Chapter 4
Legislative framework

Introduction

4.1 Many of the complaints made regarding the current system of compensation and rehabilitation for veterans are related to the overall legislative framework. In this context, this chapter will cover discussion concerning:

- previous reviews of compensation arrangements;
- recent proposed legislative reform;
- key compensation issues;
- issues concerning complexity and inconsistency;
- support for a large scale review; and
- issues raised regarding the role of the Repatriation Medical Authority (RMA) and application of the Statements of Principles (SoPs).

Previous reviews of military compensation arrangements

4.2 DVA noted that Australia's military compensation arrangements have been regularly reviewed and updated since their introduction prior to the First World War. It listed 12 major reviews of compensation arrangements between 1975 and 2000.[1] In particular, *A Fair Go: Report on Compensation for Veterans and War Widows* undertaken by Professor Peter Baume (Baume review) in 1994 led to significant changes. DVA highlighted findings of three previous reviews:

- the Review of the Military Compensation Scheme (Tanzer review) in 1999;
- the Review of Veterans' Entitlements (Clarke review) in 2003; and
- the Review of Military Compensation Arrangements (MRCA review) in 2011.

4.3 The findings of the *Independent Study into Suicide in the Ex-Service Community* by Professor David Dunt (Dunt review) in 2009 are also relevant.

Baume review

4.4 The Baume review followed an Auditor-General report which criticised compensation arrangements for veterans and their families and a decision of the High Court in *Bushell v Repatriation* (1992) 175 CLR 408 which impacted the way in which medical evidence was required to link a disease or disability with war service.[2] The Baume review believed that the *Bushell* decision would have 'a significant effect on the acceptance rates of claims, both in the first instance, and on appeal'. It noted

1 DVA, *Submission 156*, p. 32.

2 Baume review, p. 1.

that the standard of proof used was unique to the veterans' jurisdiction but characterised it as 'confusing and complex to apply', 'subject to wide interpretation', 'excessively generous' and 'offers potential for exploitation through "doctor shopping"'.[3]

4.5 After weighing alternative options, the Baume review recommended the standard of proof should be changed to 'one which is fair and generous, while consistent in its application and legally unambiguous'. It recommended that 'the standard on proof be based on the legally accepted "civil standard" with the provision that the benefit of doubt be in the favour of veterans with operational service'.[4] It noted:

> The intention of this amendment is to move away completely from the inappropriate and confusing reverse criminal standard with the reasonable hypothesis test. The aim is to use a test which already is well tested but make it more beneficial than usual.[5]

4.6 The Baume review also recommended that an independent expert medical committee be established to resolve general medical issues and to formulate statements of principle for application to all decision-making.[6] The Australian Government did not accept the Baume review's recommendation and retained the concepts of 'reasonable hypothesis' and the reverse onus of proof to the criminal standard. However, the Baume review led to the introduction of Statements of Principles (SoPs) and the establishment of the Repatriation Medical Authority and the Specialist Medical Review Council (SMRC).[7]

Tanzer review

4.7 The Tanzer review arose from issues relating to compensation differences between the VEA and SRCA following the Black Hawk crash in Townville in June 1996. The Tanzer review concluded that it would inappropriate to attempt to amend the VEA and SRCA and considered that there should be new scheme. It suggested 'a single self-contained military compensation scheme for peacetime service which recognises the different nature of military service from civilian employment'.[8] The recommendations of the Tanzer review led to the enactment of a new military compensation scheme under the MRCA in 2004.

Clarke review

4.8 As the MRCA was being developed, the Clarke review was established in 2002 to examine perceived anomalies in access to veterans' entitlements and of levels

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3 Baume review, p. 13.

4 Baume review, p. 13.

5 Baume review, p. 25.

6 Baume review, p. 13.

7 Professor Dennis Pearce, *Review of the Repatriation Medical Authority and Specialist Medical Review Council*, 1997, p. iii.

8 Tanzer review, p. 5.

of benefits available to disability pensioners. It observed that '[a]lthough many legislative measures were consolidated with the passage into law of the VEA in 1986, the eligibility provisions remain complex and partly reflect historical concepts that are difficult to apply'.[9] The review's report in 2003 made 109 recommendations relating to the extension of coverage under the VEA, changes to the disability compensation pension structure and the establishment of an integrated and comprehensive rehabilitation program.[10]

Dunt review

4.9 As noted above, an independent study into suicide in the ex-service community was undertaken by Professor David Dunt. The terms of reference of the study included 'highlighting changes in current policies, procedures and practices that exist in DVA that would minimise potential stress'. The Dunt review commented:

> It is widely recognised that the three military compensation schemes – Veterans' Entitlement Act (VEA), Safety Rehabilitation and Compensation Act (SRCA) and Military Rehabilitation and Compensation Act (MRCA) - are difficult for veterans to navigate and DVA delegates to advise and process. They also have differing aims - VEA is essentially a military compensation scheme, SRCA a worker's compensation scheme oriented to rehabilitation and MRCA has features of both…It would simplify the scheme considerably if the three acts could be rolled-up into one successor Act. It is worth noting that Canada and US have one scheme only and the UK one past and present scheme operating.[11]

4.10 The Dunt study review observed that 'the operation of MRCA and veterans' compensation more generally will be reviewed in 2009' and the report did not include a recommendation on this matter. The report acknowledged 'it is also not clear if it is possible to roll-up VEA, SRCA, MRCA into a successor scheme so that only one scheme exists and again do this without detriment to the existing benefits that a veteran would otherwise be entitled to obtain under existing arrangements'.[12]

MRCA review

4.11 The MRCA review was conducted by a steering committee chaired by the then Secretary of DVA, Mr Ian Campbell PSM. DVA noted that MRCA review had broad terms of reference which included 'the examination of the performance of DVA in relation to the operation of the MRCA, review of the size of benefits payable for death and serious injury under the MRCA' and an analysis of any anomalies that existed between the MRCA and other veterans entitlements.[13]

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9 Clarke review, p. 5.

10 *Submission 156*, p. 33.

11 Dunt review, p. 12.

12 Dunt review, p. 85.

13 *Submission 156*, p. 35.

4.12 The MRCA review produced its report in March 2011. It concluded that the objectives of the MRCA were sound and that the unique nature of military service justified rehabilitation and compensation arrangements specific to the needs of the military. It also made a large number of recommendations concerning opportunities for improvements. Accepted recommendations have been progressively implemented and the MRCA Review was formally closed with ministerial approval in September 2016.[14]

4.13 DVA emphasised that the MRCA review steering committee 'considered the complexities which exist for clients who have eligibility across two or three Acts and acknowledged that reducing the amount of military compensation legislation would be highly desirable':

> However, the Steering Committee also confirmed that consolidating entitlements into one Act would require the resolution of several complex, sensitive and potentially controversial issues.
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> Apart from the different entitlements under the three Acts, other reasons why there is no simple, singular approach to address or fix the current complexities include:
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> - there are accrued rights issues in changing entitlements once they have been accrued through periods of service;
> - complex transitional arrangements would be needed to protect existing entitlements and ensure no detriment to individuals; and
> - uniform compensation benefits could be seen as inconsistent with the nature of military service, and would imply, or could be interpreted to mean, that all military service is the same.
>
> Given the complexity of these legislative issues, the MRCA Review recommended that DVA concentrate on continuing to simplify the claims process for potential claimants.[15]

Recent proposed legislative reform

4.14 The Parliament is currently considering the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016. This bill will duplicate the existing SRCA as a standalone act, with appropriate amendments to give full control of the act to the Minister for Veterans' Affairs. The standalone act created by the bill will be titled the Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988 (DRCA).

4.15 DVA has noted that the DRCA was being created by the bill to 'enable the Minister for Veterans' Affairs to solely administer all legislation relating to veterans' entitlements [allowing] the recognition of the unique nature of military service that may not be appropriate for civilians under the SRCA'. This would allow the Minister

14 *Submission 156*, p. 37.

15 *Submission 156*, p. 30.

for Veterans' Affairs 'opportunities to start examining streamlining, simplification and alignment of legislation'.[16]

4.16 On 9 February 2017, the Senate referred the provisions of the Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 to the Senate Foreign Affairs, Defence and Trade Legislation Committee for inquiry and report by 20 March 2017. The committee considered that the amendments would be 'a positive change to ensure that all three of the main legislative compensation and rehabilitation schemes for ADF members, veterans and their dependents can be responsive to the unique nature of military service'. This would facilitate 'reform to simplify and harmonise the legislative schemes, departmental practices and the claims processes for ADF members and veterans'.[17]

Key issues concerning compensation arrangements

4.17 DVA characterised establishing appropriate compensation levels for veterans as 'a fine balance of a number of principles'. It listed these principles as:

- meeting the needs and expectations of veterans and their families;
- recognition of the unique nature of military service;
- meeting community expectations of support and care for veterans and their families;
- ensuring modern approaches to rehabilitation and compensation;
- recognition of other Australian government compensation payments; and
- responsible economic management.[18]

4.18 DVA acknowledged that a '[c]omparison of compensation levels across the three Acts is not simple as there are different forms of compensation and other support structures, eligibility rules, assessment methods and scales of compensation in each Act'. It stated:

> Compensation provided under each Act cannot be considered in isolation. Each Act has different thresholds and other complementary benefits that must be taken into consideration to make an accurate comparison. The compensation provided must be considered in terms of the total benefits that are available.[19]

4.19 In this context, Mr Craig Orme from DVA highlighted the important role of the Commonwealth Superannuation Corporation (CSC) and access to invalidity class A, class B and class C benefits:

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16 Ms Carolyn Spiers, *Committee Hansard*, 15 March 2017, pp 25-26.

17 Senate Foreign Affairs, Defence and Trade Legislation Committee, *Safety, Rehabilitation and Compensation Legislation Amendment (Defence Force) Bill 2016 [Provisions]*, March 2017, p. 17.

18 *Submission 156*, p. 32.

19 *Submission 156*, p. 32.

> If a member is medically discharged, the first assessment that is made on discharge, or prior to discharge, is the determination under the [CSC], which is effectively the insurance scheme covering ADF employment, which is not about liability but simply about the capacity of the individual to work. If a member is injured outside of work hours in a private capacity, they may not be covered under the [MRCA]. They are covered, however, by the [CSC]. If they are medically discharged, if their invalidity or impairment to work is assessed at 60 per cent or higher they are given an invalidity class A pension; if it is 30 to 59 per cent there is an invalidity class B pension, and below that there is a capability to work and access to certain superannuation benefits.[20]

4.20 In comparison to public servants covered by SRCA, Ms Carolyn Spiers, Principal Legal Adviser, DVA observed:

> The rates payable for permanent impairment under MRCA are higher than that under SRCA. There are things like the Gold Card available under MRCA that are not available under SRCA. There is the safety net of the SRDP pension under MRCA that is not under SRCA.[21]

4.21 DVA provided a table of indicative compensation outcomes for a member of the ADF with paraplegia related to service under MRCA compared to indicative compensation outcomes for a public servant with a work related injury that results in paraplegia under the SCRA.[22]

Table – indicative compensation outcomes

	MRCA	SRCA
Permanent Impairment	96 impairment points (IP) under the Guide to Determining Impairment and Compensation - $335.73 weekly amount (including maximum lifestyle effects). This can be converted to a partial or total lump sum. **Total lump sum $448,971.73** Plus; • 80 or more IP – additional compensation of $86,429.75 for any dependent children along with a gold health care card and access to MRCAETS education assistance per child. • 60 or more IP – automatic entitlement to Gold Card (see below). • 50 or more IP – consideration for Special Rate Disability Pension (SRDP; see below). • Eligibility for financial and legal advice up to $2,549.31 each.	99% WPI whole person impairment under the Comcare Guide to the Assessment of the Degree of Permanent Impairment - $181,204.49. Plus maximum non-economic loss (NEL) - $68,638.10. **Total PI lump sum $249,842.59**

20 *Committee Hansard*, 6 February 2017, p. 56.

21 *Committee Hansard*, 6 February 2017, p. 53.

22 DVA, response to question on notice from hearing 6 February 2017.

4.22 The DVA submission also provided the following summary of entitlements for veterans and their dependents (as at October 2016).[23]

Table – Summary of entitlements for veterans and dependents

	Military Rehabilitation and Compensation Act 2004		*Safety, Rehabilitation and Compensation Act 1988*	*Veterans' Entitlements Act 1986*
	Periodic	**Lump Sum**	**Lump Sum**	**Periodic**
Compensation for permanent impairment	$335.73 (pw) (maximum)	$448,971.73 (maximum aged based conversion) $86,429.76 (Additional compensation in respect of each dependent child for persons assessed at 80+ impairment points)	$251,672.94 $78,235.87 (*Defence Act 1903* additional compensation for severely injured) $85,750.21 (Additional compensation for each dependent child)	Disability pension for life, with the rate depending on the degree of incapacity Rates $pw Special 673.45 Intermediate 457.20 EDA 372.00 General (10% to 100%) 27.40 – 239.40 (incl energy supplement)
Incapacity Payments	100% of normal earnings reducing to 75% after 45 weeks		100% of normal earnings reducing to 75% after 45 weeks. These amounts are both less 5% notional superannuation contributions.	Clients may be eligible for Loss of Earnings Allowance which tops up the disability pension
Compensation after Death – Widow(er)	$445.65 (pw)	$753,193.07 (maximum aged based conversion) $144,049.60 (Additional compensation where the death is service-caused)	$528,433.70 (shared with child dependants, if any) $58,339.81 (Defence Act 1903 additional compensation) $85,750.21 (Defence Act 1903 dependent child benefit)	$445.65 (pw) Up to $131.55 (pw) (means tested Income Support Supplement)
Compensation after Death – Dependent Child	$143.75 (pw) (while younger than 16 years- or from 16-24 years if in full-time education)	$86,429.75	$528,433.70 (shared with all dependents including widow(er). $145.32 (pw) (while younger than 16 years- or from 16-24 years if in full-time education)	Pension if war/service caused death of parent – conditions apply if child is older than 16 years eg not eligible if receiving education benefits. $49.60 (pw) if one parent deceased $99.10 (pw) if both parents deceased
Funeral Expenses	$11,654.06		$11,654.06	$2,000

23 Note: veterans' pensions were altered from 20 March 2017 following the latest round of indexation adjustments.

4.23 A range of views concerning compensation for veterans were raised during the inquiry. For example, Mr Peter Reece, a former DVA official, described the Australian system of military compensation as 'without doubt the most generous in the world – not just for the quantums available, but for the ease of access'. He considered the current system was 'more generous than any scheme for civilians, and for other like careers such as police forces and paramedics'.[24]

4.24 Mr Reece argued that implementing an appropriate system of income support for veterans should be the direction of reform rather than overreliance on the compensation system to deliver income support. He noted that '[c]ompensation is there to give people redress for actual, substantial losses in their income earning capacity and their career prospects and for the degree of suffering and physical shortfalls that they have to endure—it is not an income support policy'.[25] He told the committee:

> The system is designed for benefits that are in finality. Access to their disability under their superannuation, to Centrelink benefits, and all the rest of it is a complete mess. They are administered by different authorities with different regulations and rules. These people are pushed around from one to the other, and they come back to compensation because it is the only thing that people know and understand—particularly in the ex-service organisations.[26]

4.25 The RSL also raised issues about the appropriate balance between compensation, rehabilitation and healthcare in the current arrangements:

> A question that is rarely asked is whether this time, effort and cost results in the best benefit to the veteran concerned? In other words is the award of monetary compensation the optimum outcome or, might something else, rather than a compensation payment, such as comprehensive lifetime health care (i.e. the issue of a gold card) be more appropriate in some circumstances?...
>
> What is in question is whether the balance between offering monetary compensation and taking other forms of action such as the provision of comprehensive through-life health care and rehabilitation are in the best interests of individuals and of the nation. It should be noted that acceptance of monetary compensation by those assessed as eligible for the Special Rate of Pension significantly constrains their future lives by heavily restricting their opportunities to work.[27]

4.26 Mr Allan Anforth, a barrister, argued that the VEA would not provide inadequate compensation for veterans compared to the SRCA and MRCA in most cases. He noted that the level of incapacity benefits paid under SRCA and MRCA for a veteran unable to work (at 75 per cent of the index normal weekly earnings at the

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24 *Submission 378*, p. 1.

25 *Committee Hansard*, 5 May 2017, p. 23.

26 *Committee Hansard*, 5 May 2017, p. 22.

27 *Submission 216*, p. 12.

time of injury) is 'vastly greater than the level of disability pension paid under VEA including the pension paid at the TPI rate under the VEA'.[28] While the VEA granted access to the Gold Card where the veteran is on the TPI rate under VEA (and a few other special circumstances), Mr Anforth argued that the value of the Gold Card to a veteran or their partner has to be discounted by the sheer loss of incapacity payments, permanent impairment and death benefits payable and the offset from Medicare.[29]

4.27 Several advocates and ESOs argued that lump sum compensation payments were inappropriate for many veterans, particularly younger veterans. For example, the TPI Federation noted that a contentious issue with the eligibility for Special Rate Disability Pension (SRDP) was that a veteran must make a life-long choice of whether to take the incapacity payments along with a lump sum or to take the SRDP. It stated:

> There is no provision to change back to the other alternative if an incorrect decision has been made. MRCA provides funding for the member to gain advice from a Financial Adviser prior to making a decision on this course of action. The TPI Federation contends that most Financial Advisers would, in most cases, recommend the Lump Sum Payment, which comes with the Incapacity Payment until age 65, as this is a bias to receive a commission.
>
> Where a young person is faced with the proposition of obtaining a very large sum of money or a small fortnightly compensation payment, the overriding temptation to take the lump sum payment is extreme. They do not think of the ramifications of when they 'hit the wall' and are no longer able to work and earn a living. In this case they cannot double dip and revert to the SRDP. DVA considers that their job has been done.[30]

4.28 In relation to this issue, DVA noted that it provided compensation up to a statutory limit (currently $2,549.31) to be paid for the cost of financial or legal advice in three separate circumstances. In particular:

> Where a person is chronically incapacitated and meets certain eligibility criteria, a person may be offered the choice to receive the Special Rate Disability Pension (SRDP) in lieu of ongoing incapacity payments. These persons are also offered compensation for the cost of obtaining financial or legal advice in respect of that choice. If the person wishes to choose SRDP, obtaining financial advice is mandatory.[31]

Complexity and inconsistency

4.29 DVA acknowledged that the 'current legislative framework for veteran entitlements is complex, with individuals potentially having compensation coverage under one, two or three Acts, depending on their date of service and date of injury'. It observed that this situation 'reflects the evolution of the repatriation system and

28 *Submission 208*, p. 5.

29 *Submission 208*, p. 7.

30 *Submission 307*, p. 1.

31 DVA, response to written question on notice 6 February 2017 public hearing.

Government decisions over decades in response to changes in circumstances and expectations'.[32]

4.30 The complexity of the three legislatives schemes and the inconsistency of their application to veterans were a key issues raised during the inquiry. It was identified as a key cause or contributing factor to a range of problems for veterans seeking to access compensation, rehabilitation, health services and other support. For example, the South Australian Government commented:

> This legislative framework is cumbersome, complex, confusing and difficult to navigate for advocates, DVA staff and members of the serving and ex-serving community. In some circumstances a veteran may have a claim under more than one Act requiring the claimant (or their advocate) to make a number of applications to more than one compensatory scheme. The assessment process within DVA requires delegates to have a thorough understanding of all legislation in order to assess the validity of a claim. The complexity of the legislative framework can lead to significant delays to the processing of claims adding unwarranted stress to those involved.
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> It is worth noting that both the US and Canada operate a single scheme and the UK operates one past and one current scheme. This approach removes any overlap between legislative elements simplifying the process. Consideration should be given to a complete review of Commonwealth veteran related legislation that preserves veterans' entitlements while simplifying the process under a single Act.[33]

4.31 Similarly, Mr John Burrows, an advocate, commented:

> The current veteran legislation is very confusing, complex, not client friendly and from my perspective adds a considerable barrier to providing viable advice, practical guidance and support to veterans, their families and supporting agencies. Having to consult three separate Acts on many occasions to identify eligibility, entitlement and access to benefits can be overwhelming, confusing and simply negates many endeavours to apply for an obtain benefits and support!
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> The inability to interpret many aspects of the complexities and various combinations available in duel and tri-eligible situations often result in veterans and their families being disadvantaged.[34]

4.32 Colonel David Jamison (rtd) from the Alliance of Defence Service Organisations (ADSO) told the committee:

> [W]e believe a significant factor contributing to the problem lies in the legislative framework on which support to veterans is based. The three rehabilitation and compensation schemes result in a very complicated system that sets up an adversarial claims process and a bureaucratic structure that many see as complicated and unfriendly towards veterans

32 *Submission 156,* pp 29-30.

33 *Submission 187*, p. 4.

34 *Submission 189,* Supplementary submission 1, p. 9.

> seeking support. It is abundantly clear from social media groups that veterans from the more recent conflicts feel alienated and see the system as biased against them.[35]

4.33 Mr Peter Reece argued that it all 'comes back to the legislation' and without 'dramatically simplified' law, policy and administration there 'there will be no improvement'.[36] In this context, he cautioned:

> These changes need to be made before the current DVA I/T systems are reengineered, as set out in the latest Budget. I fear that spending that money on the DVA claims system, based on the current policy and administrative framework will not just be excessively complex and expensive, but will lock in a policy which is simply decrepit.[37]

4.34 Other issues were also highlighted. For example, Mr Peter Thornton considered that 'some of the issues surrounding claims processing stems from legislation [and] regulation being too prescriptive [which] in turn limits and restricts the flexibility and discretion departmental Claims and Reviewing Officers have, when dealing with and satisfying claims'. He recommended that DVA Claims and Reviewing Officers be provided with increased levels of discretion in determining claims.[38]

4.35 The impacts of the differences and inconsistencies between each legislative scheme were also emphasised by submitters. For example, ADSO submitted that the differences between the VEA and the MRCA 'colour the veteran community's perceptions of MRCA'. It stated:

> Advocates with long VEA experience perceive MRCA to be complex. As a result, some advocates are known to refuse to support veterans that are subject to MRCA. Through misunderstanding or otherwise, the resulting grievances are aired angrily on social media.
>
> For those advocates with long experience - and therefore familiarity – with VEA, the recency of MRCA's enactment and, as yet, limited number of judgements cause uncertainty for advocates. The [MRCA's] 'stable and permanent provisions' (ss68, 71 and 199 in conjunction with ss68 and 71) and medical examination provisions (s328, in conjunction with ss325 and 326) are known to frustrate veterans awaiting PI, SRDP and INCAP compensation determinations.[39]

4.36 The VVFA identified a number of 'anomalies or inconsistencies' in the application of the VEA, SCRA and MRCA 'in determining necessary compensation for veterans who have suffered some form of injury or damage while a member of the ADF'. For example, the VVFA noted differences in the measurement of incapacity:

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35 *Committee Hansard*, 18 November 2016, p. 19.

36 *Committee Hansard*, 5 May 2017, p. 24; *Submission 378*, Supplementary submission, p. 1.

37 *Submission 378*, Supplementary submission, p. 1.

38 *Submission 335*, p. 16.

39 *Submission 172*, p. 14.

> Under the VEA, injuries and diseases do not have to meet a minimum degree of incapacity indicated by percentages or impairment points. However, SRCA uses a 'whole of body' impairment system and a minimum of 10% of 'whole of body' impairment for an injury or disease must be reached before compensation is awarded. Similarly, MRCA contains an 'impairment points system' requiring a minimum of 10 impairment points before compensation is triggered.[40]

4.37 The VVFA stated that the 'imposition of a higher standard of evidence for one group of veterans visà-vis another, and between one Act and another, is not only inconsistent, it is also confusing to veterans'. It recommended a '[c]omprehensive review and comparison of all three Acts and identification of same or similar provisions affecting veterans, including contemporary veterans'. It considered this 'review is long overdue'.[41]

4.38 Ms Lee Withers, a former ADF Transition Manager drew the committee's attention to the unfairness of the inconsistencies between the schemes:

> [I]t was horrendous to try and explain to different soldiers and their partners or parents why, when both sustained the same life changing injuries, one would receive enough money to support themselves and medical and physical assistance paid for by DVA, while the other one would not get any ongoing payments or support and a much reduced level of medical care. All they see is they both served together and got hurt together and need the same care and support. They don't care what government decisions changed the levels of care for one because he/she joined on a different date or whatever. That kind of perceived injustice is going to stick for years and years and coupled with other issues post discharge such as lesser income, injury/pain management and mental anguish, is enough to tip someone over the edge.[42]

4.39 An advocate, Mr Rod Thompson, considered the three legislative schemes are 'for the most part are not mutually compatible for veterans' who have multiple deployments and eligibility'. He highlighted that there were many 'different types of service (warlike, non-warlike, hazardous, operational, peacekeeping and peacetime) over approximately 84 gazetted and scheduled conflicts / operations'.[43] He argued:

> An injured / ill veteran is the same whether they are 18 or 80, currently we are seeing SRCA and a significant number of MRCA veterans becoming a sub-class of veteran not being provided with the Beneficial provisions and concessions (both state and federal) provided to those solely under the VEA.[44]

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40 *Submission 277*, p. 10.

41 *Submission 227*, pp 11-12.

42 *Submission 22*, p. 1.

43 *Submission 334*, p. 12.

44 *Submission 334*, p. 14.

4.40 The TPI Federation highlighted that currently some TPI veterans are denied access to a number of DVA services 'purely because they don't have operational service'. It stated:

> This is discriminatory and a failure to recognise that a non-operational TPI suffers the same consequences as an operational TPI even to the extent of not having access to a service pension at age 60, but must rely on a Centrelink Disability Support Pension. A salient point, worth remembering, is more service people have been killed or injured in non-operational theatres since the Vietnam War; by example the Black Hawk tragedy, the WESTRALIA incident and other numerous non-operational occurrences that have caused fatalities or injury.[45]

4.41 To illustrate the range of differences between the schemes, TPI Federation noted that 'under the MRCA, a DVA client's family is currently eligible to $11,654 as a funeral allowance [but this] is markedly different with the VEA client's family where the same allowance is $2,000'.[46]

4.42 Similarly, Mr Frank O'Neill questioned the rules which could impact veterans when their partner was employed:

> The means tested Service Pension of a maximum amount of $22,804 pa for single disabled is added to the TPI rate which at the combined maximum amounts to $57,804 pa. However the Service Pension is withdrawn when the single veteran marries someone participating in the workforce…I walked down the aisle single as a $58,000 pa man. I walked back up the aisle married a $35,000 pa man. There was no miracle health cure at the alter to explain why the DVA System cut my replacement income by 40 percent.[47]

4.43 Others argued that a realistic approach to reform of veterans' compensation would be necessary. Mr Peter Larter advised the committee:

> The complexities in the framework and legislation, in the [VEA] and all the acts are better for some and worse for others. If you were to draw a line in the sand—and I think there could be a future for this—the most important person in the room would be the Treasury department that needs to sign off. I do not think it would be fair to a veteran who, in certain situations, in one act—and even in the MRCA Act, which is a new one—will be worse off in his entitlements than someone under the VEA or SRCA. A roomful of good advocates would be able to give you plenty of examples of that.
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> But that comes at a cost: a cost to government, a cost to the taxpayer et cetera; I understand that. So, if we were to go forward, I do not think it would be fair for the veteran to go backwards in entitlements. More than

45 *Submission 307*, p. 3.

46 *Submission 307*, p. 5.

47 *Submission 305*, p. 12.

> likely we would be going forward with entitlements, and that will come with a dollar value…[48]

Non-liability health care

4.44 There was significant positive feedback during the inquiry concerning the expansion of non-liability health care for all mental health conditions. Some recommended that further expansion of non-liability heath care should be explored to reduce complexity and simplify administrative processes.

4.45 For example, Dr Jon Lane, a consultant psychiatrist, noted that since the expansion of non-liability healthcare coverage for mental health and substance abuse problems he had seen an increase in veterans. He described this as 'a very good thing', noting it 'demonstrates that opening access to services with minimal administrative requirements works in terms of Veterans accessing these services'. He recommended that the Government extend the non-liability health care to all service veterans, for all health conditions. He stated:

> This may have an initial higher cost, but as seen with the limited access to specific mental health conditions now, it would improve access to treatment, and therefore reduce the overall level of treatment required, as well as the duration of that treatment. This should reduce the administrative cost and workflow burden to DVA in terms of the liability determinations which are the majority of the basis for complaints, as well as the ongoing administrative and treatment costs by ensuring that veterans get adequate and early treatment for problems.[49]

4.46 This proposal was also raised in the Joint Standing Committee on Foreign Affairs, Defence and Trade's (Joint Committee) report on the *Care of ADF Personnel Wounded and Injured on Operations* in 2013. The Joint Committee was 'concerned that a significant difference exists in the treatment of personnel who discharge with a condition that is recognised by DVA, and those who discharge and subsequently develop a service-related condition'. It recommended that the Government conduct a cost-benefit study of a comprehensive uncontested veteran healthcare liability model and publish the results.[50] However, this recommendation was not supported. The Government response stated:

> Any proposal to further extend "non-liability" access to DVA health care arrangements to a broader group of former service personnel would involve significant additional financial costs to the Commonwealth and is not a priority at this time. Also under DVA arrangements comprehensive health care is available for treatment of conditions which have been accepted by the Department as service related.[51]

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48 *Committee Hansard*, 5 May 2017, p. 13.

49 *Submission 78*, pp 1-4.

50 Joint Committee report, pp 96-97.

51 Government response to Joint Committee report, December 2013, pp 6-7.

4.47 DVA noted that any further expansion of on-liability health care would need to be considered by Government in the Budget context:

> Financial modelling can be based on existing non-liability health care recipients and generally applied to extensions. Some costs will be partially offset with the Department of Health. Data on incidence rates and estimates of those with one or more additional mental health conditions co-occurring with an existing non liability health care mental health condition are also relevant when providing advice to Government on the costs associated with extending non-liability health care options for veterans.[52]

Support for a review

4.48 In the context of the issues raised above, many submitters expressed support for a large scale review of military compensation and the framework of entitlements for veterans often proposing a focus on simplification. For example, Mr Peter Reece, a former DVA official, critically assessed each of the previous reviews of military compensation arrangements considering they had 'only deal superficially with operational issues with the current legislation'.[53] He considered that there was a need for a comprehensive basic 'ground-up review of military compensation'. Due to it being an 'enormous, longstanding, complex and very detailed issue' he considered it would be a task for 'the Productivity Commission or a judicial inquiry of some kind, something with a lot of horsepower'.[54] He stated:

> The outcomes, I would hope, would be the rationalisation of the scheme into something which every other public servant and citizen in this country enjoys—that is, good, sensible, transparent and fair compensation…The outcomes ought to be rationalisation and, I dare say, some savings in costs, because remember that Veterans' Affairs these days has a budget of $12½ billion, which is the annual downstream cost of Defence. It is not counted in the Defence budget. But is more than money: I do not really mind how much veterans are paid, so long as it is fair, even, consistent, simple and easily administered; it is none of those things.[55]

4.49 The RSL noted that the last major review was in 2011 and considered that 'it would be prudent to have another look at the interplay between the various Acts and the effectiveness of the administration of those Acts by the DVA'. It recommended:

> That an independent Review be set up, with broad Terms of Reference, to investigate the interplay between the three extant Acts administered by DVA, their procedural interaction with ComSuper, and whether having three separate Acts remains an effective approach to the support and compensation of veterans in Australia.[56]

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52 DVA, responses to written question on notice, public hearing 6 February 2017, p. 1.

53 *Committee Hansard*, 5 May 2017, p. 19.

54 *Committee Hansard*, 5 May 2017, p. 19.

55 *Committee Hansard*, 5 May 2017, p. 20.

56 *Submission 216*, p. 9.

4.50 Mr Arthur Ventham, Chair of the Northern Suburbs Veterans Support Centre, also highlighted it was five years since the last review. He stated that 'in the current environment, it would be prudent to have another look at the interplay between the various Acts and the effectiveness of the administration of those Acts by the DVA which on the surface appears to have become extremely dysfunctional'.[57] Like many submitters, the Northern Suburbs Veterans Support Centre argued that the objective of legislative reform should be a single piece of legislation to cover compensation and rehabilitation for all veterans. It proposed:

> A new Rehabilitation and Compensation Act be developed to replace VEA, SRCA and MRCA so that unjust discrimination that is found today is eradicated and all Members are treated equally when it comes to rehabilitation and compensation.[58]

4.51 Similarly, Mr Ben Johnson, a former senior public servant, proposed that legal advice be sought from 'the Office of Parliamentary Council (OPC) in the Attorney General's Department on options for either preparing an Omnibus Amendment Bill to consolidate the current complexity of DVA managing both the VEA and MRCA' and 'streamlining of the claim processes for veterans and the assessment of compensation and support for injuries incurred as a result of different periods of service'. Alternatively, an MRCA amendment which would 'effectively triage or prioritise the claims from contemporary veterans to ensure that those veterans with the most serious medical claims are assessed with the highest level of priority accorded a rapid resolution of their claim'.[59]

4.52 Some argued for the establishment of a Royal Commission.[60] For example, the Royal Commission into DVA Working Group had 'no faith in the current senior and middle management of DVA's capability to rectify over a decade of neglect, we consider the only option to be a Royal Commission that can make binding legal directions to DVA looking into all aspects of the Repatriation System, Defence Transitions and the Wider Veteran Landscape including ESOs'. It stated:

> [A]ll the reports and findings of recent inquires have contained the two words, COMPLEXITY and SIMPLIFICATION. Neither of which have been addressed by DVA's senior management, in fact DVA has embarked on further complication with the introduction of the proposed DRCA legislation making five conflicting legislations creating sub-classes of veterans many falling below the poverty line struggling with homelessness and financial stress all while suffering in some cases significant mental and physical injuries exacerbated by an adversarial and complex system and all the bureaucracy that comes with 5 separate and conflicting legislations.[61]

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57 *Submission 295*, p. 5.

58 *Submission 279*, p. 5.

59 *Submission 264*, p. 7.

60 For example, Mr John Lawler, *Submission 7*, p. 22.

61 *Submission 453*, pp 22-23.

4.53 However, DVA observed that the idea that there should be a single piece of veterans' affairs legislation has been examined in a number of inquiries, most recently by the MRCA review in 2011:

> The [MRCA review] Steering Committee noted that the MRCA was introduced to address the complexities created by the concurrent operation of the [VEA] and the [SRCA]. However, as it is still possible for claims to be made under the VEA or SRCA for conditions arising from service before 1 July 2004, the operation of these three Acts continues to create complexity and confusion for some claimants, particularly for those who have coverage under more than one of these Acts. It is likely that this situation will remain for some time to come, because while MRCA claims will become the majority of claims received in the decades to come, claims under the VEA and SRCA will not be exhausted for many years.
>
> After considering options for simplifying DVA's legislative framework, the [MRCA review] Steering Committee concluded that consolidating entitlements into one Act would be extremely difficult and would require the resolution of several complex, sensitive and potentially controversial issues, including the fact that compensation entitlements under the three Acts are structured differently.[62]

4.54 DVA outlined a number of reasons why 'there is no simple, singular approach to address or fix the current legislative complexities'. These included:

- there are accrued rights issues in changing entitlements once they have been accrued through periods of service;
- complex transitional arrangements would be needed to protect existing entitlements and ensure no detriment to individuals; and
- uniform compensation benefits could be seen as inconsistent with the nature of military service, and would imply, or could be interpreted to mean, that all military service is the same.[63]

4.55 DVA noted that it was 'identifying opportunities to align and streamline its practices and procedures within the current legislative framework to make it simpler for DVA clients to understand what they are entitled to and how to claim'. It also highlighted that the amendments creating the DRCA 'give the Minister for Veterans' Affairs policy responsibility for all relevant compensation legislation for ADF members and veterans'. It pointed out that the DRCA would 'enable the Minister and the Military Rehabilitation and Compensation Commission to consider possible changes to align the Act with the MRCA, which would not have been appropriate for civilians with coverage under the Act'.[64]

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62 DVA, response to written question on notice from public hearing 6 February 2017.

63 DVA, response to written question on notice from public hearing 6 February 2017.

64 DVA, response to written question on notice from public hearing 6 February 2017.

The Repatriation Medical Authority (RMA) and Statements of Principles

4.56 The Repatriation Medical Authority (RMA) is an independent statutory authority, based in Brisbane, responsible to the Minister. The RMA consists of a panel of five practitioners eminent in fields of medical science. The role of the RMA is to determine Statements of Principles (SOPs) for any disease, injury or death that could be related to military service, based on sound medical-scientific evidence. The SOPs state the factors which 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death. The SOPs are disallowable instruments which are tabled in Parliament and are binding on various decision makers.[65] The RMA explained:

> In determining SOPs, the RMA is required to rely upon sound medical-scientific evidence (SMSE), as defined in section 5AB of the VEA…All available SMSE is evaluated by the RMA against accepted epidemiological criteria. These criteria include strength of association; consistency; specificity; temporality; biological gradient; plausibility; experimental evidence; and analogy and may not each be relevant in all decisions of whether or not a factor should be included in a SOP.[66]
>
> The VEA and MRCA provide for two different standards of proof which apply to claims for compensation by veterans and serving members. The RMA is also required by the legislation to apply two standards of proof when determining the contents of SOPs. For each condition, two SOPs are determined.
>
> The more beneficial standard, known as the "reasonable hypothesis" standard, applies to veterans and serving members who have operational (or equivalent) service….The less beneficial "balance of probabilities" standard (also known as reasonable satisfaction) applies to eligible war service (other than operational service) and defence service (under the VEA), and peacetime service (under the MRCA).[67]
>
> The different standards of proof will often lead to some factors being included in the "reasonable hypothesis" SOP with weaker evidence than is required for inclusion in the "balance of probabilities" SOP. The "reasonable hypothesis" SOP will often contain more causal factors and/or the specified exposure contained in a factor may be easier to satisfy. The result is that it is generally easier for veterans and members with operational service to successfully claim that a medical condition was related to their service.[68]

4.57 In 1997, a review was conducted of the RMA and the Specialist Medical Review Council (SMRC) the body which was created to hear appeals against decisions of the RMA relating to the making of SOPs. The reviewer, Professor Dennis

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65 See 'Introduction to the RMA', available at http://www.rma.gov.au (accessed 12 September 2016)

66 RMA, *Submission 32*, pp 2-3.

67 RMA, *Submission 32*, p. 4.

68 RMA, *Submission 32*, p. 5.

Pearce, while making recommendations for improvement, concluded that the amendments creating the RMA and SMRC had created 'a more equitable system for the compensation of veterans' which was 'more efficient and non-adversarial than that previously existing'.[69]

4.58 The Joint Committee report on *Care of ADF Personnel Wounded and Injured on Operations* included a recommendation that DVA 'review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted'. However, the government response to the Joint Committee report did not support this recommendation. It stated:

> While the Department of Veterans' Affairs (DVA) seeks to be flexible in its service delivery to clients, introducing flexibility to the Statements of Principles regime would undermine its purpose and reduce its value in underpinning evidence based decisions…The Statements of Principles regime is a well established and core element of the Repatriation system. They are internationally recognised as providing a quality decision making tool. There is strong support for the Repatriation Medical Authority and the Statements of Principles regime from ex-Service organisations and the ex-Service community.[70]

4.59 The RMA has a schedule for regular review of its SOPs and reviews the contents of each SOP at least once every 10 years (7 to 8 years on average). The RMA monitors developments in medical science and epidemiological understanding of disease aetiology. Where it becomes aware of significant new sound medical-scientific evidence, it initiates reviews of the relevant SOPs earlier than the usual cycle. SOPs are also reviewed more frequently where a request is received from an eligible party to do so with sufficient relevant information to support the request.[71]

4.60 The RMA indicated that for the period January 2014 to December 2016, the RMA received 63 requests to undertake investigations or reviews.[72]

4.61 In particular, during the inquiry, the RMA reconsidered the SOPs concerning suicide and attempted suicide. Mr Peter Larter's submission included his request to the RMA to review this SOP, in particular factors 3 and 4 which 'stipulate that a person must experience a 1A or 1B stressor within 2 and 5 years before the suicide in order to establish that death from suicide is connected to a person's relevant service'. Mr Larter noted:

> A situation presents itself where a spouse or dependent may not be able to connect the person's suicide to relevant service where the suicide occurred

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69 Professor Dennis Pearce, *Review of the Repatriation Medical Authority and Specialist Medical Review Council*, 1997, p. iii.

70 Australian Government, *Government response to JSCFADT report into Care of ADF Personnel Wounded and Injured on Operations*, December 2013, pp 12-13.

71 DVA, response to question on notice 8, Budget Estimates, 30 May 2017, p. 1.

72 RMA, response to question on notice from public hearing 6 February 2017.

> after 2 and 5 years from date of experiencing the category 1A or 1B stressor and they cannot establish enough evidence to satisfy any other factor in the SOP.
>
> It is possible that a person with relevant service has a delayed onset (more than 5 years) of a significant disorder of mental health and has not received or being treated for any impairment regarding symptomology of a mental health condition.
>
> In this instance the surviving spouse or dependent claim for compensation will fail and they will be ineligible for any entitlements as the suicide occurred after the 2 and 5 year time period as stipulated in the SOP's.[73]

4.62 Consequently, the RMA made beneficial changes regarding these SoPs:

> The RMA's assessment of the sound medical-scientific evidence relating to suicide was that it supported a causal link between both exposure to a category 1A stressor, and a clinically significant mental health disorder, and suicide where the suicide took place within five years of exposure to the stressor. Where a suicide occurred more than five years after experiencing the stressor, the RMA considered that the suicide was likely to be related to the stressor via another causal pathway, most probably one of the specified mental health conditions.
>
> In response to a request for review of the time frames, the RMA has recently reviewed the available sound medical-scientific evidence. The RMA has now concluded that the limited evidence in support of the timeframes, together with the difficulties being experienced by claimants in posthumously establishing the existence of a clinically significant disorder of mental health, warranted removing the current time frames applying to category 1A and 1B stressors. The Amendment Statements of Suicide (Instruments Nos. 26 and 27 of 2017) have now been lodged with the Federal Register of Legislation and will take legal effect from 27 March 2017.[74]

4.63 There was dissatisfaction expressed amongst submitters with how the SOPs were being developed and applied. Professor Nick Saunders, Chair of the RMA, acknowledged:

> The most common issues that have been raised seem to us to be that the statements of principles are not up to date, that they are inflexible, that they are too complex for non-expert people to use with ease, that they are designed to hinder rather than assist veterans who are seeking to make a claim and that the use of two standards of proof to write the statements of principles is inherently unfair.[75]

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73 *Submission 1*, p. 1.

74 RMA, response to question on notice from public hearing 6 February 2017.

75 *Committee Hansard*, 6 February 2017, p. 36.

4.64 However, Professor Saunders noted that SOPs were introduced to create a transparent and consistent system which now covers 93 per cent of claims made. He commented:

> Each statement of principle is based on sound medical scientific evidence that is available to the authority at the time that the SOP is written, and that evidence is identified by an extensive search of the English-language medical and scientific literature. The SOPs provide an exhaustive list of factors that are known to cause the disease, illness or injury under consideration. The list of factors is based on a generous interpretation of the evidence, and a veteran only needs to establish one factor for the claim to be successful.[76]

4.65 Criticisms of the SOPs focused on their rigid application to the situation of veterans. The ADSO commented that while the SOPs provide a high level of certainty for an ESO's Compensation Advocate when assessing the probable viability of a claim or appeal, the 'inflexible application of the SOP Risk Factors in determining veterans claims was inconsistent with the beneficial intent and provisions of the legislation'.[77]

4.66 Similarly, Mr Brian Briggs from Slater and Gordon Lawyers noted:

> When compared to a common law claim, or a claim being assessed under the SRCA, the Statements can be seen as quite limiting in terms of the assessment of liability. This is because a claim will be rejected if at least one of the factors in the applicable Statement is not proven, even if the claimant has medical evidence or opinion from a qualified specialist, linking the onset of their condition to some event, injury or activity occurring during service.
>
> Further, the strict time frames within the Statements, which relate to the date of onset of symptoms relative to the date of initial trauma or injury cause particular difficulty. Often, our clients discover when going through the claims process that an injury or trauma they have suffered has not been properly documented by Defence medical staff…[78]

4.67 He recommended that to alleviate these issues an acknowledgment or direction be inserted within the legislation or SOPs to the effect that the SOPs are to be used as a guide only. Further, he suggested amendment of the SOPs 'to extend or remove the strict time frames frequently inserted to dictate when "onset" must occur following specific events'.[79]

4.68 A joint submission from Dr Catriona Bruce and others noted that 'the RMA's definition of a condition does not necessarily correspond with a doctor's diagnosis of a condition in terms of normal standards of modern medicine'. They considered this discrepancy means that veterans are unlikely to be able to have their medical

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76 *Committee Hansard*, 6 February 2017, p. 36.

77 *Submission 172*, Supplementary submission 172, p. 1.

78 *Submission 160*, p. 24.

79 *Submission 160*, p. 24.

conditions comprehensively categorised and recognised under the RMA system. They proposed:

> Restore benefit-of-doubt to veterans. Interpretation of Veteran Legislation was intended to be in the interest of the veteran. This concept has now been set aside, and the onus of proof is now on the veteran. Claims outside a defined RMA Statement of Principles (SoP), but supported by registered specialist Medical/Psychiatric practitioners should be accepted.[80]

4.69 RSL (Tasmania) considered that while 'SOPs do provide a degree of certainty and consistency in claims decisions when properly applied, they do create an anomaly when military compensation claims are compared to civilian claims where the circumstances of an injury are similar'. It noted that the SoPs do not apply to claims under the SRCA, but that DVA has indicated that delegates should be 'guided by' the SOPs.[81]

> One difficulty with SOPs is that they are based upon the totality of available sound medical evidence for causative factors of a condition, while claims not based upon an SOP are based upon medical opinion and the suggestive evidence of a claim. This creates an anomaly in that, under the balance of probabilities, medical opinion and the circumstances of a claim may suggest a link between a condition or injury and a claimant's service. However, the totality of available medical research may suggest that the evidence for causation is not strong enough to create a statistically significant link. This means that the research suggests that a link might be possible, but not probable statistically and therefore not worthy of inclusion in and SOP, while medical opinion available in a particular case, along with the evidence available in a particular case might be sufficient to meet the legal balance of probabilities test required by the Acts.
>
> The difficulty here is that, under VEA and MRCA, SOPs have the force of law, so they are required to be used, even though they may set the bar higher than what is strictly required by the legal test required in the Acts.[82]

4.70 The RSL (Tasmania) observed this situation raises a series of difficult questions relating to 'the interactions of two potentially different standards of proof (statistically significant evidence of causation in medical research versus the legal balance of probabilities test, which is less rigorous), potential disadvantages to military claimants introduced by these differences, and public interest questions with regard to consistency of determinations'.[83]

4.71 Mr Anforth observed that the SOPs were original introduced 'to do away with the cost and repetition of veterans having to prove the medical causation issues case after case'. However, he argued that this has been lost in subsequent statutory amendments. He noted that in non-operational service cases, even if a SOP is

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80 *Submission 171*, p. 2.

81 *Submission 169*, p. 12.

82 *Submission 169*, p. 12.

83 *Submission 169*, p. 13.

satisfied, a claim can still be denied on the basis of other evidence that contradicts the proposition of the SOP. Further, even if there is a large body of expert medical evidence pointing to the service cause of the injury, if the SOP is not satisfied the claim fails. He described as 'unfair' that if the 'SOP does not favour the veteran then the veteran cannot rely on other evidence to support what may otherwise be a valid claim'.[84]

4.72 DVA appeared to confirm this assessment of the rigid application of the SOPs to claims. It stated:

> The Commission must apply SoPs and accordingly, it does not (and cannot) seek evidence which contradicts the relevant SoP in the circumstances of an individual case. Claims are decided on the basis of the totality of evidence available to the Commission, with the relationship of the claimed condition to the veteran's service being determined according to the relevant SoP.
>
> DVA does not have any discretion in applying existing SoPs and must apply the factors strictly as they appear in the SoPs to claims made under the [VEA] and the [MRCA].[85]

4.73 Other views were also expressed. The RSL was supportive of the objective approach to evidence that is at the heart of the SOPs and noted that New Zealand has recently moved to incorporate the idea of SOPs into their veterans support framework.[86]

Conclusion

An independent review

4.74 A key contextual factor in the administrative burdens described by veterans in dealing with DVA is the complex legislative framework. With the notable exception of DVA, there was broad support expressed for a review aimed at simplification of the legislative framework. Many submitters argued for simplification of the current arrangement under the VEA, SRCA and MRCA, others supported reforms to create a single legislative scheme. Specific aspects of unfairness and inconsistency in the current arrangements which could be rectified were identified. The point was repeatedly made that excessive legislative complexity was a burden on veterans, advocates and the operations of DVA itself.

4.75 The committee considers that a system which is as complex and challenging to navigate as the current arrangements will compromise any efforts to make claim processes 'veteran centric'. It is apparent that the Australian Government, through recent legislative amendments (such as the DRCA), is laying the groundwork for a simpler set of military compensation and rehabilitation arrangements. Unfortunately, the committee does not have the resources to determine the most effective

84 *Submission 208*, p. 9.

85 DVA, response to written question on notice from public hearing 6 February 2017.

86 *Submission 216*, p. 10.

arrangement of the complex range of benefits, entitlements, rehabilitation and compensation schemes in relation to serving members and veterans.

4.76 The terms of reference of the inquiry directed the committee to investigate the 'failings' of previous reviews of military compensation arrangements. However, in the view of the committee the previous reviews have been undertaken diligently and appropriately. Incremental and beneficial reforms have been made to military compensation arrangements based on the findings of these reviews. It is also appropriate to acknowledge that not all recommendations of these previous reviews have been accepted and implemented by the Australian Government.

4.77 However, previous reviews of military compensation arrangements and the incremental reforms which were adopted have contributed to the overall complexity of arrangements. Many of these reviews have been undertaken or primarily supported by DVA and Defence officials. While this has the advantage of incorporating institutional knowledge, it also risks institutional inertia. The committee considers that the previous recent reviews of military compensation arrangements have been too willing to accept the status quo. The committee agrees with the many submitters who argued that a robust independent review of military compensation arrangements was needed to re-examine long-standing issues in this portfolio.

4.78 It is time for a comprehensive rethink of how the current system operates and will operate into the future. As Colonel Rob Manton, Director of Veterans SA, advised the committee, any reforms will needs to be directed 'at the next 50 years' taking into account the many veterans of the deployments which have occurred since Australia's involvement in Timor-Leste in 1999.

4.79 In conducting this review, there should be no topics which are off-limits including the differences in relation to operational service, standards of proof and the provision of services through DVA or alternative government agencies. The committee recognises this will not be an easy or uncontroversial review process. Systemic reform may even moderately disadvantage some individual veterans in the process of improving outcomes for serving members and veterans overall.

4.80 A large scale review will require a public research organisation, or an independent taskforce, with established policy and economic analytical capabilities. In particular, it should be able to draw on the expertise of DVA and Defence officials but should be substantially independent. In the view of the committee, the Productivity Commission would be appropriate to undertake this systemic review and make recommendations to the Australian Government for changes to streamline the legislative framework for the benefit of serving members and veterans. The terms of reference for this review should be directed to simplification, efficiency and achieving fair outcomes.

Statements of Principle

4.81 The SOPs prescribe the factors which must as a minimum exist before a reasonable hypothesis can be said to be raised connecting an injury or disease with a person's service. While the SOPs prepared by the RMA appear to promote consistency in decision making, examples were raised where they have been applied rigidly and

unfairly. In the view of the committee, this structure can be unduly restrictive on claims in specific circumstances which is not in keeping with the beneficial objective of veterans' entitlements.

4.82 During the inquiry the SOPs in relation to suicide and self-harm were reviewed by the RMA and updated. Amendments such as this inevitably lead to questions about earlier claims by veterans which were rejected due to previous more restrictive interpretations of the factors listed in SOPs. It is unfair that a person who has rendered military service and been injured would be unable to claim for that injury because a body of sound medical evidence linking that injury to their service has not been developed at that point. The psychological impact on veterans of having a legitimate claim rejected in these circumstances would be immense.

4.83 The committee considers that there is sufficient justification to re-examine how the SOPs are utilised in the determination of compensation claims. Given the frequently cited 'beneficial' nature of the VEA and the MRCA, it is inappropriate that system of SOPs would be rigidly applied. This situation is particularly acute in relation to veterans without operational service.

4.84 A better system might be one closer to that envisaged by the Baume review with one standard of proof (the civil standard, with a benefit of doubt in favour of veterans with relevant operational service), initially determined by the delegates primarily guided by the SOPs prepared by the RMA. However, delegates should not be completely bound by the SOPs. Keeping in mind, the beneficial nature of entitlements for veterans, delegates should have within their discretion the capacity to determine claims provided there is a reasonable link to a person's service on the balance of probabilities. However, this matter should be considered in detail by the review.

Recommendation 6

4.85 **The committee recommends that the Australian Government make a reference to the Productivity Commission to simplify the legislative framework of compensation and rehabilitation for service members and veterans. In particular, this review should examine the utilisation of Statements of Principle in the determination of compensation claims. The report of this systemic review should be completed within 18 months and tabled in the Parliament.**