Veterans Support Centre
Belconnen
ABN: 58534419650
9 Burkitt Street PAGE ACT 2614
PH (02) 6255 1599
Email office@vscact.org.au
Website www.vscact.org.au

Patron: Air Vice-Marshal Chris Debble AO CSC

Veterans Compensation and Rehabilitation Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2604

A Submission to the Veterans Compensation and Rehabilitation Inquiry being conducted by the Productivity Commission is attached.

The submission has been jointly developed by the Vietnam Veterans and Veterans Federation Inc. ACT (Veterans Support Centre Belconnen) and the Belconnen RSL Sub Branch.

We and our volunteer staff as appropriate are available to discuss or clarify any issues at any mutually convenient time. Indeed, Commission staff are very warmly invited to visit the Veterans Support Centre, Belconnen ACT if it would assist in gaining an understanding of the modus operandi of an effective veteran's support organisation.

Ian Thompson
President
Vietnam Veterans and Veterans Federation Inc ACT Belconnen
23rd June 2018

Ian Sayers, OAM
President
RSL Sub Branch
23rd June 2018

JOINT SUBMISSION INTO THE INQUIRY INTO VETERANS' AFFAIRS' LEGISLATIVE FRAMEWORK AND SUPPORTING ARCHITECTURE FOR COMPENSATION AND REHABILITATION FOR VETERANS (SERVING AND EX-SERVING) AUSTRALIAN DEFENCE FORCE MEMBERS BY THE VIETNAM VETERANS AND VETERANS FEDERATION ACT INC AND BELCONNEN RSL SUB BRANCH ACT

INTRODUCTION

This submission made jointly by the Vietnam Veterans and Veterans Federation ACT Inc (VV &VFACT) and the Belconnen RSL Sub Branch, is intended to offer the opinion of two Ex – Service Organisations (ESOs) who, in regularly seeking the delivery of services from the Department of Veterans' Affairs (DVA), are involved in the day to day business of supporting veterans.

It recognises that the inquiry will examine whether the system of compensation and rehabilitation for veterans (Serving and Ex-serving Australian Defence Force members) is fit-for-purpose now and into the future and review the efficiency and effectiveness of the legislative framework for compensation and rehabilitation of ex-service personnel and veterans and also acknowledges the Issues Paper released by the Commission in respect of the inquiry.

In being supportive of many views and perceptions expressed in, or assumed from, the Issues Paper, this submission takes the liberty to nonetheless provide detailed assessments and examples relating to the complexity of current legislation and difficulties encountered in the DVA claim entitlement assessment process. Comment is also offered on some wider strategic considerations of veteran support that are intended to be useful in helping the Commission to develop views as to how an alternate approach to veteran support might be reached.

The submission also is cognizant of a currently active ANAO audit into the efficiency of Veterans service delivery by the Department of Veterans' Affairs (DVA) to which the Vietnam Veterans and Veterans Federation ACT Inc and the Belconnen RSL Sub Branch made a joint submission.

This submission represents the views of some 800 members of the two organisations and importantly that of the Veterans Support Centre Belconnen ACT[1].

---

[1] The Veterans Support Centre Belconnen is an organisation operating under the umbrella of the VV& VFACT that delivers support services such as entitlements advocacy and welfare and is supported by Belconnen RSL Sub Branch.

VERY SPECIAL NATURE OF MILITARY COMPENSATION

At the outset, this submission is obliged to highlight the very special nature of reparation and support for veterans of the ADF that is justified by their exclusive vocation. No other Australian is expected to or may be directed to engage in conflict or war-like activity either within the country or oversea to defend their countries' interests. For almost a century this exclusivity and justification has been recognised by Governments and the citizenship of the land such that it has led to the formation of unique and specific Acts of Parliament to provide ongoing support to veterans. Very importantly, this distinction takes the needs of veteran's way beyond the bounds of generalised industrial style compensatory systems or straightforward public welfare. Thus this submission very strongly argues that veterans must continue to be treated expressly in a unique and specialised manner. They would not at all be tolerant of or consent to a policy that regards them as being recipients of public welfare.

As outlined in the Issues Paper, the term veteran is regarded as a person who has served in the nations' armed forces. However within that term, some veterans have endured Warlike service and the associated horrors of war whilst others have not notwithstanding that they may have encountered operational service with inherent danger. Very importantly, this submission states categorically that the veteran with Warlike Service must be treated with special distinction in respect of compensation and support. The justification for this belief simply is that war-like service produces physical and mental disabilities far more extreme than those resulting from peacetime operational service.

That is, within any restructuring of veteran's support legislation, different levels of compensatory support will be necessary to distinguish between the service person with War/Warlike service and those without. It will not be satisfactory for a legislative outcome of one degree of compensation for all.

Moreover, the use of the term 'veteran' as being anyone who has served at least one day in the ADF, including those with Warlike, Non-Warlike or peacetime service[2], leads to confusion, tends to moderate the meaning of 'veteran' and likely to draw an unfortunate discernment that all serving/ex-service people should be treated the same for compensatory purpose. Bluntly, its nonsense to argue that a person with just a few days service in the ADF can be regarded as a veteran and neither the general public nor the ADF fraternity would accept that it is so. In short, all persons who have served for more than one day in the ADF can be validly categorised as 'serving/ex-service' with a number of those being veterans of war or warlike service - this submission uses these terms.

That said, it is noted that technological developments in warfare can blur the distinction between those serving/served people who are not veterans and those who are as to the manner in which harm can be generated and imposed. For example, a serving/served person located in a Headquarters far distance geographically to the point of being in risk of no physical harm can yet be exposed to psychological trauma from exposure to graphic images or communications. It would be a simple case of that person being able to access compensatory support as a serving/served personage.

---

[2] Productivity Commission Issue Paper- May 2108

OVERALL VALUE OF CURRENT MILITARY COMPENSATORY SYSTEM

The Issues Paper suggests that veterans get better and more generous compensation than those in civilian field[3]. Whilst the VSC Belconnen can only make a very rudimentary comparison with other compensation systems, such a broad statement is surely arguable from a number of perspectives. But importantly, why should it not be so anyway? So this submission endeavours to outline the particular value and shortcomings of the DVA compensatory system as judged by experiences of people regularly involved in welfare and advocacy work and their very limited knowledge of the civilian systems.

The major advantages and values of the existing system are seen as the following:

a. Beyond the claim entitlement process, the DVA system works tolerably well. That is, once the serving/served person has an entitlement or benefit approved, then the system tends to run smoothly (pensions paid, medical services obtained, transportation arranged reliably and so on).

b. The Veterans Liaison Officer service provided at major hospitals is particularly valuable in providing guidance and assistance to veterans (note that it does not apply to serving/served people who are not veterans) particularly for post discharge, end of life and palliative care planning.

c. Three very important and valuable advantages of the medical treatment available from general practitioners, specialists, and hospitals are:

    1. It avoids any waiting list imposed by the public health system and generally ensures a choice of doctor.

    2. Veterans also avoid the very considerable 'gap' costs of surgeons and anaesthetists that must be met under private health by those who wish to avoid waiting queues.

    3. A range of prescriptive pharmaceuticals medicines are accessible that are not normally available

d. The DVA transportation system for transit to and from health services is valuable. DVA pensions carry valuable side effects such as a service pension being paid earlier in life and a war widow's pension being tax free (war widows also have access to beneficial income support supplements).

---

[3] Quote from Issues Paper: 'The unique features of military service have led to a system separate from, and more generous overall than, the system of workers' compensation and support generally available to civilian workers, including:

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

e. Budget Papers 2017/2018 indicate a DVA intention to spend $143m or roughly 1.2% of budget on commemoration. This is accepted as reasonable and an effective rejoinder to an oft-heard request from the veteran community to spend less on commemoration and more on benefits for the contemporary veteran.

f. Whether these functions or their equivalents are performed more reliably or efficiently or at all than in the civilian system is unknown.

The major disadvantages are seen as the following:

a. As outlined in considerable detail hereunder, the major shortcoming of current legislation is its complexity and adversarial nature with an attendant burden of proof for the claimant to a degree that is assumed to be far more frustrating than in the civilian compensatory field. For example, surely a person who say is seeking compensation for a motor car accident through green slip/CTP insurance would not have to endure the claim entitlement process (its complexity, need for advocacy, prospect of rejection, and requirement for onus of proof) that a serving/served person undergoes. That system is believed to be on a 'no fault' or 'no onus of proof'. Whether a member of the public in dealing with Centrelink for a pension would be subject to the sort of difficulties that some veterans and their advocates have faced in dealing with DVA[4] is questionable.

b. At some risk of appearing ungracious, some veterans judge that the fiscal value of many benefits and entitlements such as service and war widows pensions, are really quite comparable in value to public pensions to the point that they seem not to be all that different or overly generous.

c. Measured in monetary terms, DVA entitlements to medical services are basically on a par with the public health system. That is and in broad terms, a GP or specialist is paid the scheduled fee plus a fifteen percent supplement to provide services to veterans.

d. Nonetheless, the DVA system under either a Gold Card or White Card carries limitations that in some cases have forced veterans to maintain private health insurance. This has happened when DVA have refused to meet the costs of a specialist surgeon and then if the patient wishes to continue under the DVA system, the patient is forced to search and find a surgeon who will accept DVA payment. This might sound a prudent approach by DVA for efficiency purpose but the patient then has to search and haggle around the corridors of surgeons rather than being able to accept the specific recommendation of their GP. The problems are that other surgeons might not exist in the region or waiting lists and availability might apply.

[4] See examples at the Annex.

e. The existing system is short of the equivalent of private health cover in the sense that there is no automatic entitlement to private hospital although it is recognised that DVA has arrangements with some hospitals for the accommodation of serving/served personnel in private hospital. But veteran patients are regularly to be found in the public wards of hospitals.

Frankly, this submission is forced to a view that the Issues paper statement that the DVA system provides easier access to support (through a lower burden of proof for accepting liability for a condition) and a higher level of compensation than that available to other Australian Government employees is questionable. It leads to a very basic question as to why then and for what purpose is a large component of the $12b DVA budget being paid for basically what is available from the public system. In fact, a fair component of the DVA budget is perhaps offsetting the cost of public health anyway.

Whether these views are accurate or not are not so much the point but rather it is the perception that many veterans develop particularly when faced with the complex and adversarial nature of the existing system.

VIEWS ON RESOURCE ASPECTS OF EXISTING MILITARY COMPENSATORY SYSTEM

Overall, the DVA appears to spend about $12b[5] on the support of veterans. No doubt, there are many checks and balances to ensure that this commitment of public monies is done with due propriety. The underlying question is to what extent and how efficiently these funds serve veterans. This submission broadly suggests that the funds seem to be reasonably effectively spent once the veteran has gained an entitlement but the current system of entitlement assessment is hopelessly mired in the complexity and adversarial nature of legislation.

Beyond DVA's financial commitments, there is an attendant need to ensure that the total cost of the current system is taken into account because what tends to be not seen is the cost of advocacy that is met largely by ESOs. These organisations generally are run on 'shoe string' budgets with income largely derived from charitable donations and fund raising activities together with grants from areas such as the DVA BEST program. But the cost of meeting facility hire and office running costs can be substantial with for example, Veteran Support Centres in Canberra running at an annual budget of several hundred of thousands of dollars. Budgets of this magnitude place enormous strain on volunteer charitable organisations to remain financially viable.

The VSC Belconnen spends about $4506 per claim submitted to DVA. Interestingly, Budget Papers 2017/2018 indicate that the DVA planned to spend $269 evaluating a claim[7]. So a

---

[5] DVA Budget Papers 2017/2018
[6] See page 10
[7] Page 38, Budget Papers 2017/2018

logical and rather staggering conclusion is that the VSC Belconnen spends more than 1.5 times as much in preparing and following up a claim as has the DVA planned to spend in actually assessing and approving it! That is simply a damning indictment of the efficiency of existing arrangements. What it also demonstrates is the resources needed for advocacy purpose to investigate, develop and submit a claim under the existing complex and adversarial legislation.

It's an interesting aside that one of the major costs of the adversarial and complex military compensation system, namely that of advocacy and representation for the claimant, is not directly funded by the Government that establishes the legislation! One would rather think that a Government truly intent on providing care for its returned service people would want to financially assist those organisations who materially assist its veterans. For years, the Government has abrogated this responsibility and left it to the ESO community to accept and be carried out by volunteers. But an associated essential point is that ongoing grant funding of ESO's is critical if a credible system of advocacy representation is to continue.

A further worrying aspect surrounding the advocacy resource issue is the difficulty that ESO's are facing in maintaining the volunteer resources necessary to service the advocacy needs of serving/served personnel. Almost all ESO's are facing severe problems in one, enlisting volunteers for advocacy and two, convincing them to undertake the extensive training involved to develop competency and to spend upwards of three to five days a week on case management. Younger volunteers just are not coming forward with a result that ESO's are struggling to maintain numbers of advocates. For example, the advocate base at a Canberra based VSC has dwindled in the space of five years from a high of 25 Advocates/Pension Officers to 13 currently. Each of these has about fifty cases to manage at any one time.

It is presumed that the veterans' advocacy and support services scoping study being led by Mr Robert Cornall [8] will address this issue. In a 2001 audit, ANAO suggested that to ensure greater consistency in the level of service provided by voluntary advocates, DVA should consider the costs and benefits of supplementing their work with an advocacy service of choice funded on a fee-for-service basis. If advocacy must continue then this submission supports that recommendation but for different reasons. It is contended that ESO proficiency levels are normally well managed and certainly are so in the VSC Belconnen. Rather, the option of an 'outsourced' advocacy service should be seriously entertained for reasons of one, relieving overworked volunteer staffs in ESO's[9], two, providing an alternative path for dispensing advocacy services[10] and three, committing Government finally to accept responsibility for funding advocacy needs arising from their complex and adversarial legislation.

[8] Page 7 of Issues paper

[9] VSC Belconnen has volunteers working at least 2 full days per week & in some cases up to five.

[10] The volunteer numbers of ESO's is seriously threatened by ageing people & an inability to recruit younger veterans.

However, ESO financial resources are currently totally absorbed to accommodate advocacy needs met by the employment of volunteer advocates. That is, there are likely to be very limited resources available within ESOs to pick up the extra costs if they should have to employ paid advocates.

COMPLEX AND ADVERSARIAL MILITARY COMPENSATORY SYSTEM

Although the Issues Paper conveys a strong perception that the Legislative framework for the support of veterans is overly complex, this submission takes the liberty to very firmly reiterate that contention. Overall, the efficiency of both ESO's in making claims on behalf of serving/served personnel and DVA in delivering services is markedly affected and constrained by two key factors, namely the complexity of the Legislative framework and the adversarial nature of the claim entitlement process.

From a complexity viewpoint, there are currently three major legislations under which service claims can be made for veterans with eligible service; namely Veterans' Entitlements Act 1986 (VEA), Safety Rehabilitation and Compensation (Defence-Related Claims) Act 1988 (DRCA) and Military Rehabilitation and Compensation Act 2004 (MRCA) . Additionally, some ex-service people without Qualifying War or Warlike service also have entitlements, such as current arrangements for Non-Liability Health Care (Mental health and Cancer) and Declared Occupational Diseases (F-111 Reseal and Deseal, ADF Firefighters, Navy Jason Pistol Operators, British Nuclear Test Participants and Oberon Class Submarine Crew). Moreover, the DVA seems to be used by Government as a sort of a generalised convenient body to dispense industrial-style compensatory services for the ADF and in so doing, is extending its role to not only have responsibility to look after veterans of conflict, but in some cases, for all service and ex-service people.

This complexity is a direct function of legislative architecture and implicitly affects the efficiency with which personal claim entitlements are prepared by or on behalf of claimants and how those claims are assessed and processed by DVA. Both the process of claim preparation and claim assessment require organisations to counteract the complexity by having trained, knowledgeable, competent staff able to correctly assess the various Acts of Legislation. If incorrect judgements are made, then they can result in long iterative processes of claim rejection, counter arguments with reconsiderations and appeals that simply waste the time of both DVA and ESOs. There is statistical evidence available that points to such inefficiencies.

What is worrying in the opinion of the VSC Belconnen is that the impact of the legislation complexity seems to be getting worse. For example, more effort than that needed in the past is required these days to prepare cases with some contemporary veterans now in an age bracket where they have dual eligibility under both the VEA and DRCA together with the extension of entitlements under the transitional provisions of the MRCA Act. Currently, ESOs really need to make two claims on behalf of a veteran in these instances for the same case.

Moreover, different claim forms have to be completed for claims made under each legislation[11]. Additionally, DVA organisational changes with attendant staff reductions and relocations made ostensibly to improve efficiency as the VEA population decreases are believed to have actually produced inefficiencies in claim entitlement management as staff experience levels have dropped due to the impact of organisational restructure.

Veteran entitlement legislation is beneficial legislation, however, the fact that it is used as an adversarial system requires a veteran to make a claim for services on DVA and for that organisation then to disprove their case – the onus of proof is on the client. Again, this represents government policy but it's an inefficient system that encourages DVA staff to firstly establish that a veteran's claim is valid and if it is not then to reject claims. It very much depends on the training and experience levels of DVA staff to make correct decisions and to correctly apply the maxim that assessments should be made to the benefit of the veteran wherever possible. The flow on effect can reach way beyond the bounds of inefficiency because the difficulties of making claims by veterans simply leads to feelings of 'what's the use', 'it's all too hard' with an unfortunate result that entitled veterans don't get access to their entitlements. In the case of claimants with psychological or mental difficulties, these frustrations can be very demoralising, potentially harmful and life threatening.[12]

The system complexity makes it very difficult for a veteran to claim an entitlement without seeking assistance from an advocate. Generally, this advocacy assistance is provided by trained, experienced volunteer specialists from ESO's[13]. There are of course costs in providing this service to meet the need for the provision of consulting rooms, IT systems and administrative support staff. For example, the VSC Belconnen has a substantial annual budget of expenditure that is met by fund raising, donations and Government grants. Each claimed condition costs the VSC Belconnen in excess of $450 per condition.[14]

---

[11] A common form should be available to constitute a single 'funnel' to permit the entry of claims into DVA whatever the applicable Act.

[12] VSC Belconnen has an example where there is reasonable basis for believing that a suicide was contributed to by the nature of DVA claim responses.

[13] One such ESO is the VSC Belconnen

[14] Noting additionally that VSC Belconnen advocates are volunteers for whom VV& VFACT and the Belconnen RSL carry responsibility for their provision, training and support.

INEFFICIENCIES IN CLAIM MANAGEMENT

This submission opines that notwithstanding the findings and recommendations of previous ANAO audits, inefficiencies remain in DVAs' claim management processes particularly in respect of establishing and approving entitlements. Rejections lead, of course, to ESO review of the decision and determination and very likely to reconsideration requests being placed on DVA. This becomes a tiresome and burdensome iterative process of reconsideration for both DVA and VSC Belconnen that can extend for months and sometimes years, leading right through to review by the Veterans Review Board (VRB) and in some cases ultimately to an Administrative Appeals Tribunal hearing. Data from the Veterans Practitioner Activity Database (VPAD) relating to VSC Belconnen and which is indicative of both the claim submission workload together with the rejection rate for a 12 month period January/December 2017 is as follows:

- A total of 550 claims were submitted by VSC Belconnen; 70% were primary claims, 10% were for VRB action and 6% for AAT hearings.
- In respect of claims processed by VSC Belconnen and DVA for the period, a total of 390 were managed with 35% of claims rejected.

It is of course recognised that some rejections may be valid, but there are far too many that should have been simply found in favour of the claimant without the need for wasteful reconsiderations and reviews; this results in much inefficiency both within DVA and ESO's.

Statistics to differentiate between valid and invalid rejections are not readily available although outcomes from VRBs and AATs hearings give some indication of invalid initial assessments. At the moment for example, one VSC Belconnen advocate has five claims awaiting VRB review and four of these are confidently expected to be approved. In fact, ninety percent of VSC Belconnen claims assessed by the VRB are resolved in the favour of the claimant. In general and of all claims rejected, an advocate would normally expect an average success rate of 80% on appeal.

VSC Belconnen believes that the rejection rate is far too high and reflects a lack of understanding, experience and knowledge of claim departmental managers – often they do not seem to understand service organisations, structures, 'ways of doing business', service 'lingo', medical reports or even in some cases, relevant internal DVA directives and the Legislative Acts. VSC Belconnen advocates are very experienced and knowledgeable and in addition to the wasted time and effort in the ongoing counter argument of the validity of claims, it's a source of great frustration for them to be faced with incorrect judgements made by inexperienced staff. Specifically, VSC Belconnen advocates believe that DVA delegates lack:

- Knowledge of military service
- Ability to interpret service health records
- Ability to interpret medical reports
- Ability to correctly apply compensation acts
- Knowledge of Commission directives and guidelines.
- Ability to apply Beneficial Legislation principles.

Advocates sometimes feel that the DVA initial claim/s delegates are just processing the claims in a rudimentary and perfunctory manner without full investigation as required by the different Acts (VEA Section 35H - Duties of Commission in relation to claim, SRCA Section 72 - Manner in which claims are to be determined and MRCA Section 333 - Determination of claims).

Moreover, there is a perception within VSC Belconnen that DVA staff are prone to deliberately seek information (particularly medical opinions) or engender interpretations that support claim rejection[15]. Rather than acting in the best interests of the veteran; DVA staff often do not seem to accept the convention (indeed, expressly written into the various Acts) that where there is uncertainty or the validity of the case is finely balanced, a decision should favour the veteran. It does seem to advocates that DVA delegates sometimes go out of their way to reject claims and in some cases, appear to seek and then accept medical opinion that contradicts judgement containing substantial legitimacy and well-nigh impeccable professional diagnosis from specialists.

Some examples of incorrect claim assessments are at the Annex. Many more examples are held on VSC Belconnen files and the Commissions's review of them can be arranged as required – indeed, this submission would urge the Commission to include such a review as part of the inquiry.

So this submission is forced to a view that despite several audit findings dating back to 2001 and subsequent reviews, DVA has been unable to minimise the level of appeals; indeed, the situation may have regressed. Moreover, it's not clear that suitable strategies have been developed to encourage the settlement of appeals at the earliest possible stage.

Reference is sometimes made to varying levels of ESO advocacy service to veterans 'arising from their different levels of knowledge, expertise, experience and workload capacity. Whilst some degree of varying levels of advocate expertise will undoubtedly exist across such a large range of disparate volunteer organisations, the VSC Belconnen advocates are experienced and trained[16] and this submission contends that they do not contribute to inefficiency in claim management due to experience levels. It should be noted that ESO's do not commit their volunteer advocates to advocacy work unless they are qualified through

[15] VSC Belconnen has case examples available to support these contentions

[16] VSC Belconnen advocates have an average of 12.5 years of experience across the three relevant Acts.

appropriate mentoring, training and experience[17]; it would expose an ESO to substantial and unacceptable liability risks if it did so[18]. VSC Belconnen would be most willing to open its advocate competency procedures to the Commission.

However and in line with the comment above relating to a linkage between high claim rejection rates and DVA staff competency, the question of the management of experience and proficiency levels of DVA reviewing staff (particularly delegates) needs some evaluation. Whilst ESO advocates willingly recognise that there are some excellent staff within DVA, they also see varying levels of competency amongst DVA staff and in fact, also within the VRB; opinions provided by specialists can also vary widely in quality. The unfortunate consequence is a lack of consistency in claim management that leads to inefficiencies associated with claim reconsiderations.

Frankly, this submission opines that DVA demonstrably is incapable of developing and maintaining the required level of competency to handle claim entitlement processing within the current complex Legislation. Obviously, the Legislation must be less complex and the system of processing must be simplified.

This submission also categorically denies evidence to the Senate Inquiry which is suggestive that advocates routinely direct their clients to claim under the VEA because they lack SRCA and MRCA knowledge and further that they are trained by DVA and thus have a compliant attitude to accept a DVA outcome. That is simply not the case for VSC Belconnen and is fairly easily rebutted by consideration of the number of claims submitted under each Act and also the number of rejected claims that are then argued and taken to VRB and AAT.

MEDICAL ASSESSMENT ASPECTS

The Terms of Reference indicate that the use of the Statements of Principles and presumably the work of the Repatriation Medical Authority (RMA)[19] will be subject to specific examination during the Inquiry. This submission's view broadly is that in the current system where compensation entitlement is based on a claimant proving that a condition is due to their service, the Statements of Principles (SOPs) does help in consistent decision-making and provides reasonably sound medical-scientific evidence and the RMA is a respected and valued organisation. Notwithstanding, VSC Belconnen has encountered some difficulties with SOPs and has found them to be inflexible and not able to cover all conditions emanating from a single cause. However, and if the onus of proof remains for a claimant in any revised approach, then the arrangement should remain. The point is nonetheless made that if, the onus of proof is removed (as is for example the case of any Vietnam veteran aged 70 or more), and then the RMA probably could be dispensed with.

[17] Through TIP training in the past and now through the Advocacy Training and Development Program (ATDP) regime.
[18] VITA insurance policy requires advocates and welfare officers to be trained and authorised.
[19] Issues Paper – 'the use of the Statements of Principles as a means to contribute to consistent decision-making based on sound medical-scientific evidence'

Of far greater concern is DVA's use of Medico Legal Consultants of Australia (MLCOA) to provide specialist medical advice which tends to add to the complexity and efficiency of case resolution particularly when the MLCOA input seems to be generally supportive of the Department's decision makers when other evidence favourable to the applicant is not taken into account or may not have been given weight in the group's reports. MLCOA's independence is also questionable and the perception that then develops is whether because DVA engages and pays them (MLCOA), it feels some obligation to the Department rather than providing independent unbiased advice. It's another example of efficiencies arising from the adversarial nature of legislation and how DVA's management strategies tend to amplify the impact.

In fact, the matter of conflicting medical reports between DVA and claimants leads to an immense amount of emotion, animosity, frustration and lack of goodwill on the part of advocates and claimants. Surely, this business of 'medical specialists and reports at 10 yards' is almost infantile in nature and really the veterans of this nation deserve something better! One particular psychiatrist who exclusively has a DVA/military clientele is known to be simply giving up at the end of 2018 because he is extremely unhappy about DVA non-specialised medical opinion overriding his reports.

COMMUNICATIONS

Advocates and welfare officers get very frustrated by the inefficiencies in the DVA communication system and particularly the telephone arrangements. Long waiting times are very frequent and in the case of calls to the Canberra VAN office, a call often will simply ring out. It can be frustratingly difficult for an advocate to speak to a delegate on a particular case. Sometimes, the responses indicate that the DVA representative simply doesn't know the answer and reverts to 'put it in writing'. The transport line only operates in business hours so a veteran who has a transport booking fault after hours can get no assistance from DVA.

It is generally difficult to get through to DVA on some 1800 numbers without encountering delays. Frustratingly for over-worked and busy advocates and welfare officers, the same voice recording has been used by DVA to interminably advise of 'a higher number of calls than anticipated' for several years. It might save some money but whether it really is efficient is questionable. Certainly, it results in a lower standard of service because many callers simply give up and cannot then access the Department at all to receive services.

WAYS AHEAD TO IMPROVE AN INTOLERABLE SITUATION

There have been many reviews[20] in the past with a recent rash of studies, inquiries and audits. DVA keep making pledges to improve efficiency and introduce new paradigms of management with the most recent being the 'veteran centric'. Yet serving/served people end up still not receiving adequate compensation such that many don't know where to go to for assistance or how to get that assistance to the point that they are actually in risk of harm from the very system that should be supporting them. A range of options are apparent, ranging from the wholesale reconstruction of the system to continuing refinements and management initiatives:

- Move to a no fault/no liability compensatory system.
- Re-legislate to a single all-embracing Act
- Initiate more proactive measures to prevent conditions occurring in the first place and introduce the ADF to an incentive based involvement and sharing of the financial cost of military compensation.
- Improve advocacy and DVA management of claim submittal and entitlement processing.
- Various mixtures of one or more of the above.
- No Fault/No Liability/No Proof /Automated Approach

Noting that the DVA compensatory system works reasonably well once the claimant has gained approval, but it does stumble over the claim entitlement process. Surely one simple approach is to get rid as far as possible, the adversarial and complex approach that is a consequence of current legislation and which leads directly to most of the existing difficulties with DVA claim processing and ESO advocacy. That is, a 'no fault/no liability/no proof automated approach' approach should relieve DVA and ESO's of performing claim entitlement and submittal respectively with a consequential offset of resources.

Actually, a form of no fault/no liability compensation exists currently with the automatic 'Gold Card' entitlement of Vietnam veterans aged 70 or more. Presumably, it would not be difficult to extend the 'Gold Card' immediately to all discharged veterans (that is, those who have Qualifying War/Warlike service) of whatever age. The effect on cost structures, the offsets available versus the increases in costs arising from the increased 'Gold Card' population would need to be assessed. Moreover and noting that it might be a vexed issue with some GPs and specialists who currently charge more than the scheduled rate some thought needs to be given to the impact on the medical fraternity – there might be a risk of some not being prepared to treat an increased number of Gold Card' recipients.[21]

---

[20] DVA itself appears to have undergone about 15 reviews since 2001.

[21] GPs and specialists who charge more than the DVA adjusted scheduled fee but who treat under the gold card actually provide a medical service on a charitable basis.

Whether the 'Gold Card – no liability/proof' approach should be extended to cover all serving/served personnel is a vexed question, primarily because it would convey the same benefits to all whether having been exposed to war or not. Many veterans, particularly Vietnam veterans would believe that to be grossly unfair given the time they waited for a version of 'no proof' compensation and the shameful way they were treated.[22]

On balance, this submission does not contend that a 'Gold Card' status be given to all members on discharge from the ADF whether with Qualifying War Service or not. As argued previously, the veteran of conflict should be treated specially in terms of compensation. Unfortunately, this does imply that some form of claim advocacy and entitlement processing would have to continue where serving/served people with no qualifying service are treated by say a form of 'White Card' that recognises certain conditions.

However, it should be feasible to reduce the amount of claim advocacy and entitlement processing. Firstly, a 'White Card' equivalent could be issued to all serving/served people with no Qualifying War/Warlike service at point of discharge that carries automatic entitlements to any condition developed during service[23]. It would simply be up to a medical practitioner to authorise future treatment judged to be in accordance with the specified condition. There is no reason why a standard range of particular conditions could not be developed and applied based on an individual's service employment category.[24] DVA currently recognises 'top 15 conditions' that are claimed under the different Acts[25].

Clearly, some provisions need to be allowed for latent conditions occurring after discharge but caused by past service. These could include claim advocacy and entitlement assessment along current lines but of course this would mean that advocacy and claim entitlement would persist with continuing cost and the adversarial problem - this should be avoided if at all possible and options seriously considered.

As an example, one slightly radical approach could be for a discharged 'White Card' serving/served person with no qualifying service with a condition that person believes to be caused by past service to present for medical assistance and seek to be treated by a medical practitioner on the basis of the past service. The medical practitioner would certify such and seek payment from DVA accordingly. If DVA don't agree with that assessment, then the Department can then make argument at which point perhaps advocacy and further representation is needed. This then becomes a more proactive approach with the onus of proof moving from the claimant to the DVA.

---

[22] Quote by Air Chief Marshal Binskin, AC - Chief of Defence Force in Order of Australia Association Oration - 20 July 2015 'As a nation, we should be ashamed at how our Vietnam veterans were treated & the stigma they were forced to endure'.

[23] These conditions should be agreed by both ADF and DVA prior to discharge – that is, discharge does not occur until the conditions are noted, agreed and applied.

[24] For example, that all people who have been employed on parachuting operations will suffer from certain predetermined conditions.

[25] These are listed in the DVA Annual Report 2016-17, Part 1 - Performance.

The submission must concede that the greatest benefit would be obtained from moving totally to a no fault/no proof automated entitlement concept for both the serving/served and veteran bases by virtue of the ability to virtually dispense largely with the claim advocacy and assessment processes. Moreover, the submission acknowledges that the Government's mental health commitment to provide services to any serving/served person does provide a precedent for the granting of benefits to all serving/served personnel.

The military compensatory system which costs overall about 40% of the Defence budget, is very much defensive in nature rather than proactive; that is, the system is designed to respond to the adverse health conditions caused by military service particularly in War-like conditions rather than the application of pre-emptive measures designed to prevent the medical occurrence in the first place. As an example, much of the mental stress of service people deployed on Warlike Service results from their number of deployments. It's not uncommon to find service people on their eighth deployment over a three year period and spending 27 months of those three years on deployment. The impact on the individual and their families can be well imagined. The simple fact is that following reviews and downsizing, the ADF is under resourced in numbers of people with little forces in reserve to call on to supplement deployments. Again simply, the cost of meeting veterans' compensatory needs could be avoided by increasing the numbers of people in the ADF! That is, save money and the pain of conflict in the first place[26].

Frankly, there is a thread of hypocrisy in the Government's current approach to military compensation. On the one hand, the serving person is being subjected to stress arising from not only the specific needs of military service but also that arising from efficiency drives and reductions in resources. On the other, that person is discharged into an adversarial and complex compensatory system that has many faults and in some cases will not only provide inadequate compensation but can also actually cause additional harm. The serving/served person is not unwise and can readily see the falseness.

The ADF itself needs to be brought into the compensation system by exposure and commitment to the financial obligations arising from military service. Currently, it seems to the serving/served person that the ADF can wilfully submit its people to whatever conditions are needed and then simply cast them on discharge onto the DVA system. Some form of financial incentive system needs to be devised to encourage the ADF to be more proactive in its handling of people and their service induced disabilities.

The ADF needs also to look really closely at its health management organisation in terms of whether it is structured and able to effectively provide serving members with the appropriate, timely and effective medical support that is so important in a proactive sense for the ongoing management of ex-service people. While the ADF understandably must focus on operational capability, it is imperative that medical conditions caused by service are promptly, fairly and accurately recognised, recorded and managed.

---

[26] A side benefit clearly is that the ADF also increases its capability with an increase in personnel numbers.

ESO's hear repeated anecdotal evidence that key Joint Health Facilities are unable to maintain the required garrison health level of support and KPIs due to workforce limitations and operational priorities. In particular, there are apparently ongoing difficulties in arranging MECRBs, delays and complications in arranging specialist appointments that are now organised by off base contractors via an impersonal booking service, and medical staff with limited understanding of Defence health, policies and processes. On the latter issue, it is concerning that less than five percent of doctors in the ADF are in uniform [27] and the question then becomes of what impact that has on the critical member/Medical System/Chain of Command relationship.

There appears to be some evidence that the rationalisation and centralisation of single service health capabilities into Joint Health Command ADF health has resulted in a complex, dysfunctional and frustrating medical service that Units have trouble understanding and working with. No longer do ADF units have a dedicated Doctor and this probably results in poor member/unit relationships with the Joint Health Units.

Another enduring problem in ADF health is that people are often reluctant to present with conditions that might harm their prospects of remaining in service or their vocation category of service – that is, there is an enduring mistrust by serving people in medical classification process that seriously undermines the integrity of both the ADF's and the veteran's basis for health management. This has been a perennial problem for years that of course is neither in the interests of the ADF or the service person. But whilst it exists, medical discharge and more broader transition to civilian life remains complex, challenging and frustrating. Most importantly from a mental health perspective, there are probably ongoing stigma and workforce complications (such as needing to maintain high-level security clearances) associated with mental health and the need to ensure members receive the mental health support they need without fear of it impacting their career.

THE DO'S AND DONT'S FOR A REFORMED SYSTEM

Do have:

- Recognition of the special needs of serving and ex-service people together with the special needs of those who have endured the rigours of War or Warlike service
- A system with benefits of compensation that is based on those special needs of those who have served their country and not based or necessarily related to public welfare system.
- A 'no fault/no proof required automated entitlement' methodology for claim entitlement.
- A system that is broad enough to encompass both proactive and reactive methods of preventing, alleviating and treating serving/served people
- An incentivised system that involves the ADF in financial obligations for military compensation.

[27] Less than five percent of doctors in ADF health are believed to be in uniform.

- Single, simple Legislation
- Avoid need for the advocacy and claim assessment processes
- 'No fault' basis

Don't have:

- An adversarial system
- Requirement for advocacy and claim assessment
- Any conflict from medical assessments
- Any form of retrospective legislation that removes existing benefits from any person.

CONCLUSIONS AND RECOMMENDATIONS

Veteran legislation remains complex and adversarial in nature and in some respects, the impact has a more adverse impact now than in previous years. This complexity results in DVA inefficiency, particularly in the assessment of claims through incorrect entitlement judgements, iterative claim processing following claim rejections, VRB referrals and reconsiderations. Despite previous ANAO audits, the claim approval process within DVA remains inefficient and wasteful of effort with rejection and lengthy iterative reviews largely caused by inexperienced staff and perhaps exacerbated by a tendency to reject first and not find in favour of the veteran when the validity of a case is finely balanced.

Given the number of audits conducted that have all identified DVA shortcomings and inefficiencies in claim management over the last 15 years or so, this submission logically is forced to deduce that DVA is demonstrably incapable of effectively managing claim entitlement assessment under the current legislative regime.

The Commission might well find, as other reviews and inquiries have done, that the competency and experience levels of DVA claim approval delegates are inadequate particularly in respect of military service knowledge, ability to interpret service health records and medical reports and capacity to correctly apply legislation and associated directives and guidelines.

Overall, the DVA system is reasonably effective once a person becomes entitled. However the claim entitlement assessment process with its complexity and adversarial methodology is frankly defective and unworthy or indeed capable of being rectified. Simply put, it does not meet the needs of either serving/served or veterans and there is evidence to suggest that it can have a harmful effect. The legislation is complex and adversarial in nature and its application results in much argument and counter argument between delegates and advocates with a certain degree of frustration and animosity. A considerable bureaucracy has built up around the adversarial system involving reviews and VRBs and AAT actions. Then there are very frustrating and soul destroying conflicts between claimant and the DVA in respect of specialist medical reports (my report outguns yours). ESO's spend considerable

resources (more than what DVA spends on claim assessment) on the advocacy role and they are having difficulty in maintaining volunteer numbers.

After years of tinkering with the complex and adversarial system, it's time for change and the adoption of a simplified approach embracing no fault/no liability/automated entitlement to avoid as much as possible claim advocacy and claim entitlement assessment. One such approach might embrace the following:

- Issue of a 'Gold Card' to all veterans at point of discharge.
- Issue of a white card to serving/served people who do not have war or warlike qualifications at point of discharge that carries entitlements for treatment of conditions arising through service including some predetermined inevitable conditions arising due to service occupations.

Some increase in medical costs would occur but then there would be resource offsets arising from reductions in the claim advocacy and entitlement assessment processes.

A more proactive approach needs to be adopted for the compensatory management of serving/served and veterans particularly by the ADF who should be encouraged to take greater interest and involvement in their welfare. Some form of incentive program should be developed by the ADF so that they have a financial stake in promoting veteran welfare and in sharing the cost of people harmed by ADF service. Moreover, the ADF needs to examine the adequacy of its health system to contribute to the ongoing welfare of ex-service people.

ANNEX TO JOINT SUBMISSION FOR THE INQUIRY INTO VETERANS' AFFAIRS' LEGISLATIVE FRAMEWORK AND SUPPORTING ARCHITECTURE FOR COMPENSATION AND REHABILITATION FOR VETERANS (SERVING AND EX-SERVING) AUSTRALIAN DEFENCE FORCE MEMBERS BY THE VIETNAM VETERANS AND VETERANS FEDERATION ACT INC AND BELCONNEN RSL SUB BRANCH ACT

EXAMPLES OF CLAIM REJECTIONS/RECONSIDERATIONS

EXAMPLE ONE - RECONSIDERATION SUBMISSION

This submission is based on the contention that the investigating delegate did not consider all the relevant matters of the claim, as required by Section 333 Determination of claims, of the Military Rehabilitation and Compensation Act 2004 (MRCA). Section 333 of the MRCA states:

> *After the Commission has investigated a claim under section 324, the Commission must:*
>
> *(a) Consider all matters that, in the Commission's opinion, are relevant to the claim;*

The investigating delegate, in the letter of Decision, referred to several reports and in particular the specialist report from................, dated 21 October 2013. The other reports were from ....

In the evidence considered by the delegate it is clearly recognized that ....was suffering from Anxiety and Depressive Disorder prior to the diagnosis of Panic Disorder and was prescribed medication for their management and is receiving ongoing treatment for those conditions. The delegate makes no mention of these psychological disorders and has not given them any consideration in determining the claim.

It should be noted that Anxiety Disorder is a Statement of Principles (SoP) factor for Panic Disorder, Instrument No. 69 of 2009, Factor 6(e) which states, 'having a clinically significant psychiatric condition from specified list 1, at the time of the clinical onset of Panic Disorder'.

……………….'s Anxiety and Depressive Disorders should have also been assessed in the course of the investigation using the relevant SoP, Anxiety Disorder, Instrument No. 103 of 2014 and Depressive Disorder, Instrument No. 28 of 2008.

……………..' Anxiety and Depression were the result of being posted unaccompanied to Darwin in the Northern Territory and the circumstances she found herself in. The circumstances being the totally unfamiliar military culture and the uncertainty and concern with the betting pool of who could have sex with the new women on base. …………….had very little contact with the military during her University training and the practical requirements of her degree at Calvary Hospital in Canberra ACT. As ………..states, she wasn't even shown how to wear her uniform properly, let alone attending an induction course or advised of the proprieties and protocols of being a Commissioned Officer in the Army.

The Anxiety Disorder's relevant Factor is 6 (a) (iv) which states, 'experiencing a category 2 stressor within the six months before the clinical onset of anxiety disorder'. The category 2

Stressor applicable in this case are, (a) being socially isolated and unable to maintain friendships or family relationships, due to physical location, by being posted unaccompanied to Darwin in the Northern Territory, some 3000 kilometres away, (c) having concerns in the work environment, experiencing bullying in the work environment, by being criticized for her lack of military knowledge, being reprimanded for fraternizing and the uncertainty and concern with the sex betting pool. This was further exacerbated by telephone calls from her unit in Darwin, while receiving psychiatric treatment in Canberra.

The Depressive Disorder's relevant Factor is 6 (a) (v) which states, 'experiencing a category 2 stressor within six months before the clinical onset of depressive disorder'. The category 2 stressors applicable in this case are the same as for anxiety disorder.

From the evidence considered and used by the investigating delegate in the decision, it is evident that the anxiety and depressive disorders were present prior to the diagnosis of panic disorder. It is contended that if all the matters relevant to the claim had have been considered, then the panic disorder should have been accepted as a service injury because an anxiety disorder is a Factor for panic disorder. Therefore, the decision to reject the claim should be revoked.

………………

Pensions Officer

EXAMPLE TWO - MILITARY REHABILITATION and COMPENSATION ACT 2004 (MRCA) - RECONSIDERATION SUBMISSION

Re: ....

DVA No: ....

In a letter of decision dated 12 November 2015, Folio 1 to 14, a delegate of the Military Rehabilitation and Compensation Commission (MRCC) rejected a MRCA claim, Folio 15 to 25, submitted by Ms. .... for a labral tear of the right shoulder. This was later diagnosed as osteoarthritis of the right shoulder with an onset date of 12 February 2015, Folio 5.

It should also be noted that on 16 May 2015 .... had a right shoulder AC joint sprain injury accepted as a service injury, Folio 26 to 33. The injury was considered not to be permanent and stable so no Permanent Impairment payment could be made.

The reasons for requesting the Reconsideration by the MRCC are as follows:

1. In the Letter of Decision the delegate considered the definition of "trauma to the affected joint" from the Statement of Principles (SoP), Instrument No. 14 of 2010, Osteoarthritis, Factor 6 (f), Folio 9. A copy of the SoP is attached, Folio 34 to 45.

   The delegate stated:

   'In this instance, you stated that you felt a tear in your shoulder during a mock attack in 2011'.

   'However, I was unable to find any entries in your service medical records confirming any service related injuries to the right shoulder in 2011, let alone consider any further information supporting that a trauma occurred'.

   It should be realized that the service medical records provide by Defence Archive only relate to ....Regular Army Service. The years 2011 and 2012 are not included because .... was serving in the Army Reserve at that time. Perhaps these records are kept in another archive or retained by the administrating unit. Did the MRCC delegate attempt to obtain these records?

2. In considering the 2011 injury the delegate relied on a report by Dr................., dated 6 February 2015, Folio 46 to 48. The 2011 injury is only

the first of four right shoulder injuries. The MRCA Claim, Folio 15 to 23, and the attached Injury or Disease Details Sheet, Folio 24 to 25, lodged on 26 June 2015 attributes the right shoulder injury to the second injury which happened in 2013, not 2011, and is recorded in ....'s service medical records.

The delegate continues and further states:

> *'I have also found a notation on your service records dated 13/08/2013, where you presented with right shoulder pain after a fall the previous night when you hit a picket fence with your right shoulder. However, there are no further notations on whether you sustained the injury during work or even how long the symptoms lasted for the injury (for considering if it satisfies the "trauma" definition.*
>
> *As there is no other information supporting either event, this factor cannot be satisfied and linked to your ADF service'.*

In this instance, the delegate has not fully read or understood the notations made in ....'s medical records.

In an Outpatient Clinical Record dated 1600 hrs. 10 August 2013, Folio 49 to 51, notes in part:

- *Pt evacuated from Nav ex with pain in R shoulder and mid back, 7/10 (pain scale).*
- *Fell yesterday from standing height hit R shoulder on **star picket**.*
- *Evacuated pt to RAP for further assessment.*
- *Took 400mg ibuprofen with nil effect.*
- *11 August 2013 member given Cryo Cuff, Folio 51 to 52, for right shoulder.*

The notations translate into:

- Patient evacuated from Navigation Exercise and was therefore on duty at the time on a military field exercise. A Navigation Exercise is carried out in the field and involves the movement from one position to a second distant unseen position cross-country using a map and compass.
- The injury occurred on 9 August 2013 and was recorded on the 10 August not the 13 August 2013.
- Right shoulder hit **star picket**. This is a steel stake of various lengths used extensively by the military for constructing defensive obstacles

and barriers and usually involves the stringing of barbed wire in single strands or coils. It is not a picket fence, such as a wooden picket fence seen out the front of a suburban house.

- Patient evacuated from field exercise area back to main base Regimental Aid Post.
- Given pain management medication on 10 and 11 August.
  - 400 mg of ibuprofen with nil effect.
  - Mydol x 2 (paracetomol 500, doxylamine 5.1, codeine 10 mg)
  - Analgesia pm and routine medication
  - Anti-inflammatory 10g oxycodone
  - Panadine forte, panadine.
- Cryo Cuff fitted, see Folio 52.

It is clear that .... was on duty at the time of the injury, that she did suffer a trauma to the affected joint and the injury/s were serious enough to see her evacuated back to base and hospitalized overnight and for the next day. The injuries were such that medical intervention was required with a series of pain relief medications and the need to immobilize and support the right arm and shoulder with a Cryo Cuff.

3. In addition, the delegate investigating the claim has not considered Section 333, Determination of Claims, in the MRCA.

   Section 333 states:

   'After the Commission has investigated a claim under Section 324, the Commission must:

   (a) Consider all matters that, in the Commission's opinion are relevant to the claim; and
   (b) Determine the claim in writing in accordance with this Act'.

The delegate has not considered all matters that are relevant to the claim because:

(a) If .... already has a right shoulder service injury accepted by the MRCC it follows that.......... must have been on duty when the injury occurred to her right shoulder. Yet the delegate makes no mention of this accepted injury in the assessment of the new claim.

(b) The delegate has not included the **third** right shoulder injury that occurred on 28 February 2014, Folio 53, whilst on a military exercise at the Puckapunyal Army Training Area in Victoria and the on-going

difficulties associated with that injury, Folios 53 to 69, and then the aggravation of the injury which occurred on 28 July 2014, Folio 70 -71.

4. In the letter of Decision, Folio 1 the delegate stated:

*'I have **rejected** liability under Section 23 of the MRCA for;*
***Osteoarthritis of the right Shoulder** diagnosed on 12 February 2015.*

As I understand Section 23, it deals with the acceptance of liability for service injuries and disease. From the recorded evidence of ....'s service medical records, it is clear that the injury should have been **accepted** in accordance with Section 23 (1) (a) which states:

(a) 'the person's injury or disease is a service injury or disease under section 27'.

In this case Section 27 (a) and (b) would apply, which states:

27 Main definition of service injury and service disease

*For the purpose of this Act, an injury sustained, or a disease contracted, by a person is a **service injury** or a **service disease** if one or more of the following apply:*

(a) 'the injury or the disease resulted from an occurrence that happened while the person was a member rendering defence service'.

(b) 'the injury or disease arose out of, or was attributed to, any defence service rendered by the person while a member'.

It is contended that any one of these injuries or a combination of the injuries would have led to the final diagnosis of ....'s right shoulder injury.

Given ....'s well recorded 'on duty' injury history, the already accepted condition involving the right shoulder, the documented evidence recorded in her service medical records and the requirements of Section 23 of the MRCA, her right shoulder injury should have been accepted as a service injury.

If I can be of any further assistance, I can be contacted by the above contact details.

Mr. ....

Pensions Officer

EXAMPLE THREE - SECTION 31 REVIEW SUBMISSION

Re: ....

DVA No: ....

My grounds for appeal are as follows:

In a letter of Decision dated 13 December 2016 a delegate of the Repatriation Commission rejected a Veterans' Entitlement Act 1986 (VEA) claim for adhesive capsulitis of the left shoulder.

The cause of the claimed injury was having to have her shoulder immobilized in a sling after treatment for epicondylitis of the left elbow.

The delegate seems to have rejected this claim because the left elbow operation was not attributable to eligible or operational service. The elbow injury itself is currently subject to a Section 31 Review decision.

Factors the delegate failed to consider are:

1. Consider all matters relevant to the claim as required by Section 35H of the VEA;

2. The elbow operation and ensuing rehabilitation was medical treatment provided by the Commonwealth. Refer to the Consolidated Library of Information and Knowledge (CLIK): Compensation and Support Policy Library, Part 4, Disability Compensation Eligibility, para 4.4 Causal Connection of Injury or Disease with Service, sub-para 4.4.7 Injuries Resulting from Medical Treatment;

3. .... was required and obligated by her defence service to undergo all and any necessary medical and rehabilitative treatment required to maintain her medical and physical fitness to carry out her duties and maintain her operational preparedness as required by, the Military Personnel Policy Manual, Part 3: Medical and Physical Employment Standards, Chapter 1, para 1.7d and 1.7f and Australian Military Regulations, Section 435 respectively;

4. Using a sling was necessary in the rehabilitation process following the elbow operation and consequently, immobilizing her shoulder which caused the shoulder injury; and

5. The need for the sling was the single contributing factor for the left shoulder injury. Refer to the CLIK: Compensation and Support Policy Library, Part 4, Disability Compensation Eligibility, para 4.4 Causal Connection of Injury or Disease with Service, sub-para 4.4.2 Relationship of Injury or Disease to Service/Material Contribution.

Considering the above factors, an injury sustained as the result of medical treatment provided by the Commonwealth, is a requirement and member obligation to undergo such treatment and is the sole cause of that injury, then the adhesive capsulitis of the left shoulder should be accepted as a service injury.