then rehabilitation would be provided for all former ADF members for conditions that they had treated for in Service, but not new conditions. A simple statement of injuries/illnesses incurred during service should provide access to care post discharge. Compensation payments should be managed in a similar manner as present where liability needs to be established. A great source of frustration for veterans is the inability to access care until the compensation liability has been determined. This can sometimes be difficult because of poor record-keeping, especially on operations. Without some form of written evidence detailing a specific event causing injury, the determination of compensation liability can become fraught.

How have veterans' needs and preferences changed over time? How can the system better cater for the changing veteran population and the changing needs of veterans?

Veterans needs remain unchanged. They require ongoing health care for injuries/illnesses sustained during service. They want to be working as best they are able. They require income support if they are unable to work. But employment is a key component of health and well being, and specific efforts should be addressed to assist transitioning members to obtain employment. Unfortunately the healthcare system has changed. The system of repatriation hospitals provided preferential access and care with an understanding of the background circumstances that contributed to injury or illness. With the disbanding of repatriation hospitals, veterans are now required to seek care within the civilian community. This is not a bad thing per se, but the public health system is under extreme pressure, and in particular mental health services have also been subjected to rationalisation with a model that focuses on care in the community. Unfortunately many veterans, especially younger veterans, suffer from PTSD and often have suicidal ideation and attempts. These are acute emergency scenarios which often require inpatient stay. There are inadequate beds for members of the general community for acute psychiatric emergencies and veterans must compete with this very unwell segment of the community, often not meeting the very high threshold for admission. There are also severe shortages of Psychiatrists in the medical workforce. (See Attachments A1 and A2)

What are the sources of complexity in the system of veterans' support? What are the reasons and consequences (costs) of this complexity? What changes could be made to make the system of veterans' support less complex and easier for veterans to navigate?

As noted above, it is the linkage of rehabilitation to compensation that creates complexity. To create an entitlement for ongoing rehabilitation would make the process much simpler. There will be cost implications if government persists with a model of care that relies exclusively on private providers of healthcare. Private medical costs have increased well in excess of inflation and the CPI. An alternative that would provide preferential access and reduced costs, would be a centre of excellence model utilising salaried and visiting medical specialists. Establishing centres that provided care to both serving and retired members would provide significant efficiencies, as facilities would be well utilised and run at high levels of capacity. Such centres of excellence should specialise in the areas where the ADF generates high numbers of ill and injured members, specifically in the area of orthopaedics/sports medicine, gastroenterology and mental health. Running their own operating theatres and providing surgery at these centres of excellence would provide significant cost savings and introduce competition to the private sector. Defence is generally a fee taker in areas such as orthopaedics as many specialists will not accept the contracted Defence fee. DVA consulting fees are generally linked to the MBS fee structure, and many private specialists decline to see patients under those circumstances. DVA have contract arrangements with a number of hospitals which provide gold card members free care. I am unaware of what those contract rates are, but suspect that they are considerably more expensive than what could be achieved utilising a Defence/DVA run facility. Fee-for-service arrangements will need to continue for veterans living in rural and remote areas of Australia. Apart from a cost perspective, there is also an ethical one. Defence personnel should not be competing with the general population for access to scarce medical resources. Defence /DVA providing additional treatment services will significantly lessen demand on existing public facilities.

Can you point to any features or examples in other workers' compensation arrangements and military compensation frameworks (in Australia or overseas), that may be relevant to improving the system of veterans' support?

The United States Department of Defence continues to provide health services to serving and retired military personnel and their dependents. The British Army has 15 military Departments of Community Mental Health (DCMH) providing outpatient mental health care and staffed by psychiatrists and mental health nurses. <https://www.army.mod.uk/personnel-and-welfare/health-and-wellbeing/>

How could the administration of the claims and appeals process be improved to deliver more effective and timely services to veterans in the future?

Again, the delinking of rehabilitation from compensation will allow the delivery of effective and timely rehabilitation services to veterans. Compensation arrangements involving the payment of income support or lump sums should continue as per present arrangements.

Will the Veteran Centric Reform program address the problems with the administration of the veterans' support system?

The recent determination to grant free access to the Veterans and Veterans family Counselling Services (VVCS) to all former members has already established the precedent of allowing access to treatment services without first having an accepted compensation claim.

Have the Statements of Principles helped to create a more equitable, efficient and consistent system of support for veterans? Are there ways to improve their use?

The statements of principle are important within the framework of the legalistic determination of liability and the likelihood that any disease or injury was attributable to specific or low-level repeated exposures. They remain important in establishing grounds for grounds for compensation. They have no utility for the provision of rehabilitation services.

What obligations should be placed on the ADF and individual unit commanders to prevent service-related injuries and record incidents and injuries when they occur? To what extent do cultural or other issues create a barrier within the ADF to injury prevention or record-keeping?

The Defence Injury Prevention Program (DIPP) had proven effectiveness (see attachment B1 pg 46). Unfortunately the program was terminated because of the lack of a committed internal Defence owner and dedicated resourcing. It would be feasible to resurrect DIPP with modern technology, utilising the pre-existing data framework and supporting documentation. Data could be collected via a DIPP app and stored in a secure external server, possibly with an existing Defence contractor. ADF personnel would need to enter data onto the app when they attend a Defence medical centre using either their personal phone or a handheld/desktop terminal. Not utilising the Defence Restricted Network (DRN) removes a number of security, logistical and cost concerns. It could be a secure "internet banking" type product with 2 factor security for those accessing the database, similar to that currently used by Defence in the form of the Defence Online Services Domain (DOSD). It would need 3 full-time equivalent (FTE) staff located centrally to do analysis and provide interpretation, recommendations and reporting. Local occupational health and safety (OHS) representatives would receive the reports and discuss the findings with local Commanders. Only if you achieve local organisational/unit buy-in do you achieve change. If all commanders have to do is read a report and make decisions regarding corrective action, they will view that as a help and not a hindrance. Anything less than this will likely be resisted, as unit staff already feel burdened by a range of mandatory compliance requirements

The Defence owner should be Army, acting as the "Single Service manager". Army would require a dedicated funding allocation plus the 3 FTE and should provide the service for Navy and RAAF. The internal Army owner should be either the OHS cell or the Directorate of Army Health. As this will involve checking electronic health records for health outcome

and morbidity data, it may best reside with Army Health. Making it a Health task also reduces the potential for conflict with Sentinal (the Department of Defence OHS data collection system for both military and civilians). Government must determine if it wishes Injury prevention to be a priority and then to resource it. Accompanying any resourcing should be a requirement that the ADF report its injury prevention performance on annual basis.

The ADF is not financially accountable for the cost of compensation or for the cost of treating service-related injuries and illnesses after a veteran leaves the ADF. Is this a barrier to the ADF having an adequate focus on preventing injury and illnesses and providing early intervention and rehabilitation support? If so, how might this be remedied?

Defence has no financial incentive to reduce or completely resolve injuries or illnesses prior to discharge. In many ways, once a member becomes injured or ill for a prolonged they are on a one-way conveyor belt into the community requiring DVA assistance and support. There have been notable positive exceptions in the Seriously Wounded and Ill Program (SWIP), with a number of very severely wounded or ill members being given exceptional support and retraining options. Most employers are incentivised by workers compensation insurance premiums. Whilst this may not be practicable in Defence, the use of a notional insurance premium based on state workers compensation actuarial models, would be a very useful key performance indicator for Government in determining Defences efforts in injury prevention and injury management. The cost of injury to Defence and Government more broadly is very high. See attachment B

For those veterans who receive compensation, are there adequate incentives to rehabilitate or return to work? Are there examples of other compensation schemes that provide support for injured workers and successfully create incentives to rehabilitate or return to work?

From my personal experience, soldiers wish to be rehabilitated and return to some form of productive work. Having a job is a very important component of overall health and mental well-being. The battles that soldiers face seeking to prove their compensation cases in order to access rehabilitation, can easily lead them into a compensation mindset. Compensation should only be considered when rehabilitation fails, but this would require immediate access to rehabilitation and medical services on transition.

Veterans who are medically discharged are generally in higher needs categories than people who access other rehabilitation and compensation schemes, and have exhausted options for return to work in the ADF. How should this be reflected in the design of rehabilitation services for veterans?

The specialised needs of Defence members warrants the establishment of centres of excellence. These centres would focus on achieving maximal physical and mental capabilities for employment. The current model relies on external service provision with variable results. Having combined DVA/Defence centres of excellence for the treatment of orthopaedic injury and mental health conditions will allow the development of specialised expertise and the ability to accurately determine outcomes. Both Defence and DVA spend considerable sums

of money on the provision of external medical services, but I am unaware if there has been any determination of the cost effectiveness of those services in terms of reduced morbidity and improved employment outcomes. Whilst it's important to consider injury prevention, this is primarily in the realm of primary prevention. Equally important are secondary and tertiary prevention. Secondary prevention speaks to adequate rehabilitation and tertiary prevention speaks to avoiding the necessity for surgery. The single biggest risk factor for injury is a previous injury. Reducing the risk of subsequent injury can only be achieved through aggressive and effective rehabilitation. The best examples of this are within Australia's professional sporting codes, and in particular the AFL. If the ADF/DVA were to establish centres of excellence they should be benchmarked against the staffing and service provision of AFL clubs.

How should the effectiveness of transition and rehabilitation services be measured? What evidence is currently available on the effectiveness of transition and rehabilitation services? How can the service system be improved?

There are a range of standardised instruments to assess improvements in mental health. In the case of PTSD these include the clinician administered psychological screen (CAPS) and the post-traumatic checklist (PCL). The US Department of defence has recently established criteria for response and remission in both PTSD and depression. (See attachment C). For PTSD in 2016, the United States Department of defence reported a response rate of 18.7% and remission rate of 1.3% using currently available evidence-based therapies. This would suggest that the effectiveness of currently utilised therapies is poor and there is an urgent requirement to explore novel therapies with improved outcomes. Unfortunately both DVA and Defence are extremely cautious in their approach, relying on expert advice which is focused on psychological therapies. The use of any therapy outside of existing clinical guidelines is not generally supported, resulting in a complete lack of any innovative therapies which may improve outcomes. There has been recent extensive debate in the United States about the use of guidelines <https://www.psychologytoday.com/au/blog/theory-knowledge/201802/debate-about-ptsd-treatment-guidelines>

The current Australian PTSD treatment guidelines (Attachment D), focus heavily on psychological therapies. A Cochrane collaboration review found very low evidence supporting the use psychological therapies, with high rates of dropout (Attachment E) and a meta-analysis from United States found that whilst studies reported positive outcomes from the use of psychological therapies, between 60 and 70% of patients retained their PTSD diagnosis post-treatment. (Attachment F)

Novel therapies addressing physiological disturbance had been ignored. Examples of this include the use of rivastigmine (Attachments G and H) and stellate ganglion blocks (Attachment I). In addition, suicide is an increasing problem in both the civilian and veterans communities. Suicide attempts have been linked to physiological (autonomic) arousal and efforts to reduce this hyperarousal of thought to potentially reduce the incidence of suicide (Attachment J). Ketamine, which is a powerful antidepressant, can significantly reduce hyper arousal, and has been shown to be highly effective in reducing suicidal ideation (Attachment K). The use of ketamine in acute crisis situations could very rapidly reduce risk without

compromising safety. Unfortunately the general reluctance to explore new therapies prevents this potentially life-saving intervention. Defence and DVA should be at the forefront of conducting research studies examining the effectiveness of novel therapies. The current default position is one of passive waiting for other nations or organisations to develop the evidence. It would be my contention that the problem is sufficiently great to warrant the initiation of randomised controlled studies evaluating the effectiveness of novel therapies with some evidence for clinical improvement.