CHAPTER THREE

ADMINISTRATION, COORDINATION AND INFORMATION

3.1 Some of the evidence provided to the Committee suggested that problems experienced by current ADF personnel, reservists and veterans, arose from the lack of effective electronic data collection and retrieval systems, incomplete links between Defence and DVA, and what was seen as a shortage of adequate information.

Data collection

3.2 In terms of health information, Defence has stated that there are two records kept of relevant information on injuries, illnesses and treatment, including that arising from pre and post deployment assessments, and from the deployment itself. These are the Unit Medical Record (UMR) and the Central Medical Record (CMR).[1]

> The unit medical record is raised the minute that someone is formally inducted into the ADF. It is intended to contain a record of the day–to–day health care delivered to the individual in their presentations for outpatient care. It also contains any specialist referrals that may be made; the results of any investigations, such as X–rays, pathology tests and those sorts of things; and copies of routine health forms, such as the annual health assessment or the comprehensive health promotion examination. It will contain copies of any other medical examinations that may be done—for instance, pre overseas deployment, pre promotion, pre change of category or pre engaging in specialist activities such as parachuting or scuba diving. It will also have embedded in it the record of vaccinations… The medical record will also usually contain the results of the annual fitness test.
>
> The central medical record is a duplicate of the unit medical record, and the only thing that it contains over and above the unit medical record is copies of any documents that arise as a consequence of in-patient care. So, if you are admitted to surgery for, let us say, an appendicectomy, the discharge summary will be in the unit medical record to acknowledge that this has taken place and whatever happened, but the actual detailed documentation such as the nursing notes and the progress notes during the hospitalisation will go into the central medical record.[2]

3.3 At present, such files lack any information arising from injuries for which compensation is claimed under SRCA,[3] although steps are being taken to address this gap. The individual medical record may remain with the individual, including when personnel are posted overseas (non–deployment postings) so there is a certain level of responsibility on the individual to ensure that new material on the individual file is

---

1 *Submission* 9, Defence Organisation, p. 3, paragraph 15.

2 *Committee Hansard*, pp. 75–76.

3 See *Committee Hansard*, p. 79.

copied and sent on to the central file. Files for reservists are held by the reserve unit and activated when the individual is involved in a full time service:

> …every time they have a health interaction—dental, medical or whatever it might be—that record is updated with that information. If they in fact separate from the ADF—in other words, no longer have any affiliation with us—their record is physically transferred to the central medical records store. If nothing further happens, it sits there, and that is it.[4]

3.4 One organisation in particular believed that files were incomplete both because some immunisations might have been recorded only in a WHO booklet and not in their medical file, and some drugs were not recorded when their administration was 'a command initiated action and not an exclusively health one'.[5] As noted in Appendix 3, the attitude to recording vaccinations has varied, and it is possible that some files are incomplete or inaccurate in this respect.

3.5 Defence agrees that there has been a limited capacity to provide an integrated file, as:

> A member's health profile is captured through up to 14 disparate IT systems including medical and dental records, psychological file, and compensation and rehabilitation data.[6]

HealthKEYS

3.6 As part of a major overhaul of its data collection systems, the ADF is developing a tri service approach which 'will seek to establish uniform processes and information systems for the collection and collation of health information'.[7] This system is called HealthKEYS, and is expected to be rolled out over several years.[8] It is now 'the only corporate health information management system approved to operate in the Defence Standard Operating Environment'. Nonetheless, although some other systems have been decommissioned or will be, when replaced by HealthKEYS,[9] the project itself will not be fully operative for some years, with the second phase expected to be completed by 2009.[10]

3.7 A broad objective of HealthKEYS is to gather information which will help to change and develop health services to meet needs:

---

4 *Committee Hansard*, pp. 77–78.

5 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 3, paragraph 17.

6 *Submission* 9, Defence Organisation, p. 4, paragraph 18.

7 *Submission* 9, Defence Organisation, p. 4, paragraph 19.

8 *Committee Hansard*, p. 77.

9 See Department of Defence, Joint Health Support Agency, DJHSA Directive 07/04, *Implementation of HealthKEYS*, 18 March 2004, www.defence.gov.au/dpe/dhs/jhsa/publications/djhsadirectives.

10 Somewhere between three to five years from early 2004, *Committee Hansard*, p. 77. Another source refers to 2009, Additional Estimates, FADT, 18 February 2004, *Answers to Questions on Notice*, Defence, part 2, p. 68.

> …for those men and women who remain in the ADF the issue is clear, because gathering the data and some of the analysis of that data is to assist us in the delivery of health care to those people. So that re–emphasises the point made …that, at the end of the day, the data can be used for different reasons. In our case, whilst those men and women remain in uniform, clearly my interests are to provide focused health care to those people which is appropriate; to identify trends or areas of concern so that we can review current practices; and to try to forecast future problems so that again we can make sure our strategies moderate that.[11]

3.8 Healthkeys is not unique to the ADF since it is a commercial clinical practice management system[12] with the potential to maintain records, generate recalls, and collect event and pattern data on which more detailed studies can be based. In terms of being a vital part of the ADF deployable service, it is stated that 'the system will be deployed on larger ships and in field hospitals and will interchange information with a number of other Defence systems to reduce double keying of data'.[13] This approach should help reduce lost data through providing at least some of the records needed for individual files and provide a better service through ready access to existing patient information.

> The goal of the project we have in place at present—the HealthKEYS project—is to provide a single point data management system for the health record. That is its stated goal. It is a three-phase project and we are only in phase one of the project, which is essentially putting in the administrative bedrock on which the rest of the clinical material will be built.[14]

3.9 A further advantage of HealthKEYS will be the capacity to link individual data with event data sets in order to develop a picture of the individual's exposure, including in deployments, to a range of environmental, chemical and other substances:

> We will hopefully be in a position to inject into that data set, in real time, the occupational and environmental threats to which they are exposed.[15]

3.10 Such links, coupled with information on the individual's health status, should facilitate the development of a better health profile, allowing rapid access to information on likely exposures and therefore suggesting required treatment.

> The Americans had enormous problems following Gulf War I in terms of being able to assess the threat exposure for their individuals, and they have put an enormous amount of effort into trying to address that. They did so during the recent Iraq conflict, where they put on the ground health

11 *Committee Hansard*, p. 67.

12 'Some of the key elements in the database will obviously be biographical data, but they may include things like height, weight, BMI, vaccination status, medical employment classification and history of previous injuries', *Committee Hansard*, p. 70.

13 www.ibatech.

14 *Committee Hansard*, p. 70.

15 *Committee Hansard*, p. 73.

> assessment teams that were doing air, soil and water sampling in real time. They were then linking that to the personnel records and to things such as geospatial imagery to look at things like smoke and oil plumes, sandstorms and so on, so that they could build an almost three–dimensional data set…[16]

3.11 It is also expected that the linking of sections of Defence will facilitate the inclusion of data that will help provide a better profile of an individual's health:

> That will facilitate us bringing psychological and mental health related issues into the central health record. I think that is going to be an extremely important part of our data manipulation.[17]

3.12 Such individual records would also have the benefit of being able to provide better background information to veterans in the future when they may wish to check exposures and link these to possible disorders:

> They could work out very specific hazard profiles for individuals, and that was important to be able to reassure people.[18]

3.13 The Repatriation Commission also outlined the potential benefits of HealthKEYS, including the capacity to provide, among other reports:

> Regular analysis of the health status of deployed veterans …compared with serving members who have not served overseas, as well as with the Australian population Compilation of regular reports on the health status of veterans and serving members for the purpose of informing policy development.[19]
>
> The long–term envisaged plan is that, for every deployment that goes overseas, there will be a systematic collection of data and a program of ongoing monitoring for things such as mortality and cancer incidence. We will vary that standard approach according to the deployment. It probably would not be, for example, so appropriate to have such a complete approach to a deployment like Bougainville, which was much less stressful than our deployment to Afghanistan and Iraq. Within the overall framework of having an ongoing process of monitoring the health of all groups of deployed, we will vary it to make it appropriate to the type of deployment that is occurring.[20]

3.14 However, as at early 2004, no individual data was on HealthKEYS:

> At this stage, no clinical components of the member's medical record are electronic. It is the intent of the HealthKEYS project to change that, but the

16 *Committee Hansard*, p. 73.

17 *Committee Hansard*, p. 70.

18 *Committee Hansard*, p. 73

19 *Submission* 8, Repatriation Commission, p. 18, paragraph 90.

20 *Committee Hansard*, Repatriation Commission, p. 66.

> entry of clinical data—in other words, the day–to–day working clinical data—will not come up until phase 2 of the project.[21]

3.15 It was also stated that even currently serving personnel would not have existing information scanned into the data base:

> …there is no viable way of migrating the extant paper record into healthKEYS. For continuity of care purposes and our archiving requirements, we will still need to keep that paper record.[22]

3.16 This must necessarily limit the effectiveness or usefulness of any environmental information relating to recent deployments since it would have nothing on an individual against which to register. Some service organisation witnesses expressed an interest in the operation of HealthKEYS,[23] but for the majority of their current members it is likely to be of limited advantage. There still remains a need, therefore, to obtain and retain as much information as possible on environmental factors in deployments as this will be the background against which many claims in the future are likely to be based.

3.17 This was noted in one submission which, while acknowledging that there had been improvements in relation to occupational health issues in a non–deployment context, believed that the lack of integrated files could result in future problems:

> …there does not appear to be one agency in the Department that links these [exposure records] with personnel records.[24]

3.18 It is to be hoped that the greater awareness of occupational health and safety issues[25] and the capacity to link personnel to other records[26] will also cover these exposures. In the context of the anthrax issue, the capacity to evaluate and monitor the health of those who received vaccinations,[27] must also be affected through the absence of electronic information. While it may be that the fact of vaccination is recorded as part of general deployment information, this will not provide information on the individual or make possible connections with later illness. Unless a separate detailed

---

21 *Committee Hansard*, p. 77. See also p. 70 on the likely contents of individual data: 'Some of the key elements in the database will obviously be biographical data, but they may include things like height, weight, BMI, vaccination status, medical employment classification and history of previous injuries. All of those things, hopefully, will be coming from that one central database. I do not wish to go into the technical jargon, but what we can do is set up data cubes, Cognos cubes, which allow you to extract data from your master database, move it aside and, if need be, de-identify it so that it can then be used by a research facility, be that the Centre for Military and Veterans Health or one of our existing research organisations. They can do work on the data, and if need be it can be reinjected back into the database'.

22 *Committee Hansard*, p. 77.

23 *Committee Hansard*, p. 3.

24 *Submission* 5, Regular Defence Force Welfare Association, p. 3.

25 See above, Chapter 2, paragraphs 2.92–2.97.

26 See Additional Estimates, FADT, 18 February 2004, p. 70.

27 *Committee Hansard*, p. 66.

health review is undertaken for each deployment—and it is suggested this will not be the case—only future deployments will have this level of detail.

EpiTrack

3.19 EpiTrack is an electronic system into which event data can be entered, primarily in order to track patterns of events such as injuries and disease, especially those related to deployments.[28] It is a commercial system which can be adapted to identify other event patterns.[29]

> The EpiTrack system records the principle reason for presentation at health facilities and the impact of such attendances on manpower availability.
>
> The key components of EpiTrack are EVENT codes, which contain descriptors that are a mix of the causal event and the diagnosis, with the causal event taking precedence
>
> All ADF health units will conduct health surveillance during deployments and field exercises. EpiTrack is also to be used across the National Support Areas (NSA) to allow familiarity with use when deployed.[30]

3.20 The system can provide regular updates on the main causal factors of ill health and can therefore inform those in command of 'the general health of their forces'.[31] The extent to which this will allow active intervention 'before disease or injury can limit mission accomplishment',[32] however, may be open to debate, given that many people may have been injured or exposed to communicable disease prior to patterns becoming obvious. However, this type of information does have the potential to reduce health issues that may occur over a longer time period:

> …whilst undoubtedly at some point in a cost–benefit analysis you would factor in some value for that better information available on claims—as a

---

28 A separate system is commercially available to track vaccinations and reactions/adverse events arising from these. However, it is more logical to have this type of event on HealthKEYS to ensure such information was readily available to medical officers treating a patient especially during deployments.

29 It is described as 'a real-time system for tracking the spread of infectious diseases', see www.ovistech.com/indexnsf/373d, *'Several solutions, many industries'*. See also *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 4, which refers to EpiTrack being based on the United Kingdom Army Health Surveillance System, J97 EPINATO.

30 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraphs 4, 5, 7 and 9.

31 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 3.

32 *Submission* 9, Defence Organisation, Attachment C, Department of Defence, Director–General Defence Health Service, Health Directive No 128, *Health Surveillance in the Australian Defence Force*, 2003, paragraph 3.

> possible offset saving or equally and in most cases, in fact, as a cost consequent on having additional information—far greater significance is attached to the possibility of preventing the logical consequence of a disease train being set in motion by that deployment. If, for example, it is possible to intervene on the basis of information flowing from our health studies—for example, by taking some sort of preventative or prophylactic action in a way that might minimise the risk of lung cancer developing downstream—then we think that is a legitimate saving to factor into our cost-benefit analysis.[33]

The interaction between HealthKEYS[34] and EpiTrack

3.21 The data provided by HealthKEYS and EpiTrack has the potential to provide both systemic data on broad trends and patterns, including occupational health and safety issues, and on individuals who may also demonstrate patterns of injury or illness. Whether information from EpiTrack will be available to DVA is not stated, but in terms of DVA's current responsibilities concerning compensation such access would be valuable. The identification of problem areas, in theory, would help to limit compensation claims and the loss of personnel from preventable injuries.

Health reviews

3.22 The government stated in 1999 that deployments would be subject to health reviews, and, according to DVA, these would need to vary to reflect the nature and size of the deployment.[35] Such reviews would presumably use data obtained from the health assessment undertaken 3 months after personnel returned from deployments as well as other data from HealthKEYS and EpiTrack. However, the limited information available through HealthKEYS at present suggests that detailed health reviews will only be available in the future.

3.23 As is noted by DVA, the value of studies depends on the objective, and the methodology needs to suit this. The absence of information via current systems therefore does not necessarily affect all reviews and research:

> The recent deployments to the Solomon Islands and Bougainville would have little effect on cancer incidence statistics, assuming any would ever be observed, until an appropriate latent period had elapsed… Such deployments could probably be more effectively studied by examining the effects of social and psychological distress, involving techniques such as surveys and small group interviews and monitoring mortality and cancer incidence over time.[36]

---

33 *Committee Hansard*, p. 70.

34 HealthKEYS is also expected to be linked with the Defence personnel data system so that issues such as discharge through injury can also be monitored—see Additional Estimates, FADT, 18 February 2004, p. 70.

35 *Submission* 8, Repatriation Commission, p. 11, paragraph 52.

36 *Submission* 8, Repatriation Commission, p. 11, paragraph 53.

3.24 Nonetheless, an overall picture of the health outcomes of deployments would require that information of this type would need to be considered alongside the broad event patterns provided by HealthKEYS.

DVA access to electronic information

3.25 Currently, DVA does not have electronic access to HealthKEYS, although it is expected that in time such access will be available.[37] Defence is responsible for data entry and DVA is able to access this data if required. The records of veterans, including reservists, are available only as paper files, although in time some veterans' records will be in electronic format since they will have been entered when the individual was a current ADF member. For the short to middle term, electronic data will not be available to DVA on the majority of those making claims under the VEA. Similarly, those making claims under the VEA will need to operate under the procedures currently in place—that is, obtaining a paper record.[38]

3.26 The fact that existing data on medical records will not be incorporated into HealthKEYS also means that the records for currently serving personnel will be incomplete—some will remain as paper records because it is considered that entry of existing data will create a slower result time:

> …firstly, it would require someone scanning the information into an electronic format and then putting it into a format that makes it readily accessible… [and secondly] the practical issues of bandwidth: as that record becomes bigger and bigger, it becomes more difficult—the turnaround times become greater. So at this stage we do not believe it is viable to put that in electronically.[39]

3.27 To some degree, this problem could be overcome by the use of electronic tags which incorporate 'exposure data and accurate medical record keeping.'[40] Such tags may have been seen in the past as too invasive and as a threat to privacy, but, with increasing capacity to secure medical records, they may be extremely useful. DVA has undertaken trials on smartcards with respect to services for veterans, and this may provide some information on the security of data:

> DVA has been involved in a trial with the Brisbane Waters Private Hospital and an ICT firm called Smart Health Solutions as part of a NOIE IT Online grant. The aim of the trial was to evaluate the functionality of smartcards in providing authorisation to securely access patients' online clinical information and transmission of hospital discharge information.

37 *Committee Hansard*, pp. 82, 83.

38 *Committee Hansard*, p. 82. See also comment on the HealthKEYS system in respect of non current members, *Committee Hansard*, p. 73: 'we cannot construct historic data. If the data does not exist, I have no way of generating that'

39 *Committee Hansard*, p. 77.

40 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 3, paragraph 16.

> DVA's component of the evaluation of the trial was to conduct interviews and collate and analyse attitudinal and perceptive feedback from veterans and health care providers. These findings are of interest, and will report to, the HealthConnect project—the proposed national health information network to facilitate the safe collection, storage and exchange of consumer health information between authorised healthcare providers.[41]

3.28 DVA also noted that smartcards are a further way of obtaining secure access to medical records:

> The use of smartcards is one method that can be used to authenticate and access computerised medical records. Computerised medical records can be authenticated and accessed by other means such as a login and passphrase. Smartcards were used in this trial as an authentication and access method for a range of reasons including the generally accepted use of cards within the veteran community (Gold & White DVA Treatment cards), and with the Australian public (Medicare cards). Smartcards and their embedded chips can also be used to strengthen the identification and/or authentication for authorised card holders of that card—an important feature for ensuring security of computerised medical records.
>
> The outcomes of the trial will also contribute to the body of studies that will inform the national HealthConnect project in its role to develop a better connected health system for all Australians. Use of smartcards and other technologies are being assessed in a number of electronic health record implementations both within Australia and overseas.[42]

Problems identified in relation to the collection of medical data

3.29 One of the main issues identified by witnesses was the absence of systematic event recording, especially of events which might be productive of later psychological problems. There were at least two aspects to this, the failure to record and the limited understanding of psychological factors relating to service such as peacekeeping:

> There are continuing difficulties with Defence's recording of critical incidents that may affect psychological well being, and DVA's recognition of them in relation to compensation. There has been substantial anecdotal evidence that many incidents, which form potential stimuli for possible mental health problems have not been accurately reported by Defence. The current systems major problem is its susceptibility to human error.
>
> In 2000, an International Force in East Timor (INTERFET) veteran… was involved in a combat incident. The veteran later suffered a psychological condition, which can be linked to the stimuli of the incident. The incident was not however recorded by Defence and the veteran's account was in contradiction to a DVA historian's opinion that it 'never occurred', and the veteran's claim subsequently disallowed.[43]

41 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 2.

42 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 3.

43 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp.1–2, paragraphs 6–7.

3.30 The Australian Peacekeepers & Peacemakers Association also believed that there was limited understanding of the distinction between mental health issues experienced by those undertaking warlike service, peacekeeping, and peacemaking operations.[44] While this may result in lack of appropriate service provision, affected personnel may also consider their experiences are less important if relevant events are not recorded. This is an issue which would obviously also affect older veterans, for whom relevant events are more distant and something they may have difficulty remembering. Nonetheless, DVA notes that older veterans are also making claims in respect of PTSD, although it is not clear how many of these are successful, or if others are receiving treatment because they hold a Gold Card which does not require health problems to be war–related:

> The number of PTSD claims by older veterans has risen in recent years overtaking generalised anxiety as the most common mental health disability approved for this group. Other mental health problems may arise from a range of life experiences and adjustments relating to retirement, loss and bereavement and physical or mental health degenerative conditions related to ageing, such as dementia.[45]

3.31 DVA notes that there are many factors involved in the development of psychological problems, not all of them related to service. However, it does obtain information from other sources on issues, even though this would not necessarily provide information on precipitating events for individuals to making a claim:

> …DVA's picture of the mental health state of young veterans continues to be improved by the following:
>
> - findings of the Gulf War Study and the Pathways to Care Research Project;
> - presentation of young veterans to the Vietnam Veterans Counselling Service;
> - closer liaison with ADF on health issues such as mental health, alcohol and substance misuse;
> - participation in and representation of the APPA in forums, such as the DVA National Younger Veterans Consultative Group and the DVA Alcohol Management Health Promotion Working Group;
> - the Transition Management Service including the Defence Transition Pilot Scheme involving VVCS in Townsville which is providing assistance to those exiting the ADF and will also provide information about needs and ongoing assistance required by young veterans; and
> - ACPMH collaboration with the ADF on development of a post–deployment adjustment program from which further knowledge will be gained about the needs of young veterans.[46]

---

44 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 2, paragraph 11. See also below, Chapter 4, paragraphs 4.76–4.79.

45 *Submission* 8A, Repatriation Commission, Department of Veterans' Affairs, p. 13.

46 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 12. See also: 'The amount of information available to veterans and health providers on mental health and

3.32 DVA is also able to obtain information from services required by veterans which can help identify needs and ascertain if services are appropriate:

> Through the structure of the Medical Benefits Scheme a specific item number is used to identify the service accessed by a veteran. This item number also specifies the "fee" payable to the service provider. HIC collects this data which is transmitted to DVA on a daily basis. Through DVA's Departmental Management Information System the data can be manipulated to analyse usage and treatment trends.[47]

3.33 The limited information which may be available on a veteran's file can be enhanced, although, again, much of this is unlikely to provide evidence of specific causal factors. Additionally, there are limitations to the access of some data on the grounds of privacy and data integrity,[48] although data from research projects and AIHW will also help to identify needs:

> The Department of Veterans' Affairs (DVA), however, does obtain data from the Australian Institute of Health and Welfare on disorder prevalence in the community.
>
> The prevalence of various disorders for groups of veterans is being studied by DVA through research projects commissioned by DVA that deal with specific conflicts, such as the Gulf and Korean wars. DVA also conducts a Survey of Veterans, War Widow(er)s and their carers every three years that collects data on self–reported disorders. The last survey was conducted in 2003.[49]

3.34 In addition, with the development of programs to address mental health and related issues, DVA has provided training to staff which can aid them in assisting veterans:

- State Offices have conducted various customer service training sessions that encompasses awareness of mental health issues;
- training provided to Departmental claims and assessment officers incorporates information of the diagnostic criteria of a range of psychiatric and related conditions;
- a resource booklet available to staff and managers provides information and guidelines on how to respond to clients who present with challenging behaviours including mental health and related problems;

---

related problems and coping strategies has improved with the implementation of their respective mental health and alcohol management strategies. However, as with the general community, the problem of poor mental health literacy and concern about the stigma of mental health disorders remain significant barriers for young veterans. Continued work is required to improve awareness and understanding of the nature of mental health problems experienced by veterans and ways to access assistance and treatment' (p.12).

47 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 1.

48 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 1.

49 *Submission* 8A, Repatriation Commission/Department of Veteran' Affairs, pp. 1–2.

- professional staff of the VVCS have the opportunity for professional clinical development through training and external supervision; and
- The Mental Health Policy Unit of DVA is formulating a strategy for improving mental health literacy that will include a consideration of the needs of DVA staff.[50]

Effects of lack of data collection

3.35 The lack of data collection in the past reflects the limitations of previous eras including awareness of the fact that there may be long term outcomes of various events. It also reflects the absence of information and technologies which increased awareness of the effect of substances and had the capacity to measure these. Referring to the Amberly de–seal/re–seal program, the ADF noted:

> We should, in a perfect world, have quite high–fidelity data on the risk exposure for an individual, but I put it to you that that is extraordinarily difficult.

3.36 Notwithstanding these limitations, there have been some efforts to obtain information on levels of exposure to substances in past events such as Hiroshima and Nagasaki and the series of bomb tests undertaken by various countries at which both defence and civilian personnel were present. With respect to Australian veterans, DVA has been involved in such measures, including the use of dosimetry at Maralinga and other test sites:[51]

> There are some difficult elements associated with the estimation of dose which the scientific advisory committee have suggested that we should look at, and in relation to that work there is still some ambiguity about exactly how long that work will take.[52]

3.37 Available information on likely radiation exposure in Japan at the end of World War 2 has also been assessed:

> In the case of BCOF,[53] they said, 'We accept fully that radiation causes these cancers; there is no doubt about that at all. For our veterans who were in Nagasaki they will be covered by the RMA's statements of principle and compensation will flow to them. But for our Hiroshima veterans, despite our best efforts, we cannot get within several orders of magnitude enough exposure to allow compensation to flow'. The level of science was not just at the margin, it was really quite a bit away. They did so looking at water, food, beer...

50 *Submission* 8A, Department of Veterans' Affairs, p. 13.

51 See below, Chapter 4, paragraph 4.10.

52 Budget supplementary estimates, FADT, 5 November 2003, p. 7.

53 BCOF, British Commonwealth Occupying Forces, who occupied Japan and other areas after the end of the War; some were also present at the British series of tests at Maralinga and other sites.

> I should also say that the BCOF veterans are a group of veterans that do actually have some health problems that we need to carefully consider. There were quite a lot of them exposed to mustard gas and quite a few of them were exposed to psychological stresses, and we do very carefully make sure that all of our statements of principle recognise BCOF service. Various infective agents which are only found in southern Japan are put into the statements of principle to make sure that the BCOF veterans are covered. But with respect to radiation, although we have been together on a path of exploration for some years, Ken maintains there was enough radiation and our best expert advice is that there was not enough radiation.[54]

3.38 Thus, there may well be instances in which what might be called retrospective collection of equivalent data will provide valuable information. Such technology as is now available can use a range of data to recreate or model various events such as exposures[55] (although this may not always be to the satisfaction of veterans):[56]

> Our experience with Vietnam was that at the time we did not know that dioxin was going to be a problem, but because we had pretty good unit records, in some cases it was possible to go forth and construct a model of exposure. This was done in the royal commission, and one of your previous committees also attempted to do that. You can get a proxy model for exposure. It might also be important to keep things like geographical information in addition to the medical information.[57]

3.39 The Repatriation Commission has also outlined the processes it undertakes in respect of specific events, although these will not necessarily assist every individual:

> A veteran who comes along with a compensation claim will say, 'I experienced a murder,' or, 'I saw atrocities,' and that sort of information is not kept—or is very rarely kept—on their central medical record. In fact, the usual thing is for a veteran exposed to such a traumatic event not to tell anyone about it for some time….
>
> We have a range of mechanisms in place for our people to go out and test the veracity of those sorts of statements. They include looking at patrol records and speaking to other members of the unit. There are a variety of mechanisms that we use to train our people to work out whether or not something was the case. There are obviously some cases where it is manifestly self–evident: if POW J says he saw people being killed, it is evident that he did….in some situations, particularly those involving, for example, naval deployments to Vietnam, where whole ships' companies may have been in the same spot at the same time—and contained in a metal ship, in the main—we have in the past made a practice of seeking an expert

54 *Committee Hansard*, pp. 46–47.

55 See also below, Chapter 4, paragraphs 4.4–4.5, 4.10, 4.18, 4.20, 4.26, 4.34–4.35, 4.38–4.39, 4.40–4.43, 4.73–4.82.

56 Similar work has also been undertaken in the United States, including civilian exposure to radiation arising from testing.

57 *Committee Hansard*, p. 68.

> historian's advice. As you would be aware, that has caused some ripples from time to time. But fundamentally it is our responsibility to investigate each claim and, if it is a legitimate means of inquiry, to ask a historian to assemble the ships' logs and the facts and compare the evidence introduced by the claimant against that. I think that is fair enough.[58]

3.40 Some of the processes which are now in place with deployments should overcome these problems through personnel being asked to identify issues or events experienced, prior to their return. This process will not necessarily provide full details or recollections, nor may all personnel choose to provide this information, but it is one means of identifying potential problems and working to overcome these.

3.41 Other instances of absence of information do not require such detailed assessment of the past, although administration changes may be required in order to ensure that full deployment event records are available. As was stated above, the practice of UN hospitals retaining records[59] has been a problem in the past, but should be overcome eventually if copies of hospital information are provided or electronically mailed to a source such as HealthKEYS or EpiTrack.

Nominal rolls

3.42 The nominal rolls for various conflicts have been the source of some dissatisfaction among veterans because the absence of these can delay research and the making of claims. The nominal roll for the British nuclear tests, although suggested by the 1985 Royal Commission, was not completed until fourteen years later.[60] There is still no BCOF roll, and one is unlikely 'as there has not been any separate listing of Service personnel during the period of service which would specifically define [members]'.[61]

3.43 Research on the Korean War was delayed also because of the need to establish a nominal roll.

3.44 Ascertaining the reasons for delay of such processes is difficult, but the main reasons are likely to be the absence of relevant information and the lack of staff and other resources. A further factor may be the absence of perceived need—DVA notes that Korean War veterans' specific concerns were only established some six years ago:

> Until about six years ago, the Korean War veteran community did not raise any specific need for such studies. When the community raised this issue, Government responded promptly to their needs, and began preliminary

58 *Committee Hansard*, p. 81.

59 Chapter 2, paragraph 2.49.

60 Chapter 4, paragraphs 4.8, 4.9

61 *Submission* 4, British Commonwealth Occupation Force, p. 1.

> work, such as the construction of a Nominal Roll. Once this was completed, the Cancer Incidence and Mortality studies were completed. [62]

3.45 However, the same factors may also reflect an earlier more reactive than proactive approach both to research and to the identification of needs of particular groups. While it may be the case that Korean veterans have only recently raised issues, it could also be said that the Vietnam experience much later almost forced the awareness of many specific problems and development of services to meet these.[63] Applying the same principles to other conflicts and undertaking relevant research is an appropriate task for the department, and one that is now much more likely to initiate.

Better coordination and management through the Links project

> The program… has been under way for some years, and it is motivated by two things. One is that the Department of Defence and the Department of Veterans' Affairs, by working more closely together, can hopefully achieve more effective services for serving personnel and veterans and more cost-effective services for the taxpayer. It is also motivated by an understanding that, as the World War II population passes on and Veterans' Affairs scales down to some extent, it needs to have a clear view about its future in the defence family, and that requires ongoing attention.[64]

3.46 The current components of the Links project include the Defence/DVA Medical Advisory Panel (MAP) which has a review, coordination and assessment role in elation to health, rehabilitation and compensation matters:

> The Defence/DVA Medical Advisory Panel:
>
> - Coordinates the examination of health issues emerging from Defence operations;
> - Assesses the state and direction of research, identifies gaps and recommends joint Defence/DVA research directions and priorities;
> - Reviews patterns of injury, disease and compensation claims from current and retired members of the Australian Defence Force to provide direction on appropriate joint preventive health responses, including rehabilitation;
> - Reviews outcomes of joint health care trials and health care provision arrangements;
> - Provides advice on health monitoring and health–related data collection activities;

62 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 4.

63 See Chapter 4, paragraphs 4.46–4.47, 4.48–4.54.

64 Budget supplementary estimates, FADT, 5 November 2003, p. 4, see also www.dva.gov.au: 'The objectives of the Links Project are to: improve service delivery and cost–effectiveness to ADF members and ex-members within existing resources; improve the cost–effectiveness of the services provided; and to take opportunities where appropriate to move functions, particularly transition, post–discharge and closely associated services, to DVA. Some possible options to achieve these objectives include: elimination of duplication; and increased coordination'. See also *Submission* 9B, Defence Organisation, p. 8, Q5(d).

- Reviews joint Defence/DVA health training and education; and
- Develops linkages with organisations in the provision of military and veteran health.[65]

3.47 It also includes the Transition Management project, which is to improve the transition from military to civilian life for ADF members; the Mental Health Focus Group;[66] and Records Management which has as an objective the more efficient management of data contained in personnel files.[67]

3.48 These projects have the capacity to streamline management and administration especially through limitation of duplication, including of research, and facilitation of greater awareness of DVA services by ADF members.

3.49 Some of the duplication or ineffective management that currently exists arises from factors beyond the control of either department—for example, the scattered information that comprises ADF health records, and the tendency for former members to seek records from DVA when they already have much of the available material. There is also recognition that with improved information gathering, services can be more proactive than reactive:

> Threat identification and investigation has shown that both of the organisations are very highly motivated to adopt a much more proactive approach to health related issues rather than the traditional reactive approach.[68].

3.50 DVA also has links with other departments, such as the Department of Health and Ageing,[69] both in the management of projects and in limiting duplication of research:

> DVA has close links with the Department of Health and Ageing though involvement in major research projects such as the Coordinated Care Projects.
>
> DVA operated a research grants program up to the round that commenced in early 2004. This program is being phased out in order to free up resources for more commissioned research. Individual grants extend over a three or four year term.
>
> The grants program was advertised nationally, as a component of the NHMRC research grants program, and applications were submitted in the

65 See www.dva.gov.au/adf/dlp/medadvisory.

66 'The DHS and DVA have very strong links through the Defence/DVA Links Program and the Mental Health Focus Group that is part of this program,' *Submission* 9B, Defence, p. 8, Q5(d)

67 See www.dva.gov.au/

68 *Committee Hansard*, p. 90.

69 *Submission* 8ARepatriation Commission/Department of Veterans' Affairs, p. 3.

> first instance to the NHMRC for scientific evaluation. This prevented duplication between the two agencies.[70]

Dissemination/discussion of information

Limited investigation of claims

3.51 The Regular Defence Force Welfare Association advised that one particular problem for claimants was a failure by DVA to identify any material lacking in a claim prior to consideration:

> The delegate…almost never identifies deficiencies in the information supplied in support of the claim, and seeks to have them rectified—as he/she might, if genuinely investigating it—and almost never contacts the claimant or his/her representative to advise… of any problems that are likely to arise as a result of deficiencies in information supplied….As a result, the onus is always on the claimant to supply whatever information he/she imagines the delegate will need to consider the claim fully and fairly.[71]

3.52 This problem was identified by the organisation as arising from a number of administrative factors, including:

- A lack of knowledge and experience on the part of the primary decision–makers
- The general lack of understanding of the circumstances of military service likely to have been experienced by veterans.[72]

3.53 While the first may be true, primary decision makers generally work to a guide as to key factors which must be present, and this helps limit adverse effects of inexperience. Nonetheless, it is possible that pressure to complete claims quickly and a need to remain separate from the claimant may result in required information not being asked for after the claim has been lodged.[73] DVA advises claimants that they should get assistance in completing the form, and that staff may also help, with Form D2582 (Claim for Disability Pension)[74] noting at the beginning:

> You are strongly encouraged to seek the assistance of an ex–service organisation of your choice in lodging this claim. An ex–service organisation should be able to provide you with advice on how the factors identified in the Statements of Principles may apply in your case.

---

70 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 5.

71 *Submission* 5A, Regular Defence Force Welfare Association, p. 1.

72 *Submission* 5A, Regular Defence Force Welfare Association, p. 2.

73 These are both issues also raised by *Submission* 5A, Regular Defence Welfare Association Inc, p. 2.

74 This form is also used for claims relating to injuries by those still in the ADF.

Assistance from Veterans' Affairs

Veterans' Affairs staff can also help you to complete this form.
Note: It would be to your advantage to have each condition you are claiming properly diagnosed prior to completing this form. This will help to prevent delays in the time taken to process your claim.

The Basis for decisions

The decision on whether your disabilities are service-related is based on up–to–date medical and scientific evidence. This information is detailed in the Repatriation Medical Authority's Statements of Principles.

If your claim is for a condition not included in the Statements of Principles, it will be determined based on the best scientific and medical evidence available.[75]

3.54 The second factor (lack of military experience on the part of the assessor) should not be relevant, as the form is designed to elicit the required facts, many of which are to be completed by a medical practitioner. The lack of military experience may be more relevant for the RMA, although only one example has been explicitly identified.[76] The Committee has suggested that there should be some input from the ADF to address any such concerns.

3.55 However, because of the complexity of the RMA SOPs, and a not particularly user-friendly RMA website, it is possible that claimants, ESOs and medical practitioners have some difficulty in obtaining relevant information about causal factors. While SOPs are necessarily written in terms of a specific disorder, the 'View by Category'[77] approach, and even the alphabetical listing available, do not provide the claimant with a readily understandable guide or indicate the relevance of particular causal factors.[78] As a preventive approach, it may be useful to indicate what disorders have been linked to causal factors to alert individuals to potential health problems.

3.56 Although the United States DVA list of compensable disorders[79] may require less specific links to service, the fact that it lists these disorders under specific conflicts must assist claimants in determining if they are eligible. It is a good model which could be adapted if only as a layperson's guide to the SOPs.

3.57 A third issue was the extent to which claimants might be encouraged to apply for assistance citing an 'approved' illness if there was currently no SOP which recognised their real disorder. The Regular Defence Force Welfare Association Inc. noted that often claimants might try to second–guess what the assessor was looking

75 See www.dva.gov.au/forms.

76 See above, Chapter 1, paragraphs 1.26, 1.28.

77 www.rma.gov.au.

78 See above, Chapter 1, paragraphs 1.29, 1.31.

79 United States, Department of Veterans Affairs, *Federal Benefits for Veterans and Dependants*, 2004.

for, but distinguished this from ' "fitting" or adapting the facts about the circumstances of a claimant's service to fit the decision-maker's requirements'.[80] In the specific case provided in a submission, the claimant was clearly frustrated by the lack of a formal recognition of disorders such as Gulf War syndrome or the effects of multiple environmental and other exposures. A related frustration was the belief that what he perceived as disorders with a physiological basis were being transformed into psychiatric problems, and that departmental staff encouraged veterans to apply citing a psychiatric disorder.

3.58 As noted above,[81] there remain difficulties with the formal classification of some symptoms, but this in itself does not prevent the Repatriation Commission being able to provide access to treatment. Where there is a possibility that a veteran is experiencing PTSD there is no wrongdoing on the part of the department in suggesting a claim be made under this, since the claim will need to be supported by medical evidence and meet the SOP standards.

Updating of RMA Standards of Principles

3.59 Some submissions stated that the RMA was either not up to date or needed to review 'all present medical standards…for authenticity and relevance to the illnesses which Service personnel may encounter during their overseas service.'[82] However, the RMA's workload is likely to be such that it is unable to meet all needs for revision, and it does continually update SOPs. In addition, it receives advice on areas of need:

> In terms of the RMA's determination of its priority for the consideration of SOPs, DVA keeps the RMA informed on the frequency with which medical conditions are the subject of claims under the Veterans' Entitlements Act.[83]

Distribution and discussion of information

3.60 Notwithstanding the publication of detailed bulletins and updates and good websites provided both by Defence[84] and DVA, many of the issues affecting veterans are perceived by them as not being discussed openly or in detail:

> The first recommendation of the *Australian Gulf War Veterans Study 2003* was that:

80 *Submission* 5A, Regular Defence Force Welfare Association Inc., p. 2.

81 See Chapter 1, paragraphs 1.40, 1.44.

82 *Submission* 4, British Commonwealth Occupation Force, p. 2.

83 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 4.

84 *Committee Hansard*, p. 14: 'There is much greater awareness within Defence and the defence community on mental health strategies. I think a lot of very good work has been done within Defence on providing information pre and post deployment and on lots of available resources through their mental health strategy. In that way, I think there has been a big improvement. I have not seen any difficulties associated with it.'

> "There should be wide promotion of the study findings to the veterans and service communities, the Departments of Defence and Veterans' Affairs, the Repatriation Commission …"
>
> To date, some six months after the release of the Study, there has been no Government Response as to how this recommendation is to be implemented. We consider that some action is required to target veterans and their providers in the dissemination of this knowledge and that the mere placing [of] the report on some departmental website does not go far enough in implementing such a recommendation. The fact that only two hard copies of the report were provided to this Association and that additional copies could only be obtained at some significant cost are indicative of a lack of "wide promotion".[85]

3.61 Other submissions have noted that in some instances there has been little information provided which could assist personnel to identify potential problems.

> In the case of environmental exposures, however, a notated list of possible exposures are recorded on the ADF members file with little or no detail as to level of exposure or risk to health… Although deployment on specified operations preclude reporting to Comcare as the regulator, Defence still has the requirement under the Act [Commonwealth Employees Occupational Health and Safety Act] to raise and retain specified records. In the main, the Federation does not believe this is occurring.
>
> …recent discussions by Federation staff with East Timor veterans identified that many of them were unaware of many of the chemicals and substances which were known by Defence to be present in the area of operations. Although it is accepted that many of these hazards did not become apparent until personnel were in–country, subsequent briefings and information have not been forthcoming or adequately recorded for future reference.[86]

3.62 Another submission referred to the anthrax vaccination controversy in stating that 'Defence must be pro-active in providing accurate health information', and that, because of greater community awareness of environmental hazards and illnesses which may take a long time to develop or present as a cluster of inexplicable symptoms, 'it is understandable that veterans are concerned that they may be susceptible to a new or unexplained disease caused by their exposure in a hazardous environment'.[87]

---

85 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29.

86 *Submission* 3, Armed Forces Federation of Australia, p. 1.

87 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 4, paragraphs 20, 21. See also *Committee Hansard*, p. 3 'Our experience, and that of servicemen who took part in the 1990 Gulf War, has been one of inadequate record keeping. The department seemed confused about who received preventative vaccinations and at what time they were given, and there are deficiencies in individual records. This led to justified concerns among those who were deployed—not so much at the time but later when they were trying to reconstruct a medical history—which may explain the symptoms that they reported in later years. We therefore believe that the department should be required to implement a record keeping system that combines an individual's health record with accurate details of his or her exposure to

3.63 Concern was also expressed about the lack of aggregate data on earlier deployments:

> …when men who have served in the various campaigns and deployments, going right back to the Vietnam days, come to lodge claims for compensation or reviews of entitlements arising out of matters which they think relate to their service activities, they often come up against the almost impenetrable wall of privacy. I do not say that is necessarily a bad thing, but it is a problem in the field for people supporting their claim, because they cannot get access to extra or comparative or aggregate information. So that is a problem, but you say it is being attended to.[88]

3.64 Generally, these issues suggest that there is concern about both a lack of pro-active strategy which either advises of potential hazards in advance or as soon as these are known, and the lack of recognition of various health problems that individuals and groups attribute to deployments. Disorders, such as gulf war syndrome and, previously, chronic fatigue syndrome may not be classified as a distinct 'disorder',[89] with only some symptoms being apparent. Although longer–term outcomes are measured, these depend on 'all medical presentations from each deployment'.[90] Not all 'injuries' may have been notified either during or immediately after deployments, and the significance of these may not be understood:

> It is always difficult to determine what is a legitimate syndrome and what is an imagined syndrome based upon legitimate feelings.[91]

3.65 In these circumstances, it is the individual or group which is likely to be disadvantaged because there is no formal acknowledgment of the illness even though its effects may be substantial. This situation is understood by DVA, with reference previously being made to the availability of treatment in some circumstances for symptoms which are not yet a disease.

---

environmental threats and that is capable of receiving continual updating on the nature and extent of environmental exposure'.

One submission also noted that when there was an absence of information on a particular issue, it might be suggested that the individual seeking to make a claim relied in other factors instead (*Submission* 2, Confidential, p. 3). It is not possible to assess the accuracy of this statement, which reflects that there is no formal recognition as yet by the RMA of any ill health resulting from combined effects of biological and environmental exposures with other factors, whereas there is recognition of PTSD. Insofar as the individual suffers from PTSD it is appropriate for DVA to advise him to make such a claim.

88 *Committee Hansard*, p. 68.

89 See *Submission* 8, Repatriation Commission, p. 16, paragraph 81 on the difficulty of determining the validity of some syndromes ('Gulf War syndrome' as opposed to others (e.g. chronic fatigue syndrome, CFS). However, the Commission does not note that CFS itself was once perceived as 'a collection of symptoms' rather than a syndrome, i.e. it is often more a matter of time and an increase in the number of reports, than a change in the nature of a disorder, that allows it to be seen as a causal factor which is 'evidence based'.

90 *Submission* 9, Defence Organisation, p. 4, paragraph 17.

91 *Committee Hansard*, p. 74.

3.66 There are numerous other instances of delays in awareness of health issues, such as the recent investigation into the re–seal/de–seal of F1–111s at Amberley. Bearing in mind that there will be occasions when several years of assessment reveals limited causal connection with illness, there may be room for a much more pro-active strategy of information about health issues. Although there is good information available on research projects, and DVA believes that many veterans are aware of these,[92] perhaps more effort is needed to advise of research that has been undertaken in Australia and elsewhere on the range of concerns that currently serving members and veterans have, to provide readily comprehensible data on these issues, and to develop information strategies which include more personal contact. Although DVA may believe its role will decline with the passing of World War 2 veterans, there appears to be a demand from an informed audience for a continued level of service.

3.67 Where there is other physical evidence of injury, disease or exposure to events the individual may need still to take the initiative in documenting this until such time as processes are in place for institutionalised collection of data. It is also possible that keeping veterans up to date on information about particular issues may help allay some concerns. One example is exposure to depleted uranium (*du*) which has caused some concern, although evidence provided by the ADF indicates that exposure to this in the 1st Gulf War was limited as Australian forces were primarily naval where the risk of exposure was limited.[93]

3.68 Notwithstanding the fact that neither Defence nor DVA see *du* as likely to be a major problem in the future, it will continue to be a problem for some if the reasons for this belief are not clear. The relevant ADF Health Bulletin provides explanations,[94] but it also notes some changes in the previous assessment made by the RMA which considered *du* in the context of the Balkans conflict:

> …in reaching its view, the Expert Committee made various assumptions about background radiation levels in the Balkans region. These assumptions may not have been entirely relevant to the Gulf and Iraq regions. It is no longer safe to assume that the risks to health are as low as previously thought; however, the level of risk to Australian troops is still likely to be low.[95]

92 See Chapter 4, paragraph 4.80.

93 Budget Supplementary Estimates, FADT, 5 November 2003, p. 27.

94 Department of Defence, Director–General Defence Health Service, *Australian Defence Force Policy on Depleted Uranium Health Screening* (6 August,2003), Annex B, paragraph 5.

95 Department of Defence, Director–General Defence Health Service, *Australian Defence Force Policy on Depleted Uranium Health Screening* (6 August, 2003), Annex A, p. 2, last dot point. Nonetheless, the Health Bulletin also notes that the risks from *du* are less likely to be from radiation than from chemical toxicity. This is in line with overseas research which places little emphasis on the radiation problems and hence on urinary screening. See also Additional estimates, FADT, 18 February 2003, *Answers to questions on notice*, Defence, part 2, Question W22, p. 53, where further information is provided on Australian input into the level of *du* in the Balkans.

3.69 For Australian veterans, who do not appear to have experienced such levels of exposure, there may be very limited risk. If this is the case, it may be useful to ensure that a summary of US studies is made regularly available on the internet so that individuals can assess their levels of exposure against those persons who are the subject of study. As much the same information is available in the above–cited Health Bulletin, this should not create excessive additional work and would demonstrate the appropriate level of interest in the well being of those no longer serving.[96]

3.70 The United Kingdom Ministry of Defence also has substantial information on the Gulf War and related issues, which outlines in detail the research being undertaken, the discussion of various illnesses, and the situation with respect to claiming a war pension for symptoms as opposed to a disorder.

96 With respect in particular to information issues, it was considered the RMA might contribute to the more pro–active assessment of issues relevant to future deployments—something akin perhaps to the provision of data required for the development of health plans: 'A substantial amount of their work involves assessment of environmental factors. At present the information which is gained, in the form of Statements of Principles (SOPs), is used in a retrospective way to determine the acceptability of claims for compensation…There might therefore be scope for using their considerable expertise in monitoring, and anticipating, environmental hazards both for ongoing peacetime service in Australia and for overseas deployments'. However, this is not a suitable role for the RMA. Some of the issues raised about the role of the RMA may be overcome by the fact that the RMA is an observer of the Medical Advisory Panel (*Submission* 8, Repatriation Commission, p. 12, paragraph 59) which, among other things, reviews patterns of injury, disease and compensation.